Avalon Gardens Rehabilitation & Health Care Center, LLC

Deficiency Details, Complaint Survey, March 4, 2011

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PFI: 0949
Regional Office: MARO--Long Island sub-office

Back to Inspections page

F323 483.25(h): FACILITY IS FREE OF ACCIDENT HAZARDS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 29, 2011

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.

Citation date: March 4, 2011

Based on observation, record review and staff interviews during an abbreviated survey the facility did not ensure that each resident with wandering behaviors was assessed and care planned for to prevent elopement and protect the resident's well-being. Specifically, one of six residents reviewed for elopement (Resident #1), with a history of wandering was not identified as at risk for elopement. Resident #1 was observed at approximately 3:05 PM to exit an alarmed gate by two staff members, who did not attempt to retrieve the resident. The facility was unaware of the resident's whereabouts for approximately 25 minutes until a passerby alerted facility staff of the resident's location.
ne This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Complaint ID Number: NY00092071nene Resident #1 is 63 years old who was admitted to the facility on 4/23/10 with diagnoses including Bi-Polar Disorder and ETOH (alcohol)-induced Dementia.nene The Hospital Patient Review Instrument dated 4/23/10 documented that the resident "has limited ability to communicate and can become disorganized."nene The Hospital Discharge Summary dated 4/23/10 documented that the resident is "poorly communicative, displaying disorganized behavior, poor insight and judgment."nene The Comprehensive Care Plan (CCP) for behavior dated 4/27/10 documented that the resident exhibits wandering/walks aimlessly. The CCP lacked documented Monitoring interventions.
ne The CCP for adjustment to long-term care updated on 8/3/10, documented the resident walks aimlessly.nene The Psychiatric Consultation Report dated 4/28/10 documented that the resident has alcohol induced persisting dementia.nene The Minimum Data Set 2.0 (MDS) (an assessment tool) dated 5/4/10 documented that the resident's short-term memory and long-term memory are impaired. Cognitive Skills for Daily Decision-Making is moderately impaired. Wandering behavior is coded as occurring daily and not easily altered. The resident ambulates independently.nene The Elopement Risk Assessment (ERA) dated 4/29/10 and updated 8/10/10 documented that the resident was at low risk for elopement. The ERA's predisposing risk factors included a section for wandering behavior was not completed. This risk factor would automatically place Resident#1 at high risk for elopement, requiring a plan of care including the placement of a wander guard (an electronic device worn by residents which sounds an alarm at

