

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/10/2016
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NAME OF PROVIDER OR SUPPLIER  TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00206088, Complaint IN00206172, and Complaint IN00206946.</p> <p>Complaint IN00206088 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00206172 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00206946 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250 and F323.</p> <p>Survey dates: August 9 and 10, 2016</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Census bed type: SNF/NF: 73 Total: 73</p> <p>Census payor type: Medicare: 9 Medicaid: 55 Other: 9 Total: 73</p>	F 0000	Craig A. Hestand, HFA 08/19/2016 Interim Executive Director The Timbers of Jasper	
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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 0250 SS=D Bldg. 00	<p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on August 12, 2016.</p> <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. Based on observation, interview, and record review, the facility failed to manage behaviors of intrusive wandering, for 2 of 4 residents reviewed with behaviors, in a sample of 8.( Residents C and F)</p> <p>Findings include:</p> <p>1. On 8/9/16 at 12:05 P.M., during an interview with LPN # 1, she indicated Resident C had wandering behaviors.</p> <p>On 8/9/16 at 3:45 P.M., Resident C was</p>	F 0250	<p>F-250</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice</b></p> <p>Resident C was placed on 15 minute checks, behavior monitoring reviewed and updated, plan of care updated with preventative</p>	08/19/2016

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	<p>observed coming out of her room with a male resident.</p> <p>On 8/9/16 at 4:00 P.M., Resident C was observed coming out of an adjoining resident room. A resident was lying in a bed in that room.</p> <p>On 8/9/16 at 4:50 P.M., the clinical record of Resident C was reviewed. Diagnoses included, but were not limited to, dementia.</p> <p>A quarterly MDS assessment, dated 5/4/16, indicated a brief interview for Mental Status was not performed, and the resident was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated Resident C had wandered daily in the previous 7 days, required extensive assistance of one staff for transfer, and required supervision while walking in the room and corridor.</p> <p>A Care Plan, initially dated 3/15/16 and reviewed 8/3/16, indicated: "Problem, resident wanders and pacing through out cottage." The Approaches indicated: "Encourage resident to be take [sic] rest periods if she is wandering/pacing to [sic] much. Encourage resident to participate in activities. Offer snack/fluids. Offer toileting or incont [incontinent] care."</p>		<p>interventions.</p> <ul style="list-style-type: none"> <li>Resident F was placed on 15 minute checks, behavior monitoring reviewed and updated, plan of care updated with preventative interventions.</li> </ul> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will taken?</b></p> <ul style="list-style-type: none"> <li>All other residents residing on the Cottage displaying behavior of intrusive wandering have the potential to be affected by the alleged deficient practice</li> <li>Any resident identified as intrusive wandering will be assessed by the IDT with appropriate plan of care updated on or before 8/19/16.</li> </ul> <p><b>What measures will be put into place or what systematic changes will be made to ensure the deficient practice doesn't reoccur</b></p> <ul style="list-style-type: none"> <li>Cottage staff will be in-serviced on or before 8/19/16 by</li> </ul>	

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	<p>There were no additional interventions dated after 3/15/16.</p> <p>A Monthly Behavior summary, dated 7/8/16 at 12:01 P.M., indicated: "Behavior being monitored, Displays intrusive bx's [behaviors] including grabbing items, disturbing environment neg, et combative upon redirection. Days (Number of episodes) - 45, Evenings (Number of episodes) - 34, Nights (Number of episodes) - 3, Interventions on days do not appear to be effective. Care plan to be reviewed et updated if needed...."</p> <p>Resident Progress Notes included the following notations:</p> <p>7/19/16 at 9:52 P.M.: "Resident continues to wonder [sic] into other residents room taking personal belongs [sic] upsetting others. Resident has wondered [sic] hallway continuously this shift... Will continue to monitor for resident safety."</p> <p>7/20/16 at 9:05 P.M.: "Resident continues to wonder [sic] into other residents room taking personal belongs [sic] upsetting others... Will continue to monitor for resident safety."</p> <p>7/21/16 at 10:37 A.M.: "F/U note for</p>		<p>the DNS/designee—on preventative interventions placed for intrusive wanderers.</p> <p>How the corrective action will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be utilized?</p> <p>-The ED or designee will complete the QAPI tool for 15 minute checks weekly x 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter.</p> <p>· Findings from the QAPI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%.</p>				

