

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/02/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
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F0000	<p>This visit was for Investigation of Complaints IN00101495, IN00103219, and IN00104289.</p> <p>Complaints: IN00101495 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>IN00103219 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F279 and F323</p> <p>IN00104289 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey dates: February 28 &amp; 29, March 1 &amp; 2, 2012</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF/NF: 159 Total: 159</p>	F0000		

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>Census payor type: Medicare: 37 Medicaid: 95 Other: 27 Total: 159</p> <p>Sample: 7 Supplemental sample: 2</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/07/12 by Suzanne Williams, RN</p>				

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a physician was notified, in that when a resident had an existing fracture, and then sustained an additional fall with extensive bruising and</p>	F0157	F-157It is the intention of Kindred Transitional Care and Rehabilitation Center to immediately inform the resident, consult with the physician; and if known the resident's legal	04/01/2012			

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	<p>increased pain, the facility failed to ensure the physician was updated regarding the resident's condition, in the event of possible intervention, for 1 of 3 residents with fractures in a sample of 7. [Resident "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 02-28-12 at 2:00 p.m. Diagnoses included, but were not limited to, status post left hip fracture, right fractured ankle, seizure disorder and mild mental retardation. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Diagnostic and Evaluation," dated 04-22-11, indicated the resident had surgery which included a "voluntary laminectomy with a posterior lateral fusion at C [cervical] 3 - C5, and also report that neck pain is "excruciating." The evaluation also indicated the resident had "generalized weakness and history of multiple falls" and "benefits from intensive supervision due to fall risk, medical support needs, severe pain issues, poor judgement, and limited cognitive/academic skills" and "benefits from support with major decisions regarding care and services."</p>		<p>representative or interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer the resident from the facility. The facility must also notify for a change in room assignment. The facility must record and periodically update address and phone numbers of the resident's legal representative or interested family member. - What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident "C" currently resides in the facility. The resident fell on 02/11/2012. The MD and family were informed of the fall. The MD was informed of the pain and bruising on an ongoing basis from the time of the fall through DC to hospital. Therapy notes were reviewed as well and the MD was kept informed.. Medical records were reviewed and the use of PRN medication increased and the pain score increased. Ativan was added to the regimen by the NP on 02/17/2011, as it was felt the resident was having anxiety related to the therapy from the identified ankle fracture. MD notification noted on 02/11/2012 through the time of transport to</p>		

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	<p>Review of a "post fall evaluation," dated 02-10-12 indicated the resident was found sitting on the bathroom floor at 7:30 a.m. The resident was sent to a local orthopedic center and it was determined the resident had a fractured ankle. A walking boot was applied.</p> <p>The record indicated the following day, 02-11-12 at 6:30 a.m., while walking with a rolling walker, the resident tripped over the "cast" and fell to buttocks. The "post fall evaluation" indicated "no immediate injury noted," - however a subsequent notation, at 12:30 p.m., indicated the resident had a "bruise to coccyx noted."</p> <p>The nurses notes dated 02-11-12 at 6:30 a.m. indicated the following: "Resident ambulating in hall with walking cast, rolling walker and one staff member. Fall onto buttocks tripped over new 'cast' boot. No immediate injury noted. c/o [complains of] 'sore' at this time. MD [Medical Doctor] and family aware."</p> <p>Subsequent Resident Progress Notes indicated the following: "02-11-12 - 12:30 p.m. Resident noted with large discoloration measuring 5 cm [centimeters] by 3 cm dark purple to coccyx area. Medicated with Norco [a narcotic analgesic] per request. MD and</p>		<p>the hospital. The resident complained of ankle pain to nursing staff. The ankle was treated by the MD. The presentation of injury was focused on the right ankle only. The resident did not complain of the hip pain. When the resident complained of hip pain an x-ray was obtained and the resident was sent for treatment. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Residents with an injury have the potential to be affected by this practice. Injuries are reviewed for 72 hours. If there is no further injury, the focus observation will decrease, as appropriate. If the injury persists the focus charting will continue until resolution. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Residents with injury will be reviewed for 72 hours. If the injury resolves, the resident observation will decrease. If the injury persists, the focus observation will continue. The new electronic charting implemented by Kindred will place the identified resident on the 'dashbord', for increased focus and increased attention to the injury, with subsequent observation and assessment. Therapy has been</p>				

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	<p>family aware."</p> <p>"02-11-12 - 10:00 p.m. walking cast on when up. Walker in med [medication] room until PT [physical therapy] (eval)."</p> <p>"02-12-12 - 3:15 a.m., Bruise to right buttocks remains. Denies pain or discomfort."</p> <p>"02-12-12 - 2:00 p.m. [Family member] states resident difficult to transfer due to ankle 'cast' boot. Resident with c/o general pain and right ankle pain. Discoloration to coccyx [arrow pointing downward] right buttock continues post fall."</p> <p>"02-12-12 - 9:00 p.m. Resident stayed in room for dinner after outing 'c.o tired' 1+ edema to right ankle. Encourage to elevate when in bed. Discoloration at coccyx [arrow pointing to the right] R [circled] buttocks. c/o general discomfort."</p> <p>"02-13-12 - 3:15 a.m. Discoloration to R [circled] buttocks persists no c/o pain to same. 1+ edema to right ankle, elevated as tolerated."</p> <p>"02-13-12 - 11:30 a.m. Discoloration to R [circled] buttocks remains. c/o pain to right ankle PRN [as needed] pain med</p>		<p>instructed on 03/16/2012, that they are to write communication of any useful information on an MD order for review. This will alert the Unit Manager or designee and MDS or designee. This will bridge communication with therapy and nursing. Nursing will continue with the responsibility to inform the MD or NP of an acute change of condition. - How will the corrective action will be monitored to ensure the deficient practice does not recur; what performance improvement (quality assurance) program will be put into place. The Performance Impovement Committee will monitor complince for a period of 6 months, or until substantial compliance is achieved. The audit tool will address the resident order, events, room transfers, and notification, as a double check these item were completed. The audit and monitoring will be completed by the DNS, ADNS, Unit Manager or designee one time per week for four weeks, then one time a month for six months or until substantial compliance is achieved. The DNS, ADNS, Unit Manager or designee is responsible to ensure compliance is maintained. Substantial compliance goal equals 100%.</p>				