exits).nene The Policy and Procedure on Elopement Prevention (PPEP) documented that an elopement assessment is reviewed within 24 hours of admission. PPEP specified indicators of wandering or elopement behavior as: MDS assessment indicating 'wandering behavior' , mobility and history of substance abuse.nene The Occurrence Report dated 9/24/10 documented that the resident was seen by a Certified Nursing Assistant (CNA) and a recreation therapist walking outside the gate. The nursing supervisor was immediately notified and the resident was brought back inside. No injuries were noted and a wander guard was placed on the resident.nene The Occurrence Investigative Report Summary [undated] documented "this facility has responded appropriately with assessing the resident and following policy on elopement prevention ...Elopement policy and missing resident policy and procedures have been reviewed which was found to be compliant."nene The Integrated Progress Notes dated 9/27/10 documented that the Registered Nurse Manager (RNM) spoke with the resident's niece, regarding placement of a wander guard on the resident the niece was in agreement with the facility because the resident had eloped in the past.nene In a written statement to the facility dated 9/27/10 a Certified Nursing Assistant (CNA) admitted to taking a group of residents outside the facility to smoke. The CNA was waiting for the resident to finish smoking but left the resident in the courtyard to bring other residents back into the facility. The CNA did not see the resident leave the courtyard and there was never a head count policy for bringing residents out to smoke. [The CNA refused to be interviewed by the surveyor.] nene On 10/13/10 at 1530 the Director of the Behavioral Unit (DBU), where the resident resides, was interviewed. The DBU stated that the resident has antisocial behavior and wander around the unit but has not been at risk for elopement. The DBU stated that she thought the resident saw an opportunity to leave and took it. nene On 10/14/10 at 1110 the Security Guard (SG) was interviewed. The SG stated he initially received a call from the Recreation Aide about a resident walking outside. Subsequently, he received a call from a passerby stating that there was a guy wearing pajamas and slippers on Route 25A (a four lane highway). The SG called the nursing supervisor, who issued a Code Amber (an alert to staff of a missing resident). The SG stated that he would not have known if the resident was an elopement risk because the resident's picture was not on the wander guard list. nene On 10/14/10 at 1334 the Director of Social Services (DSS) was interviewed. The DSS stated that wandering behavior is exhibited by a resident roaming back and forth and is not necessarily an exit-seeking behavior. The DSS indicated that Resident #1 had known wandering behavior.nene The DSS explained that an Elopement Risk Assessment is done by nursing and takes into account a resident's history. The DSS was not employed by the facility at the time of Resident #1's admission, she is not certain if a complete psychosocial was obtained. The DSS stated that she was aware of note in the Resident #1's medical record on the "Surrogate List " dated 8/26/10, where it documented that a history would be obtained from the resident's niece. The DSS was certain that a history was never obtained. After Resident #1's incident on 9/28/10, the nursing supervisor made contact with the resident's niece, who informed the supervisor that the resident had made successful elopement attempts from previous facilities in the past.nene In a subsequent interview with the DSS on 10/15/10 at 0959 the DSS stated that Resident #1's niece was identified as his contact on the resident's contact sheet prior to 8/26/10 and a full psychosocial history should have been obtained.nene On 10/14/10 at 1359 the Director of Nursing (DON) was interviewed. The DON stated that, if a resident actively seeks an exit, then a wander guard is placed on the resident. Wandering behavior is very individualized and Resident #1 was at low risk for elopement. The DON stated that "there is a difference between someone who just ambulates and someone who walks aimlessly. That would be high risk." The DON did not think that Resident #1 walked aimlessly.nene On 10/14/10 at 1528 the 3:00 PM to 11:00 PM Registered Nurse Supervisor (RNS), was interviewed. The RNS stated that he performed the Elopement Risk Assessment on Resident #1 on the day the resident was admitted to the facility [the ERA was dated six days after the resident's admission to the facility]. nene The RNS stated that the resident displayed wandering behavior but did not seem to seek an exit, so the RNS did not trigger wandering on the assessment. The RNS stated that, if he had triggered wandering on the assessment, the resident would automatically be considered at high risk for elopement. The RNS stated that "the issue of wandering can be confusing."nene On 10/15/10 at 1336 the Registered Nurse Manager (RNM), was interviewed. The RNM stated that she received a call from the operator, who had transferred a call from the Recreation Aide to the RNM. The Recreation Aide informed the RNM that someone was walking outside in pajamas but did not say it was a resident. The Recreation Aide told the RNM that she did not know who it was because it was not her resident. The RNM called a Code Amber.nene The RNM stated that head counts were taken through the facility and it was realized that Resident #1 was missing. At some point within the hour, someone from the outside called the facility to report that a man wearing pajamas and slippers was walking on Route 25A. Facility staff went to find and retrieved the resident, who was assessed by the RNM to have no injuries.nene The RNM stated that the residents on the A and D unit are taken outside into the courtyard for different activities. The RNM stated that she does not believe there is any specific policy regarding doing a head count of residents, but it would be normal practice to do a count and recount of residents any time residents are off the unit.nene The RNM stated that an Elopement Assessment is done on every resident upon admission to the facility and updated when/if a change in the resident's behavior is observed. The RNM stated that she did know that the resident wandered and that any resident who has

