STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155374	A. BUILDING 00 B. WING	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
POPLAR CARE STRATEGIES	313 POPLAR ST LOOGOOTEE, IN 47553

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00442476. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00442476 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: September 10, 11, & 12, 2024 Facility number: 000571 Provider number: 155374 AIM number: 100266920 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 5 Medicaid: 23 Other: 4 Total: 32 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed September 13, 2024.	F 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 09/12/2024 to the state findings of the recent complaint investigation. We are requesting paper compliance.	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a secured environment was in place to prevent a resident with dementia from exiting the facility and leaving the property. On	F 0689	It is the practice of this facility to ensure adequate supervision and a secured environment. **1 What corrective actions will be accomplished for those**	09/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Le Ann Petit | Administrator | 09/20/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	9/3/24, after being last seen by facility staff around 2:20 P.M., a resident exited the facility and was not realized to be missing until 3:15 P.M. when a search for the resident began. The resident was located by the Activity Director approximately 200 yards off facility property along a gravel road. (Resident C) This Immediate Jeopardy began on 9/3/24 when the facility failed to ensure Resident C did not exit the facility through an unsecured door toward the back of the building, located near the facility kitchen, and either walked behind or wheeled herself off the property and approximately 200 yards along a gravel road. The Activity Director located Resident C in a wheelchair alongside the gravel road while searching in a vehicle. Resident C was returned to the facility without incident or injury. The facility Administrator was notified of the Immediate Jeopardy on 9/10/24 at 4:45 P.M. The Immediate Jeopardy was removed on 9/11/24, but noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Finding includes: A review of facility reported incidents on 9/10/24 at 11:15 A.M., included an IDOH (Indiana Department of Health) Reportable Incident form completed by the Facility Administrator, with an incident date of 9/3/24 at 3:15 P.M., indicated that staff noticed Resident C was not in the facility and initiated missing person procedure. The resident was located and returned to the facility without injury. A follow up to the reported incident, added 9/5/24, indicated Resident C had exited through a back door of the facility and the door alarm did not sound.		**residents found to be affected by the deficient practice:**A Resident was located and returned to the facility. The patient was assessed and had no injuries noted. B Resident was placed on 1:1 monitoring until transferred to a secured dementia facility. The family was in agreeance to this transfer.C An all-staff in-service on elopement including identification of exit-seeking before and immediate action(s) to be taken if observed as of 9/10/2024.D All door alarms including alarm panels have been tested by Maintenance and no further issues identified. **2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:**a A nursing advantage elopement assessment was completed on all residents with a diagnosis of dementia or cognitive impairment and completed by 9/11/2024.b Elopement care plans were updated to reflect the current outcome of elopement assessments and staff alerted to those residents identified at increased risk. **3 What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:**a Daily inspection of exit doors will be conducted by	

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	On 9/10/24 at 11:20 A.M., the Facility Administrator indicated that Resident C had been outside in a courtyard with other residents and Activities staff on 9/3/24 and had been assisted back into the facility and left in a common area with other residents around 2:20 P.M. At approximately 3:15 P.M., RN 6 began a search for Resident C after she realized the resident had not been seen for a while. The Activity Director took a van to search off the facility property and found Resident C along a gravel road that passed along the facility property. It was believed the resident had exited out a back door near the facility kitchen. After the resident returned to facility, it was found that the back door near the kitchen was not alarming when opened. An observation of the back door and facility property on 9/10/24 at 11:25 A.M. included that the back door was not locked, but had a key pad that required a code to disable the alarm system. After exiting the door onto a concrete pad and parking area, the facility property ended along Elm Street, which turned from pavement to gravel just passed the facility's property. A horse pasture and barn were observed approximately 200 yards from the end of the facility property. The Facility Administrator indicated Resident C was found in a wheelchair along the facility side of the gravel road across from the barn and was returned to the facility at approximately 3:25 P.M. on 9/3/24. An observation of an electronic security control panel behind the nurse's station on "Hall 2" on 9/10/24 at 11:30 A.M., included a light and a push button for each facility door. The Facility Administrator indicated staff were able to see when a door had been opened and if the key code had not been used prior to opening the door, an		the maintenance director and/or designee. Immediate corrections will be made if any malfunctions are found, including necessary increased supervision and/or secondary alarm placed, as necessary, until said corrections completedb All staff have been in-serviced on door alarms and alarm panels as of 9/11/2024. c A checklist has been posted at both alarm panels for staff to confirm alarms are on and functioning every two hours. Immediate corrections will be made if any malfunctions are found including necessary increased supervision and/or secondary alarm placed, as necessary, until said corrections completed.d All staff have been in-serviced on elopement as of 9/10/2024.e An elopement/dementia in-service will be done quarterly and as needed for all staff.f Elopement drills will be conducted every month and/or as needed.g 30-minute safety checks added to residents that identify as an increased risk of elopement. Plan of care have been updated.h Any residents that are actively exit seeking will be placed on 15-minute checks for 24 hours and re-evaluated for further observation needs. i An audit will be completed Weekly x4 weeks, monthly for 3 months, then quarterly for 2 quarters to ensure alarms are being checked every	

