

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155145	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/21/2012
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NAME OF PROVIDER OR SUPPLIER WASHINGTON NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 603 E NATIONAL HWY WASHINGTON, IN 47501
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F0000	<p>This visit was for the Investigation of Complaint IN00110032.</p> <p>Complaint IN00110032 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F201, F202, F203, F323 and F514.</p> <p>Survey dates: June 19, 20, and 21, 2012</p> <p>Facility number: 000068 Provider number: 155145 AIM number: 100274980</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 7 SNF/NF: 78 Total: 85</p> <p>Census payor type: Medicare: 10 Medicaid: 61 Other: 14 Total: 85</p> <p>Sample: 4</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

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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	Quality review completed 6/26/12 Cathy Emswiller RN			

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F0201 SS=D	<p>483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT</p> <p>The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</p> <p>The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>The safety of individuals in the facility is endangered;</p> <p>The health of individuals in the facility would otherwise be endangered;</p> <p>The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or</p> <p>The facility ceases to operate.</p> <p>Based on interview and record review, the facility failed to ensure appropriate documentation of the need for the transfer of a resident from the facility to a geriatric psychiatric (geri-psych) facility for 1 of 3 residents reviewed for behaviors of wandering in a total sample of 4. (Resident #A)</p>	F0201	<p>1. Resident #A no longer resides in the facility. The order to transfer Resident #A out of the facility on 6-11-12 was obtained from the physician on 6-10-12, the nurse failed to document the verbal order on a telephone order sheet. 2. Any resident who requires transfer out of the facility could be affected. See below for corrective measures. 3. Licensed</p>	07/06/2012	

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	<p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6-19-12 at 3:10 p.m. Her diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke) with right sided weakness and aphasia (lack or impairment of speech), seizure disorder, diabetes, high blood pressure, coronary artery disease (heart problems), anxiety, anemia, and depression with unspecified psychosis.</p> <p>Review of the clinical record indicated Resident #A was transferred from the facility to an area geri-psych facility on 6-11-12 at 7:30 p.m., following an elopement from the facility the previous evening. Review of the documentation indicated an absence of a physician's order to be transferred elsewhere. Documentation included the notification of the physician of the elopement and a suggestion by the physician for a wanderguard placement, which the resident had already in place prior to the elopement. Physician progress notes did not indicate any significant change in behaviors or any issues related to the elopement. The most recent physician progress note in the clinical record was dated 4-6-12.</p> <p>The Administrator provided a copy of</p>		<p>Nurses were inserviced on 6-20-12 regarding appropriate procedures for completion of necessary documentation for all out of facility transfers, specifically physician orders, transfer summary information and Transfer/DischargeForms. Discharges from the facility will be reviewed by the DON or her designee within 24 hours prior to/following a discharge to ensure paperwork has been completed accordingly. These reviews will be completed until 3 consecutive months of zero negative findings is achieved. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>				

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	<p>what was identified as the "Transfer paperwork," on 6-20-12 at 1:45 p.m. This paperwork included a document entitled, "Notice of Transfer or Discharge." This document was incomplete, in that the resident's name, date of issue of the document, effective date of transfer, place to which the resident will be transferred, address of the transfer site, and reason for the transfer were all blank. Another document, entitled, "Notice of Transfer or Discharge Request for Hearing," was also in this packet. All areas of this document were blank, as well.</p> <p>In interview with LPN #1 on 6-20-12 at 4:52 p.m., she indicated she was working on the same unit as Resident #A resided on the evening of 6-11-12. She indicated she had been told by the day shift nurse that Resident #A's transfer paperwork "was filled out and ready to go." She indicated, "I should have looked it over, but was told it was ready." She indicated, "the day nurse had said she had talked to the doctor about getting the orders okay 'd for the transfer. I didn't give it any thought that she hadn't written them, but once again, I should have checked for myself."</p> <p>In interview with the Administrator on 6-20-12 at 4:52 p.m., he indicated the facility staff had met with a family</p>			
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	<p>member of Resident #A on the morning after the elopement. He indicated, "We discussed why [name of Resident #A] needed to go out to [name of geri-psych facility]to be evaluated for her own safety to make sure this would be a safe place for her or if she would go elsewhere." He indicated the day shift nurse who had who had spoken to the physician and received the orders was currently on vacation and unable to provide the information on the physician orders.</p> <p>This Federal tag relates to Complaint IN00110032.</p> <p>3.1-12(a)(1) 3.1-12(a)(4)(A) 3.1-12(a)(4)(B) 3.1-12(a)(4)(C) 3.1-12(a)(4)(D)</p>				