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	<p>given."</p> <p>"02-16-12 - 2:00 a.m. Res. [resident] c/o bil. [bilateral] ankle et [and] bil. foot pain et requested 'pain pill' PRN Norco 10/325 mg [milligrams] times 1 given."</p> <p>"02-18-12 [no time noted] Condition change form. Resident with increased pain. C/O pain 'all over left hip and left buttocks with old yellow purple discoloration. Order obtained for x-ray of left hip."</p> <p>"02-18-12 [no time noted] Condition change form. X-ray report received. Acute subcapital femoral neck fx. [fracture] and acute fx. left superior pubic ramus with mild displacement. Order obtained to send to [name of local area hospital]."</p> <p>A Review of the "Weekly - Physical Therapy Progress Note" from "02-11-12 to 02-17-12" indicated the following:</p> <p>"Functional Impairment Addressed - #3 left knee pain. Last week right hip pain. Current cont's [continues] to c/o pain."</p> <p>"Functional Impairment Addressed #4 amb. [ambulate] with RW [rolling walker]. Last week 100 feet with min. [minimum] CGA [contact guard</p>			

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	<p>assistance]. Current Stood at RW only secondary to pain."</p> <p>"Using a comparative statement, summarize significant progress toward goals as a result of skilled intervention provided: Pt. - increased c/o pain in left thigh and knee area. Writer spoke to nurg. [nursing] re [regarding]: based on previous therapy sessions - Pt. has shown signif. [significant] change in mobility and tolerance to therapy esp. [especially] movements and for std. [standing] act's [activity's]. Pt. often found drawing up left lower extremity towards chest for comfort. Nrsng. report no changes in meds since right ankle. Pt. refusing to go to dr [dining room] for meals and today not dressed; per [resident] request. Change of condition noted. written and discussed with P.T."</p> <p>A review of the Medication Record for 02-2012 indicated that between 02-10-12 and 02-18-12 the resident had increased pain with a score of "8," based on an scale of 1 - 10, on 02-11-12, "6" on 02-12-12, "10" on 02-15-12, "8" on 02-16-12, "10" on 02-17-12 and "two scores on 02-18-12 "8" [day shift] and "9" [night shift]."</p> <p>Further review of the Medication Record indicated the resident required pain medication [Norco] 02-10-12, 02-11-12,</p>						

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	<p>02-12-12, 02-13-12, 02-15-12, 02-16-12 and 02-17-12 [times two]" and Ultram 50 mg [a pain medication] on 02-18-12, and Ativan [an antianxiety medication] on 02-14-12 and again on 02-17-12.</p> <p>The record lacked documentation from 01-25-12 by the physician or nurse practitioner related to the status of the resident or the increased awareness of the need for additional pain medication, until 02-22-12 when the nurse practitioner noted the resident "returned to ECF [extended care facility] from Hosp. [hospital] after fall - had left hip ORIF [open reduction and internal fixation] performed."</p> <p>During interview on 02-29-12 at 12:00 p.m., the case manager from the local area hospital indicated the resident had fallen and sustained a fracture to the right ankle and then the following day fell again. "The Emergency Room physician [name given] was concerned that in light of the resident's diagnoses, it appears there was a delay in treatment for the resident - a whole week went by."</p> <p>Review of facility policy on 03-02-12 at 9:00 a.m., titled "Notifications," and dated 10-31-07 indicated the following:</p> <p>"Policy [bold type] Staff informs the</p>			

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	<p>resident, consults with their attending physician, and notifies the resident's surrogates when: The resident that is in an accident involving injury that may require physician intervention, a significant change occurs in the resident's physical, mental or psychosocial status, treatment needs to be altered significantly; or a decision is reached to transfer or discharge the resident from the center."</p> <p>This Federal tag relates to complaint IN00104289.</p> <p>3.1-5(a)(1) 3.1-5(a)(2) 3.1-5(a)(4)</p>				

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure a resident received appropriate social service interventions, in that when a resident was admitted to the facility for short term rehabilitation and frequently informed the nursing staff of wanting to leave the facility to return home, and subsequently left the facility and was involved in a multiple motor vehicle accident, the Social Service staff failed to intervene and assist the resident with identified concerns of discharge or relocation, for 1 of 1 resident with behaviors related to ongoing threats to leave the facility, in a sample of 7. [Resident "B"].</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 02-29-12 at 1:15 p.m. Diagnoses included but were not limited to depression, diabetes mellitus, hypertension, severe alcohol abuse, and osteoarthritis. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident was</p>	F0250	F-250It is the intention of Kindred Transitional Care and Rehabilitation Center to provide medically related social services to attain or maintain the highest practical physical, mental, and psychosocial well-being of each resident. - What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident "B" currently resides in the facility. This resident was granted a gaurdian of self immediately following the car accident. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The facility will practice to preserve and uphold the residents rights. All residents will be allowed to make his or her own decision. The facility will educate the resident on the consequences of poor decision. The facility will keep the MD informed of the poor decisions. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The process of discharge will begin upon admission. Social	04/01/2012			

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	<p>admitted to the facility after an evaluation by a local area hospital physician for rehabilitation. The hospital notations, dated 12-08-11 indicated "[resident] is falling almost every day and at times when [resident] fall in bathroom and lay there all night as did not has &lt;sic&gt; strength to get up from the floor. [Resident] reports depression as [spouse] is in nursing home and [resident] has no human contact for weeks. [Resident] feels lonely. Reports OA [osteoarthritis] of left knee and locks up that leads to fall. [Resident's] spouse is in [Kindred Transitional Care - Greenwood] and patient favors going there and being close to [spouse]."</p> <p>The admission "Patient Nursing Evaluation," dated 12-12-11 indicated the resident had "severe depression with functional decline," identified as a "high risk" for falls, but not an elopement risk. In addition, the evaluation indicated the resident arrived at the facility via "taxi."</p> <p>Review of the Physician Progress Note, dated 12-15-11, indicated the resident "c/o [complained of] left knee pain; left side numbness - gradual onset over past 3 - 4 months. Hx. [history] of falls - feels as if left leg gives out."</p> <p>Review of the signed January 2012</p>		<p>Services, Case Manager or designee will conduct ongoing family meetings with resident and family to explore the discharge plans. Resident rights will be maintained at Kindred Transitional Care and Rehabilitation. The MD will be informed of ongoing refusals of treatment. The family will be kept informed with ongoing refusals of treatment when appropriate. Social Services will contact the Ombudsman and Adult Protective services for refusals of care that could cause harm to the resident for direction. - How will the corrective action will be monitored to ensure the deficient practice does not recur; what performance improvement (quality assurance) program will be put into place. The audit and monitoring tool will cross reference behaviors with interventions to ensure all interventions are accounted for. The social service director or designee will be responsible for completing the tool and ensuring compliance. The performance improvement committee will monitor for a period of six months to ensure compliance or until compliance is achieved. The compliance goal is 100%.</p>				

