

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155355	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2015
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NAME OF PROVIDER OR SUPPLIER  WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00182617. This visit resulted in a Partially Extended Survey - Immediate Jeopardy.</p> <p>Complaint IN00182617 - Substantiated. Federal/State deficiencies related to the complaint are cited at F250 and F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: September 18, 19, 20 and 21, 2015 Extended survey dates: September 22 and 23, 2015</p> <p>Facility number: 000246 Provider number: 155355 AIM number: 100275420</p> <p>Census bed type: SNF/NF: 87 Total: 87</p> <p>Census payor type: Medicare: 19 Medicaide: 59 Other: 9 Total:87</p>	F 0000		
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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 0157 SS=D Bldg. 00	<p>Sample: 3 Supplemental sample: 2</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 14454 on September 30, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal</p>			

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	<p>representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a Resident's guardian timely of a change in condition and need to transfer the Resident to an acute care facility. This deficient practice affected 1 of 5 Residents reviewed for change in condition. (Resident B)</p> <p>Findings include:</p> <p>On 9/18/15 at 11:00 A.M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 10/21/13, with diagnoses including but not limited to, Alzheimer's disease and Dementia with behavioral disturbances.</p> <p>A Nursing Progress note, dated 9/14/15 at 10:15 A.M., indicated "...Shortly after breakfast, resident noted to be upset and stated he wanted to go home see his friend because he is dying. Resident stated he was going to leave facility. Staff offered to walk with resident to</p>	F 0157	<p><b>F157 – Notify of Changes (Injury/Decline/Room, etc.)Itis the practice of this provider to promptly notify the resident, consult withresident’s physician, resident’s legal representative or interested familymember when there is a significant change in condition in the resident’sphysical, mental or psychosocial status in either life threatening conditions,clinical complication, the need to alter treatment, need to transfer ordischarge the resident to an acute care facility or change in room or roommateassignment. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice: The facility Executive Director spoke with the resident’s guardian followingthe event and apologized for the lack of timely communication surrounding thehospitalization. Resident is</b></p>	10/23/2015

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	<p>console him. Resident refused and became aggressive with staff. resident attempted to hit staff. This writer intervened. Resident stated he was going to throw the chair at the window and leave the facility. MD [Medical Doctor] notified and order received to send resident to ER [Emergency Room]. Call placed to 911. Policeman and paramedics arrived at facility. After much encourage, resident agreed to be taken to ER for evaluation...."</p> <p>The SBAR (Situation, Background, Assessment and Recommendation) Physician communication tool, dated 9/14/15, indicated "...Background: Alert and oriented x 3...Agitated...Combative...Recommendation: Other describe-send to ER (Emergency Room)...Family Notified: Yes...Date/Time: 09/14/2015...10:08 AM...."</p> <p>On 9/19/15 at 12:35 P.M., an interview was conducted with Resident B's wife who is his legal guardian. Resident B's wife indicated she was not notified the facility had sent her husband to the Emergency Room on 9/14/15. She found out her husband had been sent out on 9/15/15 when she was notified of his elopement from the facility. Resident B's wife further indicated, "...Protocol is</p>		<p><b>currently at an inpatient psychiatric center. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p><b>Any resident can be affected by this finding. An audit of acute care transfers for the last 30 days will be conducted by Nursing Administration to ensure that all notifications have been made and appropriately documented. Moving forward, a daily review will be conducted by the Nurse Management Team to review all resident's physician, resident's legal representative or interested family member notified timely in the event of a significant change in condition in the resident's physical, mental or psychosocial status in either life threatening conditions, clinical complication, the need to alter treatment or need to transfer or discharge the resident to an acute care facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p><b>An nursing in-service will be conducted by the DNS/designee on or before 10/23/2015. This in-service will</b></p>	

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	<p>protocol, I should have been notified...."</p> <p>On 9/23/15 at 10:45 A.M., an interview was conducted with Avenue of Reflection Unit Manager, LPN #1. The Unit Manager indicated she completed the ASC SBAR Physicians Communication Tool on 9/14/15 which reflected Resident B's family had been notified on 9/14/15 at 10:08 A.M. The Unit Manager further indicated she did not notify Resident B's family of the events of that morning her main focus was Resident B and that the Administrator and the Director of Nurses had actually been the persons responsible to notify the family.</p> <p>On 9/23/15 at 11:50 A.M., an interview was conducted with the Administrator. The Administrator indicated he did not notify Resident B's wife that he had been sent to the ER on 9/14/15.</p> <p>On 9/23/15 at 11:55 A.M., an interview was conducted with the Director of Nurses. The Director of Nurses indicated that Resident B's wife had not been notified of Resident B's ER visit until 9/15/15, when she was notified of his elopement.</p> <p>The current Resident Change of Condition policy, with a revision date of</p>		<p><b>include review of the facility policy titled, "CHANGE OFCONDITION". This in-service will especially emphasize the policyregarding prompt notification to physicians, resident's legal representative orinterested family member when there is a significant change in condition in theresident's physical, mental or psychosocial status in either life threateningconditions, clinical complication, the need to alter treatment or need totransfer or discharge the resident to an acute care facility. Continuedcompliance with prompt notification will be monitored through daily Clinicalmeeting review where change of condition is reviewed and verification ofnotification will occur. In addition, the DNS/Nurse Management Team designee willreview change of condition and subsequent notifications on the weekends andholidays to ensure ongoing compliance with prompt physician notification. How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place:To ensure ongoing compliance with this corrective action, the</b></p>		

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	<p>1/2015, was provided by the Director of Nurses on 9/22/15 at 11:50 A.M. and reviewed on 9/23/15 at 12:05 P.M. The policy indicated the following: "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...2. Acute Medical Change...a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician...c. The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken...."</p> <p>3.1-5(a)(2)</p>		<p><b>DNS/designee will be responsible for completion of the CQI Tool titled, "Change in Condition" which includes notification to appropriate parties of changes in condition to include acute transfers, daily for 2 weeks followed by monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. By what date the systemic changes will be completed: Compliance Date: 10/23/15.</b></p>		
F 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a</p>				

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	<p>court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate and report to other state officials a Resident's elopement from the facility for 1 of 1 Resident's reviewed for elopement. (Resident B)</p>	F 0225	<p><b>F225 – Investigate/Report Allegations/Individuals</b> It is the practice of this provider that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and</p>	10/23/2015

