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	06/03/2023

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00409757. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00409757 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: June 1, 2, and 3, 2023. Facility number: 012809 Provider number: 155799 AIM number: 201136580 Census Bed Type: SNF/NF: 27 SNF: 4 Residential: 17 Total: 48 Census Payor Type: Medicare: 4 Medicaid: 27 Total: 31 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 8, 2023.	F 0000		
F 0689 SS=J 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			

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

Tamera Shirels | ED | 06/21/2023

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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	possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision for a resident with a known risk of elopement. This deficient practice resulted in the resident ambulating with his walker approximately 1.4 miles away from the facility, in a busy residential area, with temperatures exceeding 84 degrees F (Fahrenheit) for 1 of 3 residents reviewed for elopement risks (Resident B). The immediate jeopardy began on 5/30/23 when Resident B, a severely cognitively impaired resident, eloped from the facility on foot, down a 30 degree driveway decline, without staffs' knowledge. His whereabouts were unknown for approximately two hours, and he was found unsupervised in a busy residential area approximately 1.4 miles away from the facility. The low temperature on 5/30/23 was 84 degrees F and the high temperature was 89 degrees F, between the hours of 3:30 p.m. and 5:30 p.m. The Administrator, Regional Vice President of Operations, and the Regional Nurse Consultant were notified of the immediate jeopardy at 3:49 p.m. on 6/1/23. The immediate jeopardy was removed, and the deficient practice corrected, on 6/3/23. Findings include: Review of a facility self-reportable, dated 5/31/23, indicated Resident B had left the facility to check on his home, was located at his former residence, and returned to the facility with out incident. He was to remain on	F 0689	Tag number: F689 I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident was placed on 1:1 supervision immediately, head to toe assessment was completed on the resident by NP upon returning to campus. Resident was referred to facilities in Marion area that have secured memory care units. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; New protocols for allowing SNF residents to sit in designated areas outdoors were established, Elopement drills will be conducted at different times for 8 weeks and then quarterly, exit doors will be inspected daily for proper functioning and staff will be randomly quizzed by their supervisor monthly on elopement. III. What measures will be put into place and what systemic	06/04/2023

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	one on one supervision until placement on a secured unit was arranged. On 6/1/23 at 8:48 a.m., Resident B was observed in his room alone. He was dressed in street clothing and was ambulating in his room with his walker. He was not being provided one on one supervision. On 6/1/23 at 11:07 a.m., he was observed sitting on his walker seat near the nurses station. On 6/1/23 at 2:59 p.m., he was observed sitting on his walker seat near the nurses station. Resident B's clinical record was reviewed on 6/1/23 at 9:54 a.m. Diagnoses included cerebrovascular disease, impulse disorder, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, acute and chronic respiratory failure with hypoxia, unspecified systolic (congestive) heart failure, paroxysmal atrial fibrillation, old myocardial infarction, atherosclerotic heart disease of native coronary artery without angina pectoris, presence of coronary angioplasty implant and graft, cognitive deficits following cerebral infarction, essential (primary) hypertension, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. His orders included, clopidogrel bisulfate (blood thinner) 75 mg daily, losartan (blood pressure) 25 mg daily, insulin glargine (insulin) 13 unit subcutaneously twice daily, escitalopram (antidepressant) 5 mg daily, metoprolol succinate (blood pressure) 100 mg daily, and memantine (dementia) 10 mg in the morning, and 5 mg at bedtime.		changes will be made to ensure that the deficient practice does not recur; All staff was educated on the residents who are at risk for elopement, their interventions, including redirecting away from exit doors, on behavioral signs and symptoms of elopement of wanting to go home. Re-education on elopement prevention and procedure annually and upon hire. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Care plans of any residents identified as being at risk for elopement will be reviewed and revised, as necessary, along with the elopement risk assessments and the elopement binders by Social Services/designee. Maintenance Supervisor/designee will inspect all facility exit doors daily for proper functioning. Maintenance Supervisor/designee will conduct weekly elopement drills for all 3 shifts times 4 weeks and then bi-monthly for all 3 shifts times 8 weeks. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved	

