

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00160773.</p> <p>Complaint IN00160773-Substantiated. Federal/State deficiency related to the allegation were cited at F323.</p> <p>Survey Dates: December 15 and 16, 2014</p> <p>Facility number: 000072 Provider number: 155152 AIM number: 100287440</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF: 14 SNF/NF: 85 Total: 99</p> <p>Census Payor type: Medicare: 17 Medicaid: 64 Other: 18 Total: 99</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after January 15, 2015</p>	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F000323 SS=D	<p>Quality review completed on December 17, 2014, by Janelyn Kulik, 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. Based on observation, record review, and interviews, the facility failed to ensure a resident with a history of elopements, had an intervention of a Physician's ordered Wanderguard (alarmed bracelet) in place, to prevent the resident from further elopement, for 1 of three residents reviewed for elopement risk, in a total sample of 6. (Resident #C)</p> <p>Findings include:</p> <p>During an interview on 12/15/14 at 3:50 a.m., LPN #1 indicated Resident #C has had prior elopements from the facility and the resident has a Wanderguard bracelet, which the facility puts in the</p>	F000323	<p>It is the practice of this provider to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Based on the information provided, Resident C's care plan and elopement risk were reviewed. Resident C was admitted to a secure unit in the facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient</p>	01/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>resident's coat pocket because when it was applied to his ankle, the would take the bracelet off. She indicated sometimes the bracelets were applied to the resident's wheelchair.</p> <p>During an observation on 12/15/14 at 6:15 a.m., Resident #C was sitting on the side of his bed, the wheelchair was sitting next to the bed. The resident had a flannel coat on. The wheelchair did not have a Wanderguard bracelet attached and the resident indicated there was nothing in his pockets of the coat.</p> <p>At the time of the observation, the Director of Nursing (DoN) indicated on "12/11/14 or 12/12/14", the Wanderguard bracelet had been removed from the resident's coat pocket and applied to the resident's ankle. The DoN indicated the resident no longer had the bracelet on his ankle. The DoN stated, "I don't know what happened." Resident #C, then self propelled the wheelchair down the hall towards the dining room.</p> <p>During an interview on 12/15/14 at 7:05 a.m., the DoN indicated Resident #C had his Wanderguard bracelet on his ankle on 12/12/14. The DoN indicated she was investigating where the Wanderguard bracelet was. She indicated Resident #C had no other attempts to leave the</p>		<p>practice and what corrective action will be taken?</p> <p>All residents that are at risk for elopement have the potential to be affected by the alleged deficient practice.</p> <p>The interventions and care plans for residents at risk for elopement have been reviewed to ensure compliance. Residents with physician's orders for a wanderguard were reviewed to ensure the wanderguard is in place by the Director of Nursing Services or her designee.</p> <p>The aide assignment sheets have been updated to reflect appropriate elopement risk interventions. Nursing staff will be re-educated on elopement risk intervention by January 15, 2015 by the Clinical Education Coordinator or her designee.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Nursing staff will be re-educated on elopement risk interventions by January 15, 2015 by the Clinical Education Coordinator or her designee.</p> <p>A Post Test will be administered. Aide Assignment sheets are updated to reflect changes in the residents' needs regarding elopement risk. Each resident's care plan is reviewed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>building.</p> <p>During an interview 12/15/14 at 7:40 a.m., LPN #1 indicated the Wanderguard bracelets were to be checked for positioning every night. LPN #1 indicated no one had informed her the bracelet had been taken out of the resident's coat pocket. LPN #1 indicated it was documented on the Medication Administration Record (MAR), dated 12/14, the bracelet was checked for placement and function. LPN #1 indicated she was going by what the Evening Nurse had said.</p> <p>Resident #C's record was reviewed on 12/15/14 at 6:50 a.m. The resident's diagnoses included, but were no limited to diabetes mellitus, kidney disease and schizophrenia.</p> <p>The Admission Minimum Data Set assessment, dated 11/17/14, indicated the resident was cognitively intact, had no behaviors, required extensive assistance of two for transfers and one for locomotion.</p> <p>A care plan, dated 10/13/14, indicated the resident wandered, wanted to leave the facility, and was exit seeking. The interventions included, 10/13/14-monitor whereabouts and redirect as needed.</p>		<p>and updated quarterly and as needed to reflect the residents' needs regarding elopement risk. The Charge Nurse will ensure that resident's elopement risk interventions are in place and ensuring CNA assignment sheets are followed each shift per the care plan by conducting rounds .