

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/07/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/24/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>
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F 000 INITIAL COMMENTS

F 000

An Abbreviated/Partial Extended Survey investigating KY#00021220 was initiated on 01/21/14 and concluded on 01/24/14. KY#00021220 was substantiated with deficiencies. Immediate Jeopardy was identified on 01/23/14 and determined to exist on 01/15/14 with deficiencies cited at 42 CFR 483.20 Resident Assessment, F 282 and 42 CFR 483.25 Quality of Care, F323 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F323. The facility was notified of the Immediate Jeopardy on 01/23/14.

On 01/15/14 at approximately 6:30 PM, Resident #1, who resided on the Reflections Unit, which was a secured locked unit for residents with Alzheimer's Dementia and other cognitive impairments, opened a newly installed window, which was not supposed to open more than six (6) inches, in his/her room and eloped from the facility without staff knowledge. Facility staff noticed Resident #1 missing and immediately initiated a search for the resident at approximately 7:05 PM. Resident #1 was found at approximately 7:28 PM by the Sheriff's Department approximately four (4) tenths of a mile from the facility. The outside temperature was approximately thirty (30) degrees Fahrenheit. The resident was fully dressed in personal clothing including a coat. Resident #1 was fully assessed upon return to the facility by the Physician at the facility on 01/15/14 at 7:45 PM and found to have no negative effects.

An acceptable credible Allegation of Compliance (AOC) was received on 01/23/14, which alleged

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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removal of the Immediate Jeopardy on 01/17/14, prior to the initiation of the abbreviated survey. The State Survey Agency determined the deficient practice was corrected on 01/17/14 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.

F 000

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
SS=J

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure a safe environment was provided by qualified persons in accordance with each resident's Plan of Care for one (1) of five (5) sampled resident (Resident #1).

The facility failed to ensure the care plan for Resident #1 was implemented. Resident #1's Comprehensive Care Plan revealed the resident's whereabouts were to be monitored on an ongoing basis and the goal was the resident would not elope from the facility. On 01/15/14 Resident #1, who resided on a secure unit, eloped from the facility on 01/15/14 through a newly installed window and was found by the Deputy Sheriff approximately four (4) tenths of a mile from the facility. (Refer to F323)

The facility's failure to have an effective system in place to ensure implementation of care plan

Past noncompliance: no plan of correction required.

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F 282	<p>Continued From page 2</p> <p>interventions was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 01/23/14, and was determined to exist on 01/15/14. The facility was notified of the Immediate Jeopardy on 01/23/14.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/14, which alleged removal of the Immediate Jeopardy on 01/17/14, prior to the initiation of the abbreviated survey. The State Survey Agency determined the deficient practice was corrected related to ensuring provision of care in a safe environment with the Plan of Care on 01/17/14 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Elopement/Wandering Residents", with an effective date of December 2010, revealed any resident displaying significant wandering behavior was to be assessed for elopement/wandering risk and care planned appropriately. Further review revealed care plans and individual behavior plans were to address wandering as a specific problem. According to the policy, approaches were to be formulated, patterns identified and causes determined were to be addressed.</p> <p>Review of the facility's policy titled "Goals and Objectives, Care Plans", revised April 2011, revealed care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence.</p> <p>Review of Resident #1's record revealed the facility admitted the resident on 11/04/13, with</p>	F 282		
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F 282	<p>Continued From page 3</p> <p>diagnoses which included Large Left Frontal Parietal (lobes of the brain at the top of the head, including areas concerned with the reception and correlation of sensory information) Stroke, Sensory Fluent Aphasia (disorder impairing the expression and understanding of language), Bipolar Disorder, Psychosis and Dementia. Review of the Physician's Order dated 11/04/13, revealed the Physician had ordered a wanderguard (a device used to alert staff of attempts to elope for residents at risk) to be worn by Resident #1 related to his/her being at risk for elopement.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Assessment, date 12/02/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) as three (3) out of fifteen (15), indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as requiring supervision only, with ambulation and transfers.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 11/18/13, revealed an elopement risk care plan which indicated Resident #1 was at risk for elopement related to behavioral disturbances secondary to diagnoses of Bipolar Disorder and Psychosis. Continued review of the elopement risk care plan revealed a goal for the resident not eloping from the facility and interventions which included monitoring the resident's whereabouts on an ongoing basis.</p> <p>Review of a Nurse's Note, dated at 01/15/14 untimed, revealed State Registered Nursing Assistant (SRNA) #2 had seen Resident #1 at approximately 6:30 PM on 01/15/14. Continued</p>	F 282		
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F 282	<p>Continued From page 4</p> <p>review of the Note revealed at about 7:05 PM, Resident #1 was reported missing; and at around 7:30 PM the resident was found. Further review of the Nurse's Notes revealed the window company discovered they had failed to install a sliding mechanism in Resident #1's window; and the window company was to complete its safety checks of the windows on 01/16/14.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/22/14 at 9:50 AM, who was in charge of the Reflections Unit on the evening of 01/15/14, revealed SRNA #1 informed her staff were not able to locate Resident #1. LPN #1 stated she went into Resident #1's room, and while there looked at the window, attempted to open it and was able to open the newly replaced window all the way.</p> <p>Interview with SRNA # 1, who was assigned to Resident #1 on 01/15/14, on 01/22/13 at 9:30 AM, revealed Resident #1 was not monitored at specific intervals except for every two (2) hours when he/she was checked for incontinence.</p> <p>Interview with the Unit Manager, on 01/22/14 at 9:15 AM, revealed it was her expectation for staff to follow care plans developed for each resident. The Unit Manager further stated Resident #1 was not being monitored at any specific time frame's except for approximately every two (2) hours to check for incontinence.</p> <p>Interview with the Director of Nursing (DON), on 01/24/14 at 12:15 PM, revealed the Reflections Unit was to ensure safety and protection for residents who had decreased safety awareness. The DON indicated her expectations were for staff to follow care plans.</p>	F 282		
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F 282	Continued From page 5	F 282		
	<p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 01/23/14, which alleged removal of the IJ effective 01/17/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> <li>1) On 01/15/14, Resident #1 was fully assessed by the Physician in the facility, including vital signs. No injuries were noted. Resident #1 was placed on one on one observation.</li> <li>2) On 01/15/14 a facility head count was performed when Resident #1 was discovered missing and a "Code Green" was initiated.</li> <li>3) On 01/15/14 all windows in the facility were checked by staff for proper functioning and safety.</li> <li>4) On 01/15/14, all windows were checked by the contractor.</li> <li>5) On 01/15/14 all doors were checked by facility's staff.</li> <li>6) On 01/15/14 all wanderguards were checked by the Staffing Coordinator.</li> <li>7) On 01/15/14, all residents were re-assessed for elopement potential by licensed nurses and care plans were reviewed for any changes found on the elopement assessments. Elopement books were updated to reflect current elopement assessments.</li> <li>8) On 01/15/14, the Administrator and Human Resource Director were re-educated by regional nurse consultants.</li> </ol>			

