

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155280	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/28/2012
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NAME OF PROVIDER OR SUPPLIER WATERS OF DILLSBORO-ROSS MANOR THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12803 LENOVER ST DILLSBORO, IN 47018
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F0000	<p>This visit was for the Investigation of Complaints IN00118770, IN00119553, and IN00120062.</p> <p>Complaint IN00118770 - Substantiated. Federal/state allegations related to the allegations are cited at F152 and F514.</p> <p>Complaint IN00119553 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00120062 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: November 26 and November 28, 2012</p> <p>Facility number: 000178 Provider number: 155280 AIM number: 100273840</p> <p>Survey team: Jennie S. Bartelt, RN</p> <p>Census bed type: SNF/NF: 91 Total: 91</p> <p>Census payor type: Medicare: 5</p>	F0000	<p>Enclosed please find this is the Plan of Correction for The Waters of Dillsboro-Ross Manor for complaint survey conducted and completed 28 November 2012. We allege compliance as of 14 Decemember 2012 We respectfully request a desk review for this survey. Please review our Plan of Correction and accept this as Proof of Compliance. This Plan of Correction does not constitute an admission or agreement by this facility of the issues alleged or conclusion set forth in this statement of deficiencies. The Plan of Corection and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.</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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	<p>Medicaid: 76 Other: 10 Total: 91</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 12/03/12 by Suzanne Williams, RN</p>			

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F0152 SS=D	<p>483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE</p> <p>In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.</p> <p>In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.</p> <p>Based on record review and interview, the facility failed to ensure the resident's appointed health care representative was consulted timely in regard to clarification of the resident's resuscitation status in the event of cardiac or respiratory arrest for 1 of 6 residents reviewed related to resuscitation status in a sample of 6. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 11/28/12 at 2:00 p.m. The record indicated the resident was admitted from the hospital on 7/11/12.</p> <p>The hospital History and Physical, dated 7/5/12, indicated, "History of Present Illness: "...mentally</p>	F0152	<p>The resident sited in this survey is no longer a resident at this facility. No other residents were found to be affected by sited deficient practice. A 100% audit will be conducted on the medical records of the residents of this facility. All code status will be checked for accuracy and ensure that document contains all required signatures. All new residents will have their code status reviewed by the DON and/or designee upon admission nursing staff will ensure that the code status has been completed and contains proper signatures of resident and/or the residents responsible party determined by documents or desire of the resident. All new admissions medical record will be reviewed at PAR with-in 72 hours of admission to ensure proper documentation. Medical Records and/or designee will review 5 records weekly for 4 weeks and</p>	12/14/2012

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	<p>challenged male....Unable to get a history from the patient secondary to his MR [mental retardation]."</p> <p>The Continuity of Care for Receiving Facility: Physician Instructions, signed 7/11/12, by the resident's attending physician at the hospital, who was also the resident's attending physician at the facility, indicated, "Code Status: Full Code."</p> <p>The Admission Orders & Plan of Care, dated 7/11/12, indicated, "Code Status: Full Code."</p> <p>The Resident Information Face Sheet indicated in the "Contacts" section, "Responsible Party Name [Name of Person #1]...Relationship: Responsible Pty [party]" and "Alternate: [Name of Person #2]...Relationship: Aunt/Health Care Rep [Representative]."</p> <p>A notarized "Appointment of Healthcare Representative" document, signed by Person #2 on 1/12/03, indicated Person #2 was Resident C's Healthcare Representative. A letter, dated 7/26/07, and signed by Person #2, indicated, "To Whom It May Concern: I am writing to make my wishes known concerning [name of Resident</p>		then 5 records monthly for 4 months to ensure required documents are reviewed and accurate. Records will be reviewed on an ongoing basis at the weekly PAR meetings. The QA team will monitor monthly for 3 months then quarterly ongoing.		

