

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2014
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NAME OF PROVIDER OR SUPPLIER HERITAGE POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N HUNTINGTON AVE WARREN, IN 46792
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 4, 5, 6, 7, 8 and 11, 2014</p> <p>Facility number: 000542 Provider number: 155705 AIM number: 100267380</p> <p>Survey team: Jason Mench, RN, TC Angela Selleck, RN Tina Smith Staats, RN Shelley Reed, RN (August 4, 5, 6, 7 and 11 2014) Vickie Nearhoof, RN (August 4, 5, 6, 7 and 8 2014) Deb Barth, RN (August 4, 5, 6, 7 and 8 2014)</p> <p>Census bed type: SNF: 8 SNF/NF: 138 Residential: 172 Total: 318</p> <p>Census payor type: Medicare: 8 Medicaid: 69 Other: 241 Total: 318</p>	F000000	<p>Heritage Pointe is submitting our facility's Plan of Correction to the deficiencies of the Health Survey conducted by your department on August 4, 2014 through August 11, 2014 Our staff wants to compliment the team of Jason Mench, RN TC; Angela Selleck, RN; Tina Smith Steats, RN; Shelley Reed, RN; Vickie Nearhoof, RN; and Deb Barth, RN, who performed the ISDH survey this year, for their professionalism and cooperation during the survey</p> <p>This letter and Plan of Correction serves as our allegation of compliance that by August 23, 2014, Heritage Pointe will have corrected the cited deficiencies and have all of the systemic changes implemented to comply with State and Federal regulations. In view of the fact that the noted deficiencies cited fall at a Level D with no quality of care findings on the scope and severity scale, we would like for you to consider accepting the enclosed written paper compliance as evidence of correction to confirm our substantial compliance in lieu of an on-site visit.</p> <p>We have requested an IDR for the following deficiencies: F225 and F226. Please review the supporting documentation to support this request.</p> <p>We heartily thank you and your</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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F000225 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in</p>		department for your service.		

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	<p>progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to report an incident of a resident harming themselves to the appropriate agency for 1 of 3 residents reviewed for abuse. (Resident #68)</p> <p>Findings include:</p> <p>During an interview with Social Worker #2 on 8/6/14 at 11:05 a.m., she indicated Resident #68 was sent to an inpatient psychiatric hospital on 6/23/14 for evaluation in regards to an incident on 6/23/14. Resident #68 used a razor to scratch her wrist.</p> <p>Resident #68's clinical record was reviewed on 8/6/14 at 8:50 a.m. Diagnoses included, but were not limited to, senile dementia with delusional features and depression. A review of Resident #68's Minimum Data Set Assessment (MDS) indicated the Resident was moderately cognitively impaired.</p>	F000225	<p>F225 Plan of Correction: How other residents were identified for the potential to be affected by the same deficient practice: All incident reports were reviewed for the past quarter. No other residents were identified to at this time to be affected by the same practice. What corrective action for residents found to have been affected by the deficient practice were put into place? The incident was reported to ISDH, APS, Ombudsman, and local police via fax upon instructions of on-site surveyors. Measures put into place or changes that will be made to prevent re-occurrence. The facility's policy for abuse labeled "Abuse Prevention/Intervention" reviewed. All staff is being in-serviced on the facility's policy regarding abuse and reporting Indiana state rule IAC16.2-3.1-13 (g) reviewed. How corrective actions will be monitored to prevent</p>	08/14/2014			

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	<p>A "Report of Concern" investigation, dated 6/23/14, provided by the Administrator on 8/11/14 at 10:00 a.m., indicated the resident had been found alone in her room, sitting in her wheel chair with blood on her left wrist and a razor sitting on the bedside table. Five superficial scratches were noted to Resident #68's left wrist upon assessment. MD and family were notified and the resident was sent out to a behavioral psychiatric hospital for evaluation.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 8/6/14 at 12:00 p.m., the Administrator indicated this incident was not reported because it did not meet the requirements of their policy for reporting incidents to the State.</p> <p>A policy, "Abuse Investigation", dated 2011 and updated in 2013, provided by the Administrator on 8/7/14 at 2:00 p.m., indicated:</p> <p>"Policy Statement: All reports of resident abuse, neglect, misappropriation of resident property and injuries of an unknown source shall be reported immediately to the Administrator/CEO of the facility and to other officials in</p>		<p>re-occurrence: Staff will continue in-services regarding facility abuse policies upon hire quarterly Any concerns will be reviewed by the QA committee quarterly and as needed We respectfully request an informal dispute resolution (IDR) for Tag F-0225 (paper review): The facility's policy for abuse labeled "Abuse Prevention/Intervention" reviewed. All staff is being in-serviced on the facility's policy regarding abuse and reporting. Indiana state rule 41 IAC 16.2-3.1-13 (g) reviewed. Staff will continue in-services regarding facility abuse policies upon hire and quarterly. All incident reports were reviewed for the past quarter. Any concerns will be reviewed by the Q.A. committee quarterly and as needed The cited deficiency states the facility failed to report an incident of a resident to the appropriate agency for 1 of 3 residents reviewed for abuse. Please see the supporting documentation regarding the investigation of self-harm. The Reportable Incidents policy released from ISDH with an effective date of 11/15/1997 with a last reviewed date of 6/30/2011 and last revision date of 1/15/2013</p>				

