

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/16/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00197582 and Complaint IN00200354.</p> <p>Complaint IN00197582 - Substantiated. Federal/State deficiencies are cited at F323.</p> <p>Complaint IN00200354 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: June 15 and 16, 2016</p> <p>Facility number: 000016 Provider number: 155042 AIM number: 100291500</p> <p>Census bed type: SNF/NF: 103 Total: 103</p> <p>Census payor type: Medicare: 15 Medicaid: 70 Other: 18 Total: 103</p> <p>Sample: 6</p> <p>This deficiency reflect State findings</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323 SS=G Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on June 20, 2016.</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 supervision to prevent falls, resulting in a fall with a head laceration requiring sutures; and failed to ensure supervision to prevent a resident from eloping, for 3 of 5 residents reviewed for supervision, in a sample of 6. Resident A, Resident E, and Resident C</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident A was reviewed on 6/15/16 at 1:40 P.M. Diagnoses included, but were not limited to, dementia and history of falls. Documentation indicated the resident resided on the Alzheimer's Care Unit.</p>	F 0323	<p><u>F 323- Free of Accident Hazards/Supervision/Devices</u> What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident A expired. Resident C was discharged from Willow Manor. Resident E who has a history of falls within the last 3 months has been reassessed by the IDT. New interventions have been added to Care Plan. Fall Audits will continue to be done by nursing staff weekly. IDT will reassess Resident E no less than weekly during Behavior Management Meetings. Residents Care Plan will be modified as needed. If potentially unsafe behaviors are noted, resident will be placed on 1:1 supervision immediately. This 1:1</p>	07/16/2016

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	<p>Nurse's Notes included the following notations:</p> <p>3/2/16 at 4:30 P.M.: "Resident was up in w/c [wheelchair] this nurse just put shoes back on resident and this nurse turned to get sock off table resident pulled self out of chair by grabbing on to table et [and] slid out of w/c...."</p> <p>A Minimum Data Set (MDS) assessment, dated 3/15/16, indicated Resident A was unable to complete a brief interview for mental status, had a short- term and long-term memory problem, and was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated Resident A required extensive assistance of one staff for bed mobility and transfer, and did not ambulate. A test for balance during transitions and waling indicated, "Not steady, only able to stabilize with staff assistance" while moving from a seated to standing position, and surface-to-surface transfer. The resident had fallen since the previous assessment.</p> <p>A Care Plan, dated 4/30/14 and updated with a goal of 7/28/16, indicated, "Potential for Falls related to: unaware of limitations, weakness, dementia with behaviors. History of falls." The</p>		<p>will continue until IDT hasre-assessed and determine that a decrease in monitoring is warranted. Resident Ewill be reassessed no less than weekly to determine level of monitoring and/orneed for discharge if determined that we cannot meet his needs.</p> <p>How other residentshaving the potential to be affected by the same deficient practice will be identifiedand what corrective will be taken:</p> <p>IDT will reassess allresidents for fall and elopement risks. The Care Plan will be modified toreflect any new interventions. Interventionsmay include 1:1 supervision, 15 minute checks, Tab alarms, up to discharge ofthe resident.</p> <p>What measures will beput in place or what systemic changes will be made to ensure that the deficientpractice does not recur:</p> <p>Fall Audits are completed no less then weekly. Behaviormetings weekly. The elopement at risk binder is reviewed at least weekly. Maintenance to continue safety checks on all egresses tomake sure windows and doors are functioning properly as part of preventive maintenance.</p> <p>Staff will be in-serviced on Fall Preventions/Free ofaccidents/hazards/supervision/de vices, and elopement prevention. Staff will bein-serviced on monitoring residents, anticipating need, and providing adequate</p>	

