

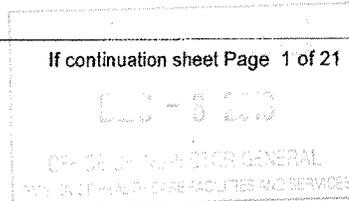
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185205</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/30/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREEN VALLEY HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1206 ELEVENTH STREET CARROLLTON, KY 41045</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 11/22/13</p> <p>An abbreviated and partial extended survey was initiated on 10/22/13 and concluded on 10/30/13 to investigate KY20873. The Division of Health Care substantiated the allegation with Immediate Jeopardy identified on 10/24/13 and determined to exist on 10/19/13 at 42 CFR 483.25 Quality of Care (F323 at S/S of "J") resulting in Substandard Quality of Care at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 10/24/13.</p> <p>On 10/18/13 approximately 2:54 PM, the facility admitted Resident #1 with diagnoses that included Vascular Dementia and Manic Behavior. An Initial Admission Skilled Nursing Observation, dated 10/18/13 at 3:20 PM, revealed Licensed Practical Nurse (LPN) #1 had documented "received in report resident wanders". However, an Elopement Risk Assessment, completed by LPN #1, failed to identify the resident to be at risk for elopement even though the resident triggered for an elopement risk based on the assessment guidelines. Interview with LPN #1 revealed she felt some of the questions were not fair on the Elopement Risk Assessment and that staff needed to promote resident freedom. Per interview, LPN #1 used her own judgment when assessing the resident's elopement risk, and chose not to implement interventions for increased supervision, which may include applying a Code Alert device per the facility's policy. Interview with Registered Nurse (RN) #1 revealed Resident #1 wandered throughout the night; following and staying by RN #1's side. On</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *[Signature]* (X6) DATE **11/26/13**

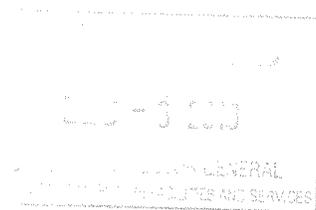
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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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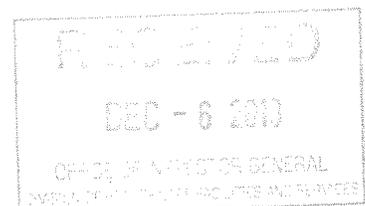
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F 000	Continued From page 1 10/19/13 at 8:15 AM, approximately seventeen (17) hours and fifteen (15) minutes after admission, Resident #1 exited through the front door of the main lobby of the facility without staff knowledge, and was discovered at a neighboring home, half a block from the facility, wanting to enter the residence. The resident was returned to the facility by local law enforcement on 10/19/13 at approximately 9:00 AM, after the facility was informed by a neighbor that the resident was in police custody. Further interview with LPN #1 revealed even after Resident #1 had successfully eloped from the facility, she stood by her assessment and if she had to do it again, she would not place a Code Alert on the resident because in her judgment, the resident was not exit seeking and not having behaviors.  The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/25/13 alleging the Immediate Jeopardy was removed on 10/26/13. The State Survey Agency verified Immediate Jeopardy was removed on 10/26/13 as alleged, prior to exit on 10/30/13, with remaining non-compliance at 42 CFR 483.25 Quality of Care. The scope and severity for F323 was lowered to a "D" while the facility's Quality Assurance continues to monitor the elopement policies and protocols, assessments and care plan development.	F 000	1. Resident returned to facility on 10/19/13 and immediately assessed for injury by unit nurse. It was determined through assessment and self-report that no injury occurred. Unit nurse immediately placed a Code Alert on resident and verified it was functioning properly, and then updated the initial care plan to reflect this intervention. Resident was placed on 1:1 constant supervision until she was re-admitted to the St. Elizabeth's geriatric psych unit at 9:22 p.m. on 10/19/13. Physician, family, Director of Nursing and Administrator were notified.	11/15/13	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			



