STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155042		02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW MANOR	3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00192171, Complaint IN00192350, and Complaint IN00192370. Complaint IN00192171 - Substantiated. Federal/State deficienices are cited at F282, F309, F314, and F323. Complaint IN00192350 - Substantiated. Federal/State deficiencies are cited at F282, F309, F314, and F323. Complaint IN00192370 - Substantiated. Federal/State deficiencies are cited at F282 and F314. Unrelated deficiency was cited. Survey dates: February 7, 8, 9, and 10, 2016 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Census bed type: SNF/NF: 123 Total: 123 Census payor type:	F 0000	By submitting the enclosed material we are not admitting thetruth or accuracy of any specific findings or allegations. We reserve the rightto contest the findings or allegations as part of any proceedings and submitthese responses pursuant to our regulatory obligations. The facility requests thatthe plan of correction be considered our record of compliance effective March11, 2016 for the survey completed February 10, 2016.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Medicare: 18 Medicaid: 89 Other: 16 Total: 123 Sample: 14 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 17, 2016 by #02748.			
F 0224 SS=D Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure resident's personal property was safeguarded from employee's use for 1 of 3 residents reviewed for misappropriation of property, in a sample of 14. Resident E Findings include: On 2/8/16 at 2:55 P.M., the Director of	F 0224	**What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Residents E's missing money was replaced by the employeeinvolved and the facility. The money that was "loaned" was replaced by theemployee and the rest by the facility. The employee was terminated. This was reported to the Indiana State Department of Healthby self	03/11/2016

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	Nursing (DON) provided an Incident Form that was sent to the Indiana State Department of Health (ISDH). The form indicated, "Incident Date: 02/04/2016... [Resident E] states that she was having with her lockbox and asked [Housekeeper # 2] the housekeeper to help her with it. Afterwards she says she had 4 $5 dollar bills and 20 $1 dollar bills missing. She also reports that she loaned $20 to [Housekeeper # 2] because she didn't have any money and no food for her kids. [Housekeeper # 2] told her she would repay her back but never has." On 2/9/16 at 9:50 A.M., during an interview with Resident E, she indicated she "was missing $40.00 or so." She pointed to the door, where Housekeeper # 1 had been mopping, and indicated, "I think she probably was the one who took it." Resident E indicated she had a lock box, where she kept her money, and the housekeeper saw where she had placed her key. Resident E indicated Housekeeper # 1 had told her "a sad story that she didn't have any money, and needed money for this and that." She indicated she loaned the housekeeper $20.00, but that the housekeeper had not asked her for the money. She indicated the housekeeper told her she would pay her back. Resident E indicated there were 2 housekeepers who worked together, but		reporting. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents that have money have the potential to beaffected. An inservice will be conducted with all staff concerning financialabuse of a Resident and not to barrow money from Residents. A letter will besent to all potential residents about 1). Lockboxes, 2). Locking up your moneyor valuables, 3). Reporting missing items immediately to staff, 4). EncouragingResidents to not loan money to employees. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A signature sheet will become a part of Employee GeneralOrientation that will state the facts about financial exploitation of Residentswith the Do's and Don'ts. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool "Exploitation of Residents" will becompleted monthly to make sure this sheet is being signed during	

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	that she did not know the other housekeeper's name. On 2/9/16 at 9:55 A.M., the clinical record of Resident E was reviewed. A Minimum Data Set assessment indicated the resident scored a 15 out of 15 for cognition, with 15 indicating no memory impairment. On 2/9/16 at 10:20 A.M., during an interview with the Administrator and DON, the DON indicated that Resident E was interviewed after the incident, and was "adamant it was "Housekeeper # 2]." The Administrator indicated Housekeeper # 2 indicated that she did accept $20.00 from the resident, and had been terminated. The Administrator indicated he had interviewed Housekeeper # 1, and she denied taking any money. On 2/10/16 at 1:20 P.M., the Administrator provided a follow-up report send to the ISDH. The report included: "...Investigation revealed that [Housekeeper # 2] did borrow $20 off of [Resident E]. [Resident E] did admit that she had loaned the money to her... [Resident E] stated that after that money was loaned out she knows that [Housekeeper # 2] knew where her key was to the lockbox...the next day to find		GeneralOrientation. This will be reported monthly to the Quality Assurance Team. Alsoan audit tool "Financial Exploitation" will be completed on any financial abuseallegations to determine compliance. This will be presented monthly to theQuality Assurance Team. **By what date thesystemic changes will be completed:** 3/11/2016	

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	out another $20 was missing. She feels with all her heart that [Housekeeper # 2] took that too. [Resident E] also identified another individual as being [Housekeeper # 2's] sidekick...that person was never identified through interviews nor by positive ID in front of [Resident E]...." On 2/10/16 at 1:20 P.M., the Administrator provided the current facility policy on "Abuse Prevention," revised 7/2011. The policy included: "...Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc. to assist in preventing resident abuse...Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings without he resident's consent...." 3.1-28(a)			

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F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the policy for the protection of resident's personal property was followed by all staff; resident's personal property was taken and used by an employee for 1 of 3 residents reviewed for misappropriation of property, in a sample of 14. Resident E Findings include:	F 0226	**What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Residents E's missing money was replaced by the employeeinvolved and the facility. The money that was "loaned" was replaced by theemployee and the rest by the facility. The employee was terminated. This was reported to the Indiana State Department of Healthby self reporting.	03/11/2016

