

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/01/2012
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NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222
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F0000	<p>This visit was for the Investigation of Complaints IN00102637, IN00102643, and IN00102811.</p> <p>Complaint IN00102637 - Substantiated. Federal/state deficiencies related to the allegations are cited at F279, F315, and F323.</p> <p>Complaint IN00102643 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00102811 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: January 30, 31, February 1, 2012</p> <p>Facility number: 000376 Provider number: 155717 AIM number: 100275510</p> <p>Survey team: Charles Stevenson, RN</p> <p>Census bed type: SNF/NF: 57 Total: 57</p> <p>Census payor type: Medicare: 7 Medicaid: 42</p>	F0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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	<p>Other: 8 Total: 57</p> <p>Sample: 11</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/7/12 by Jennie Bartelt, RN.</p>			
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F0279 SS=D	<p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a resident had a health care plan to communicate the plan for use of leg bag for safety with the resident's indwelling Foley catheter (Resident B) for 1 of 6 residents reviewed for health care plans in a sample of 11.</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 1/30/12 at 1:00 p.m.</p> <p>Diagnoses included, but were not limited to, progressive dementia, hypertension, depression with psychosis, and renal failure.</p>	F0279	<p>F 279– Develop Comprehensive Care PlansIt is the policy of the Alpha Home to utilize the results of the assessments to develop and revise the resident’s comprehensive care plan. The care plan will include measureable objective with a timetable to meet a resident’s medical nursing, and mental, and psychosocial assessment. The facility care plan with the service provided will be used to attain or maintain the highest practical physical mental and psychosocial wellbeing. <u>Corrective Action Taken Related to this Finding:</u> Resident B, new</p>	03/02/2012	

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	<p>Nurse's notes indicated:</p> <p>1/13/12 2:05 p.m., "Res (resident) sent out to...hosp (hospital)...."</p> <p>1/16/12 4:30 p.m., "Resident returned to facility...Foley cath (indwelling urinary catheter) anchored...."</p> <p>1/18/12 3:10 p.m., "...M.D. notified by writer requesting urinary leg bag...."</p> <p>1/20/12 (no time), "Order given for...leg bag for catheter...."</p> <p>1/28/12 9:00 a.m., "Resident pulled out his Foley catheter with bulb inflated. Has moderate amount of bleeding. Direct pressure held...Emergency 911 notified."</p> <p>1/28/12 2:00 p.m., "Resident returned from hospital...Foley catheter intact...orders received to leave leg bag on to prevent resident from pulling catheter out...."</p> <p>1/28/12 8:30 p.m., "...catheter...in place draining bloody red drainage...."</p> <p>A physician's order, dated 1/20/12, indicated, "May have leg bag for catheter."</p>		<p>assessment has been completed; along with the care plan modified to include addressing the specific catheter bag, according to the physician order and this resident's need. The new Alpha Home assessments and reassessment form is completed upon return from hospital, In-serviced with staff completed on 2/23/2011. The MDS coordinator is utilizing the assessments, the nurses notes, the physician orders, the direct care staff assignment sheets, behavior logs, and significant changes to attain and maintain Resident B highest practicable physical mental and psychosocial well-being. Care Plans modification and communication addressed with the interdisciplinary team with recommendation to the, nurses and direct care staff daily, <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> All other residents having the potential to be affected by the finding had their care plans review with the internal audit. 100 percent of the care plans audits have been completed. The weekly monitoring will continue with the unit manager and the director of nurses. The unit charge nurse will comply by adding any new orders, significant changes, or other pertinent information to the twenty hour report, for communication and inclusion in the care plan. <u>III. Measures and</u></p>				

