STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155490	A. BUILDING 00 B. WING	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMBASSADOR HEALTHCARE	705 E MAIN ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00292210. Complaint IN00292210 - Substantiated. Federal/state deficiency related to the allegations is cited at F689. Survey date: April 17, 2019 Facility number: 000456 Provider number: 155490 AIM number: 100288750 Census Bed Type: SNF/NF: 121 Total: 121 Census Payor Type: Medicare: 7 Medicaid: 104 Other: 10 Total: 121 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1 Quality review completed on April 22, 2019	F 0000		
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §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			

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

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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to prevent an elopement of 1 of 3 residents reviewed for exit seeking and elopement from the facility's secured behavioral care unit. (Resident B) Findings include: In an interview with LPN 3 on 4-17-19 at 10:10 a.m., she indicated "There was an incident last week where [name of Resident B] got out of the building without us knowing it. I was on duty. There was a delivery man here and unloading his stuff into the supply room. He had the outside door open that goes into the supply room. While he was in there, he needed to go to the bathroom and propped open the door between the supply room and what we call the gray room, just a sitting area for the residents. Normally, the outside door is locked and so is the supply room to the gray room. So, long story short, [name of Resident B] got outside. Since the two doors that were open are normally locked and only accessible by staff, they were not alarmed. [Name of Resident B] was found by one of the CNA's and they brought him back. When we talked to him [Resident B], he said he crossed the little bridge on the property that goes over to the church parking lot and was found near the church...[name of Resident B] couldn't tell us where he was going, but many times when he is exit-seeking, he is trying to find his family or his dog." LPN 3 demonstrated the location of the gray room and the adjacent locked supply room and explained on the west wall of the supply room is a door that previously was an exterior door and the	F 0689	p class="Paragraph SCXW191120540 BCX1" lang="EN-US" lang="EN-US" xml: paraeid="{ab944357-4085-4879-a3 b9-3c367117e1bc}{17}" paraid="680450184">By submitting the enclosed documents, we are not admitting the truth or accuracy of any specific findings or allegations as in any proceedings and submit these responses pursuant to our regulatory obligations. We are requesting a desk review for this survey. F OF ACCIDENT HAZARDS/SUPERVISION/DEVIC ES Resident B was located and returned promptly to the facility. .	05/17/2019

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	door in which the delivery person had opened to unload his delivery. LPN 3 demonstrated the location of the small foot bridge and the adjacent church property and church parking lot from a southwest window on the behavioral unit. She clarified it appeared Resident B did not walk out onto the highway, but walked across the facility's property that adjoined to a church parking lot and was located near the church parking lot property. In an interview with CNA 4 on 4-17-19 at 2:21 p.m., he indicated he was on his way home from work on 4-10-19, around 2:00 p.m. He indicated he saw Resident B, "walking over by Mattie Harris and School Road. I recognized him and stopped to try to get him to go with me, so I could take him back to the facility. I was a little worried he might be upset or combative with me, but he seemed very calm and willingly got in my car and buckled up. I asked him where he was going and he said he he had lost his keys, really nothing else. So, I brought him directly back to the unit and then stopped by the office to tell them what had happened. He didn't seem injured in any way, just a little tired. From the behavior unit, you can see where I picked him up, over near the church." In an interview with the Interim Administrator on 4-17-19 at 11:10 a.m., she indicated in the incident on 4-10-19, Resident B was able to tell the facility staff "that he got out the door in the supply room. Apparently the delivery driver propped the door open from the supply room to the sitting area right outside of the supply room in order for him to go to the bathroom. And still had the outside door into the supply room open and [name of Resident B] was able to get out that way. To the best of my knowledge, this had never happened before. Thankfully, one of the CNA's recognized him and brought him back in their care. To the best of our		An immediate head count was completed to ensure all residents were accounted for and no other resident had left the facility. p paraeid="{2a41aa26-ca3e-4571-94 e8-bf573e5767e8}{78}" paraid="2109336081"> A systematic change was made to the delivery process immediately. All nursing supply order deliveries are now brought in through the front entrance. All staff was notified immediately to this change in delivery status and notices were posted at all previous delivery points. These notices were and staff was notified on 4/10/2019. The doorway in the supply room that led to the outside was closed	

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	knowledge, he was out of the building a total of about 13 minutes. [Name of Resident B] has been known to use the sitting area to sit when things might be noisy on the unit." In an interview with the Director of Nursing on 4-17-19 at 3:35 p.m., she indicated, "Who would have ever thought about this kind of thing happening? I've been here a long time and I don't remember it ever happening before. When I had a chance to look over the video of the behavior unit during that time, I could see [name of Resident B] come back from activities around 1:48 p.m. Then he walked down the hall from the TV room, past the nurse's station to the sitting room and the supply room door was propped open with a box and he seemed drawn to that opening and he went in there and straight out the door to the outside. Then a few seconds later, I could see on the video the delivery man walked out of the bathroom on the behavior unit. Apparently he had propped the supply room door open to the sitting area so he could go to the bathroom. If he had only let the door close and lock like he should have, none of this would have happened. All he would have had to do then was ask someone to unlock the door for him and [name of Resident B] wouldn't have gotten out of the building." The facility submitted a self-reported incident report of this event on 4-10-19 to the Long Term Care division of the Indiana State Department of Health. It indicated on 4-10-19 at 2:01 p.m., CNA 4 "brought resident into facility via employee's car...missing approximately 10 minutes before picked up by staff member. Resident was 844.8 feet away from facility...Delivery person was delivering boxes to supply room from outside entrance which is a room of of the behavior unit. Delivery propped door open without any staff		off and is no longer an exit. Maintenance completed closing off the doorway on 4/11/2019. p paraeid="{2a41aa26-ca3e-4571-94e8-bf573e5767e8}{152}" paraid="1340372733"> The Administrator and or his/her designee will perform and ongoing audit to ensure all nursing supply deliveries are made through the front entrance. Ongoing monitoring will . . The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: May 17, 2019	

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	member knowing, to use bathroom on west station [behavior unit]. Door to supply room, that is on west station, has automatic closer and automatically locks so that is why he [delivery person] propped it open so he would have access to get back into supply room." The clinical record of Resident B was reviewed on 4-17-19 at 9:22 a.m. His diagnoses included, but were not limited to, alcohol abuse, unspecified psychosis, anxiety and unspecified dementia with behavioral disturbance. His most recent Minimum Data Set (MDS) assessment, dated 2-23-19, indicated he is moderately cognitively impaired, ambulates independently and wanders 1 to 3 days of each week. The most recent elopement risk for Resident B, dated 1-12-19, indicated he was identified as being an elopement risk. A care plan for Resident B, initiated on 12-5-17, identify concerns with cognitive impairment related to dementia, with disorganized thinking and wandering. A care plan for elopement risk and aimless wandering was initiated on 12-1-17, with a revision date of 4-12-19 related to Resident B exiting the building on 4-10-19. Interventions and tasks related to this concern include close supervision by staff of one to one or every 15 minute checks as deemed appropriate, use of a wanderguard and provision of diversional and structured activities. This Federal tag relates to Complaint IN00292210. 3.1-45(a)(1) 3.1-45(a)(2)			