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	<p>physician re-write/orders indicated the resident was "capable of making own health decisions," however required supervision to "go out on pass."</p> <p>Review of the resident progress notes indicated the following:</p> <p>"12-17-11 9:00 a.m. Res. [Resident] ambulated with walker to other unit and asked them to call a cab, [resident] was going home. Nurse went to talk with res. [resident]. [Resident] got ahold of [family member] before nurse arrived. States [family member] is coming to pick [resident] up in a few [minutes] 'needs stuff from home and will be back.' Assisted into lobby to wait for [family member]. Reminded [family member] or self needs to sign chart when [family member] picks [resident] up. Res. states ok." 9:15 a.m. Resident witnessed leaving facility - didn't sign chart or inform staff [resident] [family member] was here to get [resident]."</p> <p>"12-17-11 [no time noted] Condition Change Form - new order for Wanderguard received and noted after speaking with DON [Director of Nurses] regarding res. leaving without signing out." A subsequent physician order, dated 12-19-11, instructed the nursing staff to discontinue the use of the Wanderguard</p>			

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	<p>device due to the resident's non-compliance and right to sign out."</p> <p>"12-19-11 Pt. own POA [power of attorney] and requested to go LOA for a few hours and return. Pt. signed out."</p> <p>"12-22-11 1:00 p.m. Called &lt;sic&gt; made to Dr. office concerning resident's trips to [resident's] car where there is known to be wine, the concern being possible mixtures with [resident's] meds. [medications] was advised that Doctor would be notified. No new orders at this time."</p> <p>"12-23-11 12:15 p.m. SS [social service] 14 day assess [assessment] (12-20-11 through 12-26-11). Res. wanting to leave today and take [spouse] who is also a res. here with [resident]. Explained to res. and [spouse] if left would be AMA [against medical advise]. Resident stated wasn't going to leave but wanted to go out to car and look through some papers. Writer and DON walked res. to car. Res. had to take several breaks to catch breath also carried out empty cup to car. Once at car, res. sat in car and shuffled papers. Writer and UM [Unit Manager] escorted back. Res. stating wanting to leave by Christmas. DON explained to res. doesn't have order from MD to D/C [discharge], not safe at this time that if chose to leave could be would be AMA."</p>			

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	<p>"12-25-11 - Res. c/o that doesn't feel well. When asked what is wrong res. states is 'just sad.'"</p> <p>"12-31-11 Res. came to nurses station wanting to sign self out. Nurse asked res. who was picking [resident] up - [resident] did not answer. Nurse asked if [family member] was picking [resident] up - stated 'yes.' Nurse explained that [family member] needed to come sign out. Res. then states [family member] wasn't picking [resident] up - [resident] car is in parking lot. [Resident] was driving self home for an hour then will be back. Explained to res. after speaking with ADON [Assistant Director of Nurses] [resident] can't drive self off facility grounds."</p> <p>"01-07-12 Social Service note - Resident alert and oriented to self, room, facility. Has impaired decision making abilities. Has had 2 recent falls, has PA (personal alarm). Has temp [temporary] guardian for finances."</p> <p>"01-08-12 Attempted to leave facility this AM, but states car wouldn't start. CNA [certified nurses aide] followed resident out of building an &lt;sic&gt; observed while resident looked for items in car."</p>						

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	<p>"01-14-12 Res. had coat on and walker toward door. Nurse asked resident if [resident] was leaving with someone. Hatefully states 'I'm not leaving ! Just going to make sure my car starts !' Staff observed res. to make sure didn't drive car off grounds. Res. sat in car approx. [approximately] 5 mins. [minutes] to 10 mins. Never started car, then returned to facility."</p> <p>"01-24-11 12:00 p.m. Pt. [patient] returned from going LOA [leave of absence] at approx. 11:30 (went to parking lot/car area) signed out. Pt. reported fell, knees gave out and buckled. Reports hitting head; posterior intact not open. stl. [slightly] red."</p> <p>"01-27-12 Social Service note - Res. wants to go home."</p> <p>"01-27-12 4:00 p.m. LE [late entry] for 01-25-12 at 11:45 a.m. Res. returned from LOA accompanied by Police was taken to Administrators office then returned to this unit. Res. told writer he had been in a car accident et [and] totaled [resident] car."</p> <p>The record indicated the resident was assessed and found to have a right hip bruise 15 cm [centimeters] by 4 cm, right flank bruise 18 cm by 5 cm, left thumb</p>						

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	<p>bruise with swelling, left index finger cut."</p> <p>Review of the local area hospital treatment record, dated 01-25-12, indicated the air bag deployed during the motor vehicle accident, which involved two other vehicles. The hospital record also included the resident had a right flank hematoma and left knee pain. The emergency room physician ordered an MRI [magnetic resonance imaging] of the resident's head due to "confusion" and x-ray left forearm due to "pain/trauma." "Provisional diagnoses" included hematuria [blood in urine], hematoma left upper extremity and confusion s/p [status post] MVA [motor vehicle accident]." "Clinical impression: abrasion left hand, right hand, contusion - abdomen."</p> <p>Further review of the facility record indicated additional documentation related to Guardianship in which the facility obtained guardianship for the resident which included not only "estate" but also "person" after the multiple motor vehicle accident on 01-25-12.</p> <p>The record lacked social service intervention for a resident who displayed elopement risk, continued behaviors related to wanting to leave the facility, and known alcoholic beverages in</p>			