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	<p>No health care plan related to use or care of an indwelling urinary catheter was found in the clinical record.</p> <p>During an interview on 1/31/12 at 9:55 a.m., L.P.N. #2 indicated she was the nurse who "regularly" took care of Resident B. She indicated she had called the physician to get an order for a catheter leg bag for Resident B due to safety concerns, due to the resident's dementia. She indicated she believed Resident B was at risk for pulling out his catheter, either by pulling it out himself, or ambulating with the standard gravity catheter bag attached to the bed or his wheelchair. She indicated she discussed this with the resident's family and all agreed the leg bag was an appropriate intervention to prevent this from happening. When she learned Resident B had pulled out his catheter on 12/28/12, she indicated, "That's terrible. I told them that would happen."</p> <p>During an interview on 1/31/12 at 9:20 a.m., R.N. #1 indicated she was the nurse called to Resident B's room when he was found with his catheter out. She indicated he had a regular gravity catheter bag hanging from his bed. The leg bag was not in use. She indicated, "He had a lot of bleeding." In a subsequent interview on 1/31/12 at 9:55 a.m. with the D.O.N.</p>		<p><u>Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> All the residents care plan audits have been completed. Care Plans will additionally address new physician orders, significant, changes, updated progress noted from service provides and contributing information that address the resident care. The unit manager will continue to monitor the twenty four reports with the audit sheets for communication and compliance with review with the Director of nurse. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff. <u>IV. Corrective Actions will be monitored to Ensure Compliance by:</u> The Alpha Home corrective action plan to ensure compliance shall be accomplished by. The interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its</p>				

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	<p>(Director of Nursing) present, R.N. #1 indicated Resident B had the gravity urinary bag in place at the start of her shift and she was unaware Resident B had an order to use the leg bag exclusively.</p> <p>During an interview with the D.O.N on 2/01/12 at 3:00 p.m., she indicated she had no further information or documentation to provide concerning Resident B, and she indicated there was no health care plan for an indwelling catheter for Resident B.</p> <p>This federal tag relates to Complaint IN00102637.</p> <p>3.1-35(a)</p>		<p>scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion 03/02/2012</p>		

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F0315 SS=G	<p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to ensure a resident with an indwelling catheter (Resident B) was not injured by dislodgement of the catheter. The facility failed to follow a physician's order or plan care to prevent the accidental removal of the catheter. The accidental removal of the catheter resulted in bleeding and required transfer to an emergency room for treatment. This deficient practice affected 1 of 3 residents reviewed for catheter care in a sample of 11.</p> <p>Findings include:</p> <p>1. The record of Resident B was reviewed on 1/30/12 at 1:00 p.m.</p> <p>Diagnoses included, but were not limited to, progressive dementia, hypertension, depression with psychosis, and renal failure.</p> <p>Nurse's notes indicated:</p>	F0315	<p>F 315– No Catheter, Prevent UTI, Restore Bladder It is the policy of the Alpha Home to complete the resident assessment with assurance of residents not receiving an indwelling catheter unless the resident's condition demonstrates that catheterization was necessary. <u>Corrective Action Taken Related to this Finding:</u> Resident B, new assessment has been completed; along with the care plan modified to include addressing the specific catheter bag, according to the physician order and this resident's need. The facility medical director reviewed the order for resident B catheter bag and determined staff followed the order correctly, using the catheter bag. Resident B has relocated from the Alpha Home. Upon return from the hospital all residents receive reassessments, with confirmation for updated physician orders, and significant changes that are noted on the residents individualized care plan. The facility interdisciplinary team</p>	03/02/2012			

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	<p>1/13/12 2:05 p.m., "Res (resident) sent out to...hosp (hospital)...."</p> <p>1/16/12 4:30 p.m., "Resident returned to facility...Foley cath (indwelling urinary catheter) anchored...."</p> <p>1/18/12 3:10 p.m., "...M.D. notified by writer requesting urinary leg bag...."</p> <p>1/20/12 (no time), "Order given for...leg bag for catheter...."</p> <p>1/28/12 9:00 a.m., "Resident pulled out his Foley catheter with bulb inflated. Has moderate amount of bleeding. Direct pressure held...Emergency 911 notified."</p> <p>1/28/12 2:00 p.m., "Resident returned from hospital...Foley catheter intact...orders received to leave leg bag on to prevent resident from pulling catheter out...."</p> <p>1/28/12 8:30 p.m., "...catheter...in place draining bloody red drainage...."</p> <p>A physician's order, dated 1/20/12, indicated, "May have leg bag for catheter."</p> <p>No health care plan related to use or care of an indwelling urinary catheter was</p>		<p>reviews the incidents and accident reports, and provides an intervention for prevention with these incidents. The intervention is communicated and presented to the nurse and direct care givers in a daily communication meeting at the nurse's station. The MDS coordinator collects all the information for documentation into the residents individualizes care plans. <u>II. Other Residents with Potential to be affected by this finding will be identified by:</u> All other residents having the potential to be affected by the finding had their care plans review with the internal audit. 100 percent of the care plans audits have been completed. The weekly monitoring will continue with the unit manager and the director of nurses. The unit charge nurse will comply by adding any new orders, significant changes, or other pertinent information to the twenty hour report, for communication and inclusion in the care plan. <u>III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows:</u> All the residents care plan audits have been completed. Care Plans will additionally address new physician orders, significant changes, updated progress noted from service provides and contributing information that address the resident care. The</p>				