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	<p>accordance with State law and thoroughly investigated....</p> <p>"...6. In addition to the family and physician, the person in charge of the investigation will notify the Ombudsman, Adult Protective Services and the Indiana State Department of Health, within 24 hours, that an investigation is being conducted. One or more Law Enforcement entities and the secretary of Health and Human Services shall also be notified....</p> <p>"...7. If the event results in serious bodily injury, the report shall be made by calling 9-1-1 immediately, but not later than 2 hours after forming the suspicion. This includes any injury that involves extreme pain, risk of death, loss or impairment of the function of a body part, organ, or mental faculty or requiring medical intervention such as surgery, hospitalization or physical rehabilitation...."</p> <p>A policy "Abuse Reporting," dated 2011, and provided by the Administrator on 8/7/14 at 2:00 p.m., indicated:</p> <p>"...3. When an alleged or suspected case of mistreatment, neglect, abuse, or injuries of an unknown source is reported; the facility administrator or</p>		<p>states the following: (5) <i>Injuries of an unknown source</i> <i>An injury should be classified an injury of unknown source when both of the following are met:</i></p> <p><i>1. The source of the injury was not observed by any person or the source of the injury could not be explained by the residents and</i></p> <p><i>2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g. the injury is an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time.</i></p> <p>(6) Significant Injuries A) <i>Examples, but not inclusive of all:</i></p> <p><i>1) injuries sustained while a resident is physically restrained:</i></p> <p><i>2) large areas of contusions or large lacerations as identified in facility policy:</i></p> <p><i>3) fractures sustained by a totally dependent resident (as defined on MDS):</i></p> <p><i>4) burns greater than first degree:</i></p> <p><i>5) serious unusual and/or life threatening injury:</i></p> <p><i>6) choking requiring hospitalization</i></p> <p>The injury to resident #68 on 6/23/2014 was self-inflicted per the resident's self-report. Resident#68 had a BIMS completed on 6/13/2014 indicating resident is interviewable. Resident reported to house supervisor at the time of the incident that she was trying to get a scab off of her wrist then stated she was trying to shave</p>				

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	<p>designee will notify the following persons or agencies such incident.</p> <ul style="list-style-type: none"> a. State Board of Health b. Ombudsman c. Resident representative d. Adult Protective Services e. Local Law Enforcement f. Resident Physician <p>"4. If the incident results in bodily harm to a resident or anyone receiving services in the facility, the police must be notified within 2 hours by contacting the local police or by dialing 9-1-1. "</p> <p>3.1-28(c)</p>		<p>her face. Resident reported to the social worker approximately thirty minutes later after shaving her whiskers that she had picked an area on her face until it bled then she wiped her face with her wrist and used the razor to get the blood off of her wrist. Resident denied any intent of self-harm. Resident received 5 superficial scratches which were treated with first aid. The son of resident #68 was contacted and notified of the incident and immediately reported to the facility. The resident had experienced an increase in behaviors over the previous two weeks prior to this incident; therefore, upon physician notification at the time of the incident, the physician gave orders for the resident to be admitted to an inpatient behavioral health unit. The resident's safety was ensured by a staff member sitting 1:1 with the resident until the resident exited the facility with EMS staff. The above incident did not meet the facility's reporting policy for abuse or unusual occurrences policy. The above incident did not meet the guideline of the ISDH Reportable Incidents Policy. "Per the above stated guideline, injuries should be classified as unknown source when both of the following are met"</p> <p>1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and</p>		