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F 323	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to have an effective system to ensure the provision of adequate supervision to prevent accidents for one (1) of eight (8) sampled residents (Resident #1). The facility failed to ensure staff followed guidelines to assess a resident's risk for elopement.  On 10/18/13 at approximately 2:54 PM, the facility admitted Resident #1 with diagnoses that included Vascular Dementia and Manic Behavior. An Initial Admission Skilled Nursing Observation, dated 10/18/13 at 3:20 PM, revealed Licensed Practical Nurse (LPN) #1 had documented "received in report resident wanders". However, an Elopement Risk Assessment, completed by LPN #1, failed to identify the resident to be at risk for elopement even though the resident triggered for an elopement risk based on the assessment guidelines. Further review of the assessment revealed LPN #1 failed to provide a rationale for not identifying the resident as an elopement risk per the instructions on the assessment form. Interview with LPN #1 revealed she felt some of the questions were not fair on the Elopement Risk Assessment and that staff needed to promote resident freedom. Per interview, LPN #1 used her own judgment when assessing the resident's elopement risk, and chose not to implement interventions for increased supervision, which may include applying a Code Alert device per the facility's policy. Interview with Registered Nurse	F 323	2. The supervising nurse conducted a resident head count immediately when it was learned of the elopement on 10/19/13. All other residents were safe and accounted for. There were 13 additional residents with code alerts. Supervising nurse checked all 13 code alert transmitters and found them in place and working properly on 10/19/13. All residents in facility re-assessed by Director of Nursing and Quality Assurance nurse on 10/21/13 to ensure all residents with were properly identified and assessed, and found no other residents at risk.		



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F 323	Continued From page 3 (RN) #1 revealed Resident #1 wandered throughout the night; following and staying by RN #1's side. On 10/19/13 at 8:15 AM, approximately seventeen (17) hours and fifteen (15) minutes after admission, Resident #1 exited through the front door of the main lobby of the facility without staff knowledge, and was discovered at a neighboring home, half a block from the facility, wanting to enter the residence. The resident was returned to the facility by local law enforcement on 10/19/13 at approximately 9:00 AM, after the facility was informed by a neighbor that the resident was in police custody. Further interview with LPN #1 revealed even after Resident #1 had successfully eloped from the facility, she stood by her assessment and if she had to do it again, she would not place a Code Alert on the resident because in her judgment, the resident was not exit seeking and not having behaviors.  The facility's failure to provide adequate supervision placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 10/24/13 and was found to exist on 10/19/13. The facility was notified of the Immediate Jeopardy on 10/24/13.  The facility provided a credible Allegation of Compliance (AOC) on 10/25/13. The State Survey Agency verified Immediate Jeopardy was removed on 10/26/13 as alleged, prior to exit on 10/30/13 which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to achieve and maintain compliance.	F 323	3. All floor nurses, supervising nurses, administrative nurses, and Social Services Director re-educated by weekend supervisor on 10/20/13 and by Director of Nursing and Staff Development Coordinator on 10/21/13 on elopement policy and procedures, the assessment process, the implementation of interventions, and the necessity of not deviating from the elopement policy. No changes were made allowing any nurse to deviate from the elopement risk policy. Any nurse not completing the re-education will not be allowed to work her/his shift. All new nurses will continue to be educated on the elopement policy and procedure during orientation by Staff Development Coordinator. The nurse completing the assessment in question has	