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F0202 SS=D	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>Based on interview and record review, the facility failed to ensure appropriate documentation of the need for the transfer of a resident from the facility to a geriatric psychiatric (geri-psych) facility for 1 of 3 residents reviewed for behaviors of wandering in a total sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6-19-12 at 3:10 p.m. Her diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke) with right sided weakness and aphasia (lack or impairment of speech), seizure disorder, diabetes, high blood pressure, coronary artery disease (heart problems), anxiety, anemia, and depression with unspecified psychosis.</p>	F0202	<p>1. Resident #A no longer resides in the facility. The order to transfer Resident #A out of the facility on 6-11-12 was obtained from the physician on 6-10-12, the nurse failed to document the verbal order on a telephone order sheet. 2. Any resident who requires transfer out of the facility could be affected. See below for corrective measures.3. Licensed Nurses were inserviced on 6-20-12 regarding appropriate procedures for completion of necessary documentation for all out of facility transfers, specifically physician orders,transfer summary information and Transfer/DischargeForms. Discharges from the facility will be reviewed by the DON or her designee within 24 hours prior to/following a discharge to ensure paperwork has been completed accordingly. These reviews will be completed until 3 consecutive months of zero negative findings</p>	07/06/2012			

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	<p>Review of the clinical record indicated Resident #A was transferred from the facility to an area geri-psych facility on 6-11-12 at 7:30 p.m., following an elopement from the facility the previous evening. Review of the documentation indicated an absence of a physician's order to be transferred elsewhere. Documentation included the notification of the physician of the elopement and a suggestion by the physician for a wanderguard placement, which the resident had already in place prior to the elopement. Nursing progress notes did not indicate documentation of receipt of orders for a transfer to another facility.</p> <p>Physician progress notes did not indicate any significant change in behaviors or any issues related to the elopement. The most recent physician progress note in the clinical record was dated 4-6-12.</p> <p>In interview with LPN #1 on 6-20-12 at 4:52 p.m., she indicated she was working on the same unit as Resident #A resided on the evening of 6-11-12. She indicated she had been told by the day shift nurse that Resident #A's transfer paperwork "was filled out and ready to go." She indicated, "I should have looked it over, but was told it was ready." She indicated, "the day nurse had said she had talked to the doctor about getting the orders okay 'd</p>		is achieved. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.				

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	<p>for the transfer. I didn't give it any thought that she hadn't written them, but once again, I should have checked for myself."</p> <p>In interview with the Administrator on 6-20-12 at 4:52 p.m., he indicated the facility staff had met with a family member of Resident #A on the morning after the elopement. He indicated, "We discussed why [name of Resident #A] needed to go out to [name of geri-psych facility]to be evaluated for her own safety to make sure this would be a safe place for her or if she would go elsewhere." He indicated the day shift nurse who had who had spoken to the physician and received the orders was currently on vacation and unable to provide the information on the physician orders.</p> <p>This Federal tag relates to Complaint IN00110032.</p> <p>3.1-12(a)(5) 3.1-12(a)(5)(A) 3.1-12(a)(5)(B)</p>				

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F0203 SS=D	<p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State</p>			

