

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E683	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER Morgantown Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 140 W Washington St Morgantown, IN 46160	

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 - Immediate jeopardy to resident health or safety</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** 44849</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent a resident with a history of elopement from walking out the same emergency exit door on 3 consecutive days for 1 of 3 residents reviewed for elopement. Resident B was found 1.1 miles in an empty commercial lot by the police. (Resident B)</p> <p>The Immediate Jeopardy began on March 23, 2024, when Resident B exited the facility without staff supervision. The Administrator and the [NAME] President of Clinical Operations were notified of the Immediate Jeopardy, on March 27, 2024 at 10:45 a.m. The Immediate Jeopardy was removed, on 3/28/24 at 4:45 p.m., but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>On 3/26/24 at 7:02 a.m., Resident B was observed lying in bed resting. Resident B was not on 1-on-1 (continuous) supervision.</p> <p>During an interview on 3/26/24 at 7:05 a.m., CNA 1 (Certified Nursing Aide) indicated CNA 1 knew Resident B had left the facility on [DATE] (Saturday) on evening shift. Resident B left the facility again, on 3/25/24 (Monday) on evening shift. Resident B was not on 1-on-1 supervision when CNA 1 arrived at the facility, on 3/25/24 at approximately 11:00 p.m., nor was Resident B on 1-on-1 supervision during night shift, from 3/25/24 at approximately 11:00 p.m. until 3/26/24 at approximately 7:00 a.m., when CNA 1 left work.</p> <p>On 3/26/24 at 7:07 a.m., the emergency exit door in the dining room was observed. The emergency exit door was shut and had a keypad to the right of the door. The small, battery operated, door alarm was not observed on the door nor the door frame. The door led out to a front porch that was not secured. The porch was approximately 15 feet from a busy main street. There were cars parked on each side of the street which caused poor visibility to see oncoming traffic.</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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/24 at 7:35 a.m., the VPCO (Vice President of Clinical Operations) indicated, on 3/23/24 at an unknown time, Resident B walked out the emergency exit door in the dining room, at the front of the facility. The alarms did not sound because that door was not connected to the internal alarm system, but did have a small, battery operated, generic alarm that would sound like a doorbell if the door was opened. The staff received a call from the county police department, on 3/23/24 at approximately 10:27 p.m., and asked if Resident B was a resident at this facility. Resident B returned to the facility accompanied by police, on 3/23/24 at approximately 10:35 p.m. The officer reported to the nurse that Resident B said he was just getting fresh air and wanted to go to Indianapolis to visit his mother. When Resident B returned to the facility with the police, Resident B was placed on 15-minute checks. The VPCO had just been informed that Resident B walked out the same emergency exit door, on 3/24/24 (one day after the initial elopement), and again, on 3/25/24 (two days after the initial elopement). Resident B eloped in July of 2023 as well. The staff should have notified the VPCO when Resident B left the facility each time. The information regarding the elopements on 3/24/24 should have been documented by the DON (Director of Nursing) and the elopement on 3/25/24 should have been documented by the agency nurse. Resident B should have been on 1-on-1 supervision to prevent the elopements.</p> <p>During an interview on 3/26/24 at 8:35 a.m., Resident B indicated he went outside over the past few days to get fresh air and walk.</p> <p>During an interview on 3/26/24 at 9:49 a.m., LPN 1 (Licensed Practical Nurse) indicated LPN 1 was the nurse that worked evening shift, on 3/23/24 from 7:00 p.m. until 7:00 a.m. LPN 1 received a call from the county police dispatch, on 3/23/24 at approximately 10:25 p.m. The police dispatcher asked if Resident B lived at this facility. The police dispatcher indicated Resident B was found by police approximately 1.1 miles from the facility walking in an empty commercial lot on Highway 135. LPN 1 verified Resident B was returned to the facility by police, on 3/23/24 at approximately 10:35 p.m. Resident B indicated to LPN 1 and the police officer that Resident B just wanted to walk, get fresh air, and go see his mother in Indianapolis. Resident B was wearing pajama pants, a long sleeve dark green shirt, and non-skid socks. Resident B was not wearing shoes. Resident B had a small abrasion on the right side of his ankle, but Resident B could not remember how the abrasion happened. Resident B was immediately placed on 15 minute checks. When LPN 1 checked the emergency exit door in the dining room, LPN 1 found a small battery-operated doorbell alarm with corroded batteries inside. LPN 1 changed the batteries and resecured the emergency exit.