STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 00 B. WING	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457595 and IN00458454. Complaint IN00457595 - No deficiencies related to the allegations are cited. Complaint IN00458454 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: May 13 and 14, 2025 Facility number: 001127 Provider number: 155771 AIM number: 200247220 Census Bed Type: SNF/NF: 34 NF: 93 Residential: 143 Total: 270 Census Payor Type: Medicare: 11 Medicaid: 97 Other: 19 Total: 127 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 15, 2025.	F 0000	The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to prevent a severely	F 0689	**What corrective action(s) will be accomplished for those**	05/19/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon	Logan	05/30/2025

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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	cognitively impaired resident from exiting the facility without staff knowledge for 1 of 3 residents reviewed for elopement. (Resident B) Findings include: During an interview on 5/13/25 at 11:26 a.m., Qualified Medication Aide (QMA) 1 indicated, on 4/27/25, Resident B got on the elevator after the dietary aide scanned their badge to open the elevator doors. Resident B wore a wanderguard so an alarm should have sounded when she approached the threshold of the elevator. On 5/13/25 at 11:29 a.m., observed Health Center (HC) 2's elevators from the HC2 common area. There were two elevators side by side marked 2 (elevator on the right side) and 2A (elevator on the left side). To the right of each elevator door, were the up and down buttons and a little black box marked elevator. To the right of elevator 2's door was another black box marked code alert and above the box marked code alert was a larger white box with a touch screen to enter a number code. Elevator 2 opened to a common area, on the first floor, that led to the front entrance. At that time, LPN 1 indicated the staff had to scan their badge on the black box marked elevator for the elevator door to open. The black box marked code alert, and the larger white box were for the wanderguard alarm, so if a resident who wore a wanderguard approached the threshold of the elevator an alarm sounded, and staff had to scan their badge or type a code into the larger white box to shut off the alarm. LPN 1 used another wanderguard to approach the elevator threshold and the alarm sounded. The alarm was shut off when LPN 1 scanned her badge on the black box marked code alert.		**residents found to have been affected by the deficient practice?** No other residents were affected. Resident B was at risk for elopement related to impaired safety awareness. Resident had removed wander guard and hid it behind a picture frame. Wander guard was replaced for Resident B on 4/27/2025. Care plan interventions included, but not limited to Distract Resident B from wandering by offering pleasant diversions, structured activities, food, conversation, or television. Nurse Supervisor in serviced Health Center 2 staff on 4/27/2025 (Attachment #1). DON and Supervisors in serviced all other clinical staff on 4/28/2025 (Attachment #2). The Culinary Director in serviced culinary Staff on 5/3/2025 (Attachment #3). The Culinary aide was given a disciplinary action by the Culinary Director dated 4/28/2025 (Attachment #4). All staff received a mandated elopement training via Relias on 5/14/2025 with completion by 5/30/2025. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who have a wander guard and/or are an elopement risk have the potential to be	

