

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155771	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2024
NAME OF PROVIDER OR SUPPLIER  Otterbein Franklin Seniorlife Comm Res & Com Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1070 W Jefferson St Franklin, IN 46131	

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>44849</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision to prevent a cognitively impaired resident who resided on a secured memory care unit from walking out of the facility for 1 or 3 residents reviewed for elopements. (Resident B)</p> <p>Finding includes:</p> <p>On 9/25/24 from 9:25 a.m. until 9:30 a.m., observed the North 33 exit door on the secured memory care unit that led outside to a courtyard. The glass exit door was unlocked by CNA 1 using a button behind the nurse's station. The courtyard was enclosed by a brick privacy fence with a wooden door. The wooden door had a deadbolt lock and a shiny silver metal latch with another lock. Outside the wooden door was a set of concrete stairs that led down to a sidewalk and then to the parking lot. The parking lot was approximately 60 feet from a street in an independent living neighborhood on the facility's property. At that time, CNA 1 indicated Resident B had a history of exit seeking behaviors. The staff supervised him more often. When Resident B tried to elope in the past he told staff he was going to work.</p> <p>During an interview on 9/25/24 at 11:47 a.m., the Maintenance Director indicated the lock on the wooden door in the courtyard was working prior to Resident B walking out to the parking lot. The wooden door should never be unlocked.</p> <p>During an interview on 9/26/24 at 8:42 a.m., the Administrator indicated her understanding was, on 9/9/24 at approximately 5:45 a.m., Resident B told CNA 2 he had to go to work. CNA 2 explained that Resident B didn't have to go to work and that she would get him some coffee after she finished with another resident. When CNA 2 was finished working with the other resident, the phlebotomist was on the unit looking for another resident. CNA 2 helped the phlebotomist find a resident and that was when CNA 2 noticed Resident B was not in his room and reported to the nurse. Meanwhile, at approximately 5:50 a.m., the facility received a phone call that a person had fallen in the parking lot. The night supervisor and another nurse walked outside to see what happened. Resident B was on the ground in the north parking lot and was sent to the hospital.</p> <p>On 9/25/24 at 10:00 a.m., the Administrator provided the facility investigation into Resident B's elopement. The investigation included, but was not limited to:</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>An undated witness statement indicated, at 6:00 a.m. CNA 2 informed Licensed Practical Nurse (LPN) 1 that a resident was missing. CNA 2 picked up a phone and immediately began searching rooms and called the supervisor. CNA 2 was informed that Resident B had fallen outside in the parking lot. The door to the courtyard did not latch when LPN 1 pushed the button at the beginning of her shift and found the wooden door open upon further investigation.</p> <p>An undated witness statement indicated at approximately 5:30 a.m., Resident B told CNA 2 that he had to go to work. CNA 2 explained that Resident B did not have to go to work. CNA 2 went back to the resident she was assisting. The phlebotomist was looking for another resident, so CNA 2 took the phlebotomist to that resident. CNA 2 noticed Resident B wasn't in his room and had begun looking in the common area and dining area. CNA 2 notified the nurse. Then called another unit and was told a resident was found in the parking lot.</p> <p>A witness statement, dated 9/9/24, indicated RN 1 followed the night supervisor to the northside parking lot for a report of a person down on the ground. Upon observation and assessment, it was determined to call 911. When RN 1 returned to the unit, he informed CNA 2 that she needed to go to the parking lot to see if Resident B was the person on the ground.</p> <p>The clinical record for Resident B was reviewed on 9/25/24 at 10:11 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and osteoporosis.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 7/10/24, indicated Resident B was severely cognitively impaired.</p> <p>A care plan, dated 2/20/23, indicated Resident B was an elopement risk related to impaired safety awareness. Interventions included, but were not limited to, distract Resident B from wandering by offering pleasant diversions, structured activities, food, conversation, television, books Resident B prefers, and reside on secured unit for increased safety.</p> <p>A care plan, dated 3/7/23, indicated Resident B had at times placed all his belongings on his bed, had stated he was going home, and he needed to go to work. Interventions included, but were not limited to, provide emotional support as needed and offer activities of interest such as listening to his favorite music.</p> <p>A progress note, dated 9/9/24 at 7:00 a.m., indicated Resident B was up wandering before breakfast. Resident B told CNA 2 he was going to work. While CNA 2 and LPN 1 were in another resident's room providing assisting, Resident B exited the unit through the door to the courtyard. After entering the courtyard, Resident B opened the gate and entered the employee parking lot where he fell. The night supervisor assessed Resident B and called 911.</p> <p>An Interdisciplinary Team (IDT) note, dated 9/10/24 at 10:00 a.m., indicated the IDT met to discuss the fall and elopement.</p> <p>On 9/25/24 at 10:08 a.m., the Administrator provided a copy of a facility policy, titled Elopement, dated 11/6/19, and indicated this was the current policy used by the facility. A review of the policy indicated it was the policy of the facility that all necessary steps were taken to protect elders from the risk of elopement.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	This Federal tag relates to Complaint IN00442884.  3.1-45(a)(2)