STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155684	A. BUILDING _____ B. WING _____	C 12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHFIELD VILLAGE	6450 MIAMI CIR SOUTH BEND, IN 46614

(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 Complaints IN00369177. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00369177 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey dates: December 20 & 21, 2021 Facility number: 002662 Provider number: 155684 AIM number: 200315930 Census Bed Type: SNF/NF: 38 SNF: 13 Residential: 46 Total: 97 Census Payor Type: Medicare: 5 Medicaid: 28 Other: 18 Total: 51 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/27/21.	F 000		
F 689 SS=J	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	F 689		

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

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F 689	Continued From page 1 as free of accident hazards as is possible; and §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 a resident with severe cognitive deficits, who was identified as a high risk for elopement and wore a wanderguard (electronic wander management device), did not exit the building unattended for 1 of 3 residents reviewed for elopement, of 14 residents at risk for elopement. (Resident B) The Immediate Jeopardy began on 12/9/21 at 11:36 P.M., when Resident B was last observed on the facility's video surveillance system exiting the facility. The resident spent the night outside, and was located by a staff member 7 ½ hours later, on 12/10/21 at 7:10 A.M. The Administrator was notified of the Immediate Jeopardy on 12/20/21 at 1:56 P.M. The deficient practice was removed, and the deficient practice corrected on 12/17/21, prior to the start of the survey and was therefore Past Noncompliance. Finding includes: During a tour of the kitchen, on 12/20/21 from 9:50 A.M. - 9:54 A.M., an entrance/exit door from the dining room to the kitchen area was observed. In the kitchen, on the other side of the room, was another exit door to an employee corridor with an entrance/exit door to an outside dock area with a sidewalk/driveway which led to the employee parking lot.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

A facility self-reported incident, dated 12/10/21 at 7:10 A.M., indicated Resident B was found outside the facility and staff had been unaware of her location. An investigation was conducted and it was determined the resident was able to gain access to the kitchen and exited from the loading dock.

On 12/20/21 at 10:58 A.M., a review of Resident B's clinical record was conducted. The resident's diagnoses included, but were not limited to: dementia, adult failure to thrive and muscle weakness.

The Annual Minimum Data Set (MDS) Assessment, dated 11/24/21, indicated the resident had severe cognitive deficits and had wandering behaviors daily, with no risk of getting outside the facility, and she wore a wander/elopement alarm daily.

A Care Plan, dated 3/2/21, indicated the resident was at risk of an elopement. The interventions included, but were not limited to: apply wanderguard to wrist and monitor placement/function, if attempting to leave re-direct and conduct an "at risk to wander" assessment per policy.

The Elopement Assessment, dated 11/29/21, indicated resident was high risk for an elopement and wore a wanderguard.

A Progress Note, dated 12/10/21, indicated ..."resident was found outside wondering [sic] in back of building, resident has no explanation on how and why she got out the building, when first found BP [Blood Pressure] was 183/99 HR [heart rate] 98, temp [temperature] 96.0, at 7:15 am,

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when resident was found, knees to pants and shoes had dirt on them, no injuries or alterations to skin noted, resident had no change in LOC [Level of Consciousness], at 7:45 am BP was 153/97, temp 96.4, HR 86, [resident daughter's name] was notified ...will continue to monitor, full body assessment was performed, resident has redness and swelling to ankles, which is usual, also has slight redness to right side of scalp and right ear, resident is currently in bed resting with no pain noted ...."

The local area weather history for December 10, 2021, indicated the temperature at 12:54 A.M. was 38 degrees , at 4:13 A.M., the temperature was 34 degrees and at 7:12 A.M., the temperature was 31 degrees.

During an interview on 12/20/21 at 11:12 A.M., Resident B's daughter indicated she was told about the elopement the day they found her mother outside near a maintenance truck. Her mother told her the day before she had seen her husband outside in his truck. The administrator had called her early on 12/10/21 indicating her mother had been outside overnight and spent time in the maintenance truck. He reported her mother was seen on a camera going through a door, into the kitchen, walked through the kitchen, out a door to an employee corridor between 11:00 P.M. -11:30 P.M., and then walked out the outside door. The door locked behind her. She was seen walking towards the parking lot but that was as far as the camera could see her. She and her brother had seen her mom that day and she was fine. The facility had assessed her thoroughly and they did not feel the need to send her to an emergency room. She indicated her mother was a DNR (Do Not Resuscitate). She feels that her

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mother is safe, as they had put a lock on the dining room door which goes into the kitchen.

On 12/20/21 at 11:35 A.M., the resident was observed awake and in the bathroom, with a CNA combing her hair. A wanderguard was observed on her left wrist. The resident was alert to self only.

On 12/20/21 at 2:10 P.M., the video of the resident's elopement was observed with the Maintenance Director and the Administrator. On 12/9/21 at 11:33 P.M., Resident B was observed entering the kitchen through the dining room door. She was viewed to walk through the kitchen and exit into the corridor at 11:34 P.M. The resident headed toward the exit door and looked out the window, then at 11:36 P.M., she walked out the door. She was viewed on the video to proceed down the walkway/driveway toward the employee parking lot and out of view. The resident was wearing shoes, sweat pants and sweat shirt, but no coat. The Maintenance Director indicated there was no other camera view out in the parking lot. The Administrator indicated the resident was located the next morning near a maintenance truck. The truck door was open and blankets were inside, in a different location per the Maintenance Director. They both believed the resident spent time inside the truck with the blankets.

On 12/20/21 at 3:48 P.M., the Administrator indicated he was unable to conclude why staff did not realize the resident was not in the building, as he had statements from two staff members who were assigned to Resident B stating they seen her that night, which he believed was not possible. He indicated there had never been a

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wanderguard alarm on the door when entering the kitchen from the dining room nor on the employee exit door, where the resident had exited the facility.

During an interview, on 12/21/21 at 9:32 A.M., RN 3 indicated she had worked the night shift and on the morning of 12/10/21, as she was pulling away from her parking spot when she noticed a lady standing near the facility trucks. One of the truck doors was open and the lady was having difficulty standing and she thought it looked like a resident. (RN was not assigned the hallway where the resident resides and she was employed with an Agency) She went to the lady, asked her name, called the Director of Nursing and then assisted her back into the building. She was not involved in assessing the resident after she was back inside the building.

On 12/20/21 at 11:10 A.M., the Administrator provided a current policy titled, "Elopement and Unsafe Wandering", dated 2/2020 and revised on 12/2021. The policy indicated " ...This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk ...."

The past noncompliance immediate jeopardy began on 12/09/21. The immediate jeopardy was removed and the deficient practice corrected by 12/17/21, after the facility implemented a systemic plan that included the following actions: the facility placed an alarm and locks on doors that could lead to an exit door, conducted

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F 689	Continued From page 6 house-wide elopement education, implemented an elopement binder for each unit with updated elopement risk assessments for each resident and conducted elopement drills until a pattern of compliance was maintained. This Federal tag relates to complaint IN00369177. 3.1-45(a)(1) 3.1-45(a)(2)	F 689		