

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 11/13/2014
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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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F000000	<p>This visit was for the Investigation of Complaint IN00158859.</p> <p>Complaint IN00158859 - Substantiated, Federal/State deficiencies related to the allegations are cited at F250, F323, and F353.</p> <p>Survey dates: November 10,12, and 13, 2014</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Survey team: Anne Marie Crays, RN-TC Amy Wininger, RN (11/10/14)</p> <p>Census bed type: SNF/NF: 78 Total: 78</p> <p>Census payor type: Medicare: 6 Medicaid: 52 Other: 20 Total: 78</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings</p>	F000000		

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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F000250 SS=E	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on November 14, 2014 by Jodi Meyer, RN</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 ensure residents who exhibited behaviors of wandering, physical aggression, and yelling out, had interventions in place to assist in managing the behaviors and were monitored for those behaviors, for 4 of 4 residents sampled with behaviors, in a sample of 9. (Residents F, B, A, and C)</p> <p>Findings include:</p> <p>1. On 11/10/14 at 9:15 A.M., during the initial tour of the locked Alzheimer's Unit, "Stop" signs were observed</p>	F000250	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on December 13, 2014.</p> <p>F250 What corrective action(s) will be accomplished for those residents found to have been affected by the</p>	12/13/2014

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	<p>attached by Velcro and placed across 3 different resident room doors. The Director of Nursing (DON) indicated at that time, that the signs helped remind some residents that those rooms were not their rooms.</p> <p>On 11/10/14 at 9:50 A.M., during interview with RN # 1 and the Memory Care Facilitator (MCF) of the Alzheimer's Unit, they indicated Resident F had behavior symptoms of wandering, and that there were stop signs in place over other resident room doors.</p> <p>On 11/10/14 from 9:50 A.M. until 10:55 A.M., during constant observation of the Alzheimer's Unit, Resident F was observed to be almost constantly pacing up and down the halls. At 10:05 A.M., Resident F was sitting in another resident's room, and CNA # 4 was observed to state, "Come on," and he left the room. CNA # 4 indicated at that time, "He's one of my wanderers." At 10:15 A.M., Resident F was observed to pick up an alarm box at the nurses station. RN # 1 indicated, "Put it down," which he did. Resident F would play with cards for a few minutes, and then start walking down the hall.</p> <p>On 11/10/14 at 3:30 P.M., Resident F was observed to be sitting in a chair in a</p>		<p>deficient practice?</p> <ul style="list-style-type: none"> Residents F and B no longer resident at the facility. Residents A and C affected by the alleged deficient practice have been identified by the interdisciplinary team and have had their behaviors of wandering, physical aggression, and yelling out assessed. Through assessment interventions have been updated, monitoring tools put in place, care plans updated, and physician evaluation as needed. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed a care plan audit on every current resident who exhibits behaviors, wandering, physical aggression and yelling out and updated care plans as needed with behavior monitoring tools put in place if needed and interventions to address resident specific behaviors. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Education on behavior management and reportables has been provided to all staff by 		

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	<p>female resident's room. He pulled the call light out of the wall, and the Clinical Education Coordinator responded and assisted the resident out of the room.</p> <p>On 11/10/14 at 3:40 P.M., the Social Services Director (SSD) indicated she did not take care of the Alzheimer's Unit, but that since the MCF was fairly new, she "tried to help her out."</p> <p>On 11/10/14 at 3:45 P.M., Resident F was observed to be going in and out of resident rooms.</p> <p>The clinical record of Resident F was reviewed on 11/12/14 at 10:50 A.M. Diagnoses included, but were not limited to, frontotemporal dementia and Pick's disease (a disease that causes progressive destruction of the nerve cells in the brain. Symptoms include dementia and loss of speech).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/21/14, indicated the resident was unable to complete a test for cognition, had a short-term memory problem, and was moderately impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident had exhibited no behaviors in the previous 7 days, and was independent in ambulation.</p>		<p>CEC/DNS/SSD/Designee by December 13, 2014.</p> <ul style="list-style-type: none"> ·DNS/CEC/nurse manager/designee will conduct daily audits of progress notes and behavior notes to ensure behavior has been assessed, care plan updated, that interventions are documented on the behavior monitoring tool and reviewed to ensure effective. ·DNS/CEC/nurse manager/designee will conduct daily audits on current interventions for behavior management to make sure it is up-to-date and effective. <p>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?</p> <ul style="list-style-type: none"> ·DNS/nurse manager/SSD/MCF/Designee will daily utilize Behavior management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. ·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. <p>Compliance date: December 13, 2014</p>				

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	<p>Resident Progress Notes included the following notations:</p> <p>10/9/14 at 2:34 A.M.: "...Resident continues to wander into room across hall, opening blinds and then walking out. Able to redirect resident...."</p> <p>10/10/14 at 9:44 P.M.: "...Resident in and out of other residents rooms this shift causing distress to others. Can redirect for short periods of time...Resident will take food and drinks that belong to others with what seems no understanding of this [sic]. Resident will go to kitchen and place dishes in sink and turn water on then walk away. Resident will get into refrigerator and take out food if refrigerator left unlocked...."</p> <p>10/21/14 at 9:30 A.M.: "Behavior review. Resident walked passed [sic] other resident and 'popped' him on the head. Residents were separated immediately...IDT [interdisciplinary team] believes root cause of behavior to be residents [sic] diagnosis of Pick's Disease. Staff will rearrange common sitting area to divert resident walking directly past co-resident."</p> <p>10/24/14 at 3:59 P.M.: "Resident has been out of bed and pacing the floor."</p>			

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	<p>Resident paces mostly from his room to residents room beside of him."</p> <p>11/1/14 at 4:04 P.M.: "This nurse saw resident hit other resident on top of the head lightly. Other resident did not show signs of distress at the time and [Resident F] was told that he could not do this to other residents. Resident stated, 'Ok.' Resident has been redirected out of other residents room. Resident was found in room [number] laying on the bed. This room has two ladies that share the room. Resident has been redirected out of this room three different times this afternoon. Will continue to monitor for any changes."</p> <p>11/2/14 at 3:24 P.M.: "Resident has been going into other residents rooms and walking around looking at their stuff. Resident has been redirected and still continues to go into other residents rooms. Spouse has told him to stay out and he continued to go into the rooms. Will continue to redirect resident out of other residents rooms."</p> <p>11/5/14 at 4:05 P.M.: "Resident continues to go into other residents rooms and lay down on their beds, readjust [sic] the thermometer in their rooms, and push the call light buttons. Resident has not been able to redirect.</p>			

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	<p>Staff has told resident to stay out of other peoples rooms but he continues to return to the rooms and do the same things over again."</p> <p>11/7/14 at 3:11 P.M.: "Res. cont. to wander into other res. rooms. Res was found today lying in [room number] bed...Will cont. to monitor."</p> <p>11/9/14 at 1:12 A.M.: "Res. up pacing hallway @ times this shift. Res entering other res room @ times...Will cont. to monitor."</p> <p>11/10/14 at 9:34 P.M.: "Resident wandering in and out of rooms, turning on call lights, using restrooms, opening and shutting blinds, sitting in chairs...Resident redirected with activities."</p> <p>11/11/14 at 10:23 A.M.: "Resident has been in several different rooms this AM and is picking up things that belongs to the other residents. He had the remote to [Resident H's] tv and had the stuffed animals out of [Resident I's] room. Resident has been redirected with no success. Resident continues to wander into other residents rooms."</p> <p>11/11/14 at 10:28 A.M.: "Resident was in the spa room putting his shoes on and</p>						

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	<p>[Resident G] was coming in to use the bathroom. [Resident F] hit [Resident G] on the bottom as he walked by [Resident F]. Will continue to monitor for any changes. Social Services aware."</p> <p>11/11/14 at 11:30 A.M.: "Recorded as Late Entry on 11/12/2014 at 9:25 A.M.) IDT behavior review. Resident was in spa putting his shoes on with assist from CNA...As CNA opened door, [Resident G] walked pass [sic] [Resident F] who was sitting near door and [Resident F] hit [Resident G] on bottom. Residents immediately separated...Neither resident had any s/s [signs or symptoms] of distress noted...IDT believes root cause of behavior to be d/t [due to] diagnosis of Pick's disease...."</p> <p>11/11/14 at 12:25 P.M.: "Resident was in [another resident's room] going through residents stuff. Resident was unable to be redirected."</p> <p>Documentation of a behavior monitoring sheet was not found in the clinical record. Documentation of a care plan addressing intrusive wandering or of physical aggression was not found in the clinical record.</p> <p>On 11/12/14 at 11:25 A.M., during an interview with CNA # 2, she indicated</p>				