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	<p>Interventions included: "Alarms as ordered. Dycem to wheelchair. Encourage resident to be compliant with limitations and to ask for assistance as needed. Evaluate all falls for cause and attempt to prevent further falls, innitiate [sic] appropriate interventions...."</p> <p>Nurse's Notes included the following notations:</p> <p>4/2/16 at 8:30 A.M.: "Resident asleep in bed till this time in shift, upon arising, this nurse noted deep purple bruise (4 x 8 cm) to [right] temporal [head] area. Resident states she fell - but doesn't recall when...Will monitor."</p> <p>4/4/16 at 7:45 P.M.: "Resident alert and cooperative. She was sitting in dining room peacefully. Environmental aid [sic] walked to front of hallway to redirect another resident and this nurse heard a large crash. After investigation it was noted this resident had fallen out of wheelchair onto ground in dining room. This resident was noted to be laying on left side with head laying on ground. She is able to move all extremities...Upon body assessment a hematoma [raised bruise] was noted to left temporal lobe...Resident placed in bed and alarms were turned on. Call bell within reach...."</p>		<p>supervision.</p> <p>The Nurse Aide Assignment sheets will updated to highlight residents who are considered high fall risk.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</p> <p>Monitoring will occur thru the daily 24 hour Report, shift to shift assignments sheets, no less then weekly Fall Audits, and no less then weekly Behavior Management meetings. Maintenance log for facility doors and windows.</p> <p>By what date the systemic changes will be completed.</p> <p>07/16/2016</p>	

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	<p>4/7/16 at 9:15 P.M.: "Resident was checked on to find her sitting on floor/mat in room. resident was attempting to sit on edge of bed and slid to ground...."</p> <p>4/14/16 at 5:00 P.M.: "Resident was [up] in w/c earlier pulling self up by the handrails on wall, CNAs put resident in regular chair [with] alarm resident rocking in chair leaned to the left and tipped chair over CNA's [sic] broke resident's fall she would not hit head. Resident received bruise to the [left] side of neck shoulder area...."</p> <p>4/28/16 at 6:45 P.M.: "...CNA called for this nurse. This nurse ran back the hall [sic] to find resident laying on right side unresponsive with eyes shut legs slightly bent with right arm under left arm bent and head touching floor. Wheelchair was pulled away from table. Under head blood was noted...asked other nurse to call 911...attempted sternum rub on resident several times as well as attempting to say resident's name several times...EMT was en route."</p> <p>4/28/16 at 7:00 P.M.: "EMT arrived...to hospital."</p> <p>4/28/16 at 3:00 P.M. "Back charting - Resident was restless this nurse took</p>			

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	<p>resident on a walk outside. Resident was in wheelchair...brought resident back inside. Resident began to scream...assisted CNA to laying resident down in bed...Resident began to yell and then attempted to get out of bed. This nurse assisted CNA to place resident in wheelchair...Resident was then set at table on 1:1 with CNA so she could eat a snack and have a drink."</p> <p>4/28/16 at 6:30 P.M. "Back charting. Resident sitting at table in wheelchair with head looking down (appears to be resting). [No] c/o [complaints of] pain/discomfort noted."</p> <p>4/28/16 at 7:15 P.M.: "Once resident was on way to hospital this nurse obtained witness accounts from both CNA's [sic]. [CNA # 1] stated resident was sitting to her direct right. CNA heard alarm sound 1 time. CNA turned around at same time residents [sic] head hit the floor. CNA stated wheelchair was locked in position at table. As CNA moved wheelchair backwards she yelled for this nurse. This nurse then approached seen [sic] (dining room) to assess resident...."</p> <p>4/29/16 [sic] at 9:00 P.M.: "This nurse called [name of hospital] ER to check on condition of resident. ER nurse stated bleeding was from arterial tare [sic]. No</p>			

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	<p>abrasion to head noted...Resident had 2 sutures placed in artery and bleeding subsided...She was admitted for observation."</p> <p>An Emergency Room note, dated 4/28/16, indicated, "Chief Complaint: Fall...Apparently she has one-on-one assistance at the nursing home and has some dementia. Today she was up and got away from the staff and fell onto the right frontal area of her head...There is some bleeding at the right frontal area with a puncture type laceration...the area of bleeding was addressed with two nylon sutures...."</p> <p>A hospital history and physical, dated 4/28/16, indicated, "Chief Complaint: Forehead/scalp hematoma secondary to a fall. History of Present Illness: ...She was sent to the emergency room on this occasion because of a large forehead/scalp injury from a fall...The ER physician put 2 sutures to stop the bleeding...the family claims that she is now less responsive...The patient is only responsive to painful stimuli...Assessment and Plan: 1. Acute encephalopathy/unresponsiveness and large right frontoparietal forehead/scalp hematoma secondary to a fall...."</p> <p>On 6/15/16 at 2:30 P.M. during an</p>			