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9) On 01/15/14, all staff present in the facility were re-educated on elopement and missing resident policy as well as on reporting any plant operations concerns by the Human Resource Director.

10) Staff not present would not be able to return to work until re-education had been completed.

11) Wandering and Elopement Policy along with how to report plant operations concerns or equipment was to be included in orientation of new employees.

12) All windows and doors were to be checked for proper function every shift by a member of nursing staff until Immediate Jeopardy was removed and all concerns were to be reported to the Administrator immediately. An audit of windows and doors was to continue once a week for two (2) weeks, then monthly.

13) On 01/16/14, an Emergency Quality Assurance (QA) meeting was held at 01:24 AM to identify the root cause of the incident and development of a plan to prevent re-occurrence.

14) On 01/15/14, the Administrator was educated by Vice President of Operations on reviewing all work completed by outside vendors for proper functioning and safety on a daily basis.

15) On 01/16/14 the Plant Operations Director was educated by the Administrator on reviewing all work completed by outside vendors for proper functioning and safety on a daily basis as well as maintaining log of all completed work by outside vendors. This log was to be reviewed by the

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F 282	<p>Continued From page 7</p> <p>Administrator upon completion of vendor work daily.</p> <p>16) Beginning 01/15/14, Social Services was to visit Resident #1 daily for 7 days, then weekly for four weeks to monitor for any psychosocial harm or changes in behavior.</p> <p>17) On 01/15/14, the Vice President of Operations, Chief Nurse Executive and two regional nurse consultants were on site to oversee and review the Quality Assurance/Performance Improvement (QAPI) Process, reviewed education, and reviewed all assessments performed.</p> <p>18) On 01/16/14, the Vice President of Plant Operations and Director of Plant Operations conducted additional audit of the facility windows for proper working order.</p> <p>19) On 01/16/14, all residents assessed as at risk for elopement had been reviewed by nursing staff and nurse consultants to ensure care plans were in place and interventions were appropriate.</p> <p>20) Plant Operations was to check windows daily for proper function and safety until Immediate Jeopardy was lifted. This was to continue for two (2) weeks and then decrease to three (3) times per week for four (4) weeks.</p> <p>21) The Administrator or Director of Nursing were to review all audits and education for compliance daily, Monday through Friday.</p> <p>22) The Administrator had been in the facility daily since 01/15/14 to ensure resident safety and audit completion.</p>	F 282		
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F 282	Continued From page 8	F 282		
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23) All department directors assigned by the Administrator were to have a presence in the facility daily to ensure the audits were completed and ensure resident safety. After the Immediate Jeopardy was removed the department directors were to be present daily for one (1) month to ensure residents' safety.

The State Survey Agency validated the implementation of the facility's AOC as follows:

1) Review of Resident #1's record revealed on 01/15/14 a full assessment was performed on the resident by the Medical Director. Interview, on 01/24/14 at 6:38 PM, with the Medical Director revealed the full body assessment of Resident #1 had been completed on 01/15/14 with no concerns identified.

2) Interview, on 01/22/14 with Registered Nurse (RN) #1 at 3:50 PM and Licensed Practical Nurse (LPN) #1 at 9:50 AM, revealed the head count and "Code Green" had been conducted on 01/15/14 after Resident #1 was discovered missing. Review of the facility's resident census revealed checks beside all residents' names which indicated all residents were present except Resident #1 on 01/15/14. Continued review of this census revealed no check beside Resident #1's name.

3) Interviews, on 01/24/14 with the Quality of Life (QOL) Director at 11:28 AM, SRNA #10 at 11:32 AM, and the Staffing Coordinator at 11:16 AM revealed all facility windows had been checked on 01/15/14. Review of the statement written by the QOL validated there were teams assigned to check all windows in the facility 01/15/14, which

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included the QOL Director, SRNA #10 and the Staffing Coordinator. Continued review of the written statement revealed all units including the dining room were assigned a staff member to check the windows. Further review revealed during these checks on 01/15/14, only two (2) windows raised fully open, Room 130, Resident #3's room; and Room 415, Resident #1's room.

4) Interview with the Contractor, on 01/22/14 at 12:34 PM, revealed he came to the facility on 01/15/14 and checked all windows. Review of the Contractor's signed statement revealed he had inspected all facility windows on 01/15/14; and re-inspected all windows on 01/16/14 with facility staff at appropriately 9:30 AM.

5) Review of the DON's written statement revealed she had arrived at the facility at approximately 7:10 PM on 01/15/14 after receiving a phone call informing her Resident #1 had eloped. Continued review of the statement revealed when she arrived staff was searching for the resident inside and outside the building. Further review revealed all staff had been instructed to check all windows for proper functioning and doors to ensure alarms were functioning; and all wanderguards were being checked to ensure they were in place and functioning. Interview, on 01/24/14 at 11:10 AM, revealed with the DON had arrived at the facility on 01/15/14 at approximately 7:10 PM as indicated in her statement. She stated all doors were checked for proper functioning and found to be in working order. Interview on with SRNA #4 on 01/22/14 at 3:35 PM, revealed she had participated in ensuring all doors were checked for proper functioning on 01/15/14.

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6) Review of the Preventative Maintenance Task Sheet dated 01/15/14 revealed nineteen (19) residents with wanderguards had their wanderguard bracelet checked and were noted to have passed the test. Interview with the Staffing Coordinator, on 01/24/14 at 11:16 AM, confirmed on 01/15/14 he had verified all wanderguards in the building were checked for proper functioning. Observation, on 01/21/14 at 2:20 PM, revealed Resident #5 was wearing a wanderguard which alarmed when the resident approached the exit doors of the Reflections Unit.

