

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2013
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NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710
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F000000	<p>This visit was for the Investigation of Complaint IN00134240.</p> <p>Complaint IN00134240 Substantiated - Federal/State deficiencies are cited at F250.</p> <p>Survey dates: August 14 and 15, 2013</p> <p>Facility number: 000069 Provider number: 155148 AIM number: 100288980</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 10 SNF/NF: 80 Total: 90</p> <p>Census payor type: Medicare: 15 Medicaid: 66 Other: 9 Total: 90</p> <p>Sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F000000	<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. Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey on or after September 14, 2013. Thank you. Janie Swedenburg, Executive Director North Park Nursing Center Evansville, Indiana 47710 812-425-5243</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	16.2. Quality review completed on August 16, 2013, by Jodi Meyer, RN			

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on interview and record review, the facility failed to ensure a behavior plan to manage a resident's intrusive wandering was developed and implemented, for 1 of 4 residents reviewed with behavior symptoms, in a sample of 5. Resident B</p> <p>Findings include:</p> <p>1. On 8/14/13 at 10:10 A.M., during the initial tour of the locked Alzheimer's Unit, the Director of Nursing (DON) and Guest Relations Manager indicated Resident B was a resident who was currently in a psychiatric unit for behaviors including wandering.</p> <p>The clinical record of Resident B was reviewed on 8/14/13 at 2:35 P.M. The resident was admitted to the facility on 7/23/13 with diagnoses including, but not limited to, senile dementia.</p>	F000250	<p>F250 1. Resident B returned from geriatric psych unit on 8-16-2013 and has appropriate behavior care plans in place specifically to address intrusive wandering. 2. All residents have the potential to be affected by the alleged deficient practice. All resident behavior care plans were reviewed by Social Service Director and Corporate Social Service Consultant. Care plans were updated to reflect appropriate and effective behavior interventions specifically to address intrusive wandering. Nursing staff were in-serviced on 9-3-2013 on using behavior flow sheets and behavior event forms in order to identify and communicate behavior interventions that are not effective. The IDT was in-serviced by Corporate Social Service Consultant on 8-29-2013 on initiating appropriate behavior care plans upon admission specifically addressing intrusive wandering. Social Service Consultant will review new/ worsening behaviors over the last 30 days and provide recommendations and guidance. 3. Nursing staff were in-serviced on 9-3-2013 by Executive</p>	09/06/2013	

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	<p>A Temporary Care Plan, dated 7/23/13, did not document any potential behavior problems.</p> <p>Progress Notes included the following notations:</p> <p>7/24/13 at 10:03 P.M.: "Resident has been up all eve. wandering on this cottage unit. Resident likes to socialize, but really doesn't know how in a approbiate [sic] way. Resident has wandered in et [and] out of other residents room, this writer has redirected her, shes easily redirected. Residents [sic] roommate asked for help, this nurse asked what I could do, resident stated that this resident was sitting on her, et she was tired of it. Assisted resident back to her bed she slept for a little, than [sic] she woke up again the [sic] went over to her roommate et tried crawling on top of roommate, then made a verbal sexual remark...redirected back to bed, will place on a 15 min check. During supper taking other residents supper plates from them et tried eating their food, found this residents tray, served her but when she finished her meal, once again she stared [sic] wandering from table to table trying to eat others food...Well [sic] continue to monitor."</p>		<p>Director and Social Service Director on utilizing appropriate interventions that are outlined in a resident's care plan and also utilizing behavior event forms to identify new/ worsening behaviors which will trigger the IDT to assist in finding more effective interventions. The IDT was in-serviced on 8-29-2013 on developing care plans with appropriate interventions upon admission and when a new/ worsening behavior event occurs specifically addressing intrusive wandering. Social Service Director will review nursing documentation daily to identify behavior interventions that are not working and need adjusting as well as new behavior care plan development with new behaviors. Consultant will also review all new /worsening behaviors weekly to determine if appropriate interventions are in place specifically addressing intrusive wandering. 4. Social Service Director / designee will complete behavior CQI weekly for 4 weeks, monthly for 6 months and quarterly thereafter until threshold is met for 2 quarters in a row. Results will be forwarded to monthly QA and action plans developed as needed. If 95% threshold is not met an action plan will be developed.</p>				

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	<p>7/25/13 at 6:25 A.M.: "Was up and down through out the night. Remains very restless and exit seeking behaviors despite multiple attempts at redirection per multiple staff... Will continue with close observation...."</p> <p>7/25/13 at 3:30 P.M.: "Resident has been up and down hall this shift...Very confused not easely [sic] directed. Wanders around unit...."</p> <p>7/25/13 at 9:44 P.M.: "[Name of psychiatrist] here this eve. N/O [new order] received...."</p> <p>A Psychiatric Evaluation, dated 7/25/13, included: "Ptn. [patient] is a new admission to [facility]. Ptn is anxious, wanders a lot and is difficult to redirect. Ptn. gets agitated easily. She paces at night into others places and she sits on their bed or go the others' rooms. Ptn is incoherent and has no orientation. She is unable to comprehend or answer questions...Recommend inptn [in patient] psych hosp. when bed available."</p> <p>Progress Notes continued:</p> <p>7/26/13 at 4:37 A.M.: "...Up at approx. 0400 [4:00 A.M.] is wondering [sic]</p>				