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	<p>interview with CNA # 1, she indicated she was "agency staff," but that she frequently worked on Resident A's unit. She indicated Resident A "liked to lunge" out of her chair. She indicated on 4/28/16 Resident A had been agitated, and she had brought her up to the dining area. She indicated she stood up and "was opening snacks for everyone," when Resident A fell sideways out of her chair. She indicated she thought that she was within an arm's length of the resident.</p> <p>On 6/15/16 at 2:45 P.M., during an interview with LPN # 1, she indicated she was "agency staff." She indicated she did not usually work that particular unit. She indicated she was working on 4/28/16, and Resident A had increased agitation. LPN # 1 indicated she did not know how the accident happened, because she had put the resident on 1:1 monitoring "because she was so agitated." LPN # 1 indicated she was at the nursing station when CNA # 1 yelled out for her. She indicated she did not hear an alarm, but that the CNA told her it had sounded.</p> <p>2. On 6/15/16 at 10:15 A.M., during the initial tour of the Alzheimer's Care Unit, the Director of Nursing (DON) indicated Resident E had recently fallen.</p> <p>The clinical record of Resident E was</p>			

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	<p>reviewed on 6/16/16 at 9:20 A.M. Diagnoses included, but were not limited to, dementia.</p> <p>A Minimum Data Set (MDS) assessment, dated 4/19/16, indicated Resident E was unable to complete a brief interview for mental status, had a short-term and long-term memory problem, and was severely impaired in cognitive skills for daily decision making. The MDS assessment indicated the resident required extensive assistance of one staff for bed mobility and transfer, and extensive assistance of two+ staff for ambulation. A test for balance during transitions and walking indicated "Not steady, only able to stabilize with staff assistance" while moving from a seated to standing position, walking, turning around, and surface-to-surface transfer. The resident had fallen since the previous assessment.</p> <p>A care plan, dated 5/10/12 and updated to a goal of 6/20/16, indicated, "The resident has a potential for falls r/t [related to] history of falls, decreased vision, dementia, psychotropic meds." The Interventions included, "The resident needs a safe environment...Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for</p>			

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	<p>assistance as needed...4-24 A [assist] x 2 [with] ambulation.</p> <p>An additional care plan, undated, indicated, "At risk for physical injury from falls related to: Unsteady ambulation, Use of high risk medication." The Interventions included: "Assist of [two] for transfers. 6/15/16 [Change] to A x 1. Bed alarm. 5-14-16 Place in high traffic area..."</p> <p>Nurse's Notes included the following notations:</p> <p>4/24/16 at 3:45 A.M.: "Res [resident] fell to floor on bottom while being walked by CNA to BR [bathroom], [no] injury, denies pain, will continue to monitor."</p> <p>4/27/16 at 1:00 A.M.: "Has gotten out of bed by self x 2 to go to BR. Bed alarm on [and] functioning. Assisted to BR [one] person. Gait unsteady [with] [decreased] balance. No complaints."</p> <p>4/27/16 at 12:30 P.M.: "Res cont q [every] 15 min staff checks - Res frequently self transfers. Res gait unsteady...Res enc to use call bell or ask for staff assist...."</p> <p>5/14/16 at 11:00 A.M.: "Resident was in room alarm sounding...entered room</p>			

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	<p>resident trying to stand up wanting to make bed lost balance fell backward et [and] hit head on chair resident was assessed by nurse...Intervention to place in high traffic area...."</p> <p>5/22/16 at 10:00 P.M.: "Res alarm sounded. Staff responded. Res found lying on side [with] head near tray stand. Approx 10 ml blood on floor and back of head. Cleansed site [with] saline. Sm [small] abrasion approx 2 cm x 1 cm...."</p> <p>6/4/16 at 5:00 P.M.: "...Staff asked family to please stay [with] resident due to high risk of falls. This writer was told to hire more people. I explained resident falls often and to pls [sic] not leave unattended. Wife again said his needs are high hire more help. Res frequently is redirected due to self transferring. Res cued for needs and wants by staff."</p> <p>6/10/16 at 4:35 A.M.: "This nurse checked resident at 0430 [4:30 A.M.], resident in bed et alarm on. At 0435 resident was on bathroom floor laying on [right] side [with] blood coming from [right] hand, alarm had been shut off...Skin tear on [right] knuckle had re-opened, skin tear noted on [right] pinky, [right] ring finger, et [right] middle finger...."</p>			