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	A current elopement care plan, initiated on 8/9/22, indicated he was at risk for elopement related to disorientation to place and he had impaired safety awareness. His goal was he would accept redirection within two minutes of staff intervention and his safety would be maintained through the review date. His interventions were distract him from wandering by offering pleasant diversions, structured activities, food, conversation, television, or book. He preferred coffee and sat by the nurses station (initiated 8/9/22, revised 6/1/23). Provide structured activities: monthly resident birthday celebrations, coffee social, musical entertainment, reorientation strategies including signs, and pictures (initiated 8/9/22, revised 6/1/23). An elopement/unauthorized leave risk assessment, dated 10/7/22, indicated he was at risk for elopement and should be placed on the Elopement Risk Protocol and an elopement care plan was indicated. A quarterly MDS (Minimum Data Set) assessment, dated 5/9/23, indicated he was severely cognitively impaired. He required limited assistance for bed mobility, dressing, toilet use, and personal hygiene. He required supervision for transfers, walking in his room and in the corridor, and locomotion on and off the unit. He used a walker. The weather for Marion, Indiana on 5/30/23, retrieved from the website "Local Conditions," at www.localconditions.com/weather-marion-indiana /46952/past, indicated the low temperature was 84 degrees F and the high temperature was 89 degrees, between the hours of 3:30 p.m. and 5:30 p.m.		x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	A nurses note, dated 5/30/23 at 5:51 p.m., created on 5/31/23 at 3:41 p.m., indicated the resident left the facility to check on his former home. He was located at his former residence and was returned to the facility. He was assessed with no injuries noted. Vital signs were obtained and they were within normal limits. The NP (Nurse Practitioner) was notified and was on her way to the facility to assess him. He was offered, and accepted, four cups of fluids to drink. He was offered a supper tray and consumed 100%. He was placed on one on one supervision immediately upon return to the facility with the nursing staff. The DON, Administrator, and POA (Power of Attorney) were notified. A NP note, dated 5/30/23 at 6:10 p.m. and created on 5/31/23 at 4:57 p.m., indicated he was evaluated in the morning and was found to be in his normal, pleasantly confused state, although his behavior was easily redirectable. When he returned to the facility from checking on his house, he was flushed, slightly wheezy, and was difficult to redirect. He was fixated on returning to his house, and was somewhat unsteady on his feet. He was encouraged to drink ample fluids, although he did not want to readily drink water as offered. The ER (Emergency Room) was called and his case was discussed with a doctor. His POA was notified that he would be sent to the ER for further evaluation. The POA refused for him to be sent and requested him to be given dinner and treated in-house. Instead, STAT (immediately) labs were ordered. After he returned to the facility he was alert to self, hard of hearing, anxious, difficult to redirect, constantly stated he was going home, and attempted to leave the area. He required one on one supervision. He had scattered wheezes and crackles in his lungs, mild tachycardia			

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	(elevated heart rate) and his bowel sounds were sluggish. His skin was flushed, dry, and he had poor skin turgor. A nurses note, dated 5/30/23 at 6:32 p.m. and created on 5/31/23 at 3:51 p.m. indicated the POA was made aware the NP wanted to send the resident to ER for evaluation and treatment. The POA refused to send him to the ER. The NP was notified and STAT labs were ordered. During an interview with CNA 7, on 6/1/23 at 8:50 a.m., she indicated someone had just called the nurse and told her Resident B was to be a one on one with staff, and to make sure someone was with him. She was not aware of his elopement on 5/30/23 and had just heard about it from the nurse. During and interview with LPN 13, on 6/1/23 at 8:54 a.m., she indicated she was told in report by the night shift nurse of Resident B's elopement. The resident was taken out front to sit, was left alone, and then wandered off. He was to be one on one and to keep an eye on him when he was out of his room. She didn't know he was supposed to have someone with him at all times and it was a miscommunication. The Receptionist had just told her he was supposed to be with someone at all times. During an interview with the Receptionist, on 6/1/23 at 9:00 a.m., she indicated on Tuesday (5/30/23) a little after 3:00 p.m., Resident B came up to the front desk and was looking to go outside and was talking about the weather. She asked him if he wanted to go out and he went outside. He sat outside for about 10 minutes, came back in, and he indicated it was too hot. He sat in the front foyer area for a couple seconds and then walked back towards his room. She had left him out before, but			

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	he didn't go out very often. He had never left the property when he was outside. She left at 4:30 p.m. and no one was outside when she left. During an observation, at the time of the interview, a keypad was located to the right of the exit doors (to allow for a code to be entered to unlock the doors). During an interview with Resident B's POA, on 6/1/23 at 10:28 a.m., she indicated the resident had been let out of the facility previously, in the fall of last year. The BOM (Business Office Manager) held the door for him and let him outside. He was later found in the facility's parking lot. This time, someone let him outside to sit on the front porch and didn't watch him. She was told he was gone for awhile. He walked to his previous home, where he had not lived at for over four years. It was a long way for him to walk, it was so hot out that day, and he was so frail. The facility told her he was an elopement risk and needed to be placed somewhere else. It was not typical for him to want to leave. She felt he was only an elopement risk when someone let him out the front door. During an interview with the Administrator, on 6/1/23 at 11:19 a.m., she indicated on 5/30/23, Resident B went to the end of the month birthday party, as she saw him around 3:45 p.m. walking back towards his room. She went outside to water the flowers. She heard at some point, he came back to the front of the building and the Receptionist let him out to sit on the front porch. She left the facility between 4:20 p.m. and 4:30 p.m. and he was not outside when she left. She received a phone call at 5:50 p.m. from the DON, who indicated she had received a call from the facility that a former employee called and reported Resident B was at his old neighbors house. Two			