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	<p>vehicle.</p> <p>During an interview on 03-01-12 at 3:00 p.m., the resident verified admission to the facility for rehabilitation but didn't want to stay. "I want to go home." The resident acknowledged a guardian had been appointed but felt as if [resident] was being "held" at the facility.</p> <p>Although the resident continued to express a desire to leave the facility, the facility failed to explore alternative options for the resident prior to 03-01-12, when the Guardian was contacted by the corporate attorney who requested a less restrictive placement for the resident.</p> <p>This Federal tag relates to complaint IN00103219.</p> <p>3.1-34(a)</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <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 observation, record review and interview, the facility failed to develop a plan of care, which addressed the resident's possibility of elopement for 2 of 2 supplemental sampled residents reviewed with exit seeking behaviors. [Residents "H" and "I"].</p> <p>Findings include:</p> <p>1. The record for resident "H" was reviewed on 03-01-12 at 2:05 p.m. Diagnoses included but were not limited to hepatic encephalopathy, degenerative</p>	F0279	F-279It is the intention of Kindred Transitional Care and Rehabilitation to use the results of assessments to develop, review and revise the resident's plan of care. - What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident "H" and Resident "I" were assessed and plan of care was developed. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Upon admission the questions will be	04/01/2012	

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	<p>joint disease, and seizure disorder. These diagnoses remained current at the time of the record review.</p> <p>Review of the hospital discharge summary, dated as "corrected on 02-26-12," indicated the resident had "decompensated cirrhosis with anasarca as well as worsening alcoholic metabolic encephalopathy, in addition to impaired judgement and decreased safety awareness." "Precautions" included the resident was a fall risk and was highly impulsive.</p> <p>A review of the Patient Nursing Evaluation, indicated the resident was not at risk for wandering/elopement. Instructions to this component of the evaluation indicated "complete on all new/readmission patients. If yes to one or two [questions] complete FRM 61001 wander/elopement risk evaluation. Complete quarterly and annually if identified as potential risk for wandering/elopement or if significant change occurs changing patient's risk for wandering/elopement."</p> <p>During an interview on 03-01-12 at 9:20 a.m. Certified Nurses Aide employee #10 indicated when Resident "H" was admitted the nurse wanted to place [name of resident] in a room down here by the</p>		<p>answered by the licensed nurse. If the trigger is launched by answering 'yes' to the questions on the assessment, the wander elopement risk assessmnet will be completed. If the resident is at risk for wandering outside of the facility, the wandergaurd system will be initiated. The wander elopement book is kept up to date at the front desk for those residents who are at risk. The wandergaurd system trips the lock on the doors and will not allow to open. There is no option to hold the door for 20 seconds as suggested by the surveyor to gain access to opening. A \$26,000 system was installed in 2011.A plan of care will be completed for each resident with an assessment that confirms a risk to wander or elope. The plan of care will be intitated by the licensed nurse, MDS nurse, unit manager or designee. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The new electronic charting system is linked for a care plan to be created with each wander elopement risk assessment. This will trigger each licensed nurse to complete the plan of care. This assessment and care plan process will be verified by the MDS, unit manager or designee. The electronic computer system is a system that will not allow error. It will flag to be completed</p>				

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	<p>exit door. I told the nurse 'no, I didn't think that was a good idea because [resident] kept wandering around. They finally placed [resident] on the middle hall - that was safer."</p> <p>When requested on 03-01-12 at 9:35 a.m., the Director of Nurses provided a list of residents who currently wore an assistive device to alert the nursing staff of possible resident elopement. The resident's name did not appear on the listing.</p> <p>Review of the nurses notes, dated 02-29-12 at 8:50 a.m. indicated "Res. asking where [resident] is at and if relatives/friends are here to &lt;sic&gt;. Sensor alarms D/C [discontinued] r/t [related to] res. unplugging them and knows how to disable them. Wanderguard in place now r/t res. ambulating in halls by self and risk for wandering."</p> <p>During an observation on 03-01-12 at 11:00 a.m., the resident was observed with the Wanderguard bracelet attached to left wrist.</p> <p>The record lacked a plan of care in which the problem was identified, approaches/interventions determined related to the resident's risk for elopement.</p>		<p>and must be completed. The assessment will continue to be completed for each resident, annually, quarterly, or for an episodic event. The care plan will be completed for each resident with a risk for wander and elopement. The policy will continue to be followed for each resident to ensure safety. - How will the corrective action will be monitored to ensure the deficient practice does not recur; what performance improvement (quality assurance) program will be put into place. The assessments are in the computer and are reviewed 5 days per week by the unit manager or designee. The computer system prompts, so staff will see the assessments. The monitoring tool will be completed as a checklist to ensure the assessment and care plan are complete. The MDS coordinators or designee will be responsible this deficiency is corrected. The performance improvement committee will monitor compliance for a period of six months, or until substantial compliance is achieved. The compliance goal is 100%.</p>				

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	<p>2. The record for Resident "I" was reviewed on 03-01-12 at 2:45 p.m. Diagnoses included but were not limited to recurrent falls, alcohol dependence/withdrawal, hypertension, history of dementia likely multifactorial and alcohol related. These diagnoses remained current at the time of the record review.</p> <p>The admission evaluation indicated the resident was not at risk for elopement.</p> <p>However a review of the resident progress notes, indicated the following:</p> <p>"02-10-12 Res. stating, "I'm going home today. If my [spouse] doesn't take me I will find another way. I'll walk home if I have to."</p> <p>"02-11-12 [spouse] on unit and res. getting angry. Demanding the [spouse] take [resident] home. States 'I'll just leave on my own.'"</p> <p>The nursing staff received a physician order dated 02-11-12 for 15 minute checks times 72 hours - Wanderguard bracelet at all times."</p> <p>"02-12-12 Res. angry and exit seeking</p>			