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	<p>the stop signs were across resident doors because "[Resident F] wanders in and out of everyone's rooms."</p> <p>On 11/12/14 at 11:30 A.M., during an interview with CNA # 4, she indicated there were stop signs on the resident rooms because, "[Resident F] likes to wander in a few rooms and look around."</p> <p>On 11/12/14 at 4:05 P.M., 7 resident rooms on the Alzheimer's Unit had stop signs across them.</p> <p>On 11/13/13 at 11:30 A.M., during an interview with the Administrator and Corporate Nurse, they indicated Resident F was now one-on-one with a staff member. The Administrator indicated the resident had previously just paced up and down the halls, and the behavior of intrusive wandering had been fairly recent. The Administrator indicated she did not know why the care plan was not completed. The Administrator indicated the SSD should have been assisting the MCF in completing the behavior care plans for residents with behaviors.</p> <p>2. On 11/10/14 at 9:40 A.M., during an interview with the Memory Care Facilitator (MCF) and RN # 1, they indicated Resident B had behaviors. RN # 1 indicated, "She grabbed another</p>			

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	<p>resident's wrist." Resident B was observed at that time sitting in a chair across from the nurses station, with a family member present.</p> <p>The clinical record of Resident B was reviewed on 11/10/14 at 10:55 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>Resident Progress Notes included the following notations:</p> <p>10/18/14 at 12:50 P.M.: "Resident is alert to self with confusion, she has been looking for family several times this AM...."</p> <p>10/18/14 at 6:43 P.M.: "Resident has been very confused this evening. Wanting to know where her car is and when her children are going to be home...She has been upset and then pleasant [sic]...Will continue to monitor for any changes."</p> <p>10/19/14 at 2:19 P.M.: "...Resident has asked many times where she can get out to go home so she can bake a cake. Resident is redirected but asks many different times how she can get out...."</p> <p>A care plan, dated 10/20/14, indicated: "Behavior: Resident becomes agitated</p>			

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	<p>while looking for her car, wondering where her children are at.</p> <p>Approaches, Offer resident to call and talk with daughter. Offer activity of interest such as jig saw puzzle, music, socializing with others. Provide resident with calm environment. Review meds quarterly and as needed for possible reduction."</p> <p>Resident Progress Notes included the following notations:</p> <p>10/22/14 at 7:07 P.M.: "Resident is agitated, pacing the halls yelling and going into other residents rooms. Resident slapped another resident on the arm...Both residents are safe and free from harm at this time. Will continue to monitor."</p> <p>10/23/14 at 9:00 A.M.: "Behavior review: Resident walked into another residents [sic] room and slapped her on the arm because other resident had paper towels under her feet. Resident stated, 'You're making a mess of this room.' Resident had just returned to facility after having surgery...IDT believes [sic] the root cause of her behavior to be pain, new environment, and sun downing...."</p> <p>10/26/14 at 12:28 A.M.: "Resident up naked in the hallway. Dressed, toileted</p>			

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	<p>and laid in bed. Resident again up in hallway no bottoms on, defecated in middle of hallway just outside room...."</p> <p>10/26/14 at 9:28 P.M.: "...was seen at end of hall with another resident yelling down hall shes [sic] going into my room. Resident went under stop sign, aid [sic] began running down hall to room, other resident entered room and aid found this resident holding wrist of the other resident and began shaking arms, she let go grabbed a clock and threw in floor...Bed alarm and chair alarm put into place, 15 minute safety checks initiated. Resident educated on importance of not entering others rooms...."</p> <p>10/26/14 at 10:50 P.M.: "N/O [new order] to send res to behavior unit in the morning. Family aware."</p> <p>The resident returned to the facility on 11/3/14.</p> <p>Documentation of a new plan of care regarding the resident's behaviors, dated after 10/20/14, was not observed in the clinical record. Progress Notes continued:</p> <p>11/4/14 at 12:40 P.M.: "Resident is alert to self with confusion most of the time. She was looking for her sweater in the kitchen cabinets, when she could not get</p>			

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	<p>the cabinets to open, she became ver [sic] upset and was unable to be redirected...."</p> <p>11/5/14 at 6:45 A.M.: "Resident was in the dining room this am and this nurse asked her what she was looking for and she told me it was none of my business. She proceed [sic] to get out the suction machine and I told her that was medical equipment and that she needed to leave that alone...She then started swinging and trying to hit this nurse...Staff tried to redirect resident to a different seat and she refused to move...."</p> <p>11/5/14 at 10:50 A.M.: "Resident was sitting in a recliner in the tv room and she kicked her walker half way across the room...Will continue to monitor for any changes."</p> <p>11/6/14 at 6:56 P.M.: "...Had incontinent episode in closet removing brief, defecating and urinating on closet floor...Resident with one episode of cursing two other residents in hallway. All separated, resident easily redirected...."</p> <p>11/7/14 at 2:42 P.M.: "This nurse went to get res. for breakfast. Res. was not in room but has a trail of BM from her room into res. room [number]. This nurse found res. in [another resident's room]</p>			

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	<p>not wearing pants and had urinated and defecated on [room number's] bed and floor next to bed...Res. then slapped this nurse three times and told me to leave her alone...This nurse explained to res. again she was in the wrong room...Res. then called this nurse a 'stupid b---h' and that she did not want my help...."</p> <p>11/7/14 at 9:03 P.M.: "Resident cooperative with care, combative at times...Incontinent episodes in closet, room, and another residents room and hallway...Resident wanders into other residents rooms, messes with their belongings...At times unable to redirect easily...."</p> <p>11/8/14 at 1:39 P.M.: "CNA reported that during set up for noon meal resident kept taking others silverware and was not easily redirected talking nonsensically [sic]. Will continue to monitor."</p> <p>11/8/14 at 9:31 P.M.: "...Has become combative with redirection. has been in other resident's rooms, has hit staff several times this shift. Educated resident about hitting others...."</p> <p>11/9/14 at 8:34 P.M.: "Resident grabbed wrist of another resident leaving bruise on right wrist. Resident was trying to assist other resident to bed. Able to</p>			

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 11/13/2014	
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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	<p>redirect resident and abed at this time...."</p> <p>11/10/14 at 10:45 A.M.: "This writer spoke with resident r/t [related to] behavior that occurred over the weekend. Resident states that she has no issues with any resident or staff member. Resident does not appear to recall incident...Will continue to observed resident for any further mood or behavior issues."</p> <p>On 11/10/14 at 11:00 A.M., RN # 1 and the MCF indicated the behavior sheets were kept in the Medication Administration Records (MAR). A behavior sheet for Resident B was not found in the MAR.</p> <p>On 11/11/14 at 12:00 P.M., the MCF provided a behavior flowsheet for Resident B. The MCF indicated she must have forgotten to print out a new flowsheet for the resident, since the resident had been in and out of the hospital. She provided a behavior flowsheet at that time. The behavior flowsheet indicated: "Behavior: Resident becomes agitated while looking for her car, wondering where her children are at." Interventions included: "Offer resident to call and talk with daughter. Offer activity of interest such as jig saw puzzle, music, socializing with others.</p>						

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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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	<p>Provide resident with calm environment. Review meds quarterly and as needed for possible reduction."</p> <p>There was not a behavior flowsheet nor a plan of care relating to the resident's physical aggression, voiding and defecating in inappropriate places, or wandering.</p> <p>3. On 11/10/14 at 9:50 A.M., during an interview with RN # 1 and the Memory Care Facilitator of the Alzheimer's Unit, they indicated Resident A had behaviors of wandering, and they tried to redirect her with paperwork. Resident A was observed sleeping in her bed at that time.</p> <p>The clinical record of Resident A was reviewed on 11/10/14 at 10:35 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>Resident Progress Notes included the following notations:</p> <p>9/20/14 at 3:45 A.M.: "CNA found this resident in [another resident's room] hitting this res in arms. Separated immediately...This res escorted out of [room number] and directed back to res own room. Bed alarm placed on this res to alert staff when res gets up. Also 15</p>						

