

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/17/2013
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NAME OF PROVIDER OR SUPPLIER  ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F000000	<p>This visit was for the Investigation of Complaint IN00137784.</p> <p>Complaint IN00137784-Substantiated. Federal/State finding cited at F-323.</p> <p>Survey dates: October 16 and 17, 2013</p> <p>Facility number: 000135 Provider number: 155230 AIM number: 100266820</p> <p>Survey team: Angel Tomlinson, RN, TC Sharon Lasher, RN</p> <p>Census bed type: SNF/NF: 73 SNF: 7 Total: 80</p> <p>Census payor type: Medicare: 18 Medicaid: 43 Other: 19 Total: 80</p> <p>Sample: 4</p> <p>This deficiency reflects State finding cited in accordance with 410 IAC</p>	F000000	<p>This Plan of Correction constitutes the centers Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</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 completed on October 21, 2013, by Janelyn Kulik, RN.				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review the facility failed to have preventive measure of a wandergaurd in place for a resident who was at high risk for elopement and failed to accurately assess a resident for elopement resulting in a cognitively impaired resident leaving the building unsupervised for 1 of 4 residents sampled for elopement (Resident #A).</p> <p>Finding include:</p> <p>During initial tour of the secured Alzheimer's Unit on 10-16-13 at 9:30 a.m. Resident #A was not on the unit and was sitting in the long term care dining room in an activity. Interview with the Director of Nursing Services (DNS) at this time indicated all residents that resided on the Alzheimer's Unit had some cognitive impairment.</p> <p>The record for Resident #A was reviewed on 10-16-13 at 10:45 a.m. the resident's diagnoses included, but</p>	F000323	F323 Free of Accident Hazards/Supervision/Devices; It is the practice of Rosebud Village to 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. What corrective action will take place for those residents found to be affected by the deficient practice? Resident #A was not harmed during the alleged deficient practice. Resident #A's elopement assessment was updated immediately following occurrence and a security bracelet was placed. Care Plan and Profile were also updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with cognitive impairment had the potential to be affected. Facility conducted audit of all residents to ensure that all residents have an elopement risk assessment that is up to date and accurate. All residents identified as an elopement risk have a security	11/04/2013			

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	<p>were not limited to, osteoarthritis, osteoporoses, depression, Alzheimer's Dementia and Cerebral Vascular Accident (CVA) (stroke).</p> <p>The record of Resident #A indicated she was admitted to the facility on 4-30-13 on the Alzheimer's Unit.</p> <p>The local hospital notes for Resident #A dated, 4-21-13 indicated the resident had confusion and agitation. The resident was living at an assisted living facility and staff reported the resident had increased confusion and difficulty with direction. The resident had walked out into the street without looking.</p> <p>The local psychiatry note for Resident #A dated, 4-22-13 indicated the resident was found wandering in the streets unsupervised after leaving the assisted living facility causing the resident to be in potential harm. The resident had increased confusion and walked into traffic.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #A dated, 8-1-13 indicated the following: the resident's cognition was severely impaired, had disorganized thinking, was able to walk in room, corridor and off the unit with supervision and setup</p>		<p>bracelet on per physician order. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS/Designee provided facility staff in-service on missing resident/resident elopement policy and procedure. DNS/Designee will review assessment for all new/quarterly assessments and any resident experiencing a significant change to ensure residents are assessed timely and accurately for elopement risk and a security bracelet is placed when applicable. Charge nurse will check for security bracelet placement for each resident assessed to have a security bracelet each shift. How will the corrective actions be monitored to ensure they do not occur again? An elopement CQI monitoring tool will be completed by DNS/designee weekly times four weeks and then monthly times 2 months and quarterly times 1 to total at least six months. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 90% is not met. By what date will the changes occur? 11/04/2013</p>				

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	<p>help only, the resident used a walker.</p> <p>The elopement assessment for Resident #A dated, 5-30-13 indicated the resident was at risk for elopement due to the resident was independently mobile, often request to go home, had a history of elopement, wanders aimlessly and exhibits cognitive impairment. The intervention put in place was monitor the resident's whereabouts. No security bracelet was assigned to the resident.</p> <p>The elopement assessment for Resident #A dated, 8-1-13 indicated the resident was independent with ambulation, did not have a history of eloping and did not have cognitive impairment. The assessment indicated the resident was not at risk for elopement.</p> <p>A progress note dated 6/18/13 at 1:12 a.m., indicated Resident #A was up wandering some of the shift.</p> <p>The progress note date 9/13/13 at 2:00 p.m., indicated Resident #A was up wandering.</p> <p>The progress note for Resident #A dated, 10-4-13 at 9:34 p.m. indicated at approximately 6:20 p.m. the resident left the unit and went outside</p>				

