

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for the Investigation of Complaint IN00192653.</p> <p>Complaint IN00192653 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F323.</p> <p>Survey dates: February 16 and 17, 2016</p> <p>Facility number: 001138 Provider number: 155632 AIM number: 200157070</p> <p>Census bed type: SNF/NF: 42 Residential: 16 Total: 58</p> <p>Census payor type: Medicare: 6 Medicaid: 33 Other: 3 Total: 42</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation and execution of this plan of correction doesnot constitute admission or agreement by this facility of the truth of thefacts alleged or conclusions set forth in the Statement of Deficiencies. ThePlan of Correction is prepared and executed solely because the provisions offederal and state law require it. The facility maintains that the alleged deficienciesdo not individually or collectively jeopardize the health and safety ofresidents nor are they of such character as to limit the facility's capacity orrender adequate care.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0282 SS=E Bldg. 00	<p>Quality review completed on February 19, 2016, by #02748.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a physician's order for a secure unit was followed, by allowing the secured locked Memory Care Alzheimer's Unit to be unlocked and unsecure from 7:00 P.M. until 7:00 A.M., for 2 of 3 residents sampled residing on the Memory Care Alzheimer's Unit, in a sample of 7. This had the potential to affect all residents residing on the secure locked Alzheimer's unit. Residents E and C</p> <p>Findings Include:</p> <p>1. The clinical record of Resident E was reviewed on 2/16/16 at 2:30 P.M.</p>	F 0282	<p>The facility does ensure physician's order are followed. Admission orders were clarified to state that a resident may reside on a secured unit. This clarification promotes resident choice that they may explore social activities, community activities and other activities which may be offered to any resident that resides in the facility. An audit of all orders for residents residing on memory care occurred on 2/25/16 to ensure that all individuals which may be affected by physician's orders were correct. Changes were made to complete appropriateness of the physician orders summary. A mandatory all staff inservice will be completed by March 18, 2016 by the Director of Nursing and Maintenance Director to go over changes, including physician orders and exit door magnetic locks. The Director of</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Diagnoses included, but were not limited to, dementia, agitation and psychosis.</p> <p>A Social Service progress note, dated 1/21/16 at 1:29 P.M., indicated, "Resident has had some issues w [with] exit seeking behavior since admission. He has triggered door alarms x 4 per documentation. He wants to 'go home.' He went outside yesterday, immediately retrieved by staff...resident was placed on 15 minute checks @ that time...He will be a resident on the secure Memory Unit."</p> <p>A Social Service progress note, dated 1/25/16 at 2:04 P.M., indicated, "...Cognitive limits: Confused, identified wanderer...Resident was wandering and exit seeking upon admission, is now residing in the secure Memory Care unit, continues to go to exit doors and attempt to open them."</p> <p>A Social Service progress note, dated 1/25/16 at 2:48 P.M., indicated, "Admission assessment. Resident was admitted to the facility on 1/18/16...His sister heard about the secured unit and wanted her brother to move here for his safety. He is an identified wanderer, and also has been exit seeking @ the other facility. Upon his arrival the unit was not yet secured, and resident did try to exit</p>		<p>Nursing or designee will review all admission orders on a daily basis during stand up meeting. The Director of Nursing or designee will audit admission orders daily X's 4 weeks then monthly for 6 months. Any negative findings will be reported to Quality Assurance Performance Improvement (QAPI) committee.</p> <p>The facility amends our response to reflect the following: Residents E and C were reassessed, physicians consulted and it was determined that residents did not need an order for a locked unit. Orders for secured unit will be dc'd by deficiency corrected date as appropriate. Doors will remain unlocked; however, resident's safety will stay maintained. Facility will consult with all other residents including physicians to determine that the need for a locked unit is not necessary. In the event there is need, reassessment of resident for appropriate placement will take place. All management staff will be reeducated on memory care guidelines. The DON will review orders and assessments of all residents of the memory care unit quarterly for the next 6 months to ensure continued compliance. Any negative findings will be reported to the quality assurance committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>the building @ least 4 x, exiting once...The unit is now secure, and resident cannot exit, however he still goes to the doors of the unit and attempts to open them...."