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	<p>07/20/2016. Res noted by staff to be wandering through Cottage et picking up random items that may or may not belong to her. Staff monitors Res and Res room for these items et wandering. Res is care planned for wandering and interventions for such are in place. Root cause for Res wandering is r/t Res having Dx of dementia et Res communication skills are extremely impaired along with understanding others...Care plan to be reviewed et updated as needed."</p> <p>7/31/16 at 7:40 P.M.: "Res was seen walking out of room [number not her own] with res [number] fan. Staff intervned and took fan back into room and turned on for res [number]."</p> <p>7/31/16 at 9:09 P.M.: "Staff heard loud bang and went to investigate. This res was seen exiting room [number, not her own]. Staff went into this room and found TV on floor face down in front of credenza. TV placed back on credenza...No injuries to noted to res...."</p> <p>8/3/16 at 3:18 P.M.: "Res has...unclear speech, sometimes understood, rarely/never understands...BIMS [brief interview for mental status] 00 indicating severely impaired cognition. Res has inattention continuously, with disorganized thinking, altered level of</p>						

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	<p>consciousness...Res wanders daily...."</p> <p>2. On 8/9/16 at 12:05 P.M., during an interview with LPN # 1, she indicated Resident F had wandering behaviors.</p> <p>On 8/9/16 at 3:45 P.M., upon entrance to the Memory Care unit, Resident F was observed exiting a female resident's room. Staff were observed at the other end of the hallway.</p> <p>On 8/9/16 at 4:00 P.M., Resident F was not observed to be in his room, nor in the common activity room. It was observed that 5 resident room doors were shut, towards the end of the hallway where Resident F was last seen. At 4:10 P.M., CNA # 1 came down the hall, and indicated Resident F "was probably in his room." CNA # 1 indicated that Resident F "sometimes closes the doors." Resident F was then found in an empty resident room, with the door closed.</p> <p>The clinical record of Resident F was reviewed on 8/10/16 at 10:20 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>Resident Progress Notes included the following notations:</p> <p>5/6/16 at 1:20 P.M.: "Notified MD of</p>			

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	<p>increased difficulty distracting res. while wandering. Wanders in other res. rms (resident rooms) [sic]. Increased confusion...Will cont. to observe."</p> <p>5/17/16 at 5:04 P.M.: "Res. wandering into female res. room to use res. restroom."</p> <p>5/17/16 at 10:05 P.M.: "Res attempting to enter other rds [residents] rooms at times this evening with female co-res. Staff redirected each time with positive result. Continues on 30 min safety checks. Will monitor."</p> <p>5/18/16 at 8:54 P.M.: "...Resident wandered continuously throughout entire unit. Staff continuously had to redirect resident out of co-residents rooms. Resident redirects easily with no behaviors. Will continue to monitor."</p> <p>5/22/16 at 9:02 A.M.: "Res. continues to wander on unit et entering female and male res. rooms...."</p> <p>5/31/16 at 5:27 P.M.: "Resident has been wandering throughout unit et into co-resident's rooms with resident [number]...Staff continue to redirect resident as much as he will allow...."</p> <p>6/1/16 at 9:00 A.M.: "F/U note: for</p>			

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	<p>wandering.. Res is care planned for wandering et intrusive wandering. Res can be difficult to redirect at times but does not display neg bx's. Res has attached himself to another female Res which he believes is his wife. No inappropriate bx's noted concerning female Res. Will cont to observe Res et redirect if needed."</p> <p>6/9/16 at 9:51 P.M.: "Resident wandering into other resident's rooms this evening. Resident difficult to redirect... Will continue to observe."</p> <p>6/19/16 at 1:08 P.M.: "Res. following female res. on unit. Grabbing res. at times to keep res. from entering a male res. rooms."</p> <p>6/26/16 at 2:44 P.M.: "Resident continuously wandering throughout unit attempting to go into co-resident's rooms. Staff are continuously attempting to redirect resident...all are ineffective... Will continue to monitor."</p> <p>A quarterly MDS assessment, dated 6/29/16, indicated Resident F scored a 1 out of 15 for cognition, with 15 indicating no memory impairment. The resident exhibited wandering behaviors daily for the previous 7 days, and required supervision while ambulating in</p>			