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	On 2/8/16 at 2:55 P.M., the Director of Nursing (DON) provided an Incident Form that was sent to the Indiana State Department of Health (ISDH). The form indicated, "Incident Date: 02/04/2016... [Resident E] states that she was having with her lockbox and asked [Housekeeper # 2] the housekeeper to help her with it. Afterwards she says she had 4 $5 dollar bills and 20 $1 dollar bills missing. She also reports that she loaned $20 to [Housekeeper # 2] because she didn't have any money and no food for her kids. [Housekeeper # 2] told her she would repay her back but never has." On 2/9/16 at 9:50 A.M., during an interview with Resident E, she indicated she "was missing $40.00 or so." She pointed to the door, where Housekeeper # 1 had been mopping, and indicated, "I think she probably was the one who took it." Resident E indicated she had a lock box, where she kept her money, and the housekeeper saw where she had placed her key. Resident E indicated Housekeeper # 1 had told her "a sad story that she didn't have any money, and needed money for this and that." She indicated she loaned the housekeeper $20.00, but that the housekeeper had not asked her for the money. She indicated the housekeeper told her she would pay		**How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents that have money have the potential to beaffected. An inservice will be conducted with all staff concerning financialabuse of a Resident and not to barrow money from Residents. A letter will besent to all potential residents about 1). Lockboxes, 2). Locking up your moneyor valuables, 3). Reporting missing items immediately to staff, 4). EncouragingResidents to not loan money to employees. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Staff will be inserviced on financial exploitation ofResidents. Willow Manors current “Abuse and Neglect Policy will be used toaccomplish this education. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool “Exploitation of Residents” will becompleted monthly to make sure this sheet is being signed during GeneralOrientation. This will be	

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	her back. Resident E indicated there were 2 housekeepers who worked together, but that she did not know the other housekeeper's name. On 2/9/16 at 9:55 A.M., the clinical record of Resident E was reviewed. A Minimum Data Set assessment indicated the resident scored a 15 out of 15 for cognition, with 15 indicating no memory impairment. On 2/9/16 at 10:20 A.M., during an interview with the Administrator and DON, the DON indicated that Resident E was interviewed after the incident, and was "adamant it was "Housekeeper # 2]." The Administrator indicated Housekeeper # 2 indicated that she did accept $20.00 from the resident, and had been terminated. The Administrator indicated he had interviewed Housekeeper # 1, and she denied taking any money. On 2/10/16 at 1:20 P.M., the Administrator provided a follow-up report send to the ISDH. The report included: "...Investigation revealed that [Housekeeper # 2] did borrow $20 off of [Resident E]. [Resident E] did admit that she had loaned the money to her... [Resident E] stated that after that money was loaned out she knows that		reported monthly to the Quality Assurance Team. Alsoan audit tool "Financial Exploitation" will be completed on any financial abuseallegations to determine compliance. This will be presented monthly to theQuality Assurance Team. **By what date thesystemic changes will be completed:** 3/11/2016	

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	[Housekeeper # 2] knew where her key was to the lockbox...the next day to find out another $20 was missing. She feels with all her heart that [Housekeeper # 2] took that too. [Resident E] also identified another individual as being [Housekeeper # 2's] sidekick...that person was never identified through interviews nor by positive ID in front of [Resident E]...." On 2/10/16 at 1:20 P.M., the Administrator provided the current facility policy on "Abuse Prevention," revised 7/2011. The policy included: "...Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc. to assist in preventing resident abuse...Misappropriation of resident property is defined as deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings without he resident's consent...." 3.1-28(c)			

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident's wound dressing was changed every day as ordered (Resident L), and failed to administer medications as ordered (Resident B) for 4 days, for 2 of 6 residents reviewed for following the plan of care, in a sample of 14. Resident L, Resident B Findings include: 1. On 2/7/16 at 4:30 P.M., during the initial tour, RN # 1 indicated Resident L had an open area near his coccyx, that was not pressure related. On 2/9/16 at 3:10 P.M., a skin assessment was requested. The Unit Manager assisted the resident in turning. A large amount of dried brown drainage was observed on the resident's sheet. The Unit Manager indicated it was "probably from his wound." As the resident turned, a saturated dressing fell from the	F 0282	**What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Resident L's dressing was changed immediately. The UnitManager was educated on the scope of practice for QMA's. For Resident B thenurse involved was educated about proper Medication Administration. Medicationerror report was completed and the physician was notified. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** There were no other Residents identified with latedressing changes or medication errors. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All Nursing staff will be educated on following physicianorders for	03/11/2016

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	resident's wound. The date on the dressing was 2/7/16. Resident L indicated the dressing was changed "usually 2 times a week, on my shower days." The Unit Manager indicated at that time that the dressing was to be changed daily. The Unit Manager indicated the previous day, a QMA was working on that hall, and QMAs were not allowed to change dressings. The Unit Manager indicated she was the person who should have changed the dressing, but that she "didn't realize QMAs couldn't change dressings." The clinical record of Resident L was reviewed on 2/9/16 at 3:45 P.M. Diagnoses included, but were not limited to, multiple sclerosis, bilateral above the knee amputee, and perineal cellulitis. A "Significant Change" Minimum Data Set (MDS) assessment, dated 1/18/16, indicated the resident scored a 15 out of 15 for cognition, indicating no memory impairment. The MDS indicated the resident required limited assistance of one staff for transfer and personal hygiene. A "Non-Pressure Skin Condition Report" indicated, "Date First Observed: 12/31/15, Site/Location: posterior upper		Dressing changes and the medication administration. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** The audit tool "Medication /Treatment Administration"will be utilized for both Medication Administration and Dressing Changes. Thisaudit tool will be completed monthly and reported to the Quality Assurance Teammonthly x 3 and then if no problems noted quarterly x 3. **By what date thesystemic changes will be completed:** 3/11/2016	