</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · The CQI tool titled "Elopement Risk" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed as a threshold of 95% is not met to ensure continual compliance. · The Director of Nursing Services or her designee is responsible to monitor for compliance. <p>Compliance Date: January 15, 2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>10/13/14-Wanderguard applied to the resident's ankle.</p> <p>The care plan was again reviewed on 12/16/14 at 12 p.m. and the following had been added, 12/15/14-Wanderguard to wheelchair. Check placement and function per policy and motion sensor to doorway when in room.</p> <p>The resident's Care/Need Sheet (CNA's guide for care), dated 12/10/14 at 4:14 p.m. and received from RN #2, indicated the resident had a Wanderguard bracelet on the wheelchair and the resident was an elopement risk. The sheet indicated the Wanderguard in the resident's coat had been discontinued (a line was drawn through the intervention).</p> <p>A Physician's Order, dated 10/31/14, indicated and order for a Wanderguard, Check for placement every shift, 7 a.m. through 3 p.m., 3 p.m. through 11 p.m., and 11 p.m. through 7 a.m.</p> <p>The MAR, dated 12/14, indicated the Wanderguard bracelet had been checked for placement and function on every shift, including 12/14/15, 11 p.m. through 12/15/14 7 a.m. shift.</p> <p>A Social Service Progress Note, dated 10/10/14 at 3:34 p.m., indicated the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident had been deemed mentally incompetent and had an appointed Guardian. The note indicated the resident had attempted to go outside of the facility.</p> <p>A Nurses' Note, dated 12/06/14 at 10:30 a.m., indicated when the Nurse returned from break, she was informed the resident had been found outside the building, walking down Main Street with an unsteady gait. The note indicated CNA's had been outside and observed the resident going towards Main Street. The note indicated the resident was brought back to the building and was upset and wanted to go home.</p> <p>A Nurses' Note, dated 12/06/14 at 10:45 a.m., indicated the resident had been placed on 15 minute checks.</p> <p>A Nurses' Note, dated 12/06/14 at 11:07 a.m., indicated the facility attempted to place a new Wanderguard on the resident and the resident refused.</p> <p>A Nurses' Note, dated 12/06/14 at 12:11 p.m., indicated the resident got out of the building two more times.</p> <p>A Nurses' Note, dated 12/06/14 at 3:28 p.m., indicated a Wanderguard bracelet was placed on the resident's wheelchair.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The Safety Check List-15 Minutes, indicated 15 minute checks had been completed on 12/6/14, 12/7/14, 12/8/14, 12/9/14, 12/10/14 until 11:45 a.m., then resumed on 12/11/14, 12/12/14, 12/13/14, 12/14/14, and 12/15/14 until the resident went on a leave of absence at 8:30 a.m.</p> <p>An interview with LPN #3 (Nurse working 12/06/14) on 12/15/14 at 8:49 a.m., LPN #1 indicated when the resident left the building the other two times, the alarms went off and staff responded immediately.</p> <p>During an interview with LPN #3 on 12/15/14 at 10:05 a.m., LPN #3 indicated the resident had pulled Wanderguard bracelet off the wheelchair after the second elopement. LPN #3 indicated the elopements had been witnessed by the staff after the alarm on the door alerted them the resident was opening the door.</p> <p>A Nurses' Note, dated 12/10/14 at 10:22 p.m., indicated the resident had a Wanderguard bracelet on his ankle.</p> <p>A Nurses' Note, dated 12/13/14 at 9:57 a.m., indicated the resident had been sitting by the front door and a visitor had held the door open for the resident and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>when the resident attempted to go out the door the alarm sounded and the staff immediately responded.</p> <p>During an interview on 12/15/14 at 8:20 a.m., LPN #1 indicated at the time of the elopement attempt on 12/13/14, the resident had the Wanderguard bracelet was located on the resident's ankle and as soon as the alarm sounded, the staff were there and the resident had not stepped out of the building.</p> <p>During an interview on 12/15/14 at 12:15 p.m., the Administrator indicated the Nurse working on 12/14/15 on the 7 a.m. to 3 p.m. shift had indicated the Wanderguard bracelet was on the resident's ankle.</p> <p>During an interview on 12/16/14 at 11:15 a.m., the DoN indicated the facility was still investigating when the Wanderguard bracelet had been taken off. She indicated the resident's care plan did not indicate where the Wanderguard had been applied to and did not indicate the resident would removed the Wanderguard.</p> <p>A facility policy, dated 10/13, titled, "Elopement (Risk and Missing Resident)", received from the DoN as current, indicated, "...Residents at risk for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>elopement may utilize a security bracelet...will be checked for placement and function no less often than daily..."</p> <p>This Federal Tag relates to complaint IN00160773.</p> <p>3.1-45(a)(2)</p>			