

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155519	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Gentle Care Strategies		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16th St Vincennes, IN 47591	

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>39130</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and a secured environment was in place to prevent a resident with dementia from exiting the facility unsupervised. On 9/21/24, while on 15-minute checks, a resident was noticed to be missing at 5:20 A.M. Staff quickly located the resident outside the Hall 2 emergency exit door where the resident exited the facility and apparently fallen while unsupervised. (Resident C)</p> <p>Finding includes:</p> <p>A review of facility reported incidents on 9/30/24 at 11:15 A.M., included an IDOH (Indiana Department of Health) Reportable Incident form completed by the Facility Administrator, with an incident date of 9/21/24 at 5:30 A.M., indicated that staff was notified that Resident C was missing from her room at approximately 5:20 A.M. Staff went to the Hall 2 exit door and found Resident C sitting on the ground outside of the facility. Resident C was noted to have a small abrasion on her palms with a scant amount of fresh blood around left temple area. Resident was assessed and assisted back into the facility at approximately 5:30 A.M.</p> <p>On 9/30/24 at 11:20 A.M., LPN 4 indicated that Resident C was at risk for wandering and elopement and wore a WanderGaurd bracelet (a device that triggers door alarms and locks monitored doors to prevent the resident from leaving unattended). Resident C was on one-to-one observation at that time due to exit seeking behaviors.</p> <p>During an observation on 9/30/24 at 11:25 A.M. Resident C was sitting in her room with a staff member sitting next to her. The emergency exit door on Hall 2 was observed to have a magnetic alarm attached to it that would sound if the door were opened.</p> <p>During record review on 9/30/24 at 11:30 A.M., Resident C's diagnoses included, but were not limited to vascular dementia with behavioral disturbance, unsteadiness on feet, altered mental status, and auditory hallucinations.</p> <p>Resident C's most recent Admission Minimum Data Set (MDS) assessment, dated 9/14/24, indicated the resident had severe cognitive impairment, had no functional impairments to extremities, used a walker for ambulation, could walk 10 feet with supervision of one staff, wandered daily, and that the resident's wandering behavior put the resident at significant risk of getting to a dangerous place (including outside of the facility).</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>Resident C's comprehensive care plan included, but was not limited to:</p> <p>A focus of resident is at risk for elopement due to attempting to exit seek upon admission and wandering at previous facility (initiated 9/14/24) with interventions that included, check function of WanderGaurd every shift, respect resident's right to make decisions, and WanderGaurd placement on resident's wrist at all times.</p> <p>A focus of resident is at risk for wandering and elopement (initiated 9/14/24) with a goal of resident will not leave facility unattended.</p> <p>Resident C's elopement risk evaluation, dated 9/14/23, indicated Resident C had a history of elopement or an attempted elopement while at home and wandered aimlessly.</p> <p>Resident C's physician orders included, but were not limited to, WanderGaurd bracelet with an order date of 9/5/24, and 1:1 supervision to ensure safety with an order date of 9/21/24.</p> <p>Resident C's nurse's progress notes included, but were not limited to the following:</p> <p>On 9/9/24 at 5:55 P.M. - Resident had multiple attempts to exit seek today. WanderGaurd in place and functioning properly.</p> <p>On 9/15/24 at 3:50 P.M. - staff notified nurse that resident had been exit seeking. Thirty (30) minute safety checks changed to 15-minute safety checks. Physician, Administrator, and Direct of Nursing (DON) notified.</p> <p>9/21/24 at 5:30 A.M. - Incident occurred when resident opened emergency exit door and stepped outside. As resident was going outside, she stepped down and lost balance causing her to scrape body against the brick on the outside of the facility. Resident has abrasions on her arms and on to her face. Resident redirected back inside facility. Administrator, DON, and family notified.</p> <p>A review of the facility's investigation of Resident C's elopement on 9/21/24 included a typed note dated 9/25/24, and signed by RN 6. The note indicated, on 9/21/24 RN 6 was alerted by LPN 9 that at approximately 5:20 A.M., that she needed assistance locating Resident C. LPN 9 indicated that Resident C had been exit-seeking earlier in the night on Hall 2. RN 6 immediately check outside the emergency exit door located on Hall 2 and found Resident C sitting on the ground outside of the facility. Resident C was noted to have a small abrasions on palms and scant amount of fresh blood on left temple area. Resident C was assisted back into the building at approximately 5:30 A.M. LPN 9 indicated that Resident C had been exit-seeking at around 2:00 A.M. but that staff was able to redirect resident back to room and that no administrative staff was notified of the behavior. CNA on hall indicated the last bed check was completed at 5:15 A.M.</p> <p>During an interview on 9/30/24 at 11:45 A.M., the Facility Administrator indicated that Resident C had been on 15 minute safety checks the morning of 9/21/24 and that the 15 minute checks were documented in the Point of Care (POC) charting system.</p> <p>A review of Resident C's 15-minute safety checks on 9/30/24 at 11:50 A.M., indicated the resident had been 15-minute safety checks the morning of 9/21/24. Documented 15-minute checks included the following times:</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>9/21/24 - 12:01 A.M.</p> <p>9/21/24 - 1:09 A.M.</p> <p>9/21/24 - 3:23 A.M.</p> <p>9/21/24 - 3:29 A.M.</p> <p>9/21/24 - 3:32 A.M.</p> <p>9/21/24 - 3:33 A.M.</p> <p>9/21/24 - 4:23 A.M. (last documented 15-minute check observation of resident before missing at 5:20 A.M.)</p> <p>During an interview on 9/30/24 at 1:10 P.M., the DON indicated after reviewing the incident and interviewing staff who were on duty the morning of 9/21/24, she did not believe the emergency exit door had alarmed as it should have when pushed open by Resident C when she was able to exit the facility unsupervised. It was not clear as to why the alarm did not sound as it was functioning correctly when all doors were checked following Resident C's elopement. Staff had not indicated that the alarm alerted them that Resident C had exited the door, rather LPN 9 realized Resident C was not in her room at 5:20 A.M. The DON also indicated that if LPN 9 had notified other staff of Resident C's exit seeking behavior on 9/21/24 at 2:00 A.M., an intervention of placing the resident on 1:1 observation could have been implemented. The DON also indicated that an additional alarming device was added the the emergency exit door on Hall 2.</p> <p>A review of daily door checks on 9/30/24 at 1:25 P.M., indicated all doors had been check the day prior to Resident C's elopement and all door alarms were functioning correctly.</p> <p>On 9/30/24 at 2:20 P.M., the DON supplied a facility policy titled Elopement/Wander Risk Policy, dated 07/2023. The policy included, .3. Staff members are asked to notify the nurse on duty of any Resident that is suspected of being an elopement risk or found trying to leave the building 5.All fire doors are equipped with an alarming mechanism regardless of wander-guard in place to alarm staff when a resident is attempting to go out the fire doors .</p> <p>This citation relates to Complaint IN00444101.</p> <p>3.1-45(a)(2)</p>