</p> <p>A Physician's order, dated 1/27/16, indicated, "Secure unit."</p> <p>A Nursing Note, dated 1/27/16 at 3:29 P.M., indicated, "Moves about freely on the unit, needs supervision by staff d/t resident being at risk for elopement."</p> <p>A Nursing Note, dated 1/27/16 at 4:14 P.M., indicated, "Elopement/Wandering Assessment:...History of Wandering: Yes, within past 3 months Resident has a history of wandering at nursing home prior nursing home. Current frequency of wandering 4-6 times a day/daily. At times resident will get up from room or activity room and take off walking no purpose noted. History of Elopement: prior to admission at prior nursing facility no issues since admission to this facility...Resident resides on Memory Care Unit at time [sic] he will walk randomly without purpose no attempts have been made to elope since placement on Memory Care Unit."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 1/28/16, indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>resident scored a 4 out of 15 for cognition, with 15 indicating no memory impairment, and required limited assistance of one person for walking in the room and corridor. The MDS assessment indicated the resident had not wandered in the previous 7 days.</p> <p>A Social Service progress note, dated 2/2/16 at 3:45 P.M., indicated, "Resident has been pacing up and down hallway since arriving back to facility...."</p> <p>Nursing Notes continued:</p> <p>2/6/16 at 2:27 P.M.: "Requires no help from staff to walk in corridor. Walks independently in corridor. Does not move about the unit. Resident is on secure unit."</p> <p>2/7/16 at 7:20 P.M.: "Wandering: behavior occurred daily resident wandered out the main entrance 1910 [7:10 P.M.]...Intervention: 1:1, ask resident not to leave building, reminded of potential for injury. Outcome: unchanged...A wanderguard bracelet/anklet may be an appropriate intervention."</p> <p>2/7/16 at 9:05 P.M.: "Resident went out main entrance door times 2 this shift, was easily redirected back into facility. In</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Activity room at present, will continue to monitor."</p> <p>A Social Service progress note, dated 2/8/16 at 8:28 A.M., indicated, "Resident continues to be restless and exit seeking. Friday 2/5/16, resident was noted as pacing up and down hallway of secure unit, getting to the door and pounding on it. Has to be diverted/redirected from this activity...On 2/7/16, it is noted that when secure doors opened @ 7 pm, resident exited out of the main entrance of facility...."</p> <p>A Social Service progress note, dated 2/11/16 at 11:02 A.M., indicated, "Resident continues to do fairly well, he does continue to pace the hallway, usually @ evening time or so than daytime...."</p> <p>A Care Plan, dated 1/22/16, indicated, "Problem: Identified wanderer (Resident is now on secure Memory Care Unit) Related to: Alzheimer's/dementia Manifested by: Pacing, wanders near exits/wanders to exits (prior to secure unit)." The Approaches included: "Be able to identify resident, Know whereabouts, Exit door alarms on, Orient resident as needed."</p> <p>An additional Care Plan, dated 2/8/16,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>indicated, "Identified wanderer, exit seeker Related to: Dementia, identified wanderer, exit seeking behavior, Related to: Dementia, Pschosis [sic] (wander guard placement), Manifested by: pacing toward exit, attempting to open exit door, confusion/disorientation to place and time...pacing, pounding on doors, walking rapidly toward exits, has exited building 2/7/16..." The Approaches included: "Place wander guard, check alarms on doors, know resident's whereabouts...redirect/divert as needed, Call light within reach..." The Goal indicated, "Safety will be maintained (resident needs unit for safety of self)..."</p> <p>2. On 2/16/16 at 9:15 A.M., during the initial tour, the Director of Nursing (DON) indicated 6 residents resided on the locked Alzheimer's Unit.</p> <p>A "Stop Sign" was observed attached with velcro across Resident E's door. The DON indicated at that time, "Sometimes [Resident C] gets lost and can't find his room."</p> <p>The clinical record of Resident C was reviewed on 2/16/16 at 1:05 P.M. Diagnoses included, but were not limited to, dementia.</p> <p>Social Service Notes included the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>following notations:</p> <p>1/12/16 at 10:36 A.M.: "Yesterday 1/11/16, resident went outside through alarmed door, and was immediately escorted in be staff. Wandering care plan created/updated, w [with] 15 minute checks through night...Resident is awaiting the Memory Care Unit to open."</p> <p>1/12/16 at 10:40 A.M.: "IDT [Interdisciplinary team] discussion regarding interventions for identified wandering...decision made to place red stop signs @ each exit that resident attempts to open...signs will remain in place until resident is on Memory Unit."