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	<p>halls and is not easily redirected at this time...agitated hitting at staff and pushing...Several redirection techniques...attempted with no result. Will continue to attempt redirection and 15 min checks for safety...."</p> <p>7/27/13 at 6:00 A.M.: "Res. [resident] in and out of bed throughout noc. [night]. Very combative with staff during care. Wanders throughout unit per self; difficult to redirect at times. Will cont. to monitor [sic]."</p> <p>7/27/13 at 1:34 P.M.: "Res. wanders in and out of other rooms. Tried to redirect res..."</p> <p>7/27/13 at 9:51 P.M.: "...Resident did wander up and down hall, and into other's rooms."</p> <p>7/27/13 at 10:28 P.M.: "Resident ambulated down the hall with her pants and brief pulled down to thighs. When trying to redirect, the resident started slapping this nurse and cussing. Other staff reported that her roommate stated that she was trying to get in her bed."</p> <p>7/29/13 at 3:00 A.M.: "During 15 min. checks, res. found amb. out of bathroom into adjacent room. Attempted to redirect res. into her</p>						

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	<p>room, res. became agitated. Sat on bed by door. Attempted to explain to res. that there was a lady in that bed. Res. allowed this nurse to redirect her back to the bathroom. After entering bathroom, res. turned around and went to second bed in room, sitting on res. in that bed. managed to get res. to stand up, but res. would not leave room. Cont. to attempt to get into bed...."</p> <p>7/30/13 at 2:09 P.M.: "Social Service...[Resident B] has been wandering in and out of other resident's rooms due to not being able to find her bed. Wandering is noted 7/24/13, 7/25/13, 7/26/13, and 7/29/13. [Resident B] also has agitation and being resisitive to care...."</p> <p>8/4/13 at 4:13 A.M.: "While CNA was walking down hallway, heard someone yell 'Nurse!' Soon after, call light to this room came on. Upon entering room, CNA noted this res. sitting on roommate's bed slapping roommate's leg. Res. roommate was telling res. 'Ouch, stop, that hurts.' Res. cont. to hit roommate in the leg. While CNA attempted to remove res. from roommate's bed, res. became physically abusive toward CNA...."</p>			

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	<p>8/5/13 at 11:47 A.M.: "Due to continued behavior (slapping room mate's legs) called [hospital] and SS [social services] spoke with [name]. Room available and faxing information for review."</p> <p>8/5/13 at 12:53 P.M.: "Res started on 1:1 at this time...."</p> <p>8/6/13 at 9:14 P.M.: "...has been ambulating up and down hall, entering other residents rooms. Staff providing 1:1 care."</p> <p>The resident was transferred to a psychiatric unit on 8/7/13.</p> <p>A care plan indicated: "Problem Start Date: 8/8/13, [Resident B] has the potential for another altercation due to a hx [history] of recent altercation with room mate."</p> <p>Additional care plans, dated 8/8/13, indicated, "[Resident B] has dementia and exhibits intrusive wandering," and "Behaviour: Due to her dementia dx [diagnosis] [Resident B] is combative with care and redirection when wandering."</p> <p>Care plans prior to 8/8/13 regarding the resident's wandering and other behaviors was not found in the clinical</p>			

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	<p>record.</p> <p>On 8/15/13 at 9:40 A.M., during interview with the Social Services Director [SSD], she indicated she was usually responsible for the facility not including the locked unit. She indicated she had been covering the locked unit for the previous 2-3 weeks. The SSD indicated the Memory Care Facilitator was usually responsible for the locked unit, and the facility currently did not have someone in that position. The SSD indicated she was aware of Resident B and had been present when the psychiatrist had visited. The SSD indicated the psychiatrist had recommended an inpatient stay on a psychiatric unit, but there had been no beds. The SSD did not indicate why a care plan regarding the resident's intrusive wandering and other behaviors was not care planned until 8/8/13.</p> <p>2. On 8/15/13 at 3:40 P.M., the Administrator provided the current facility "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</p>				

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	<p>non pharmacological...Procedure: 1. Care plans should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other residents...The IDT [interdisciplinary team] review should be a discussion with the team as to the behavior event, an evaluation of interventions, presentation of new interventions if applicable and an assessment of any underlying causes of the distressed behavior...."</p> <p>This Federal tag relates to Complaint IN00134240.</p> <p>3.1-34(a)</p>			

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