

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155732	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/19/2012
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NAME OF PROVIDER OR SUPPLIER RIVEROAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1244 VAIL ST PRINCETON, IN 47670
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F0000	<p>This visit was for the Investigation of Complaint IN00110922.</p> <p>Complaint IN00110922 Substantiated, Federal/State deficiencies related to the allegations are cited at F514 and F9999.</p> <p>Survey date: July 19, 2012</p> <p>Facility number: 004130 Provider number: 155732 AIM number: 200491050</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 19 SNF/NF: 37 Residential: 31 Total: 87</p> <p>Census payor type: Medicare: 11 Medicaid: 22 Other: 54 Total: 87</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>	F0000	<p>Preparation 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 on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during complaint survey review concluding on July 19, 2012. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before August 18, 2012. We respectfully request a desk review for compliance.</p>	
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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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	16.2. Quality review 7/23/12 by Suzanne Williams, RN			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation was accurate regarding a resident's elopement from the facility, in that the original documentation was taken from the clinical record and replaced with false information, for 1 of 3 residents reviewed for elopement documentation, in a sample of 3. Resident A</p> <p>Findings include:</p> <p>The clinical record of Resident A was reviewed on 7/19/12 at 9:55 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>An "Exit Seeking Circumstance Investigation," dated 3/24/12 and</p>	F0514	<p>There were no other residents affected by this alleged deficient practice and through inservicing will ensure documentation remains in medical record with modification if need be. Licensed nurses will be inserviced on documentation guidelines and investigation procedures to ensure accurate information is contained in medical record. Executive Director or her designee will review all elopement documentation and verify with nurse accuracy of event. All elopement occurrences and Executive Director review will be reviewed by QA Committee monthly for 12 months.</p>	08/18/2012			

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	<p>completed by the Director of Nursing [DON], included the following: "...Time of location 1600 [4:00 P.M.], Location found exiting HC [health campus] main door, Who found resident: [LPN # 1], When was the last time seen? same, Was exit witnessed? Yes...Activity prior to exit: In hall by TV room...Stated she was waiting for someone to pick her up...."</p> <p>A nurses note detailing the elopement was not found in the clinical record. During interview with the Medical Records Director on 7/19/12 at 10:20 A.M., she indicated she was unable to locate additional documentation regarding the resident's elopement, but that the "Exit Seeking Circumstance Investigation" also served as a nursing note.</p> <p>During interview with LPN # 1 on 7/19/12 at 11:45 A.M., she indicated she was working the day of 3/24/12, "when someone came up and said [Resident A] was outside in the parking lot. We all ran out there, brought her back in, and put on a wanderguard." LPN # 1 indicated the resident "doesn't really talk," and didn't say anything. LPN # 1 demonstrated where she saw Resident A, which was approximately 25 feet from the main entrance doors. LPN # 1 indicated she thought it was Activity Assistant # 1 who first saw the resident.</p>						

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	<p>During interview with LPN # 2 on 7/19/12 at 12:00 P.M., she indicated she was the nurse caring for Resident A on 3/24/12. She indicated Activity Assistant # 1 saw Resident A outside without a family member, and notified staff. She indicated LPN # 1 went to get the resident. LPN # 2 indicated she wrote about the incident in the nurses notes, and filled out an "Exit Seeking Circumstance Investigation." LPN # 2 indicated she later looked for the circumstance form and was unable to locate it in the clinical record; when she asked the DON about the form, the DON informed her "it needed to be cleaned up."</p> <p>During interview with the Activity Assistant # 1 on 7/19/12 at 2:40 P.M., he indicated he was in one of the front offices, looked out the front window, and saw Resident A outside in her wheelchair without a family member. Activity Assistant # 1 indicated he yelled to the nurses, and went outside to check on the resident. Activity Assistant # 1 demonstrated where he found the resident, which was approximately 20 yards from the main entrance doors. Activity Assistant # 1 indicated the resident told him she "was going home." Activity Assistant # 1 indicated he did not remember if the DON had spoken to him</p>						