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	scrotum/perineum, area where boil opened up...." The most recent measurements of the area, dated 2/2/16, indicated: 5.5 cm (centimeters) x 2.7 cm x 4 cm. A Physician's order, dated 1/26/16, indicated, "...Continue daily wet to dry dressing to perineal area cover with foam dressing [change] daily." A Care Plan, dated 1/28/16, indicated: "Problem, Impaired skin. Interventions...Treatment as ordered...." 2. The clinical record of Resident B was reviewed on 2/8/16 at 11:55 A.M. Diagnoses included, but were not limited to, chronic kidney disease, diabetes mellitus, COPD, and heart failure. Documentation indicated the resident returned to the facility on 1/5/16 following a hospitalization. A hospital discharge instruction sheet, dated 1/5/16, indicated the resident was to receive the following medications: Duoneb 2.5/0.5 mg by nebulizer every 6 hours (used for breathing difficulties) Allopurinol 100 mg by mouth every day			

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	(used for gout) Amiodarone 100 mg twice daily (a heart medication) Aspirin 81 mg every day (used for heart) Venelex 1 application 3 times daily (an ointment for wounds) Calcium Carb 500 mg every day Sensipar 30 mg every day (lowers the amount of calcium in the blood) Coumadin 4 mg daily (a blood thinner) Breo Ellipta 1 puff by inhaler every day (for breathing difficulties) Neurontin 300 mg twice daily (used for nerve pain) Metoprolol Tartrate 12.5 mg twice daily (used for blood pressure) Liothyronine 25 mcg daily (use for low thyroid) Pravastatin 40 mg 1 tablet daily at night (used to lower cholesterol) Ranexa 500 mg 1 tablet twice daily (a heart medication)			

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	Renvela 800 mg three times daily with meals (a dialysis medication) Senokot 17.2 mg twice daily (a stool softener) Lamictal 25 mg every day (used as a mood stabilizer and for seizures) Provera 20 mg three times daily (a hormone) Melatonin 6 mg at bedtime (a sleep aid) Protonix 40 mg every day (used for stomach acid) Miralax 17 gm every day (used for constipation) Theophylline 300 mg twice daily (used for breathing difficulties) Kionex 15 gm on non-dialysis days, Monday - Wednesday - Friday - Sunday (a dialysis medication used to treat high potassium) Trazodone 100 mg at bedtime (an anti-depressant) Xanax 0.5 mg 3 times a day as needed (an anti-anxiety medication)			

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	A Medication Administration Record (MAR), dated January 2016, listed the medications as ordered on 1/5/16. There were no initials indicating the medications were administered as ordered on 1/5/16. Documentation did not indicate the time the resident was admitted to the facility on 1/5/16. The following medications were initialed as given on 1/6/16 at 9:00 P.M.: Pravastatin and Trazadone. There was no further documentation that medications were administered until 1/7/16 at 11:30 A.M. and 12:00 P.M.; the resident received Provera and Sevelamer (Renvela). At 4:00 P.M., and the following were initialed as given: Coumadin, Gabapentin, Senna, Metoprolol, and Sevelamer. Medications were not initialed as given on 1/8/16; except at 9:00 P.M., Gabapentin, Mag oxide, Metoprolol 12.5 mg, Pravastatin, Ranexa, and Senna were initialed. On 2/8/16 at 2:50 P.M., during an interview with the Unit Manager, she indicated she had started as Unit Manager on 1/1/16. She indicated, "An agency nurse admitted the resident and did the medication sheets all wrong." She			

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	155042		02/10/2016

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	indicated when she discovered it, she rewrote the MARs. She indicated she was unsure if the resident received the medications as ordered. She indicated the resident was not very responsive when he first came back, and so he may have been unable to take the medications, "but that should have been charted." This Federal tag relates to Complaint IN00192171, Complaint IN00192350, and Complaint IN00192370. 3.1-35(g)(2)			

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F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to adhere to the facility's policy regarding a resident's low blood sugar, resulting in the resident's fall with a head laceration, for 1 of 3 residents reviewed for diabetic care, in a sample of 14. Resident H Findings include: On 2/7/16 at 4:40 P.M., during the initial tour of the locked Alzheimer's Unit, LPN # 1 indicated Resident H had recently fallen. The clinical record of Resident H was reviewed on 2/7/16 at 6:45 P.M. Diagnoses included, but were not limited to, dementia and diabetes. An annual Minimum Data Set (MDS) assessment, dated 1/12/16, indicated Resident H scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated Resident H required limited	F 0309	**What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Resident H was sent to the Hospital after the fall forproper treatment. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All Diabetic residents have the potential to be affected.No other residents were identified. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** Educate Nursing staff on the Hyper/Hypoglycemic policy. **How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** An audit tool “Hyper/Hypoglycemic	03/11/2016