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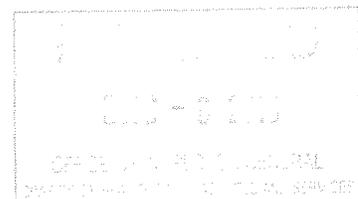
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F 323	Continued From page 4  The findings include:  Review of the facility's policy titled Elopement, dated 01/01/09, revealed residents would be assessed upon admission/readmission, between day three (3) and day seven (7), between day thirty (30) and forty-five (45), quarterly and with significant change in activity of daily living (ADL) function or cognitive function using the Elopement Risk Assessment. The policy also revealed any resident identified at risk of elopement would have a plan developed to eliminate or reduce the risk of elopement. The plan may include frequent visual checks, use of 1-on-1 services, bed alarms, motion detectors at doorway, activity programs and Code Alert bracelet or wandering monitoring system. The facility would maintain a list of all residents identified at risk for elopement and be kept at the reception area and in each Medication Administration Record (MAR). The policy did not specifically state whether the nurse had the autonomy to deviate from the policy or the elopement risk assessment form.  Review of the Elopement Risk assessment sheet, revised 12/08, revealed five (5) questions, and each question was to be answered with a yes or a no. Questions: 1. Is the resident physically able to leave the facility on his/her own, with or without assistive devices? If no, disregard remaining questions. 2. Is the resident a new admission (less than three days)? 3. Does the resident exhibit periods of confusion? 4. Does the resident have a history of leaving the facility or home (actual or reported)? 5. Does the resident exhibit periods of pacing, agitation or wandering? Further review of the Elopement Risk Assessment, revealed if two (2) or more answers	F 323	been counseled by Director of Nursing on 10/21/13 and a performance improvement plan in place. Assessment form amended 10/22/13 requiring two nurses assess all at-risk residents upon admission or re-admission. This form was implemented and staff educated by Director of Nursing and Staff Development Coordinator on 10/22/13. All elopement risk assessments for new and re-admissions will be reviewed by the Staff Development Coordinator within 72 hours to ensure accurate assessments and appropriate interventions and to review the rationale if two "yes" responses and no elopement risk determined by both nurses performing the assessment. The purpose of the second nurse assessment is to ensure appropriate assessment and		



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F 323	<p>Continued From page 5</p> <p>were a yes, this would indicate a possible risk for elopement. If the resident had two (2) or more yes answers and was determined to not be at risk, staff was to provide the rationale for not identifying the resident as an elopement risk. However, the assessment did not provide guidelines/criteria as to when a resident who triggered at risk would not be identified an elopement risk.</p> <p>Review of the facility's Initial Report, dated 10/21/13 and signed by the Administrator, revealed Resident #1 was admitted the afternoon of 10/18/13 and assessed by Licensed Practical Nurse (LPN) #1 utilizing the Elopement Risk assessment. However, the LPN assessed the resident as not at risk for elopement. On 10/19/13, eighteen (18) hours after admission, the resident was found walking from the facility in the neighbor's yard. Resident #1 was returned to the facility by the Sheriff's Department. The staff then implemented an intervention for Resident #1 of immediate application of a code alert device and staff monitoring 1-on-1. The Post Event Investigation, dated 10/24/13 and signed by the Administrator, detailed that "LPN #1 failed to appropriately assess a new resident and follow policy and procedure". The Post Event Investigation identified the resident triggered in four (4) of five (5) elopement questions, but no Code Alert was applied.</p> <p>Review of the nurses notes, dated 10/18/13 at 3:20 PM, revealed an Initial Admission Skilled Nursing Observation on which LPN #1 had documented "received in report resident wanders" under the mood and behavior; chronic behavior notes section. A nurses note dated 10/19/13 at 8:30 AM, revealed the facility spoke</p>	F 323	<p>interventions placed until the 72 hour review by the Staff Development Coordinator. The 3-7 day, 30-45 day, and quarterly elopement assessments are completed by the Director of Social Services, reviewed with each MDS assessment, and reviewed at care plan meetings as necessary. These assessments are audited and results presented at QA not less than quarterly.</p> <p>4. A QA meeting was held on 10/21/13 to address the plan of correction, and again on 10/22/13 to ensure remediation plan complete and in place. The Medical Director was contacted on 10/19/13, 10/21/13, and 10/23/13 to apprise him of the situation, and to review the plan of action. The Quality Assurance nurse will audit all new and re-admissions for proper</p>	