</p> <p>On 3/26/24 from 11:05 a.m. until 11:17 a.m., the location where the police officer found Resident B, on 3/23/24 at approximately 10:25 p.m., was observed. The empty commercial parking lot was approximately 1.1 miles from the facility, located on State Highway 135. From the facility, Resident B walked approximately 0.3 miles and crossed over train tracks. After the train tracks, the sidewalks ended. At 0.4 miles from the facility, the speed limit increased to 55 miles an hour, there were no street lights, and the terrain from approximately 0.4 miles to the empty commercial parking lot was rough gravel approximately 1.5 feet wide next to the highway and tall grass and weeds.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/26/24 at 12:38 p.m., CNA 2 indicated CNA 2 worked evening shift, on 3/25/24 (2 days after the initial elopement). Resident B left the facility at an unknown time and returned on his own by walking to the employee entrance, on 3/25/24 at approximately 9:00 p.m. CNA 2 knew Resident B was at the employee entrance because the wander guard alarm sounded, so CNA 2 turned off the alarm, and walked Resident B to his room. Resident B was wearing sweatpants, a t-shirt, and non-skid socks. Resident B was not wearing shoes. The agency nurse told Resident B that he could not pace on the front hall near the dining room because the staff could not supervise him. After dinner, CNA 2 saw Resident B pacing up and down the front hallway near the dining room and emergency exit door. CNA 2 and an agency nurse were the only clinical staff working during evening shift, on 3/25/24. CNA 2 knew Resident B should have been on 1-on-1 with a staff member, but CNA 2 could not provide 1-on-1 supervision as other residents needed care as well.</p> <p>The historical weather report for the facility was reviewed, on 3/26/24 at 2:30 p.m. The AccuWeather indicated:</p> <p>On 3/23/24 from 8:00 p.m. until 10:30 p.m., the temperature was approximately 36 to 38 degrees Fahrenheit.</p> <p>On 3/24/24 from 5:00 p.m. until 5:45 p.m., the temperature was approximately 53 to 55 degrees Fahrenheit.</p> <p>On 3/25/24 from 7:00 p.m. until 9:00 p.m., the temperature was approximately 64 to 66 degrees Fahrenheit.</p> <p>During an interview on 3/27/24 at 8:04 a.m., the VPCO indicated Resident B walked out the same emergency exit door in the dining room, on 3/24/24 (1 day after the initial elopement). There were staff in the dining room, but the staff were assisting other residents.</p> <p>The clinical record for Resident B was reviewed on 3/27/24 at 8:40 a.m. The diagnoses included, but were not limited to, non-traumatic brain dysfunction, schizophrenia, psychotic disorder, and bilateral hand amputation.</p> <p>A Court Order Appointing Guardian Over Incapacitated Person, dated 8/16/23, indicated Resident B was an incapacitated person and was not unable to make health care decisions due to schizophrenia. A guardian was granted for Resident B.</p> <p>An Outpatient Burn Hospital Physical Therapy Note, dated 3/1/23, indicated Resident B sustained frostbite to bilateral hands, face, and heels. Resident B left his group home in the night and was exposed to extreme cold for an unknown amount of time. Resident B required bilateral wrist amputations in January 2023.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, dated 2/6/24, indicated Resident B was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A care plan, dated 7/19/23 and current through 5/6/24, indicated Resident B was at risk to wander from the facility secondary to a long history of homelessness and Resident B expressed his wish to leave. The care plan was reviewed on 8/9/23, 11/7/23, 2/6/24, and 3/26/24. The care plan also indicated, on 7/24/23, elopement and, on 3/26/24, care plan reviewed no changes made. Undated interventions included, but were not limited to, monitor placement of bracelet alarm and document presence and check function of bracelet alarm at the front and back doors.</p> <p>An Elopement Risk Assessment, dated 7/17/23, indicated Resident B was not an elopement risk. Resident B was alert and had not had an elopement. A hand written note at the bottom of the assessment, dated 7/17/23, indicated a wander guard was to be utilized because Resident B was ambulatory and expressed a wish to return to street life.