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	assistance of one person for walking in the room and corridor. A test for balance indicated "Not steady, but able to stabilize without staff assistance" while moving from seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer. A Physician order on the January 2016 orders included: "Accuchecks as needed for s/s [signs or symptoms] of hypo/hyperglycemia [low/high blood sugar]." An additional Physician's order, on the January 2016 orders, indicated, "Follow hypo/hyper glycemic protocol." Nurses Notes included the following notations: 1/23/16 at 7:45 A.M.: "Res in A hall BR [bathroom]. This nurse heard loud crash, upon entering res was lying on back [with] blood coming from back of head. Res was awake but not responding to this nurse, accu [check] 47 mg/dl...2 deep lacerations to back of head noted [with] mod [moderate] active bleeding...prepared for transfer to [name of hospital] ER...." A hospital ER note, dated 1/23/16, indicated, "[Resident H]...who fell, struck his head on a can that was in his room and when he hit the trash can, had no loss		audit" tool will beutilized monthly. These will results will be reported to the Quality AssuranceTeam monthly x 3 and then if no problems are noted it will be completedquarterly. **By what date thesystemic changes will be completed:** 3/11/2016	

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	of consciousness...Exact circumstances are uncertain. Apparently his blood sugar was low and this may have contributed to his fall...He had two lacerations occipital [head] area, oozing of blood...Six skin staples were placed with good wound approximation...Impression: 1. Blunt head injury 2. Scalp laceration...." Nurses Notes continued: 1/23/16 at 11:10 A.M.: "Res back to facility, 6 staples noted to lacerations...." 1/23/16 at 7:35 A.M. "Late entry": "Res accu [check] 27 mg/dl, rechecked et [and] was 33 mg/dl, res asymptomatic [sic], sitting at dining room table eating breakfast, O.J. given to resident, extra sugar given to res cereal et O.J. et at 0745 [7:45 A.M.] Res had fall in BR." A Care Plan, initially dated 5/10/12 and updated 10/30/15, indicated, "The resident has Diabetes Mellitus." The Interventions included: "Diabetes medication as ordered by the doctor...Monitor/document/report to MD PRN [as needed] s/sx [signs/symptoms] of hypoglycemia...." On 2/8/16 at 2:55 P.M., the Director of Nursing provided the current facility policy "Hypo/hyperglycemic Protocol,"			

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	undated. The policy indicated: "Upon admission, MD must be notified of our facility protocol and an order should be written to 'follow facility hypo/hyperglycemic protocol.' The MD must be asked the parameters that he wishes to be called. For example, if BS [blood sugar] is below 60 or above 350, the Physician should be notified. This must also be included on the order...1. If BS is <60 and resident is conscious and has no swallowing difficulties: give 4 oz orange juice with granulated sugar by mouth followed by peanut butter and crackers...Report results to MD and any reasons that BS could be fluctuating...Request orders for the next scheduled does of insulin. Repeat accucheck in 15-30 minutes...." The DON indicated at that time that the nurse had not followed the facility protocol regarding a low blood sugar, and the low blood sugar was "probably what caused the resident to fall." This Federal tag relates to Complaint IN00192171 and Complaint IN00192350. 3.1-37(a)			
F 0314 SS=D Bldg. 00	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of			

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	a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's pressure ulcer was free from contamination from BM, and failed to ensure a dressing was secured over the area, for 1 of 3 residents reviewed with pressure ulcers, in a sample of 14. Resident K Findings include: On 2/7/16 at 4:30 P.M., during the initial tour, RN # 1 indicated Resident K had a pressure area on his coccyx, had a wound vac, and went to the wound care center. On 2/8/16 at 9:25 A.M., during an interview with the local long term care ombudsman, she indicated she had received complaints from the hospital Wound Care Center regarding Resident	F 0314	**What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** The dressing on Resident K was changed afteridentification that the wound may be contaminated with BM. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** All residents with wound dressing have the potential tobe affected. No other residents were identified with this issue. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** All Nursing Staff, including C.N.A's will be educated tomonitor for soiled dressings and, if identified, those dressing should bechanged immediately	03/11/2016

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	K's care. She indicated the Wound Care Center staff had shown her BM under the resident's wound vac dressing, directly on the pressure ulcer. The clinical record of Resident K was reviewed on 2/9/16 at 2:30 P.M. Diagnoses included, but were not limited to, buttock decubitus with wound vac. A quarterly Minimum Data Set (MDS) assessment, dated 10/28/15, indicated the resident scored a 12 out of 15 for cognition, with 15 indicating no memory impairment. The resident required total dependence of two + staff for bed mobility and toilet use, and extensive assistance of one person for personal hygiene. The resident was "always incontinent" of bowels. The MDS assessment indicated the resident had 1 Stage 4 ("Full thickness loss with exposed bone, tendon, or muscle...Often includes undermining and tunneling") pressure ulcer. A Wound Care Center note, dated 1/21/16, indicated, "Wound Location: Coccyx...Wound Measurements: Length: (cm) [centimeters] 2, Width: (cm) 1, Depth: (cm) 0.9...Exudate [drainage] Amount: small, Exudate Type: Serous, Color: Yellow...Assessment Notes, Pt [patient] arrived with foul odor coming		**How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** A wound dressing check will be added to the 2-hoursnursing rounds for identification of soiled wound dressings. If a dressing isfound to be soiled, it will be changed immediately. An Audit of the 2-hourround sheet will be completed and presented to the Quality Assurance Teammonthly x 3 and then if no problems are noted will be presented Quarterly x 3. **By what date thesystemic changes will be completed:** 3/11/2016	

