STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155665	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAJESTIC CARE OF NORTH VERNON	**701 HENRY STREET NORTH VERNON, IN 47265**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate supervision was in place when a resident (Resident B) with a moderately impaired cognition and elopement risk, exited the facility through the bedroom window unsupervised. She was found 1.2 miles away from the facility. Findings include: The incident report, dated 6/2/20 at 10:50 a.m., indicated the Administrator was notified that Resident B had exited the facility and was located at her son's place of employment. The clinical record for Resident B was reviewed on 6/8/20 at 2:44 p.m. [DIAGNOSES REDACTED]. The admission MDS (Minimum Data Assessment), dated 2/21/20, indicated the resident's cognition was moderately impaired. The Wandering/Elopement Risk Scale, dated 5/18/20, indicated the resident was at risk for elopement due to a history of wandering and a medical [DIAGNOSES REDACTED]. During an interview on 6/8/20 at 3:58 p.m., the Administrator indicated the residents' room windows opened horizontally and each window had a screw which prevented the windows from opening more than 3 inches. The resident had lifted the window up over the screw which allowed the window to open completely. The resident then exited out the window and ambulated to the senior apartments, right past the hospital, where she used to live. From there, she ambulated to her son's work and the son alerted us as to where she was. On 6/8/20 at 4:40 p.m., the Administrator provided a current copy of the document titled Elopement (Risk and Missing Resident), dated October 2019. It included, but was not limited to, Policy .Care Team Members who have residents under their care are responsible for knowing the location of those residents This Federal tag relates to Complaint IN 398 3.1-45(a)(2)

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

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.