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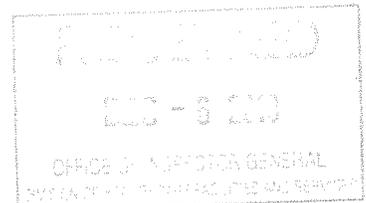
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F 323	Continued From page 6 with the POA regarding transfer to the hospital psych unit and the POA requested to speak with the MD (Medical Doctor) first. A nurses note, dated 10/19/13 at 8:40 AM, revealed the resident disappeared after breakfast; went to a residence next door; and, knocked on their door. The person from that home transported the resident to the police station. Per the nurses note, on 10/19/13 at 8:40 AM, that person then came to the facility and asked if a resident was missing, and that was when it was discovered Resident #1 had "escaped". The Police station was called and the Police escorted Resident #1 back to the facility. Further review of the nurses notes revealed an entry dated, 10/19/13 at 6:45 PM and titled a summary of the day, which stated the resident displayed behaviors of agitation, going in and out of resident rooms, following staff during medication pass, and was not easily redirected. The resident was subsequently transferred to the hospital for evaluation at 9:05 PM on 10/19/13, and was admitted on 10/20/13.  Interview with the Police Officer, on 10/23/13 at 3:23 PM, revealed on 10/19/13 Resident #1 was found at a neighbor's house, banging on the door (about a block away from the facility). The Police Officer stated Resident #1 was "disoriented and medically intact". The Police Officer stated he asked Resident #1 who, where and what questions, but Resident #1 did not have a clue. The Police Officer stated he decided to transport Resident #1 to the Hospital (which was two (2) minutes from the facility) to ensure Resident #1 was not suffering from a stroke. The Police Officer stated he could not relay time frames as he did not complete a report.  Interview with Weekend House Supervisor, on	F 323	elopement assessment and placement of devices, and will report results of audit at QA on 10/24/13 and not less than weekly thereafter for a minimum of 3 months. Audits and QA meetings to review compliance will continue weekly until 3 consecutive months of 100% compliance is sustained. Audits and QA meetings to review compliance will then continue monthly until 12 additional consecutive months of 100% compliance is sustained. Audits and QA meetings will continue not less than quarterly thereafter.	
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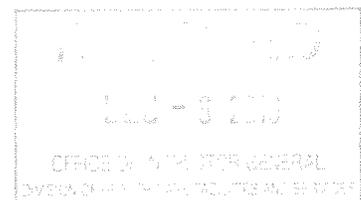
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F 323	<p>Continued From page 7</p> <p>10/23/13 at 3:40 PM, revealed she was not familiar with Resident #1, but on the morning of 10/19/13 a gentleman (neighbor) came in and stated he took a gray haired person to the police station. The Weekend House Supervisor stated she then began a head count and a staff member informed her Resident #1 was missing. The Weekend House Supervisor then called the Police Department and the Police Officer brought Resident #1 back to the facility. Resident #1 was assessed without injury and cleaned up at that time, and a code alert device was placed on the resident and 1-on-1 monitoring was initiated by staff.</p> <p>Further interview with the Police Officer, on 10/23/13 at 3:23 PM, revealed it was raining that day and Resident #1's jogging suit was found to be damp.</p> <p>Review of weather report from the National Weather Service recorded the weather conditions in Carrollton, Kentucky on 10/19/13 as having precipitation with a low of thirty-seven (37) degrees Fahrenheit and a high of fifty-two (52) degrees Fahrenheit.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 10/23/13 at 1:50 PM, revealed when Resident #1 came back into the facility, Resident #1's clothes had to be changed because it was raining and then staff put a code alert device on him/her. CNA #1 stated Resident #1 was upset because he/she was in the facility.</p> <p>Further interview with the Weekend House Supervisor, on 10/23/13 at 3:40 PM, revealed she</p>	F 323			