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	from VAC, upon removing VAC found perfect circle of brown loose BM saturating black foam and inside of wound, wound edges irritated and raw." A Wound Care Center note, dated 2/4/16, the most recent measurements of the pressure ulcer as: 2 cm x 0.9 cm x 0.7 cm. The note indicated, "Exudate Amount: Small, Exudate Type: Serous, Color: Yellow...." A Physician's order, dated 2/4/16, indicated, "Wound vac orders: endofoarm, wet [with] NS [normal saline], covered [with] black foam bridge to hip...[Change] tues, sat - wound care center thurs." A Care Plan, initially dated 8/15/14 and updated 12/6/15, indicated, "Potential for further skin breakdown, related to: weakness, decreased mobility, pain, and dependence for all turning and repositioning needs." The Interventions included: "Manage incontinence with briefs, check and change every two hours and as needed. Turn and reposition every two hours and as needed." An additional Care Plan, initially dated 8/15/14 and updated with the most recent target date of 11/22/15, indicated, "The resident admitted with DTI [deep tissue			

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	injury] on coccyx...11/13/14 surgical wound d/t [due to] skin grafting to coccyx area." The Interventions included: "The resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. Administer treatments as ordered and monitor for effectiveness...Monitor dressing to ensure it is intact and adhering. Report lose [sic] dressing to treatment nurse...." On 2/9/16 at 2:45 P.M., a skin assessment was requested. LPN # 1 and CNA # 1 turned the resident over. A dried brown ring was observed on the resident's draw sheet. BM was observed mid-way up the resident's back. The dressing was not secure over the wound vac foam and/or the pressure ulcer. The wound vac foam was saturated with BM. Around the pressure ulcer itself, the skin was red and irritated. There were indentations on the resident's thighs from the draw sheet. Resident K indicated at that time that the last time that he was given care was "yesterday, when they cleaned me up." CNA # 1 indicated she had just started her shift. On 2/9/16 at 3:15 P.M., during an interview with LPN # 1, she indicated, "We just have 1 CNA on this hall for 21 residents." LPN # 1 indicated she was			

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	unsure what time the resident had last received care, but that "he will usually tell us if he has a BM." This Federal tag relates to Complaint IN00192171, Complaint IN00192350, and Complaint IN00192370. 3.1-40(a)(2)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident			

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	environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide supervision to prevent falls; utilized alarms in place of supervision; and did not respond to alarms in a timely manner, resulting in falls with lacerations, for 4 of 4 residents reviewed for falls; and failed to provide supervision to prevent an elopement, for 1 of 3 residents reviewed for elopement (Resident F), in a sample of 14. Residents C, F, G, H, and P Findings include: 1. On 2/7/15 at 4:40 P.M., during the initial tour of the locked Alzheimer's Unit, Resident P was observed sitting in a wheelchair in the hallway. Bruising was observed around both eyes. LPN # 1 indicated at that time that Resident P had fallen recently. The clinical record of Resident P was reviewed on 2/8/16 at 10:45 A.M. Diagnoses included, but were not limited to, dementia. A Care Plan, initially dated 4/30/14 and updated 1/22/16, indicated, "Potential for	F 0323	**What Correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice:** Residents C, G, H, and P were assessed for injuries andwere treated for such. Fall risk Assessments were completed on all falls. FallInterventions were implemented and careplans and assignment sheets were updatedfor Residents C, G, H, and P. Resident F, elopement, was retrieved from theoutside and assessed for injuries. No injuries were noted. Resident F was calmand easily redirected once back in the building. Resident F was placed on 15minute checks and no further incidences were noted. **How otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken:** Fall Risk Assessments will be completed on everyResident. Interventions, Careplans, and assignment sheets will be reviewed andupdated as needed. Elopements assessment, Careplans, and Behavior Managementplans were completed, reviewed, and	03/11/2016

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	Falls related to: unaware of limitations, weakness, dementia with behaviors. History of falls." The Interventions included: "Alarms as ordered. Encourage resident to be compliant with limitations and to ask for assistance as needed. Evaluate all falls for cause and attempt to prevent further falls. Keep call light in reach and encourage resident to use it to ask for assistance. Pull alarm at all times. 1-22-16 Keep in high traffic areas." A Nurses Note, dated 11/20/15 at 4:45 P.M., indicated, "Resident was in A wing dining room sitting in chair pull alarm attached to back of chair another resident was pulling on alarm in [sic] pulled resident out of chair and onto floor...." A Nurses Note, dated 12/16/15 at 2:15 P.M., indicated, "Res [resident] slid out of chair et [and] fell to floor hitting buttocks on floor...New order received for dycem to chair to prevent sliding." A quarterly Minimum Data Set (MDS) assessment, dated 12/24/15, indicated Resident P had a short-term and long-term memory problem and was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated Resident P required extensive assistance of one person for bed mobility and transfer, and did not		updated as necessary. All staff signed a“Door Alarm Response” which instructed staff on how to respond to door alarms.An “Elopement Prevention Management” inservice was completed for all staff. TheExit Door on the Secured Unit were originally set up on a 15 second delay.Those delays were removed and the doors were placed on Key Pads to preventResidents from unintentionally leaning up against the door bar or intentionallypushing the bar and the door opening. Elopement drills were conducted duringthis week to familiarized staff with what to do in the event of an Elopement.All staff were taken to exit doors and were familiarized with the sound of theexit door alarms. **What measures willbe put into place or what systemic changes will be made to ensure that thedeficient practice does not recur:** A third staffing agency was signed on 2-10-2016.Recruiting efforts are still in place with ads running online. A help wantedsign was placed in the front of the Willow Manor Property. An attempt toincrease staffing is ongoing. Staff will be educated on prevention of falls andwhat to do when they occur. The Elopement education for all staff was completedon 2.4.2016.	