7) Review of the elopement books kept on each unit revealed all residents were reassessed for elopement. Review of the Elopement Risk Evaluation assessment forms revealed forms for all residents dated 01/15/14 signed by nursing staff. Review of three (3) sampled resident care plans revealed they had been updated for any changes identified from the reassessments. Interviews with RN #1, on 01/22/14 at 3:50 PM, and Reflections Unit Manager, on 01/24/14 at 11:22 AM, revealed they assisted in performing the elopement risk assessments on 01/15/14 and review of the care plans to ensure they were updated as necessary.

8) Review of an e-mail from the Regional Nurse Consultant, dated 01/23/14 at 7:28 PM, revealed the Administrator and HR Director had been re-educated by her on 01/15/14. Continued review of the e-mail revealed she had re-educated the Administrator and HR Director on elopement, missing persons and reporting concerns related to facility operations and safety.

Interviews with the Administrator, on 01/24/14 at 11:30 AM, and HR Director, on 01/24/14 at 11:25

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NAME OF PROVIDER OR SUPPLIER  <b>FOUNTAIN CIRCLE CARE &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 GLENWAY ROAD WINCHESTER, KY 40391</b>		
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F 282	<p>Continued From page 11</p> <p>AM, revealed the Regional Nurse Consultant had provided re-education on elopement and missing resident policy; and on how to report facility plant operations concerns and safety.</p> <p>9 and 10) Review of a memo, dated 01/15/14, sent out to staff by the HR Director revealed it was in regards to attending a mandatory in-service before reporting to work; and the in-service was to be completed before staff could be placed on the work schedule.</p> <p>Review of staff re-education revealed it was provided by the HR Director from 01/15/14 to 01/21/14. Continued review revealed the re-education material discussed the elopement policy, where the elopement books were kept, the proper code for elopement, who to contact when a resident was missing, as well as, reporting facility plant operations concerns. Review of the post tests performed after the re-education revealed approximately one hundred and sixty-five (165) staff had completed the re-education and taken the test which they had signed and dated, from 01/15/14 to 01/21/14. Review of the post tests revealed three (3) new hires had received the education and taken the test.</p> <p>Review of certified mail receipts 01/23/14 revealed the memo had been sent to four (4) staff who had not yet received the re-education and were not placed on the work schedule.</p> <p>Interview, on 01/22/14 at 9:30 AM, with SRNA #1 revealed she had received the re-education on 01/15/14 after Resident #1's elopement.</p> <p>Interview on 01/24/14 at 11:30 AM, with SRNA #10; at 11:10 AM with the Housekeeping Director</p>	F 282		

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F 282	<p>Continued From page 12 and at 11:16 AM with the Staffing Coordinator revealed they had received the re-education after Resident #1's elopement 01/15/14.</p> <p>Interviews on 01/24/14 at 11:10 AM with the DON; at 11:16 AM with the Staffing Coordinator; and at 11:25 AM with the HR Director revealed staff was to be educated before being allowed to return to work. The HR Director confirmed the re-education had been performed and post tests taken to ensure competency. The DON stated there were some staff who had not received the education yet and these staff would not be placed on the work schedule until they had received the education.</p> <p>11) Review of the agenda for new employee orientation revealed it included the elopement and missing resident policies; work orders procedure; and emergent facility plant operation procedure which indicated emergent conditions were to be reported to Plant Operations Director immediately.</p> <p>12) Review of the log book revealed staff were recording the checking of every window in the facility every shift beginning on 01/16/14 and continuing to 01/24/14.</p> <p>Interview, on 01/24/14 at 11:10 AM with the DON, and at 11:30 AM with the Administrator, revealed all windows had been checked every shift beginning on 01/16/14 and continuing until 01/24/14. The Administrator indicated she was to be notified of any concerns; and the audits would continue once a week for two (2) weeks and then monthly.</p> <p>13) Review of the Emergency QA meeting notes</p>	F 282		
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F 282 Continued From page 13  
dated 01/16/14 at 01:24 AM, revealed six (6) signatures. Review revealed the signatures included the RN Staff Development Coordinator (SDC), Reflection Unit Manager, the DON, the Social Worker (SW), the HR Director and the Administrator. Continued review of the notes revealed the QA Committee discussed the root cause of Resident #1's elopement from the facility as being the new windows which had been installed by an outside contractor and were not properly installed. Review revealed the QA Committee members present discussed the audit of the windows which had been performed and documented as completed. The audits were to continue once a week for two (2) weeks, then monthly. Further review revealed the QA Committee developed additional action plans to be implemented to ensure resident safety.

Interviews on 01/24/14, at 11:30 AM with the Administrator; at 11:10 AM with the DON; at 11:25 AM with the HR Director; and at 11:22 AM with the Reflection Unit Manager revealed they had all attended the Emergency QA Committee meeting on 01/16/14 and discussed the incident extensively to include the root cause and audit performed. They indicated action plans had been developed and had been implemented.

14) Review of an e-mail dated 01/23/14 at 7:34 PM, written by the Vice President of Operations revealed on 01/15/14, he/she re-educated the Administrator that all work completed by outside vendors/contractors was to be checked as soon as the work was completed to ensure proper functioning and resident safety. Interview with the Administrator on 01/24/14 at 11:30 AM, revealed she had received the re-education by the Vice President of Operations on 01/15/14.