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	<p>Findings include:</p> <p>On 9/18/15 at 8:30 A.M., an Incident Report, dated 9/16/15 at 10:19 A.M., was reviewed. The Incident Report indicated that while rounding to escort resident's to breakfast, the charge nurse, RN #4, noticed Resident B was missing from his room, the charge nurse had noted seeing Resident B earlier in the morning. The charge nurse then notified the Executive Director and initiated a Code Silver (a means to alert staff that a elderly resident cannot be located) and a search of the interior and exterior parameters of the facility and grounds was conducted. Upon unsuccessful attempts to locate Resident B, the facility then called the South Bend Police Department. The police department arrived at the facility and began an investigation into the elopement of Resident B.</p> <p>On 9/18/15 at 11:00 A. M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 10/21/13, with diagnoses, including but not limited to, Alzheimer's disease and Dementia with behavioral disturbances.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 7/3/15, indicated</p>		<p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with Statelaw. It is also the practice of this provider to keep evidence that all alleged violations are thoroughly investigated and to prevent further potential abuse while the investigation is in process. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B's elopement has subsequently been thoroughly investigated as a portion of the ISDH investigation. The reportable event has also been forwarded to Adult Protective Services and the Ombudsman. Resident is currently at an inpatient psychiatric center. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents are at risk to be affected by this finding. Resident incidents that could rise to the level of reporting will be reviewed by Nursing Administration for the past 30 days. All incidents will be reviewed by Nursing Administration for appropriate investigation in accordance with facility policy and reporting to the ISDH and other</p>		

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	<p>Resident B had a Brief Interview for Mental Status (BIMS) score of 5, indicating he was severely cognitively impaired.</p> <p>A Nursing Progress note, dated 9/14/15 at 10:15 A.M., indicated "...Shortly after breakfast, resident noted to be upset and stated he wanted to go home see his friend because he is dying. Resident stated he was going to leave facility. Staff offered to walk with resident to console him. Resident refused and became aggressive with staff. resident attempted to hit staff. This writer intervened. Resident stated he was going to throw the chair at the window and leave the facility. MD [Medical Doctor] notified and order received to send resident to ER [Emergency Room]. Call placed to 911. Policeman and paramedics arrived at facility. After much encourage, resident agreed to be taken to ER for evaluation...."</p> <p>A Nursing Progress note, dated 9/14/15 at 1:14 P.M., indicated "...Resident displayed agitation and aggression this morning, becoming verbally and physically aggressive towards staff. 911 was called to request resident be admitted for inpatient stay. Hospital reported resident could not be admitted at the time and would be returning to facility. Upon</p>		<p>state officials to include the Ombudsman and Adult Protective Services. Notifications and investigations will be conducted should the results of the audit indicate areas for improvement. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> An in-service will be conducted by the Director of Operations for the ED and DNS relative to conducting investigation for any allegation or statement regarding resident neglect, abuse/mistreatment or misappropriation of resident property to include immediate initiation and documentation of a full investigation as well as ensuring notification to the MD, family, ISDH and other agencies outlined in the facility policy. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> Compliance with this corrective action will be monitored through the CQI Program. The ED/DNS or designee will be responsible for completion of the CQI Audit Tool titled, Abuse, Prohibition and Investigation daily for 2 weeks followed by monthly for 6 months. If a threshold of 100% is not met, an action plan will be developed. In addition, the Director of</p>		

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	<p>return to facility resident was calm, however, continued to walk around building. Resident continued to be on 15 minute safety checks due to exit seeking behaviors...."</p> <p>An Interdisciplinary Team (IDT) progress note, dated 9/15/15 at 2:49 P.M., indicated "... IDT reviewed new and worsening behavior. Behavior: Resident was noted to become verbally and physically aggressive towards staff. Resident continued to actively exit seek and would not be redirected. Resident B stated he had a friend in the hospital. No reported friend in the hospital, staff attempted to comfort and encourage resident regarding thoughts about his friend, however, he refused to be comforted. Resident B remained on 15 minute safety checks. At 8 AM on 9/15/15, resident was noted to have eloped from the building. A code silver was called and staff and authorities have continued to attempt to locate resident. Family and MD [Medical Director] aware. Assessment: Upon assessment the environment was quiet. Resident's roommate passed away over the weekend. Although the two did not appear close, it is possible that roommate's death triggered some trauma for Resident B. Resident B's family was also in to visit on 9/10/15. Resident</p>		<p>Operations or Director of Nursing Specialist will review compliance with the investigation and reporting process during monthly visits for at least 6 months. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 10/23/2015</p>	

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	<p>reported he thought he was going home and since that time (9/10/15) he cut off his wanderguard and refused to have it placed back on. Staff attempted to explain the importance of wanderguard, however, resident continued to refuse. 15 minute safety checks initiated due to exit seeking behaviors. Resident was unable to be calmed although many different staff members with good rapport attempted to talk to resident. 911 was called and resident was escorted by police to ER for evaluation. IDT called report to [hospital] to request inpatient stay, however, hospital was unable to admit at that time. Resident B was sent back to the facility. Resident B has dx of dementia with behavioral disturbances, depressive disorder, and Alzheimer's disease. Resident B has most recent BIMS score of 5 [severe cognitive impairment], however Resident B will often refuse to answer questions asked. This could be related to cognitive impairments, intelligence, (Resident B is illiterate) or personality. No recent medication changes have taken place. Resident will periodically refuse medication, however, he can often be redirected and will then take medications. Root cause: IDT discussed that root cause could be related to seeing family members and having roommate recently pass as a trigger. Resident B has history</p>			

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	<p>of eloping two years ago in the fall. Intervention: At the time of behavior 911 was called after several attempts to calm resident. Resident sent to ER [Emergency Room] for evaluation, however, was not admitted as requested. Resident continued on 15 minute safety checks. IDT recommends to continue efforts with authorities and staff to search for resident to secure safety. Upon resident's return he will be placed on secured unit. IDT will continue discussion proper placement upon return to facility...."</p> <p>A Care Plan with a problem start date of 10/26/13, indicated, "... Resident has history of elopement episode and at times will actively exit seek. Resident remains an elopement risk. Resident removed wanderguard on 9/10/15 and refused to have it replaced. Order remains, staff to continue to attempt to place wanderguard as able and will remain on 15 minute safety checks until wanderguard is able to be replaced...Long Term Goal...Resident will not exit facility unsupervised thru next review...Approaches: All facility exits secured... Wanderguard per order...Coat hat and suitcase stored outside of his room...Encourage resident and family to keep personal snacks in the kitchen rather than in his room to promote increased supervision and</p>			

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	<p>discourage time spent out of his room...Encourage participation in activity outside of his room..."</p> <p>On 9/18/15 at 2:30 P.M., an interview was conducted with CNA (Certified Nurse Aide] #2. CNA #2 indicated he was working the morning of 9/15/15 and that he provided care for Resident B. CNA # 2 indicated Resident B was awake earlier than usual that morning and pacing the halls, CNA #2 indicated he observed Resident B sitting in his chair in the hallway then he would get up walk to the end of the hallway turn around and come back walk into his room then come back out into hallway and sit in his chair then he would stand up and repeat the sequence. CNA #2 indicated the Executive Director has spoken to Resident B around 6:30 A.M. CNA #2 indicated he last saw Resident B between 7:40 A.M. and 7: 45 A.M. CNA #2 indicated he was asked by RN #1 to accompany her to administer Resident B's morning medications and that is when they discovered he was not in his room.</p> <p>On 9/18/15 at 3:05 P.M., during an interview, RN #1 indicated that she had gotten report about 6:00 A.M. the morning of 9/15/15 and that Resident B had been peeking around the corner and approached her asking if he could leave.</p>			

