STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155210		12/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF GREENSBURG	410 PARK RD GREENSBURG, IN 47240

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00188212. Complaint IN00188212 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: December 14 and 15, 2015 Facility number: 000117 Provider number: 155210 AIM number: 100266460 Census bed type: SNF/NF: 63 Total: 63 Census payor type: Medicare: 3 Medicaid: 33 Other: 27 Total: 63 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 34849 on December 21, 2015.	F 0000	Please accept this Plan of Correction as our credible allegation of compliance for the deficiencies noted in the 2567 for Heritage House of Greensburg. In respectfully submitting the required Plan of Correction our facility is not admitting to the allegations of non-compliance contained within. We are alleging compliance January 14, 2016 and request a paper compliance review if applicable.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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=G Bldg. 00	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 provide supervision to prevent the elopement and subsequent fall with injury to one cognitively impaired resident (Resident B) for one of three residents reviewed for accidents. This deficient practice resulted in harm in that Resident B was found face down on the porch of a private home across the street from the facility and sustained a comminuted, displaced and depressed nasal fracture. Findings include: During an unannounced visit on 12/14/2015, an initial tour was conducted with RN (Registered Nurse) # 1 at 9:30 a.m. The following observations were	F 0323	F323 The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistive devices to prevent accidents.Resident B has been re-evaluated and placed on the secured dementia unit and is wearing a wanderguard device to ensure safety. Resident B's injury healed without complications. The psychologist evaluated resident B on 12-16-15. He is uncertain if actions are a result of her mild Mental Retardation, Schizophrenia, depression, anxiety, or dementia. Resident B's Bims score is 10/15 indicating moderately impaired. Resident B's physician evaluated her. Labs were obtained and within normal range. .Resident B's medication regime was reviewed	01/14/2016

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	made about the facility layout: 1. There was no keypad/security inside the front entrance of the facility. 2. The facility was in an "H" format, with the main entrance being in the middle of the east wing of the facility. 3. Upon entering the facility, the main dining room was to the south, and therapy areas and offices were to the north. 4. There was a long hallway which ran east to west from the main entrance, with staff offices along the east end (near entrance) and resident rooms beginning on the west end (further from entrance). 5. There was a front office located where the three halls intersected, which was open by two sliding glass windows which met at the corner. 6. Station 4, the main and first nurses station encountered after entering the facility, was located on the far end of the west hall, with resident rooms running down a long hall from north to south. Resident B's clinical record was reviewed on 12/14/2015 at 11:10 a.m. Diagnoses included, but were not limited to, mild		without additional changes. A new elopement assessment and fall risk assessment were done on resident B. The plan of care has been revised to reflect current and appropriate interventions. A significant change MDS is scheduled to be completed by 1-14-16. Resident B has not had any further falls or exit from the facility.No other residents were found to be affected by this practice.All current residents will have a new elopement assessment completed by 1-14-16. Any resident with a score of 5 or above will be evaluated as an elopement risk and appropriate interventions put in care plan and communicated to the staff.All current residents fall care plans will be reviewed for appropriate interventions and communicated to the staff.All residents will have an elopement assessment done upon admission, quarterly, annually and significant change. The policy and procedure has been updated to reflect this. See Attachment A.All residents will have a fall risk assessment completed upon admission, quarterly, annually and significant change. All care plans will be implemented or revised for appropriate interventions and communicated to the staff.All nursing staff will be in-serviced on the fall prevention and elopement processes by 1-14-16. All nursing staff with be	

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	mental retardation, schizophrenia disorder, major depressive disorder, chromosomal anomaly, insomnia, seizure disorder (epilepsy), and history of making suicidal statements. Resident B's quarterly Minimum Data Set (MDS) assessment, dated 11/2/2015, indicated a Brief Interview for Mental Status (BIMS) score of 6 of 15; indicating the resident was moderately cognitively impaired. Resident B ambulated independently, but required setup help and supervision for locomotion on and off the unit (how the resident moved between locations in his/her room and adjacent corridor on the same floor, and how the resident moved to and returned from distant areas, such as dining, activities or treatments, on the floor). A current care plan for Resident B, initiated 8/14/2015, indicated, "Resident has impaired decision making skills. Resident requires cues and supervision....Interventions: ...Gently reorient resident as needed...." A current care plan for Resident B, initiated 8/14/2015, indicated, "Resident has memory problems R/T [related to]: long term memory deficit, short term memory deficit as evidenced by:		in-serviced/education on the fall and elopement prevention processes during dementia training, annually and as needed.A Quality Assurance Tool titled "Fall Risk Management Review" will be completed X 3 months then quarterly thereafter.A Quality Assurance Tool titled "Fall Risk Management Review" will be completed monthly X 3 then quarterly thereafter.The results of the audits will be reviewed by the Quality Assurance Committee monthly and any recommendations made shall be followed.All corrections to be completed by 1-14-16.	