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F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policy related to an incident of a resident harming herself to the appropriate agency for 1 of 3 residents reviewed for abuse. (Resident #68)	F000226	2.The injury is suspicion because of the extent of the injury or the location of the injury. The injury was self-injurious per the resident's report eliminating the "injury of unknown source" reporting guideline. ·The resident's safety (from further self-inflicting injuries) was ensured by a staff member remaining with the resident until time of transfer. ·There was no significant harm. ·The injury was documented per the nurse responding at the time of the incident as 5 superficial scratches. The guidance does not list criteria as occurred with this incident As a result, the facility respectfully requests F-0225 and F-0226 be deleted Please note the facility's Suicide Prevention policy was followed and the administrator, physician, and family were immediately notified per policy F226 Plan of Correction: How other residents were identified for the potential to be affected by the same deficient practice: All incident reports were reviewed for the past quarter What corrective action for	08/14/2014	

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	<p>Findings include:</p> <p>During an interview with Social Worker #2 on 8/6/14 at 11:05 a.m., she indicated Resident #68 was sent to an inpatient psychiatric hospital on 6/23/14 for evaluation in regards to an incident on 6/23/14. Resident #68 used a razor to scratch her wrist.</p> <p>Resident #68's clinical record was reviewed on 8/6/14 at 8:50 a.m. Diagnoses included, but not limited to, senile dementia with delusional features and depression. A review of Resident #68's Minimum Data Set Assessment (MDS) indicated the Resident was moderately cognitively impaired.</p> <p>A "Report of Concern" investigation, dated 6/23/14, provided by the Administrator on 8/11/14 at 10:00 a.m., indicated the resident had been found alone in her room, sitting in her wheel chair with blood on her left wrist and a razor sitting on the bedside table. Resident #68 had requested the razor at shift change to shave her chin. Five superficial scratches were noted to Resident #68's left wrist upon assessment and first aid was given. The MD and family were notified and the resident was sent out to a behavioral psychiatric</p>		<p>residents found to have been affected by the deficient practice were put into place? The incident was reported to ISDH, APS, Ombudsman, and local police via fax upon instructions of on-site surveyors</p> <p>Measures put into place or changes that will be made to prevent re-occurrence The following facility's policies for reporting abuse policy labeled "Abuse Reporting", "Abuse Investigation", and "Reporting a Reasonable Suspicion of a Crime" were reviewed. The facility policy "Unusual Occurrences – Reportable to I.S.D.H." reviewed. Indiana state rule IAC16.2-3.1-13 (g) reviewed</p> <p>How corrective actions will be monitored to prevent re-occurrence: Staff will continue in-services regarding facility abuse policies upon hire quarterly Any concerns will be reviewed by the QA committee quarterly and as needed We respectfully request an informal dispute resolution (IDR) to Tag F-0226 (paper review) The following facility's policies for reporting abuse policy labeled "Abuse Reporting", "Abuse Investigation", and "Reporting a Reasonable Suspicion of a Crime" were reviewed. The facility policy "Unusual Occurrences – Reportable to</p>				

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	<p>hospital for evaluation.</p> <p>During an interview with the Administrator and Director of Nursing (DoN) on 8/6/14 at 12:00 p.m., the Administrator indicated this incident was not reported because it did not meet the requirements of their policy for reporting incidents to the State.</p> <p>A policy, "Abuse Investigation", dated 2011 and updated in 2013, provided by the Administrator on 8/7/14 at 2:00 p.m., indicated:</p> <p>"Policy Statement: All reports of resident abuse, neglect, misappropriation of resident property and injuries of an unknown source shall be reported immediately to the Administrator/CEO of the facility and to other officials in accordance with State law and thoroughly investigated....</p> <p>"...6. In addition to the family and physician, the person in charge of the investigation will notify the Ombudsman, Adult Protective Services, and the Indiana State Department of Health, within 24 hours, that an investigation is being conducted. One or more Law Enforcement entities and the secretary of Health and Human Services shall also be notified....</p>		<p>I.S.D.H." reviewed.</p> <p>Abuse policies continue to be provided to staff upon hire and quarterly. Concerns will be addressed by the Q.A. Committee quarterly and as needed. The cited deficiency states based on interview and record review, the facility failed to implement their policy related to an incident of a resident harming herself to the appropriate agency for 1 of 3 residents reviewed for abuse. The facility policy states that any time an alleged violation involving mistreatment, neglect, abuse, or injuries of an unknown source is reported, the facility administrator or designee will notify the following persons or agencies of such incident.</p> <ol style="list-style-type: none"> 1. State Board of Health 2. Ombudsman 3. Resident representative 4. Adult Protective Services 5. Local Law Enforcement 6. Resident physician <p>There was no alleged violation of the facility's policy requiring such report be submitted. The facility has a policy in place regarding abuse. The policy is followed as evidenced by review of all reportable investigations sent into the appropriate entities through the year. The facility has reported over 50 incidents over the past year. While one might argue this does not happen every day (thus seen as "unusual"), one would question why it was seen as a deficient</p>				