wandering behavior should be considered at risk for elopement. The RNM further stated that the resident's niece told the RNM that the resident had successfully eloped from facilities in the past. The RNM did not think that Resident #1 was assessed as at risk for elopement.nene On 10/15/10 at 1258 the Director of Maintenance (DOM) stated that the alarmed gate on the courtyard had been checked daily at 10:00 PM prior to the day of the incident, but staff never logged that it was checked. Therefore, the DOM did not have a documented log of the alarmed gate functioning.nene In a telephone interview with the Certified Nursing Assistant (CNA1) on 10/15/10 at 1425, CNA1 stated that she saw the resident walking outside, but CNA1 was not sure if she supposed to go out after him. She stated that, had she went out after the resident, she would have set off the alarmed door.ne CNA1 stated that she heard Code Amber called a few minutes later but was not sure what to do. CNA1 stated that she thinks a head count was done.nene In a telephone interview with the Recreation Aide (RA) on 10/15/10 at 1429, the RA that she saw the resident walking outside, but did not initially question this because she thought the resident may have had an out on grounds pass. The RA stated that she later heard a Code Amber but was not sure how to answer it. The RA thought that she should go out and look for the resident but also was trained to never leave her post.nene In a subsequent interview with the DON on 10/15/10 at 1604, the DON stated that every person on the locked A and D units of the facility have the propensity to elope and are considered at risk for elopement. The DON stated that not all residents on the A and D units have wander guards "because we don't have enough wander guards quite honestly."ne The DON stated there is no separate list for elopement risks except the list for residents with wander guards. When asked regarding monitoring residents at risk for elopement, the DON stated, "Well, they're on a locked unit." The DON stated that the facility has not allowed an out on grounds pass for over one year and that there is no policy in effect for doing a head count on residents. The DON further stated that all staff have been rein-serviced on elopement prevention and the PPEP is being revised.

415.12(h)(1)(2)

F250 483.15(g)(1): MEDICALLY RELATED SOCIAL SERVICES

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 29, 2011

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Citation date: March 4, 2011

Based on staff interviews and record review during an abbreviated survey, it was determined that the facility did not provide medically related social services to attain the highest practicable, physical, mental and psychosocial well-being for each resident with history of elopement attempts. Specifically, one of six residents reviewed (Resident #1) for behavior with a history of wandering did not have a complete psychosocial assessment to accurately identify Resident #1 as at risk for elopement, put measures in place to meet the resident's needs and protect his health and safety
ne This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.nene Complaint ID Number: NY00092071nene The finding is:nene Resident #1 is 63 years old who was admitted to the facility on 4/23/10 with diagnoses including Bi-Polar Disorder and ETOH (alcohol)-induced Dementia.nene The Hospital Patient Review Instrument dated 4/23/10 documented that the resident " has limited ability to communicate and can become disorganized. "nene The Hospital Discharge Summary dated 4/23/10 documented that the resident is " poorly communicative, displaying disorganized behavior, poor insight and judgment. "nene The Comprehensive Care Plan (CCP) for behavior dated 4/27/10 documented that the resident exhibits wandering/walks aimlessly. Monitoring interventions were not included.nene The Psychiatric Consultation Report dated 4/28/10 documented that the resident has alcohol induced persisting dementia.nene The Social Work Initial Assessment/Psychosocial History (SWIAPH) dated 4/29/10 documented that the resident had a psychiatric history, poor insight and poor judgment. Resident #1's functional status prior to placement, substance abuse history, hobbies/interests and customary routine was not documented.nene The Minimum Data Set 2.0 (MDS) (an assessment tool) dated 5/4/10 documented that the resident's short-term memory and long-term memory are impaired. Cognitive Skills for Daily Decision-Making is moderately impaired. Wandering behavior is coded as occurring daily and not easily altered. The resident ambulates independently.nene The Elopement Risk Assessment (ERA) dated 4/29/10 and updated 8/10/10 documented that the resident was at low risk for