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	Forgetfulness. Unable to recall three words...Interventions: Assess for UTI if increased cognitive deficit noted...." A current care plan for Resident B, initiated 8/14/2015, indicated, "Resident has a history of making suicidal statements about killing self or wishing they were dead. Resident stated to nurse, 'If I say I'm going to kill myself, can I go out? I just need a break, and want to get out of here.'..." A current care plan for Resident B, initiated 11/6/2015, indicated, "Resident is at risk for falls R/T [related to] epilepsy, medications, HX [history of], chronic pain, doesn't like to wear shoes...Interventions: ...cues/redirect PRN [as needed]...Instruct/remind/encourage resident to call for assist with mobility or transfers as needed...Observe for safety. Placed secure ankle bracelet on pt. [patient] left ankle to alert staff pt. out of facility (Date Initiated: 12/05/2015)...." A current care plan for Resident B, initiated 12/5/2015, indicated, "Resident is at risk for wandering from facility secondary to MR [mental retardation] and schizophrenia. Resident thought she saw her son's motorcycle and went to see him. Goal: resident will not			

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	wander/elope from facility through next review...." An Incident/Accident Report for Resident B, dated 12/5/2015, was provided by RN # 1 on 12/14/2015 at 11:12 a.m. The document indicated, "Date of Incident/Accident: 3:30 p.m. Time: 3:30 p.m. Exact Location of Incident/Accident: [checked] Other/Specify: Across street family's porch...Property Involved: concrete porch/step. Was person authorized to be at location of accident/incident [not indicated]. Describe exactly what happened...: Dietary [staff] called to [LPN (Licensed Practical Nurse) # 2] ask if pt allowed to go across street. Then 2 CNA's (Certified Nursing Assistants) went over to find pt. lying on front porch face down in pool [of] bl [blood]. [RN # 5] over there....[resident] brought to nursing home...Indicate on the diagram location of injury: [lines drawn to indicate forehead, face, cheeks, eyes, neck, and "bruising" to left knee. Additional documentation indicated, "Hematoma both eyes...bruising cheeks down neck."]...Was person involved taken to a hospital: Yes. Name/Title...of Witness(es): Dietary [staff] just saw pt across road. Additional Comments and or Steps Taken to Prevent Recurrence: Secure Care Ankle bracelet on (L) [left]			

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	ankle...." Resident B's Elopement Risk Assessment, dated 12/6/2015 at 12:54 p.m., indicated a total score of two; indicating the resident was not an elopement risk. A positive answer to number four (historical behavior patterns) or a score of five or higher would indicate an elopement risk. The document indicated the following: "1. Relevant Diagnoses: a. Alzheimer's, Dementia, TBI, Mental Illness, MR/DD: Yes [one point]. 2. Cognitive Patterns: b. Memory problem, memory recall impaired, decision-making skills impaired, indicators of delirium: No ["Yes" would add one point]...4. Historical Behavioral Patterns: d. Purposeful exit seeking, frequently searching for home or something familiar: No ["Yes" would add two points]....6. Mobility Status: f. Independently mobility with or without assistive devices." Nursing Progress Notes, dated 12/5/2015 at 3:30 a.m., indicated, "...Dietary [staff] called to nurse [LPN # 2] and ask if pt. allowed to go across street. Then 2 CNA's went over to find pt lying on front porch face down in pool of blood...Nurse noted nose swollen and bruises on chin neck both eyes were turning black...Pt			

