

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Woodland Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 343 S Nappanee St Elkhart, IN 46514	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31719</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident received adequate supervision and the facility's elopement policy was followed for a resident with a traumatic brain injury with cognitive deficits, who was transferred off facility property, to a physician's office appointment, (Resident B)</p> <p>Finding includes:</p> <p>During an interview on 6/13/24 at 12:45 P.M., a Van Driver indicated he transported Resident B to an office building located next to an acute care hospital in a nearby city on 6/5/24 for a 10:00 AM appointment. During the ride the resident was quiet until he reached the (neighboring city name) and began to talk and point out familiar places and indicated this was his old stomping grounds. The van driver parked in front of the building and assisted the resident into the building to the specific physician's office and checked him in with Receptionist 1. The van driver told the receptionist he would be back, he had to park the van. When the van driver returned to the physician's office waiting room, the resident was already being seen in the doctor office. The van driver indicated he never went into the exam rooms with the residents due to privacy. The van driver indicated he waited in the lobby, of the suite area, for over an hour for the resident to reappear from the exam room. Finally, he asked Receptionist i2 f the resident was close to being done with his exam. Receptionist 2 indicated the resident had left through another door about an hour ago. The van driver asked [NAME] way he had gone and asked them to call security. The physician's office contacted security and they assisted the van driver to search for the resident. Resident B was not located, the office security looked at their cameras and was able to determine how Resident B had exited the building. The van driver then called the facility to report what had happened and the police were contacted. The van driver indicated it was his first time he had taken Resident B anywhere and he had never met him prior to the transport.</p> <p>On 6/13/24 at 2:13 P.M., a review of the clinical record for Resident B was conducted. Resident B was admitted to the facility on [DATE]. Diagnoses included, but were not limited to: cocaine dependence-remission, stimulant dependence, cannabis dependence, history of pedestrian/collision traffic accident with traumatic subdural hemorrhage.</p> <p>The resident's profile information on admission indicated the resident had no legal Power of Attorney (POA), was his own responsible party and had one emergency contact, a sister.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Social Service Note, dated 3/1/24 at 12:17 P.M., indicated the resident was admitted to the facility after being struck by a vehicle, with an admitting diagnosis of traumatic subdural hemorrhage. Resident B had a cocaine and nicotine dependence and severe cognitive deficits. He required cueing and reminders for daily care. The resident had previously been homeless and was to remain in the facility, for long term placement.</p> <p>A Care Plan, dated 3/1/24, indicated the resident had an alteration in neurological status related to a traumatic brain injury. The interventions included, but were not limited to: cueing and reorientation as needed.</p> <p>An Elopement/Wander Risk Evaluation, dated 3/12/24, indicated the resident was forgetful, had no history of wandering and was a low risk for elopement.</p> <p>A Nursing Progress Note, dated 6/5/24 at 12:30 P.M., indicated the facility had been notified of the resident exiting a physician's office out of the view of the van driver. The note indicated the van driver had alerted the hospital's security and the office building was searched. Resident B was unable to be located. Facility staff were dispatched to assist the van driver with the search for Resident B.</p> <p>A Nursing Progress Note, dated 6/5/24 at 1:27 P.M., indicated the department was local police department was called and an officer met with the interim Director of Nursing (DON) at the doctor's office. The officer was made aware Resident B was unable to be located. The Police officer spoke with the hospital's security and viewed the cameras to see where the resident had gone. The officer indicated he would talk to his superior to see if they could file a missing person report. At 2:55 P.M., the hospital security officer stated Resident B was seen on the office camera leaving the office at approximately 10:55 A.M. Staff from the facility searched the surrounding areas, including places where the resident had frequented before his admission. Local emergency rooms and police stations were contacted and advised of the situation. As of 6/5/2024 at 1:27 P.M., when the note was documented, the resident had not been located.