

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155632	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/13/2016
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NAME OF PROVIDER OR SUPPLIER  LODGE OF THE WABASH	STREET ADDRESS, CITY, STATE, ZIP CODE 723 E RAMSEY RD VINCENNES, IN 47591
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00201930 and Complaint IN00203522.</p> <p>Complaint IN00201930 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00203522 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: July 12 and 13, 2016</p> <p>Facility number: 001138 Provider number: 155632 AIM number: 200157070</p> <p>Census bed type: SNF/NF: 40 Residential: 15 Total: 55</p> <p>Census payor type: Medicare: 3 Medicaid: 30 Other: 7 Total: 40</p> <p>Sample: 5</p>	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because the provisions of federal and state law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity or render adequate care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on July 14, 2016.</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure supervision was provided to manage a resident from wandering into other residents' rooms uninvited and outside of his unit unattended, for 1 of 3 residents reviewed for behaviors, in a sample of 5. (Resident B)</p> <p>Findings include:  On 7/12/16 at 9:35 A.M., during the</p>	F 0323	<p>The facility revises the QAPI audits to be conducted weekly for a month, then monthly for six months, or if necessary until 100% compliance is achieved. Facility will update care plan for resident B to show more individualized approaches for activities reflecting resident preferences. Social history will be completed by Social Service Designee for resident B. The care plan and social history will be completed by 8-12-16. Facility will review and update care plans and social histories for all residents having potential to be affected as appropriate. All care plans and social histories will be updated as</p>	08/12/2016

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	<p>initial tour, LPN # 1 indicated she and RN # 1 were the nurses working on day shift. She indicated RN # 1 was also responsible for the Memory Care Unit.</p> <p>At that time, the Memory Care Unit was observed to be located behind 2 wooden doors. The doors were shut, but LPN # 1 indicated the doors were not kept locked. She indicated the staff consisted of 2 CNAs on that unit.</p> <p>On 7/12/16 at 9:40 A.M., CNA # 1 was interviewed. She indicated she and another CNA were the staff on day shift. She indicated the Memory Care Director also worked during the day, and was "probably in her office." CNA # 1 indicated, "If we need the nurse we can get her." CNA # 1 indicated there were 7 residents who resided on that unit. She indicated Resident B exhibited behaviors, but was in the hospital at that time.</p> <p>On 7/12/16 at 1:30 P.M., the Memory Care Director was interviewed. She indicated she scheduled staff for that unit, and planned the activities.</p> <p>The clinical record of Resident B was reviewed on 7/12/16 at 1:40 P.M. Diagnoses included, but were not limited to, Alzheimer's disease.</p>		<p>needed by 8-12-16. The MemoryCare Director was inserviced by the corporate consultant regarding programmingand interventions for individuals with Alzheimers or dementia. The inservice included content regardingindividualized interventions, and resource materials for care plan development.An audible alarm system will be placed at the Memory Care doors requiring akeypad for entry. If activated, the alarm will sound in a manner that does notdisrupt the ease of entry and exit. A reference manual will be provided formemory care employees to ensure that employees have information needed forindividual interventions. Care plan team will be inserviced on the importanceof the individualized care planning process as well as memory care staff onappropriate interventions for use of care plan interventions and available resourcesto address resident supervisory needs. Administrator and Memory Care Directorpurchased additional activity items for the memory care area and will continueto purchase items as needed. Staff is developing a list of alternativeinterventions for wandering. All action items will be completed by 8-12-16. The Directorof Nursing or designee will conduct QAPI audits to ensure continuedcompliance. The audits will be</p>		

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	<p>A Minimum Data Set (MDS) assessment, dated 3/15/16, indicated the resident had a short term and long term memory problem, and was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident exhibited "Other behavioral symptoms not directed toward others" 1 to 3 days in the previous 7 days, "Significantly intrude on the privacy or activity of others," and "Significantly disrupt care or living environment." The MDS assessment indicated the resident had wandered 1 to 3 days in the previous 7 days, and that the wandering "significantly intrude(d) on the privacy of activities of others." The resident required supervision and one person physical assist to ambulate in the room and corridor.</p> <p>A Care Plan, dated 3/21/16, indicated, "Problem: Resident is an identified pacer/wanderer...Related to: Dementia, anxiety, restlessness. Manifested by: When resident becomes tearful and restless, he begins wrings hands [sic], cannot sit for any length of time, paces halls, sometimes enters other resident's rooms and is difficult to divert." The Approaches included: "Assess for pain, administer meds ordered and appropriate, Involve family as needed, attempt to divert resident's attention by using</p>		<p>conducted weekly for a month, then monthly for six months, or if necessary until 100% compliance is achieved. The Director of Nursing will report the results of the audits to the QAPI Committee who will determine the need for further monitoring.</p>		