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NAME OF PROVIDER OR SUPPLIER  WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 W WASHINGTON AVE SOUTH BEND, IN 46619
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	<p>RN #1 indicated she asked the Executive Director to talk to him as he was pointing at her and getting in her face, she further indicated after the ED talked to Resident B he seemed to settle down. Between 7:30 A.M., to 7:45 A.M., Resident B was observed pacing he would sit down in his chair then get up walk the hall and go into his room and come out again repeating the pacing sequence. At 8: 00 A.M. RN #1 felt uncomfortable going Resident B's room alone so she indicated she had asked CNA #2 to accompany her to administer Resident B's medications. When CNA #2 entered Resident B's room he was not found. RN #1 indicated at that time the facility began searching for Resident B and a code silver was called.</p> <p>On 9/19/15 at 12:00 P.M., a family member was interviewed. The family member indicated she found the resident at another family members house. He went from a friends house to a family members home. She indicated the resident had told her, he left the facility at night by going through the chapel windows and he "jumped" off the roof. He told her he did not use a ladder. He indicated he walked to the south side of town to a friends house. The family member indicated this would have been 3 to 4 miles.</p>			

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	<p>On 9/21/15 at 10:30 A.M., video footage of channel 7 and 8 (cameras that were positioned and recording events for the hallway Resident B resided on) were reviewed with the Corporate Nurse, the Executive Director and the Director of Nursing Services. The Corporate Nurse indicated there was a 38 minute lapse of time between the time shown on the film and the actual time of day. To get the correct time, 38 minutes should be added to the time on the footage. This is consistent throughout the footage. The video indicated the following events with recorded times: "... 5:21 A.M. Resident B is seen sitting in a chair outside his room...5:37 A. M. He was observed with his winter coat and red ball cap on...5:40 A.M. was observed talking to RN #1...5:42 A.M. Observed in the hallway talking to Executive Director...5:43 A.M. Observed in chair...5:45 A.M. Observed walking into his room and back to hallway with his hat and coat on...5:48 A. M. Talking to nurse near nurses station, this was not in cameras view... 5:51 A.M. Resident walked the hallway then proceeded back to his room...5:57 A.M. Walked hallway to nurses station and returned to chair...6:03 A.M. Walked back down the hallway and returned to room...6:10 A.M. Observed sitting in his chair outside of his room...6:12 A.M.</p>			

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	<p>Resident stood up and was visualized walking into the chapel...." This observation indicated the resident was not on a secured unit.</p> <p>On 9/21/15 at 11:15 A.M., the Executive Director and Director of Nursing Services were interviewed. The Director of Nursing Services indicated 6:12 A.M. was the last time Resident B was visualized in the facility. He further confirmed the actual elopement time was 6:51 A.M. and not 7:55 A.M. that was previously reported to ISDH.</p> <p>On 9/21/15 at 11:40 A.M., A Safety Check List - 15 Minute form, dated 9/15/15, and provided by the Director of Nursing Services on 9/20/15 at 3:50 P.M. was reviewed. The Safety Checklist Form indicated Resident B had been checked on at 7:00 A. M., 7:15 A.M., 7:30 A.M. and 7:45 A.M.</p> <p>On 9/21/15 at 12:20 P.M., a second interview was conducted with the Director of Nursing Services. The Director of Nursing Services indicated he became aware that the Safety Check List indicated Resident B was checked at 7:00 A.M., 7:15 A.M., 7:30 A.M., and 7:45 A.M. on 9/18/15 when he began reviewing Resident B's chart. He further indicated the nurse who documented the</p>			

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	<p>15 minute checks had been suspended pending an investigation.</p> <p>On 9/21/15 between 2:00 P.M., and 3:00 P.M., an interview was conducted with the Special Investigator with Adult Protective Services (APS). The Special Investigator indicated APS had not been notified of the elopement that occurred on 9/15/15.</p> <p>On 9/23/15 at 12:45 P.M., the facility investigation for the elopement of Resident B was provided by the Administrator and reviewed. During an interview, at that time, the Administrator indicated the facility had wrote a timeline of the elopement and that was the investigation. The Administrator further indicated he talked to his staff regarding the elopement of Resident B but he did not document it.</p> <p>On 9/23/15 at 3:40 P.M., the Abuse Prohibition, Reporting, and Investigation Policy and Procedure revised July 2015 and provided by the Administrator on 9/23/15 at 10:15 A.M., was reviewed. The policy indicated the following: "... Policy/Procedure: Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded t the</p>			

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	<p>Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations...Resident Abuse...8. an incident report will be initiated, following the guidelines for " Unusual Occurrence Reporting", along with a narrative description in the nurses' notes...9. Residents will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing...10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...11. the investigation will include: Facts and observations by involved employees...Facts and observations by witnessing employees...Facts and observations by witnessing non-employees...Facts and observations from others who might have pertinent information...Facts and observations by the supervisor or individual whom the initial report was made...."</p> <p>3.1-28(d)</p>			

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure its policy for the investigation and reporting to other state officials of a Resident's elopement from the facility was implemented for 1 of 1 Resident's reviewed for elopement. (Resident B)</p> <p>Findings include:</p> <p>On 9/18/15 at 8:30 A.M., an Incident Report, dated 9/16/15 at 10:19 A.M., was reviewed. The Incident Report indicated</p>	F 0226	<p><b>F226 – Develop/Implement Abuse/Neglect, etc. Policies</b> It is the practice of this provider to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident#B's</b> elopement has subsequently been thoroughly investigated as a</p>	10/23/2015

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	<p>that while rounding to escort resident's to breakfast, the charge nurse, RN #4, noticed Resident B was missing from his room, the charge nurse had noted seeing Resident B earlier in the morning. The charge nurse then notified the Executive Director and initiated a Code Silver (a means to alert staff that a elderly resident cannot be located) and a search of the interior and exterior parameters of the facility and grounds was conducted. Upon unsuccessful attempts to locate Resident B, the facility then called the South Bend Police Department. The police department arrived at the facility and began an investigation into the elopement of Resident B.</p> <p>On 9/18/15 at 11:00 A. M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 10/21/13 with diagnoses, including but not limited to, Alzheimer's disease and Dementia with behavioral disturbances.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 7/3/15, indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 5, indicating he was severely cognitively impaired.</p> <p>A Nursing Progress note, dated 9/14/15</p>		<p>portion of the ISDH investigation. The reportable event has also been forwarded to Adult Protective Services and the Ombudsman. Resident is currently at an inpatient psychiatric center. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents are at risk to be affected by this finding. Resident incidents that could rise to the level of reporting will be reviewed by Nursing Administration for the past 30 days. All incidents will be reviewed by Nursing Administration for appropriate investigation in accordance with facility policy and reporting to the ISDH and other state officials to include the Ombudsman and Adult Protective Services. Notifications and investigations will be conducted should the results of the audit indicate areas for improvement. <b>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> An in-service will be conducted by the Director of Operations for the ED and DNS relative to conducting investigation for any allegation or statement regarding resident neglect, abuse/mistreatment or misappropriation of resident</p>	