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	<p>the room and corridor.</p> <p>A monthly Behavior Symptom form, dated 7/8/16 at 10:54 A.M., indicated: "Behavior being monitored, Res wanders into other Res rooms. Days (Number of episodes) - 68, Evenings (Number of episodes) - 40, Nights (Number of episodes) - 0. Evaluation of Interventions, Interventions of snacks, fluids, toileting, magazines, TV help decrease the restlessness, offer chores or sweeping floor, clean table...Interventions help for short periods of time. checklist that therapy designed for him. Interventions are not effective as a long term solution...."</p> <p>Resident Progress Notes continued:</p> <p>7/31/16 at 7:40 P.M.: "Res was seen by staff member turning off [another resident's] O2 [oxygen] concentrator. Staff member turned O2 back on and escorted res out of room...."</p> <p>A Care Plan, dated 6/8/16, indicated: "Problem, Res noted to wander into other Res rooms and at times is intrusive." The Approaches included: "When intrusive wandering in [sic] noted, offer Res to take a walk outside as a distraction technique when weather allows. Offer Res act [activity] of interest such as</p>			

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	<p>hunting and fishing mags [magazines] or tractor mags. Offer Res a chore or task such as sweeping the floor or cleaning the tables...." There were no documented interventions since 6/10/16.</p> <p>On 8/10/16 at 2:00 P.M., during an interview with the DON, she indicated the facility had hired a new Memory Care Facilitator, but that she would not be starting until the first of September. She indicated a new Unit Manager would also be staffed on the Cottage, and she thought that would help with supervision.</p> <p>On 8/10/16 at 2:45 P.M., during an interview with the Social Services Director, she indicated the Memory Care Facilitator was the staff member responsible for the behavior care plans on the Cottage. She indicated she was responsible for the care plans for the rest of the facility.</p> <p>On 8/10/16 at 3:00 P.M., Medical Records Staff # 1 provided the current facility policy on the "Behavior Monitoring Program Guidelines," undated. The policy included: "...Ideally, there should only be 3-5 interventions for each behavior. These should be interventions that have been shown to be both personalized and effective in altering the resident's behavior...New and</p>			

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F 0323	<p>worsening behaviors will still need to be reviewed, focusing on an evaluation of interventions and give a plan of action in response to the root cause of the behavior...Always consider need for increased supervision to ensure safety of other residents...."</p> <p>This Federal tag relates to Complaint IN00206946.</p> <p>3.1-34(a)</p>			

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SS=D Bldg. 00	<p><b>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b> The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to provide supervision to prevent falls and intrusive wandering, for 3 of 5 residents reviewed for falls and wandering behaviors, in a sample of 8. (Residents E, C, and F)</p> <p>Findings include:</p> <p>1. On 8/9/16 at 9:15 A.M., during the initial tour of the Memory Care unit, the Director of Nursing (DON) indicated Resident E had fallen recently.</p> <p>The clinical record of Resident E was reviewed on 8/10/16 at 11:50 A.M. Diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>Resident Progress Notes included the following notations:</p>	F 0323	<p>F-323</p> <p><b>What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice</b></p> <ul style="list-style-type: none"> <li>· Resident C has been identified and was placed on 15 minute checks. Behavior monitoring and fall interventions reviewed and updated with preventative interventions implemented.</li> <li>· Resident F has been identified and was placed on 15 minute checks, behavior monitoring reviewed and updated, plan of care updated with preventative interventions implemented.</li> <li>· Resident E has been identified and was placed on 15 minute checks. Resident care plans, profiles and fall interventions were reviewed and updated with preventative interventions implemented.</li> </ul>	08/19/2016			