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	<p>found in the clinical record.</p> <p>During an interview on 1/31/12 at 9:55 a.m., L.P.N. #2 indicated she was the nurse who "regularly" took care of Resident B. She indicated she had called the physician to get an order for a catheter leg bag for Resident B due to safety concerns, due to the resident's dementia. She indicated she believed Resident B was at risk for pulling out his catheter, either by pulling it out himself, or ambulating with the standard gravity catheter bag attached to the bed or his wheelchair. She indicated she discussed this with the resident's family and all agreed the leg bag was an appropriate intervention to prevent this from happening. When she learned Resident B had pulled out his catheter on 12/28/12, she indicated, "That's terrible. I told them that would happen."</p> <p>During an interview on 1/31/12 at 9:20 a.m., R.N. #1 indicated she was the nurse called to Resident B's room when he was found with his catheter out. She indicated he had a regular gravity catheter bag hanging from his bed. The leg bag was not in use. She indicated "He had a lot of bleeding." In a subsequent interview on 1/31/12 at 9:55 a.m. with the D.O.N. (Director of Nursing) present, R.N. #1 indicated Resident B had the gravity</p>		<p>unit manager will continue to monitor the twenty four reports with the audit sheets for communication and compliance with review with the Director of nurse. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff. <u>IV. Corrective Actions will be monitored to Ensure Compliance by:</u> The Alpha Home corrective action plan to ensure compliance shall be accomplished by. The interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. <u>V. Corrected Action Completion Date 03/02/11</u></p>		

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	<p>urinary bag in place at the start of her shift and she was unaware Resident B had an order to use the leg bag exclusively.</p> <p>During an interview with the D.O.N on 2/01/12 at 3:00 p.m., she indicated she had no further information or documentation to provide concerning Resident B.</p> <p>This federal tag relates to Complaint IN00102637.</p> <p>3.1-41(a)(2)</p>			
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F0323 SS=E	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents at risk for elopement were provided appropriate interventions to prevent elopement and potential injury. The facility failed to ensure residents assessed to need Wanderguard security devices had them in place at all times for 2 residents (Residents B and J) and failed to ensure residents at risk for elopement were assessed for elopement risk for 6 residents (Residents B, H, J, K, L, M). This deficient practice affected 6 of 6 residents reviewed for elopement risk in a sample of 11.</p> <p>Findings include:</p> <p>The facility's "Transmitter Test Log" book was reviewed on 1/31/12 at 2:45 p.m. At that time the Nursing Unit Manager indicated all residents with Wanderguard devices were included in this book. The log book was reviewed again on 2/01/12 at 11:15 a.m.</p> <p>1. The record of Resident B was reviewed on 1/30/12 at 1:00 p.m.</p> <p>Diagnoses included, but were not limited</p>	F0323	<p>Addendum F - 323 Facility # 00376 Provider # 155717 Survey Event Id Py1911 Survey Date February 1, 2012 F- 323 Please indicate how you will ensure all residents assigned wander guards are wearing them on at all times? First, all the residents' assessments have been completed to validate residents in need of wander guard. Each direct care staff person at the beginning of each shift checks the residents for wander guard bracelets. The direct care staff document on the audit sheet and notified the charge nurse of the residents wander guard. The Charge nurses are responsible for the wander guard being supplied, with reporting to the Director of Nurses of any noncompliance and corrective action. Charge nurses will therefore be responsible for ensuring the wander guard bracelet is on the resident. The wander guards will be tested each shift by a staff person using the transmitter and the door alarms. The Unit Manager reviews the audit sheets every 24 hours with any noncompliance corrected with the director of nurses. F 323</p>	03/02/2012			