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	<p>at 10:15 A.M., indicated "...Shortly after breakfast, resident noted to be upset and stated he wanted to go home see his friend because he is dying. Resident stated he was going to leave facility. Staff offered to walk with resident to console him. Resident refused and became aggressive with staff. resident attempted to hit staff. This writer intervened. Resident stated he was going to throw the chair at the window and leave the facility. MD [Medical Doctor] notified and order received to send resident to ER [Emergency Room]. Call placed to 911. Policeman and paramedics arrived at facility. After much encourage, resident agreed to be taken to ER for evaluation...."</p> <p>A Nursing Progress note, dated 9/14/15 at 1:14 P.M., indicated "...Resident displayed agitation and aggression this morning, becoming verbally and physically aggressive towards staff. 911 was called to request resident be admitted for inpatient stay. Hospital reported resident could not be admitted at the time and would be returning to facility. Upon return to facility resident was calm, however, continued to walk around building. Resident continued to be on 15 minute safety checks due to exit seeking behaviors...."</p>		<p>property to include immediate initiating and documenting a full investigation as well as ensuring notification to the MD, family, ISDH and other agencies outlined in the facility policy.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> Compliance with this corrective action will be monitored through the CQI Program. The ED/DNS or designee will be responsible for completion of the CQI Audit Tool titled, Abuse, Prohibition and Investigation daily for 2 weeks followed by monthly for 6 months. If a threshold of 100% is not met, an action plan will be developed. In addition, the Director of Operations/Director of Nursing Specialist will review compliance with the investigation and reporting process during monthly visits for at least 6 months. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 10/23/2015</p>	

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	An Interdisciplinary Team (IDT) progress note, dated 9/15/15 at 2:49 P.M., indicated "... IDT reviewed new and worsening behavior. Behavior: Resident was noted to become verbally and physically aggressive towards staff. Resident continued to actively exit seek and would not be redirected. Resident B stated he had a friend in the hospital. No reported friend in the hospital, staff attempted to comfort and encourage resident regarding thoughts about his friend, however, he refused to be comforted. Resident B remained on 15 minute safety checks. At 8 AM on 9/15/15, resident was noted to have eloped from the building. A code silver was called and staff and authorities have continued to attempt to locate resident. Family and MD [Medical Director] aware. Assessment: Upon assessment the environment was quiet. Resident's roommate passed away over the weekend. Although the two did not appear close, it is possible that roommate's death triggered some trauma for Resident B. Resident B's family was also in to visit on 9/10/15. Resident reported he thought he was going home and since that time (9/10/15) he cut off his wanderguard and refused to have it placed back on. Staff attempted to explain the importance of wanderguard, however, resident continued to refuse. 15			

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	<p>minute safety checks initiated due to exit seeking behaviors. Resident was unable to be calmed although many different staff members with good rapport attempted to talk to resident. 911 was called and resident was escorted by police to ER for evaluation. IDT called report to [hospital] to request inpatient stay, however, hospital was unable to admit at that time. Resident B was sent back to the facility. Resident B has dx of dementia with behavioral disturbances, depressive disorder, and Alzheimer's disease. Resident B has most recent BIMS score of 5 [severe cognitive impairment], however Resident B will often refuse to answer questions asked. This could be related to cognitive impairments, intelligence, (Resident B is illiterate) or personality. No recent medication changes have taken place. Resident will periodically refuse medication, however, he can often be redirected and will then take medications. Root cause: IDT discussed that root cause could be related to seeing family members and having roommate recently pass as a trigger. Resident B has history of eloping two years ago in the fall. Intervention: At the time of behavior 911 was called after several attempts to calm resident. Resident sent to ER [Emergency Room] for evaluation, however, was not admitted as requested.</p>			

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	<p>Resident continued on 15 minute safety checks. IDT recommends to continue efforts with authorities and staff to search for resident to secure safety. Upon resident's return he will be placed on secured unit. IDT will continue discussion proper placement upon return to facility...."</p> <p>A Care Plan with a problem start date of 10/26/13, indicated, "... Resident has history of elopement episode and at times will actively exit seek. Resident remains an elopement risk. Resident removed wanderguard on 9/10/15 and refused to have it replaced. Order remains, staff to continue to attempt to place wanderguard as able and will remain on 15 minute safety checks until wanderguard is able to be replaced...Long Term Goal...Resident will not exit facility unsupervised thru next review...Approaches: All facility exits secured... Wanderguard per order...Coat hat and suitcase stored outside of his room...Encourage resident and family to keep personal snacks in the kitchen rather than in his room to promote increased supervision and discourage time spent out of his room...Encourage participation in activity outside of his room...."</p> <p>On 9/18/15 at 2:30 P.M., an interview was conducted with CNA (Certified</p>			

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	<p>Nurse Aide) #2. CNA #2 indicated he was working the morning of 9/15/15 and that he provided care for Resident B. CNA # 2 indicated Resident B was awake earlier than usual that morning and pacing the halls, CNA #2 indicated he observed Resident B sitting in his chair in the hallway then he would get up walk to the end of the hallway turn around and come back walk into his room then come back out into hallway and sit in his chair then he would stand up and repeat the sequence. CNA #2 indicated the Executive Director has spoken to Resident B around 6:30 A.M. CNA #2 indicated he last saw Resident B between 7:40 A.M. and 7: 45 A.M. CNA #2 indicated he was asked by RN #1 to accompany her to administer Resident B's morning medications and that is when they discovered he was not in his room.</p> <p>On 9/18/15 at 3:05 P.M., during an interview, RN #1 indicated that she had gotten report about 6:00 A.M. the morning of 9/15/15 and that Resident B had been peeking around the corner and approached her asking if he could leave. RN #1 indicated she asked the Executive Director to talk to him as he was pointing at her and getting in her face, she further indicated after the ED talked to Resident B he seemed to settle down. Between 7:30 A.M., to 7:45 A.M., Resident B was</p>			