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	<p>6/28/16 at 8:39 A.M.: "IDT [Interdisciplinary Team] fall f/u [follow up] note: for witnessed fall on 06/27/2016 at approx 1445 [2:45 P.M.]. Per MCF [Memory Care Facilitator] that witnessed fall, Res [resident] was sitting in dining room in a dining room chair on the outside of the table. Res then stood up, caught her foot on dining chair leg et [and] fell to the floor on her Lt [left] side without hitting her head...Res is currently taking an ATB [antibiotic] for tx [treatment] UTI [urinary tract infection]...Res does have Dx [diagnosis] of dementia. Immediate intervention was to monitor Res for unsteady gait...Future intervention to include staff to anticipate increased assist and/or needs with Res r/t [related to] any infectious process."</p> <p>6/29/16 at 11:13 P.M.: "Call light sounding CNA [name] entered room and resident was sitting on floor next to bed on bottom with call cord in her hand and under her bottom...Small closed abrasion noted to R [right] elbow...15 minute checks initiated. Mat with dycem placed on floor on R side of bed..."</p> <p>6/30/16 at 5:53 A.M.: "Resident noted to have bruise to L [left] hip area believed to be from previous fall."</p> <p>6/30/16 at 9:08 A.M.: "Resident up</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will taken?</b></p> <ul style="list-style-type: none"> <li>· All other residents residing on the Cottage have the potential to be affected by the alleged deficient practices</li> <li>· Any resident identified as intrusive wandering will be assessed by the IDT with appropriate plan of care updated on or before 8/19/16.</li> <li>· Audit on falls for residents residing on the Cottage was completed by the DNS/designee on or before 8/19/16 for the past 30 days to ensure the Fall Management Program was followed and intervention in place to prevent further accidents/injuries. Those residents identified without current plan of care/profile/interventions were further reviewed with appropriate interventions implemented</li> </ul> <p><b>What measures will be put into</b></p>		

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	<p>throughout shift with assistance x 1-2 from staff d/t having a very unsteady gait with increase [sic] loss of balance. Staff have assisted resident to regain balance multiple times throughout the shift. Resident appears to be more confused this AM...Will continue to monitor."</p> <p>7/1/16 at 10:22 A.M.: "Resident sitting at dining room table at this time with pressure alarm under her et gait belt on; has been one on one throughout early AM hours...Resident is extremely unsteady with ambulating et requires x 2 assist et gait belt. When attempting to transfer from sitting to standing position resident falls backwards until staff assist her with regaining balance...Lower body weakness observed...MD notified...new orders for resident to be sent to ER for eval et tx as indicated...."</p> <p>7/1/16 at 3:05 P.M.: "Res. returned form ER. No N.O.'s [new orders]. Res. restless, very unsteady, leaning to left, ext. [extensive] assist of 2 to ambulate...Bruising remains to L hip...Will cont. to observe."</p> <p>An annual Minimum Data Set (MDS) assessment, dated 7/18/16, indicated Resident E had a short term memory problem, and was severely impaired in cognitive skills for daily</p>		<p><b>place or what systematic changes will be made to ensure the deficient practice doesn't reoccur</b></p> <ul style="list-style-type: none"> <li>-Cottage staff will be in-serviced on or before 08/19/16 by the DNS/designee—on preventative interventions placed for intrusive wanderers and the fall management program.</li> <li>-DNS/designee will conduct rounds each shift to ensure fall interventions/supervision are in place on the Cottage per plan of care.</li> <li>-The DNS/designee will review daily report/progress notes/Physician orders and CARE rep. rounding logs daily on the Cottage to ensure supervision needs are adequate and or if fall interventions are needed</li> </ul> <p>How the corrective action will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be utilized?</p> <ul style="list-style-type: none"> <li>-The ED or designee will complete the QAPI tool for fall program and 15 minute checks weekly x 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter.</li> </ul>		

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	<p>decision-making. The resident required extensive assistance of two + persons for transfer, and one staff for ambulation. A test for balance during transitions and walking indicated, "Not steady, only able to stabilize with staff assistance." The resident had fallen since the prior MDS assessment; 2 or more with no injury, and 1 with "Injury (except major)...."</p> <p>Resident Progress Notes included the following notations:</p> <p>7/22/16 at 9:18 A.M.: "IDT f/u note for witnessed fall that occurred on 07/21/2016 at approx 1845 [6:45 P.M.]. Res was ambulating towards the nurses station and lost her balance. Res attempted to grab onto the nurses desk and fell to the floor on her Rt side before the staff could get to Res. Res did not hit her head. Res had previously been sitting in the common area...Res was noted to have small superficial abrasion to Rt elbow that measured 0.3 x 0.2 cm...Res was assisted off the floor with 2 assist and gait belt...Immediate intervention was 15 min checks for safety...IDT team concludes reason for fall is Res has unsteady gait and ambulation r/t Res dx of dementia...Future intervention: hipsters to be worn by Res at all times for prevention of injury...."</p>		<p>Findings from the QAPI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%.</p>				

