STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING 00 B. WING	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE MARION LLC	614 WEST 14TH STREET MARION, IN 46953

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00387834 and IN00391902. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 7/12/22. Complaint IN00387834 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00391902 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: October 4, 5, 6, and 7, 2022. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 49 SNF: 3 Residential: 13 Total: 65 Census Payor Type: Medicare: 3 Medicaid: 38 Other: 11 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 12, 2022	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to provided adequate supervision to prevent a cognitively impaired resident from exiting the building and property without supervision (Resident E) Findings include: The clinical record for Resident E was reviewed on 10/6/22 at 2:36 p.m.. Diagnoses included, but were not limited to, left side hemiparesis/hemiplegia related to history of cerebral vascular accident, history of falls, encephalopathy and diabetes. Review of a current Minimum Data Set (MDS), dated 9/23/22, indicated the resident was moderately cognitively impaired and ambulated with a cane. Review of an elopement assessment, dated 9/16/22, indicated the resident was not at risk for elopement. Review of a care plan for falls, dated 9/19/22, indicated the resident had encephalopathy that may effect the resident's safety awareness and/or judgment.	F 0689	**Facility respectfully requests paper review/compliance for this citation.** **F689** **1. What corrective actions will be accomplished for those residents found to have been affected by the practice.** Resident was assessed at the time of the event and was found to have no injuries. Resident was placed on 1:1 observation from 10/1/22 at the time of the event until 10/2/22 when he was transported to a secured unit at one of our sister facilities. **2. How will other residents having the potential to be affected by the same practice and what corrective action will be taken:** Audit was conducted to identify those residents residing in the facility that are identified to be as risk for elopement. Identified	10/20/2022

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	Review of an elopement assessment, dated 10/1/22, indicated the resident was at risk for elopement. Review of a police report, dated 10/1/22, indicated a missing persons call was received at 11:07 a.m. Police arrived at the facility at 11:26 a.m. and at 11:33 a.m. the resident had returned to the facility. During an interview, on 10/6/22 at 2:52 p.m., the Executive Director (ED) indicated the facility did not have security video. The ED indicated they believed another resident, currently discharged from the facility, opened the door for Resident E. During an interview, on 10/7/22 at 9:11 a.m., QMA 16 indicated on 10/1/22, she last saw the resident at approximately 7:30 a.m. The resident had been walking through the facility per his usual routine. During an interview, on 10/7/22 at 9:31 a.m., the Activity Director indicated she was contacted by Activity Aide 14 on the morning of 10/1/22 and informed that Resident E had eloped. The Activity Director instructed the Activity Aide to stop the activities and assist the staff with the search for the resident. The Activity Director then called the ED and informed her of the elopement. During the survey multiple attempts were made to contact Activity Aide 14 and were unsuccessful. During an interview, on 10/7/22 at 8:59 a.m., LPN 10 indicated around 8:30 a.m. on 10/1/22, the resident had been seen returning from breakfast. At approximately 10:30 a.m. a therapist asked if anyone knew where the resident was. Staff initiated a facility search and when the resident had not been located, LPN 10 called the police and reported the missing resident. LPN 10 then drove		residents had their care plans and interventions reviewed and updated, as necessary. **3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.** Facility Staff in-servicing initiated immediately per the Executive Director on Elopement policy on 10/1/22. All staff will receive re-education by DON/Designee relative to elopement prevention and procedures. Newly hired staff will be educated upon initial orientation, at least annually, and as needed on Elopement Protocol. Door Security checks will be completed weekly times 4 weeks, then bi-monthly for 6 months by Maintenance Supervisor/Designee. Door security checks remain on a preventative maintenance program to be completed by Maintenance Supervisor/Designee. Maintenance Supervisor/Designee will provide results of door security checks to the QAPI Committee monthly. Elopement Drill was completed on all shifts by Executive Director. Maintenance Supervisor/Designee will conduct elopement drills weekly to include all shifts for 4 weeks then bi-monthly to include all 3 shifts for 8 weeks.	

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	around the area and asked anyone if they had seen anyone fitting the description of the resident. An unknown person indicated they thought they had seen the resident at a local gas station located less than a mile from the facility. LPN 10 then went to the gas station and was told the resident had been there. LPN 10 then looked around the gas station and found the resident at a store located near the gas station. The resident indicated he had been out for a walk. LPN 10 was able to return the resident to the facility without incident. During an interview on 10/7/22 at 10:19 a.m., Receptionist 15, who was working on 10/1/22, indicated she arrived at the facility at 9:30 a.m., obtained a cup of coffee for the resident about 10:30 a.m. and had not seen the resident until he was returned to the facility at approximately 11:22 a.m.. Review of the investigative timeline indicated the resident was out of the facility, without supervision for approximately an hour. No further information was provided. This federal tag relates to Complaint IN00391902. 3.1-45(a)(2)		**4. How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place.** Director of Nursing/Social Service Director/Designee will review Elopement Risk Assessment (ERA) UDAs on all newly admitted/readmitted residents daily, ongoing, during scheduled morning clinical meetings and weekly during comprehensive clinical review meetings; as well as monthly during the Quality Assurance/Performance Improvement with any identified concerns promptly addressed with the responsible individual(s). Results of the door security checks will be presented to the QAPI committee by the Maintenance Supervisor/Designee; results of the reviews of Elopement Binders will be presented to the QAPI committee by the SSD/Designee; staff response to elopement drills will be presented to the QAPI committee by the Maintenance Supervisor/Designee; and results of ERA reviews will be presented to the QAPI committee by the DON/SSD/Designee, all will be reviewed in Quality Assurance meeting monthly for 6 months or until 100% compliance is achieved for 3 consecutive months.	

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