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	<p>C]. If [name of Resident C's] health should deteriorate further & a decision must be made, I do not want him to be put on artificial life support, including a feeding tube....If at all possible, I don't want him to be given CPR [cardiopulmonary resuscitation] because his bones are so fragile...."</p> <p>A Code Status Consent Form, dated 7/11/12, was signed by Person #1 in the line for Resident/Responsible Party Signature and indicated, "Do Not Resuscitate (DNR)/No Code/No CPR." The document was blank on the lines for Facility Representative Signature and Witness Signature.</p> <p>A State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order was completely blank and without signatures except in the section for Out of Hospital Do Not Resuscitate Order. The Out of Hospital Do Not Resuscitate section indicated, "I [name of attending physician], the attending physician of [name of Resident C], have certified the declarant as a qualified person to make an Out of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue</p>				

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	<p>cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out of Hospital Do Not Resuscitate Declaration is revoked. The document was signed by the attending physician on 7/11/12.</p> <p>A Social Services Progress Note with Assessment Reference Date of 7/16/12, indicated, "Res [resident] is able to express wants & needs, however res shows poor decision making...." The note indicated the resident's discharge plan was to return to his group home. In the section for "Advance Directives & Code Status" was indicated, " DNR, [symbol for no] living will, [name of Person #2] is healthcare rep [representative]."</p> <p>Nurse's Notes on 7/15/12 at 8:10 a.m. indicated the resident was discharged to a behavior unit. Nurse's Notes on 7/19/12 at 6:40 p.m., indicated the resident was readmitted to the facility.</p> <p>The Admission Orders and Plan of Care, dated 7/19/12, indicated, "Code Status: Full code." Handwritten above the check mark for "Full code" was "Error DNR 7-20-12." No verbiage was crossed out.</p> <p>A physician's order, dated 7/20/12,</p>			

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	<p>indicated, "Clarification Code Status DNR."</p> <p>During interview on 11/28/12 at 4:30 p.m., the Social Worker indicated, "[Name of company operating Resident C's group home] tend to have their people as full codes."</p> <p>During interview on 11/28/12 at 5:15 p.m., the Director of Nursing #1 indicated she spoke with [name of Person #2] about Resident C's code status and obtained the clarification order on 7/20/12.</p> <p>This federal tag is related to Complaint IN00118770.</p> <p>3.1-3(d)</p>			

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F0323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure a resident at risk for elopement was supervised to prevent elopement. The deficient practice affected 1 of 3 residents reviewed related to wandering and potential for elopement in a sample of 3. (Resident B) Resident B sustained a fracture to the right ankle and suspected fracture to the right ribs when he eloped through a window on the secured unit.</p> <p>Findings include:</p> <p>During Initial Tour on 11/26/12 at 10:45 a.m., Resident B was observed seated in a recliner in the lobby area of the secured Reflections unit. The resident's eyes were closed and respirations even. The resident's legs were elevated, and a cast was on the resident's right leg. During interview at this time, Director of Nursing (DON) #1 indicated the resident had broken his ankle when he left the building through a window in an unoccupied</p>	F0323	Resident has returned to the facility and has an elopement care plan in place. Resident continues to be on 15 minute checks due to his medical condition and resident trying to stand on cast. The Resident has made no other attempts to leave the building. The facility psychiatrist interviewed resident and no emotional distress was noted. The occurrence was reviewed with family of resident and no concerns were noted. No other residents were found to be affected. All windows in the facility were adjusted so that opening of windows will not open wide enough for a person to fit through. All residents that wonder will be reviewed for the need of an elopement care plan. In-service was started with all staff in regards to the occurrence. The facility will continue to monitor resident as part of the behavior monitoring program and any concerns will be immediately addressed. All residents that require an elopement care plan will be reviewed weekly x4 then monthly x4 by DON and/or Designee along with Social	12/14/2012			

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	<p>resident room on the secured unit. DON #1 did not indicate the date the resident exited the facility. DON #1 indicated before admission, the resident lived at home and walked 15 to 16 miles per day, and the police would bring him home. DON #1 indicated the resident begged to go home every time his wife came to visit. DON #1 indicated the resident was "seen in the lobby [of the Reflections unit] at 6:45 p.m.," and when the nurse went to the resident's room at 7:00 p.m. to administer routine medications, the resident was not in his room. DON #1 showed the room and window Resident B exited through. She indicated all windows in the facility are "now screwed shut." The window was observed to be above ground level and led into an enclosed courtyard with a high wooden fence. The gate leading out of the courtyard was observed to have two boards nailed across the opening. DON #1 indicated the gate was nailed shut after Resident B's elopement. DON #1 indicated Resident B was found "down the street" and had walked "about a half a mile" when found. During Initial Tour, DON #1 indicated the facility did not use a Wander Guard system.</p> <p>On 11/26/12 at 12:40 p.m., the</p>		<p>Service to assure that the interventions put in place are appropriate. All wondering residents will be evaluated for the need of an elopement care plan. All elopement at risk residents will be reviewed on an ongoing basis at the weekly PAR meetings. The elopement process will be reviewed by the QA team monthly for 3 months then ongoing at the quarterly QA meetings.</p>		

