STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNSTER MED-INN	**7935 CALUMET AVE MUNSTER, IN 46321**

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 **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 observation, record review, and interview, the facility failed to provide adequate supervision to prevent elopement of a cognitively impaired resident with a Wander Guard (device to alarm if a resident has left the building) in place. The whereabouts of the resident were unknown to any facility staff for approximately 4 hours and 30 minutes. (Resident B) The Immediate Jeopardy began on 7/06/20 when Resident B, who was assessed as at risk for elopement and had a Wander Guard in place, rode the elevator off of the floor he resided on, signed himself out at the desk, and a staff member entered the exit code at the front door, allowing the resident to exit the building. The resident was noted to be missing one hour and 15 minutes later, a search began and the police were notified. The resident was located four hours and 30 minutes after he left the facility at a park approximately one mile from the facility. The Administrator, Assistant Administrator, Director of Nursing and the Nurse Consultant were notified of the Immediate Jeopardy on 7/16/20 at 1:26 p.m. Findings include: The record for Resident B was reviewed on 7/15/20 at 8:55 a.m. [DIAGNOSES REDACTED]. The resident was receiving Hospice services. The 6/9/2020 MDS (Minimum Data Set) Significant Change assessment indicated the resident's cognitive skills for decision making were moderately impaired. Resident B was independent with walking in his room, bed mobility and transfers. The resident expressed he had been feeling tired or having less energy in the past several days. He received antidepressant and opioid medications 3 days during the 7 day reference period. A care plan, initiated on 3/24/20 and last revised with a target goal date of 9/30/20, indicated the resident was at risk for elopement related to increased confusion, lack of safety awareness, and impulsive nature which may be related to progression of his disease related to a [DIAGNOSES REDACTED]. Review of a police report indicated the local police department was notified on 7/06/20 at 4:42 p.m. and proceeded to the facility. The police report indicated staff reported Resident B missing from the facility. Social Service staff 2 advised the police that RA (Resident Assistant) 1 was working the door area. RA 1 told the police Resident B had signed out in the log book at 2:27 p.m. and left the building. The police viewed security footage from a drive thru fast food business across the street. A male matching Resident B's build was seen exiting the facility. The resident was found approximately 4.5 hours later at 7:00 p.m He was wearing a black sweatshirt, blue jeans, and a black and white winter stocking cap when he was located. Review of accuweather.com on 7/16/20 indicated the high temperature in the area was 91 degrees F on 7/06/20. A Nursing Progress note, completed on 7/6/20 at 7:19 p.m. indicated Resident B was assessed by nursing staff. No apparent cuts, scratches, scrapes or bruising was noted. The resident denied any pain or discomfort. A Nursing Progress note, completed on 7/6/20 at 7:29 p.m., indicated the resident's Wander Guard was checked and functioning. The resident was moved to a room on the Memory Care dementia unit. Documentation from the facility's investigation, dated 7/7/20, indicated Resident B left the faciity on [DATE]. Seven employees and Resident B were interviewed. Resident B stated upon return to the DON (Director of Nursing) he was going to the doctor and then to the harbor with my friends. The ambulance service was contacted by the facility related to the incident. A manager at the ambulance service stated he would inservice the drivers regarding the need to be aware of their surroundings. The follow up indicated Resident B had signed out at the front desk at 2:30 p.m. When interviewed on 7/16/20 at 12:50 p.m., RA 2 indicated she had worked the day Resident B left the facility. Two ambulance staff and Resident B came from the elevator area and approached the desk. RA 2 indicated she heard the ambulance staff say, he's with us and he prefers to walk. The resident then walked out the door as they were being opened by her for the ambulance staff. When interviewed on 7/16/20 at 11:05 a.m., RA 1 indicated she was working at the check-in table inside the entrance of the building on 7/6/20 when Resident B left the building. The resident signed out on the log to be completed when residents and vendors leave the facility. Ambulance transfer members were also present. No alarms sounded from the elevator. RA 2 turned off the alarm at the front door exit for the ambulance staff and they left. RA 1 did not observe Resident B exit, though she did confirm that RA 2 cut the alarm off at this time. There was no Elopement Book available at the table for staff reference. RA 1 indicated RA 2 was not working the front desk at this time. She came down from her unit on her break to talk to RA 1. When interviewed on 7/16/20 at 11:35 a.m., the Director of Nursing indicated they confirmed Resident B had entered the elevator on the 4th floor. Ambulance staff informed the facility Resident B did ride down the elevator with them on 7/6/20. The ambulance staff were leaving after dropping off another resident on the 4th floor after he attended an appointment. The Director of Nursing indicated if the resident had a Wander Guard on, when he got in the elevator, he nor the ambulance staff would be able to exit the elevator without someone on the elevator punching in a code. Telephone attempts made to speak with the transport staff were unsuccessful. The facility Elopement and Search Policy (Code Pink) was reviewed on 7/17/20 at 8:15 a.m. All Nursing personnel were responsible for knowing the whereabouts of residents for which they are assigned. Department Supervisors are responsible for conducting resident rounds. Observations are made at no less than two hour intervals by nursing staff. Elopement prevention devices are to be checked daily for function. In an event a resident cannot be located a Code Pink is to be implemented over the paging system. When the resident is found a licensed nurse will announce the Code Pink is clear. A clinical assessment will be completed by a licensed nurse. Appropriate security measures will be implemented. The Immediate Jeopardy that began on 7/6/20 was removed on 7/17/20 when the facility assessed all residents with wanderguard to ensure proper functioning and current staff members, as well as vendors, were inserviced on the facility Elopement Policy and Protocol, including the addition of an Elopement Book and ability to exit confirmation procedure at the check out desk. The Immediate Jeopardy was removed on 7/17/20, 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, because not all staff had been educated on updated elopement procedures and monitoring of the check out desk procedure was ongoing. This Federal tag relates to Complaint IN 122. 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.