elopement. The ERA's predisposing risk factors included a section for wandering behavior was not completed. This risk factor would automatically place Resident #1 at high risk for elopement, requiring a plan of care including the placement of a wander guard (an electronic device worn by residents which sounds an alarm at exits).nene The Integrated Progress Notes dated 9/27/10 documented that the Registered Nurse Manager (RNM) spoke with the resident's niece regarding placement of a wander guard on the resident; the family member was in agreement with the facility because the resident had eloped in the past.nene The Policy and Procedure on Elopement Prevention (PPEP) documented that, at the time of admission, staff are responsible to ascertain, through interview/record review, if a resident has a history of or propensity for wandering or elopement.nene On 10/14/10 at 1:34 PM the Director of Social Services (DSS) was interviewed. The DSS stated that wandering behavior is exhibited by a resident roaming back and forth and is not necessarily an exit-seeking behavior. The DSS indicated that Resident #1 had known wandering behavior.nene The DSS stated that an Elopement Risk Assessment is done by nursing and takes into account a resident's history. The DSS was not employed by the facility at the time of Resident #1's admission; she is not certain if a complete psychosocial was obtained. The DSS stated that she was aware of a note in Resident #1's medical record on the " Surrogate List " dated 8/26/10, where it documented that a history would be obtained from the resident's niece. The DSS was certain that a history was never obtained. After Resident #1's incident on 9/28/10, contact was made by the nursing supervisor with the resident's niece, who informed the supervisor that the resident had made successful elopement attempts from previous facilities in the past.nene In a subsequent interview with the DSS on 10/15/10 at 0959, the DSS stated that Resident #1's niece was identified as his contact on the resident's contact sheet before 8/26/10 and a full psycho-social history should have been obtained.nene On 10/15/10 at 1336 the Registered Nurse Manager (RNM), was interviewed. The RNM stated that an Elopement Assessment is done on every resident upon admission to the facility and updated when/if a change in the resident's behavior is observed. The RNM stated that Resident #1 wandered and that any resident who has wandering behavior should be considered at risk for elopement. The RNM further stated that the resident's niece told the RNM that the resident had successfully eloped from facilities in the past. The RNM did not think that Resident #1 was assessed as at risk for elopement.nene 415.5(g)(1)(i-xv)

F333 483.25(m)(2): RESIDENTS FREE FROM SIGNIFICANT MEDICATION ERRORS

Scope: Isolated
Severity: Potential for more than Minimal Harm
Corrected Date: April 29, 2011

The facility must ensure that residents are free of any significant medication errors.

Citation date: March 4, 2011

Based on observation, interview and record review, the facility did not ensure that each resident's drug regimen was free of significant medication error. Specifically one (Resident #1) of three sampled residents was not administered the medication MetroGel (an antibiotic gel with bactericidal effect) one application twice a day (bid) for 5 days as prescribed by the physician. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Complaint ID Number: NY00094588

Resident #1 is a 36-year-old, admitted to the facility on 12/30/2009 with diagnoses including Diabetes Mellitus, legal blindness related to retinal detachment, renal dialysis and End Stage Renal Disease.

The Minimum Data Set (MDS) Assessment dated 12/4/10 documented that the cognition for the resident was cognitively intact.

The Consultation Report dated 11/24/10 documented that the resident was sent for yeast infection and foul smelling urine. Recommendation, MetroGel one application to the vagina BID for 5 days and return in 2 weeks for follow up.

The Doctor's Order dated 11/24/10 documented a telephone order MetroGel one application to vagina BID for 5 days and follow up GYN in 2 weeks.

The Integrated Progress Notes dated 11/24/10 documented that the resident returned from the GYN consult with a medication order for MetroGel one application to the vagina bid for 5 days and follow up in 2

weeks.

The Integrated Progress Notes dated 11/26/10 documented that the MetroGel order was clarified .To start vaginal suppository at 3:00 PM-11:00 PM every day for 5 days secondary to discharge.

The Doctor's Order dated 11/26/10 documented a telephone order for clarification with MetroGel one application vaginally every day for 5 days.

The Integrated Progress Notes dated 11/30/10 7:00 am-3:00 pm documented MetroGel administered to the resident.

The Treatment Record dated 11/8/10-12/5/10 documented MetroGel one vaginal insertion every day for 5 days. On 11/24/10 and 11/25/10, the treatment record lacked documented evidence that the treatment was administered to Resident #1 as ordered. The Treatment Record dated 11/26/10 documented an " x " and was not signed to indicate that the treatment was administered to Resident #1. The Treatment Record dated 11/27/10 documented a circle (O). The reason/result MetroGel was not given to the resident, since the resident out to dialysis.