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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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	<p>min checks initiated @ this time...."</p> <p>9/22/14 at 9:12 P.M.: "Resident very anxious this shift. Wandered in out [sic] of residents rooms, redirected without success...."</p> <p>9/23/14 at 3:22 P.M.: "Resident has not had any episodes of hitting today...Resident cont to have issues of going in and out of rooms, difficult to redirect at times."</p> <p>9/23/14 at 5:50 P.M.: "Resident with anxiety earlier in the shift, she was exit seeking and was unable to redirected...Immediatedly [sic] after dinner resident went to room and then was found sitting in middle of hallway. She stated she was tired and wanted to go to bed and was carrying night clothes and a plate. The plate from another resident's room...."</p> <p>9/24/14 at 1:16 P.M.: "Res. is alert with confusion...Res. walks in and out of res. rooms multiple times during the day. Res. can be easily redirected but becomes agitated at time [sic] when doing so...Will cont. to monitor."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 9/24/14, indicated the resident scored a 3 out of 15 for</p>			

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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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	<p>cognition, with 15 indicating no memory impairment. The resident exhibited the following behavioral symptoms in the previous 7 days: Physical behavior directed toward others daily; Other behavioral symptoms not directed toward others 4 to 6 days; and Wandering 1 to 3 days. The MDS assessment indicated the resident required extensive assistance of one staff for walking in the room and corridor, and locomotion on and off of the unit.</p> <p>Resident Progress Notes continued:</p> <p>9/27/14 at 2:51 A.M.: "...resident has undone her bed alarm twice this shift and has went into other resident's room [Resident C]...."</p> <p>9/28/14 at 8:44 P.M.: "...She wandered in and out of rooms and at bed time became argumentative with roommate and kept telling roommate to get out...."</p> <p>9/29/14 at 2:21 P.M.: "Resident is alert to self with confusion...Resident continues to go into other residents rooms and look thru their things...Resident is not able to be redirected...."</p> <p>9/30/14 at 2:32 P.M.: "Resident has been redirected out of others rooms, several times this afternoon, redirects only</p>						

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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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	<p>briefly...."</p> <p>10/1/14 at 7:01 P.M.: "...Has been wandering in and out of residents rooms trying on shoes this shift and has been redirected multiple times...."</p> <p>10/3/14 at 2:33 P.M.: "...Res. walks in and out of res. rooms multiple times during the day. Res. can be easily redirected by becomes agitated at times when doing so...."</p> <p>10/3/14 at 9:34 P.M.: "...Continues to wander in and out of resident's rooms with several residents asking for help to remove her. She searches through their things...She is able to be redirected although becoming agitated and at times will physically push to get into rooms...."</p> <p>10/5/14 at 9:30 P.M.: "Resident was found in bed with a male resident in [room number] at 2010 [8:10 P.M.]. Asked resident to get out of bed and come with this nurse. Redirected resident to her room...."</p> <p>10/10/14 at 9:16 P.M.: "Resident alert and oriented to self and environment, wandering this shift from room to room, behind desk, kitchen...Very agitated at times and unable to redirect. Resident exit seeking and disturbing other</p>			

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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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	<p>residents...."</p> <p>10/13/14 at 11:18 P.M.: "Found sitting on floor beside bed of [another room number]...."</p> <p>10/14/14 at 3:00 P.M.: "Resident walked up to another resident and kissed him. Residents were separated immediately. Resident has a diagnosis of dementia...IDT believes that the root cause of behavior is that resident has a diagnosis of dementia and is lonely and does not realize that kissing someone else is not appropriate. Staff will monitor for any further issues or escalation of behavior."</p> <p>10/17/14 at 3:32 P.M.: "...Res. is alert with confusion...Res. is up ad lib on unit during the day...has a bed alarm when going to bed...Res. walks in and out of res. rooms multiple times during the day. Res. can be easily redirected but becomes agitated at time when doing so...."</p> <p>10/20/14 at 10:45 P.M.: "Res found sitting on floor beside roommates bed...."</p> <p>10/23/14 at 12:56 P.M.: "...Res. then was going in and out of other res. room 'looking for her things.' Another res. was upset that she was coming in and out of her room going through her</p>				

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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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	<p>things...When this nurse and aide tried to asst. res. from behind N.S. [nurses station], res. hit this nurse and shoved the aide...."</p> <p>10/24/14 at 6:35 P.M.: "Resident has not hit any other residents. She has continuously went in and out of other residents rooms and has many of the other residents upset. Resident was not able to be redirected...."</p> <p>10/26/14 at 2:37 P.M.: "...redirected easily out of others room...."</p> <p>11/1/14 at 11:13 P.M.: "Resident went into other residents room only on two occasions this shift. Resident was able to be redirected...."</p> <p>11/2/14 at 12:53 P.M.: "Resident has not hit any staff or other residents but she continues to go into other residents room...Resident redirected out of rooms but she will turn around and go right into another one."</p> <p>11/4/14 at 3:40 A.M.: "Res up in room causing alarm to sound...Res encouraged to lay down again but refused to. Res. then began going into co-res rooms disturbing them. Res redirected...."</p> <p>11/7/14 at 3:02 P.M.: "...Res walks in and</p>			

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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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	<p>out of res. rooms multiple times during the day...."</p> <p>11/8/14 at 7:50 A.M.: "...Awoke and CNA toileting roommate in bathroom and res opened door stating 'get out of my house!'...all attempted interventions unsuccessful...While nurse at med cart res grabbed onto my hair and would not let go...Res then pulling on CNA's uniform and pushing her around...."</p> <p>11/9/14 at 8:28 P.M.: "Resident in hallway on bench. Another resident was holding wrist and trying to get her up. Heard resident say stop it and immediately separated residents...noted bruising R [right] wrist...."</p> <p>A "New Skin Event," dated 11/9/14 at 11:27 P.M., indicated, "Right wrist, 10 cm [centimeters] x 6 cm, Bruise/Hematoma, dark purple...."</p> <p>A Care Plan, dated 9/18/14, indicated: "Problem, Behavior: Resident becomes very agitated and wants to go home. AEB [as evidenced by] Resident pushing on exit doors, asking to go home, and is combative with staff. Approach, Have resident sort make-up. Provide resident 'paper work' to sort and or go through. Talk to resident about cruise ships. Allow resident to voice</p>			

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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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	<p>thoughts and feelings. Offer resident to call son. Review meds quarterly and as needed for possible reduction."</p> <p>An additional Care Plan, dated 9/18/14, indicated: "Problem, Behavior: Insomnia, AEB Walking halls at night, voicing not sleeping well. Approach, Offer to turn lights off at bedtime. Offer back rub at bedtime. Provide resident with a quiet area. View meds quarterly and as needed for possible reduction."</p> <p>"Behavior Flowsheets," dated November 2014, included the same wording as the care plans, and indicated the resident exhibited no insomnia from 11/1/14-11/10/14. The Behavior flowsheet indicated the resident was agitated on 11/1/14 and 11/7/14, and no interventions were effective.</p> <p>Documentation of updates and changes to the care plan regarding the resident's behavior was not found in the clinical record.</p> <p>On 11/12/14 at 4:05 P.M., Resident A's right wrist was observed to have dark purple bruising.</p> <p>Resident A's clinical record was reviewed</p>			

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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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	<p>again on 11/13/14 at 9:00 A.M.</p> <p>A Resident Progress Note, dated 11/11/14 at 10:07 P.M., indicated, "Res became upset when CNA tried to remove res from behind nursing station. Res. scratched CNA in face...Res resistive and difficult to redirect most of shift. Res wandering into other rsds [residents] rooms and going under stop signs after watching nurse go under stop signs to pass meds...."</p> <p>On 11/13/14 at 11:30 A.M., during interview with the Administrator and Corporate Nurse, they indicated they did not know why the behavior care plan had not been updated.</p> <p>4. On 11/10/14 at 9:50 A.M., during interview with RN # 1 and the Memory Care Facilitator, they indicated Resident C had been exhibiting behaviors of yelling out.</p> <p>On 11/10/14 at 10:05 A.M., Resident C was observed sitting in a chair in his room. There was a "Stop" sign attached across his door.</p> <p>The clinical record of Resident C was reviewed on 11/10/14 at 3:10 P.M. Diagnoses included, but were not limited to, dementia, Alzheimer's disease,</p>						