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	<p>6/11/16 at 7:30 P.M.: "...Assist of [two] [with] ambulation...resident attempted several times to get up on his own alarm sounding...."</p> <p>6/15/16 at 3:40 A.M.: "Res alarm sounding. CNA responded to alarm to find res on floor. Res hit head and L [left] elbow. Res tore his alarm up in process of getting up out of bed...Placed res on Q 2 [hour] toileting schedule...."</p> <p>6/15/16, untimed: "Clarification - Res on Q 1 [hour] toileting schedule...to be evaluated for UTI [urinary tract infection]...."</p> <p>6/16/16 at 1:30 A.M.: "...large dark purple bruise noticed on [right] arm above elbow...Res. alarm on and working. Res. was reminded to call for help when getting up...."</p> <p>On 6/16/16 at 9:40 A.M., CNA # 2 and CNA # 3 indicated they were going to ambulate Resident E to the bathroom. CNA # 3 indicated Resident E "was a two person assist." Using a gait belt, CNA # 2 and CNA # 3 ambulated the resident. The resident did not verbalize, and gait was slow and unsteady. A dark purple bruise was observed on the resident's right hip. CNA # 3 indicated, "He fell early yesterday."</p>			

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	<p>On 6/16/16 at 9:55 A.M., the Unit Manager indicated staff had found a large bruise on Resident E's right arm following the resident's fall. The resident was observed to have a large dark purple bruise on his right upper inner arm. The Unit Manager indicated it was measured at 24 cm x 20 cm. She indicated, "The resident probably tried to break his fall with that arm."</p> <p>On 6/16/16 at 2:15 P.M., the DON provided the current facility policy on "Fall Management," revised November 2014. The policy included: "Each resident is assisted in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and/or functional programs as appropriate to minimize the risk for falls..A Plan of Care is developed and implemented...with ongoing review...."</p> <p>3. The closed clinical record of Resident C was reviewed on 6/16/16 at 11:30 A.M. Diagnoses included, but were not limited to, Alzheimer's disease and cerebrovascular disease. Documentation indicated the resident resided on the Alzheimer's Care Unit.</p>			

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	<p>A hospital note, dated 4/12/16, indicated, "...While a patient [at nursing facility] he was exit seeking, restless, anxious, demanding...Even so much as crawled out a window and facility and the police saw him walking down the road...Judgment: Impaired, Insight: Impaired...Poor cognitive and physical ability..."</p> <p>An Elopement Risk Assessment, dated 4/14/16, indicated, "Is the resident cognitively impaired with poor decision making skills (i.e. intermittent confusion or disorientation) No. Does the resident have a diagnosis of dementia...Alzheimer's...? Yes. Does the resident ambulate independently? Yes. Does the resident have a history of elopement...Yes. Does the resident have a history of leaving the facility without the need for supervision? Yes. Has the resident verbally expressed the desire to go home...? Yes...Resident is at risk for elopement related to: [left blank]."</p> <p>Nurse's Notes included the following notations:</p> <p>4/27/16 at 6:30 P.M.: "Res became abruptly upset and demanded to leave. Res stated he will start breaking windows out unless he leaves...Res was telling staff repeatedly he will leave sometime</p>			

