

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155803	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/08/2014
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NAME OF PROVIDER OR SUPPLIER HAMILTON POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3800 ELI PLACE NEWBURGH, IN 47630
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F000000	<p>This visit was for the Investigation of Complaint IN00152039.</p> <p>Complaint IN00152039 - Substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: August 7 and 8, 2014</p> <p>Facility number: 012966 Provider number: 155803 AIM number: 201110390</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 27 SNF/NF: 55 Residential: 50 Total: 132</p> <p>Census payor type: Medicare: 17 Medicaid: 40 Other: 75 Total: 132</p> <p>Sample: 3</p> <p>This deficiency reflects state findings</p>	F000000	<p>The facility requests paper compliance for this citation. <i>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</i></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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F000323 SS=G	<p>cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 13, 2014 by Jodi Meyer, RN</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a cognitively impaired resident was supervised while outdoors unattended, resulting in a fall with multiple skin tears, laceration, and a pelvic fracture, for 1 of 3 residents reviewed for falls, in a sample of 3. Resident A</p> <p>Findings include:</p> <p>1. On 8/7/14 at 9:25 A.M., during the initial tour, RN # 1 indicated Resident A had fallen recently in the courtyard. RN # 1 indicated no staff was with the resident when she fell.</p> <p>The clinical record of Resident A was</p>	F000323	<p>1) Immediate Actions taken for those residents identified:</p> <ul style="list-style-type: none"> · Resident A has been re-assessed utilizing the new policy for residents "Going Outside Unattended" and resident does not qualify to go outside unattended. · Resident CNA care sheets and care plan updated with assessment findings. <p>2) How the facility identified other residents:</p> <ul style="list-style-type: none"> · An audit was run and any other residents identified as having an order to go outside unattended was re-evaluated for meeting policy criteria. <p>3) Measures put into place/System changes:</p> <ul style="list-style-type: none"> · All staff training on policy for resident's "Going Outside Unattended". · All new employees will be trained on policy for resident's "Going 	08/29/2014

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	<p>reviewed on 8/7/14 at 10:40 A.M. Diagnoses included, but were not limited to, dementia, macular degeneration, abnormality of gait, and glaucoma.</p> <p>A resident care plan, dated 2/17/14, indicated: "The resident is at risk for falls r/t [related to] Vision/hearing problems, Gait/balance problems...Interventions: The resident needs a safe environment...Follow facility fall protocol...Ensure appropriate footwear."</p> <p>An additional resident care plan, dated 2/17/14, indicated: "The resident has impaired cognitive function or impaired thought processes r/t short term memory loss, Dementia...Interventions: Communicate with family regarding residents [sic] capabilities and needs...Keep routine consistent...."</p> <p>A Fall Risk Evaluation, dated 5/17/14, included: "Intermittent confusion, 1-2 falls in past 3 months, Vision Status Adequate...." The resident's score rate was documented as "13.0," and Category of fall risk was "High."</p> <p>A Minimum Data Set (MDS) assessment, dated 5/21/14, indicated the resident had a cognitive score of 6, with 15 indicating no memory impairment. The MDS assessment indicated the resident</p>		<p>Outside Unattended". · All residents requesting to go outside unattended will have the following assessment and subsequent interventions prior to allowing to go outside unattended: · Assessment of cognitive status (utilizing BIMS and diagnosis of "dementia" will automatically exclude resident from being allowed to go outside unattended.) · If cognitively alert, resident and responsible party will be informed of potential negative outcomes of being outdoors unsupervised including falls, injury, lack of immediate medical attention if it should be needed, etc. This will be documented in the clinical record. · Physician's order will be obtained stating resident may go outside the facility unsupervised or unescorted. · The resident/responsible party must sign a consent/waiver that states they are aware of the potential negative outcomes of being outdoors unsupervised. This will be witnessed by a facility representative. · A care plan will be initiated to address the resident going outside of the facility unattended with interventions that include a way for the resident to communicate with staff when they are outside of the facility unattended. · The resident's physical and cognitive status should be reviewed periodically to determine the appropriateness of the resident</p>	

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	<p>required extensive assistance of one staff for transfer and ambulation. A test for "Balance During Transitions and Walking" indicated, "Not steady, only able to stabilize with staff assistance." The assessment indicated the resident had fallen one time since the previous assessment.</p> <p>Nursing Progress Notes included the following notations:</p> <p>6/30/14 at 4:43 P.M.: "Resident found outside, face down on concrete, unattended. Resident had a new skin tear to her left forearm and her forehead. Resident sent to [name of hospital] via ambulance...."</p> <p>An Emergency Room history and physical, dated 6/30/14 at 6:00 P.M., indicated: "90 year old female presents to the Emergency Department [ED] from [name of facility] post fall. Patients [sic] daughter states that patient fell out of wheelchair on concrete on the patio at nursing home 1.5 hours prior to arrival...Patient complains of pain to her head, and has a hematoma and laceration to right eye. Patient presents to ED with skin tears to her right knee, left forearm, and right eye. Patient has [prior medical history] of dementia...Physical Exam...2 cm [centimeter] skin tear on right patella</p>		<p>going outdoors unsupervised.</p> <p>4) How the Corrective Actions will be monitored: · Residents will be reviewed quarterly if have MD order to go outside unattended to reassess if resident still meets the criteria to safely go outside unattended. · Residents with current MD order and signed Waiver will be noted in a binder at the nurse's station and noted on the CNA care sheets. 5) Who is Responsible for Monitoring: · DON/Designee 6) Date of Compliance: · August 29, 2014</p>	