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	<p>long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>Based on interview and record review, the facility failed to ensure the resident and/or the family member and legal representative were notified in writing of the reason for the transfer of a resident from the facility to a geriatric psychiatric (geri-psych) facility for 1 of 3 residents reviewed for behaviors of wandering in a total sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6-19-12 at 3:10 p.m. Her diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke) with right sided weakness and aphasia (lack or impairment of speech), seizure disorder, diabetes, high blood pressure, coronary artery disease (heart problems), anxiety, anemia, and depression with unspecified psychosis.</p>	F0203	<p>1. Resident #A no longer resides in the facility. The order to transfer Resident #A out of the facility on 6-11-12 was obtained from the physician on 6-10-12, the nurse failed to document the verbal order on a telephone order sheet. 2. Any resident who requires transfer out of the facility could be affected. See below for corrective measures.3. Licensed Nurses were inserviced on 6-20-12 regarding appropriate procedures for completion of necessary documentation for all out of facility transfers, specifically physician orders,transfer summary information and Transfer/DischargeForms. Discharges from the facility will be reviewed by the DON or her designee within 24 hours prior to/following a discharge to ensure paperwork has been completed accordingly. These reviews will be completed until 3 consecutive</p>	07/06/2012			

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	<p>Review of the clinical record indicated Resident #A was transferred from the facility to an area geri-psych facility on 6-11-12 at 7:30 p.m., following an elopement from the facility the previous evening. Documentation in the nursing notes indicated the family was informed by phone of the elopement.</p> <p>In interview with a family member of Resident #A's on 6-20-12 at 11:59 a.m., she indicated she had spoken with the Administrator the day after the elopement and understood the seriousness of the event and understood why Resident #A had to have a psychiatric evaluation. She indicated on 6-14-12, she had a conversation with the Administrator and was told Resident #A would be returning to the facility, but to a room closer to the nurse's station. She indicated she was informed the resident "would have to wear an armguard [sic]" and would have to sign a paper that said if Resident #A had another incident like before, she would be discharged. She indicated she was under the assumption the resident would remain at the geri-psych facility and would have another assessment before returning to the facility. She indicated the Administrator "must have asked for another assessment from the doctor and wanted the doctor to guarantee</p>		<p>months of zero negative findings is achieved. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.</p>	

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	<p>she wouldn't try to get out of the building again. She indicated on 6-18-12 "at 5:00 p.m., I got a call from the Administrator and he wanted to know why I or [name of another family member] wasn't at the meeting [that same date]." She indicated she was not informed of a meeting. She indicated the Administrator told her at that time that due to safety reasons, the facility would not be able to accept her back. She indicated, "Was upset that I wasn't given that information on Thursday [6-14-12] that she couldn't stay. She is moving to [another facility] today. It could have been handled better and given me more time to find a place for her." She indicated she was not given any paperwork regarding the transfer or discharge process.</p> <p>The Administrator provided a copy of what was identified as the "Transfer paperwork," on 6-20-12 at 1:45 p.m. This paperwork included a document entitled, "Notice of Transfer or Discharge." This document was incomplete, in that the resident's name, date of issue of the document, effective date of transfer, place to which the resident will be transferred, address of the transfer site, and reason for the transfer were all blank. Another document, entitled, "Notice of Transfer or Discharge Request for Hearing," was also in this packet. All areas of this document</p>			

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	<p>were blank, as well.</p> <p>In interview with LPN #1 on 6-20-12 at 4:52 p.m., she indicated she was working on the same unit as Resident #A resided on the evening of 6-11-12. She indicated she had been told by the day shift nurse that Resident #A's transfer paperwork "was filled out and ready to go." She indicated, "I should have looked it over, but was told it was ready."</p> <p>In interview with the Administrator on 6-20-12 at 4:52 p.m., he indicated the facility staff had met with a family member of Resident #A on the morning after the elopement. He indicated, "We discussed why [name of Resident #A] needed to go out to [name of geri-psych facility] to be evaluated for her own safety to make sure this would be a safe place for her or if she would go elsewhere."</p> <p>This Federal tag relates to Complaint IN00110032.</p> <p>3.1-12(a)(5) 3.1-12(a)(9) 3.1-12(a)(9)(A) 3.1-12(a)(9)(B) 3.1-12(a)(9)(C) 3.1-12(a)(9)(D) 3.1-12(a)(9)(E) 3.1-12(a)(9)(F)</p>						

