

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 08/22/2011
NAME OF PROVIDER OR SUPPLIER JEWEL HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 607 VIRGINIA AVE MADISON, IN47250		
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R0000	<p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure survey completed on May 20, 2011.</p> <p>Survey date: August 22, 2011</p> <p>Facility number: 004352 Provider number: 004352 AIM number: N/A</p> <p>Survey team: Diana Sidell RN, TC Penny Marlatt RN Janie Faulkner RN</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Census payor type: Other: 30 Total: 30</p> <p>Sample: 5</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review 8/29/11 by Suzanne Williams, RN</p>	R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>		

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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R0117	<p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review, interview, and observation, the facility failed to ensure staff provided for a resident's safety from potential injury from elopement, in that a severely cognitively impaired resident repeatedly left the facility. This affected 1 of 1 resident in a closed record reviewed for elopement in a sample of 5. (Resident #51)</p> <p>Findings include:</p> <p>Resident #51's closed record was</p>	R0117	<p>Citation #1 R 117 410 IAC 16.2-2-5-1.4 (b)) Personnel What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #51 had their medical status reviewed with the family regarding this residents needs as to a medication adjustment to help minimize the risk for future behaviors. The intervention proved to be successful however the resident no longer resides at our community.</p>	10/01/2011	

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	<p>reviewed on 8/22/11 at 11:50 a.m. The record indicated Resident #51 was admitted with diagnoses that included, but were not limited to, dementia and high blood pressure.</p> <p>A "Folstein Mini Mental Status Examination" dated 5/23/11, indicated Resident #51 had a score of 10, and indicated "A score of 24 is considered normal...10 or less severe deficit...."</p> <p>A document from a physician's office visit dated 5/11/11, prior to admission, indicated: "...HISTORY OF PRESENT ILLNESS: The patient presents to the office stating that she is fine. The patient unfortunately has substantial dementia and is unable to really assist me anymore with the history...She is, however, leaving the house now that the weather is warm because it is 'nice outside' which is apparently what she tells the family. She then is lost and apparently recently had an episode within the last few days where she left on her own and they were unable to find her without some assistance from the police...."</p> <p>Resident Services Notes indicated the following: - 6/9/11 at 9:20 p.m.: "Resident went out side door, was walking fast, got to street before I got her to come back inside with</p>		<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director was re-educated to the company's stance as to the ALC Incident Reporting Guidelines regarding potential adverse situations and consultation with the Regional team as to the appropriate measures in the event of a behavioral disturbance and/or event requiring prompt intervention and resolution. The Residence Director and/or Wellness Director will be responsible to communicate incidents to the Regional team for intervention as indicated per our guidelines regarding Incident Reporting Guidelines for intervention as needed.</p> <p>How will 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? The Wellness Director and/or Designee will perform a random ongoing weekly review of incident</p>		

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	<p>me, took her to room then she came in courtyard and sit for a little bit. Came back inside, went out side door again, put her back in room..." An entry dated 6/10/11 indicated "...Resident remained in staff view throughout incident from previous evening. No N/O (new orders) from MD @ this time."</p> <p>- 7/2/11 at 9:15 (no time): "N.E. (Northeast) door alarm sounded. This CNA immediately went to door & looked out. Did not see resident; came back in and went to resident's room. Res. (Resident) was not in room. Came to front of building. Res. was trying to get in front door. Res. was not injured. She immediately went to her room, laid down on couch & is watching TV...Res. was out of building approx. 3 min."</p> <p>- 7/3/11: "@ 1:53 AM Res. was up wandering opened S.E. (Southeast) Door, Door alarm went off. Res was Redirected Back to room."</p> <p>- 7/3/11 at 11:30 a.m.: "Res. went out south East door. Came back in front door. Res. stated it looked nice outside...."</p> <p>- 7/6/11 (no time): "Res went out the N.E. Door after bringing resident back into facility. She then went out the S. E. door twice. Staff asked Res why she was</p>				<p>reports to ensure continued compliance with reporting requirements as indicated within the Incident Reporting Guidelines to Regional personnel to ensure appropriate interventions are introduced to eliminate potential adverse events.</p> <p>By what date will the systemic changes be completed? Compliance Date: 10/1/11</p>		

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	<p>exiting the building, res replied 'I'm going home.' Staff re-directed Res to her apt (apartment)...."</p> <p>An admission "Assessment and NEGOTIATED SERVICE PLAN SUMMARY" indicated: "Staff will be giving [Resident #51] her medications due to her dementia...has been identified as an elopement risk due to her dementia. She has a history of wandering and will require redirection from staff. [Resident] will wear a wanderguard to decrease her elopement risk. Resident will require frequent safety checks from staff."</p> <p>A "BEHAVIOR STRATEGY PLAN" (no date) indicated: "Behavioral Concern: wandering, exit seeking behavior. Potential Stimulus Triggering Behavior: cognitive impairment, disorientation, separation from familiar people & places, wishes 'to go home.'</p> <p>Potential Strategy To Control Stimuli: Staff instructed to round routinely on resident identified as elopement risk on task sheet, staff instructed to assess for physical needs during episodes (hunger, thirst), resident to be redirected to courtyard when wanting to go outside. Encourage social interaction, assist resident to appropriate activities... (updated 7/3/11) to implement activity plan appropriate to resident needs.</p>				