The facility's policies for Consultations (undated) documented that upon completion of the consultation the nurse will review the report recommendations, medications or treatments. The nurse will notify the attending physician and if applicable receive telephone orders. Management of hemodialysis residents (not dated) documented that the time of administration of medications may be readjusted as needed to accommodate the dialysis schedule. The medication administration policy (not dated) documented that daily medication are administered at 9:00 AM.

During an interview with the Director of Nursing (DON) on 2/9/11 at 9:30AM. The DON stated that the nurse who accepts a resident after a consult visit is responsible to review the MD's consult recommendations. The nurse is to contact the attending MD or the Nurse Practitioner. The nurse is to obtain an order from the medical provider and call the pharmacy for the prescription to get the medication. The DON stated that the facility has an in house pharmacy. The pharmacy is open from 9:00 AM-5:00 PM. After hours, there is a closet with stock medication items. When the pharmacy is closed, the nurse is to notify the nurse manager who goes and gets the medication. If the medication is not there or it is STAT (immediately), the MD is contacted. The DON stated that according to the Medication Closet List MetroGel is in house in the pharmacy. The DON also stated that a medication that is ordered for every day is to be administered at 9:00 AM. This could be changed by the MD and be administered at a different time.

During an interview with Resident #1 on 2/10/11 at 10:50 AM, she stated that on 11/24/10, 11/25/10, 11/26/10 11/27/10 she was not administered the cream or suppositories to her vaginal area and no one examined the area. She recalled that on Friday 11/26/10 she asked nurse #17 to check on her prescription. The nurse told her that the prescription was never sent.

The Emerald Unit 6:00AM-3:00PM shift CNA (Certified Nurses Aide) #21 who was on duty on 11/25/10 was interviewed on 2/10/11 at 11:30AM. The CNA stated that she cared for the Resident#1 and she observed her to have a dark green vaginal discharge .She recalled that the resident told her that she was supposed to get a vaginal medication for the discharge. The CNA reported this to the nurse (name not recalled)

The Emerald Unit 11:00PM-7:00AM and the 7:00AM-3:00PM shift Licensed Practical Nurse (LPN) #17 who was on duty on 11/26/10 was interviewed on 2/10/11 at 11:40AM . She stated that Resident #1 rang (time not recalled) and stated that she was supposed to get a treatment with MetroGel to the vaginal area but that no staff had completed the treatment for her. She checked the consult dated 11/24/11 and the MD orders. She called the hospital's GYN department and they clarified the order to MetroGel one application once a day for 5 days.

The Facility Supervisor 7:00am-3:00pm shift RN (Registered Nurse) Supervisor #19 who was on duty on 11/25/10 was interviewed on 2/10/11 at 12:00 PM. She stated that no one reported that Resident #1 went to a GYN consult appointment 11/24/10 and that a treatment was ordered. She stated that when a resident has a consult, the nurse is to review the information and contact the attending MD for an order. The chart is then supposed to be flagged for the next nurse to verify the MD order.

The Emerald unit 7:00PM-7:00AM shift RN #18 Treatment Nurse who was on duty on 11/26/11 was interviewed on 2/10/11 at 12:30PM. She recalled that a treatment was ordered for Resident #1, MetroGel one vaginal insertion every day for 5 days. She stated that she gave the resident the treatment, but she

could not recall the date or the time. She is supposed to sign the treatment sheet right after giving any treatment but sometimes she forgets.

The Supervisor 3:00pm -11:00pm shift, RN Supervisor #16 who was on duty on 11/24/10 was interviewed on 2/10/11 at 4:30 PM. She stated that Resident #1 returned on that date with a consult with recommendations. She reviewed the consult, contacted the MD and she obtained a telephone order for MetroGel BID. She did not enter this on the Treatment Administration Record or the 24 hour report. She did not flag the record for the oncoming shift to review. She recalled that she put a copy of the MD order in the box for the pharmacy.

415.12(2)

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Page last modified: February 20, 2015