

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155830	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2015
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NAME OF PROVIDER OR SUPPLIER HARRISON'S CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 395 8TH AVENUE TERRE HAUTE, IN 47804
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00185419, IN00185772, and IN00187034.</p> <p>Complaint IN00185419- Substantiated. Federal/State deficiencies are cited at F 323.</p> <p>Complaint IN00185772- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00187034- Unsubstantiated due to lack of evidence.</p> <p>Survey dates: November 23 and 24, 2015</p> <p>Facility number: 013335 Provider number: 155830 AIM number: 201290670</p> <p>Census bed type: SNF: 33 SNF/NF: 10 Residential: 30 Total: 73</p> <p>Census payor type: Medicare: 26 Medicaid: 8 Other: 9</p>	F 0000	Preparation or execution of this plan correction does not constitute admission or agreement of provider of the truth of facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey IN00185419 on November 24, 2015. Please accept this plan of correction as the provider's compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance	
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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.

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F 0323 SS=D Bldg. 00	<p>Total: 43</p> <p>Sample: 6</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed November 25, 2015 by 29479.</p> <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. Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent a cognitively impaired resident from eloping from the facility for 1 of 1 resident reviewed for elopement risk. (Resident B).</p> <p>Finding includes:</p> <p>On 11/24/15 at 10:36 a.m., Resident B was observed walking independently, with a slow and unsteady gait in the hallway of the 200 hall. The resident's wander guard bracelet was observed on</p>	F 0323	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice:</p> <p>Resident B was immediately assessed for injury upon return to unit on 10/24/2015. No injury was noted. On 10/25/2015 a wanderguard was applied to Resident B wrist. On 10/26/2016 LPN #3 was given a written discipline for</p>	12/11/2015
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	<p>her right ankle.</p> <p>On 11/23/15 at 12:53 p.m., during an interview, (Certified Occupational Therapy Assistant) COTA #1 indicated on 10/24/15 at approximately 12:00 p.m., she observed Resident B walking out of the front door of the facility and grabbing at a door handle of a car parked directly in front of the building. COTA #1 indicated she asked the resident if she needed assistance and the resident indicated she was going for a ride. COTA #1 indicated she assisted the resident into the front seat of the car. She indicated she was not aware that the person she assisted into the car was a resident of the facility. COTA #1 indicated she was passed by people, she believed to be the owners of the car, as she re-entered the building.</p> <p>On 11/23/15 at 1:24 p.m., during an interview, the (Assistant Director of Nursing Service) ADNS indicated she was the on-call supervisor for the weekend of the event. She was first told of the elopement during shift change report on 10/25/15 at approximately 6:00 a.m. She indicated she immediately placed the resident on 15 minute checks, contacted the Administrator, Director of Nursing Service (DNS), the resident's physician, and the resident's husband.</p>		<p>not following Elopement Policy and Procedure (Exhibit A). LPN #3 was also re-educated on Elopement Policy and Procedure at this time. 11/27/2015 COTA 1 was educated on facility Elopment Policy and Procedure.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</p> <p>No other residents had the potential to be affected by the alleged deficient practice as no other residents identified as elopement risks.</p> <p>Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:</p>		

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	<p>The ADNS indicated the physician ordered a wander guard bracelet to be placed on the resident. She indicated the 15 minute checks were discontinued once the wander guard was activated and verified to be working. The ADNS indicated the wander guard is checked for function and placement every shift.</p> <p>On 11/23/15 at 1:36 p.m., Therapy Manager, (Physical Therapist) PT #2, was interviewed. She indicated COTA #1 was inserviced on the elopement policy and procedure on 10/27/15, which was the very next date COTA #1 was scheduled to work.</p> <p>On 11/23/15 at 2:50 p.m., the Administrator and DNS were interviewed. The DNS indicated Resident B ambulated throughout the facility daily. She indicated the resident had never exhibited any exit seeking behavior prior to or since the event. The Administrator indicated there were no other residents in the facility identified as elopement risks. The Administrator indicated she had reviewed the security video which showed Resident B was assisted into the car by COTA #1, and the owners of the car immediately spoke with the resident, and the resident returned to the facility independently within one minute. The Administrator indicated facility staff</p>		<p>Monthly Elopement drills for all staff completed per Director of Plant Operations or designee.</p> <p>All employees, including contracted employees will be educated on the Elopement Policy and Procedure upon hire and annually thereafter.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</p> <p>Elopement drills, attempted elopements and resident who exit seek will be reviewed monthly at Quality Assurance Meeting x 6 months.</p> <p>Date: December 11, 2015</p>	

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	<p>were inserviced on the elopement policy and procedure on 11/2/15. The DNS indicated the charge nurse on Resident B's unit was disciplined and inserviced on the elopement policy and procedure on 10/26/15.</p> <p>On 11/24/15 at 10:30 a.m., during a telephone interview, (Licensed Practical Nurse) LPN #3 indicated she was the charge nurse for the 200 hall on 10/24/15. She indicated she was told about Resident B exiting the facility by LPN #8 at approximately 7:00 p.m., on 10/24/15. LPN #8 indicated to her she had been contacted by the owners of the car and told of the resident being in the front seat of the car. LPN #3 indicated she discussed the event with other nursing staff and she decided to pass the information along to the night shift to have it reported to the ADNS who was scheduled to work the day shift on 10/25/15. LPN #3 indicated she performed an assessment on the resident as soon as she was notified of the event and no injury was observed.</p> <p>On 11/23/15 at 11:15 a.m., review of Resident B's medical record indicated the resident's diagnoses included, but were not limited to, Huntington's disease and dementia without behavioral disturbance.</p>			
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	<p>Review of the resident's quarterly Minimum Data Set (MDS) assessment, dated 10/20/15, indicated the resident had severe cognitive deficit and exhibited no wandering behavior.</p> <p>Review of the resident's initial nursing assessment, dated 3/25/15, indicated the resident was not at risk for wandering into a dangerous place or intruding into the privacy of others. The assessment indicated the resident was not a risk for elopement.</p> <p>A care plan, dated 10/26/15, indicated the resident was at risk for elopement related to her disease process. Interventions included, but were not limited to, wander guard in place at all times.</p> <p>On 12/23/15 at 12:00 p.m., review of the form titled, "Indiana State Department of Health Incident Report Form," dated 10/26/15, indicated written statements were obtained from LPN #3 and LPN #8. The statements concluded that the resident exited the building and was found sitting inside a visitor's car parked in front of the building. The statements also concluded that LPN #3 reported the incident to the night shift staff to inform the ADNS at shift change for the day shift of 10/25/15.</p>			

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	<p>On 11/23/15 at 2:56 p.m., a copy of a policy titled, "Procedure Guidelines Missing Persons," dated 11/16/11, was provided by the DNS. The policy indicated, "Procedure: 1. It is the responsibility of all personnel to report any resident attempting to leave the premises...2. Should a resident be observed leaving the premises: a. Attempt to prevent the departure...c. Instruct another staff person to inform the charge nurse...that a resident is leaving the premises...."</p> <p>This Federal tag relates to Complaint IN00185419.</p> <p>3.1-45(a)(2)</p>						