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	<p>Administrator provided a file pertaining to Resident B's elopement. During interview at this time, the Administrator indicated the resident eloped from the building on Veteran's Day. She indicated staff called her at home, and she came to the facility and accompanied the resident to the hospital. She indicated she thought the resident might have gone to the American Legion and was concerned because it was getting dark and cold that evening. She indicated the resident was sitting in a chair down the street. She pointed to a plastic baggie containing coins on her desk and indicated the resident had the money in his pocket and his coat on when he was found.</p> <p>The elopement file included a copy of the "Initial with Follow-up" report to the Indiana State Department of Health. The report indicated, "Brief Description of Incident: Resident was admitted to facility on 10/26/12 to the facility [sic] from home due to the inability of wife to care for him in the home setting. Resident has a diagnosis of dementia. He has impaired decision making ability but is alert to person, place and time. Resident ambulates on his own and does walk up and down the hallway. Resident was placed on 15 minute</p>			

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	<p>behavior monitoring due [to] identifying the keypad code to the door on 11/9/12. The code to the key pad was changed at that time.....Resident was found down the street at 7:20 p.m. When asked what he was doing, the resident stated, "I was going for a walk but my ankle hurts. I think I twisted it when I went out the window." Resident returned to facility and complete assessment of resident was completed. Resident stated his ankle was sore and was sent to ER [emergency room] for evaluation...."</p> <p>The elopement file included a copy of a Missing Person Report Form indicating the resident was last seen in his room [sic] on 11/11/12 at 6:45 p.m. The form indicated, "...History of previous elopements and intervention plan: none [a large question mark was handwritten next to the entry]; Suspected mode of leaving facility: Out window...Potential outside safety concerns for resident (traffic, lakes): lake, traffic...." Post Elopement Information on the form indicated the resident was noted missing by the nurse on the resident's unit at 7:00 p.m. and was found by the local police at 8:00 p.m.</p> <p>The elopement file also included a</p>			

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	<p>copy of an ambulance run report, dated 11/11/12, indicating the following: The call for the ambulance was received at 7:57 p.m., and police were on the scene. The "Narrative" indicated, "Responded emergent to an elderly male dementia pt [patient] that was found near machine shop that had wandered away from nursing home. Pt. was at the garage belonging to the [name] on a dead end street. Pt c/o [complained of] pain in R [right] ankle. Tenderness noted upon palpation....Pt. stated he was on his way to [name of nearby town]....Pt stated, 'I climbed out the window, my wife is expecting me to call her @ 8 p.m.' Pt. was last seen @ nursing home at 6:45 p.m. Blankets placed on pt due to pt shivering....Transported pt to [name of local hospital]...."</p> <p>The elopement file also included a copy of a Visit Summary Report for the local hospital Emergency Room. Nurses Notes on 11/11/12 at 8:45 p.m., indicated, "...Pt reported to be a resident of Waters of Dillsboro. It is reported that pt frequently tries to escape. Pt reports jumping out of the window '8 to 10 feet'...."</p> <p>The elopement file also included copies of "Resident Location</p>			