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F 323	Continued From page 8 began her investigation and made phone calls to the family, Director of Nursing and the Administrator. She interviewed the nursing staff to see who saw Resident #1 last and they stated at breakfast. She stated LPN #1 was working that morning and she interviewed LPN #1 to see why she did not place a code alert device on Resident #1. LPN #1 stated she did not place a code alert device on Resident #1 because he/she was not showing any signs of wandering at the time of the initial Elopement Risk assessment. The Weekend House Supervisor stated LPN #1 should have placed a code alert device on Resident #1 because on Resident #1's elopement assessment there were two (2) or more questions answered with a yes.  Review of Resident #1's Elopement Assessment, dated 10/18/13, revealed LPN #1 assessed Resident #1 to being physically able to leave the facility on his/her own; was a new admission (less than three (3) days); had periods of confusion; and, exhibited periods of pacing, agitation or wandering. The Elopement Assessment instructions stated two (2) or more yes answers indicated the resident was a possible risk for elopement, and Resident #1 triggered "yes" on four (4) of five (5) elopement questions. However, LPN #1 failed to identify Resident #1 at risk for elopement and failed to provide a rationale, per the instructions, as to why the resident was not an elopement risk. Therefore, no interventions were implemented for Resident #1 at the time of the assessment per the facility's policy related to elopement. Further review of the assessment revealed LPN #1 documented staff was to observe and document the resident's behaviors in the nursing notes and update the plan and assessment as needed.	F 323			



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F 323	Continued From page 9  Interview with LPN #1, on 10/24/13 at 9:03 AM, revealed she remembered obtaining report from the Hospital about Resident #1 on 10/18/13 at approximately 12:49 PM. LPN #1 stated she was informed that Resident #1 was combative with family and liked to be busy doing things, like cleaning tables. Per interview, there was no information about the resident wandering or leaving home; even though the Initial Admission Skilled Nursing Observation, dated 10/18/13 by LPN #1, stated "received in report resident wanders". LPN #1 stated when Resident #1 was admitted to the facility, the resident sat in the foyer and did not appear to be exit seeking and at risk for elopement. LPN #1 stated when she received report from the night shift nurse, Registered Nurse (RN) #1 on the morning of 10/19/13, RN #1 reported Resident #1 did not sleep and followed the nurse all night. However, LPN #1 stated she did not place a Code Alert on Resident #1, because Resident #1 was not exhibiting any behaviors or exit seeking the morning of 10/19/13 and the resident was sitting in the dining room, drinking coffee at approximately 8:15 AM. LPN #1 further stated she felt some of the questions were not fair on the Elopement Risk assessment and that staff needed to promote resident freedom. Continued interview revealed even though the resident triggered "yes" to four (4) of five (5) questions on the assessment and had successfully eloped from the facility, the LPN stood by her assessment and if she had to do it again she would not place a Code Alert on the resident because the resident was not exit seeking and not having behaviors.  Interview with Registered Nurse (RN) #1, on	F 323		



