

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER Hillside Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E National Highway Washington, IN 47501	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>39130</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient behavioral health care for 1 of 1 residents reviewed for elopement. A resident with documented behaviors was not provided additional monitoring or services during a behavioral episode that resulted in the resident eloping from the facility, unwitnessed. (Resident B)</p> <p>Finding includes:</p> <p>During a review of facility reported incidents on 3/21/24 at 10:45 A.M., an incident dated 2/25/24 at 8:20 P.M. , included that Resident B was requesting nursing staff to buy him cigarettes throughout the day. Resident B was upset and demanded to go to the gas station across the street for cigarettes. While staff was down the hall, Resident B went outside into the courtyard and exited the courtyard gate.</p> <p>During record review on 3/21/24 at 12:00 P.M., Resident B's diagnoses included, but were not limited to undifferentiated schizophrenia, acquired absence of right leg below knee, partial traumatic amputation of left midfoot and nicotine dependence, cigarettes.</p> <p>Resident B's most recent MDS (Minimal Data Set) dated 2/16/24, included that the resident had severe cognitive impairment, had not displayed behaviors, used a wheelchair for mobilization, and had one-sided lower extremity impairment.</p> <p>Resident B's care plan included, but was not limited to resident is at risk for behavior problem due to schizophrenia (dated 11/9/23).</p> <p>Care plan interventions for behaviors included, administered medications as ordered and monitor for effectiveness (11/9/23), explain all procedures to the resident before starting and allow the resident to adjust to changes (11/9/23), and mental health referral as needed (11/17/23).</p> <p>Resident B's care plan was not updated following the incident on 2/25/24.</p> <p>Resident B's physician orders included, but were not limited to, Lorazepam 2mg/ml (milligram per milliliter), give 2 mg intramuscularly 3 times a day as needed every 8 hours for agitation (started 1/30/24). The medication was not administered during the month of February.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident B's progress notes included no documentation of resident behavior on 2/25/24 prior to or following the reported elopement from the facility. No documentation of the elopement on 2/25/24 was found in the resident's notes.</p> <p>A recent behavioral health facility discharge summary, dated 1/2/24, included expected plans of Resident B will demonstrate improved impulse control, decreased aggression and improved ability to self-regulate and express emotions in more appropriate ways.</p> <p>During an observation on 3/21/24 at 11:00 A.M., Resident B wheeled himself up and down the front hall from the facility administrator's office to the front nurse's station, repeatedly asking the nurse for cigarettes by putting one finger up. The front hall nurse told Resident B that she already gave him cigarettes.</p> <p>During an interview on 3/21/24 at 11:45 A.M., the DON (Director of Nursing) indicated that Resident B was in his wheelchair and exited the facility courtyard unwitnessed on 2/25/24. He crossed the highway and went to a gas station about half a block away. The gas station then called facility to alert them that the resident was there. The DON indicated Resident B is alert and knows what he is doing. He was mad about the cigarettes. He had not previously attempted to elope and had never been considered exit seeking prior to the incident.</p> <p>During an interview on 3/21/24 at 12:45 P.M., the Facility Administrator indicated that Resident B had thrown a temper tantrum over his cigarettes on 2/25/24.</p> <p>During an interview on 3/21/24 at 12:55 P.M. QMA 6 indicated she had never observed Resident B exit seeking. No residents are allowed to smoke unsupervised, but residents are allowed onto the courtyard and doors from facility are unlocked to courtyard. There is a gate in the courtyard, but it should be kept locked.</p> <p>During an interview on 3/22/24 at 1:50 P.M., the DON indicated that Resident B should have a behavioral tracking log in his record but that the resident did not have one.</p> <p>On 3/22/24 at 11:25 A.M., the DON supplied a facility policy titled, [Facility] Behavior Management Program, dated 02/2015. The policy included, Purpose: To manage, and track inappropriate behaviors that affect a residents' psychosocial well-being. The program will provide specific interventions for staff to manage reduce or eliminate harmful behavior to help ensure all residents safety. Policy: [Facility] will provide a Behavior management Program for the safety, protection and well-being of all residents. Resident in the facility who present behavior issues or potential behavior patterns will be tracked in the program . 