</p> <p>A Nursing Progress Note dated 6/6/24 10:31 P.M., indicated staff had searched the surrounding areas from 9:30 A.M. to 1:30 P.M. Staff resumed their search later in the evening. due to a staff member had reported seeing Resident B in a nearby city in the afternoon. Resident B was not located. The local police department was provided with resident information and the resident's sister was updated.</p> <p>A Nursing Progress Note, dated 6/7/24 at 5:41 P.M., indicated staff had resumed their search throughout the day in the surrounding areas. There were no sightings of Resident B. The resident's sister and the police were updated.</p> <p>A Nursing Progress Note, dated 6/8/24 at 3:15 P.M., indicated the police had called the facility indicating the resident had been found and the sister was aware.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An Indiana Department of Health (IDOH) Incident Report dated 6/5/24 at 02:21 P.M. indicated .Resident transported to ortho appt [appointment] per facility bus driver. The driver is familiar with the facility as he had transported other residents to this location. Driver escorted resident into the building and checked in at the office reception desk, telling the staff he was going to move the facility bus to a parking area. After bus moved, driver immediately returned to the waiting area. Resident was in the exam room being seen. After a period of approximately an hour, driver approached the desk to inquire about the resident, speaking to a different receptionist as the original one was not available. Receptionist stated the resident had already left. The driver had been in the waiting area the entire time after moving the bus. Resident had not exited from the usual door driver picks residents up at, but exited in his wheelchair from a different door that was not visible from where the driver was seated. Driver requested for receptionist to contact security. Driver searched all floors of medical facility, but unable to locate resident. Driver notified facility that resident was unable to be located. The police (case number INC-2-24-000640) were notified. They observed resident on the camera footage leaving the facility. Family and physician notified. Information received from resident sister regarding places resident frequented as he had previously lived in this area. Facility staff members sent to area to assist with search for resident on date of occurrence and again this date. Resident currently unable to be located</p> <p>A Nursing Progress Note, dated 6/11/24 at 2:06 P.M., indicated a Wanderguard (a device to track residents within set borders) had been placed on the resident's right ankle.</p> <p>An Elopement Assessment, completed on 6/13/24, indicated the resident was at moderate risk for an elopement.</p> <p>A Care Plan, initiated on 6/13/24, indicated the resident had exhibited behaviors, such as leaving the facility without notice and talking about living in the woods. The interventions included: Wanderguard placement to remind resident not to leave building alone and IDT (Interdisciplinary Team) to review behavior management program quarterly and as needed.</p> <p>During an observation on 6/13/24 at 3:50 P.M., the resident was located out in the courtyard by himself. He was alert to self and place but not oriented to the month or to the name of the current president, but said it really did not matter to him. During an interview with Resident B, on 6/13/2024 at 3:50 P.M., he indicated he had left the doctor's office because he was done and decided to check out some familiar places and friends in the area. He stayed with his friends and ate with them one day, but traveled to a nearby city by walking behind his wheelchair or propelling himself while sitting in it. Resident B indicated he wanted to check on some things. He had lived in the woods nearby and wanted to see if his things were still there. Resident B stayed in his former shelter and ate the canned goods he had stored there. He had built the shelter out of tarps and had lived there several months before he was hit by a truck in a parking lot. Resident B indicated he just wanted to be free and live by himself in his home in the woods. The police had stopped him 3 times, after he left the physician's office and asked where he belonged and if he needed anything. He told them he did not need anything. At one point, the police told him the facility was looking for him, Resident B told them he did not live there anymore. He wanted to live in his shelter, try to get a job and get his food card pin number and just be free. Resident B indicated the facility had been nice to him and helped him recuperate from the accident, but he just really wanted to go back to his shelter. He was upset his sister had told the facility where to look for him. Resident B willingly came back with a lady who worked at the facility. Resident B stated again he just wanted to be free to live back in his home-made shelter.</p> <p>(continued on next page)</p>		

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