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	<p>[knee]; 11 cm skin tear over the ...forearm; 2.9 cm laceration skin tear above right eye; black eye and abrasion to right orbital...Pertinent Results, X-Ray Pelvis...Possible fracture right superior pubic ramus...Procedures...Location above right orbital, Length (cm) 2.9...wound closed with wound adhesive...."</p> <p>The hospital Patient Discharge Disposition document indicated: "Diagnosis, Contusion of head, Fall on same level from slipping...Gait disturbance, Multiple skin tears, Laceration of face, Abnormal x-ray of pelvis."</p> <p>Nursing Progress Notes continued:</p> <p>6/30/14 at 9:00 P.M.: "Resident returned to facility per car, family with her...skin tear to right eye brow - 3.0 x 0.1, skin tear right knee 2.3 x 0.1 with abrasion, skin tear left forearm 8.1 x 0.1...will monitor."</p> <p>7/1/14 at 2:44 P.M.: Received call from triage that pelvic xray shows possible fracture. Triage in [sic] scheduling CT scan...."</p> <p>A CT pelvis report, dated 7/2/14, indicated, "Nondisplaced fracture right</p>			

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	<p>paramidline pubic ramus."</p> <p>On 8/7/14 at 1:20 P.M., during an interview with the Director of Nursing (DON), she indicated her investigation into the incident with Resident A on 6/30/14 revealed CNA # 1, who was on light duty, took the resident outside and left her unattended at approximately 1:40 P.M. CNA # 1 visually checked on the resident at 1:50 P.M., and then went off-duty at 2:00 P.M. CNA # 1 informed the DON that she was given permission by LPN # 1 to take the resident outside. At approximately 2:45 P.M., a housekeeper observed the resident outside lying on the ground, and notified the nurse. The DON indicated she terminated both CNA # 1 and LPN # 1. The DON indicated there was a policy in place regarding leaving residents outside unattended, but that the resident would not have been eligible anyway due to her impaired cognition, unsteady gait, and blindness. The DON indicated that CNA # 1 should have stayed with the resident.</p> <p>On 8/7/14 at 2:00 P.M., the DON provided statements from staff regarding Resident A. A statement written by CNA # 1 indicated, "On June 30th 2014 around 1:15 I was aproched [sic] by [name] asking me to sit with the residents that were in the dining room finishing up.</p>			

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	<p>While sitting there I noticed that [Resident A] was walking and looked as if she was gonna fall. I got her wheelchair and she sat down in it. She stated that she wanted to go outside. I had never took care of [Resident A] and was not sure if she could sit out there by herself. I then pushed her to the nurses station. I asked [LPN # 1] if she was her nurse. [LPN # 1] stated yes and it was okay for her to sit outside it was around 1:25 pm that I took her outside. Around 1:50 I checked on her and she was fine...."</p> <p>An additional statement, written by the DON, indicated: "On the evening of June 30th, I ask [sic] [LPN # 1] who had taken [Resident A] out in the courtyard. [LPN # 1] stated that she did not know [Resident A] was in the courtyard until [housekeeper # 1] had reported it to her. [LPN # 1] left duty without completing an incident report or completing a statement of incident...On the morning of July 1, 2014, I requested a statement of the incident from [LPN # 1]. She at that time informed me that she was not sure but thought that she may have mistakenly thought that [CNA # 1] was referring to another resident...No written statement provided. [LPN # 1 was terminated July 1, 2014."</p> <p>On 8/7/14 at 2:50 P.M., housekeeper # 1</p>						

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	<p>was interviewed. She indicated she was taking her break on 6/30/14 from 2:30 P.M. until 3:00 P.M. She indicated she was unsure what time she looked outside, but "it was probably closer to 3." She indicated she saw Resident A lying face down on the concrete, with her wheelchair behind her. She indicated she immediately ran outside, and the resident was yelling, "Help, help." She indicated, "It was hot out that day." She indicated she then notified a nurse.</p> <p>According to the National Weather Service, on 6/30/14 at 1:54 P.M., it was 90 degrees; at 2:54 P.M., it was 91 degrees.</p> <p>2. On 8/8/14 at 9:45 A.M., the Director of Nursing provided documentation of inservices that she gave to the nursing staff on 6/30/14 and 7/1/14. An In-Service Training Record indicated, "Subject/Topic: Residents are not to be left unattended in the courtyard." An additional In-Service Training Record indicated, "Protocol for Residents Going Outside." The protocol for "Residents Going Outdoors at the Facility Unattended," dated 6/29/09, included: "Residents requesting to go outdoors unattended must have the following criteria completed: 1. Cognitive status should be assessed. MDS section...Short</p>			

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	<p>Term Memory and ...Daily Decision Making Skills should not be impaired nor should the resident have a Diagnosis of Dementia. (If impaired the resident should not be allowed to go outside unsupervised). 2. Resident and responsible party should be informed of potential negative outcomes of being outdoors unsupervised including falls, injury, lack of immediate medical attention should it be needed etc. (This should be documented in the resident's clinical record). 3. A physician's order must be obtained that states the resident may go outside the facility unsupervised or unescorted...A care plan should be initiated to address the resident going outside of the facility unattended with interventions that include a way for the resident to communicate with staff...may include a walkie-talkie, personal cell devise..." Included with the protocol was a "Consent/Waiver To Go Outdoors Unsupervised" which included: "I have been informed of the potential negative outcomes of being outdoors unsupervised such as, but not limited to: Heat and Cold Exposure, Sunburn, Risk of Falling, Injury, Lack of Immediate Medical Attention Should it be Needed...."</p> <p>This Federal tag relates to Complaint IN00152039.</p>			

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