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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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	<p>depression, and anxiety.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/14/14, indicated the resident scored a 9 out of 15 for cognition, with 15 indicating no memory impairment. The resident had exhibited no behaviors in the previous 7 days. The resident required extensive assist of two + staff for transfer, and extensive assistance of one staff for ambulation.</p> <p>Progress Notes included the following notations:</p> <p>10/7/14 at 9:13 P.M.: "...Resident with behaviors this evening, standing in doorway in underwear yelling for help please to be covered up. This nurse and aide were busy with other residents at time and explained that he had to be patient. Resident continued to yell until this nurse could secure patient safety of resident being assisted and went to room and covered resident up...."</p> <p>10/9/14 at 2:32 P.M.: "...Resident became agitated d/t [due to] another resident wandering into room and opening blinds then walking out. Redirected both residents and no other incidents this shift."</p> <p>10/10/14 at 9:36 P.M.: "...Has</p>			

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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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	<p>complained of another resident walking into room to look out window. Resident yells down hall at HS [bedtime]...Has little patience when working with other residents and not able to immediately help...."</p> <p>10/25/14 at 10:32 P.M.: "...Resident with behavior this shift. Standing in doorway yelling 'Can anyone please help me?' 'What does a person have to do to get help around here?'...Explained to resident to use call light and that part of his therapy was to cover self up each night...."</p> <p>10/28/14 at 2:58 P.M.: "Res. has had to be redirected several times this AM during breakfast and other times throughout the day. Res. would come to this nurse and yell/curse that he 'wants that d--n sign taken off his door, its nothing but a nuisance.' This nurse tried to explain to res. that the sign wasn't to keep him out of his room but to keep others out... Res. stated he felt like it was a bad joke that someone had done to him to put up the sign. This nurse took the sign down after the third time of the resident complaining...."</p> <p>10/28/14 at 10:39 P.M.: "Stop sign applied to door this evening d/t res [Resident F] coming in and out of res</p>			

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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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	<p>room. Explained to this res that this would help other res from entering his room...."</p> <p>11/1/14 at 11:18 P.M.: "Resident yelled out into hallway wanting help to take TED hose off. This nurse complied with residents demands, but redirected by [sic] explained to resident when he yells into the hall it scares other resident...to please use call light when he needs assistance...."</p> <p>11/6/14 at 11:08 A.M.: "Resident standing behind CNA and yelled 'I need shaved' resident redirected."</p> <p>11/6/14 at 3:01 P.M.: "At lunch table resident loudly requesting coffee, however when given coffee, stated I didn't order that [sic]."</p> <p>11/8/14 at 1:54 P.M.: "Resident has yelled out numerous times this day, wants to know why he doesn't get the good treatment everyone else gets, or wanting his coffee not...."</p> <p>11/10/14 at 5:45 A.M.: "Res yelling out loudly this AM while staff was busy answering call lights/alarms. Res stating why nobody helps him and why everyone hated him. Explained to res the urgency to answer alarms first and nobody hated</p>			

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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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	<p>him...."</p> <p>Documentation of a care plan regarding the resident's yelling out, or a behavior flow sheet to monitor behaviors, was not found in the clinical record.</p> <p>On 11/10/14 at 3:45 P.M., during an interview with the MCF, she indicated she did not have a behavior sheet on Resident C, because "he really wasn't hurting anyone, it was just a change for him."</p> <p>5. On 11/12/14 at 3:30 P.M., the Nurse Consultant provided the current facility policy on "Behavior Management Policy & Procedure," undated. The policy included: "It is the policy...to provide behavior interventions and monitoring for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's distressed behavior.</p> <p>Procedure:</p> <ol style="list-style-type: none"> Care plans should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other residents... The behaviors that have been 			

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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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	<p>identified as requiring monitoring...and associated interventions identified on the care plan should then be transferred to the monitoring form...New or worsening behaviors are reviewed by the IDT [Interdisciplinary team]. All altercations should be reviewed by the IDT... 6....Care should be taken to ensure that interventions and behaviors are changed on the care plan, behavior monitoring record, or CNA assignment sheet if applicable...."</p> <p>This Federal tag relates to Complaint IN00158859.</p> <p>3.1-34(a)</p>			

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 11/13/2014	
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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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to ensure a resident with unsteady balance was safely positioned in bed, and instead was left sitting on the side of the bed, then fell, sustaining a left hip fracture; and failed to provide supervision for a resident at risk for falls, for 2 of 4 residents sampled for falls, in a sample of 9. (Resident E, Resident A)</p> <p>Findings include:</p> <p>1. On 11/10/14 at 9:00 A.M., during the initial tour, the Director of Nursing (DON) indicated Resident E had fallen recently and sustained a fracture. The DON indicated the resident was not currently in the facility, but had been admitted to the hospital.</p> <p>The clinical record of Resident E was</p>	F000323	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on December 13, 2014.</p> <p>F323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident E no longer resides in the facility · Resident A has been evaluated by the physician with interventions, care plan and profile updated to assist in prevention of future falls. 	12/13/2014			

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	<p>reviewed on 11/12/14 at 10:25 A.M. The resident had diagnoses including, but not limited to, dementia, history of subdural hemorrhage, history of rib fracture, and history of fall. The resident resided on the locked Alzheimer's Unit.</p> <p>A Physical Therapy (PT) Plan of Care, dated 10/13/14, indicated, "Reason for Referral:...presents to therapy due to a fall...resulting in subarachnoid hemorrhage...resulting impairments in memory, balance, and command follow noted...Environmental Factors/Social Support: The patient will have assistance from nursing for transfers and mobility. However, patient would benefit from increased stability to minimize risk for falls...Prior Residence and Living Arrangement:...Patient reports ambulating throughout home prior to hospitalization...but hospital records indicate frequent falls noted...Underlying Impairments, Cognition, Safety Awareness moderately impaired...medium fall risk...."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 10/17/14, indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of one staff for bed mobility, and extensive assistance of</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed audit on environment to ensure free of accident hazards and assistance devices are in place to prevent accidents. ·DNS/Designee reviewed/updated care plans for residents at risk for falls to ensure fall prevention interventions are in place and effective. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on fall prevention has been provided to all staff by CEC/DNS/SSD/Designee by December 13, 2014. ·DNS/CEC/nurse manager/designee will conduct daily audits of falls and environmental hazards per resident plan of care. Any resident at risk for falls will have a care plan in place to address fall risks and Interdisciplinary team will review fall care plan quarterly or with a significant change to ensure fall interventions are effective. ·DNS/Designee will conduct 				

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	<p>two+ staff for transfer. A test for "Balance during Transitions and Walking" indicated, "Not steady, only able to stabilize with staff assistance." The MDS assessment indicated the resident had fallen in the 2-6 months prior to admission, and had a fracture related to a fall in the previous 6 months prior to admission.</p> <p>A PT Progress Note, dated 10/20/14, indicated, "Remaining Functional Deficits/Underlying Impairments, Patient continues to have deficits in strength, balance and safety awareness which limit ability to complete functional transfers and mobility safely and independently throughout environment at this time...Complicating factors, including decreased strength, balance and safety awareness prevent the patient from achieving all established goals. Updates to Treatment Approach, Continued strength and balance training required in order to improve safety in all functional transfers and ambulation with decreased fall risk..."</p> <p>Resident Progress Notes included the following notations:</p> <p>10/21/14 at 12:23 A.M.: "Resident was found at table in dining room. Lethargic...N.O. [new order] to receive</p>		<p>rounds every shift to ensure fall interventions are in place per the plan of correction.</p> <p>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?</p> <p>·DNS/nurse manager/Designee will daily utilize fall management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place.</p> <p>·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: December 13, 2014</p>				

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	<p>UA [urinalysis]...."</p> <p>10/22/14 at 1:02 A.M.: "Res [resident] alert to self...Requires 1 assist with ADLs [activities of daily living]...Bed alarm in place and functioning."</p> <p>10/23/14 at 3:41 P.M.: "...Res. is a one asst. [sic] with ADLs and transfers...Res. has bed and chair alarms for decrease in safety awareness...."</p> <p>10/23/14 at 3:46 P.M.: "Res. was sitting at MDR [main dining room] table with head down on table after lunch. Res. stated she did not feel well. Res. could hardly hold head up and was very quiet and clammy. Res. was also pale in the face. This nurse and aide asst. res. into WC [wheelchair] and down to room and into bed...Res. then stated she was starting to feel better...Will cont. to monitor."</p> <p>10/23/14 at 9:35 P.M.: "Resident alarm went off. This nurse answered alarm, resident found in bed with husband [roommate]. Walked resident with walker to her bed. Bed alarm in place and in working order. Resident sitting on side of bed and given medication. Resident started to stand up and fell over to left side...resident c/o [complains of] pain to left hip area with movement. Immediate</p>			