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	<p>Executive Director and the Director of Nursing Services. The Corporate Nurse indicated there was a 38 minute lapse of time between the time shown on the film and the actual time of day. To get the correct time, 38 minutes should be added to the time on the footage. This is consistent throughout the footage. The video indicated the following events with recorded times: "... 5:21 A.M. Resident B is seen sitting in a chair outside his room...5:37 A. M. He was observed with his winter coat and red ball cap on...5:40 A.M. was observed talking to RN #1...5:42 A.M. Observed in the hallway talking to Executive Director...5:43 A.M. Observed in chair...5:45 A.M. Observed walking into his room and back to hallway with his hat and coat on...5:48 A. M. Talking to nurse near nurses station, this was not in cameras view... 5:51 A.M. Resident walked the hallway then proceeded back to his room...5:57 A.M. Walked hallway to nurses station and returned to chair...6:03 A.M. Walked back down the hallway and returned to room...6:10 A.M. Observed sitting in his chair outside of his room...6:12 A.M. Resident stood up and was visualized walking into the chapel..." This observation indicated the resident was not on a secured unit.</p> <p>On 9/21/15 at 11:15 A.M., the Executive</p>			
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	<p>Director and Director of Nursing Services were interviewed. The Director of Nursing Services indicated 6:12 A.M. was the last time Resident B was visualized in the facility. He further confirmed the actual elopement time was 6:51 A.M. and not 7:55 A.M. that was previously reported to ISDH.</p> <p>On 9/21/15 at 11:40 A.M., A Safety Check List - 15 Minute form, dated 9/15/15, and provided by the Director of Nursing Services on 9/20/15 at 3:50 P.M. was reviewed. The Safety Checklist Form indicated Resident B had been checked on at 7:00 A. M., 7:15 A.M., 7:30 A.M. and 7:45 A.M.</p> <p>On 9/21/15 at 12:20 P.M., a second interview was conducted with the Director of Nursing Services. The Director of Nursing Services indicated he became aware that the Safety Check List indicated Resident B was checked at 7:00 A.M., 7:15 A.M., 7:30 A.M., and 7:45 A.M. on 9/18/15 when he began reviewing Resident B's chart. He further indicated the nurse who documented the 15 minute checks had been suspended pending an investigation.</p> <p>On 9/21/15 between 2:00 P.M., and 3:00 P.M., an interview was conducted with the Special Investigator with Adult</p>			

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	<p>Protective Services (APS). The Special Investigator indicated APS had not been notified of the elopement that occurred on 9/15/15.</p> <p>On 9/23/15 at 12:45 P.M., the facility investigation for the elopement of Resident B was provided by the Administrator and reviewed. During an interview, at that time, the Administrator indicated the facility had wrote a timeline of the elopement and that was the investigation. The Administrator further indicated he talked to his staff regarding the elopement of Resident B but he did not document it.</p> <p>On 9/23/15 at 3:40 P.M., the Abuse Prohibition, Reporting, and Investigation Policy and Procedure revised July 2015 and provided by the Administrator on 9/23/15 at 10:15 A.M., was reviewed. The policy indicated the following: "... Policy/Procedure: Upon completion of the investigation, which must occur within 5 working days of the reporting of an occurrence, a report of the investigation must be forwarded t the Long Term Care Division of the Indiana State Department of Health. Copies of the completed investigation must also be sent to Adult Protective Services, Ombudsman, and Director of Operations...Resident Abuse...8. an</p>			

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	<p>incident report will be initiated, following the guidelines for " Unusual Occurrence Reporting", along with a narrative description in the nurses' notes...9. Residents will be questioned (if alert and competent) about the nature of the incident and their statement will be put in writing...10. An investigation will be done to assure other residents have not been affected by the incident or inappropriate behavior, and the results documented...11. the investigation will include: Facts and observations by involved employees...Facts and observations by witnessing employees...Facts and observations by witnessing non-employees...Facts and observations from others who might have pertinent information...Facts and observations by the supervisor or individual whom the initial report was made...."</p> <p>3.1-28(a)</p>			

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F 0250 SS=D Bldg. 00	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to monitor and adequately supervise a resident who was exhibiting increased agitation and exit seeking behaviors. This deficient practice affected 1 of 5 Residents reviewed for behaviors. (Resident B)</p> <p>Finding includes:</p> <p>On 9/18/15 at 11:00 A. M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 10/21/13 with diagnoses, including but not limited to, Alzheimer's disease and Dementia with behavioral disturbances.</p> <p>A Quarterly Minimum Data Set (MDS)</p>	F 0250	<p><b>F250 – Provision of Medically Related Social Services</b> It is the practice of this provider to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident B is currently receiving care in a psychiatric services facility. Should Resident B return to the facility for continued care and service, behavior patterns will be assessed and his care plan reviewed and updated to reflect his current status. The updated care plan includes behavior management for a history of exit seeking behaviors. <b>How other residents having the potential</b></p>	10/23/2015

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	<p>assessment, dated 7/3/15, indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 5, indicating he was severely cognitively impaired.</p> <p>A Nursing progress note, dated 9/10/15 at 9:20 P.M., indicated "... Resident was visited by sister this evening, res thought that the sister was coming to get him and so he took off the wander guard, packed his bags ready to go, res was redirected by staff and latter calmed down, no self exit seeking behaviors noted this time, will continue to monitor...."</p> <p>A Interdisciplinary Team (IDT) progress noted, dated for 9/11/15 but entered on 9/15/15 at 10:21 A.M., indicated, "... IDT reviewed resident's refusal to wear wanderguard and resident will remain on 15 minute checks until wanderguard is replaced...."</p> <p>A Nursing Progress note, dated 9/14/15 at 10:15 A.M., indicated "...Shortly after breakfast, resident noted to be upset and stated he wanted to go home see his friend because he is dying. Resident stated he was going to leave facility. Staff offered to walk with resident to console him. Resident refused and became aggressive with staff. resident attempted to hit staff. This writer</p>		<p><b>to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential to be affected by this finding. A facility audit will be conducted by the IDT. This audit will identify all residents with behavioral symptoms and/or who are currently on Behavior Management Programs. The IDT will identify any resident with problematic or distressing behaviors such as exit seeking behaviors affecting themselves or other residents and ensure that appropriate behavior interventions are in place for those residents. Care plans will be reviewed and/or initiated for any behavioral issues identified. Updates and changes to resident behavior interventions and care plans will be communicated to all direct care staff. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> An in-service will be held on or before 10/23/15 by the ED/DNS or designee. This in-service will include review of the facility policy related to the Behavior Management Program and the importance of conducting timely and accurate assessments for any resident exhibiting behavior symptoms. The process for reviewing and updating the</p>	

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	<p>intervened. Resident stated he was going to throw the chair at the window and leave the facility. MD [Medical Doctor] notified and order received to send resident to ER [Emergency Room]. Call placed to 911. Policeman and paramedics arrived at facility. After much encourage, resident agreed to be taken to ER for evaluation...."</p> <p>A Nursing Progress note, dated 9/14/15 at 1:14 P.M., indicated "...Resident displayed agitation and aggression this morning, becoming verbally and physically aggressive towards staff. 911 was called to request resident be admitted for inpatient stay. Hospital reported resident could not be admitted at the time and would be returning to facility. Upon return to facility resident was calm, however, continued to walk around building. Resident continued to be on 15 minute safety checks due to exit seeking behaviors...."</p> <p>A Nursing Progress note dated 9/14/15 at 1:30 P.M., indicated "... Resident returned to facility from ER [Emergency Room] via [by way of] ambulance. No new orders. Resident in pleasant and cooperative mood. Currently sitting outside of room...."</p> <p>A Nursing Progress note dated 9/14/15 at</p>		<p>care plan interventions to accurately reflect each resident's current status will also be discussed. Any resident exhibiting a new and/or worsening behavior will be reviewed by the IDT and/or Weekend Manager. The careplan will be reviewed and/or updated to reflect identified behavior issues. In addition, the Social Services Director has been inserviced by the Regional Social Services Director on potential interventions available to support behavior management given the severity of the situation or potential risk to the resident up to and including one to one supervision. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> The DNS/SSD or designee will be responsible for completion of the CQI Audit Tool titled, "Behavior Management" daily for 2 weeks and monthly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 10/23/2015</p>	