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	<p>regarding the incident.</p> <p>On 7/19/12, during confidential interview with a staff member, she indicated she was aware the original documentation regarding the elopement had been taken out of the resident's chart, and the documentation regarding where the resident had been found had been changed.</p> <p>On 7/19/12, during confidential interview with an additional staff member, she indicated she was aware the original documentation regarding the elopement had been taken out of the resident's chart, and the facts had been altered so the elopement "would not have to be reported to the state."</p> <p>On 7/19/12, during confidential interview with an additional staff member, she indicated she heard Resident A had been found outside in the parking lot and that Activity Assistant # 1 had found her. The staff member indicated she had questioned where the circumstance report was, and was told that the DON or Administrator had it in their office, and a new report was made that had different information.</p> <p>On 7/19/12 at 2:05 P.M., during interview with the Administrator, she indicated the</p>				

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	<p>DON had called her on a Sunday evening and told her that Resident A "was exiting out the main Health Center exit." The Administrator did not offer additional information regarding the documentation. The DON was not available for interview.</p> <p>This federal tag relates to Complaint IN00110922.</p> <p>3.1-50(a)(2)</p>			

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F9999	<p>State findings</p> <p>3.1-13 Administration and management</p> <p>The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents....</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to report a cognitively impaired resident's elopement from the facility to the Indiana State Department of Health [ISDH], for 1 of 1 resident who eloped from the facility, in a sample of 3. Resident A</p> <p>Findings include:</p>	F9999	There were no other residents affected by the alleged deficient practice and through inservicing will ensure all elopements are reported to ISDH. The Director of Nursing and all staff will be inserviced on Reportable Guidelines. Executive Director will review all elopement documentation and ensure reports are in compliance with Unusual Occurrence Guidelines. All elopement occurrences will be reviewed by QA committee monthly for the next 12 months.	08/18/2012	

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	<p>The clinical record of Resident A was reviewed on 7/19/12 at 9:55 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>An "Exit Seeking Circumstance Investigation," dated 3/24/12 and completed by the Director of Nursing [DON], included the following: "...Time of location 1600 [4:00 P.M.], Location found exiting HC [health campus] main door, Who found resident: [LPN # 1], When was the last time seen? same, Was exit witnessed? Yes...Activity prior to exit: In hall by TV room...Stated she was waiting for someone to pick her up...."</p> <p>During interview with LPN # 1 on 7/19/12 at 11:45 A.M., she indicated she was working the day of 3/24/12, "when someone came up and said [Resident A] was outside in the parking lot. We all ran out there, brought her back in, and put on a wanderguard." LPN # 1 indicated the resident "doesn't really talk," and didn't say anything. LPN # 1 demonstrated where she saw Resident A, which was approximately 25 feet from the main entrance doors. LPN # 1 indicated she thought it was Activity Assistant # 1 who first saw the resident.</p> <p>During interview with LPN # 2 on 7/19/12 at 12:00 P.M., she indicated she</p>				

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	<p>was the nurse caring for Resident A on 3/24/12. She indicated Activity Assistant # 1 saw Resident A outside without a family member, and notified staff. She indicated LPN # 1 went to get the resident.</p> <p>During interview with the Activity Assistant # 1 on 7/19/12 at 2:40 P.M., he indicated he was in one of the front offices, looked out the front window, and saw Resident A outside in her wheelchair without a family member. Activity Assistant # 1 indicated he yelled to the nurses, and went outside to check on the resident. Activity Assistant # 1 demonstrated where he found the resident, which was approximately 20 yards from the main entrance doors. Activity Assistant # 1 indicated the resident told him she "was going home." Activity Assistant # 1 indicated he did not remember if the DON had spoken to him regarding the incident.</p> <p>On 7/19/12, during confidential interview with a staff member, she indicated she was aware the original documentation regarding the elopement had been taken out of the resident's chart, and the documentation regarding where the resident had been found had been changed.</p>				

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	<p>On 7/19/12, during confidential interview with an additional staff member, she indicated she was aware the original documentation regarding the elopement had been taken out of the resident's chart, and the facts had been altered so the elopement "would not have to be reported to the state."</p> <p>On 7/19/12 at 2:05 P.M., during interview with the Administrator, she indicated the DON had called her on a Sunday evening and told her that Resident A "was exiting out the main Health Center exit." The Administrator indicated there was not an investigation into the elopement and the elopement was not reported to the ISDH, because it was thought the elopement was witnessed.</p> <p>This state finding relates to Complaint IN00110922.</p> <p>3.1-13(g)(1)</p>				