STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Otterbein Franklin Seniorlife Comm Res & Com Care	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility without staff knowledge for 1 of 3 residents reviewed for supervision. (Resident B) Findings include:During an interview on 7/23/25 at 9:00 a.m., the Unit Secretary indicated she was working, on 7/1/25 at approximately 10:30 a.m., when Resident B exited the facility without staff knowledge. Resident B was found on the sidewalk next to the employee parking lot near the independent living houses where she used to live with her husband. Resident B was wearing a wanderguard (a bracelet that locks a door and sounds an alarm when a wandering resident approaches the door), but the door did not lock and the alarm did not sound. Resident B's wanderguard was in place when the Unit Secretary brought her back inside the facility. Resident B was normally confused and at different times she would press on the exit doors and said things like she wanted to go home. During an interview on 7/23/25 at 9:20 a.m., observed Resident B in her room, on the secured unit, lying in bed sleeping. Resident B's family member was sitting at her bedside and indicated Resident B had exited the facility a few weeks ago and he would be staying with her until her discharge at the end of the week when they were going to move out of state. The clinical record for Resident B was reviewed on 7/23/25 at 9:51 a.m. The diagnoses included, but were not limited to, dementia and delirium.A Wander and Elopement Risk Assessment, dated 6/28/25, indicated Resident B had a history of wandering, was unaware of safety concerns, had cognitive impairment, and poor decision making. A progress note, dated 6/29/25 at 8:26 p.m., indicated Resident B was confused and had been displaying exit seeking behaviors. A progress note, dated 7/1/25 at 10:56 a.m., indicated Resident B was found wandering in the employee parking lot on the sidewalk near the independent living homes. An admission Minimum Data Set (MDS) assessment, dated 7/2/25, indicated Resident B was severely cognitively impaired and had not displayed wandering behaviors.A Care Plan, dated 7/2/25, indicated Resident B was at risk for wandering and an elopement because she was disoriented to place, wandered, and had impaired safety awareness. Resident B had attempted to follow family members out of the facility, had searching behaviors, and had spoken about going home. During an interview on 7/23/25 at 10:02 a.m., the Administrator indicated Resident B walked out the door to the rehab unit, on 7/1/25 at 10:22 a.m. Resident B then walked to another exit where residents were taken outside when they were being transported. Resident B walked along the sidewalk that lined the employee parking lot where she was found by the Unit Secretary standing on the sidewalk. Resident B was brought back into the facility at 10:34 a.m. The rehab unit was not a secured unit. However, the door had a wanderguard alarm and a keypad, so when Resident B approached the door with the wanderguard, the door should have alarmed and locked but it did not. On 7/23/25 at 11:28 a.m., observed the path Resident B walked to the sidewalk where she was located by the Unit Secretary. Resident B walked out of the rehab unit door into a hallway that led to a set of sliding glass doors approximately 60 feet from the rehab unit. The sliding doors did not have a wanderguard alarm. Outside the sliding doors was a well-kept sidewalk along a parking lot. Resident B walked along the sidewalk and around to the side of the facility where the sidewalk ended at the employee parking lot, where Resident B was located by the Unit Secretary, approximately 150 feet from the sliding doors. On 7/23/25 at 11:42 a.m. , observed the Unit Secretary hold a wanderguard in her hand and walked near the exit doors of the rehab unit. The door alarm sounded and locked. On 7/23/25 at 9:45 a.m., the Administrator provided a copy of a facility policy, titled Elopement, dated 3/27/00, 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 are taken to protect at risk elders from the risk of elopement.This citation relates to Complaint 12471943.1-45(a)(2)