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	The clinical record for Resident B was reviewed on 5/13/25 at 12:35 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, anxiety disorder, and osteoporosis. A care plan, dated 8/4/23, indicated Resident B was at risk for an elopement related to impaired safety awareness. The interventions included, but were not limited to, distract Resident B from wandering by offering pleasant diversions, structured activities, food, conversation, or television(initiated on 8/4/23) and apply wanderguard to Resident B's left ankle (initiated on 8/4/23 and revised on 4/28/25). A quarterly Minimum Data Set (MDS) assessment, dated 2/27/25, indicated Resident B was severely cognitively impaired. A Wander/Elopement Risk Assessment, dated 2/27/25, indicated Resident B was a low risk for elopement. A progress note, dated 4/27/25 at 6:17 p.m., indicated Resident B had just walked past the nurses station with her walker. Writer was charting on the computer and said hi to Resident B. At approximately 4:30 p.m., received phone call from residential unit stating that they found Resident B outside in the front of the building . Resident B was returned to the unit by the weekend supervisor. On 5/13/25 at 1:55 p.m., the Administrator in Training (AIT) provided a copy of a disciplinary action form, dated 4/28/25, and indicated this was the disciplinary action taken when the dietary aide allowed Resident B onto the HC2 elevator. A review of the document indicated, on 4/27/25, the dietary aide called for the elevator for Resident B		affected. Nurse Supervisor in serviced Health Center 2 staff on 4/27/2025 (Attachment #1). DON and Supervisors in serviced all other clinical staff on 4/28/2025 (Attachment #2). The Culinary Director in serviced culinary Staff on 5/3/2025 (Attachment #3). The Culinary aide was given a disciplinary action by the Culinary Director dated 4/28/2025 (Attachment #4). All staff received a mandated elopement training via Relias on 5/14/2025 with completion by 5/30/2025. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All residents with wander guards were audited to ensure wander guard was in place and documented on the MAR. A new wandering elopement risk screening assessment was completed for Resident B on 4/27/2025. Resident has orders for nursing staff to check placement and functionality of Resident B's wander guard every shift. Monitoring of the wander guard for Resident B is ongoing. Staff will be trained on elopement upon hire and annually thereafter. Elopement drills continue to be completed every quarter. Human Resources has been directed to ensure that the elopement trainings are programmed into the	

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	who was later found in the parking lot. The elopement policy was reviewed with the dietary aide. The document was signed by the dietary aide. On 5/14/25 at 8:41 a.m., observed the path Resident B walked when she exited through the main front entrance doors. Resident B entered the HC2 elevator 2, and went to the first floor. The elevator opened to a common area hall, with carpeted floors, that led to the main front entrance approximately 100 yards from the elevators. Just before the main front entrance door was a receptionist desk. Immediately outside the main front entrance door was a covered area 30 feet by 30 feet, that covered the driveway and entrance. A well-kept sidewalk led from the front door down, approximately 100 feet, on each side of the building. On the west side of the main entrance the sidewalk led to a smaller entrance approximately 50 feet from the main front entrance, a gazebo approximately 60 feet from the main entrance, and a stop sign at the end of the sidewalk. At the stop sign there was a driveway that led to the parking lot. On 5/14/25 at 9:02 a.m., observed the security footage, dated 4/27/25, when Resident B exited through the main front entrance. At that time, the Maintenance supervisor indicated Resident B used elevator 2 to get to the first floor. A review of the security footage indicated: - At 4:02 p.m., Resident B walked outside the main front entrance with her rollator. She stopped and turned to the right (west side of main entrance). - At 4:03 p.m., Resident B started to walk down the driveway. She did not use the sidewalk.		Relias Platform. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Unit Manager and/or her designee on each unit will do random audits to check all residents who have a wander guard have their device in place and accurately recorded. This audit will be completed daily for one week, then three times for one week, and then randomly once a week for two weeks. Unit Managers will bring the results of these audits to the monthly Quality Assurance Meeting. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. Once 100% compliance has been achieved, the committee may decide to stop the written audits. The DON and Unit Managers are responsible for implementing and monitoring this plan. **By what date the systemic changes for each deficiency will be completed?** 5/19/2025	

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	- At 4:07 p.m., Resident B walked up onto the sidewalk near the stop sign. - At 4:08 p.m., Resident B stopped near the stop sign at the end of the sidewalk and turned around. Resident B started walking back toward the gazebo. - At 4:12 p.m., Resident B walked to the smaller front entrance and tried to open the door manually instead of using the handicap button. She was not able to open the door enough to get her rollator inside. - At 4:13 p.m., another resident approached Resident B, in an electric wheelchair, and held the door for Resident B to walk back inside. The smaller front entrance entered into the residential area of the facility where she was met by staff. On 5/13/25 at 9:25 a.m., the AIT provided a copy of a facility policy, titled Elopement, dated 11/2019, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility that all necessary steps were taken to protect at risk resident from the risk of elopement. All partners will be trained on hire regarding elopement controls, elopement/wandering and missing persons policies and procedures. This citation relates to Complaint IN00458454. 3.1-45(a)(2)			