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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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	<p>tonight...."</p> <p>5/1/16 at 2:00 P.M.: "Res wants to go home, wants to know who or what he has to see or do to get out of here...Close supervision continues."</p> <p>5/3/16 at 10:05 P.M.: "...Resident continues to talk about leaving and how he needs to do it, conversation helpful for short period of time. Cont [with] close supervision...."</p> <p>A quarterly MDS assessment, dated 5/4/16, indicated the resident scored a 11 out of 15 for cognition, with 15 indicating no memory impairment. The resident required supervision and set up help only with bed mobility, transfer, and ambulation. A test for balance during transitions and walking indicated, "Not steady, but able to stabilize without staff assistance" while moving from a seated to standing position, walking, and surface-to-surface transfer. The resident had fallen since the previous assessment.</p> <p>Nurse's Notes included the following notations:</p> <p>5/15/16 at 3:00 P.M.: "Res frequently exit seeking this shift. Res was observed carrying [two] door knobs from cabinets in hand. Res was holding them to</p>			

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	<p>window. Res was observed at a different time evaluating/examining another resident window. Res redirected...."</p> <p>5/19/16 at 11:30 P.M.: "Resident pleasant wanting to leave states all he needs is screwdriver will figure out some way to get out...."</p> <p>5/28/16 at 11:30 A.M.: "(Late Entry) 06:30 CNA entered residents [sic] room to assist him...CNA went et opened curtains et noted there was a knife wedged in the top of the window near the window lock...Resident denied having the knife or using it on the window when asked about it...Cont [with] 15 min checks for resident safety...."</p> <p>6/8/16 at 10:40 P.M.: "...Expresses the need to leave the facility really wants to leave will find a way. Resident was in [another resident room] had his cane up by window pushing on the screws resident redirected to dining room...."</p> <p>A Social Service Note, dated 6/9/16 and untimed, indicated, "Nurse [name] informed social worker res was in [another resident's room] trying to open window with cane...Social worker [name] informed maintence [sic] Res was attempted [sic] to open window in [another resident's room] by using his</p>			

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	<p>cane to pry window block off...Maintenance [sic] fixed [and] checked window...Spoke to staff about resident wandering in rooms and educated them on elopement prevention. Res. remains on 15 min checks."</p> <p>Nurse's Notes continued:</p> <p>6/10/16 at 3:45 P.M.: "Resident was finishing up [with] activities in dining area et was going back to room activity assistant walked [with] resident to his room...."</p> <p>6/10/16 at 4:00 P.M.: "This Nurse went to resident's room to do his 15 minute check et resident was not in his room. This nurse also checked bathroom but was unable to locate resident...All staff members began checking each room on both units to locate resident...1615 [4:15 P.M.] Resident was located on [nearby apartment complex] grounds by staff et transported back to facility...."</p> <p>6/10/16 at 10:00 P.M.: "When res located @ 1615 he was wearing long-sleeve flannel shirt, sweat pants, socks et shoes. Res had his cane et a bag of personal belongings."</p> <p>A hospital emergency room note, dated 6/10/16, indicated, "...Pt [patient] has</p>			

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	<p>been in the nursing home for awhile...He does not like the nrg [sic] home...Today he climbed out the window and escaped...he tells me this is the 2nd time he has done this...."</p> <p>A hospital history and physical, dated 6/10/16, indicated, "...Apparently, the patient attempted to climb out of the window of his nursing home x 2 prior to reporting to the emergency department...."</p> <p>According to weather reports for the facility's location, the temperature on 6/10/16 at 4:00 P.M. was 92 degrees.</p> <p>On 6/16/16 at 9:45 A.M., during an interview with the Unit Manager, she indicated that following the resident's previous elopement attempt, a wooden block was screwed to the each window top. She indicated the room where the resident exited the window was across the hall and two rooms down from the resident's room. A wooden block, approximately 2 inches x 2 inches was screwed to the top of the window frame. The Unit Manager indicated, "We think he pried the wooden block off with his cane." The window exited to the facility parking lot. The Unit Manager indicated the resident apparently went around the side of the building, and was found on</p>			

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	<p>the grass by a nearby apartment complex. The Unit Manager indicated she felt like the resident had probably "been working on it for awhile," referring to the wood block.</p> <p>On 6/16/16 at 2:15 P.M., the DON provided the current facility policy on "Elopement Prevention, Identification, and Management," dated 6/10/16. The policy included: "It is the policy of this facility to ensure that each resident receives adequate supervision and assistive devices to prevent elopements and that all personnel will report and investigate all reports of missing residents...."</p> <p>This Federal tag relates to Complaint IN00197582.</p> <p>3.1-45(a)(2)</p>			