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	employees went to pick him up and brought him back to the facility. They called the NP to come to the facility to assess him. He was very thirsty and angry because he couldn't get in his house. He drank four glasses of water. His blood pressure was slightly elevated and his temperature was normal. He was placed on one on ones and his family was notified. He was given a cool shower, he didn't want to eat a lot, but he was urinating fine and was ready to go to bed. He was going to be moving to a secured unit at another facility. There was no video available for when, or how, he left the facility. During an interview with the BOM, on 6/1/23 at 11:29 a.m., she indicated she was coming back from break between 3:45 p.m. and 4:00 p.m. She seen Resident B in the foyer and he was pushing the door to the facility closed. She noticed the Administrator was outside watering flowers and didn't think anything about him being outside. Plus, she got stopped by another resident. Last year in the fall, he was sitting up front, and she passed him when she went to the bathroom. When she came out of the bathroom, she saw him outside and he was walking towards the front of the parking lot. She called code pink over the intercom and ran out to get him. He was easily redirected back into the building. During an interview with the DON, on 6/1/23 at 11:47 a.m., she indicated she received a phone call from the QMA/Scheduler at 5:34 p.m., who told her Resident B was out of the building. He was near his prior home and they were going to go get him. She remained on the phone the entire time, until he got back to the facility. He got in the QMA/Schedulers car with some persuasion. He thought the car had been stolen. They were back at the facility at 5:51 p.m. He was placed on one			

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	on ones. She tried to piece the timeline together. He came to the birthday party at 3:00 p.m. and left the party at 3:45 p.m. The Administrator saw him walk by her office and was heading back towards his room. The Receptionist let him outside, and he came back in. She thought he may have left sometime between 3:45 p.m. and 4:30 p.m. Around 4:40 p.m., the QMA/Scheduler was looking for him and assumed he was at another activity. The Receptionist and the BOM left at 4:30 p.m. and did not see him. This was not typical for Resident B to leave. His dementia was progressing. He usually didn't go outside or come to activities. The BOM let him out last year and he was found walking in the parking lot. That's when his information was put into the elopement binder. He needed a locked unit. During an interview with Activity Assistant 21, on 6/1/23 at 12:35 p.m., she indicated Resident B was at the birthday party and left around 3:45 p.m. She noticed him sitting outside with another resident around 4:00 p.m. She left between 4:30 p.m. and 4:40 p.m. The Administrator was outside watering flowers and the Receptionist was at the desk. Review of the Elopement Binder, on 6/1/23 at 1:59 p.m., indicated a form titled "Wandering/Elopement Risk," dated 10/7/22, with Resident B's, race, height, weight, eye color, and hair color. It listed his responsible party and physician, and if he had any identifying marks. He enjoyed socializing with other residents. The recommendations on approaching/reassuring him was to approach him in a calm manner. During an interview with QMA/Scheduler, on 6/1/23 at 2:41 p.m., she indicated the other QMA came over to her hall and asked if she had seen Resident B. He was last seen at 3:30 p.m. walking			

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	up front to an activity. A former employee called the facility and indicated the resident was at his old house visiting with his neighbors. She called the DON at 5:34 p.m. and told her they were on their way to pick him up. The DON remained on the phone. He appeared fine and happy, like he was taking a stroll through the neighborhood. She tried to get him in the car, and offered him some food and drink. He got in the car, they brought him back to the facility. They did a head to toe assessment and vitals every 15 minutes until the NP got there. They gave him water. The NP wanted to send him out, but the POA refused. He was placed on one on one supervision. She thought he was with his neighbors for 30 to 45 minutes. He had been confused from time to time, but normally was very "with it." She had never known him to go outside like that before. During an interview with LPN 27, on 6/1/23 at 3:03 p.m., she indicated Resident B attended the birthday party and was let outside to sit on the porch. Prior to the birthday party, she heard him say he was going to go home to check on his house. As soon as they found out he was missing, she contacted the DON and the Administrator. They started to search for him around 4:40 p.m. During the search, they received a call from a former employee and found out where he was. He was brought back to the facility and they initiated one on ones. She gave him water and a supper tray. The NP did an assessment and wanted to send him out to the hospital. The family refused, so they did STAT labs on him. Staff knew he was at risk for elopement. When she completed the education, she realized she should have called the code pink over the intercom. During an interview with the Maintenance Director, on 6/1/23 at 3:58 p.m., he indicated the			

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	driveway, from the facility parking lot to the street, was a decline of 30 degrees . A current facility policy, revised on 11/15/18, titled "Code Pink - Missing Resident/Elopement," provided by the Administrator on 6/1/23 at 4:00 p.m., indicated the following: "...2. Should an employee observe a cognitively impaired resident leaving the premises or attempting to exit the premises, he or Nurse or Director of Nursing...Be courteous in preventing the departure...Should an employee discover that a resident is missing from the facility, he or she should...Alert staff by announcing "Code Pink" over the paging system...." The Immediate Jeopardy that began on 5/30/23 was removed, and the deficient practice corrected, on 6/3/23 when the facility educated all staff regarding residents who were at risk for elopement, interventions and behavioral signs and symptoms of elopement, new protocols were developed for nursing home residents to sit outside unsupervised in designated areas, and elopement drills were conducted on all shifts. This Federal tag relates to Complaint IN00409757. 3.1-45(2)			