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	ambulate. A test for balance indicated "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position, moving on and off toilet, and surface-to-surface transfer. The MDS assessment indicated the resident had fallen since the prior assessment. Nurses Notes included the following notations: 1/15/16 at 7:15 P.M.: "Resident was in w/c [wheelchair] alarm et dycem [sic]. Another resident pushing resident holding onto rail tried to stand up et resident slipped out of w/c...." 1/19/16 at 10:15 P.M.: "...Neuro [checks] continue from resident falling out of bed today...." An Incident Report, dated 1/19/16, indicated, "Time of Incident: 1100 [11:00 A.M.]...Res in bed to rest before lunch et rolled out of low bed to floor scraping forehead on heater...." 1/20/16 at 2:00 P.M.: "...Pressure alarm on at all times. Closely monitored d/t [due to] [decreased] safety awareness." 1/22/16 at 7:40 P.M.: "Resident in hallway on floor. Lying Rt [right]		**How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place:** A "fall" audit tool will be implemented and reported tothe Quality Assurance Team monthly x 3 and then if no problems noted will becompleted quarterly x 3. **By what date thesystemic changes will be completed:** 3/11/2016	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	side...Resident had tried to stand up [with] railing but not strong enough. Fell on Rt side of head. Has open area [and] bruising on Rt forehead. Rt eye is black [and] blue swollen shut...she is stiff, no c/o [complaints of] pain other than face hurting. Also has a cut below Rt eye. Has laceration on Rt hand by thumb...." Documentation did not indicate if an alarm was sounding. The resident was transferred to the emergency room on 1/22/16 at 8:45 P.M., and returned to the facility at 11:45 P.M. A Nurses Note, dated 1/22/16 at 11:45 P.M., indicated, "Res [resident] returned from [name of hospital]...No broken bones noted...has steri strips on right side of forehead and under right eye. Res. has a long contusion to right eye that is deep purple...." A Nurses Note, dated 1/23/16 at 2:00 P.M., indicated, "...PRN [as needed] for c/o [complaints of] facial et back pain. Res [up] [with] max [maximum] assist of [one] staff member, requires max assist of [one]...Bruising to [left] side of face noted [with] 2 small lacerations which are steri stripped, ice to face x 2 this shift d/t swelling of [right] eye. Alarm on at all x's [times]. Close supervision required d/t			

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	poor safety awareness...." 2. On 2/7/16 at 4:40 P.M., during the initial tour of the locked Alzheimer's Unit, Resident G was observed sitting in a chair in the dining room. Bruising was observed around her left eye. LPN # 1 indicated Resident G had recently fallen. The clinical record of Resident G was reviewed on 2/7/16 at 6:30 P.M. Diagnoses included, but were not limited to, Alzheimer's disease. A Care Plan, initially dated 6/9/15 and updated 1/23/16, indicated, "Potential for Falls related to: resistive to care, psychotropic med use...unaware of safety and limitations." The Interventions included: "Encourage resident to be compliant with limitations and to ask for assistance as needed. Keep call light in reach and encourage resident to use it to ask for assistance. 1-10-16 Pull alarm @ all x's. [Up] [with] A [assist] x 1. 1-8-16 Separate res when trying to hold on to other res." An admission Minimum Data Set (MDS) assessment, dated 10/14/15, indicated Resident G had a short-term and long-term memory problem and was severely impaired in cognitive skills for daily decision making. The MDS			

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	assessment indicated Resident G required limited assistance of one person for bed mobility and transfer, and supervision of one person for walking in the room and corridor. A test for balance indicated "Not steady, but able to stabilize without staff assistance" while moving from seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer. Nurses Notes included the following notations: 12/5/15 at 2:35 P.M.: "Around 1230 resident was observed walking in hallway during dinner time bumped into the foodcart [sic] [and] fell to floor onto her knees...." 1/8/16 at 3:40 P.M.: "Pt [patient] fell @ 1515 [3:15 P.M.] pt was holding onto another pt shirt following him he turned quickly [and] pt went to floor on bottom...did not hit her head...." 1/10/16 at 10:30 A.M.: "Res was sitting in dining room et got [up] from chair, upon rising res lost balance et fell backward et hit head on arm of chair. Res has 4 cm [centimeter] laceration to back of head...Laceration bled for short period of time...Will cont neuro checks et monitor closely."			

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	A quarterly MDS assessment, dated 1/20/16, indicated Resident G had a short-term and long-term memory problem and was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated Resident G required limited assistance of one person for bed mobility and transfer, and walking in the room and corridor. A test for balance indicated "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer. Nurses Notes continued: 1/23/16 at 2:45 P.M.: "Res in chair, bent over to do something to shoe et tumbled head first out of chair, hit [left] forehead on floor, ice applied...." 3. On 2/7/16 at 4:40 P.M., during the initial tour of the locked Alzheimer's Unit, LPN # 1 indicated Resident H had recently fallen. The clinical record of Resident H was reviewed on 2/7/16 at 6:45 P.M. Diagnoses included, but were not limited to, dementia and diabetes.			