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	<p>interventions, pad alarm up at shoulders, resident to be laid down and not on side of bed unattended. Physician notified of n/o [new order] of exray [sic] to hip...."</p> <p>10/23/14 at 11:28 P.M.: "Resident c/o pain without movement stating greater than 10, PRN [as needed] Tylenol given, MD notified with n/o to send to ER family notified."</p> <p>10/24/14 at 2:00 A.M.: "Res has been admitted to [name of hospital] @ this time with a L [left] hip fx [fracture]...."</p> <p>10/24/14 at 10:47 A.M.: "IDT [interdisciplinary team] review of witnessed fall that occurred on 10/23/14 at 9:30 pm [sic]...Res alarm was answered prior to fall and Res was found getting in bed with husband. Res was assisted back to bed...Res was sitting on side of bed and had just taken medication when Res started to stand and fall to left side. Nurse reports was she [sic] securing box of alarm to bed and had back turned to Res when she was safely sitting on side of bed and when Nurse began to turn around Res had stood and was falling to left side. Nurse was unable to reach Res to assist with falling. Res landed on left side...Immediate intervention: Res was layed down immediately after fall, Res to be attended while sitting up on side of</p>			

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	<p>bed, and bed alarm positioned under shoulders to alarm when Res sits up..."</p> <p>A Care Plan, initially dated 10/14/14 and updated 10/29/14, indicated, "Resident is at risk for fall due to: weakness, confusion, new environment, age, psychotropics, HX [history] of CVA, vertigo...HX of falls, assistive devices, incontinence, impaired mobility, seizure disorder, recent surgery...requires ext [extensive] assist with ADLs..."</p> <p>The Approaches included: "10/14/2014: Call light in reach, Clean and clutter free pathways...Non skid footwear when up, Personal items in reach, Therapy screen. 10/23/2014 Res to be attended while sitting up on side of bed, bed alarm positioned under shoulders to alarm when Res sits up."</p> <p>On 11/12/14 at 2:45 P.M., during interview with the Administrator and DON, the DON indicated the nurse should have laid the resident down in bed, and made sure she was safely positioned, prior to securing the alarm box.</p> <p>2. On 11/10/14 at 9:15 A.M., during the initial tour of the Alzheimer's Unit, the Director of Nursing (DON) indicated Resident A had fallen recently. Resident A was out of her room at that time.</p>			

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	<p>The clinical record of Resident A was reviewed on 11/10/14 at 10:35 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 7/3/14, indicated the resident scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of two+ staff for transfer, and extensive assistance of one staff for ambulation. The resident had a fall in the one month prior to admission.</p> <p>Resident Progress Notes included the following notations:</p> <p>9/23/14 at 5:50 P.M.: "Resident with anxiety earlier in shift, she was exit seeking and was unable to be redirected...Immediately [sic] after dinner resident went to room and then was found sitting in middle of hallway. She stated she was tired and wanted to go to bed and was carrying night clothes and a plate. The plate was from another resident's room. No injuries at this time...found to have bruising on eyelid of right eye...."</p> <p>10/5/14 at 12:26 A.M.: "...Resident gets</p>			

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	<p>confused easily and has to be redirected...Res. has a bed alarm when going to bed to alert staff to help her with her [sic] with ADLs [activities of daily living]...."</p> <p>10/10/14 at 9:16 P.M.: "...wandering this shift from room to room... Very agitated at times and unable to redirect...."</p> <p>10/13/14 at 11:18 P.M.: "Res found sitting on floor beside bed of [another room]...Res placed on 15 minute checks as fall intervention."</p> <p>10/14/14 at 9:58 A.M.: "IDT review of un-witnessed fall that occurred on 10/14/14 at 10:30 P.M. Res was walking in hallway prior to fall. Res was found sitting on floor beside bed [room number] with gripper socks and silk pajamas...Staff believe Res was attempting to sit on side of bed and slid to floor...IDT feel root cause of fall is due to Res silk pajamas. Staff removed silk pajamas from room and will contact family regarding removal and new pajamas...."</p> <p>10/20/14 at 10:45 P.M.: "Res found sitting on floor beside roommates bed...Res assisted off floor with 2 assist and gait belt. Res fully clothed and bare footed...30 min checks in place as a</p>			

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	<p>safety intervention...."</p> <p>10/21/14 at 11:15 A.M.: "IDT review of un-witnessed fall...Res was resting in bed prior to fall. Res was found sitting on buttock beside roommates bed, fully clothed and barefoot. Res had no c/o [complaints of] pain...Res stated she was trying to sit in chair in room...New intervention: Gripper socks at HS...."</p> <p>A Care Plan, initially dated 6/27/14 and updated 10/24/14, indicated: "Problem, Resident is at risk for fall due to: new environment...anxiety, confusion, age, poor safety awareness, Hx [history] of falls, unsteady gait at times. Approach, 10/24/14 Alarm box placed on shadow box at all times, 10/14/14 Resident to wear non-silk pajamas, 9/21/14 pad alarm to bed at night, 6/27/14 Call light in reach, Non skid footwear when up...."</p> <p>On 11/10/14 at 12:00 P.M., the DON was requested to provide any additional information she had regarding the resident's falls.</p> <p>On 11/10/14 at 3:10 P.M., the DON provided "Event Reports," regarding the resident falls. The DON indicated on 10/13/14, the resident was found in another resident's room. The DON indicated on 10/20/14, the staff was</p>						

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	<p>responding to the resident's alarm, and found the resident on the floor. The Event Report, dated 10/21/14, included the IDT entry, dated 10/21/14 at 11:15 A.M. of the resident's fall, but documentation was not consistent. The Event Report had the added statement of "Res. was found sitting on buttock beside roommates bed, fully clothed and barefoot, when responded to alarm. Res had no c/o pain...."</p> <p>3. On 11/10/14 at 10:05 A.M., the DON provided a list of residents who had fallen in the previous 2 months. Six (6) current residents who resided on the Alzheimer's Unit were listed. One(1) resident did reside on the Alzheimer's Unit, but had been transferred to the Rehab Unit.</p> <p>On 11/10/14 at 10:35 A.M., during interview with RN # 1 and CNA # 5, they indicated they had "a lot of residents with alarms." They indicated 8 of 23 residents had either a personal or bed alarm, with several residents having both.</p> <p>During confidential interview with Staff # 1, he/she indicated, "I think we have 7 residents with alarms, and some with more than one." He/She indicated it was very difficult to keep the residents safe.</p>			

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	<p>During confidential interview with Staff # 2, he/she indicated, "We have so many alarms, some with 1 or 2. We have to figure out where to go."</p> <p>This Federal tag relates to Complaint IN00158859.</p> <p>3.1-45(a)(2)</p>						
F000353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS						

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	<p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staffing was adequate on the Alzheimer's Unit to provide adequate ADL (Activities of Daily Living) care, prevent falls, and manage behaviors, for 1 of 3 Units reviewed, with 23 residents potentially affected. (Resident A, B, C, F)</p> <p>Findings include:</p> <p>1. On 11/10/14 at 9:15 A.M., during the initial tour of the Alzheimer's Unit, the Director of Nursing (DON) indicated</p>	F000353	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on December 13, 2014.</p> <p>F353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	12/13/2014	

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	<p>Resident A had fallen recently. Resident A was out of her room at that time.</p> <p>The clinical record of Resident A was reviewed on 11/10/14 at 10:35 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 7/3/14, indicated the resident scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of two+ staff for transfer, and extensive assistance of one staff for ambulation. The resident had a fall in the one month prior to admission.</p> <p>Resident Progress Notes included the following notations:</p> <p>9/23/14 at 5:50 P.M.: "Resident with anxiety earlier in shift, she was exit seeking and was unable to be redirected...Immediately [sic] after dinner resident went to room and then was found sitting in middle of hallway. She stated she was tired and wanted to go to bed and was carrying night clothes and a plate. The plate was from another resident's room. No injuries at this time...found to have bruising on eyelid of right eye...."</p>		<ul style="list-style-type: none"> · Staff will be screened by the Executive Director to ensure compatibility to work with residents on the dementia unit · The residents affected by the alleged deficient practice has been identified by the interdisciplinary team and care plans reviewed/updated, progress notes reviewed, and interventions updated as needed. · Additional staffing during evening hours <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents on the Cottage have the potential to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed audit on staffing for Alzheimer's unit. · DNS/Nurse Manager/Designee conducted a review of staffing to achieve consistent assignments/staff on the Cottage. · All staff on the Cottage will be educated regarding behavior management, fall interventions and intrusive wandering by the CEC/DNS/SS/Designee by December 13, 2014. <p>What measures will be put into</p>		