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	<p>to, progressive dementia, hypertension, depression with psychosis, and renal failure.</p> <p>Resident B was listed on the facility's "Transmitter Test Log" sheets, indicating that the resident required a Wanderguard safety device to prevent elopement, for each day in January 2012.</p> <p>A Care Plan for Resident B dated 10/10/11 indicated, "Problem: Resident is at risk for elopement...Resident wanders daily. Approach: Staff to provide for his safety by using Wanderguard which alerts for high risk of AWOL [absent without leave]...."</p> <p>A Care Plan for Resident B dated 10/26/11 indicated, "Problem: Out the door yesterday 10/25/11. Approach: Wanderguard on (symbol for "and") (check mark) to be working".</p> <p>During an observation with the Nurse Unit Manager on 2/01/12 at 9:35 a.m. Resident B was seen in his room. He was sitting in his wheelchair. No Wanderguard was observed anywhere on his person. The Nurse Unit Manager felt his legs, including his sock area, and found no Wanderguard. She then went to the nurse's station, found a Wanderguard device, and put it on Resident B's left</p>		<p>Free of Accidents Hazards Supervision Devices- It is the policy of the Alpha Home to 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. <u>Corrective Action Taken Related to this Finding:</u> Specific risk assessments have been completed on resident B, H, J, K, L and Resident M. Resident B has relocated to a new facility. All residents who have been care planned with specific goals relating to risk, have updated risk assessment in their chart that corresponds to their individualized care plan. Any resident assigned a wander guard bracelet is checked with the transmitter daily. Residents upon returning from the hospital shall all receive reassessments, as it relates to goals and approaches on their care plans. The facility interdisciplinary team reviews the incidents and accident reports, elopement risks, and transmitter log sheets. There is a daily monitoring of the doors with the wander guard protection alarms. The audits once shared with the interdisciplinary team are communicated to the nurse and direct care givers in a daily communication meeting at the nurse's station. <u>II. Other Residents with Potential to be affected by this finding will be</u></p>				

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	<p>ankle.</p> <p>Resident B's record contained no assessment for elopement risk.</p> <p>During interview on 2/01/12 at 3:00 the Director of Nursing indicated she had no additional information or documentation for Resident B.</p> <p>2. The record of Resident H was reviewed on 1/31/12 at 3:30 p.m.</p> <p>Diagnoses included, but were not limited to, dementia, blindness, hypertension, anemia, and diabetes mellitus.</p> <p>Resident H was listed on the facility's "Transmitter Test Log" sheets, indicating that the resident required a Wanderguard safety device to prevent elopement, for each day in January 2012.</p> <p>A Care plan for Resident H dated 6/22/11 indicated, "Problem: Resident elopement out of back door in sight of staff. Res (resident) ambulates et (and) pushes w/c (wheel chair) and needs redirected. Approach: Wander Guard to W/C..."</p> <p>On 2/01/12 at 1:30 p.m. the D.O.N. provided an "Elopement Risk Assessment" form for Resident H dated 6/22/11. She indicated the form was</p>		<p>identified by: All other residents having the potential to be affected by the finding had their assessment reviewed and updated including the care plan. The weekly monitoring will continue with the unit manager and the director of nurses. The unit charge nurse will comply by adding any new orders, significant changes, or other pertinent information to the twenty hour report, for communication and inclusion in the care plan. <u>III.</u></p> <p>Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All the residents care plan audits have been completed. Care Plans will additionally address new physician orders, significant, changes updated progress noted from service provides and contributing information that address the resident care. The unit manager will continue to monitor the twenty four reports with the audit sheets for communication and compliance with review with the Director of nurses. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff. <u>IV.</u></p> <p>Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to</p>				

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	<p>incomplete, was not scored properly, and had no total score. She also indicated no assessment had been done prior to the resident's elopement incident of 6/22/11.</p> <p>3. The record of Resident J was reviewed on 2/01/12 at 10:45 a.m.</p> <p>Diagnoses included, but were not limited to, dementia, hypertension, history of cerebrovascular accident, anemia, and pneumonia.</p> <p>Resident J was listed on the facility's "Transmitter Test Log" sheets, indicating that the resident required a Wanderguard safety device to prevent elopement, for each day in January 2012.</p> <p>A care plan dated 3/20/11 indicated, "Problem: Res (resident) attempted to elope the building. Res followed church group out the door. Approach: Wanderguard and check for proper functioning."</p> <p>A care plan dated 4/21/10 and updated 8/22/11 indicated, "Problem: Risk for wandering due to history of wandering at the hospital. Approach: Wanderguard intact and check for proper functioning."</p> <p>A Social Service Quarterly Assessment dated 12/06/11 indicated, "He also has a</p>		<p>ensure compliance shall be accomplished by. The interdisciplinary team each week to conduct correct ed action audit review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion Date 03/02/2012 team</p>				

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	<p>history of exit seeking attempting to leave the building without staff or family assistance..."</p> <p>During an observation with the Nursing Unit Manager on 2/01/12 at 10:12 a.m. Resident J did not have his Wanderguard on.</p> <p>On 2/01/12 at 1:30 p.m. the D.O.N. provided an "Elopement Risk Assessment" form for Resident H dated 3/20/11. She indicated the form was incomplete, was not scored properly, and had no total score. She also indicated no assessment had been done prior to the resident's elopement incident of 3/20/11.</p> <p>4. The record of Resident K was reviewed on 2/01/12 at 2:10 p.m.</p> <p>Diagnoses included, but were not limited to, Alzheimer's Type Dementia, hypertension, diabetes mellitus, and depression.</p> <p>Resident K was listed on the facility's "Transmitter Test Log" sheets, indicating that the resident required a Wanderguard safety device to prevent elopement, for each day in January 2012.</p> <p>A care plan dated 6/11/11 and revised 11/18/11 indicated, "Problem: Resident at</p>						

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	<p>risk for elopement...Approach: Wanderguard and check every shift for placement and function."</p> <p>A care plan dated 7/04/11 and revised 11/18/11 indicated, "Problem: Resident has shown some inappropriate affect, disorganized thinking such behaviors as resident tries to leave the building unattended."</p> <p>Resident K's record contained no elopement risk assessment.</p> <p>5. The record of Resident L was reviewed on 2/01/12 at 2:30 p.m.</p> <p>Diagnoses included, but were not limited to, dementia, asthma, atrial fibrillation, coronary artery disease, severe cervical spondylosis, and anemia.</p> <p>Resident L was listed on the facility's "Transmitter Test Log" sheets, indicating that the resident required a Wanderguard safety device to prevent elopement, for each day in January 2012.</p> <p>A care plan dated 4/02/10 and updated 1/05/12 indicated, "Problem: Resident at risk for elopement related to resident opened up the back door on 4/06/11. Approach: Provide for safety by using Wanderguard security alert...."</p>				

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	<p>A care plan dated 10/31/08 and reviewed 1/05/12 indicated, "Problem: Resident is at risk for wandering from facility unattended D/T (due to) dementia disease...Risk for elopement and always want to go downtown and catch the bus."</p> <p>Resident L's record contained no elopement risk assessment.</p> <p>6. The record of Resident M was reviewed on 2/01/12 at 3:05 p.m.</p> <p>Diagnoses included, but were not limited to, Alzheimer's type dementia, psychosis, depression, and osteoarthritis.</p> <p>Resident M was listed on the facility's "Transmitter Test Log" sheets, indicating that the resident required a Wanderguard safety device to prevent elopement, for each day in January 2012.</p> <p>A care plan dated 10/05/11 indicated, "Problem: Resident has impaired decision making skills and resident wanders around the facility. Approach: Apply wanderguard on person for her safety per M.D. order."</p> <p>Resident M's record contained no elopement risk assessment.</p>				

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	<p>On 2/01/12 at 3:30 p.m. the D.O.N. indicated she had no additional documentation of elopement risk assessments for Residents B, H, J, K, L, or M.</p> <p>This federal tag relates to Complaint IN00102637.</p> <p>3.1-45(a)(2)</p>			
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