STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Healthcare Center	7465 Madison Ave Indianapolis, IN 46227

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44849 Based on observation, interview, and record review, the facility failed to provide supervision to prevent a cognitively impaired resident who resided on the secured memory care unit from exiting the facility property without staff knowledge. The resident was found approximately 1.5 miles from the facility. (Resident B) This deficient practice resulted in an Immediate Jeopardy. The Immediate Jeopardy began on, 4/13/25 at approximately 1:00 a.m., when the facility failed to provide supervision to a cognitively impaired resident, that resided on the memory care unit, to prevent an elopement. The Administrator, Director of Nursing, and Regional Director of Nursing were notified of the Immediate Jeopardy on 4/22/25 at 12:35 p.m. The Immediate Jeopardy was removed, and the deficient practice corrected, 4/14/24, prior to the start of the survey and was therefore Past Noncompliance. Findings include: On 4/22/25 at 8:48 a.m., the Administrator provided a copy of a facility reportable incident, dated 4/13/25 at 4:45 a.m. A review of the reportable incident indicated Resident B walked out of the facility through an emergency exit door. Resident B was located and returned to the facility by the police. On 4/22/25 at 9:00 a.m., the Administrator provided a copy of the following staff witness statements: - CNA 1, dated 4/13/25, indicated CNA 1 left the secured memory care unit to go outside to her car. On CNA 1's walk back into the facility she was made aware that Resident B exited the facility. CNA 1 was told Resident B tried to exit the secured memory care unit using the front entrance to the unit but when staff heard Resident B knocking on that door they redirected him to his room. Then the alarm on the emergency exit door located at the back of the unit had begun to sound. - CNA 2, undated, indicated CNA 2 heard a door alarm sounding, so CNA 2 went to the secured memory care unit and the emergency exit door at that back of the unit was open. The clinical record for Resident B was reviewed on 4/22/25 at 9:08 a.m. The diagnoses included, but were not limited to, Alzheimer's disease and dementia. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An order appointing guardian over ward, dated 7/18/23, indicated Resident B was an incapacitated person and was appointed a guardian over person and estate. A Nursing Admission Evaluation, dated 4/9/25 at 4:59 p.m., indicated Resident B had not shown exit seeking behavior since admission, but had a history of wandering, exit seeking behaviors, elopement, and told the nurse he wanted to go home. A Brief Interview for Mental Status (BIMS) assessment, dated 4/10/25, indicated Resident B was severely cognitively impaired. A care plan, dated 4/9/25, indicated Resident B was at risk for an elopement. The interventions included, but were not limited to, provide diversionary activities as needed (initiated 4/9/25), redirect Resident B when appropriate and assess for hunger, thirst, ambulation, and toileting needs (initiated 4/9/25). A care plan, dated 4/10/25, indicated Resident B required a secured unit. The interventions included, but were not limited to, educate Resident B and Resident B's representative of the need for a secured unit to maintain Resident B's safety (initiated 4/10/25) and provide diversionary activities as needed (initiated 4/10/25). A progress note, dated 4/9/25 at 6:33 p.m., indicated Resident B's family had come to visit and stated that Resident B was exit seeking and that when Resident B realized that he could not get out of the facility, he would start screaming. Writer assured family that Resident B was in a safe, secure environment. Resident B's son stated that Resident B exited their home and was picked up wandering the streets. A progress note, dated 4/10/25 at 11:04 p.m., indicated Resident B had been exit seeking multiple times throughout shift. Staff continued re-directing resident which was somewhat effective. A progress note, dated 4/12/25 at 11:40 a.m., indicated Resident B was confused and wandering that morning and asked about leaving. A progress note, dated 4/13/25 at 5:23 a.m., indicated Resident B had exited the facility and was returned to the facility by police escort. During an interview on 4/22/25 at 10:43 a.m., the Administrator indicated, on 4/13/25 at approximately 1:15 a.m., he was notified that staff were unable to locate Resident B. Resident B was located approximately 1.5 miles north on a main road. The CNA that was working on the secured memory care unit that night had a personal emergency and had to leave the secured memory care unit to go outside to her car. There were no staff members on the secured memory care unit when Resident B exited the facility through the emergency exit door on the secured memory care unit. On 4/22/25 at 11:00 a.m., the path Resident B walked when he exited the facility was observed. From the facility Resident B walked north on the main road. There was a concrete sidewalk and parking lots that lined the road for the entire distance. The area that the Administrator reported Resident B was located by the police was near a busy intersection approximately 1.5 miles from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/23/25 at 10:30 a.m., the Administrator provided the as worked clinical schedule, dated 4/12/25. A review of the schedule indicated CNA 1 was the only CNA schedule for the 500 hall (secured memory care unit). On 4/22/25 at 9:00 a.m., the Administrator provided a copy of an undated facility policy, titled Elopement Prevention and Management Overview, and indicated this was the current policy used by the facility. A review of the policy indicated an elopement is defined as a resident that leaves the premises or a safe area without authorization or any necessary supervision and places the resident at risk for harm. The past noncompliance Immediate Jeopardy began on 4/13/25. The Immediate Jeopardy was removed and the deficient practice corrected by 4/14/25 after the facility implemented a systemic plan that included the following actions: audits of elopement evaluations and care plans, inservicing staff on elopement procedures, and ongoing monitoring. This citation relates to Complaint IN00457472. 3.1-45(a)(2)