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F 282	<p>Continued From page 14</p> <p>She stated it had been in regards to reviewing all work completed by outside contractors/vendors to ensure the proper functioning and safety of work completed on a daily basis.</p> <p>15) Review of the typed statement, undated signed by the Administrator, revealed on 01/16/14, the Director of Plant Operations (DPO) was re-educated by her in regards to reviewing all work by outside contractors/vendors on a daily basis. Review of the statement revealed the DPO was to ensure proper functioning of anything installed and safety of installed work by the contractor/vendor. Continued review of the statement revealed the DPO was to keep a log of all outside contractors/vendors daily which the Administrator was to review daily upon completion of the work of the contractor/vendor.</p> <p>Interview with the DPO on 01/24/14 at 11:46 AM, revealed he had been re-educated by the Administrator on 01/16/14, in regards to reviewing all work completed by outside contractors/vendors; and on ensuring he kept a log of all work completed daily by the contractor/vendor. He indicated he had been keeping the log since the re-education on 01/16/14.</p> <p>16) Review of Resident #1's record revealed Social Service Progress Notes dated 01/15/14 at 10:30 PM, 01/16/14 at 4:15 PM, 01/17/14 at 3:00 PM, 01/18/14 at 7:00 PM, 01/19/14 at 4:50 PM, 01/20/14 at 4:15 PM, 01/21/14 at 3:30 PM, and 01/22/14 at 4:15 PM which noted the resident had suffered no psychosocial harm or changes in behavior.</p> <p>Interview with the Social Worker, on 01/24/14 at</p>	F 282		

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(X4) IO PREFIX TAG  F 282	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG  F 282	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	<p>Continued From page 15</p> <p>11:38 AM, revealed he/she had visited Resident #1 daily and documented the visits in the resident's medical record. She indicated she was to continue visiting the resident weekly for four (4) weeks.</p> <p>17) Review of the Chief Nurse Executive's statement revealed she and two (2) regional nurse consultants were onsite on 01/15/14 at 9:00 PM and through the early morning hours of 01/16/14. Review revealed she and the regional nurse consultants were ensuring re-education of all staff working during that time and for oncoming staff in regards to the elopement and missing resident policies; how to complete work orders; and what to do if staff identified environmental concerns. Continued review of the statement revealed the Chief Nurse Executive and the two (2) regional nurse consultants had also ensured all windows and doors had been checked.</p> <p>Interview with the Administrator, on 01/24/14 at 11:30 AM, revealed the Chief Nurse Executive and two (2) other regional nurse consultants had come to the facility on the evening of 01/15/14. She indicated they had reviewed the QA process, reviewed staff education, ensured care plan for all residents had been reviewed and reviewed all assessments performed.</p> <p>18) Review of a written statement dated 01/16/14, signed by the Vice President of Plant Operations, and the DPO revealed they were onsite on that date to conduct an audit of the facility's windows to ensure they were secure and in proper working order. Further review of the written statement revealed the results of the audit were that all windows were secure on the Reflections Unit.</p>			

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F 282	<p>Continued From page 16</p> <p>Interview with the DPO, on 01/24/14 at 11:46 AM, revealed he and the Vice President of Plant Operations were present onsite at the facility on 01/16/14. He stated they had conducted an audit of all the windows installed to ensure they were properly functioning and safe. The DPO indicated all windows were found to be secure and properly functioning.</p> <p>19) Resident #1's, Resident #6's and Resident #7's care plans and elopement assessment in the elopement books were reviewed. Continued review revealed Resident #1's care plan had been updated; however, review of Resident #6's and Resident #7's care plans revealed no updates had been indicated. The elopement assessments present in the elopement books for these residents revealed these residents had been reassessed for elopement risk on 01/15/14.</p> <p>Interviews on 01/22/14 at 3:50 PM, with RN #1 and on 01/24/14 at 11:22 AM, with the Reflections Unit Manager revealed they had assisted with reviewing residents' care plans and elopement books. The Reflections Unit Manager indicated Resident #1's care plan had been updated on 01/15/14 to include one on one (1:1) supervision. The Unit Manager stated Resident #6's and Resident #7's care planned were reviewed along with all of the residents' care plan and their's did not require revision.</p> <p>20) Review of the facility's "Window Checks Daily Rounds" log revealed windows had been checked for proper functioning and window safety from 01/16/14 to 01/23/14.</p> <p>Interview with the DPO on 01/24/14 at 11:46 AM,</p>	F 282		
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F 282	<p>Continued From page 17</p> <p>revealed all facility windows had been checked during this time frame. He indicated no further issues had been noted.</p> <p>21 and 22) Review of a calendar, which indicated the Administrator's audits of the windows and staff education were performed from 01/15/14 to 01/23/14, revealed the Administrator had signed the calendar daily from 01/15/14 through 01/23/14. Review of the Administrator's typewritten statement signed by her, revealed she had been present in the facility daily, Monday through Friday since 01/15/14 to ensure resident safety, staff education, and all audits had been completed.</p> <p>Interview with the Administrator, on 01/24/14 at 11:30 AM, revealed she had been in the facility daily, Monday through Friday, reviewing audits and staff education. She indicated her signature on the calendar indicated she had performed these items.</p> <p>Interviews, on 01/24/14 at 11:10 AM with the DON; at 11:25 AM with the HR Director; and at 11:22 AM with the Reflections Unit Manager, revealed the Administrator had been present in the facility everyday, Monday through Friday, since 01/15/14.</p> <p>23) Interviews, on 01/24/14 at 11:30 AM with the Administrator; at 11:10 AM with the DON; at 11:25 AM with the HR Director; at 11:22 AM with the Reflections Unit Manager; at 4:46 AM with the Director of Plant Operations; and at 11:10 AM with the Housekeeping Director revealed they all confirmed being present in the facility daily and would continue to be present daily for one (1) month.</p>	F 282		

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F 323  
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483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323

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.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, review of the service agreement with the Window Contractor, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure residents had a safe environment for one (1) of five (5) sampled residents (Resident #1).

Resident #1 resided on the Reflections Unit, which was a secure locked unit for residents with Alzheimer's Dementia or other cognitive impairments. On 01/15/14 sometime after 6:30 PM, Resident #1 eloped from the facility through a newly installed window in his/her room, without staff's knowledge. The facility noticed Resident #1 was missing at approximately 7:05 PM, about thirty-five (35) minutes later and initiated a search for the resident. The Sheriff's Department found Resident #1 about four (4) tenths of a mile from the facility and returned Resident #1 to the facility around 7:28 PM. The outside temperature was approximately thirty (30) degrees Fahrenheit. The resident was noted to be fully clothed including a coat. Resident #1 was fully assessed upon return to the facility by the Physician on 01/15/14 at 7:35 PM; and no negative impact was

Past noncompliance: no plan of correction required.

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F 323 Continued From page 19 noted. (Refer to F282)

F 323

The facility's failure to ensure residents had a safe environment was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 01/23/14 and was determined to exist on 01/15/14.