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	An annual MDS assessment, dated 1/12/16, indicated Resident H scored a 5 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated Resident H required limited assistance of one person for walking in the room and corridor. A test for balance indicated "Not steady, but able to stabilize without staff assistance" while moving from seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer. A Physician's order, initial date unknown but on the January 2016 orders, indicated, "Follow hypo/hyper glycemic protocol." Nurses Notes included the following notations: 1/23/16 at 7;45 A.M.: "Res in A hall BR [bathroom]. This nurse heard loud crash, upon entering res was lying on back [with] blood coming from back of head. Res was awake but not responding to this nurse, accu [check] 47 mg/dl...2 deep lacerations to back of head noted [with] mod [moderate] active bleeding...prepared for transfer to [name of hospital] ER...." A hospital ER note, dated 1/23/16, indicated, "...who fell, struck his head on			

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	a can that was in his room and when he hit the trash can, had no loss of consciousness...Exact circumstances are uncertain. Apparently his blood sugar was low and this may have contributed to his fall...He had two lacerations occipital [head] area, oozing of blood...Six skin staples were placed with good wound approximation...Impression: 1. Blunt head injury 2. Scalp laceration...." Nurses Notes continued: 1/23/16 at 11:10 A.M.: "Res back to facility, 6 staples noted to lacerations...." 1/24/16 at 6:00 P.M.: "Resident was found on floor between bathroom et room of another resident. Resident was lying on back hit his head bleeding noted to small laceration left side of head ice applied...Son [name] aware stated 'now what happened..." will monitor, gait very slow et unsteady." 1/23/16 at 7:35 A.M. "Late entry": "Res accu [check] 27 mg/dl, rechecked et was 33 mg/dl, res assymptomatic [sic], sitting at dining room table eating breakfast, O.J. given to resident, extra sugar given to res cereal et O.J. et at 0745 [7:45 A.M.] Res had fall in BR." A Care Plan, initially dated 5/10/12 and			

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	updated 1/23/16, indicated, "The resident has potential for falls r/t history of falls, decreased vision, dementia, psychotropic meds." The Interventions included: "Anticipate and meet the resident's needs. Ensure that the resident is wearing appropriate footwear 5/10/12. [Up] [with] [assist] x [one] for transfers/ambulation r/t weakness. 4. On 2/7/16 at 5:15 P.M., Resident C was observed sitting at a table in the dining area of the Alzheimer's Unit. The clinical record of Resident C was reviewed on 2/7/16 at 6:10 P.M. Diagnoses included, but were not limited to, dementia and Parkinson's disease. An annual MDS assessment, dated 9/23/15, indicated Resident C had a short-term and long-term memory problem and was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated Resident C required extensive assistance of one person for bed mobility, and walking in the room and corridor. The resident required limited assistance of one person for transfer. A test for balance indicated "Not steady, only able to stabilize with staff assistance" while moving from seated to standing position, walking, turning around, moving on and			

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	off toilet, and surface-to-surface transfer. The MDS assessment indicated the resident had fallen twice since the last assessment. Nurses Notes included the following notations: 11/10/15 at 1:30 P.M.: "Res alarm sounded, CNA entered room et res slid from chair to knees...pull alarm applied as intervention to alert staff earlier that res is getting [up]...." 12/3/15 at 8:15 P.M.: "Resident in recliner in sitting room when upon entering the room resident stated 'another resident pulled her out of her chair.' Resident was on her buttocks alarm in place. No signs of hitting head...." 12/13/15 at 9:00 P.M.: "Resident stood up sounding alarm in sitting room. CNA [name] wittnessed [sic] before able to get to her. Resident tried to sit down missing chair landing on buttocks...Will cont to monitor." 12/24/15 at 7:30 P.M.: "This nurse was assisting another resident when heard resident's alarm sound this nurse seen resident up walking when resident tried to get back to sit in her chair she fell on floor landing on her bottom. This nurse			

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	was not able to get to resident before she fell...Will cont to monitor." 1/5/16 at 3:15 A.M.: "Heard alarm sounding et found resident sitting on floor [with] back against door...Will cont to monitor." A Care Plan, dated 12/5/13 and updated 1/5/16, indicated, "The resident has potential for falls or/t Parkinson's, dementia, unaware of safety...." The Interventions included: "Be sure the resident's call light is within reach and encourage resident to use it for assistance as needed. 1/5/14 High traffic areas only...Pressure alarm @ all times 2/4/15. Dycem to chairs. 11-10-15 Pull alarm when [up] in chair. 12-3-15 Keep in high traffic area. 12-13-15 Offer position [change] several x's per shift...." On 2/8/16 at 11:05 A.M., during an interview with the Alzheimer Unit Manager, she indicated she was aware that there had been several falls on her unit. She indicated she did not schedule the staff for her unit. The Unit Manager indicated, "We need 3 CNAs and 1 additional nurse besides me on day shift, 3 CNAs and 2 nurses on evening shift, and 2 CNAs and 1 nurse on night shift." The Unit Manager indicated the staff was not currently scheduled at that ratio. The			

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	Unit Manager indicated it was especially difficult on her unit, because most of the residents required "1 on 1 attention." The Unit Manager indicated she was trying to get the Environmental aides to do activities with the residents after supper, to assist in decreasing the falls and behaviors. The Unit Manager indicated she also wished she had a more consistent staff, which she felt like would help the residents. On 2/10/16 at 10:45 A.M., the Director of Nursing (DON) provided the current facility policy on "Managing Falls and Fall Risk," revised August 2006. The policy included: "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling...If falling recurs despite initial interventions, staff will implement additional or different interventions...." 5. On 2/7/16 at 4:40 P.M., during the initial tour of the locked Alzheimer's Unit, LPN # 2 indicated Resident F had exited the facility unattended. The clinical record of Resident F was reviewed on 2/8/16 at 10:20 A.M. Diagnoses included, but were not limited			