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	<p>Redirect resident as necessary (enjoys game shows & music, likes sweet tea). Maintain daily schedule and tasks. Resident redirected [with] tasks such as folding clothes, folding napkins."</p> <p>Updated interventions included: - 7/2/11 - "Staff to round on hourly" - 7/3/11 - "(1) 1:1 supervision of resident put in place (2) "busy work" duties to be included in care plan - including folding napkins, assisting [with] setting the table, folding clothes, found to be effective, trial [no] sitter (3) resident to be assisted to daily activities (4) med list faxed to md - [no] new orders (5) order for [name of entity] Psych eval & treatment." 7/6/11 - "(1) 1:1 supervision reinstated (2) [Name of psychological team] to evaluate today (3)...to update activity plan to include 1:1 activity schedule (4) IDT (interdisciplinary team) meeting [with] family, regional nurse, [physicians] in regards to [psych hospital] placement." The resident was discharged to a hospital, and admitted to a comprehensive care long term care facility, in their Alzheimer's locked unit.</p> <p>A policy and procedure for "ELOPEMENT OR MISSING RESIDENT", with an effective date of 4/2008, was provided by the Director of Wellness Services (DWS) on 8/22/11 at</p>				

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	<p>1:35 p.m. The policy included, but was not limited to: "Elopement Definition: When a cognitively impaired resident leaves the physical structure of the residence without staff knowledge and/or supervision. The resident lacks safety awareness and is unable to distinguish/identify his or her safety needs...The practice guidelines below will guide the staff when the resident is missing or has eloped. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing to the Residence Director as soon as possible...Resident Service Plan will be reviewed with regional team members to ensure appropriate interventions are in place to safeguard resident."</p> <p>A "UNIVERSAL INCIDENT/OCCURRENCE REPORT" for elopement, dated 7/2/11 at 9:15 p.m., indicated: "...N.E. Door alarm sounded. This CNA immediately went to door & looked out. Did not see resident. Came back in & went to resident's room. Res. was not in room. Came to front of building. Resident was trying to get in front door. Resident immediately went to her room, laid down on couch & watching TV. Will continue to ck (check) on res throughout night..." The report indicated the resident was not injured and the door</p>				

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	<p>alarms activated.</p> <p>A "UNIVERSAL INCIDENT/OCCURRENCE REPORT" for elopement, dated 7/3/11 at 11:30 a.m., indicated: "...Res. went out SE door & came around to front door came back in the building...." The report indicated the resident was not injured and the door alarms activated.</p> <p>A "UNIVERSAL INCIDENT/OCCURRENCE REPORT" for elopement, dated 7/6/11 at 6:00 a.m., indicated: "...Res exited building. alarm sounded. Staff saw res exit & had eye contact [with] res. [no] injuries observed. Res came back in building [without] incident...." The report indicated the resident was not injured and the door alarms activated.</p> <p>On 8/22/11 at 1:35 p.m., the DWS provided fax documents that the elopements had been reported to ISDH within 24 hours of each occurrence. During an interview at that time, the DWS indicated they had tried a "one on one sitter" with the resident "which is what we typically do" and she became agitated with the person sitting with her, then they tried releasing the sitter to see how she did. She indicated the family refused to allow the resident to be transferred to a</p>				

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	<p>psych hospital initially. The DWS indicated they follow a chain of command for the interventions, the elopement was reported to her, and she reports it to her corporate nurse, and he directs the interventions.</p> <p>On 8/22/11 at 2:05 p.m., the resident's former room was observed with CNA #1. This room was three rooms from the short hall where the South East door is located that Resident #51 exited. This South East door opened onto a paved area adjacent to the parking lot. Upon pushing the door open, the alarm sounded. CNA #1 said there is no way to go out the door without the alarm sounding; it has to be turned off with a key, and when closed, "you have to have a key to get back in the door." CNA #1 indicated she had been in the facility when the resident had gotten out of the door, turned right, and walked around the building to the front door, and she had eye contact at all times with the resident while she walked around the facility. She indicated the resident had a wandguard, but it only works on the front door, not the other two doors she exited, the South East door and the North East door. The North East door was observed with the CNA, and this door also alarmed when pushed open. This door opened onto a short sidewalk that led to the parking lot on the right side. CNA #1 indicated when</p>						

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

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FORM APPROVED

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	the resident exited this door, she turned right, walked around the building and went in the front door. The North East door was six rooms from the resident's room.						