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	<p>from 7:00 p.m. to 8:00 p.m. states 'I gotta go home I can't be away from my [spouse]. Res. watched constantly during this time.'</p> <p>The nursing staff failed to complete a plan of care to address the resident as an elopement risk.</p> <p>This Federal tag relates to complaint IN00103219.</p> <p>3.1-35(a)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure the necessary assessment and treatment and physician notification for a resident, in that when a resident fell and sustained a fracture, and then fell again the following day, which resulted in extensive bruising, the nursing staff failed to ensure the physical well being of the resident, for 1 of 3 residents with fractures in a sample of 7. [Resident "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 02-28-12 at 2:00 p.m. Diagnoses included, but were not limited to, status post left hip fracture, right fractured ankle, seizure disorder and mild mental</p>	F0309	F-309It is the intention of Kindred Transitional Care and Rehabilitation Center Greenwood to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. - What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident "C" currently resides in the facility. The resident fell on 02/11/2012. The MD and family was informed of the fall. The MD was informed of the pain and bruising on an ongoing basis from the time of the fall through DC to hospital. Therapy notes were reviewed as well and the MD was kept informed.. Medicine records were reviewed and the use of PRN medication increased and the pain score increased. Ativan was added to the regimen by the NP on 02/17/2011, as it was felt the resident was having anxiety related to the therapy from the identified ankle fracture. MD	04/01/2012			

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	<p>retardation. These diagnoses remained current at the time of the record review.</p> <p>A review of the "Interdisciplinary Diagnostic and Evaluation", dated 04-22-11, indicated the resident had surgery which included a "voluntary laminectomy with a posterior lateral fusion at C [cervical] 3 - C5, and also report that neck pain is "excruciating." The evaluation also indicated the resident had "generalized weakness and history of multiple falls" and "benefits from intensive supervision due to fall risk, medical support needs, severe pain issues, poor judgement, and limited cognitive/academic skills" and "benefits from support with major decisions regarding care and services."</p> <p>Review of a "post fall evaluation," dated 02-10-12 indicated the resident was found sitting on the bathroom floor at 7:30 a.m. The resident was sent to a local</p>		<p>notification noted on 02/11/2012 through the time of transport to the hospital. The resident complained of ankle pain to nursing staff. The ankle was treated by the MD. The presentation of injury was focused on the right ankle only. The resident did not complain of the hip pain. When the resident complained of hip pain an x-ray was obtained and the resident was sent for treatment. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. Residents with an injury have the potential to be affected by this practice. Injuries are reviewed for 72 hours. If there is no further injury, the focus observation will decrease. If the injury persists the focus charting will continue until resolution. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Resident with an injury have the potential to be affected by this practice. Injuries are reviewed for 72 hours. If there is no further injury, the focus observation will decrease. If the injury persists the focus charting will continue until resolution. - How will the corrective action will be monitored to ensure the deficient practice does not recur; what performance improvement (quality assurance) program will</p>				

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	<p>orthopedic center and it was determined the resident had a fractured ankle. A walking boot was applied.</p> <p>The record indicated the following day, 02-11-12 at 6:30 a.m., while walking with a rolling walker, the resident tripped over the "cast" and fell to buttocks. The "post fall evaluation" indicated "no immediate injury noted," - however a subsequent notation, at 12:30 p.m., indicated the resident had a "bruise to coccyx noted."</p> <p>The nurses notes dated 02-11-12 at 6:30 a.m. indicated the following: "Resident ambulating in hall with walking cast, rolling walker and one staff member. Fall onto buttocks tripped over new 'cast' boot. No immediate injury noted. c/o [complains of] 'sore' at this time. MD [Medical Doctor] and family aware."</p> <p>Subsequent Resident Progress notes indicated the following:</p>		<p>be put into place. The Performance Improvement will monitor compliance for a period of 6 months, or until compliance is achieved. The DNS, ADNS, Unit Managers or designee will be responsible to conduct rounds to ensure safety and make adjustments accordingly. The primary care nurses have been educated to take a more wholisitic approach with assessment and look at the whole person and not specific to the injury. Compliance is 100%.</p>	

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	<p>"02-11-12 - 12:30 p.m. Resident noted with large discoloration measuring 5 cm [centimeters] by 3 cm dark purple to coccyx area. Medicated with Norco [a narcotic analgesic] per request. MD and family aware."</p> <p>"02-11-12 - 10:00 p.m. walking cast on when up. Walker in med [medication] room until PT [physical therapy] (eval)."</p> <p>"02-12-12 - 3:15 a.m., Bruise to right buttocks remains. Denies pain or discomfort."</p> <p>"02-12-12 - 2:00 p.m. [Family member] states resident difficult to transfer due to ankle "cast" boot. Resident with c/o general pain and right ankle pain. Discoloration to coccyx [arrow pointing downward] right buttock continues post fall."</p> <p>"02-12-12 - 9:00 p.m. Resident stayed in room for dinner after outing 'c.o tired' 1+ edema to right ankle. Encourage to elevate when</p>						

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	<p>in bed. Discoloration at coccyx [arrow pointing to the right] R [circled] buttocks. c/o general discomfort."</p> <p>"02-13-12 - 3:15 a.m. Discoloration to R [circled] buttocks persists no c/o pain to same. 1+ edema to right ankle, elevated as tolerated."</p> <p>"02-13-12 - 11:30 a.m. Discoloration to R [circled] buttocks remains. c/o pain to right ankle PRN [as needed] pain med given."</p> <p>"02-16-12 - 2:00 a.m. Res. [resident] c/o bil. [bilateral] ankle et [and] bil. foot pain et requested 'pain pill' PRN Norco 10/325 mg [milligrams] times 1 given."</p> <p>"02-18-12 [no time noted] Condition change form. Resident with increased pain. C/O pain 'all over left hip and left buttocks with old yellow purple discoloration. Order obtained for x-ray of left hip."</p>			

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	<p>"02-18-12 [no time noted] Condition change form. X-ray report received. Acute subcapital femoral neck fx. [fracture] and acute fx. left superior pubic ramus with mild displacement. Order obtained to send to [name of local area hospital]."</p> <p>A Review of the "Weekly - Physical Therapy Progress Note" from "02-11-12 to 02-17-12" indicated the following:</p> <p>"Functional Impairment Addressed - #3 left knee pain. Last week right hip pain. Current cont's [continues] to c/o pain."</p> <p>"Functional Impairment Addressed #4 amb. [ambulate] with RW [rolling walker]. Last week 100 feet with min. [minimum] CGA [contact guard assistance]. Current Stood at RW only secondary to pain."</p> <p>"Using a comparative statement, summarize significant progress</p>						