</p> <p>1/14/16 at 2:33 P.M.: "It is verbally reported to by AD [Activity Director] that she witnessed resident attempting to open 200 hall exit door, she states she was present, and she showed resident the stop sign, and both times he was compliant w the sign and turned and walked away...."</p> <p>1/22/16 at 7:54 A.M.: "AS of this am, resident is now secure in Memory Care Unit."</p> <p>A Physician's order, dated 1/27/16, indicated, "Secure unit."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Progress Notes included the following notations:</p> <p>2/3/16 at 2:52 P.M.: "Decision Making Ability: is disoriented, dementia, has difficulty communicating needs, moves about freely on the unit...Elopement/Wandering Assessment:...Getting lost periods of locomotion interspersed with periods of nonlocomotion...History of wandering: Yes, within past 3 months...."</p> <p>2/11/16 at 3:20 P.M.: "...Stop sign intervention has been effective aeb [as evidenced by] resident has not been wandering into other resident's room. Will continue to monitor this bx [behavior]."</p> <p>A Care Plan, dated 1/12/16, indicated, "Problem: Identified Wanderer (resident exited building 1/11/16...) Related to: Alzheimer's Dementia, no safety awareness, Manifested by: irritability, Agitation, Disoriented x 3, wanders to and or near exits." The Approaches included: "Record episodes of wandering, place red stop signs @ some exits...attempt to divert attention...."</p> <p>An additional Care Plan, dated 1/26/16, indicated, "Problem: Resident is now on secure Memory Care Unit for safety of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>self Related to: Alzheimer's/Dementia, unable to communicate wants/needs effectively, identified wanderer...exit seeking behaviors, Manifested by: wandering toward exits and setting off alarms..." The Approaches included: "Maintain resident's safety...."</p> <p>3. On 2/16/16 at 3:05 P.M., during an interview with the Social Services Director (SSD), she indicated the Memory Care Unit "unlocks their doors at 7:00 P.M."</p> <p>On 2/16/16 at 3:15 P.M., during an interview with the Administrator, she indicated the doors to the Memory Care Unit are opened at 7:00 P.M. until 7:00 A.M. She indicated the Memory Care Unit does not have separate staffing for 2nd or 3rd shift. She indicated she felt like the staffing ratio was appropriate.</p> <p>On 2/17/16 at 9:10 A.M., the Director of Memory Care provided the current facility "Guidelines for Admission" to the Alzheimer's Unit, undated. The guidelines included: "...Memory care is our secured area specifically designed to meet the needs of an individual who has Alzheimer's or dementia...Guidelines for Admission:...Wandering/Exit-seeking behavior...Is not safe to be left alone."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>On 2/17/16 at 10:00 A.M., the Corporate Consultant indicated, "We have never advertised our Memory Care Unit as a locked unit." The Director of Memory Care indicated she was unsure if the residents' physicians were aware that the unit was unlocked from 7:00 P.M. until 7:00 A.M.</p> <p>This Federal tag relates to Complaint IN00192653.</p> <p>3.1-35(g)(2)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0323 SS=D Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision for a resident at risk for wandering, allowing the resident to exit the facility, for 1 of 3 residents reviewed for wandering, in a sample of 7. Resident E</p> <p>Findings include:</p> <p>On 2/16/16 at 2:05 P.M., CNA # 1 was observed holding Resident E's hand and walking in the Memory Care Alzheimer's Unit. CNA # 1 indicated at that time that Resident E would "walk up and down the halls a lot."</p> <p>The clinical record of Resident E was reviewed on 2/16/16 at 2:30 P.M. Diagnoses included, but were not limited to, dementia, agitation, and psychosis.</p>	F 0323	<p>The facility does ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision. The facility installed magnetic locks on all doors to provide facility-wide security for individuals with altered mental status and/or cognition who may attempt to exit the facility. The magnetic lock system was put into place to ensure that all residents are in a safe and protected environment, including other residents that reside in the facility who may be affected by altered mental status and/or cognition. A mandatory all staff in service will be completed by March 18, 2016 by the Director of Nursing and Maintenance Director to go over changes, including physician orders and exit door magnetic locks. Maintenance will do daily door checks as covered by their daily PM morning rounds. Any negative findings will be reported to Quality Assurance Performance Improvement (QAPI) committee on an ongoing basis.</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Nursing Notes included the following notations:</p> <p>1/18/16 at 2:24 P.M.: "Wandering: resident is new to facility was wondering [sic] when admitted, triggered 100 hall alarm Behavior occurred 1-3 days in the last 7 days."