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	alarm would sound and affiliated light would flash. Staff then would be able to see which door was alarming and could silence the alarm by pushing the affiliated button. After silencing the alarm, staff would have to push a reset button that would then secure the door alarm. It was found on 9/3/24 that the back door Resident C was able to exit from had been silenced for an unknown reason, and had not been reset. A record review on 9/10/24 at 11:45 A.M., indicated Resident C's diagnoses included, but were not limited to, Alzheimer's disease, vascular dementia, type II diabetes, and chronic obstructive pulmonary disease. Resident C's most recent Quarterly Minimum Data Set (MDS) assessment, dated 6/19/24, indicated the resident had severe cognitive impairment, had no functional impairments to extremities, used a walker and/or wheelchair for ambulation, could walk 10 feet with supervision of one staff and could ambulate 50 feet in a wheelchair with partial to moderate assistance of one staff. Resident C's comprehensive care plan included, but was not limited to: A focus of resident had impaired cognitive function/dementia or impaired thought process due to Alzheimer's disease (initiated 6/18/24) with interventions that included, but were not limited to, cue, reorient and supervise resident as needed (initiated 6/18/24). A focus of resident had a successful elopement attempt from the facility (initiated 7/1/24) with interventions that included, but were not limited to, redirect resident from doors if exit seeking (initiated 7/3/24). A focus of resident is at risk for elopement (initiated 8/15/24) with interventions that included,		two hours. j An audit will be completed weekly x4 weeks, monthly for 3 months, then quarterly for 2 quarters to ensure elopement drills and in-services are completed.k An audit will be completed weekly x4 weeks, monthly for 3 months, then quarterly for 2 quarters to ensure effectiveness of interventions related to exit seeking.l Nursing advantage elopement assessment will be completed on admission, quarterly, and with significant changes.**4 How the corrective actions will be monitored to ensure the deficient practices will not occur:** A. Quality Assurance Assessment Audit Tool will be completed by the director of nursing/ designee weekly x 4 weeks, monthly for 3 months, then quarterly for two quarters. Any identified issues will be immediately addressed. The outcomes will be reviewed through the facility quality assurance program. Monitoring will continue as planned or will be increased by the quality assurance committee, if needed, to obtain 100% compliance. Additional action will be taken by the quality assurance committee if warranted, based on the outcomes of tools. 5. By what date the systemic changes wil be made: 9/12/2024	

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	but were not limited to, allow resident to roam through out facility freely (initiated 8/15/24) and check function of WanderGaurd every shift (initiated 8/15/24). Resident C's elopement risk evaluation, dated 6/22/24, indicated Resident C had a history of elopement or an attempted elopement while at home, had a history of elopement or attempted leaving the facility without informing staff, had verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door, wandered, and that the resident was at risk for elopement. Resident C's physician orders included, but were not limited to, WanderGaurd bracelet (a device that triggers door alarms and locks monitored doors to prevent the resident from leaving unattended) with an order date of 6/24/24. Resident C's nurse's progress notes included, but were not limited to the following: On 6/26/24 at 3:25 P.M. - Resident confused to where she is. Has been wandering throughout facility. Has WanderGaurd in place. Was looking out window on South Hall and pushed the door open. The alarm sounded and resident did not get out of the doorway. On 6/28/24 at 8:30 A.M. - Resident wandering the halls. Resident pushed on door at the end of the hall, setting off door alarm. Staff redirected resident and reset the alarm. On 6/29/24 at 11:20 A.M. - The door alarm was sounding and staff immediately went to door to find resident sitting in her wheelchair in the back parking lot. Resident had been in the parking lot		!--[if=""">a	