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	<p>"...7. If the event results in serious bodily injury, the report shall be made by calling 9-1-1 immediately, but not later than 2 hours after forming the suspicion. This includes any injury that involves extreme pain, risk of death, loss or impairment of the function of a body part, organ, or mental faculty or requiring medical intervention such as surgery, hospitalization or physical rehabilitation..."</p> <p>A policy "Abuse Reporting", dated 2011, and provided by the Administrator on 8/7/14 at 2:00 p.m., indicated:</p> <p>"...3. When an alleged or suspected case of mistreatment, neglect, abuse, or injuries of an unknown source is reported; the facility administrator or designee will notify the following persons or agencies such incident.</p> <ol style="list-style-type: none"> State Board of Health Ombudsman Resident representative Adult Protective Services Local Law Enforcement Resident Physician <p>"4. If the incident results in bodily harm to a resident or anyone receiving services in the facility, the police must be notified within 2 hours by contacting the local</p>		<p>practice for the facility's failure to report the event to ISDH when the act itself or the injury does not meet the criteria listed in the state rule nor the unusual guidance. The incident did not require emergency services for treatment of injury. The resident was provided treatment/services necessary—whether the resident's account was accurate or the act, was in fact, an attempt of self-injurious behavior, which was the most important factor. The facility is well familiar with the unusual occurrences guidance, and has a history of compliance. Had the facility believed the incident to meet the criteria, the facility in good faith would have reported accordingly. However, the guidance does not list criteria as occurred with this incident. As a result, the facility respectfully requests F225 and F226 be deleted. Please note that the facility's Suicide Prevention policy was followed and the administrator, physician, and family were immediately notified per policy.</p>				

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F000309 SS=D	<p>police or by dialing 9-1-1."</p> <p>3.1-28(a)</p> <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 observation, interview, and record review, the facility failed to implement a management plan with individualized interventions for maladaptive behaviors for 1 of 3 residents reviewed for behavior management. (Resident # 170)</p> <p>Findings include:</p> <p>Resident #170 was observed, on 8/6/14 at 3:45 p.m., in the lounge area of the unit at the medication cart trying to open the juice container. CNA #2 redirected the resident to a recliner to watch television, but did not offer him a drink.</p> <p>On 8/06/14 at 3:50 p.m., Resident #170 was sitting in the recliner in the lounge. He got up to adjust a female resident's sweater. After approximately 1 minute,</p>	F000309	<p>How other residents were identified for the potential to be affected by the same deficient practice:</p> <ul style="list-style-type: none"> ·Behavior documentation of all residents residing in the dementia unit was reviewed to identify other potential residents affected by the same practice. ·Dementia Unit Director interviewed to identify other residents potentially affected by the same practice. <p>No other residents were identified at this time to be affected by the same practice.</p> <p>What corrective actions for residents found to have been affected by the deficient practice were put into place?</p> <ul style="list-style-type: none"> ·In-servicing has been provided to all direct care staff working in the dementia units on the appropriate documentation for wandering as a behavior, and appropriateness and 	08/23/2014