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	alert and oriented to time and place and person states she was going over to house to see if her son [name] was there, had seen black motorcycle there and her son has one. When went upon porch fell face first. Porch was concrete and had a step. Called [Physician name] at 4pm and new order received to send pt to ER [Emergency Room]...returned with pt at 7:00 p.m. Pt's face more swollen eyes black cheeks now bruising. Chin neck and nose shows bruising...At 9:30 [p.m.] called DON [Director of Nursing] and notified her of incident and broken nose and that pt was off grounds...[Resident] states she was going over to that house because she saw a black motorcycle and thought it was her son's, [name]...called son [name] and explained incident and pt injury - He said he was not even in town...." Radiology Report, dated 12/6/2015 at 12:33 p.m., indicated, "Service Date: 12/05/2015 05:17:37 PM...Exam: CT Maxillofacial...Indication: Reason CT Sinus: Trauma - Fall. Pain in frontal and parietal regions post fall today. Patient was walking and fell face first into the sidewalk. Bruising under both eyes, chin, and on her nose. Patient has blood in her nose and on her lips. Impression: --Comminuted Nasal Fracture...The patient could not cooperate with routine			

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	positioning...There is a comminuted [bone is in many pieces/fragmented], displaced [bone snaps in two or more parts and moves so the two (or more ends) are not lined up straight], and depressed [fragment of the bone is depressed] nasal fracture." On 12/14/15 at 10:57 p.m. LPN # 2 indicated she was on duty 12/5/2015 during during the incident. She indicated Dietary Staff # 1 was sitting in the dining room and saw Resident B outside and asked her if Resident B was allowed to walk outside by herself. LPN # 2 indicated, "I said 'I don't think so' and I yelled back in and said, 'Where's [Resident B]?' to a CNA and she said, 'She just walked down the hall [toward the main entrance]...My daughter saw her across the street in the neighbor's lawn." LPN # 2 indicated she asked Resident B what she was doing after the incident and Resident B indicated she was looking for her son. On 12/14/2015 at 11:40 a.m. Dietary Staff # 1 indicated she was sitting in the main dining room when she thought she saw Resident B walking outside. She indicated, "I said [to LPN # 2], 'I think I just saw [Resident B] walk outside...ran over [across the street] and found her on the porch. It was a mess. There was			

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	blood everywhere...They [staff] say she's been confused before. I think she's confused." Dietary Staff # 1 indicated the main entrance doors to the facility are not locked and do not have a key pad. Dietary Staff # 1 indicated, "I come in at 4:30 in the morning and the [main entrance] doors are unlocked and I don't see anybody [staff] when I come in these doors...." On 12/14/2015 at 11:50 a.m., Resident B was observed sitting alone at a table in the main dining room. The resident had dark gray - black - green bruising and swelling throughout her face and chin. Resident B indicated (about the incident 12/5/2015), "I was black and blue all over [after the fall]...I was seeing my son and he wasn't there...I like to go outside." On 12/14/2015 at 12:42 p.m., the Director of Nursing (DON) indicated the main entrance to the facility was never locked from the inside. She indicated nursing staff is "supposed to lock the door every night after the three [p.m.] to eleven [p.m.] shift." The DON indicated there was no policy or procedure related to hours the facility is locked. The DON indicated the staff was not inserviced or provided education following the incident and the resident was not referred for a psychiatric consultation.			

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	On 12/15/2015 at 10:55 a.m., the DON indicated she did not consider Resident B an elopement risk because "she walks with purpose." The DON indicated Resident B did not have a diagnosis of dementia and was not a candidate for the facility's locked memory care unit. Resident B was interviewed in her room on 12/15/2015 at 11:00 a.m. She indicated she could not recall what happened after she walked out of the facility on 12/5/2015. She indicated, "I thought I seen my son...nothing else...no one around [the facility when she exited]." Resident B indicated she routinely left the building independently to work at [name of not-for profit organization that provides services for adults and children with mental, physical and emotional disabilities], and indicated, "I get on the bus to and from work...no one walks me out, I just know when to go." On 12/15/2015 at 12:20 p.m. the DON was interviewed regarding follow up to the incident and possible interventions to ensure future elopement by Resident B, or other residents, does not occur in the future. The DON indicated, "We haven't had a problem so far [with confused residents wandering out of the building]."			

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	The DON indicated Resident B was not required to sign out as a leave of absence when she left the facility, and staff was not required to document when the resident left the facility. The DON indicated the facility did not have a policy and/or procedure related to leaves of absence. The DON provided the Leave of Absence Log on 12/15/2015. Resident B's had 8 entries (leaves of absence) since 11/28/2013, all with her son listed under "Responsible Party or Patient", with the most recent one being 11/27/2015. This Federal tag relates to Complaint IN00188212. 3.1-45(a)(2)			