

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155608	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2016
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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00190292.</p> <p>Complaint IN00190292-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency was cited.</p> <p>Survey date: January 13 &amp; 14, 2016</p> <p>Facility number: 000515 Provider number: 155608 AIM number: 100290820</p> <p>Census bed type: SNF: 26 SNF/NF: 107 Total: 133</p> <p>Census payor type: Medicare: 33 Medicaid: 62 Other: 38 Total: 133</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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>Quality review completed by 26143, on January 19, 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. Based on record review and interview, the facility failed to ensure a resident received adequate supervision, related to a resident who was a fall risk, walked out of the facility after a staff member opened the door, and the resident then fell once outside of the building for 1 of 3 residents reviewed for elopement risk in a total sample of 5. (Resident #F)</p> <p>Findings include:</p> <p>Resident #F's record was reviewed on 01/14/16 at 12:19 p.m. The resident's diagnoses included, but were not limited to dementia and stroke.</p> <p>An Elopement Assessment, dated 12/03/15, indicated the resident was a moderate risk for elopement due to</p>	F 0323	- what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident had no negative consequences, elopement risk assessment completed and wanderguard in place. - 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; All elopement risk assessments will be reviewed and high risk residents photos and face sheets will be placed in binder at concierge desk - what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Education provide to all security, maintenance, life enrichment, business office, conceirge staff on elopement protocols. - how	02/08/2016

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	<p>dementia, cognitive impairment, and poor safety awareness.</p> <p>A Fall Risk Evaluation, dated 12/03/15, indicated the resident was a high risk for falls.</p> <p>An Admission Minimum Data Set assessment, dated 12/10/15, indicated the resident's cognition was severely impaired, and required minimal assistance for ambulation.</p> <p>A Physician's Order, dated 12/06/15, indicated an order for bed and wheelchair sensor alarms at all times.</p> <p>A Nurses' Note, dated 12/13/15 at 6:10 p.m., indicated, "called to front door by staff. Resident observed standing @ (at) receptionist desk, dirty shirt. Resident was found on ground just outside front door. 0.3 x 0.4 cm (centimeter) discoloration c/ (with) 0.2 x 0.1 (cm) scratch left cheek. Abrasion L (left) knee 3.2 x 2.8 cm c/ surrounding redness. Denies pain or discomfort..."</p> <p>A Reportable Incident form to the Indiana State Department of Health, dated 12/14/15, indicated the resident independently walked to the front door and exited the building and then fell once outside. The incident indicated a facility</p>		<p>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;and elopement drill to be performed by plant operations director or designee weekly x 3 months or until 100% compliance is reached. Findings to be reported monthly at quality assurance meeting. - bywhat date the systemic changes will be completed. FEBRUARY 8, 2016</p>	

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	<p>employee was taking coffee to another resident who was sitting outside and found Resident #F on the ground and assisted the resident.</p> <p>An investigation, dated 12/13/15, indicated the nurse was called to the receptionist desk by Maintenance #1. Maintenance #1 indicated another resident had alerted him Resident #F had fallen. The location of the fall was listed as outside the front door.</p> <p>A statement from Maintenance #1 indicated he was relieving the receptionist at the front desk and was making a cup of coffee for another resident when, "a man walked up to the door to exit the building".. Maintenance #1 indicated no alarm had activated and since the resident was walking, he (Maintenance #1), then activated the door release button to allow the resident out of the building. Maintenance #1 then finished the coffee and went outside to deliver to the resident and saw a man on the pavement on his hands and knees, and the other resident indicated Resident #F had just fallen. Maintenance #1 then went to the resident who stated he lived, "over there", (pointing at another building on the grounds). Maintenance #1 then noticed a bracelet on the resident's wrist which contained the</p>			

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	<p>resident's name and room number and Maintenance #1 escorted the resident back into the building.</p> <p>During an interview on 01/14/16 at 12:44 p.m., the Maintenance Supervisor indicated Maintenance #1 was verbally inserviced not to activate the door release button until a staff member verifies if the person was a resident or not. The Maintenance Supervisor indicated the maintenance staff in the evening relieves the receptionist when they go on their break.</p> <p>During an interview on 01/14/16 at 1 p.m., Nursing Supervisor #2 indicated she was the Supervisor on 12/13/15. Nursing Supervisor #2 indicated the resident was in the dining room for supper. She indicated the resident's family had brought the resident in the wheelchair to the dining room. She indicated the family had not re-attached the sensor alarm to the resident when they brought him to the Dining Room. Nursing Supervisor #2 indicated the resident's wheelchair was still in the dining room and the resident walked from the dining to the front door (approximately 100 feet) independently and the resident had not been observed by staff walking independently to the front door.</p>			

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	<p>During an interview on 01/14/16 at 1:46 p.m., the Assistant Director of Nursing indicated from today forward, when the Receptionist was not at the desk, anyone wanting to exit the building will be directed to the keypad instead of the door release button, and if they have difficulty with the key pad, Nursing Staff will be notified to come to the front desk. The Assistant Director of Nursing indicated the other staff who worked on 12/13/15 were not interviewed for the investigation.</p> <p>A facility policy, dated 11/06/13, titled, "Fall Reduction Protocol", received from the Assistant Director of Nursing as current, indicated, "...the facility provides an environment that was free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents..."</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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