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	<p>Monitoring" logs indicating the resident was monitored by staff every 15 minutes from 10/25/12 at 2:00 p.m. through 11/12/12 at 11:00 p.m. "OOF" (out of facility) was indicated from 7:00 p.m. until 11:00 p.m. on 11/11/12.</p> <p>The clinical record for Resident B was reviewed on 11/26/12 at 12:05 p.m. The Admission-Face Sheet Information indicated the resident was admitted from a local hospital on 10/25/12.</p> <p>The hospital History and Physical for the admission on 10/17/12 indicated, "Past Psychiatric History: ...He also has a hospitalization in July of 2012. At that time, the patient was wandering from his house...."</p> <p>An assessment by Social Services, dated 10/25/12, indicated "Yes" to the following questions: Resident is ambulatory or self-mobile in wheelchair; Resident is cognitively impaired, with poor decision-making skills, and/or pertinent diagnosis; Resident has a history of wandering; Lingering around exit doors, attempting to exit with visitors without authorization; Utilize wander detection system and careplan for risk of elopement, contact DON [Director of</p>			

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	<p>Nursing] and/or Obtain physician's order and place on secured unit if available and careplan for risk of elopement.</p> <p>The resident's care plan, dated 10/25/12, indicated, "Problem/Need/Concern: Dementia [with] secondary agitation wandering." The Goal indicated, "Will be easily redirected without frustration TNR [through next review]." No care plan related to elopement was indicated until 11/11/12. A care plan, dated 11/11/12 indicated, "Problem/Need/Concern: Elopement." The Goal indicated, "Will remain on secured unit to maintain safe environment TNR."</p> <p>During interview on 11/28/12 at 4:30 p.m., the Social Services Director (SSD) indicated a care plan related to potential for elopement had not been developed until the resident eloped. When interviewed in regard to care when the resident expressed the need to go outside the secured unit, the SSD showed on the care plan for "Dementia with secondary agitation and wandering" that she had added on 11/8/12 that the therapists would take the resident outside for therapy sessions.</p>			

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	<p>Nurse's Notes included, but were not limited to, the following on the dates and times indicated:</p> <p>10/25/12 at 9:42 p.m., "...ambulating self about unit [with] steady gait noted, stopping staff periodically asking 'Can you please help me get out'...."</p> <p>10/26/12 at 12:02 a.m., "...Res conts [continues] to ambulate about unit staying primarily in dining room to listen to the radio....Sat on porch [with] writer for about five minutes & stated, 'I need to get back in now. I can't hear the radio out here....[no] attempts to leave unit/facility so far this shift."</p> <p>10/26/12 at 8:40 p.m., "Wandering all shift....Repeatedly asking for everyone to give him code & let him out. Threatened to leave 'even if I have to break a window & climb out.' Touching staff & visitors to stop them & ask them to 'let me out of here.' Redirected repeatedly."</p> <p>10/27/12 at 11:00 a.m., "...wanders from hall to hall...."</p> <p>10/27/12 at 10:10 p.m., "...wandering during evening hours...."</p>			

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	<p>10/28/12 at 9:30 a.m., "Res wanders in & out of room and [up and down] both halls asking staff to help him get outside he wants to walk. Staff reminds res it's getting colder out...."</p> <p>10/28/12 at 10:00 p.m., "State 'enjoys walking.' Wandering during eve [evening] hrs. [hours]...."</p> <p>10/29/12 at 1:26 p.m., "Wandering around unit [with] jacket on requesting that staff & visitors let him outside. Unable to redirect."</p> <p>10/29/12 at 4:30 p.m., "...Wandering per usual...."</p> <p>10/29/12 at 3:00 a.m., "...Resd [resident] wandered most evening...."</p> <p>10/30/12 at 10:00 a.m., "...Has been up & about wandering in the hall...."</p> <p>10/30/12 at 8:00 p.m., "...resident continues to exit seek...."</p> <p>10/31/12 at 11:30 a.m., "...wandering [up and down] halls [with] no goal."</p> <p>10/31/12 at 12:30 p.m., "...Now wandering around unit...."</p> <p>10/31/12 at 6:00 p.m., "...ambulates about unit....Resident continues to</p>			