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	<p>CNA #2 noticed, then redirected Resident #170 back to the recliner and chatted with him for a moment.</p> <p>During a Stage 1 interview on 8/4/14 at 11:37 a.m., Resident #161 indicated another resident (Resident #170) wandered into his room at night. He indicated the resident was able to ambulate himself and resided in the same general area. He indicated the resident wandered into his room only at night and had done it several times. He indicated he would put on his call light and staff would then remove him. He indicated it really bothered him when the resident came into his room.</p> <p>The clinical record for Resident #170 was reviewed on 08/06/14 at 9:05 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, senile dementia with delusional features, anemia, COPD, cancer, chronic kidney disease, and CVA.</p> <p>A review of an 8/5/14 untimed Progress Notes record indicated "Doing well-stable behaviors according to staff."</p> <p>On 08/06/2014 at 2:28 p.m., a Behaviors record review, dated 7/5/14 at 7:47 a.m., indicated Resident #170 was "wandering in and out of residents' rooms without</p>		<p>effectiveness of interventions.</p> <ul style="list-style-type: none"> · In-servicing is being provided to all direct care givers throughout facility regarding appropriate behavior charting and the effectiveness of interventions in place. · Resident #170 was re-leveled utilizing the <i>Global Deterioration Scale for Assessment of Primary Degenerative Dementia</i> assessment. Resident #170 levels at a mid-5 to early 6 which indicates the resident resides in the appropriate unit per the facility's dementia programming policies. · Policy and procedure for dementia programming reviewed. · Care-plan reviewed and revised for resident #170 to meet the resident's individualized needs. · O.T. to re-evaluate dementia programming for activities of interest for resident #170. · An Activity box with activities of interest that was previously given to resident #170 will be up-dated with activity items, as identified per O.T. <p>Resident #170 is a retired minister. Religious activities to be provided to resident during times of increased wandering. DVD</p>		

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	<p>purpose, Resident #161 in room 159 was upset. Staff were able to easily redirect." There was no documentation of other interventions having been tried to prevent the resident from entering other resident rooms uninvited.</p> <p>The care plan indicated a "Problem - Chronic confusion related to altered awareness/cognition...risk for elopement due to often wanders. Goal - Resident will (everyday) participate in ADLs at the maximum of functional ability-will remain content and free from harm thru next review." Interventions included: "Approach resident in a calm manner, calling their name-decrease stimuli in environment, for example, turn off TV, take resident to quiet environment as needed-determine resident's cognitive level using screening tool as per facility policy-give one simple direction at a time and repeat it as necessary-observe for changes in cognition and adjust care/approaches as appropriate- promote sleep by providing restful environment-wanderguard on at all times- provide structured activities appropriate for ability interests-segment tasks as appropriate to not overwhelm resident-meds as ordered."</p> <p>The care plan indicated an 11/12/13 problem of "Resident has potential for</p>		<p>player withspiritual DVD's placed in resident's room with instructions for staff toutilize.</p> <p>Resident #170 sleeping pattern monitored to identifysleeping habits. If resident tends to have decreased sleep and wandering duringnight, a sensor alarm is to be placed on the resident's door to alert staff ofresident wandering in order to provide an appropriate intervention and toprovide privacy for other residents.</p> <p>Measures put into place or changes that will be made to prevent re-occurrence.</p> <p>Staff instructed to reassess resident's physical needs byoffering snacks, drinks, and activities of interest and toileting at times ofbehaviors.</p> <p>Primary care physician will review medications forpossible side effects or potential for medication reduction.</p> <p>Resident added to Behavior Management Program forbehavior management and monitoring.</p> <p>Resident currently attends fitness room exercise program2 times per week. Staff willattempt/encourage participation 4 times per week.</p>		

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	<p>wandering and exit seeking." The goal was "Resident will remain safe within bounds of secured unit." Interventions included "Encourage resident to be busy in constructive manner, independent activities, sorting match organizing-give gentle cues, reorientation when in wrong room, offer to assist him to his room, find a bathroom-help him find his room to reduce risk of wandering into other residents' rooms - secured unit for safety and specialized environment."</p> <p>On 08/06/14 at 3:55 p.m., in an interview with LPN #1, she indicated Resident #170 had behaviors and liked to wander into the next room. She also indicated Resident #161 did not like Resident #170 entering his room without permission. "We redirect Resident #170. All resident behaviors and interventions are documented in nursing notes and behaviors (incidents)."</p> <p>An interview with CNA #2, on 08/07/14 at 9:17 a.m., indicated Resident #170 wore a wanderguard and had wandering tendencies, but was easily redirected. Staff would go up to him and talk to him, bring him out to the lounge. "CNAs should tell the nurse when Resident #170 has had behaviors and they took him out of other residents' rooms." She also indicated staff had been working on</p>		<p>How correctiveactions will be monitored to prevent re-occurrence:</p> <p>Behavior documentation will be reviewed by social workerweekly to identify behaviors and resident's wandering for patterns and trendsweekly for 4 weeks. Then will re-evaluate need for further monitoring per Q.A.committee.</p> <p>Social Worker will speak with 2 staff members from firstshift and second shift weekly for four weeks then monthly for three months, toensure documentation supports staff reports of behaviors as well as reviewingappropriateness and success of interventions.</p>				