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	<p>7/23/16 at 1:15 P.M.: "[Name of physician] notified of resident fall with injury orders to send to ER if res c/o [complains of] headache or dizziness or continues to bleed...."</p> <p>7/23/16 at 3:17 P.M.: "Res c/o severe headache, dizziness with skin tear continuing to bleed called [name of hospital] ER to give report...."</p> <p>The resident was transferred to the ER on 7/23/16 at 3:35 P.M., and returned to the facility on 7/23/16 at 6:02 P.M.</p> <p>Resident Progress Notes continued:</p> <p>7/23/16 at 11:25 P.M.: "...Steri strips intact over laceration R forehead, no active bleeding noted...Bed alarm in place, mat on floor on R side of bed et 15 min checks cont...posterior R elbow, did noted [sic] 2 purple discolored areas 1 cm x 0.3 cm each...."</p> <p>7/25/16 at 9:11 A.M.: "IDT fall note for unwitnessed fall on 07/23/2016 at approx 1315 [1:15 P.M.]. Res noted to be in hallway on the Cottage [Memory Care unit] on her knees with a laceration to Rt forehead that measures 2.4 x 1.6 cm with noted bleeding...Immediate intervention: pad alarm and w/c [wheelchair] and Res to be in dining area when out of bed for</p>			

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	<p>staff monitoring...Future intervention: cont pad alarm to all sitting surfaces and w/c for Res."</p> <p>8/4/16 at 2:00 P.M.: "Res was sitting in dining room chair stood abruptly and lost balance staff went to intercept happened too quickly res denied pain...assisted to her chair with 2 assist pad alarm in place and working...."</p> <p>8/5/16 at 11:05 A.M.: "IDT fall note: Witnessed fall on 8/4/16 @ 2:00 PM. Resident stood up in DR [dining room] by another resident and turned and lost balance. Resident sitting in floor almost in lying position...Future interventions, cushion on pad alarm in sitting surfaces and offer w/c when unsteadiness anticipated."</p> <p>A Care Plan, initially dated 8/4/15 and updated 8/5/16, indicated, "Problem, Resident is at risk for fall due to: age, new environment, weakness, hx [history] of incontinence, pshychotropics [sic], poor safety awareness, confusion, Alzheimer's [sic], depression, anxiety, osteoarthritis, osteoporosis, impaired cognition, unsteady gait, lack of understanding of physical and cognitive limitations." The Approaches included: "8/5/16 Lap Blanket to all seating surfaces with pad alarm placed beneath</p>			

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	<p>it. 8/5/16 Offer the resident the use of a W/C when resident appears weak or unsteady. 7/25/16 pad alarm to all sitting surfaces while up including when Res is in w/c. 6/30/16 bed alarm. 6/28/16 staff to anticipate increased need for assistance and or needs r/t any infectious process. 5/20/16 Encourage seated activities in common area. 5/20/16 staff to monitor for s/s of increased weakness including unsteady gait/balance."</p> <p>On 8/10/16 at 9:50 A.M., a skin assessment on Resident E was requested. A healing abrasion was observed on the resident's forehead. RN # 1 indicated at that time that the area was "pretty well healed."</p> <p>2. On 8/9/16 at 12:05 P.M., during an interview with LPN # 1, she indicated Resident C had wandering behaviors.</p> <p>On 8/9/16 at 3:45 P.M., Resident C was observed coming out of her room with a male resident.</p> <p>On 8/9/16 at 4:00 P.M., Resident C was observed coming out of an adjoining resident room. A resident was lying in a bed in that room.</p> <p>On 8/9/16 at 4:50 P.M., the clinical record of Resident C was reviewed.</p>			