10. If a resident behavior put self or others at significant risk immediate action will taking (sic) to ensure the safety and well-being of the resident and others .</p> <p>3.1-37(a)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39130</p> <p>Based on interview and record review, the facility failed to ensure that complete and accurate records were maintained for 2 of 4 resident records reviewed. A resident's record contained no documentation of an elopement occurrence, nor were the behaviors that reportedly led up to the incident or any monitoring following the elopement documented. A resident's wound treatment orders were not updated in the resident's record and wound treatment documentation was not completed accordingly. (Resident B, Resident C)</p> <p>Findings include:</p> <p>1. During a review of facility reported incidents on 3/21/24 at 10:45 A.M., an incident dated 2/25/24 at 8:20 P. M., included that Resident B was requesting nursing staff to buy him cigarettes throughout the day. Resident B was upset and demanded to go to the gas station across the street for cigarettes. While staff was down the hall, Resident B went outside into the courtyard and exited the courtyard gate</p> <p>During record review on 3/21/24 at 12:00 P.M., Resident B's diagnoses included, but were not limited to undifferentiated schizophrenia, acquired absence of right leg below knee, partial traumatic amputation of left midfoot and nicotine dependence, cigarettes.</p> <p>Resident B's progress notes included no documentation of resident behavior on 2/25/24 prior to or following the reported elopement from the facility. No documentation of the elopement on 2/25/24 was found in the resident's notes nor was the incident documented in any of the resident's records.</p> <p>2. During an interview on 3/21/24 at 12:10 P.M., Resident C indicated that nursing staff do not change his wound dressing per the wound care orders.</p> <p>During record review on 3/22/24 at 10:00 A.M., Resident C's diagnoses included, but were not limited to quadriplegia, overactive bladder, neurogenic bowel, and overactive bladder.</p> <p>Resident C's most recent Quarterly MDS (Minimum Data Set), dated 12/28/23, included that the residents cognition was moderately impaired.</p> <p>Resident C's physician orders and treatments for the month of March, 2024 included but was not limited to a treatment order to right hip;</p> <p>apply SurePrep protective wipes to peri- wound skin with wound filler Puracol Plus AG (alginate) plus Collegan, with a secondary dressing of Quick and Alleevyn Gentle Border 3 times per week, dated 2/22/24. The treatment administration record for March, 2024 included that the treatment order had been completed on 3/1/24 and 3/8/24.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident C's wound care center visit notes from 3/7/24 included that the previous dressing order was changed to SurePrep protective wipes to peri-wound skin with a primary dressing of Aquacel Alginate Advantage and a secondary dressing of Quick and Allewyn Gentle Border to be done every other day for 1 week.</p> <p>Wound care center visit notes from 3/14/24 included that the previous weeks dressing order was updated to SurePrep protective wipes to peri-wound skin with wound filler Aquacel extra alginate and a secondary dressing of Allewyn Gentle Border to be done 3 times weekly for 1 week.</p> <p>Wound care center visit notes from 3/21/24 continued the order from 3/14/24.</p> <p>During an interview on 3/22/24 at 1:30 P.M., RN 4 indicated that Resident C's treatment orders should be updated in the resident's record following each treatment order change from the wound care center, and that nursing staff should document the dressing changes in the resident's treatment administration record.</p> <p>During an interview on 3/22/24 at 1:50 P.M., the DON (Director of Nursing) indicated there isn't a specific policy for documentation but that it's part of the nurse's job description and that nursing staff knows the must document in the resident's record.</p> <p>On 3/22/24 at 2:00 P.M., the DON supplied an undated Job Description for Staff Nurses. The job description included, .Performance requirements: Responsible for: . Maintains accurate and complete records of nursing observation and care .</p> <p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</p>		