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	<p>3:14 P.M., indicated "... Resident observed talking with peers. Snack offered to resident and accepted. Resident stated he is doing better than he was earlier. Attempted to apply wanderguard to resident's wrist and ankle, resident refused. POA [power of attorney] and NP [Nurse Practitioner] aware.</p> <p>A Nursing Progress note dated 9/14/15 at 8:54 P.M., indicated "...Resident found at the front office during supper time by this writer, res stated that he was ready to go home, res redirected several times by staff and latter agreed to go back to his room, res remains on 15 mins [minutes] safety checks, will continue to observe and assist..."</p> <p>An Interdisciplinary Team (IDT) progress note, dated 9/15/15 at 2:49 P.M., indicated "... IDT reviewed new and worsening behavior. Behavior: Resident was noted to become verbally and physically aggressive towards staff. Resident continued to actively exit seek and would not be redirected. Resident B stated he had a friend in the hospital. No reported friend in the hospital, staff attempted to comfort and encourage resident regarding thoughts about his friend, however, he refused to be comforted. Resident B remained on 15</p>			

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	<p>minute safety checks. At 8 AM on 9/15/15, resident was noted to have eloped from the building. A code silver was called and staff and authorities have continued to attempt to locate resident. Family and MD [Medical Director] aware. Assessment: Upon assessment the environment was quiet. Resident's roommate passed away over the weekend. Although the two did not appear close, it is possible that roommate's death triggered some trauma for Resident B. Resident B's family was also in to visit on 9/10/15. Resident reported he thought he was going home and since that time (9/10/15) he cut off his wanderguard and refused to have it placed back on. Staff attempted to explain the importance of wanderguard, however, resident continued to refuse. 15 minute safety checks initiated due to exit seeking behaviors. Resident was unable to be calmed although many different staff members with good rapport attempted to talk to resident. 911 was called and resident was escorted by police to ER for evaluation. IDT called report to [hospital] to request inpatient stay, however, hospital was unable to admit at that time. Resident B was sent back to the facility. Resident B has dx of dementia with behavioral disturbances, depressive disorder, and Alzheimer's disease. Resident B has most recent</p>			

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	<p>BIMS score of 5 [sever cognitive impairment], however Resident B will often refuse to answer questions asked. This could be related to cognitive impairments, intelligence, (Resident B is illiterate) or personality. No recent medication changes have taken place. Resident will periodically refuse medication, however, he can often be redirected and will then take medications. Root cause: IDT discussed that root cause could be related to seeing family members and having roommate recently pass as a trigger. Resident B has history of eloping two years ago in the fall. Intervention: At the time of behavior 911 was called after several attempts to calm resident. Resident sent to ER [Emergency Room] for evaluation, however, was not admitted as requested. Resident continued on 15 minute safety checks. IDT recommends to continue efforts with authorities and staff to search for resident to secure safety. Upon resident's return he will be placed on secured unit. IDT will continue discussion proper placement upon return to facility...."</p> <p>On 9/20/15 at 9:45 A.M., an interview with the Social Worker was conducted. The Social Worker indicated behavioral tracking is initiated on specific medications or for an increase in existing</p>			

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	<p>behaviors or new behaviors. When asked about Resident B's history of elopement she indicated that Resident B had no additional behaviors and no exit seeking behaviors so he was not tracked for Exit seeking. She further indicated she was notified the next day of the behaviors exhibited on 9/14/15 but by the time they conducted the IDT meeting the resident had already eloped from the building. The Social Worker indicated exit seeking behavioral tracking was not initiated for this resident and she would have initiated a walk with him to get fresh air as opposed to one on one supervision related to this was a new behavior for him.</p> <p>On 9/20/15 at 3:30 P.M., the Behavioral Management Policy revised 7/14 and provided by the Director of Nursing Services was reviewed. The policy indicated the following: "...2. When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior on the monitoring form including what interventions were attempted during the episode and whether or not they were effective...."</p> <p>This Federal tag relates to Complaint IN00182617.</p>			

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F 0282 SS=D Bldg. 00	<p>3.1-34(2)</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. Based on record review and interview, the facility failed to ensure the plan of care was followed related to labs for a resident who was receiving an anticonvulsant medication for 1 of 1 Residents reviewed for labs. (Resident B)</p> <p>Finding includes:</p> <p>On 9/18/15 at 11:00 A. M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 10/21/13, with diagnoses including but not limited to, Alzheimer's disease</p>	F 0282	<p><b>F282 – Services by Qualified Persons/Per Care Plan</b> It is the practice of this provider to provide qualified persons in accordance with each resident's written plan of care. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident B is currently receiving care at a psychiatric services facility. Should Resident B return, orders will be obtained and clarified to include laboratory draw orders and associated plan of care. <b>How other residents having the potential to be affected by</b></p>	10/23/2015

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	<p>and Dementia with behavioral disturbances.</p> <p>A Physician's order, dated 11/26/14, Divalproex [generic term for a medication Depakote that is used by some clinicians for the stabilization of moods] Amount to Administer 125mg [milligrams] oral once a day...Dx [diagnosis] Dementia w/bhvr dsturb [with behavioral disturbances]</p> <p>A Physician's order, dated 6/26/2015, indicated "... CBC [complete blood count] without Diff [differential]; CMP [comprehensive metabolic panel] (F) [fasting]; Lipid panel [a test used to measure liver function and cholesterol] (F); TSH [thyroid stimulating hormone] [a test used to measure the amount of the thyroid stimulating hormone in the blood]; Valporic Acid/Depakote [a test used to determine the level of the medication in the blood, medication strength could be adjusted if the level in the blood is not at a therapeutic level] other test: (Ammonia level) [a test used to determine the ammonia level in the blood, ammonia is broken down in the liver if the Ammonia level is increased in a person receiving Depakote it could indicate a need for the physician to discontinue the use of the medication]...Once a day on 1st Mon</p>		<p><b>the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential to be affected by this finding. Nursing Administration will conduct an audit of all current residents' orders by 10/23/15 to ensure that medications or conditions requiring associated laboratory draws have been ordered, scheduled and obtained with appropriate documentation to include notifications for refusals in accordance with the policy. <b>What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> As a portion of daily clinical meeting, laboratory orders and draws will be reviewed to ensure compliance with resident's plan of care. Results, refusals, notifications and new orders will be a portion of the discussion and appropriate monitoring or next steps taken as appropriate. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</b> The DNS/SSD or designee will be responsible for completion of the CQI Audit Tool titled, "Lab Diagnostics" daily for 2 weeks and monthly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the</p>	