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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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	<p>10/5/14 at 12:26 A.M.: "...Resident gets confused easily and has to be redirected...Res. has a bed alarm when going to bed to alert staff to help her with her [sic] with ADLs [activities of daily living]...."</p> <p>10/10/14 at 9:16 P.M.: "...wandering this shift from room to room...Very agitated at times and unable to redirect...."</p> <p>10/13/14 at 11:18 P.M.: "Res found sitting on floor beside bed of [another room]...Res placed on 15 minute checks as fall intervention."</p> <p>10/20/14 at 10:45 P.M.: "Res found sitting on floor beside roommates bed...Res assisted off floor with 2 assist and gait belt. Res fully clothed and bare footed...30 min checks in place as a safety intervention...."</p> <p>2. On 11/10/14 at 9:15 A.M., during the initial tour of the locked Alzheimer's Unit, "Stop" signs were observed attached by Velcro and placed across 3 different resident room doors. The Director of Nursing (DON) indicated at that time, that the signs helped remind some residents that those rooms were not their rooms.</p>		<p>place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All staff on the Cottage will be educated regarding behavior management, fall interventions and intrusive wandering by the CEC/DNS/SSD/Designee by December 13, 2014. ·Staff audit conducted by ED/DNS/CEC/MCF to determine appropriate staff and training to work on the Cottage. ·Additional staffing during the evening hours <p>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?</p> <ul style="list-style-type: none"> ·DNS/nurse manager/CEC/MCF/Designee will daily utilize staffing CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place. ·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months. <p>Compliance date: December 13, 2014</p>				

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	<p>On 11/10/14 at 9:50 A.M., during interview with RN # 1 and the Memory Care Facilitator of the Alzheimer's Unit, they indicated Resident F had behavior symptoms of wandering, and that there were stop signs in place over other resident room doors.</p> <p>On 11/10/14 from 9:50 A.M. until 10:55 A.M., during constant observation of the Alzheimer's Unit, Resident F was observed to be almost constantly pacing up and down the halls. At 10:05 A.M., Resident F was sitting in another resident's room, and CNA # 4 was observed to state, "Come on," and he left the room. CNA # 4 indicated at that time, "He's one of my wanderers." At 10:15 A.M., Resident F was observed to pick up an alarm box at the nurses station. RN # 1 indicated, "Put it down," which he did. Resident F would play with cards for a few minutes, and then start walking down the hall.</p> <p>On 11/10/14 at 3:30 P.M., Resident F was observed to be sitting in a chair in a female resident's room. He pulled the call light out of the wall, and the Clinical Education Coordinator responded and assisted the resident out of the room.</p> <p>On 11/10/14 at 3:45 P.M., Resident F was observed to be going in and out of</p>			

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	<p>resident rooms.</p> <p>The clinical record of Resident F was reviewed on 11/12/14 at 10:50 A.M. Diagnoses included, but were not limited to, frontotemporal dementia and Pick's disease (a disease that causes progressive destruction of the nerve cells in the brain. Symptoms include dementia and loss of speech).</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/21/14, indicated the resident was unable to complete a test for cognition, had a short-term memory problem, and was moderately impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident had exhibited no behaviors in the previous 7 days, and was independent in ambulation.</p> <p>Resident Progress Notes included the following notations:</p> <p>10/9/14 at 2:34 A.M.: "...Resident continues to wander into room across hall, opening blinds and then walking out. Able to redirect resident...."</p> <p>10/10/14 at 9:44 P.M.: "...Resident in and out of other residents rooms this shift causing distress to others. Can redirect for short periods of time...Resident will</p>						

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	<p>take food and drinks that belong to others with what seems no understanding of this [sic]. Resident will go to kitchen and place dishes in sink and turn water on then walk away. Resident will get into refrigerator and take out food if refrigerator left unlocked...."</p> <p>10/21/14 at 9:30 A.M.: "Behavior review. Resident walked passed [sic] other resident and 'popped' him on the head. Residents were separated immediately...IDT [interdisciplinary team] believes root cause of behavior to be residents [sic] diagnosis of Pick's Disease. Staff will rearrange common sitting area to divert resident walking directly past co-resident."</p> <p>10/24/14 at 3:59 P.M.: "Resident has been out of bed and pacing the floor. Resident paces mostly from his room to residents room beside of him."</p> <p>11/1/14 at 4:04 P.M.: "This nurse saw resident hit other resident on top of the head lightly. Other resident did not show signs of distress at the time and [Resident F] was told that he could not do this to other residents. Resident stated, 'Ok.' Resident has been redirected out of other residents room. Resident was found in room [number] laying on the bed. This room has two ladies that share the room.</p>			

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	<p>Resident has been redirected out of this room three different times this afternoon. Will continue to monitor for any changes."</p> <p>11/2/14 at 3:24 P.M.: "Resident has been going into other residents rooms and walking around looking at their stuff. Resident has been redirected and still continues to go into other residents rooms. Spouse has told him to stay out and he continued to go into the rooms. Will continue to redirect resident out of other residents rooms."</p> <p>11/5/14 at 4:05 P.M.: "Resident continues to go into other residents rooms and lay down on their beds, reajust [sic] the thermometer in their rooms, and push the call light buttons. Resident has not been able to redirect. Staff has told resident to stay out of other peoples rooms but he continues to return to the rooms and do the same things over again."</p> <p>11/7/14 at 3:11 P.M.: "Res. cont. to wander into other res. rooms. Res was found today in lying in [room number] bed...Will cont. to monitor."</p> <p>11/9/14 at 1:12 A.M.: "Res. up pacing hallway @ times this shift. Res entering other res room @ times...Will cont. to</p>			

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	<p>monitor."</p> <p>11/10/14 at 9:34 P.M.: "Resident wandering in and out of rooms, turning on call lights, using restrooms, opening and shutting blinds, sitting in chairs...Resident redirected with activities."</p> <p>11/11/14 at 10:23 A.M.: "Resident has been in several different rooms this AM and is picking up things that belongs to the other residents. He had the remote to [Resident H's] tv and had the stuffed animals out of [Resident I's]] room. Resident has been redirected with no success. Resident continues to wander into other residents rooms."</p> <p>11/11/14 at 10:28 A.M.: "Resident was in the spa room putting his shoes on and [Resident G] was coming in to use the bathroom. [Resident F] hit [Resident G] on the bottom as he walked by [Resident F]. Will continue to monitor for any changes. Social Services aware."</p> <p>11/11/14 at 12:25 P.M.: "Resident was in [another resident's room] going through residents stuff. Resident was unable to be redirected."</p> <p>On 11/12/14 at 11:25 A.M., during an interview with CNA # 2, she indicated</p>				

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	<p>the stop signs were across resident doors because "[Resident F] wanders in and out of everyone's rooms."</p> <p>On 11/12/14 at 11:30 A.M., during an interview with CNA # 4, she indicated there were stop signs on the resident rooms because, "[Resident F] likes to wander in a few rooms and look around."</p> <p>On 11/12/14 at 4:05 P.M., 7 resident rooms on the Alzheimer's Unit had stop signs across them.</p> <p>3. On 11/10/14 at 9:40 A.M., during an interview with the Memory Care Facilitator (MCF) and RN # 1, they indicated Resident B had behaviors. RN # 1 indicated, "She grabbed another resident's wrist." Resident B was observed at that time sitting in a chair across from the nurses station, with a family member present.</p> <p>The clinical record of Resident B was reviewed on 11/10/14 at 10:55 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>Resident Progress Notes included the following notations:</p> <p>10/22/14 at 7:07 P.M.: "Resident is agitated, pacing the halls yelling and</p>			

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	<p>going into other residents rooms. Resident slapped another resident on the arm...Both residents are safe and free from harm at this time. Will continue to monitor."</p> <p>10/23/14 at 9:00 A.M.: "Behavior review: Resident walked into another residents [sic] room and slapped her on the arm because other resident had paper towels under her feet. Resident stated, 'You're making a mess of this room.' Resident had just returned to facility after having surgery...IDT belives [sic] the root cause of her behavior to be pain, new environment, and sun downing...."</p> <p>10/26/14 at 12:28 A.M.: "Resident up naked in the hallway. Dressed, toileted and laid in bed. Resident again up in hallway no bottoms on, defecated in middle of hallway just outside room...."</p> <p>10/26/14 at 9:28 P.M.: "...was seen at end of hall with another resident yelling down hall shes [sic] going into my room. Resident went under stop sign, aid [sic] began running down hall to room, other resident entered room and aid found this resident holding wrist of the other resident and began shaking arms, she let go grabbed a clock and threw in floor...Bed alarm and chair alarm put into place, 15 minute safety checks initiated.</p>			