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	<p>following a visitor. The progress note did not indicate the resident was assessed when she was brought back to the unit.</p> <p>The physician telephone order for Resident #A dated, 10-4-13 indicated the resident was to have a wandergaurd bracelet due to exit seeking and poor safety awareness.</p> <p>The progress note for Resident #A dated, 10-6-13 indicated the resident had stood beside the exit door repeatedly throughout the shift.</p> <p>The progress note for Resident #A dated, 10-7-13 indicated the resident had been at the door attempting to exit.</p> <p>During observation on 10-16-13 at 12:15 p.m. Resident #A was ambulating independently with a walker on the Alzheimer's unit, the resident's gait was steady.</p> <p>Interview with Resident #A's family member on 10-16-13 at 1:20 p.m. indicated the resident was admitted to the facility from assisted living because she began wandering and exhibiting unsafe behaviors. The family member indicated when the resident was admitted to the facility,</p>			

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	<p>the facility was aware of the resident's unsafe behavior and wandering. The family member indicated it concerned the family the resident eloped from the facility on 10-4-13 because there was a four lane highway in front of the facility and the resident was confused. The family member indicated the resident could have gotten lost and felt the resident's well being and safety was compromised. The family indicated the resident should have had a wandergaurd placed on admission due to the history of wandering.</p> <p>During observation on 10-16-13 at 2:10 p.m. Resident #A was ambulating independently on the Alzheimer's Unit with a walker, the resident's gait was steady.</p> <p>Interview with LPN #1 on 10-16-13 at 2:00 p.m. indicated she was the nurse on duty on 10-4-13 when Resident #A left the building. LPN #1 indicated she had seen Resident #A and another resident following a visitor down the hallway. LPN #1 indicated the CNA #2 went down the hallway to get the residents. LPN #1 indicated she did not see Resident #A leave the unit and she assumed CNA #2 had gotten both residents. LPN #1 indicated she did not know the resident was gone</p>				

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	<p>until another staff member brought Resident #A back to the unit. LPN #1 indicated the resident was off the unit 5 minutes or less.</p> <p>Interview with CNA #2 on 10-16-13 at 2:16 p.m. indicated she was the CNA working on 10-4-13 when Resident #A left the facility. CNA #2 indicated she had seen Resident #A and another resident at the door with the visitor. CNA #2 indicated both residents were wanting to go with the visitor. CNA #2 indicated she went and got the residents and thought Resident #A was behind her. CNA #2 indicated when she looked back Resident #A was not behind her and she assumed the resident had gone into her room. CNA #2 indicated she did not know Resident #A was gone until another staff member brought the resident back to the unit and indicated the resident was wandering around outside the facility.</p> <p>During an observation on 10-16-13 at 2:30 p.m. from the Alzheimer Unit to the front exit doors there were 4 offices, therapy room, salon, dining room, clean linen room, dirty linen room, staff break room, housekeeping room, rehabilitation nursing station, mechanical room, pantry, laundry services, central supply, storage room</p>			

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	<p>and a dining room. There were 18 rooms from the Alzheimer's Unit to the front exit doors.</p> <p>Interview with the Maintenance supervisor on 10-16-13 at 2:35 p.m. indicated all doors to the outside alarms if a resident with a wandergaurd exits the facility.</p> <p>Interview on 10-16-13 at 2:45 p.m. with the visitor Resident #A followed out of the building on 10-4-13 indicated she knew someone was behind her when she left that evening but did not know it was a resident. The visitor indicated she was elderly and walked with a cane and was unable to watch who was behind her because she had to be careful walking down the hallway herself. The visitor indicated it was a long walk from the Alzheimer Unit to the front door and it was difficult for her to walk it. The visitor indicated when she left the facility that evening another visitor held the exit door open for her and the resident. The visitor indicated it was not until she got outside that she realized it was a resident following her. The visitor indicated Resident #A asked her if she could go with her in her car. The visitor indicated she told Resident #A she was not allowed to take her in her car. The visitor</p>						

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	<p>indicated Resident #A began walking around the right side of the building. The visitor indicated a staff member came out and got the resident. The visitor indicated she did not see the staff member take Resident #A back into the facility.</p> <p>Interview with DNS on 10-16-13 at 3:55 p.m. indicated she agreed the elopement assessment for Resident #A dated 8-1-13 was incorrect, Resident #A did have a history of elopement and did have cognitive impairment. The DNS indicated the reason a wandergaurd was not placed on Resident #A when she was admitted was because the resident was on a secured unit. The DNS indicated after the incident with Resident #A leaving the building on 10-4-13 she went over the facility policy on elopement and it indicated all residents who were at risk for elopement should have a wandergaurd in place.</p> <p>Interview with DNS on 10-16-13 at 4:15 p.m. indicated she talked with LPN #1 and the nurse had done a head to toe assessment on Resident #A when she returned to the unit on 10-4-13. DNS indicated LPN #2 did not document the assessment and did not do vital signs on the resident</p>						

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	<p>when she returned to the unit on 10-4-13.</p> <p>The missing resident/resident elopement policy provided by the DNS on 10-16-13 at 3:40 p.m. indicated the following: "It is the policy of this facility that personnel who have residents under their care are responsible for knowing the location of these residents." " Elopement risk residents will have a security bracelet on."</p> <p>This federal tag relates to Complaint Number IN00137784.</p> <p>3.1-45(a)(2)</p>				