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	<p>[Monday] of Mar [March], Sep [September]."</p> <p>The Medication Administration Record indicated the lab was due to be drawn on September 7th, 2015. The clinical record lacked documentation to indicate the lab had been drawn.</p> <p>On 9/23/15 at 12:15 P.M., an interview was conducted with the Director of Nurses (DON). The DON indicated the lab had not been drawn related to Resident B's refusal. The Director of Nurses further indicated the refusal was not documented and the lab had not been rescheduled.</p> <p>A Guideline for Lab Tracking, provided by the Director of Nurses on 9/23/15 at 2:46 P.M., indicated "...If resident refuses lab-talk with resident before lab leaves. If continues to refuse, notify MD [Medical Doctor] and follow subsequent order...."</p> <p>On 9/23/15 at 3:40 P.M., a second interview was conducted with the Director of Nurses. The Director of Nurses indicated the guideline lab tracking was what the facility utilized in regards to labs instead of a policy and that his expectation would be that if a resident refuses a lab the resident's</p>		<p>CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 10/23/2015</p>	

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F 0323 SS=J Bldg. 00	<p>physician and family be notified and that the lab would be rescheduled.</p> <p>3.1-35(g)(2)</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, record review and interview, the facility failed to ensure a resident who was established as a known elopement risk was provided adequate supervision to prevent elopement which resulted in the resident leaving the facility through the second story chapel</p>	F 0323	<p><b>F323 – Free of Accident Hazards/Supervisions/ Devices</b> It is the practice of this provider to provide qualified persons in accordance with each resident's written plan of care. <b>What corrective action(s) will be accomplished for those residents found to have been</b></p>	10/23/2015

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	<p>window for 1 of 5 residents reviewed for elopement. (Resident B) The resident left the facility at 6:51 A.M. on 9/15/15. The facility was unaware of the resident's whereabouts until the morning of 9/18/15, when family called to notify the facility of the resident's location.</p> <p>This deficiency resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 9/14/15 when the resident began to exhibit escalating exit seeking behavior. The Administrator and Director of Nursing Services were notified of the Immediate Jeopardy on 9/18/15 at 4:30 P.M. The Immediate Jeopardy was removed on 9/22/15, but noncompliance remained at the lower scope and severity of no harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Finding includes:</p> <p>On 9/18/15 at 8:30 A.M., an Incident Report, dated 9/16/15 at 10:19 A. M., was reviewed. The Incident Report indicated that while rounding to escort residents to breakfast, the charge nurse noticed Resident B was missing from his room. The charge nurse had noted seeing Resident B earlier in the morning. The Charge Nurse, RN #4, then notified the Executive Director and initiated a Code</p>		<p><b>affected by thedeficient practice:</b> Resident B was located and transferred to an acute psychiatric setting for further care and evaluation. Should Resident B return to the facility, his behavior pattern, an elopement risk assessment and his care plan willbe reviewed and updated to reflect his current status for exitseeking behaviors along with interventions appropriate to his current status</p> <p><b>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken:</b> All residents have the potential to be affected by thisfinding. All residents were reviewed by Nursing Administration to ensure that those at risk for elopement were identified, have a current and accurate elopement risk assessment, have an updated plan of care indicating a risk for elopement and have an updated profile in the elopement risk binder and on the resident Matrix/care sheet. All resident rooms and common area windows were audited by Nursing Administration for safety toinclude an opening not greater than 4 inches. Screws were replaced with an alternate screw requiring a specialized bit that would reduce the likelihood of ease of removal. Exit doors were checked for alarm/magnetic lock</p>	

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	<p>Silver (a means to alert staff that a elderly resident cannot be located), a search of the interior and exterior parameters of the facility and grounds was conducted. When Resident B was not found, the facility then called the South Bend Police Department. The police department arrived at the facility and began an investigation into the elopement of Resident B.</p> <p>On 9/18/15 at 11:00 A. M., the clinical record for Resident B was reviewed. Resident B was admitted to the facility on 10/21/13 with diagnoses including but not limited to, Alzheimer's disease and Dementia with behavioral disturbances.</p> <p>A Quarterly Minimum Data Set assessment, dated 7/3/15, indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 5, indicating he was severely cognitively impaired.</p> <p>A Nursing Progress note, dated 9/14/15 at 10:15 A.M., indicated "...Shortly after breakfast, resident noted to be upset and stated he wanted to go home see his friend because he is dying. Resident stated he was going to leave facility. Staff offered to walk with resident to console him. Resident refused and became aggressive with staff. Resident</p>		<p>functionality. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> An in-service was completed on 9.20.15 by the ED/DNS or designee related to the Elopement Policy with and their responsibility to respond to a resident in need when whereabouts are unknown. Elopement education has been added to the general orientation agenda for the education of associates new to the facility. Elopement risk assessments will be completed for all residents at the time of admission, with any significant change in condition, quarterly and annually. Weekly checks have been implemented to validate the security of windows and the ongoing placement of the screw enabling 4 inch window opening and the functioning of the wander guard doors with documentation maintained as a portion of the facility preventative maintenance program. Elopement drills will be conducted no less than three times per week on rotating shifts to enhance awareness and competency around the response process for two weeks, monthly for 6 months and quarterly thereafter. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</b></p>	

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	<p>attempted to hit staff. This writer intervened. Resident stated he was going to throw the chair at the window and leave the facility. MD [Medical Doctor] notified and order received to send resident to ER [Emergency Room]. Call placed to 911. Policeman and paramedics arrived at facility. After much encourage [sic], resident agreed to be taken to ER for evaluation...."</p> <p>A Nursing Progress note, dated 9/14/15 at 1:14 P.M., indicated "...Resident displayed agitation and aggression this morning, becoming verbally and physically aggressive towards staff. 911 was called to request resident be admitted for inpatient stay. Hospital reported resident could not be admitted at the time and would be returning to facility. Upon return to facility resident was calm, however, continued to walk around building. Resident continued to be on 15 minute safety checks due to exit seeking behaviors...."</p> <p>An Interdisciplinary Team (IDT) progress note, dated 9/15/15 at 2:49 P.M., indicated "... IDT reviewed new and worsening behavior. Behavior: Resident was noted to become verbally and physically aggressive towards staff. Resident continued to actively exit seek and would not be redirected. Resident B</p>		<p><b>into place:</b> The ED or designee will be responsible for completion of the CQI Audit Tool titled, "MissingResident/Elopement" daily for 2 weeks and monthly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for reviewand follow up. <b>By what date thesystemic changes will be completed:</b> Compliance date = 10/23/2015</p>	

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	<p>stated he had a friend in the hospital. No reported friend in the hospital, staff attempted to comfort and encourage resident regarding thoughts about his friend, however, he refused to be comforted. Resident B remained on 15 minute safety checks. At 8 AM on 9/15/15, resident was noted to have eloped from the building. A code silver was called and staff and authorities have continued to attempt to locate resident. Family and MD [Medical Director] aware. Assessment: Upon assessment the environment was quiet. Resident's roommate passed away over the weekend. Although the two did not appear close, it is possible that roommate's death triggered some trauma for Resident B. Resident B's family was also in to visit on 9/10/15. Resident reported he thought he was going home and since that time (9/10/15) he cut off his wanderguard and refused to have it placed back on. Staff attempted to explain the importance of wanderguard, however, resident continued to refuse. 15 minute safety checks initiated due to exit seeking behaviors. Resident was unable to be calmed although many different staff members with good rapport attempted to talk to resident. 911 was called and resident was escorted by police to ER for evaluation. IDT called report to [hospital] to request inpatient</p>			