</p> <p>1/19/16 at 9:01 A.M.: "Moves about freely on the unit, needs supervision by staff d/t [due to] resident being at risk for elopement."</p> <p>1/19/16 at 9:29 A.M.: "Wandering Beh [behavior] noted: Elopement/Wandering Assessment:...Independently ambulatory...was given in report that resident has hx [history] of wandering and elopement risk."</p> <p>1/20/16 at 2:05 P.M.: "Wandering: behavior occurred daily, Intervention: redirected, Outcome: unchanged...Resident opened the doors to the outside twice, and redirected both times, resident was looking for an exit."</p> <p>1/20/16 at 10:03 P.M.: "Wandering Beh noted: Resident pacing up and down hallways, appeared to be very anxious. Did get out 400 door times 2, and made attempts 2 other times to get out the 400</p>		<p>The facility amends our response to reflect the following: During situation, door alarmed and resident E was immediately brought back in by staff. Resident was sent for further inpatient assessment and workup of his exit seeking. All other residents of the memory care were assessed to assure proper care plans were in place for exit seeking. The nursing staff were reeducated on assessment and referral of exit seeking residents. Facility installed magnetic coded door alarms on all exit doors. Staff was trained on magnetic control system. The DON will review all assessments and care plans of memory care residents quarterly for the next six months to ensure training and care plans are adequate. The administrator will monitor nursing schedules in advance on weekly basis to ensure that proper scheduling of staff is taking place.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>hall door...Staff did get resident ready for bed and he did lay down in bed for awhile, got back up and was walking on 300 hall, then went back to bed... 15 minute checks done this shift per staff."</p> <p>1/21/16 at 12:50 P.M.: "Wandering Beh noted: continues to wander at times. 15 minute checks continue, staff intervened immediately after resident walked out 400 hall door."</p> <p>A Social Service progress note, dated 1/21/16 at 1:29 P.M., indicated, "Resident has had some issues w [with] exit seeking behavior since admission. He has triggered door alarms x 4 per documentation. He wants to 'go home.' He went outside yesterday, immediately retrieved by staff...resident was placed on 15 minute checks @ that time...He will be a resident on the secure Memory Unit."</p> <p>A Social Service progress note, dated 1/25/16 at 2:04 P.M., indicated, "...Cognitive limits: Confused, identified wanderer...Resident was wandering and exit seeking upon admission, is now residing in the secure Memory Care unit, continues to go to exit doors and attempt to open them."</p> <p>A Social Service progress note, dated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>1/25/16 at 2:48 P.M., indicated, "Admission assessment. Resident was admitted to the facility on 1/18/16...His sister heard about the secured unit and wanted her brother to move here for his safety. He is an identified wanderer, and also has been exit seeking @ the other facility. Upon his arrival the unit was not yet secured, and resident did try to exit the building @ least 4 x, exiting once...The unit is now secure, and resident cannot exit, however he still goes to the doors of the unit and attempts to open them...."</p> <p>A Nursing Note, dated 1/27/16 at 3:29 P.M., indicated, "Moves about freely on the unit, needs supervision by staff d/t resident being at risk for elopement."</p> <p>A Nursing Note, dated 1/27/16 at 4:14 P.M., indicated, "Elopement/Wandering Assessment:...History of Wandering: Yes, within past 3 months Resident has a history of wandering at nursing home prior nursing home. Current frequency of wandering 4-6 times a day/daily. At times resident will get up from room or activity room and take off walking no purpose noted. History of Elopement: prior t admission at prior nursing facility no issues since admission to this facility...Resident resides on Memory Care Unit at time [sic]he will walk</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>randomly without purpose no attempts have been made to elope since placement on Memory Care Unit."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 1/28/16, indicated the resident scored a 4 out of 15 for cognition, with 15 indicating no memory impairment, and required limited assistance of one person for walking in the room and corridor. The MDS assessment indicated the resident had not wandered in the previous 7 days.</p> <p>A Social Service progress note, dated 2/2/16 at 3:45 P.M., indicated, "Resident has been pacing up and down hallway since arriving back to facility...."</p> <p>Nursing Notes continued:</p> <p>2/6/16 at 2:27 P.M.: "Requires no help from staff to walk in corridor. Walks independently in corridor. Does not move about the unit. Resident is on secure unit."</p> <p>2/7/16 at 7:20 P.M.: "Wandering: behavior occurred daily resident wandered out the main entrance 1910 [7:10 P.M.]