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	<p>toward goals as a result of skilled intervention provided: Pt. - increased c/o pain in left thigh and knee area. Writer spoke to nurg. [nursing] re [regarding]: based on previous therapy sessions - Pt. has shown signif. [significant] change in mobility and tolerance to therapy esp. [especially] movements and for std. [standing] act's [activity's]. Pt. often found drawing up left lower extremity towards chest for comfort. Nrsg. report no changes in meds since right ankle. Pt. refusing to go to dr [dining room] for meals and today not dressed; per [resident] request. Change of condition noted. written and discussed with P.T."</p> <p>A review of the Medication Record for 02-2012 indicated that between 02-10-12 and 02-18-12 the resident had increased pain with a score of "8," based on an scale of 1 - 10, on 02-11-12, "6" on 02-12-12, "10" on 02-15-12, "8" on 02-16-12, "10" on 02-17-12 and "two scores on 02-18-12 "8" [day shift] and "9"</p>						

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	<p>[night shift]."</p> <p>Further review of the Medication Record indicated the resident required pain medication [Norco] 02-10-12, 02-11-12, 02-12-12, 02-13-12, 02-15-12, 02-16-12 and 02-17-12 [times two]" and Ultram 50 mg [a pain medication] on 02-18-12, and Ativan [an antianxiety medication] on 02-14-12 and again on 02-17-12.</p> <p>The record lacked documentation from 01-25-12 by the physician or nurse practitioner related to the status of the resident or the increased awareness of the need for additional pain medication, until 02-22-12 when the nurse practitioner noted the resident "returned to ECF [extended care facility] from Hosp. [hospital] after fall - had left hip ORIF [open reduction and internal fixation] performed."</p> <p>During interview on 02-29-12 at 12:00 p.m., the case manager from</p>			

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	<p>the local area hospital indicated the resident had fallen and sustained a fracture to the right ankle and then the following day fell again. "The Emergency Room physician [name given] was concerned that in light of the resident's diagnoses, it appears there was a delay in treatment for the resident - a whole week went by."</p> <p>This Federal tag relates to complaint IN00104289.</p> <p>3.1-37(a)</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.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure the supervision and application of assistive devices for a resident who was identified as a fall risk. The resident had recently returned to the facility from an appointment and was left without the personal alarm which could have alerted the staff of the resident's unassisted transfer which resulted in a fractured hip. This deficient practice affected 1 of 4 residents reviewed for falls from a sample of 7. [Resident "G"]</p> <p>B. Based on observation, interview and record review, the facility failed to perform ongoing assessment of cognitively impaired residents and the use of assistive devices, in that when residents had diagnoses which placed them at risk for elopement, the facility failed to perform ongoing assessments of resident's with the potential for elopement for 1 of 6 residents with elopement/exiting seeking behaviors in a sample of 7 and 2 of 2 supplemental sampled residents reviewed for</p>	F0323	<p>F-323It is the intention of Kindred Transitional Care and rehabilitation Center Greenwood to ensure that each resident remains free of accidents and hazzards as is possible; and each resident recieves adequate supervision and assistance devices to prevent accidents. - What corrective action will be accomplished for those residents found to have been affected by the deficient practice.No corrective action for resident "G" as this resident no longer resides in the facility. Resident "B" currently resides in the facility. This resident obtained a gaurdian following the car accident. This resident was treated with respect and the facility uphelded the resident's bill of rights. No corrective action was taken for resident "H". The residnet has since discharged home. Resident "I" was discharged from the facility. - How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.Residents with a risk of falling has the potential to be affected by this practice. All residents with a high</p>	04/01/2012

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	<p>elopement/exiting seeking and wandering behaviors. [Residents "B," "H" and "I"].</p> <p>Findings include:</p> <p>A. The record for Resident "G" was reviewed on 02-28-12 at 1:00 p.m. Diagnoses included but were not limited to thyroid cancer, hypertension, thoracic aneurysm, tracheostomy, congestive heart failure and sepsis. These diagnoses remained current at the time of the record review.</p> <p>The Resident Minimum Data Set Assessment, dated 01-20-12 indicated the resident required extensive assistance with transfer.</p> <p>Review of the local area hospital pre-admission information dated 01-13-12, provided to the facility indicated the resident was a "fall risk."</p> <p>A review of the Bed safety evaluation dated 01-13-12 and again on 01-16-12, indicated the resident had weakness, a low bed, soft mat and a tab/pull alarm.</p> <p>The resident's Social Service Careplan, dated 01-20-12 indicated the resident had STM [short term memory] impairments.</p> <p>The Physical Therapy Evaluation, dated</p>		<p>fall risk will be reviewed to ensure proper interventions for preventing a fall. Facility staff will attend the ISDH fall meeting on 03/20/2012, to better relate to the current interpretation of this regulation. The admission and quarterly assessment will be used for the trigger for a wander and elopement risk. Interventions will be used to divert this behavior. The wandergaurd system will be used as appropriate. - What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Fall risk assessments will be completed on admission and quarterly per policy. Fall interventions will be implemented with each fall, as appropriate. The electronic charting system prompts the Unit Manager or designee differently to get to the root cause of the fall and place appropriate interventions. The electronic system prompts the nurse and it has to be completed. Wander and elopement risk assessments will be completed per policy. Interventions will be used, as appropriate. - How will the corrective action will be monitored to ensure the deficient practice does not recur; what performance improvement (quality assurance) program will be put into place. The Performance Improvement Committee will follow for compliance for a period of six months, until compliance is</p>				

