

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/30/2015
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NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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F 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 6/3/15. This visit included a PSR to the State Residential Licensure Survey completed on 6/3/15.</p> <p>Survey dates: July 30, 2015</p> <p>Facility number: 001198 Provider number: 155637 AIM number: 100471000</p> <p>Census bed type: SNF: 20 SNF/NF: 108 Residential: 46 Total: 174</p> <p>Census payor type: Medicare: 23 Medicaid: 82 Other: 23 Total: 128</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	R000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revisions of federal and state law. WE ARE REQUESTING DESK COMPLIANCE	

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>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 with a known history of wandering behavior was supervised to prevent elopement from the facility for 1 of 4 residents reviewed for accidents. (Resident #218)</p> <p>Finding includes:</p> <p>Resident #218's record was reviewed on 7/30/15 at 2:30 p.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbance and anxiety.</p> <p>Resident #218 was admitted to the facility on 7/10/15.</p> <p>An Elopement Risk Assessment, dated 7/11/15, indicated the resident was physically able to leave the building on their own, had a diagnosis of Alzheimer's or dementia and was mobile, did not have a history of attempting to exit the building, did not have a history of wandering, had impaired decision</p>	F 0323	<p>F Tag 323 <b>Request Desk Review Please</b> 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice a. Resident #218 moved to the locked dementia unit. b. Elopement inservice completed for all departments regarding missing resident and elopement policy 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Residents with dementia have the potential risk to be affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Continue our re-education of all staff by development of short questionnaire which will be utilized by facility managers to assure staff knowledge of the policy related to missing resident and elopement. (Attachment #1) b. Maintenance supervisor will conduct Door alarm drills monthly on all shifts observing staffs response. (Attachment #2) 4.</p>	08/14/2015

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	<p>making ability, impaired safety awareness, and diagnosis of dementia or related disorder. The assessment indicated "resident's are at High Risk for Elopement when "Yes" is answered to both questions in section A (physically able to leave the building on their own and diagnosis of Alzheimer's or dementia and is mobile, both answered yes), or have a score of 5 or greater." The resident's score was 7.5.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 7/17/15, indicated the resident was cognitively impaired, had wandered 1-3 days, and required limited assistance of one staff member for transfers and ambulation.</p> <p>A care plan, dated 7/15/15, indicated risk for elopement and wandering as evidenced by impaired safety awareness and history of attempt to leave facility unattended. The intervention included, but were not limited to, distract from wandering by offering pleasant diversions, structured activities, food, conversation, television, redirect resident when wandering or exit seeking.</p> <p>A Nursing Note, dated 7/10/15 at 3:15 p.m., indicated Resident #218 had arrived to the facility, was confused and anxious. The note further indicated orders had</p>		<p>How the corrective action(s) will bemonitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.</p> <p>a. DON/Designee will monitorresponses of staff on short questionnaire. Managers will conduct random rounds related to asking questions on all shifts three times a week for six months. Response of all questionnaires will be forwarded to Quality Assurance Coordinator and any issues noted will be handled individually. b. Door alarm drills will be conducted monthly on all shifts and results of the door alarm drills will be forwarded to theQuality Assurance Coordinator. c. Reports of allquestionnaires and door alarm drills will be discussed at the Quality Assurance meeting monthly for six months. If deficiencies are noted the Quality Assurance Committeewill develop plan of action to correct and recommend continuation of monitoring until corrections are effective. Compliance by8/15/15</p>	

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	<p>been received from the Nurse Practitioner for a wanderguard.</p> <p>A Nursing Note, dated 7/10/15 at 6:30 p.m. indicated "Resident wandering the entire unit, going into other residents' rooms, requiring guidance when wandering."</p> <p>A Social Service Note, dated 7/11/15 at 12:00 pm, indicated Resident #218 was admitted on 7/10/15 and scored a 7.5 on the elopement assessment which indicated a high risk for elopement and a wanderguard (a bracelet device that causes an alarm to sound if device or wearer is near exit) had been placed for safety.</p> <p>A Social Service Note, dated 7/11/15 at 12:26 p.m. indicated "...Resident has a wanderguard (sic) in place and writer was told that resident wandered last night causing alarms to sound. Resident did not exit seek but wandered the unit..."</p> <p>A Nursing Note, dated 7/14/15 at 10:58 p.m. indicated "...patient was found by staff in parking lot by Eden Unit (lower level unit)...skin assessment to patient showed no apparent injuries patient was pleasant but confused patient refused care by staff and was placed in wheel chair by nurse station for one on one care."</p>			