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	to, Alzheimer's disease. An Elopement Risk Assessment, dated 10/12/15, indicated, "Is the resident cognitively impaired with poor decision making skills? Yes. Does the resident have a diagnosis of: dementia, Alzheimer's...? Yes. Does the resident ambulate independently...? Yes... Does the resident wander aimlessly? Yes. Does the resident express a desire to go home? Yes.. Is the resident cognitively impaired and has been observed standing at the exit door waiting for someone to let them out? Yes. Total Score 14. A score of 5 or more is considered to be at risk for elopement." An annual Minimum Data Set (MDS) assessment, dated 11/21/15, indicated Resident F scored a 6 out of 15 for cognition, and required limited assistance of one person to walk in his room and corridor. Nurses Notes included the following notations: 12/5/15 at 2:30 P.M.: "Around 1200 [12:00 P.M.] Resident was exit seeking set off alarm for door to unit doors of facility, nurse was able to stop him from			

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	leaving facility...Insisted he was leaving 'going home.'...Will cont to monitor." 1/11/16 at 12:00 P.M.: "Res. [resident] alert et [and] verbal [with] confusion. Asks to go home often - easily redirected...." 1/13/16 at 9:45 P.M.: "Resident has been up and down about this day wanting to leave going from side to side pushing on doors...." 1/14/16 at 11:40 P.M.: "Resident wanting to leave cursing at staff, pushing on doors, swings arms trying to hit staff et saying...'let me out of here'...." 1/15/16 at 11:50 P.M.: "Resident wanting to leave pacing the floor going from side to side door to door [sic] wanting to leave...." 1/22/16 at 9:30 A.M.: "Attempted to exit fire door. Alarm sounded et res stopped from exiting through door. Res then ambulated down other hall et attempted to exit. Alarm sounded. Res stopped from trying to get door opened. Res redirected." 1/30/16 at 6:20 P.M.: "Noted Res. had been restless - ambulating around the unit as res does this daily. Requires			

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	supervision - due to exit seeking through the eve. CNA on duty was in a room [with] a resident who was trying to get [up] alone - CNA not familiar [with] the unit - didn't recognize resident was doing out, didn't recognize the alarm - Nurse off unit to BR [bathroom] - Resident went to the road." A Care Plan, dated 12/16/13 and updated for a target date of 2/19/16, indicated, "The resident is an elopement risk/wanderer AEB [as evidenced by] Impaired safety awareness..." The Interventions included: "Disguise exits: stop sign at back door with alarm. Identify pattern of wandering...Monitor location, encourage resident to walk and participate in activity area/day room. Provide structured activities...." A Care Plan, dated 3/19/14 and updated for a target date on 2/19/16, indicated, "The resident has a behavior problem r/t [related to] elopement. Resident paces up and down looking for his car, brother, and wife. Sometimes will stand by the exit door. He lives on the locked unit. Dementia, with agitation." The Interventions included: "Anticipate and meet the resident's needs...Keep resident away from the exit doors. Monitor behavior episodes and attempt to determine underlying cause...Resident			

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	will walk around the units with staff to help calm down. Take to recliner or room to relax." On 2/8/16 at 10:35 A.M., during an interview with the Alzheimer's Unit Manager, she indicated the previous exit door would open and alarm if someone pressed on it for 15 seconds. The Unit Manager indicated the CNA who was working the evening of 1/30/16 "didn't know what the alarm was, and the other staff member was off of the floor." The CNA went to find another staff member to ask them what the alarm meant. The Unit Manager indicated the resident walked to the intersection of a county road outside of the facility, and a passer-by stopped and called the facility. The Unit Manager indicated all staff had since been trained on what the door alarms sound like and to respond immediately to the alarms. According to a weather history data site, the temperature on 1/30/16 at 5:53 P.M. was 48 degrees. On 2/9/16 at 4:15 P.M., the Administrator provided an Incident form sent to the Indiana State Department of Health. The Incident included: "Follow up added - 2/4/16 Investigation revealed the following. [Resident F], who resides			

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	on the secured Alzheimer's unit, exited the building at the end of A hall and walked in a straight line to a 4-way intersections [sic] at approximately 6:10 pm. The door alarm sounded...A passerby had stopped and was engaging [Resident F] with conversation and called the number on the sign by the intersection to inform staff there might be a resident in the road...Staff signed a 'Door Alarm Response' paper that describes what to do when a door alarm goes off...Staff were taken to the exit doors and were made aware of the sound of the alarm when the bars are being pushed and when the doors open...[Resident F's] Behavior Management plan for exit seeking was updated with interventions that were specific to him...." On 2/10/16 at 10:20 A.M., the Administrator provided the current facility policy, Elopement Prevention, Identification and Management," undated. The policy included: "It is the policy of this facility to ensure that each resident receives adequate supervision and assistive devices to prevent elopements...Elopement occurs when a resident leaves the premises or a safe area without authorization...and/or necessary supervision to do so...Prevention of Elopements...The resident's care plan is to be updated to ensure wandering and			

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	potential for elopement interventions are included...The facility will perform door alarm testing...for alarm function and staff response to the alarms... The "Elopement Prevention and Management Summary" indicated: "...Try to prevent any elopement before it happens. Try to divert any attempt to leave as nicely as possible. Get help if necessary. Go to any exit door alarm immediately and exit that door to try to find out where the resident went...." This Federal tag relates to Complaint IN00192171 and Complaint IN00192350. 3.1-45(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/10/2016
NAME OF PROVIDER OR SUPPLIER WILLOW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE