

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00184173 and #IN00185499</p> <p>Complaint #IN00184173 - Unsubstantiated due to lack of evidence. Complaint #IN00185499 - Substantiated. Federal/State deficiency related to allegations is cited at F323.</p> <p>Survey date: November 5, 2015</p> <p>Facility number: 000564 Provider number: 155484 AIM number: 100285610</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 11 Medicaid: 65 Other: 20 Total: 96</p> <p>Sample: 5</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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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F 0323 SS=D Bldg. 00	<p>Quality review completed 11/9/15 by 29479.</p> <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, interview, and record review, the facility failed to ensure adequate supervision to prevent a cognitively impaired resident from eloping from the facility for 1 of 3 residents reviewed for elopement risk. (Resident B).</p> <p>Finding includes:</p> <p>On 11/5/15 at 10:15 a.m., Resident B was observed in her bed with her eyes closed. At the same time an observation was made of the emergency exit door next to the resident's room. The glass on the exit door was frosted causing the view to the outside to be obstructed.</p> <p>On 11/5/15 at 10:30 a.m., the external area surrounding the exit door from the Reflections unit was observed. The exit door was closed. A bush large enough to obscure visibility of a person standing</p>	F 0323	<p>Facility respectfully requests a Desk Review for Compliance F323</p> <p>No other residents were affected by this isolated occurrence</p> <p>In order for this isolated event not to reoccur, the facility will ensure adequate supervision to prevent a cognitively impaired resident from eloping from the facility</p> <p>Staff Development Coordinator reviewed Elopement Policy & Procedure with staff including contracted services; Facility installed motion alarms within 3ft of exit as a secondary/back-up alarm system DNS/Designee reviewed residents at risk for elopement and validated that care plans, assessments and assignment sheets are current and resident specific Elopement books, which are located at every nurses stations and entrance, were validated as being accurate; Resident was relocated closer to the nurses station</p> <p>Continued compliance will be</p>	11/17/2015

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	<p>behind it was observed on the left side of the door.</p> <p>On 11/5/15 at 11:25 a.m., Resident B was observed walking independently, with a quick pace in the hallway throughout the Reflection's Unit. The resident's room was located adjacent to emergency exit door.</p> <p>On 11/5/15 at 11:20 a.m., during an interview, (Licensed Practical Nurse) LPN #1 indicated she was on duty on 10/11/15. She indicated she heard a door alarm going off. She indicated at 11:12 a.m., she was notified by staff from the Reflections Unit that Resident B was unable to be located by the unit's staff. LPN #1 indicated she immediately initiated the elopement protocol to facility staff. She indicated the resident was found off of the facility grounds, she believes by a dietary staff member and returned to the facility at 11:22 a.m. LPN #1 indicated she performed a full body assessment of Resident B, and found no injuries. She indicated she contacted the physician, the resident's family, the Administrator and the Director of Nursing (DON). She indicated the physician gave an order for the resident to be sent to behavioral health for evaluation.</p>		<p>reviewed monthly through Performance Improvement meetings IDT will continue to monitor and update Elopement Book during scheduled MDS assessments, new admissions and change of conditions Administrator/Designee is responsible for overall compliance</p>	

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	<p>On 11/5/15 at 11:34 a.m., (Certified Nursing Assistant) CNA #2 was interviewed. She indicated she worked on the Reflection's Unit on 10/11/15 and was in the shower room with a resident when she heard the door alarm. She was unable to leave a resident unattended in the shower room to respond to the alarm. The CNA indicated when a door alarm sounds, staff were to ensure each resident on the unit was accounted for and to report if a resident was not present and accounted for.</p> <p>On 11/5/15 at 11:50 a.m., CNA #3 was interviewed. She indicated she worked on the Reflection's Unit on 10/11/15 and was in a resident's room providing care when the door alarm sounded. CNA #3 indicated she looked out the exit door to the outside of the facility, but did not see any resident.</p> <p>On 11/5/15 at 2:30 p.m., Housekeeper #5 was interviewed. She indicated that she worked on the Reflection's Unit on 10/11/15 and was off of the unit for lunch when the door alarm sounded and Resident B could not be located. She indicated she was responsible for monitoring residents and the hallway when unit staff were in the dining area or in a resident's room. She indicated she was aware of the resident's who were at</p>			

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	<p>risk for leaving the unit.</p> <p>On 11/5/15 at 2:15 p.m. the DON and Administrator were interviewed. The Administrator indicated Resident B's elopement had been reported to the State in a timely manner. The DON indicated that all staff were in-serviced on October 12, 13, and 14, 2015, on the facility elopement protocol and emphasis was on being more alert to the resident's with high elopement risk.</p> <p>On 11/5/15 at 10:04 a.m., Resident B's medical record was reviewed. The record indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease and Hallucinations.</p> <p>Documents titled, "Wandering/Elopement Risk Evaluations were reviewed. The evaluation dated 7/8/15, indicated the resident wandered, but did not try to leave the unit. The evaluation dated 10/5/15, indicated the resident was no risk for wandering or elopement. The evaluation dated 10/19/15, indicated was an elopement risk and indicated precautions were in place that included, but were not limited a wander guard.</p> <p>The resident's annual Minimum Data Set (MDS) assessment dated 10/5/15,</p>			

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	<p>indicated the the resident required supervision with locomotion on and off the unit and indicated wandering behavior had not been exhibited during the assessment period.</p> <p>A care plan dated 10/18/15, indicated the resident was an elopement risk. Interventions included, but were not limited to, completion of an elopement risk assessment upon admission, quarterly and with significant change and continue placement on the Reflection's Unit.</p> <p>On 11/5/15 at 1:49 p.m., a copy of a policy titled, "Patient Elopement," dated 11/11/13, was provided by the Administrator. The policy indicated, "Procedure, Phase 1: 1. Provides procedures for the initial search of the Center and confirmation that the patient is missing. 3. Conduct searches...b. Inside Center...c. Center Grounds...Phase 2: 1. If patient not on center grounds...a. Divide into quadrants. b. Search the closets quadrants first, and then extend into other quadrants...."</p> <p>3.1-45(a)(2)</p>			