An acceptable credible Allegation of Compliance (AOC) was received on 01/23/14, which alleged removal of the Immediate Jeopardy on 01/17/14, prior to the initiation of the abbreviated survey. The State Survey Agency determined the deficient practice was corrected on 01/17/14 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.

The findings include:

Review of the facility's policy titled, "Elopement/Wandering Residents", with an effective date of December 2010, revealed it was the intent of the facility to determine which residents had significant wandering behavior and to enhance staff awareness and educate them on how to deal with such residents. Continued review of the policy revealed any resident displaying significant wandering behavior was to be assessed for elopement/wandering risk and care planned appropriately.

Review of the facility's policy, "Standard of Practice", with an effective date of November 2013, revealed the facility was to provide professional services required to ensure maintenance of residents' health, safety, and welfare.

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F 323	Continued From page 20  Record review revealed the facility admitted Resident #1 on 11/04/13, with diagnoses which included Bipolar Disorder, Large Left Frontal Parietal (lobes of the brain at the top of the head, including areas concerned with the reception and correlation of sensory information) Stroke, Sensory Fluent Aphasia (disorder impairing the expression and understanding of language), Dementia, and Psychosis. Further record review revealed a Physician's Order, dated 11/04/13, for a wanderguard (a device used to alert staff of attempts to elope for residents at risk) to be worn by Resident #1 related to being an elopement risk.  Review of Resident #1's Minimum Data Set (MDS) Assessment, date 12/02/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) as three (3) out of fifteen (15), indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as requiring supervision only, with ambulation and transfers.  Review of Resident #1's Comprehensive Care Plan, with a dated 11/18/13, revealed Resident #1 to be at risk for elopement related to behavioral disturbances secondary to Bipolar Disorder and Psychosis. Further review of the care plan revealed a goal for the resident to not elope from the facility and an intervention for the resident to be monitored of his/her whereabouts on an ongoing basis.  Review of a Nurse's Note, dated at 01/15/14 untimed, revealed at approximately 6:30 PM on 01/15/14, State Registered Nursing Assistant (SRNA) #2 had a conversation with Resident #1.	F 323			

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F 323 Continued From page 21  
Review of the Note revealed Resident #1 was reported missing at around 7:05 PM and found at approximately 7:30 PM.

Interview with Licensed Practical Nurse (LPN) #1, on 01/22/14 at 9:50 AM, who was in charge of the Reflections Unit on the evening of 01/15/14, revealed SRNA #1 had told her they were unable to locate Resident #1 at around 7:05 PM. She stated she then initiated the facility's elopement policy and called a "code green". She indicated a search was initiated of the unit and staff was unable to locate Resident #1. LPN #1 stated she went into Resident #1's room where she looked at the window, tried to raise it and was able to fully open it. According to LPN #1, she then asked Resident #1's roommate if he/she had closed the window. LPN #1 stated the roommate said he/she had closed it due to being cold.

Interview with State Registered Nursing Assistant (SRNA) #1, on 01/22/13 at 9:30 AM, who was assigned to Resident #1 on 01/15/14, revealed Resident #1 had not been monitored at specific intervals prior to his/her elopement. SRNA #1 stated she never thought Resident #1 could have gotten out the window in his/her room. SRNA #1 further stated residents at risk for elopement usually wore wanderguards, which would set off alarms on the doors or other restricted areas and then staff would locate the residents and redirect them.

Interview with SRNA #2 on 01/22/14 at 9:42 AM, revealed she had interacted with Resident #1 at approximately 6:30 PM on 01/15/14, and then had gone on break. SRNA #2 stated when returning to the facility after break, at around 7:00 PM, she saw a man walking along the road

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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391		
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F 323	<p>Continued From page 22</p> <p>somewhere near the facility driveway. SRNA #2 stated she returned to work on the Reflections Unit and asked if any alarms had sounded as she had seen a man outside. She stated she was told no alarms had sounded; however, staff initiated a head count to determine if any unit residents were missing.</p> <p>Interview with the Human Resources Director (HRD), on 01/24/14 at 2:00 PM, revealed she reported to the facility as a result of the "code green" then she pulled in the driveway behind the Sheriff's care and parked. She stated she got out of her car and when she got to the front door area the Sheriff was standing next to Resident #1 and asked the HRD if that was the missing resident and the HRD responded "yes". She stated this was approximately 7:35 PM. She further stated the Sheriff did not tell her that he located Resident #1 off grounds at a near by service station.</p> <p>Review of the Call for Service log for the County Sheriff's Department dated 01/15/14 and timed 7:28 PM, revealed a Deputy Sheriff had found Resident #1 in front of a service station located approximately four (4) tenths of a mile from the facility.</p> <p>Interview with the Deputy Sheriff, on 01/29/14 at 2:20 PM, revealed he "actually" found Resident #1 standing on the road in front of the service station down from the facility's grounds. The Deputy Sheriff stated he returned Resident #1 to the facility and informed a facility staff person where he had found the resident; however, was unable to recall who it was he had informed.</p> <p>Further review of the Nurse's Notes revealed the</p>	F 323			

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F 323 Continued From page 23  
window company discovered they had failed to install a sliding mechanism in Resident #1's window; and the window company was to complete its safety checks of the windows on 01/16/14.

Interview with the Reflections Unit Manager, on 01/22/14 at 9:15 AM, revealed the previous windows had not opened and the new ones did.

Review of the facility's Service Agreement with the Window Contractor, dated 12/12/13, revealed the Contractor began installing new windows at the facility 11/15/13, and the work would be completed on 01/15/14.

Review of an electronic mail (e-mail) sent to the facility from the Vice President of Operations for the Corporation, dated 01/24/14 at 11:16 AM, revealed the installation of the windows in the Reflections Unit began on 01/06/14, with Resident #1's new window being installed on 01/11/14, four (4) days prior to his/her elopement from the facility.

Interview with the Director of Plant Operations (DPO), on 01/22/14 at 12:30 PM, revealed the facility's Corporate Office was scheduled to come to the facility on 01/16/14 to do a complete walk through with the Window Contractor to inspect the work to ensure completeness and proper functioning. The DPO revealed the newly installed windows were supposed to have blocks installed to prevent the windows from opening more than six (6) inches. The DPO stated the windows were not inspected after each was installed; however, the windows were to have been inspected after all of them were replaced. The DPO further stated the windows should have

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F 323 Continued From page 24  
 been checked as they were installed to ensure the blocks had been placed to ensure resident safety.