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	<p>wander unit...."</p> <p>10/31/12 at 6:30 p.m., "Resident [with] [increased] wandering & attempting to open doors. At this point resident became very agitated grabbing door handles & pounding on glass repeatedly over and over."</p> <p>A physician's order, dated 10/31/12 indicated, "Xanax [antianxiety medication] 1 mg po [by mouth] q [every] 6 [symbol for hours] prn [as needed] agitation."</p> <p>The Medication Administration Record (MAR) for October 2012 indicated one dose was administered on 10/31/12 at 7:30 p.m.</p> <p>11/1/12 at 8:30 p.m., "...Wandering most of shift....Repeatedly asking staff & family member to let him out of facility. Continually going to outside door to see if it will open...."</p> <p>11/1/12 at 11:15 p.m., "Res was wandering in dining room...."</p> <p>11/1/12 at 12:30 p.m. [sic], "Res [up] & pacing hallways & asking to get out to several staff members...."</p> <p>11/2/12 at 7:00 p.m., "Will cont. [continue] to monitor resident for exit</p>			

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	<p>seeking behavior."</p> <p>11/3/12 at 8:58 a.m., "...has attempted to get out several X's [times] unable to redirect several X's. Finally redirected with snack."</p> <p>A physician's order, dated 11/3/12 indicated, "Xanax [antianxiety medication] 0.5 mg po X 1 dose."</p> <p>The MAR for November 2012 indicated the Xanax 0.5 mg was administered at 4:00 p.m. on 11/3/12.</p> <p>11/3/12 at 5:50 p.m., "Res [up] wandering...wanting to walk outside & leave to go home attempted to get out several X's. Also ask writer & other staff to give him code...."</p> <p>11/4/12 at 2:00 p.m., "Res [up] wandering wanting to get out...."</p> <p>11/5/12 at 4:00 p.m., "Resident [with] [increased] wandering [with] several attempts to get out doors. Slapped staff during an attempt to go out door. This nurse took resident to vending machine for snack, which he received & returned to unit [without] further incident...."</p> <p>11/5/12 at 7:30 p.m., "Resident again @ doors pounding on windows &</p>			

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	<p>wanting off unit...."</p> <p>The MAR for November 2012 indicated Xanax 1 mg was administered on 11/5/12 at 8:00 p.m.</p> <p>11/6/12 at 11:00 a.m., "...asks staff to let him out so he can walk..."</p> <p>11/7/12 at 8:30 a.m., "Res [up] & states 'I need to find a way out of here. It's making me nervous'...."</p> <p>The Medication Administration Record (MAR) for November 2012 also indicated the Xanax 1 mg was administered on 11/7/12 at 8:30 a.m., and at 9:30 a.m., the reverse side of the MAR indicated, "Eff [effective]. Calmer."</p> <p>A physician's order for 11/8/12 indicated, "Xanax 1 mg po BID [twice daily]."</p> <p>11/9/12 at 12:45 p.m., "...attends therapy. After that resident wanted to leave unit [with] therapy staff...."</p> <p>11/10/12 at 5:30 p.m., "...[up] per usual ambulating per self...."</p> <p>11/11/12 at 2:00 a.m., "...Ambulates when [up] during evenings [without] problems...."</p>						

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	<p>11/11/12 at 6:45 p.m., "Res in room [sic] sitting on bed...."</p> <p>11/11/12 at 7:00 p.m., "Went to resident's room to give him his routine meds [medications]. Res not in room. Staff on floor alerted & all areas checked for resident. Not found."</p> <p>11/11/12 at 7:05 p.m. All other units notified of resident not on unit window was found [with] screen out & open in room [number of unoccupied resident room]...."</p> <p>11/11/12 at 11:25 p.m., "Res returned per EMS [Emergency Medical Service] to DM [Dillsboro Manor] Res [with] Fx [fracture] R ankle, ribs R...."</p> <p>11/13/12 at 9:45 a.m., "When resident was taken back to his room after breakfast he looked at the window & said I shouldn't jumped out that window & was rubbing his R side."</p> <p>A report of x-ray results for the right ankle, dated 11/11/12, indicated, "Findings...three view imaging of the right ankle demonstrates an acute, complete, oblique fracture through the distal shaft of the right fibula...."</p>			