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	<p>interventions to prevent him from wandering into other residents' rooms. Resident #170 "gets to a depressed state and does not want to go with an aide." Staff tried someone else to approach him, holding his Bible and had him go into his room. "The nurse was passing meds and seen (sic) him then stating I need you to come with me to go and have lunch, or set up with a puzzle on his own. Nurse is to document on charting about wandering behaviors. Everyday in the afternoon he goes into other residents' rooms. He goes into other's rooms daily."</p> <p>During an interview on 08/07/2014 at 9:25 a.m., CNA #3 indicated Resident #170 liked to wander but was easily redirected with gentle cues, if staff listened and walked with him. Resident #170, he indicated, had wandering behaviors on a daily basis mostly in the afternoons. "We redirect him and try to keep him out of residents' rooms. We keep residents' doors closed. We have tried stop signs but were unsuccessful. It seems to draw his attention to pull the signs out."</p> <p>On 08/07/14 at 9:44 a.m., during an interview with Social Worker #1, she indicated Resident #170 had behaviors "but we don't want to use restraints because Resident #170 is independent</p>			

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	<p>and mobile on his own. We are struggling with interventions that work, can't tell resident #170 to just sit. He has a short attention span and the sensor (clip alarm) does not work. Staff state that Resident #170 goes into other residents' rooms looking for his wife. Resident #170 is mentally unable to use the phone. He just looks for his wife. Resident #170 was a minister and is looking for someone to minister to and he puts his arm around people. Stop signs in doorways have been tried, but did not work. He (Resident #170) has limited verbal skills. We need to do something more (interventions). What should we do? We are struggling. We have an activity box for more hand activities, head sets with music. His wife is in ill health with a knee injury. Resident #170 has limited attention span, just on the go, all the time, wandering. I don't know what to try. Staff have become used to his wandering and are no longer charting on how to stop him from going into others' rooms. Maybe he is wandering into other rooms to minister. We need to find alternatives and document the interventions."</p> <p>Documentation titled "Progress notes by resident - Mood & behavior incidents" were reviewed on 8/8/14 at 9:00 a.m. The only evidence documented as a</p>			

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R000000	<p>behavior incident of wandering was on 7/5/14 at 7:47 p.m. No interventions were charted for the prevention of the wandering.</p> <p>3.1-34(a)</p> <p>This visit was for a State Licensure Survey.</p> <p>Survey dates: August 4, 5, 6, 7, 8 and 11, 2014</p> <p>Facility number: 000542 Provider number: 155705 AIM number: 100267380</p> <p>Survey team: Jason Mench, RN, TC Angela Selleck, RN Tina Smith Staats, RN Shelley Reed, RN (August 4, 5, 6, 7 and 11 2014) Vickie Nearhoof, RN (August 4, 5, 6, 7 and 8 2014) Deb Barth, RN (August 4, 5, 6, 7 and 8 2014)</p> <p>Census bed type: SNF: 8 SNF/NF: 138 Residential: 172</p>	R000000	<p>Heritage Pointe is submitting our facility's Plan of Correction to the deficiencies of the Health Survey conducted by your department on August 4, 2014 through August 11, 2014 Our staff wants to compliment the team of Jason Mench, RN TC; Angela Selleck, RN; Tina Smith Steats, RN; Shelley Reed, RN; Vickie Nearhoof, RN; and Deb Barth, RN, who performed the ISDH survey this year, for their professionalism and cooperation during the survey</p> <p>This letter and Plan of Correction serves as our allegation of compliance that by August 23, 2014, Heritage Pointe will have corrected the cited deficiencies and have all of the systemic changes implemented to comply with State and Federal regulations. In view of the fact that the noted deficiencies cited fall at a Level D with no quality of care findings on the scope and severity scale, we would like for you to consider accepting the enclosed written paper compliance as evidence of</p>	

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	<p>Total: 318</p> <p>Census payor type: Medicare: 8 Medicaid: 69 Other: 241 Total: 318</p> <p>Residential sample: 9</p> <p>Heritage Pointe was found to be in compliance with 410 IAC 16.2-5.</p>		<p>correction to confirm our substantial compliance in lieu of an on-site visit.</p> <p>We have requested an IDR for the following deficiencies: F225 and F226. Please review the supporting documentation to support this request.</p> <p>We heartily thank you and your department for your service.</p>		