</p> <p>A Psychiatric Hospital Note, dated 7/26/23, indicated per facility nursing staff Resident B bolted out of the dining room during dinner and ran into the street. Resident B was threatening staff. Resident B was found later by a police canine unit and Resident B reported he was walking back to his home in Indianapolis. Resident B threatened staff prior to eloping from the secure facility and Resident B reported no one wanted him to be there so he left. Resident B had a history of substance abuse and cocaine use.</p> <p>An Elopement Risk Assessment, dated 8/8/23, indicated Resident B was an elopement risk. Resident B had intermittent confusion and had 1 to 2 elopements.</p> <p>An Elopement Risk Assessment, dated 2/3/24, indicated Resident B was an elopement risk. Resident B had intermittent confusion and had 1 to 2 elopement.</p> <p>A progress note, dated 3/23/24 at 10:55 p.m., indicated LPN 1 received a call from police dispatch. The dispatcher indicated Resident B was found walking down State Highway 135 at 10:27 p.m. Resident B returned to the facility with a police officer. Resident B indicated he needed fresh air. The police officer indicated while in transport, Resident B indicated he wanted to go to Indianapolis to see his mother. An abrasion was noted to the front of Resident B's right ankle. Resident B couldn't remember how the abrasion happened. Resident B was placed on 15-minute checks. Resident B indicated that he ran and pushed the emergency exit door in the dining room open with his body. The emergency exit door was secured when the alarm batteries were replaced.</p> <p>An Elopement Risk Assessment, dated 3/23/24, indicated Resident B was an elopement risk.</p> <p>Physician's orders initiated, on 3/24/24 at 6:30 p.m., (after the second elopement) were as follows:</p> <ol style="list-style-type: none"> 1. Increase Haloperidol (a prescription medication used to treat psychosis) tablet to 15 mg (milligrams) orally at bedtime for psychosis; 2. Increase Haloperidol decanoate (a prescription injectable medication used to treat psychosis) to 150 mg, give 1 dose when available then every 28 days for psychosis and agitation; 3. 1-on-1 direct care for the next 24 hours from 3/24/24 at 6:30 p.m. until 3/25/24 at 6:30 p.m., then re-evaluate. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The March 2024 behavior monitoring documentation indicated Resident B had auditory hallucinations every day from 7:00 a.m., until 3:00 p.m., except on 3/17/24 and 3/24/24. Resident B was not observed to have any auditory hallucinations on any other shifts. On 3/23/24 from 3:00 p.m. until 11:00 p.m. Resident B had exit seeking behaviors.</p> <p>A progress note, dated 3/27/24, indicated the elopement event from Monday, 3/25/24, was investigated. Resident B returned to facility at approximately 8:00 p.m.</p> <p>The clinical record did not include sufficient documentation to determine the specific details regarding elopement 1, on 3/23/24, elopement 2, on 3/24/24, nor elopement 3, on 3/25/24.</p> <p>During an interview on 3/28/24 at 10:50 a.m., CNA 3 indicated on 3/24/24 at approximately 5:00 p.m. CNA 3 was passing dinner trays to the residents who wanted to have dinner in their rooms. CNA 3 saw Resident B walk out to the hallway then Resident B turned and walked back into his room. Approximately 10 minutes later, Resident B wasn't in his room. CNA 3 immediately went outside and looked around the facility. CNA 3 located Resident B approximately 3 blocks from the facility walking away from the facility. When CNA 3 caught up with Resident B, Resident B indicated Resident B did not want to go back to the facility. Resident B was wearing sweat pants, long sleeve shirt, and non-skid socks. Resident B was not wearing shoes. CNA 3 brought Resident B back to the facility at approximately 5:45 p.m. The alarm did not sound when he left the facility.</p> <p>On 3/26/24 at 8:57 a.m., the VPCO provided a copy of a facility policy, titled Elopements and Wandering Residents, dated 2/16/24, and indicated this was the current policy used by the facility. A review of the policy indicated alarms are not a replacement for necessary supervision. This facility ensures residents at risk for elopement and or wandering behaviors receive adequate supervision to prevent accidents.</p> <p>The Immediate Jeopardy, that began on 3/23/24, was removed on 3/28/24 when the facility inserviced the staff 1-on-1 supervision and ensured the unsecured door was under supervision until it could be replaced, but the noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because a systemic plan of correction had not been developed and implemented to prevent recurrence.</p> <p>This citation relates to Complaint IN00431134.</p> <p>3.1-45(a)(2)</p>		