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	<p>Resident educated on importance of not entering others rooms...."</p> <p>11/5/14 at 6:45 A.M.: "Resident was in the dining room this am and this nurse asked her what she was looking for and she told me it was none of my business. She proceed [sic] to get out the suction machine and I told her that was medical equipment and that she needed to leave that alone...She then started swinging and trying to hit this nurse...Staff tried to redirect resident to a different seat and she refused to move...."</p> <p>11/5/14 at 10:50 A.M.: "Resident was sitting in a recliner in the tv room and she kicked her walker half way across the room...Will continue to monitor for any changes."</p> <p>11/6/14 at 6:56 P.M.: "...Had incontinent episode in closet removing brief, defecating and urinating on closet floor...Resident with one episode of cursing two other residents in hallway. All separated, resident easily redirected...."</p> <p>11/7/14 at 2:42 P.M.: "This nurse went to get res. for breakfast. Res. was not in room but has a trail of BM from her room into res. room [number]. This nurse found res. in [another resident's room]</p>			

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	<p>not wearing pants and had urinated and defecated on [room number's] bed and floor next to bed...Res. then slapped this nurse three times and told me to leave her alone...This nurse explained to res. again she was in the wrong room...Res. then called this nurse a 'stupid b---h' and that she did not want my help...."</p> <p>11/7/14 at 9:03 P.M.: "Resident cooperative with care, combative at times...Incontinent episodes in closet, room, and another residents room and hallway...Resident wanders into other residents rooms, messes with their belongings...At times unable to redirect easily...."</p> <p>11/8/14 at 1:39 P.M.: "CNA reported that during set up for noon meal resident kept taking others silverware and was not easily redirected talking nonsensically [sic]. Will continue to monitor."</p> <p>11/8/14 at 9:31 P.M.: "...Has become combative with redirection. has been in other resident's rooms, has hit staff several times this shift. Educated resident about hitting others...."</p> <p>11/9/14 at 8:34 P.M.: "Resident grabbed wrist of another resident leaving bruise on right wrist. Resident was trying to assist other resident to bed. Able to</p>						

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	<p>redirect resident and abed at this time...."</p> <p>4. On 11/10/14 at 9:50 A.M., during an interview with RN # 1 and the Memory Care Facilitator of the Alzheimer's Unit, they indicated Resident A had behaviors of wandering, and they tried to redirect her with paperwork. Resident A was observed sleeping in her bed at that time.</p> <p>The clinical record of Resident A was reviewed on 11/10/14 at 10:35 A.M. Diagnoses included, but were not limited to, dementia with behavioral disturbances.</p> <p>Resident Progress Notes included the following notations:</p> <p>9/20/14 at 3:45 A.M.: "CNA found this resident in [another resident's room] hitting this res in arms. Separated immediately...This res escorted out of [room number] and directed back to res own room. Bed alarm placed on this res to alert staff when res gets up. Also 15 min checks initiated @ this time...."</p> <p>9/22/14 at 9:12 P.M.: "Resident very anxious this shift. Wandered in out [sic] of residents rooms, redirected without success...."</p> <p>9/23/14 at 3:22 P.M.: "Resident has not</p>						

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	<p>had any episodes of hitting today...Resident cont to have issues of going in and out of rooms, difficult to redirect at times."</p> <p>9/23/14 at 5:50 P.M.: "Resident with anxiety earlier in the shift, she was exit seeking and was unable to redirected...Immediately [sic] after dinner resident went to room and then was found sitting in middle of hallway. She stated she was tired and wanted to go to bed and was carrying night clothes and a plate. The plate from another resident's room...."</p> <p>9/24/14 at 1:16 P.M.: "Res. is alert with confusion...Res. walks in and out of res. rooms multiple times during the day. Res. can be easily redirected but becomes agitated at time [sic] when doing so...Will cont. to monitor."</p> <p>An admission Minimum Data Set (MDS) assessment, dated 9/24/14, indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The resident exhibited the following behavioral symptoms in the previous 7 days: Physical behavior directed toward others daily; Other behavioral symptoms not directed toward others 4 to 6 days; and Wandering 1 to 3 days. The MDS assessment indicated the</p>						

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	<p>resident required extensive assistance of one staff for walking in the room and corridor, and locomotion on and off of the unit.</p> <p>Resident Progress Notes continued:</p> <p>9/27/14 at 2:51 A.M.: "...resident has undone her bed alarm twice this shift and has went into other resident's room [Resident C]...."</p> <p>9/28/14 at 8:44 P.M.: "...She wandered in and out of rooms and at bed time became argumentative with roommate and kept telling roommate to get out...."</p> <p>9/29/14 at 2:21 P.M.: "Resident is alert to self with confusion...Resident continues to go into other residents rooms and look thru their things...Resident is not able to be redirected...."</p> <p>9/30/14 at 2:32 P.M.: "Resident has been redirected out of others rooms, several times this afternoon, redirects only briefly...."</p> <p>10/1/14 at 7:01 P.M.: "...Has been wandering in and out of residents rooms trying on shoes this shift and has been redirected multiple times...."</p> <p>10/3/14 at 2:33 P.M.: "...Res. walks in</p>			

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	<p>and out of res. rooms multiple times during the day. Res. can be easily redirected by becomes agitated at times when doing so...."</p> <p>10/3/14 at 9:34 P.M.: "...Continues to wander in and out of resident's rooms with several residents asking for help to remove her. She searches through their things...She is able to be redirected although becoming agitated and at times will physically push to get into rooms...."</p> <p>10/5/14 at 9:30 P.M.: "Resident was found in bed with a male resident in [room number] at 2010 [8:10 P.M.]. Asked resident to get out of bed and come with this nurse. Redirected resident to her room...."</p> <p>10/10/14 at 9:16 P.M.: "Resident alert and oriented to self and environment, wandering this shift from room to room, behind desk, kitchen...Very agitated at times and unable to redirect. Resident exit seeking and disturbing other residents...."</p> <p>10/13/14 at 11:18 P.M.: "Found sitting on floor beside bed of [another room number]...."</p> <p>10/14/14 at 3:00 P.M.: "Resident walked up to another resident and kissed him.</p>			

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	<p>Residents were separated immediately. Resident has a diagnosis of dementia...IDT believes that the root cause of behavior is that resident has a diagnosis of dementia and is lonely and does not realize that kissing someone else is not appropriate. Staff will monitor for any further issues or escalation of behavior."</p> <p>10/17/14 at 3:32 P.M.: "...Res. is alert with confusion...Res. is up ad lib on unit during the day...has a bed alarm when going to bed...Res. walks in and out of res. rooms multiple times during the day. Res. can be easily redirected but becomes agitated at time when doing so...."</p> <p>10/20/14 at 10:45 P.M.: "Res found sitting on floor beside roommates bed...."</p> <p>10/23/14 at 12:56 P.M.: "...Res. then was going in and out of other res. room 'looking for her things.' Another res. was upset that she was coming in and out of her room going through her things...When this nurse and aide tried to asst. res. from behind N.S. [nurses station], res. hit this nurse and shoved the aide...."</p> <p>10/24/14 at 6:35 P.M.: "Resident has not hit any other residents. She has continuously went in and out of other</p>			

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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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	<p>residents rooms and has many of the other residents upset. Resident was not able to be redirected...."</p> <p>10/26/14 at 2:37 P.M.: "...redirected easily out of others room...."</p> <p>11/1/14 at 11:13 P.M.: "Resident went into other residents room only on two occasions this shift. Resident was able to be redirected...."</p> <p>11/2/14 at 12:53 P.M.: "Resident has not hit any staff or other residents but she continues to go into other residents room...Resident redirected out of rooms but she will turn around and go right into another one."</p> <p>11/4/14 at 3:40 A.M.: "Res up in room causing alarm to sound...Res encouraged to lay down again but refused to. Res. then began going into co-res rooms disturbing them. Res redirected...."</p> <p>11/7/14 at 3:02 P.M.: "...Res walks in and out of res. rooms multiple times during the day...."</p> <p>11/8/14 at 7:50 A.M.: "...Awoke and CNA toileting roommate in bathroom and res opened door stating 'get out of my house!'...all attempted interventions unsuccessful...While nurse at med cart</p>			