Interview with the Contractor, responsible for installing the new windows, on 01/22/14 at 12:40 PM, revealed the newly installed windows should have had blocks installed to prevent them from raising more than six (6) inches. The Contractor stated, during inspection on the evening of 01/15/14, Resident #1's bedroom window and another bedroom window in the facility were missing the blocks, which allowed the windows to be fully raised. The Contractor further stated three (3) other windows in the facility were missing one block each but these windows could not be fully opened.

Interview with the Administrator, on 01/23/14 at 11:40 AM, revealed she was not involved in the negotiation of the contract for the window replacement; nor was she involved in deciding when inspection of the work should have taken place. The Administrator stated she felt the windows should have been inspected as they were being installed to ensure residents' safety.

Interview with the Administrator and Director of Nursing (DON), on 01/24/14 at 12:15 PM, revealed the purpose of the Reflections Unit was to safeguard and protect residents who have decreased safety awareness. The Administrator stated the unit should have been monitored to ensure a safe and secure environment was provided for the residents residing there. She indicated again the windows replaced on that unit should have been inspected after installation to ensure the resident environment was safe.

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F 323	Continued From page 25 The facility provided an acceptable credible Allegation of Compliance (AOC) on 01/23/14, which alleged removal of the IJ effective 01/17/14. Review of the AOC revealed the facility implemented the following corrective action:  1) On 01/15/14, Resident #1 was fully assessed by the Physician in the facility, including vital signs. No injuries were noted. Resident #1 was placed on one on one observation.  2) On 01/15/14 a facility head count was performed when Resident #1 was discovered missing and a "Code Green" was initiated.  3) On 01/15/14 all windows in the facility were checked by staff for proper functioning and safety.  4) On 01/15/14, all windows were checked by the contractor.  5) On 01/15/14 all doors were checked by facility's staff.  6) On 01/15/14 all wanderguards were checked by the Staffing Coordinator.  7) On 01/15/14, all residents were re-assessed for elopement potential by licensed nurses and care plans were reviewed for any changes found on the elopement assessments. Elopement books were updated to reflect current elopement assessments.  8) On 01/15/14, the Administrator and Human Resource Director were re-educated by regional nurse consultants.	F 323			

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F 323	<p>Continued From page 26</p> <p>9) On 01/15/14, all staff present in the facility were re-educated on elopement and missing resident policy as well as on reporting any plant operations concerns by the Human Resource Director.</p> <p>10) Staff not present would not be able to return to work until re-education had been completed.</p> <p>11) Wandering and Elopement Policy along with how to report plant operations concerns or equipment was to be included in orientation of new employees.</p> <p>12) All windows and doors were to be checked for proper function every shift by a member of nursing staff until Immediate Jeopardy was removed and all concerns were to be reported to the Administrator immediately. An audit of windows and doors was to continue once a week for two (2) weeks, then monthly.</p> <p>13) On 01/16/14, an Emergency Quality Assurance (QA) meeting was held at 01:24 AM to identify the root cause of the incident and development of a plan to prevent re-occurrence.</p> <p>14) On 01/15/14, the Administrator was educated by Vice President of Operations on reviewing all work completed by outside vendors for proper functioning and safety on a daily basis.</p> <p>15) On 01/16/14 the Plant Operations Director was educated by the Administrator on reviewing all work completed by outside vendors for proper functioning and safety on a daily basis as well as maintaining log of all completed work by outside vendors. This log was to be reviewed by the Administrator upon completion of vendor work</p>	F 323		
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F 323	Continued From page 27 daily.  16) Beginning 01/15/14, Social Services was to visit Resident #1 daily for 7 days, then weekly for four weeks to monitor for any psychosocial harm or changes in behavior.  17) On 01/15/14, the Vice President of Operations, Chief Nurse Executive and two regional nurse consultants were on site to oversee and review the Quality Assurance/Performance Improvement (QAPI) Process, reviewed education, and reviewed all assessments performed.  18) On 01/16/14, the Vice President of Plant Operations and Director of Plant Operations conducted additional audit of the facility windows for proper working order.  19) On 01/16/14, all residents assessed as at risk for elopement had been reviewed by nursing staff and nurse consultants to ensure care plans were in place and interventions were appropriate.  20) Plant Operations was to check windows daily for proper function and safety until Immediate Jeopardy was lifted. This was to continue for two (2) weeks and then decrease to three (3) times per week for four (4) weeks.  21) The Administrator or Director of Nursing were to review all audits and education for compliance daily, Monday through Friday.  22) The Administrator had been in the facility daily since 01/15/14 to ensure resident safety and audit completion.	F 323			

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F 323	Continued From page 28 23) All department directors assigned by the Administrator were to have a presence in the facility daily to ensure the audits were completed and ensure resident safety. After the Immediate Jeopardy was removed the department directors were to be present daily for one (1) month to ensure residents' safety.  The State Survey Agency validated the implementation of the facility's AOC as follows:  1) Review of Resident #1's record revealed on 01/15/14 a full assessment was performed on the resident by the Medical Director. Interview, on 01/24/14 at 6:38 PM, with the Medical Director revealed the full body assessment of Resident #1 had been completed on 01/15/14 with no concerns identified.  2) Interview, on 01/22/14 with Registered Nurse (RN) #1 at 3:50 PM and Licensed Practical Nurse (LPN) #1 at 9:50 AM, revealed the head count and "Code Green" had been conducted on 01/15/14 after Resident #1 was discovered missing. Review of the facility's resident census revealed checks beside all residents' names which indicated all residents were present except Resident #1 on 01/15/14. Continued review of this census revealed no check beside Resident #1's name.  3) Interviews, on 01/24/14 with the Quality of Life (QOL) Director at 11:28 AM, SRNA #10 at 11:32 AM, and the Staffing Coordinator at 11:16 AM revealed all facility windows had been checked on 01/15/14. Review of the statement written by the QOL validated there were teams assigned to check all windows in the facility 01/15/14, which included the QOL Director, SRNA #10 and the	F 323			