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	<p>Preprinted hospital discharge instructions, dated 11/11/12, indicated, "Ankle Fracture" and "Rib Fracture." Handwritten next to "Rib Fracture" was "Suspect, non-displaced rib fracture."</p> <p>During interview on 11/26/12 at 2:25 p.m., RN #6 indicated Resident B now seems frustrated, because he is non-weight bearing on his ankle and wants to walk.</p> <p>On 11/28/12 at 11:15 a.m., the window the resident eloped through was observed from the double doors leading from the unit into the fenced courtyard. A long sloped ramp led from the doors down to the ground level. Visible beneath the window used for the elopement was a concrete foundation wall approximately 6 to 8 feet high.</p> <p>At the Exit Conference on 11/28/12 at 5:30 p.m., the Administrator indicated she was sure the resident's care plan for therapy included taking the resident outside for walks, because the therapists had asked her if that was okay to do. She indicated she would forward therapy notes indicating out of doors activities for the resident.</p>			

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	<p>On 11/29/12 at 11:47 a.m., copies of physical therapy (PT) notes for Resident B were received by e-mail. The PT Daily Therapy Notes indicated the resident received services outside the secured unit, including exercise outside the facility on some dates: 11/1, 11/6, 11/7, 11/8, and 11/9/12. "Additional Assessment Comments" on the 11/1/12 PT Daily Therapy Note indicated, "Pt [patient] is not really interested in participating in exercises unless it has to do with walking around and trying to figure out a way to leave the facility."</p> <p>This federal tag is related to Complaint IN00119553.</p> <p>3.1-45(a)(2)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure the resuscitation status of a resident was accurately documented in the clinical record for 1 of 6 residents reviewed related to resuscitation status in a sample of 6 residents. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 11/28/12 at 12:50 p.m. The record indicated the resident was admitted from the hospital on 8/30/12 for care following surgical repair of a hip fracture.</p> <p>The Physician's Orders upon admission, dated 8/30/12, with an undated signature by the physician,</p>	F0514	<p>The resident sited in this survey is no longer a resident at this facility. No other residents were found to be affected by sited deficient practice. A 100% audit will be conducted on the medical records of the residents of this facility. All code status will be checked for accuracy and ensured that document contains all required signatures. All new resident will have their code status reviewed by the DON and/or designee upon admission nursing staff will ensure that the code statues has been completed and contains proper signitures of resident and/or the residents responsible party determined by documents or desire of the resident. All new admissions medical record will be reviewed at PAR with-in 72 hours of admission to ensure proper documentation. Medical Records</p>	12/14/2012	

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	<p>included, but were not limited to, "DO NOT RESUSCITATE."</p> <p>The Physician's Orders for the month of October 1 through October 31, 2012, signed by the nurse on 9/27/12 and unsigned by the physician, included, but were not limited to, "Do Not Resuscitate."</p> <p>The Social History & Psychosocial Assessment, dated 9/5/12, indicated, "Code Status: Full code." The Assessment also indicated Person #3 was Resident D's Health Care Representative.</p> <p>A copy of a Consent to Obtain Medical Treatment form, with the heading of Resident D's group home, was signed by Person #3 on 8/25/12 with the following handwritten notation, "Any medical treatments needed and can't get ahold of [name of Person #3] contact [Person #4] or...."</p> <p>The Code Status Consent Form, signed and dated by Person #4 on 8/30/12, indicated with a check mark: "Full Code: Cardio-pulmonary resuscitative measure will be instituted in the event of cardiac arrest and/or respiratory arrest. CPR will be utilized."</p>		and/or designee will review 5 records weekly for 4 weeks and then 5 records monthly for 4 months to ensure required documents are reviewed and accurate. Records will reviewed on an ongoing basis at the weekly PAR meetings. The QA team will monitor monthly for 3 months then quarterly ongoing.				

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	<p>The Resident Transfer, dated 10/4/12, indicated the resident was transferred to the local hospital Emergency Room. The "Resuscitation Status" indicated with a check mark, "Full Resuscitation."</p> <p>During interview on 11/28/12 at 4:30 p.m., the Social Worker indicated, "[Name of company operating Resident C's group home] tend to have their people as full codes."</p> <p>During interview at this same time, Director of Nursing #1 indicated the "Do Not Resuscitate" on the resident's orders was not accurate. She indicated she thought the information was transcribed from hospital paperwork. She indicated the resident should have been identified as a "Full Code."</p> <p>This federal tag is related to Complaint IN00118770.</p> <p>3.1-50(a)(2)</p>				