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	<p>A Nursing Note, dated 7/14/15 at 10:58 p.m. indicated "...patient found outside in the parking lot wandering (sic) around."</p> <p>A Behavior Note, dated 7/14/15 at 10:59 p.m. indicated "...patient found outside in parking lot wandering (sic) around, patient opened the door and went down the stairs and outside..."</p> <p>A Social Service Note, dated 7/15/15 at 1:21 p.m. indicated " Writer met in risk meeting today with IDT (interdisciplinary team) to discuss residents elopement from Reclaim Unit (2nd floor unit). Writer was notified that resident exited out the exit door on Reclaim Unit. Staff found resident outside door and brought resident back into facility and put her on 1:1. After review IDT recommended that resident go into locked unit for safety..."</p> <p>An Incident/Accident Report, dated 7/14/15 at 10:45 p.m., indicated LPN #1 heard alarm behind R1 computer sound. LPN #1 went to R2 (Reclaim Unit #2) exit door looked through window, opened door and looked down the stairwell and did not observe anyone. LPN #1 walked back to the nurses ' station and observed LPN #2 and another staff member with Resident #218 coming off the elevator. LPN #2 indicated she</p>			

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	<p>had entered the parking lot closest to the lower level entrance, parked her car and observed a woman walking on the grass towards the lower level entrance. LPN #2 approached the woman and recognized her as Resident #218. LPN #2 indicated no injuries were observed to Resident #218, she brought the resident back to the unit, a bed check was completed, and all doors were checked and were secure.</p> <p>Interview with the Director of Nursing (DON) on 7/30/15 at 2:54 p.m. indicated there was a certain alarm for the Reclaim Unit #2 door near the computer at the Reclaim Unit nurse's station. She indicated LPN #1 was aware of the door that was alarming. She indicated LPN #1 opened the door, looked down the stairwell, saw nothing, closed the door, and came back to the nurses' station. She further indicated Resident #218's wanderguard had alarmed and was working at the time of the elopement. She indicated Resident #218 had exited the Reclaim Unit door, gone down the stairs, and exited the facility in to the parking lot. She indicated staff knew the resident was a risk for wandering but the resident had not made any previous attempts to exit the facility. She indicated staff had not followed the elopement policy and someone should</p>				

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	<p>have gone outside and checked the perimeter while someone else should have stayed inside and completed a head count of the residents. She further indicated she had spoken with the resident's son who indicated the resident barely walked at the previous facility she was at and had made no attempts to leave the building. The DON indicated if the resident wanted to get up and walk she would. She indicated following the elopement an inservice had been completed for all staff on the elopement policy and Resident #218 had been moved to the locked dementia Unit.</p> <p>A facility policy titled "Missing Resident and Elopement," dated 8/23/13, and received as current from the DON on 7/30/15 at 3:39 p.m. indicated "...When any door alarm sounds, staff shall: 1. Check the alarm panel to determine which door has been opened. DO NOT ASSUME someone else has already done this. 2. Check the exit door for any exiting resident by means of a visual check. Also perform search of the building parameter for exited resident. 3. If a resident is discovered outside the facility inappropriately, staff will assist him/her back into the facility..."</p> <p>3.1-45(a)(2)</p>			

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R 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 6/3/15.</p> <p>Residential Census: 46 Sample: 3</p> <p>Crown Point Christian Village was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Survey.</p>	R 0000	<p>R000 This plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revisions of federal and state law. WE ARE REQUESTING DESK COMPLIANCE</p>		