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	<p>01-5-12 indicated the resident's posture - "forward head, kyphosis, rounded shoulder, balance (sitting) - fair, safety awareness - fair."</p> <p>The Occupational Therapist Evaluation, dated 01-16-12 determined the resident was a "fall risk," had weakness and required frequent assistance with "safety awareness."</p> <p>Review of the Resident Progress Notes indicated the following:</p> <p>"01-17-12 Resident up in W/C [wheelchair] as requested. PSA [personal alarm] on for safety."</p> <p>"01-22-12 PA [personal alarm] in place at all times. Staff responding to alarm several times to find resident transferring "I" [circled] [independently]. Resident instructed to use call light to ask for assistance. Voices understanding."</p> <p>"01-27-12 12:30 p.m., Overall weakness decreased LOC [level of consciousness], noted jerking occ. [occasional] alert. answers questions, denies pain. 3:00 p.m. Resident returned from appt. [appointment]. Went to room in WC. Resident attempted to get up from chair, lost balance and fell on right side hip hit head on chair, left a 2 cm [centimeter] abrasion on scalp. [Name of physician]</p>		<p>achieved. Monitoring will occur will occur weekly on all areas that could be a potential hazzard. Monitoring will be completed by the Executive Director, DNS, ADNS, Social Services or designee. Compliance equals 100%.</p>	

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	<p>called, right hip x-ray ordered. 4:00 p.m. Resident c/o [complaints of] pain in right hip. hydrocodone [a narcotic pain medication] order obtained from Dr. [Doctor] PRN [as needed] Tylenol [an analgesic] given. 7:40 p.m. Received x-ray results showing right hip fracture. N.O. [new order] to send to [name of local area hospital]."</p> <p>Review of the "Post Fall Evaluation," dated 01-27-12 at 3:00 p.m. indicated the resident performed "unassisted ambulation - lost balance. Condition that may Contribute" included - unsteady gait, history of fall(s), Non-compliance." The evaluation lacked documentation of any "intervention" in place at the time of the fall.</p> <p>During an interview on 03-02-12 at 12:30 p.m., the Director of Nurses confirmed the resident did not have the PSA in place at the time of the fall, "because [resident] didn't have a physician order for it."</p> <p>B1. The record for Resident "B" was reviewed on 02-29-12 at 1:15 p.m. Diagnoses included, but were not limited to, depression, diabetes mellitus, hypertension, severe alcohol abuse, and osteoarthritis. These diagnoses remained current at the time of the record review.</p>			

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	<p>The record indicated the resident was admitted to the facility after an evaluation by a local area hospital physician for rehabilitation. The hospital notations, dated 12-08-11 indicated "[resident] is falling almost every day and at times when [resident] fall in bathroom and lay there all night as did not has &lt;sic&gt; strength to get up from the floor. [Resident] reports depression as [spouse] is in nursing home and [resident] has no human contact for weeks. [Resident] feels lonely. Reports OA [osteoarthritis] of left knee and locks up that leads to fall. [Resident's] spouse is in [Kindred Transitional Care - Greenwood] and patient favors going there and being close to [spouse]."</p> <p>The admission "Patient Nursing Evaluation," dated 12-12-11 indicated the resident had "severe depression with functional decline," identified as a "high risk" for falls, but not an elopement risk. In addition, the evaluation indicated the resident arrived at the facility via "taxi."</p> <p>Review of the Physician Progress Note, dated 12-15-11, indicated the resident "c/o [complained of] left knee pain; left side numbness - gradual onset over past 3 - 4 months. Hx. [history] of falls - feels as if left leg gives out."</p>			

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	<p>Review of the signed January 2012 physician re-write/orders indicated the resident was "capable of making own health decisions," however required supervision to "go out on pass."</p> <p>Review of the Resident Progress Notes indicated the following:</p> <p>"12-17-11 - 9:00 a.m. Res. [Resident] ambulated with walker to other unit and asked them to call a cab, [resident] was going home. Nurse went to talk with res. [resident]. [Resident] got ahold of [family member] before nurse arrived. States [family member] is coming to pick [resident] up in a few [minutes] 'needs stuff from home and will be back.' Assisted into lobby to wait for [family member]. Reminded [family member] or self needs to sign chart when [family member] picks [resident] up. Res. states ok." 9:15 a.m. Resident witnessed leaving facility - didn't sign chart or inform staff [resident] [family member] was here to get [resident]."</p> <p>"12-17-11 [no time noted] Condition Change Form - new order for Wanderguard received and noted after speaking with DON [Director of Nurses] regarding res. leaving without signing out." A subsequent physician order, dated 12-19-11, instructed the nursing staff to</p>			

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	<p>discontinue the use of the Wanderguard device due to the resident's non-compliance and right to sign out."</p> <p>"12-19-11 Pt. own POA [power of attorney] and requested to go LOA for a few hours and return. Pt. signed out."</p> <p>"12-22-11 - 1:00 p.m. Called &lt;sic&gt; made to Dr. office concerning resident's trips to [resident's] car where there is known to be wine, the concern being possible mixtures with [resident's] meds. [medications] was advised that Doctor would be notified. No new orders at this time."</p> <p>"12-23-11 12:15 p.m. SS [social service] 14 day assess [assessment] (12-20-11 through 12-26-11). Res. wanting to leave today and take [spouse] who is also a res. here with [resident]. Explained to res. and [spouse] if left would be AMA [against medical advise]. Resident stated wasn't going to leave but wanted to go out to car and look through some papers. Writer and DON walked res. to car. Res. had to take several breaks to catch breath also carried out empty cup to car. Once at car, res. sat in car and shuffled papers. Writer and UM [Unit Manager] escorted back. Res. stating wanting to leave by Christmas. DON explained to res. doesn't have order from MD to D/C [discharge], not safe at this time that if chose to leave</p>			

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	<p>could be would be AMA."</p> <p>"12-25-11 - Res. c/o that doesn't feel well. When asked what is wrong res. states is 'just sad.'"</p> <p>"12-31-11 Res. came to nurses station wanting to sign self out. Nurse asked res. who was picking [resident] up - [resident] did not answer. Nurse asked if [family member] was picking [resident] up - stated 'yes.' Nurse explained that [family member] needed to come sign out. Res. then states [family member] wasn't picking [resident] up - [resident] car is in parking lot. [Resident] was driving self home for an hour then will be back. Explained to res. after speaking with ADON [Assistant Director of Nurses] [resident] can't drive self off facility grounds."</p> <p>"01-07-12 Social Service note - Resident alert and oriented to self, room, facility. Has impaired decision making abilities. Has had 2 recent falls, has PA (personal alarm). Has temp [temporary] guardian for finances."</p> <p>"01-08-12 Attempted to leave facility this AM, but states car wouldn't start. CNA [certified nurses aide] followed resident out of building an &lt;sic&gt; observed while resident looked for items in car."</p>						