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	<p>res grabbed onto my hair and would not let go...Res then pulling on CNA's uniform and pushing her around...."</p> <p>11/9/14 at 8:28 P.M.: "Resident in hallway on bench. Another resident was holding wrist and trying to get her up. Heard resident say stop it and immediately separated residents...noted bruising R [right] wrist...."</p> <p>On 11/12/14 at 4:05 P.M., Resident A's right wrist was observed to have dark purple bruising.</p> <p>Resident A's clinical record was reviewed again on 11/13/14 at 9:00 A.M.</p> <p>A Resident Progress Note, dated 11/11/14 at 10:07 P.M., indicated, "Res became upset when CNA tried to remove res from behind nursing station. Res. scratched CNA in face...Res resistive and difficult to redirect most of shift. Res wandering into other rds [residents] rooms and going under stop signs after watching nurse go under stop signs to pass meds...."</p> <p>5. On 11/10/14 at 9:50 A.M., during interview with RN # 1 and the Memory Care Facilitator, they indicated Resident C had been exhibiting behaviors of yelling out.</p>			

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	<p>On 11/10/14 at 10:05 A.M., Resident C was observed sitting in a chair in his room. There was a "Stop" sign attached across his door.</p> <p>The clinical record of Resident C was reviewed on 11/10/14 at 3:10 P.M. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, depression, and anxiety.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 9/14/14, indicated the resident scored a 9 out of 15 for cognition, with 15 indicating no memory impairment. The resident had exhibited no behaviors in the previous 7 days. The resident required extensive assist of two + staff for transfer, and extensive assistance of one staff for ambulation.</p> <p>Progress Notes included the following notations:</p> <p>10/7/14 at 9:13 P.M.: "...Resident with behaviors this evening, standing in doorway in underwear yelling for help please to be covered up. This nurse and aide were busy with other residents at time and explained that he had to be patient. Resident continued to yell until this nurse could secure patient safety of resident being assisted and went to room</p>			

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	<p>and covered resident up...."</p> <p>10/9/14 at 2:32 P.M.: "...Resident became agitated d/t [due to] another resident wandering into room and opening blinds then walking out. Redirected both residents and no other incidents this shift."</p> <p>10/10/14 at 9:36 P.M.: "...Has complained of another resident walking into room to look out window. Resident yells down hall at HS [bedtime]...Has little patience when working with other residents and not able to immediately help...."</p> <p>10/25/14 at 10:32 P.M.: "...Resident with behavior this shift. Standing in doorway yelling 'Can anyone please help me?' 'What does a person have to do to get help around here?'...Explained to resident to use call light and that part of his therapy was to cover self up each night...."</p> <p>10/28/14 at 2:58 P.M.: "Res. has had to be redirected several times this AM during breakfast and other times throughout the day. Res. would come to this nurse and yell/curse that he 'wants that d--n sign taken off his door, its nothing but a nuisance.' This nurse tried to explain to res. that the sign wasn't to</p>			

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	<p>keep him out of his room but to keep others out... Res. stated he felt like it was a bad joke that someone had done to him to put up the sign. This nurse took the sign down after the third time of the resident complaining...."</p> <p>10/28/14 at 10:39 P.M.: "Stop sign applied to door this evening d/t res [Resident F] coming in and out of res room. Explained to this res that this would help other res from entering his room...."</p> <p>11/1/14 at 11:18 P.M.: "Resident yelled out into hallway wanting help to take TED hose off. This nurse complied with residents demands, but redirected by [sic] explained to resident when he yells into the hall it scares other resident...to please use call light when he needs assistance...."</p> <p>11/6/14 at 11:08 A.M.: "Resident standing behind CNA and yelled 'I need shaved' resident redirected."</p> <p>11/6/14 at 3:01 P.M.: "At lunch table resident loudly requesting coffee, however when given coffee, stated I didn't order that [sic]."</p> <p>11/8/14 at 1:54 P.M.: "Resident has yelled out numerous times this day, wants</p>			

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	<p>to know why he doesn't get the good treatment everyone else gets, or wanting his coffee not..."</p> <p>11/10/14 at 5:45 A.M.: "Res yelling out loudly this AM while staff was busy answering call lights/alarms. Res stating why nobody helps him and why everyone hated him. Explained to res the urgency to answer alarms first and nobody hated him..."</p> <p>6. On 11/10/14 at 9:15 A.M., during the initial tour of the Alzheimer's Unit, the Director of Nursing (DON) indicated the staffing was usually 1 nurse, 1 CNA, 1 CNA from 10:00 A.M.-6:00 P.M., and an activity aide from 8:30 A.M.-4:30 P.M.</p> <p>On 11/10/14 at 9:30 A.M., the Administrator provided the previous 2 week nursing schedule. The schedule indicated the following staff worked on the Alzheimer's Unit: Days 6:00 A.M.-2:00 P.M., 1 nurse and 1 CNA; 1 CNA 10:00 A.M.-6:00 P.M. Evenings 2:00 P.M.-10:00 P.M., 1 nurse and 1 CNA. Nights 10:00 P.M.-6:00 A.M., 1 nurse and 1 CNA. 23 residents resided on the Alzheimer's Unit.</p> <p>On 11/10/14 at 10:05 A.M., the DON provided a list of residents who had fallen in the previous 2 months. Six (6)</p>			

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	<p>current residents who resided on the Alzheimer's Unit were listed. One(1) resident did reside on the Alzheimer's Unit, but had been transferred to the Rehab Unit with a fractured hip.</p> <p>On 11/10/14 at 10:15 A.M., during an interview with CNA # 5, he indicated CNA # 7 was asked to stay over that morning on the unit. He indicated CNA # 7 worked night shift. He indicated there was usually just 1 nurse and 1 CNA until 10:00 A.M.</p> <p>On 11/10/14 at 3:30 P.M., the Clinical Education Coordinator was observed to remove a male resident from a female resident's room.</p> <p>On 11/10/14 at 3:40 P.M., RN # 1 was observed working at the nursing station. She indicated she was supposed to go home at 2:30 P.M., but that sometimes she needed to stay over.</p> <p>On 11/10/14 at 3:40 P.M., the Social Services Director (SSD) was observed walking with a resident. The SSD indicated she was not usually on the Alzheimer's Unit, but she was helping the Memory Care Facilitator out "because she's new." The SSD was observed to respond to a resident with an alarm who was standing up.</p>			

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	<p>On 11/10/14 at 3:45 P.M., the Activity Director was observed to be on the Alzheimer's Unit. She indicated she did not usually do activities on the unit, but that sometimes if there was a big musical program, she will bring residents out. She indicated she delivered mail to the unit.</p> <p>During confidential interview with a family member, he/she indicated he/she was unsure if there was enough staff to take care of his/her mother, who resided on the Alzheimer's Unit.</p> <p>During confidential interview with Staff # 1, he/she indicated, "I've cried lots of times. I can't get the work done. Think we have 15 residents on a toileting schedule, and 7 residents with alarms." Staff # 1 indicated he/she was unable to always get the showers completed. Staff # 1 indicated he/she frequently comes in to work and the residents are wearing the same clothes as the day before. Staff # 1 indicated, "It's not the staffs fault, they just don't have time."</p> <p>During confidential interview with Staff # 2, he/she indicated there was a big problem with managing behaviors, and that residents wandered in and out of rooms all day. He/She indicated there were "so many alarms, some with 1 or 2,</p>			

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	<p>and you have to figure out where to go." Staff # 2 indicated, "It's complete chaos." Staff # 2 indicated it was amazing to her how many staff would be on the Alzheimer's Unit "when state is back there."</p> <p>During confidential interview with Staff # 3, he/she indicated he/she could get the work done "if there's 2 aides working."</p> <p>During confidential interview with Staff # 4, he/she indicated, "Yeah, I can get my work done most days. I do have those days that I have to stay over a couple of hours."</p> <p>During confidential interview with Staff # 5, he/she indicated, "I can get my work done usually by the seat of my pants. It's good until 6:00 P.M., then after 6 there are just 2 staff members working. A lot of behaviors right now makes it hard."</p> <p>During confidential interview with Staff # 6, he/she indicated there was usually just 1 nurse and 1 CNA trying to put 23 residents to bed. He/She indicated they stay pretty busy, "and go with whatever." He/She indicated if a resident doesn't want to change into pajamas, he/she would not have time to argue, and would not want to cause a behavior.</p>						

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

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