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	for approximately 30 seconds before staff assisted resident back into facility. Resident wearing WanderGaurd bracelet and bracelet was functioning, however there is not a Wandergaurd security system set up at the back door. On 7/2/24 at 2:11 P.M. (Social Service Care Conference Note) - Spoke to residents family about the resident's future in the facility. If resident's condition improved and elopement was possible, would her needs be safely met in a facility that was designed more for wandering. Recommended another facility and family in agreement with recommendation. A transfer notice was presented at that time. On 7/8/24 at 6:27 P.M. - Resident pushed door open on rehab hall and set off the alarm. On 8/3/24 at 6:45 P.M. - Resident had been exhibiting exit seeking behaviors. Resident attempted to exit therapy door by shower room which was not an outside exit. Resident stated she wanted to go home. On 8/19/24 at 11:25 P.M. - Resident became agitated, confused, and combative with staff. Resident was exit-seeking and placed on one-to-one supervision. On 9/3/24 at 1:15 P.M. (back dated to incorrect time) - Resident exited back door of facility and was found sitting in her wheelchair. Staff brought resident back to facility. Resident voiced needing to check on her lawn mower. Resident has severe cognitive deficits related to dementia. WanderGaurd in place to left ankle and functioning properly. However, the back door that resident exited through was not equipped with the WanderGaurd system.			

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	During an interview on 9/10/24 at 2:30 P.M., the Facility Administrator indicated that Resident C was not discharged following the elopement on 6/29/24 and after the notice of transfer was given and agreed to on 7/2/24 due to the resident being hospitalized and had a decline shortly thereafter. Resident C knew other residents at the facility and it was decided to let her stay at the facility. During an interview on 9/10/24 at 3:35 P.M., the Director of Nursing (DON) indicated that the back door alarm system should not have been silenced at the time Resident C was able to exit the facility on 9/3/24. During an interview on 9/12/24 at 10:15 A.M., the MDS nurse indicated that a plan of care should have been created as soon as possible following the elopement risk assessment completed on 6/22/24 that indicated the resident was at risk for elopement. On 9/10/24 at 4:00 P.M., the Facility Administrator supplied a facility policy titled, Elopement Risk/Unsafe Wandering, dated 10/5/11. The policy indicated, "...Residents Identified At Risk For Elopement... Residents whose assessment identified unsafe wandering behavior shall also be considered at risk for elopement. If a resident is identified at risk for elopement the following steps may be taken: An alarm bracelet may be placed on the resident to audibly alert staff of attempts by the resident to exit. The care plan shall address behavior using resident specific goals and approaches as assessed by the Interdisciplinary Team... Facility staff will ensure that all exit alarms are responded to immediately... Resident with an elopement incident from the facility either on or off the grounds shall be considered at higher risk			

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	for further attempts at elopement. These residents will have the following precautionary measures implemented to prevent repeat incidents of elopement. Resident will wear an alarm bracelet to alert staff if he or she is trying to leave facility... When a door alarm sounds, the facility will: Check alarm panel to determine which door has been opened... Reset the door alarm after it is determined by visual check that no residents have exited the building inappropriately, or is returned to the facility... Any employee deactivating an alarm may face disciplinary action..." The Immediate Jeopardy, that began on 9/3/24, was removed on 9/11/24 when the facility in-serviced staff on elopement prevention and ensured the exit doors were secured with alarms that remained on, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to the systemic plan of correction that had been developed and implemented to prevent recurrence. This citation relates to Complaint IN00442476. 3.1-45(a)(2)			