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	<p>Diagnoses included, but were not limited to, dementia.</p> <p>A quarterly MDS assessment, dated 5/4/16, indicated a brief interview for Mental Status was not performed, and the resident was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated Resident C had wandered daily in the previous 7 days, required extensive assistance of one staff for transfer, and required supervision while walking in the room and corridor.</p> <p>A Care Plan, initially dated 3/15/16 and reviewed 8/3/16, indicated: "Problem, resident wanders and pacing through out cottage." The Approaches indicated: "Encourage resident to be take [sic] rest periods if she is wandering/pacing to [sic] much. Encourage resident to participate in activities. Offer snack/fluids. Offer toileting or incont [incontinent] care." There were no additional interventions dated after 3/15/16.</p> <p>Resident Progress Notes included the following notations:</p> <p>6/18/16 at 10:00 P.M.: "Staff at nursing station and heard noise. Staff found res sitting on buttocks leaning up against hallway wall next to room</p>			

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	<p>[number]...Small bruise with abrasion noted to L forehead with small amt [amount] of blood...Res assist off floor with 2 assist and gait belt...Hallway lights dimmed with one light by room [number] out. Res room and hallway by room [number] dark...Intermediate fall intervention: 15 min safety checks and notify maintenance of hallway light out."</p> <p>6/20/16 at 9:05 A.M.: "IDT note for fall occurring on 06/18/16 at 10pm...noted resident to be sitting on the floor...small abrasion noted to resident's forehead with a bruise surrounding it...Root cause: resident was restless, was up and down out of bed prior to fall. Future interventions: Resident will be offered a snack when up and down out of bed, encouraged to stay in the common area when not in bed and assessed for pain when restless due to chronic back pain...."</p> <p>6/29/16 at 6:38 A.M.: "This nurse found res beside bed and air unit lying on back with pillow underneath res head...Res assisted off floor with 2 assist and gait belt...Res unable to make statement as to what happened...15 min safety checks as intervention."</p> <p>Resident Progress Notes continued:</p>			

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	<p>7/19/16 at 9:52 P.M.: "Resident continues to wonder [sic] into other residents room taking personal belongs [sic] upsetting others. Resident has wondered [sic] hallway continuously this shift...Will continue to monitor for resident safety."</p> <p>7/20/16 at 9:05 P.M.: "Resident continues to wonder [sic] into other residents room taking personal belongs [sic] upsetting others...Will continue to monitor for resident safety."</p> <p>7/21/16 at 10:37 A.M.: "F/U note for 07/20/2016. Res noted by staff to be wandering through Cottage et picking up random items that may or may not belong to her. Staff monitors Res and Res room for these items et wandering. Res is care planned for wandering and interventions for such are in place. Root cause for Res wandering is r/t Res having Dx of dementia et Res communication skills are extremely impaired along with understanding others...Care plan to be reviewed et updated as needed."</p> <p>7/31/16 at 7:40 P.M.: "Res was seen walking out of room [number not her own] with res [number] fan. Staff intervened and took fan back into room and turned on for res [number]."</p>			

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	<p>7/31/16 at 9:09 P.M.: "Staff heard loud bang and went to investigate. This res was seen exiting room [number, not her own]. Staff went into this room and found TV on floor face down in front of credenza. TV placed back on credenza...No injuries to noted to res...."</p> <p>8/3/16 at 3:18 P.M.: "Res has...unclear speech, sometimes understood, rarely/never understands...BIMS [brief interview for mental status] 00 indicating severely impaired cognition. Res has inattention continuously, with disorganized thinking, altered level of consciousness...Res wanders daily...."</p> <p>3. On 8/9/16 at 12:05 P.M., during an interview with LPN # 1, she indicated Resident F had wandering behaviors.</p> <p>On 8/9/16 at 3:45 P.M., upon entrance to the Memory Care unit, Resident F was observed exiting a female resident's room. Staff were observed at the other end of the hallway.</p> <p>On 8/9/16 at 4:00 P.M., Resident F was not observed to be in his room, nor in the common activity room. It was observed that 5 resident room doors were shut, towards the end of the hallway where Resident F was last seen. At 4:10 P.M., CNA # 1 came down the hall, and</p>						