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F 323	Continued From page 29 Staffing Coordinator. Continued review of the written statement revealed all units including the dining room were assigned a staff member to check the windows. Further review revealed during these checks on 01/15/14, only two (2) windows raised fully open, Room 130, Resident #3's room; and Room 415, Resident #1's room.  4) Interview with the Contractor, on 01/22/14 at 12:34 PM, revealed he came to the facility on 01/15/14 and checked all windows. Review of the Contractor's signed statement revealed he had inspected all facility windows on 01/15/14; and re-inspected all windows on 01/16/14 with facility staff at appropriately 9:30 AM.  5) Review of the DON's written statement revealed she had arrived at the facility at approximately 7:10 PM on 01/15/14 after receiving a phone call informing her Resident #1 had eloped. Continued review of the statement revealed when she arrived staff was searching for the resident inside and outside the building. Further review revealed all staff had been instructed to check all windows for proper functioning and doors to ensure alarms were functioning; and all wanderguards were being checked to ensure they were in place and functioning. Interview, on 01/24/14 at 11:10 AM, revealed with the DON had arrived at the facility on 01/15/14 at approximately 7:10 PM as indicated in her statement. She stated all doors were checked for proper functioning and found to be in working order. Interview on with SRNA #4 on 01/22/14 at 3:35 PM, revealed she had participated in ensuring all doors were checked for proper functioning on 01/15/14.  6) Review of the Preventative Maintenance Task	F 323			

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F 323	<p>Continued From page 30</p> <p>Sheet dated 01/15/14 revealed nineteen (19) residents with wanderguards had their wanderguard bracelet checked and were noted to have passed the test. Interview with the Staffing Coordinator, on 01/24/14 at 11:16 AM, confirmed on 01/15/14 he had verified all wanderguards in the building were checked for proper functioning. Observation, on 01/21/14 at 2:20 PM, revealed Resident #5 was wearing a wanderguard which alarmed when the resident approached the exit doors of the Reflections Unit.</p> <p>7) Review of the elopement books kept on each unit revealed all residents were reassessed for elopement. Review of the Elopement Risk Evaluation assessment forms revealed forms for all residents dated 01/15/14 signed by nursing staff. Review of three (3) sampled resident care plans revealed they had been updated for any changes identified from the reassessments. Interviews with RN #1, on 01/22/14 at 3:50 PM, and Reflections Unit Manager, on 01/24/14 at 11:22 AM, revealed they assisted in performing the elopement risk assessments on 01/15/14 and review of the care plans to ensure they were updated as necessary.</p> <p>8) Review of an e-mail from the Regional Nurse Consultant, dated 01/23/14 at 7:28 PM, revealed the Administrator and HR Director had been re-educated by her on 01/15/14. Continued review of the e-mail revealed she had re-educated the Administrator and HR Director on elopement, missing persons and reporting concerns related to facility operations and safety.</p> <p>Interviews with the Administrator, on 01/24/14 at 11:30 AM, and HR Director, on 01/24/14 at 11:25 AM, revealed the Regional Nurse Consultant had</p>	F 323		

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provided re-education on elopement and missing resident policy; and on how to report facility plant operations concerns and safety.

9 and 10) Review of a memo, dated 01/15/14, sent out to staff by the HR Director revealed it was in regards to attending a mandatory in-service before reporting to work; and the in-service was to be completed before staff could be placed on the work schedule.

Review of staff re-education revealed it was provided by the HR Director from 01/15/14 to 01/21/14. Continued review revealed the re-education material discussed the elopement policy, where the elopement books were kept, the proper code for elopement, who to contact when a resident was missing, as well as, reporting facility plant operations concerns. Review of the post tests performed after the re-education revealed approximately one hundred and sixty-five (165) staff had completed the re-education and taken the test which they had signed and dated, from 01/15/14 to 01/21/14. Review of the post tests revealed three (3) new hires had received the education and taken the test.

Review of certified mail receipts 01/23/14 revealed the memo had been sent to four (4) staff who had not yet received the re-education and were not placed on the work schedule.

Interview, on 01/22/14 at 9:30 AM, with SRNA #1 revealed she had received the re-education on 01/15/14 after Resident #1's elopement.  
Interview on 01/24/14 at 11:30 AM, with SRNA #10; at 11:10 AM with the Housekeeping Director and at 11:16 AM with the Staffing Coordinator

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revealed they had received the re-education after Resident #1's elopement 01/15/14.

Interviews on 01/24/14 at 11:10 AM with the DON; at 11:16 AM with the Staffing Coordinator; and at 11:25 AM with the HR Director revealed staff was to be educated before being allowed to return to work. The HR Director confirmed the re-education had been performed and post tests taken to ensure competency. The DON stated there were some staff who had not received the education yet and these staff would not be placed on the work schedule until they had received the education.

11) Review of the agenda for new employee orientation revealed it included the elopement and missing resident policies; work orders procedure; and emergent facility plant operation procedure which indicated emergent conditions were to be reported to Plant Operations Director immediately.

12) Review of the log book revealed staff were recording the checking of every window in the facility every shift beginning on 01/16/14 and continuing to 01/24/14.

Interview, on 01/24/14 at 11:10 AM with the DON, and at 11:30 AM with the Administrator, revealed all windows had been checked every shift beginning on 01/16/14 and continuing until 01/24/14. The Administrator indicated she was to be notified of any concerns; and the audits would continue once a week for two (2) weeks and then monthly.

13) Review of the Emergency QA meeting notes dated 01/16/14 at 01:24 AM, revealed six (6)

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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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signatures. Review revealed the signatures included the RN Staff Development Coordinator (SDC), Reflection Unit Manager, the DON, the Social Worker (SW), the HR Director and the Administrator. Continued review of the notes revealed the QA Committee discussed the root cause of Resident #1's elopement from the facility as being the new windows which had been installed by an outside contractor and were not properly installed. Review revealed the QA Committee members present discussed the audit of the windows which had been performed and documented as completed. The audits were to continue once a week for two (2) weeks, then monthly. Further review revealed the QA Committee developed additional action plans to be implemented to ensure resident safety.