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	<p>familiar speech/conversation, using familiar activities, keep resident busy [with] activities, anticipate behavior as a need such as hunger, thirst, needing toileting...." The Care Plan did not indicate individualized activities the resident may enjoy, or individualized drinks and/or snacks. The Care Plan had an updated date of 6/3/16, but with no changes in the approaches.</p> <p>Nurses Notes, dated 6/3/16 at 11:32 P.M., indicated, "Wandering up and down hall going into other residents rooms...."</p> <p>A Social Service note, dated 6/6/16 at 8:57 A.M., indicated, "...resident had a bad evening 6/3/16. He was aggressive and threatening toward staff...pacing and going in and out of other resident's [sic] rooms...This am, resident is calm, but he is up and wandering into other resident's [sic] rooms; he was in a female resident's room when I arrived on MC [Memory Care], was standing @ her window looking out...."</p> <p>A Nurses Note, dated 6/6/16 at 4:49 A.M., indicated, "Wandering: Behavior occurred 1-3 days in the last 7 days...Wandering significantly intrudes on privacy of activity of others? Yes...."</p>			

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	<p>A Social Service note, dated 6/9/16 at 8:29 A.M., indicated, "...I found resident in another resident's room sobbing. The other resident was not in his room. He was sitting in the chair...continued to cry. He walked out of the room [with] me, and by indication of body language...it appeared that resident had some pain...I informed CNA that I located resident in another resident's room, she stated that she knew he was in there, but couldn't get him to come out, so she was going to re-approach him later...."</p> <p>A Social Service note, dated 6/13/16 at 7:55 A.M., indicated, "This writer was @ facility 6/11/16, and noted that resident was out of memory care area, memory care staff not present. He appeared restless/agitated. Was not angry. Memory care staff did come and get resident after about 10 minutes."</p> <p>A Nurses Note, dated 6/15/16 at 9:12 A.M., indicated, "Wandering: behavior occurred daily. Wandering significantly intrudes on privacy or activity of others? Yes."</p> <p>A Social Service note, dated 6/15/16 at 1:39 P.M., indicated, "Resident has had increased anxiety and wandering. Resident keeps saying 'come on.'...anxiety did decrease some after</p>			

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	<p>toileting but resident is now pacing some. Will continue to monitor."</p> <p>A Nurses Note, dated 6/18/16 at 12:59 A.M., indicated, "resident pacing up and down hallways this shift, have tried redirecting him several times with no success. Attempted to go in to several other residents rooms...will continue to monitor."</p> <p>A Nurses Note, dated 6/18/16 at 5:47 A.M., indicated, "Approx 3 am resident up pacing in the hallways, tearing kleenex, went into residents room and was refusing to come out....continued to pace...."</p> <p>A Nurses Note, dated 6/19/16 at 12:03 A.M., indicated, "Incident Type: Witnessed fall...Location: another residents room...."</p> <p>A Nurses Note, dated 6/19/16 at 1:38 A.M., indicated, "Resident was in another room this shift. Staff reported he passed out had been up dancing had got to [sic] hot when I got to the room he was responding...."</p> <p>A Social Service note, dated 6/20/16 at 4:52 P.M., indicated, "...Currently resident has been pacing and rummaging through others rooms. Resident grabbed</p>			

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	<p>two packages of peri wipes and started opening the bad...now pacing up and down the hallway and grabbed another resident's stop sign...This writer filled up a purse for resident to rummage through and this was effective and diverted resident for a short period of time but resident is still anxious and pacing. Will continue to monitor."</p> <p>On 7/12/16 at 3:50 P.M., CNA # 2 was interviewed. She indicated the doors to the Memory Care unit remained closed at all times. She indicated she and another CNA worked day shift on the unit from 6:00 A.M. to 6:00 P.M., and 1 CNA worked on the unit during the night shift from 6:00 P.M. to 6:00 A.M. She indicated, "We have walkie talkies too if we need to get a hold of someone."</p> <p>On 7/12/16 at 10:45 A.M., 1:25 P.M., 3:30 P.M. and 4:00 P.M. , RN # 1 was observed outside of the Memory Care Unit. The doors to the Memory Care Unit remained closed.</p> <p>On 7/13/16 at 12:00 P.M., the Social Service Director (SSD) was interviewed. The SSD indicated she "still did assessments on the Memory Unit," or if there was a concern, she "addressed it." The SSD indicated the Memory Care Director also took care of social concerns</p>			

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	<p>on the Memory Unit. The SSD indicated Resident B became very agitated, and "not redirectable at all." The SSD indicated she had not completed a social history, determining the resident's likes and dislikes, due to the resident being unable to answer questions, and the resident being "in and out of the hospital." The SSD indicated the staff had put up "stop signs" on different resident doors, and had started closing doors, to help keep Resident B from wandering into other rooms.</p> <p>This Federal tag relates to Complaint IN00203522.</p> <p>3.1-45(a)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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