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	3.1-12(a)(9)(G) 3.1-12(a)(9)(H)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155145		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/21/2012	
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F0323 SS=D	<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 interview and record review, the facility failed to ensure that 15 minute observation checks were conducted as ordered and a shower room door was locked, which resulted in a resident entering the unlocked door and eloping out of the shower room window of the facility. The resident was found soon after the elopement, approximately 0.1 miles from the facility, unharmed. This deficient practice affected 1 of 3 residents reviewed for wandering in a total sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6-19-12 at 3:10 p.m. Her diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke) with right sided weakness and aphasia (lack or impairment of speech), seizure disorder, diabetes, high blood pressure, coronary artery disease (heart problems), anxiety, anemia, and depression with unspecified psychosis. Her most recent Minimum Data Set</p>	F0323	<p>1. Resident # A no longer resides in the facility. 2. Any resident who is independently mobile has the potential to be affected. Immediately after the elopement, all the windows were checked and secured appropriately. On June 13,2012 a touch-pad activated door knob was obtained and installed to secure the shower room door. 3. The facility practice of the use of 15 minute checks has been reviewed and revised to ensure appropriate initiation, evaluation and cessation. Nursing staff will be educated regarding the same, additionally appropriate safety measures for any resident who identified as an elopement risk. The DON and Administrator, being new employees to the facility, will be educated on ensuring statements from staff are obtained while conducting investigations to ensure all necessary information is obtained and acted upon in a timely manner. The DON or her designee will check shower room doors and windows to ensure they remain secure 3x's weekly, at varied times, until four consecutive weeks of zero</p>	07/06/2012			

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	<p>(MDS) assessment, dated 4-26-12, indicated she had both short term and long term memory problems, and was indicated to have modified independence with cognition. It indicated she has unclear speech, is able to sometimes be understood by others, but is able to understand others. It indicated she is able to walk in her room and in the hallways with extensive assistance of one person assistance. It indicated she is independent with mobility on and off of her unit. It indicated she uses a walker and/or wheelchair for mobility.</p> <p>In interview with CNA #2 on 6-20-12 at 2:03 p.m., she indicated she had worked on the same hallway as Resident #A resided on the evening of 6-10-12. She indicated between 9:40 p.m. and 9:45 p.m., she and QMA #3 conducted the final bed check for her shift. She indicated she observed Resident #A in her room, lying down on the bed with a blanket over her, watching television (TV). She indicated she did not see what the resident was wearing, due to the blanket. She indicated this was not abnormal for this resident, as she likes to stay up late and watch TV. She indicated this resident normally readies herself for bed, so she had not provided bedtime assistance for her. She indicated the resident's wheelchair was located near the</p>		negative findings are achieved, then monthly thereafter on-going to ensure continued compliance.4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.		

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	<p>end of her bed, which was the usual place where the resident placed it. She indicated she did not recall the shower room door to be open, "it could have been shut and not locked. The key for the door was on a hook on the door frame."</p> <p>CNA #2 indicated she left the floor and clocked out at 10:00 p.m. She indicated she was picked up by her ride at approximately 10:05 p.m. She indicated she was then driven to a local gas and convenience store. She indicated, "As we pulled in, I saw [name of Resident #A] sitting on the curb. I jumped out of the car before it even stopped. She had a purse, coat and was carrying a pair of pants. Was dressed in jean capris, a t-shirt, tie-shoes and socks. Was the same outfit she'd had on earlier in the evening." She indicated a police officer was also present. She indicated the officer had told her the resident was not there when he had gone into the convenience store when he had gone in a few minutes earlier, but he noticed her when he came back out as she was walking towards the convenience store from the east on the sidewalk. She indicated, "He said he didn't think she would be a nursing home patient because she was walking normally. Said she just came over and sat down on the curb. He didn't make a report or get my name." She indicated the resident indicated she</p>			

