STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155682	A. BUILDING _____ B. WING _____	C 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT HEALTH CAMPUS	1325 ROCKPORT RD BOONVILLE, IN 47601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of complaint IN00430645. Complaint IN00430645: Federal/state deficiencies are cited at F689. Survey dates: March 18 & 20, 2024 Facility number: 002724 Provider number: 155628 AIM number: 200309330 Census Bed Type: SNF: 13 SNF/NF: 40 Residential: 27 Total: 80 Census Payor Type: Medicare: 13 Medicaid: 32 Other: 8 Total: 53 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 22, 2024.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate supervision was in place to prevent a resident with a history of exit-seeking behavior from exiting the facility for 1 of 3 residents reviewed for elopement. A resident unknowingly exited the facility and was found in the facility's parking lot approximately 45 minutes later. (Resident C) Finding includes: During a review of facility reported incidents on 3/18/24 at 10:15 A.M., an incident dated 3/13/24 at 7:07 P.M. included that a staff member noted resident C to be sitting in his wheelchair near the heath center sign located outside the health center entrance. During record review on 3/18/24 at 10:45 A.M., Resident C's diagnoses included, but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting non-dominant side, dysphagia, aphasia, depression, unsteadiness on feet, lack of coordination, and history of falling. Resident C's most recent quarterly MDS (Minimum Data Set) assessment, dated 1/12/24, included that the resident's cognition was severely impaired, used a manual wheelchair for locomotion, and could wheel himself 50 feet with partial/moderate assistance. Resident C's physician orders included but were not limited to check function of wandering alert	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

bracelet/device daily (started 8/28/23).

Resident C's care plan included, but was not limited to Resident exhibits exit-seeking behaviors. A target goal included, resident will not elope from the facility (started 8/28/23).

Resident C's nurse's notes included the following:

8/27/23 6:16 P.M. - Resident has been wandering today. He was sitting by front door but not trying to exit. Another resident's family exited out the door to sit on entrance. Resident C followed them out there. Staff went looking for him and found him sitting outside with other resident's family. Staff asked the family if they were going to leave, to come find staff so staff could assist Resident C back inside. Family came back in the building and left Resident C outside alone. Resident was found laying in the parking lot. When the other resident's family was leaving the facility they found Resident C near their car laying on the ground.

03/13/2024 at 8:00 P.M. - Resident was found outside by a staff member leaving for the day. Noted resident was outside the front entrance and was brought back in. Resident had wander guard on his wheelchair, but the alarm system was not functioning. Resident was brought to a secure location to monitor his safety and well being. 15 minute checks started on this resident.

During an observation on 3/18/24 at 2:40 P.M., Resident C was laying in bed with his wheelchair next to the bed. A wander guard bracelet was around the resident's wheelchair.

During an interview on 3/20/24 at 9:00 A.M., LPN

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F 689	Continued From page 3	F 689		

4 indicated that Resident C can transfer himself to his wheelchair and can wheel himself around the facility. LPN 4 indicated the resident often wanders and likes to look out the facility doors. LPN 4 indicated the main entrance door was not functioning properly when Resident C was able to exit on 3/13/24. Staff check the residents' wander guard bracelet to ensure proper functioning daily and chart in the record. Maintenance checks the doors Monday - Friday and assigned staff check the doors on the weekends.

During an interview on 3/18/24 at 1:22 P.M., Activities 6 indicated that she saw Resident C sitting outside in the parking lot just past the health center sign on 3/13/24. Activities 6 indicated that she was leaving the facility for the day when she saw Resident C and that he was happy to be outside and found it funny that he was able to get out.

During an interview on 3/18/24 at 12:52 P.M., Maintenance 8 indicated that the device he uses to check the doors indicates that door is functioning properly but the alert system did not detect the resident's wander guard bracelet and the door did not lock as it should have.

During an interview on 3/18/24 at 1:15 P.M., LPN 10 indicated that the doors should automatically lock and signal an alarm when a resident with a wander guard is in close proximity to an exit.

During an interview on 3/18/24 at 10:45 A.M., the facility administrator indicated that Resident C was observed on camera exiting the health center main exit door at 7:07 P.M. on 3/13/24 and was brought back inside at 7:53 P.M. The facility administrator indicated that the wandering alert

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F 689	Continued From page 4	F 689		

system had been checked on the doors and that the main health center door is currently not being used. A new wander alert system had been ordered and would be installed as soon as possible.

On 3/18/24 at 2:15 P.M., the facility administrator supplied a facility policy titled, Elopement Risk Assessment and Prevention, dated 12/31/23. The policy included, "...These policies assist to define the mechanisms and procedures for monitoring and managing residents at risk for elopement, help to minimize the risk of a resident leaving a safe area without authorization and/or appropriate supervision... Procedure... 8. A check will be completed of alarmed doors and individual resident alarms to ensure proper functioning..."

The deficient practice was corrected on 3/14/24 after the facility implemented a systemic plan that included the following actions: Ad HOC QAPI on 3/14/24 an action plan included inservice review of policy for elopement with all staff, wander guard sensor and testing, elopement risk assessments of all residents, and the on going monitoring of the residents for elopement risk, staff training with elopement drills, and the monitoring of the wander guard system.

This tag relates to complaint IN00430645.

3.1-45(a)(2)