...Intervention: 1:1, ask resident not to leave building, reminded of potential for injury. Outcome: unchanged...A wanderguard</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>bracelet/anklet may be an appropriate intervention."</p> <p>2/7/16 at 9:05 P.M.: "Resident went out main entrance door times 2 this shift, was easily redirected back into facility. In Activity room at present, will continue to monitor."</p> <p>A Social Service progress note, dated 2/8/16 at 8:28 A.M., indicated, "Resident continues to be restless and exit seeking. Friday 2/5/16, resident was noted as pacing up and down hallway of secure unit, getting to the door and pounding on it. Has to be diverted/redirected from this activity...On 2/7/16, it is noted that when secure doors opened @ 7 pm, resident exited out of the main entrance of facility...."</p> <p>A Social Service progress note, dated 2/11/16 at 11:02 A.M., indicated, "Resident continues to do fairly well, he does continue to pace the hallway, usually @ evening time or so than daytime...."</p> <p>A Care Plan, dated 1/22/16, indicated, "Problem: Identified wanderer (Resident is now on secure Memory Care Unit) Related to: Alzheimer's/dementia Manifested by: Pacing, wanders near exits/wanders to exits (prior to secure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>unit)." The Approaches included: "Be able to identify resident, Know whereabouts, Exit door alarms on, Orient resident as needed."</p> <p>An additional Care Plan, dated 2/8/16, indicated, "Identified wanderer, exit seeker Related to: Dementia, identified wanderer, exit seeking behavior, Related to: Dementia, Pschosis [sic] (wander guard placement), Manifested by: pacing toward exit, attempting to open exit door, confusion/disorientation to place and time...pacing, pounding on doors, walking rapidly toward exits, has exited building 2/7/16..." The Approaches included: "Place wander guard, check alarms on doors, know resident's whereabouts...redirect/divert as needed, Call light within reach..." The Goal indicated, "Safety will be maintained (resident needs unit for safety of self)..."</p> <p>On 2/16/16 at 3:05 P.M., during an interview with the Social Services Director (SSD), she indicated the first time that Resident E exited, the "unit was not secure yet." She indicated the second time that the resident exited the facility unattended, he went out the main entrance. She indicated the Memory Care Unit "unlocks their doors at 7:00 P.M."</p> <p>On 2/16/16 at 3:15 P.M., during an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>interview with the Administrator, she indicated the doors to the Memory Care Unit are opened at 7:00 P.M. She indicated the Memory Care Unit does not have separate staffing for 2nd or 3rd shift. She indicated she felt like the staffing ratio was appropriate.</p> <p>On 2/16/16 at 3:35 P.M., during an interview with LPN # 2, she indicated she was working on the evening of 2/7/16. She indicated she heard the main front door alarm, and found the resident outside of the facility on the sidewalk. She indicated the resident resided on the Memory Care, but that after 7:00 P.M., "they unlocked the doors."</p> <p>On 2/16/16 at 3:40 P.M., during an interview with LPN # 1, she indicated that Resident E "goes to the 400 door sometimes." She indicated the resident had gotten outside through the 400 door, and had to be escorted around the building to the main entrance. She indicated she thought that some staff didn't like working on the Memory Care Unit, and that there was a problem staffing it.</p> <p>On 2/17/16 at 10:00 A.M., the Corporate Consultant indicated, "We have never advertised the Memory Care Unit as a locked unit." The Director of Memory</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Care indicated at that time that there was not 1 dedicated staff member who stayed on the Memory Care unit after 7:00 P.M.</p> <p>During a confidential interview with Staff # 1, she indicated, "It's not right they open that door at 7:00 P.M. There's not enough staff to cover it. There is not a CNA on that unit after 7:00 P.M. There are usually 2 CNAs on evenings and nights for the whole building." Staff # 1 indicated she had heard Resident E "had gotten out several times."</p> <p>During a confidential interview with Staff # 2, she indicated she "didn't think it was right" that the Memory Care Unit unlocked the doors at 7:00 P.M. She indicated the doors were unlocked due to "not enough staff to cover."</p> <p>On 2/17/16 at 9:10 A.M., the Director of Memory Care provided the current facility "Guidelines for Admission" to the Alzheimer's Unit, undated. The guidelines included: "...Memory care is our secured area specifically designed to meet the needs of an individual who has Alzheimer's or dementia...Guidelines for Admission:...Wandering/Exit-seeking behavior...Is not safe to be left alone."</p> <p>This Federal tag relates to Complaint IN00192653.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/17/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	3.1-45(a)(2)			