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	<p>had walked from the nursing home by pointing towards the nursing home. She indicated she immediately called the facility to report the elopement. She indicated the resident was willing to return to the facility with her and she returned the resident to the facility. She indicated she "was surprised she was able to walk that far."</p> <p>In interview with QMA #3 on 6-20-12 at 1:35 p.m., she indicated she was working the 7:00 p.m. to 7:00 a.m. shift on the hall on which Resident #A resided on 6-10-12. She indicated she and CNA #2 conducted the last bed check before CNA #2 left for the evening at approximately 9:45 p.m. She indicated she recalled observing Resident #A at that bed check to be sitting on the side of her bed in her room, fully clothed, and watching TV. She indicated it was normal for Resident #A to stay up late and watch TV. She indicated after this, she went on to care for two more residents. She indicated when she came out of the second resident's room, "the phone was ringing and found out [name of Resident #A] was out of the building. It was [name of CNA #2]. It was about 10:10 p.m." She indicated she immediately contacted the DON (Director of Nursing), the family and the physician, as well as the other units of the facility to check all of their</p>			

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	<p>residents. She indicated the DON came in and checked the resident "head to toe twice, not a scratch on her."</p> <p>QMA #3 indicated the shower room door was left open that evening. She indicated she had been in and out of the shower room to obtain supplies that evening. She indicated the door is normally locked with the key on a hook, high up on the door frame. She indicated, "I take full responsibility for leaving the shower room door open." She did not specify if open meant physically open or unlocked only.</p> <p>QMA #3 indicated that once CNA #2 left the floor, she was the only staff member on the floor. She indicated around the time CNA #2 left the floor, she was caring for two other residents. "[The] 10 p.m. check did not get done." She indicated Resident #A had been on 15 minute observation checks "since July of last year." She indicated, "When I would ask the DON about the 15 minute checks, she would say, 'I'll let you know when to stop them.' Never provided a reason to continue them or when to stop them."</p> <p>QMA #3 indicated after she was notified of the elopement of Resident #A, she found the shower room door propped open with her wheelchair, which had the</p>						

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	<p>wanderguard attached to it. She indicated the wanderguard had been placed on the wheelchair due to the resident would remove the wanderguard if it were located on her wrist or ankle. She indicated, "That's why it was on her wheelchair, because she wouldn't go out without her wheelchair. [I had] never heard of anyone going out a wheelchair [in the six years I've worked here.] She indicated once the resident returned to the facility and was questioned about how she left, the resident "kept pointing to the shower room and the wheelchair was in the doorway...Well it made me think she really did go out the window. If it'd [sic] been me, I wouldn't have bothered to close the window."</p> <p>In interview with the Administrator on 6-20-12 at 10:01 a.m., he indicated the previous DON had conducted the investigation regarding Resident #A's elopement. He indicated he had been unaware of any residents being on 15 minute checks prior to this event, "let alone for months and months. When I asked the former DON about this, she said it was to protect us [the facility] in case something like this happened." He indicated in interview on 6-20-12 at 4:40 p.m.,the facility had not been told previously by QMA #3 that the shower room door had been unlocked or open.</p>			

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	<p>"This is new information."</p> <p>Review of the clinical record indicated a document entitled, "15 Minute Safety Checks," for 6-10-12, had documentation of each 15 minute slot initialed to indicate the resident had been observed. However, the time slot for 10:00 p.m. had that initialed slot marked through with a notation which indicated, "not in bed out of building," with staff member's initials for QMA #3. The nursing notes for 6-10-12 at 11:00 p.m. indicated, "Resident was found outside of building at 10:10 p.m. She was at the store 2 blocks away. She had just gotten there & had sat down on curb. (police officer there) [sic] Staff had stopped after work & found her. Resident says she went out shower room window. There were no injuries. One-on-one in place at this time."</p> <p>The resident's care plan for the problem of elopement risk indicated an intervention of "15 minute checks." This intervention did not indicate a specific implementation date. An identified problem associated with this care plan indicated, "Resident eloped out the window 6-10-12." This particular care plan was indicated to have been reviewed on 7-19-11, 8-3-11, 10-31-11, 1-31-12, 4-6-12 and 6-11-12. The June 2012 recapitulation orders</p>			