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	<p>stay, however, hospital was unable to admit at that time. Resident B was sent back to the facility. Resident B has dx of dementia with behavioral disturbances, depressive disorder, and Alzheimer's disease. Resident B has most recent BIMS score of 5[severe cognitive impairment], however Resident B will often refuse to answer questions asked. This could be related to cognitive impairments, intelligence, (Resident B is illiterate) or personality. No recent medication changes have taken place. Resident will periodically refuse medication, however, he can often be redirected and will then take medications. Root cause: IDT discussed that root cause could be related to seeing family members and having roommate recently pass as a trigger. Resident B has history of eloping two years ago in the fall. Intervention: At the time of behavior 911 was called after several attempts to calm resident. Resident sent to ER [Emergency Room] for evaluation, however, was not admitted as requested. Resident continued on 15 minute safety checks. IDT recommends to continue efforts with authorities and staff to search for resident to secure safety. Upon resident's return he will be placed on secured unit. IDT will continue discussion proper placement upon return to facility...."</p>			

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	<p>A Care Plan with a problem start date of 10/26/13, indicated, "... Resident has history of elopement episode and at times will actively exit seek. Resident remains an elopement risk. Resident removed wanderguard on 9/10/15 and refused to have it replaced. Order remains, staff to continue to attempt to place wanderguard as able and will remain on 15 minute safety checks until wanderguard is able to be replaced...Long Term Goal...Resident will not exit facility unsupervised thru next review...Approaches: All facility exits secured... Wanderguard per order...Coat hat and suitcase stored outside of his room...[Encourage resident and family to keep personal snacks in the kitchen rather than in his room to promote increased supervision and discourage time spent out of his room]... [Encourage participation in activity outside of his room]...."</p> <p>On 9/18/15 at 2:30 P.M., an interview was conducted with CNA (Certified Nurse Aide) #2. CNA #2 indicated he was working the morning of 9/15/15 and that he provided care for Resident B. CNA # 2 indicated Resident B was awake earlier than usual that morning and pacing the halls, CNA #2 indicated he observed Resident B sitting in his chair in the hallway then Resident B would get</p>			

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	<p>up, walk to the end of the hallway, turn around and come back, walk into his room then come back out into hallway and sit in his chair, then he would stand up and repeat the sequence. CNA #2 indicated the Executive Director has spoken to Resident B around 6:30 A.M. CNA #2 indicated he last saw Resident B between 7:40 A.M. and 7: 45 A.M. CNA #2 indicated he was asked by RN #1 to accompany her to administer Resident B's morning medications and that is when they discovered he was not in his room.</p> <p>On 9/18/15 at 3:05 P.M., during an interview, RN #1 indicated that she had gotten report about 6:00 A.M. the morning of 9/15/15 and that Resident B had been peeking around the corner and approached her asking if he could leave. RN #1 indicated she asked the Executive Director to talk to him as he was pointing at her and getting in her face. She further indicated after the ED talked to Resident B, he seemed to settle down. Between 7:30 A.M., to 7:45 A.M., Resident B was observed pacing. He would sit down in his chair then get up walk the hall and go into his room and come out again repeating the pacing sequence. At 8: 00 A.M. RN #1 felt uncomfortable going to Resident B's room alone so she indicated she had asked CNA #2 to accompany her to administer Resident B's medications.</p>			

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	<p>When CNA #2 entered Resident B's room he was not found. RN #1 indicated at that time the facility began searching for Resident B and a code silver was called.</p> <p>On 9/19/15 at 12:00 P.M., a family member was interviewed. The family member indicated she found the resident at another family members house. He went from a friends house to a family members home. She indicated the resident had told her, he left the facility at night by going through the chapel windows and he "jumped" off the roof. He told her he did not use a ladder. He indicated he walked to the south side of town to a friends house. The family member indicated this would have been 3 to 4 miles.</p> <p>On 9/21/15 at 10:30 A.M., video footage of channel 7 and 8 (cameras that were positioned and recording events for the hallway Resident B resided on) were reviewed with the Corporate Nurse, the Executive Director and the Director of Nursing Services. The Corporate Nurse indicated there was a 38 minute lapse of time between the time shown on the film and the actual time of day. To get the correct time, 38 minutes should be added to the time on the footage. This is consistent throughout the footage. The</p>			

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	<p>video indicated the following events with recorded times: "... 5:21 A.M. Resident B is seen sitting in a chair outside his room...5:37 A. M. He was observed with his winter coat and red ball cap on...5:40 A.M. was observed talking to RN #1...5:42 A.M. Observed in the hallway talking to Executive Director...5:43 A.M. Observed in chair...5:45 A.M. Observed walking into his room and back to hallway with his hat and coat on...5:48 A. M. Talking to nurse near nurses station, this was not in cameras view... 5:51 A.M. Resident walked the hallway then proceeded back to his room...5:57 A.M. Walked hallway to nurses station and returned to chair...6:03 A.M. Walked back down the hallway and returned to room...6:10 A.M. Observed sitting in his chair outside of his room...6:12 A.M. Resident stood up and was visualized walking into the chapel...." This observation indicated the resident was not on a secured unit.</p> <p>On 9/21/15 at 11:15 A.M., the Executive Director and Director of Nursing Services were interviewed. The Director of Nursing Services indicated 6:12 A.M. was the last time Resident B was visualized in the facility. He further confirmed the actual elopement time was 6:51 A.M. and not 7:55 A.M. that was previously reported to ISDH.</p>			

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	<p>On 9/21/15 at 11:40 A.M., A Safety Check List - 15 Minute form, dated 9/15/15, and provided by the Director of Nursing Services on 9/20/15 at 3:50 P.M. was reviewed. The Safety Checklist Form indicated Resident B had been checked on at 7:00 A. M., 7:15 A.M., 7:30 A.M. and 7:45 A.M.</p> <p>On 9/21/15 at 12:20 P.M., a second interview was conducted with the Director of Nursing Services. The Director of Nursing Services indicated he became aware that the Safety Check List indicated Resident B was checked at 7:00 A.M., 7:15 A.M., 7:30 A.M., and 7:45 A.M. on 9/18/15, when he began reviewing Resident B's chart. He further indicated the nurse who documented the 15 minute checks had been suspended pending an investigation.</p> <p>The Immediate Jeopardy that began on 9/14/15 was removed 9/22/15, when through observation, record review, and interview, staff had completed education related to elopement, updated the clinical records of residents deemed at risk for elopement and secured windows and exits of the facility. Even though the facility's corrective action removed the Immediate Jeopardy, the facility remained out of compliance at a reduced</p>			

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	<p>scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of on-going monitoring and assessment.</p> <p>This Federal tag relates to Complaint IN00182617.</p> <p>3.1-45(2)</p>			