Interviews on 01/24/14, at 11:30 AM with the Administrator; at 11:10 AM with the DON; at 11:25 AM with the HR Director; and at 11:22 AM with the Reflection Unit Manager revealed they had all attended the Emergency QA Committee meeting on 01/16/14 and discussed the incident extensively to include the root cause and audit performed. They indicated action plans had been developed and had been implemented.

14) Review of an e-mail dated 01/23/14 at 7:34 PM, written by the Vice President of Operations revealed on 01/15/14, he/she re-educated the Administrator that all work completed by outside vendors/contractors was to be checked as soon as the work was completed to ensure proper functioning and resident safety. Interview with the Administrator on 01/24/14 at 11:30 AM, revealed she had received the re-education by the Vice President of Operations on 01/15/14. She stated it had been in regards to reviewing all

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F 323	<p>Continued From page 34</p> <p>work completed by outside contractors/vendors to ensure the proper functioning and safety of work completed on a daily basis.</p> <p>15) Review of the typed statement, undated signed by the Administrator, revealed on 01/16/14, the Director of Plant Operations (DPO) was re-educated by her in regards to reviewing all work by outside contractors/vendors on a daily basis. Review of the statement revealed the DPO was to ensure proper functioning of anything installed and safety of installed work by the contractor/vendor. Continued review of the statement revealed the DPO was to keep a log of all outside contractors/vendors daily which the Administrator was to review daily upon completion of the work of the contractor/vendor.</p> <p>Interview with the DPO on 01/24/14 at 11:46 AM, revealed he had been re-educated by the Administrator on 01/16/14, in regards to reviewing all work completed by outside contractors/vendors; and on ensuring he kept a log of all work completed daily by the contractor/vendor. He indicated he had been keeping the log since the re-education on 01/16/14.</p> <p>16) Review of Resident #1's record revealed Social Service Progress Notes dated 01/15/14 at 10:30 PM, 01/16/14 at 4:15 PM, 01/17/14 at 3:00 PM, 01/18/14 at 7:00 PM, 01/19/14 at 4:50 PM, 01/20/14 at 4:15 PM, 01/21/14 at 3:30 PM, and 01/22/14 at 4:15 PM which noted the resident had suffered no psychosocial harm or changes in behavior.</p> <p>Interview with the Social Worker, on 01/24/14 at 11:38 AM, revealed he/she had visited Resident</p>
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#1 daily and documented the visits in the resident's medical record. She indicated she was to continue visiting the resident weekly for four (4) weeks.

17) Review of the Chief Nurse Executive's statement revealed she and two (2) regional nurse consultants were onsite on 01/15/14 at 9:00 PM and through the early morning hours of 01/16/14. Review revealed she and the regional nurse consultants were ensuring re-education of all staff working during that time and for oncoming staff in regards to the elopement and missing resident policies; how to complete work orders; and what to do if staff identified environmental concerns. Continued review of the statement revealed the Chief Nurse Executive and the two (2) regional nurse consultants had also ensured all windows and doors had been checked.

Interview with the Administrator, on 01/24/14 at 11:30 AM, revealed the Chief Nurse Executive and two (2) other regional nurse consultants had come to the facility on the evening of 01/15/14. She indicated they had reviewed the QA process, reviewed staff education, ensured care plan for all residents had been reviewed and reviewed all assessments performed.

18) Review of a written statement dated 01/16/14, signed by the Vice President of Plant Operations, and the DPO revealed they were onsite on that date to conduct an audit of the facility's windows to ensure they were secure and in proper working order. Further review of the written statement revealed the results of the audit were that all windows were secure on the Reflections Unit.

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Interview with the DPO, on 01/24/14 at 11:46 AM, revealed he and the Vice President of Plant Operations were present onsite at the facility on 01/16/14. He stated they had conducted an audit of all the windows installed to ensure they were properly functioning and safe. The DPO indicated all windows were found to be secure and properly functioning.

19) Resident #1's, Resident #6's and Resident #7's care plans and elopement assessment in the elopement books were reviewed. Continued review revealed Resident #1's care plan had been updated; however, review of Resident #6's and Resident #7's care plans revealed no updates had been indicated. The elopement assessments present in the elopement books for these residents revealed these residents had been reassessed for elopement risk on 01/15/14.

Interviews on 01/22/14 at 3:50 PM, with RN #1 and on 01/24/14 at 11:22 AM, with the Reflections Unit Manager revealed they had assisted with reviewing residents' care plans and elopement books. The Reflections Unit Manager indicated Resident #1's care plan had been updated on 01/15/14 to include one on one (1:1) supervision. The Unit Manager stated Resident #6's and Resident #7's care planned were reviewed along with all of the residents' care plan and their's did not require revision.

20) Review of the facility's "Window Checks Daily Rounds" log revealed windows had been checked for proper functioning and window safety from 01/16/14 to 01/23/14.

Interview with the DPO on 01/24/14 at 11:46 AM, revealed all facility windows had been checked

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F 323	<p>Continued From page 37</p> <p>during this time frame. He indicated no further issues had been noted.</p> <p>21 and 22) Review of a calendar, which indicated the Administrator's audits of the windows and staff education were performed from 01/15/14 to 01/23/14, revealed the Administrator had signed the calendar daily from 01/15/14 through 01/23/14. Review of the Administrator's typewritten statement signed by her, revealed she had been present in the facility daily, Monday through Friday since 01/15/14 to ensure resident safety, staff education, and all audits had been completed.</p> <p>Interview with the Administrator, on 01/24/14 at 11:30 AM, revealed she had been in the facility daily, Monday through Friday, reviewing audits and staff education. She indicated her signature on the calendar indicated she had performed these items.</p> <p>Interviews, on 01/24/14 at 11:10 AM with the DON; at 11:25 AM with the HR Director; and at 11:22 AM with the Reflections Unit Manager, revealed the Administrator had been present in the facility everyday, Monday through Friday, since 01/15/14.</p> <p>23) Interviews, on 01/24/14 at 11:30 AM with the Administrator; at 11:10 AM with the DON; at 11:25 AM with the HR Director; at 11:22 AM with the Reflections Unit Manager; at 4:46 AM with the Director of Plant Operations; and at 11:10 AM with the Housekeeping Director revealed they all confirmed being present in the facility daily and would continue to be present daily for one (1) month.</p>	F 323		