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	<p>indicated 15 minute checks were to be conducted. This order had a start date of 7-17-11.</p> <p>An "Elopement Risk Assessment," dated 7-18-11, indicated the resident had attempted to leave the building unsupervised, with no date indicated of occurrence. This was indicated on 10-31-11 and 1-31-12. On 4-6-12, it indicated she had a history of the same activity. On 6-11-12, it indicated the evidence for elopement risk as, "leaving facility w/o [without] supervision."</p> <p>The DON provided a copy of a policy entitled, "Elopement Risk Assessment Policy" on 6-19-12 at 2:00 p.m. This policy indicated, "Assess residents for potential elopement. To assure that all residents are free from harm at all times...Identify residents at risk for elopement by completing the elopement risk assessment upon admission, quarterly and with significant change." At this same time, the DON provided a copy of a policy entitled, "Missing Resident & Elopement Procedure." It indicated, "All residents [sic] whereabouts will be known at all times and safely maintained."</p> <p>This Federal tag relates to Complaint IN00110032.</p> <p>3.1-45(a)(1)</p>				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the clinical records related to the elopement of a resident were complete and accurate for 1 of 3 residents reviewed for wandering behaviors in a total sample of 4. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 6-19-12 at 3:10 p.m. Her diagnoses included, but were not limited to CVA (cerebrovascular accident or stroke) with right sided weakness and aphasia (lack or impairment of speech), seizure disorder, diabetes, high blood pressure, coronary artery disease (heart problems), anxiety, anemia, and depression with unspecified psychosis.</p>	F0514	<p>1. Resident #A no longer resides in the facility. The order to transfer Resident #A out of the facility on 6-11-12 was obtained from the physician on 6-10-12, the nurse failed to document the verbal order on a telephone order sheet. 2. Any resident who requires transfer out of the facility could be affected. See below for corrective measures.3. Licensed Nurses were inserviced on 6-20-12 regarding appropriate procedures for completion of necessary documentation for all out of facility transfers, specifically physician orders,transfer summary information and Transfer/DischargeForms. Discharges from the facility will be reviewed by the DON or her designee within 24 hours prior to/following a discharge to ensure paperwork has been completed accordingly. These reviews will be</p>	07/06/2012			

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	<p>Review of the clinical record indicated Resident #A was transferred from the facility to an area geri-psych facility on 6-11-12 at 7:30 p.m., following an elopement from the facility the previous evening. Review of the documentation indicated an absence of a physician's order to be transferred elsewhere. Documentation included the notification of the physician of the elopement and a suggestion by the physician for a wanderguard placement, which the resident had already in place prior to the elopement. Nursing progress notes did not indicate documentation of receipt of orders for a transfer to another facility.</p> <p>The Administrator provided a copy of what was identified as the "Transfer paperwork," on 6-20-12 at 1:45 p.m. This paperwork included a document entitled, "Notice of Transfer or Discharge." This document was incomplete, in that the resident's name, date of issue of the document, effective date of transfer, place to which the resident will be transferred, address of the transfer site, and reason for the transfer were all blank. Another document, entitled, "Notice of Transfer or Discharge Request for Hearing," was also in this packet. All areas of this document were blank, as well.</p> <p>In interview with LPN #1 on 6-20-12 at</p>		completed until 3 consecutive months of zero negative findings is achieved. 4. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly.				

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	<p>4:52 p.m., she indicated she was working on the same unit as Resident #A resided on the evening of 6-11-12. She indicated she had been told by the day shift nurse that Resident #A's transfer paperwork "was filled out and ready to go." She indicated, "I should have looked it over, but was told it was ready." She indicated, "the day nurse had said she had talked to the doctor about getting the orders okay 'd for the transfer. I didn't give it any thought that she hadn't written them, but once again, I should have checked for myself."</p> <p>In interview with the Administrator on 6-20-12 at 4:52 p.m., he indicated the facility staff had met with a family member of Resident #A on the morning after the elopement. He indicated, "We discussed why [name of Resident #A] needed to go out to [name of geri-psych facility]to be evaluated for her own safety to make sure this would be a safe place for her or if she would go elsewhere." He indicated the day shift nurse who had who had spoken to the physician and received the orders was currently on vacation and unable to provide the information on the physician orders.</p> <p>This Federal relates to Complaint IN00110032.</p>						

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