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	<p>"01-14-12 Res. had coat on and walker toward door. Nurse asked resident if [resident] was leaving with someone. Hatefully states 'I'm not leaving ! Just going to make sure my car starts !' Staff observed res. to make sure didn't drive car off grounds. Res. sat in car approx. [approximately] 5 mins. [minutes] to 10 mins. Never started car, then returned to facility."</p> <p>"01-24-11 12:00 p.m. Pt. [patient] returned from going LOA [leave of absence] at approx. 11:30 (went to parking lot/car area) signed out. Pt. reported fell, knees gave out and buckled. Reports hitting head; posterior intact not open. stl. [slightly] red."</p> <p>"01-27-12 Social Service note - Res. wants to go home."</p> <p>"01-27-12 4:00 p.m. LE [late entry] for 01-25-12 at 11:45 a.m. Res. returned from LOA accompanied by Police was taken to Administrators office then returned to this unit. Res. told writer he had been in a car accident et [and] totaled [resident] car."</p> <p>The record indicated the resident was assessed and found to have a right hip bruise 15 cm [centimeters] by 4 cm, right</p>			

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	<p>flank bruise 18 cm by 5 cm, left thumb bruise with swelling, left index finger cut."</p> <p>Review of the local area hospital treatment record, dated 01-25-12, indicated the air bag deployed during the motor vehicle accident, which involved two other vehicles. The hospital record also included the resident had a right flank hematoma and left knee pain. The emergency room physician ordered an MRI [magnetic resonance imaging] of the resident's head due to "confusion" and x-ray left forearm due to "pain/trauma." "Provisional diagnoses" included hematuria [blood in urine], hematoma left upper extremity and confusion s/p [status post] MVA [motor vehicle accident]." "Clinical impression: abrasion left hand, right hand, contusion - abdomen."</p> <p>In addition, the record indicated the resident had falls on 01-03-12 at 7:15 a.m., 01-05-12 at 9:30 p.m., and 02-15-12 at 6:45 p.m. The record lacked the "Post Fall Evaluation," which included information [interventions in place at time of fall, location of resident prior to fall, activity at the time of the fall, predisposing diseases, conditions that may contribute [to the fall] footwear/assistive devices at time of fall, vital signs, medications that may</p>			

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	<p>contribute or pain/fall history, summary of Interdisciplinary Team, or intervention recommendations], related to the fall on 01-24-12, in which the resident sustained a head injury.</p> <p>B2. The record for resident "H" was reviewed on 03-01-12 at 2:05 p.m. Diagnoses included but were not limited to hepatic encephalopathy, degenerative joint disease, and seizure disorder. These diagnoses remained current at the time of the record review.</p> <p>Review of the hospital discharge summary, dated as "corrected on 02-26-12," indicated the resident had "decompensated cirrhosis with anasarca as well as worsening alcoholic metabolic encephalopathy, in addition to impaired judgement and decreased safety awareness. "Precautions" included the resident was a fall risk and was highly impulsive.</p> <p>A review of the Patient Nursing Evaluation, indicated the resident was not at risk for wandering/elopement. Instructions to this component of the evaluation indicated "complete on all new/readmission patients. If yes to one or two [questions] complete FRM 61001 wander/elopement risk evaluation. Complete quarterly and annually if</p>				

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	<p>identified as potential risk for wandering/elopement or if significant change occurs changing patient's risk for wandering/elopement."</p> <p>During an interview on 03-01-12 at 9:20 a.m. Certified Nurses Aide employee #10 indicated when Resident "H" was admitted the nurse wanted to place [name of resident] in a room down here by the exit door. I told the nurse 'no, I didn't think that was a good idea because [resident] kept wandering around. They finally placed [resident] on the middle hall - that was safer."</p> <p>When requested on 03-01-12 at 9:35 a.m., the Director of Nurses provided a list of residents who currently wore an assistive device to alert the nursing staff of possible resident elopement. The resident's name did not appear on the listing.</p> <p>Review of the nurses notes, dated 02-29-12 at 8:50 a.m. indicated "Res. asking where [resident] is at and if relatives/friends are here to &lt;sic&gt;. Sensor alarms D/C [discontinued] r/t [related to] res. unplugging them and knows how to disable them. Wanderguard in place now r/t res. ambulating in halls by self and risk for wandering."</p>			

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	<p>During an observation on 03-01-12 at 11:00 a.m., the resident was observed with the Wanderguard bracelet attached to left wrist.</p> <p>The record lacked an assessment which provided early identification of the resident's risk for wandering and/or elopement.</p> <p>B3. The record for Resident "I" was reviewed on 03-0112 at 2:45 p.m. Diagnoses included but were not limited to recurrent falls, alcohol dependence/withdrawal, hypertension, history of dementia likely multifactorial and alcohol related. These diagnoses remained current at the time of the record review.</p> <p>The admission evaluation indicated the resident was not at risk for elopement.</p> <p>However a review of the resident progress notes, indicated the following:</p> <p>"02-10-12 Res. stating, "I'm going home today. If my [spouse] doesn't take me I will find another way. I'll walk home if I have to."</p> <p>"02-11-12 [spouse] on unit and res. getting angry. Demanding the [spouse] take [resident] home. States 'I'll just leave</p>			

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	<p>on my own."</p> <p>The nursing staff received a physician order dated 02-11-12 for 15 minute checks times 72 hours - Wanderguard bracelet at all times."</p> <p>"02-12-12 Res. angry and exit seeking from 7:00 p.m. to 8:00 p.m. states 'I gotta go home I can't be away from my [spouse].' Res. watched constantly during this time."</p> <p>The nursing staff failed to complete an elopement risk assessment/evaluation until 02-13-12.</p> <p>3. Review of the policy on 03-01-12 at 1:15 p.m., titled "Wander/Elopement Risk Evaluation," dated 10-01-10 indicated the following: "Who completes [bold type] licensed nurses."</p> <p>"Purpose of the Form [bold type]: to provide early identification of residents at risk for wandering and/or elopement: a. Complete on Admission/Readmission for all patients. b. Annually if wanderer or eloper. c. Quarterly if wanderer or eloper. d. New episode of wandering and/or elopement, and or [BLANK]."</p>			

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