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	<p>indicated Resident F "was probably in his room." CNA # 1 indicated that Resident F "sometimes closes the doors." Resident F was then found in an empty resident room, with the door closed.</p> <p>The clinical record of Resident F was reviewed on 8/10/16 at 10:20 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>Resident Progress Notes included the following notations:</p> <p>5/6/16 at 1:20 P.M.: "Notified MD of increased difficulty distracting res. while wandering. Wanders in other res. rms [sic]. Increased confusion...Will cont. to observe."</p> <p>5/17/16 at 5:04 P.M.: "Res. wandering into female res. room to use res. restroom."</p> <p>5/17/16 at 10:05 P.M.: "Res attempting to enter other rsds [residents] rooms at times this evening with female co-res. Staff redirected each time with positive result. Continues on 30 min safety checks. Will monitor."</p> <p>5/18/16 at 8:54 P.M.: "...Resident wandered continuously throughout entire unit. Staff continuously had to redirect</p>			

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	<p>resident out of co-residents rooms. Resident redirects easily with no behaviors. Will continue to monitor."</p> <p>5/22/16 at 9:02 A.M.: "Res. continues to wander on unit et entering female and male res. rooms...."</p> <p>5/31/16 at 5:27 P.M.: "Resident has been wandering throughout unit et into co-resident's rooms with resident [number]...Staff continue to redirect resident as much as he will allow...."</p> <p>6/1/16 at 9:00 A.M.: "F/U note: for wandering.. Res is care planned for wandering et intrusive wandering. Res can be difficult to redirect at times but does not display neg bx's. Res has attached himself to another female Res which he believes is his wife. No inappropriate bx's noted concerning female Res. Will cont to observe Res et redirect if needed."</p> <p>6/9/16 at 9:51 P.M.: "Resident wandering into other resident's rooms this evening. Resident difficult to redirect... Will continue to observe."</p> <p>6/19/16 at 1:08 P.M.: "Res. following female res. on unit. Grabbing res. at times to keep res. from entering a male res. rooms."</p>			

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	<p>6/26/16 at 2:44 P.M.: "Resident continuously wandering throughout unit attempting to go into co-resident's rooms. Staff are continuously attempting to redirect resident...all are ineffective... Will continue to monitor."</p> <p>A quarterly MDS assessment, dated 6/29/16, indicated Resident F scored a 1 out of 15 for cognition, with 15 indicating no memory impairment. The resident exhibited wandering behaviors daily for the previous 7 days, and required supervision while ambulating in the room and corridor.</p> <p>Resident Progress Notes continued:</p> <p>7/31/16 at 7:40 P.M.: "Res was seen by staff member turning off [another resident's] O2 [oxygen] concentrator. Staff member turned O2 back on and escorted res out of room...."</p> <p>A Care Plan, dated 6/8/16, indicated: "Problem, Res noted to wander into other Res rooms and at times is intrusive." The Approaches included: "When intrusive wandering in [sic] noted, offer Res to take a walk outside as a distraction technique when weather allows. Offer Res act [activity] of interest such as hunting and fishing mags [magazines] or</p>			

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	<p>tractor mags. Offer Res a chore or task such as sweeping the floor or cleaning the tables...." There were no documented interventions since 6/10/16.</p> <p>On 8/10/16 at 2:00 P.M., during an interview with the DON, she indicated the facility had hired a new Memory Care Facilitator, but that she would not be starting until the first of September. She indicated a new Unit Manager would also be staffed on the Cottage, and she thought that would help with supervision. She indicated the facility's falls had started to decrease in number.</p> <p>On 8/10/16 at 3:00 P.M., Medical Records Staff # 1 provided the current facility policy on the "Fall Management program," revised 7/2016. The policy included: "It is the policy...to ensure residents residing within the facility will maintain maximum physical functioning through the establishment of physical, environmental, and psychosocial guidelines to prevent injury related to falls...Fall Risk Interventions (not all inclusive - use as reference tool)...Cognition...Increased supervision...Review staffing during key fall times...Anticipate needs for confused residents...."</p> <p>This Federal tag relates to Complaint</p>			

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