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F 323	<p>Continued From page 10</p> <p>10/24/13 at 8:21 AM, revealed she worked with Resident #1 the night of his/her admission. Resident #1 was observed to be sweet, no wandering or exiting behaviors were observed. RN #1 stated she did not feel Resident #1 was an elopement risk that was why she did not put a code alert device on Resident #1. However, RN #1 stated Resident #1 followed her the whole night, while she did med pass, and stayed by her side. RN #1 stated Resident #1 did not wander away from her. RN #1 stated she was aware Resident #1's Elopement Risk Assessment had four (4) of five (5) questions marked as a yes and that she was to monitor the resident's behavior. RN #1 stated Resident #1 probably should have been provided a code alert device.</p> <p>Interview with LPN #3, on 10/30/13 at 2:28 PM, revealed she would put a code alert on a resident if the Elopement Risk Assessment had four (4) of the five (5) questions answered yes and also because the resident was a new admission, could be confused and may want to go home.</p> <p>Interview with RN #2, on 10/30/13 at 2:18 PM, revealed if a resident triggered "yes" on four (4) of five (5) questions on the Elopement Risk Assessment, she would have placed a code alert on the resident because of the nature of the questions and also because the resident had Dementia and was in a new place.</p> <p>Interview with the North Unit Manager RN #3, on 10/30/13 at 2:50 PM, revealed if four (4) of the five (5) elopement risk assessment questions were marked yes, the resident should be considered high risk for elopement. The North Unit Manager stated she would expect the nursing staff to put a code alert device on a</p>	F 323		
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F 323	<p>Continued From page 11 resident who was determined high risk.</p> <p>Further interview with LPN #1 revealed the Elopement policy did not give the nurses the authority to not follow the policy, but the Elopement policy gave the nurses the opportunity to use their judgment when assessing the resident for behaviors. LPN #1 stated through training, she was educated to monitor the behaviors of residents, otherwise every resident who was admitted would have to have a code alert in place because the first two questions of the Elopement assessment would most likely be a yes answer. LPN #1 stated she was educated on the Elopement Policy and assessment upon hire, on 09/07/11, and annually by the Staff Development Coordinator.</p> <p>Interview with LPN #8, on 11/22/13 at 10:37 AM, revealed she received training on the Elopement Assessment and the Elopement Policy. LPN #8 stated the Staff Development Coordinator completed the training. LPN #8 stated if two (2) of the five (5) questions on the Elopement Assessment were answered yes, she would have placed a Code Alert on the resident for safety. LPN #8 stated the Elopement Policy does not give nursing staff the authority to not follow the policy, but nurses must utilize their judgment.</p> <p>Interview with the Staff Development Coordinator, on 11/22/13 at 10:46 AM, revealed she completed the education of staff upon hire and annually. The education of the Elopement policy and assessment were also provided upon hire and annually to staff as well. The Staff Development Coordinator stated she provided an Elopement Policy and Assessment education back in March of 2013, in which she stated was a refresher</p>	F 323			



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F 323	<p>Continued From page 12</p> <p>course for the nursing staff. She further stated she educated the nursing staff to use their nursing judgment if a resident had two questions marked yes on the Elopement Assessment form and to also monitor the resident's behavior. The nurses must utilize the Elopement policy and their judgment. The nursing staff do not have the authority to not utilize the Elopement policy or assessment forms.</p> <p>Interview with the Director of Nursing (DON), on 10/24/13 at 9:44 AM, revealed she knew Resident #1 was going to need a code alert device from the pre-admission screening that stated the resident was confused and ambulatory. However, she did not inform any nursing staff at that time because the resident was not in the building. The DON stated the nurse could pick and choose which interventions to use if the resident was determined to be at risk for elopement per the policy. The policy did not inform the nurse when to put on a code alert device, but lists it as an intervention. The DON stated she felt the Elopement Risk Assessment form was not confusing and felt the questions were very clear. The DON stated she became concerned when she reviewed Resident #1's admission assessments and saw that Resident #1's elopement assessment had four (4) questions answered yes. The DON stated she asked LPN #1 why she did not put a code alert device on Resident #1 and LPN #1 responded Resident #1 was calm and not exit seeking and in her nursing judgment she felt the resident was not at risk. The DON stated she felt there was a problem with the assessment and LPN #1 should have placed a code alert device on Resident #1.</p> <p>Interview with the Administrator, on 10/24/13 at</p>	F 323		
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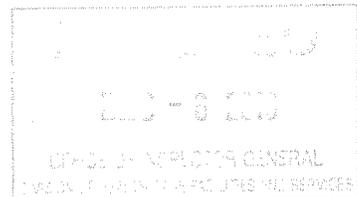
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F 323	<p>Continued From page 13</p> <p>11:03 AM, revealed through meetings with the DON he found the error occurred with the elopement assessment completed by LPN #1 and the poor judgment that was made by LPN #1. Resident #1 should have had a code alert device on, which would have prevented Resident #1 from exiting the building. The Administrator further stated the QA Committee determined the LPN used poor judgment in the assessment. The assessment was a corporate policy and if there was a gray area the nurses could use their judgment with a good rationale. Per interview, the assessment was not appropriate, even if the resident did not leave the building, because there were four (4) triggers for the resident; however, the policy did not say if four (4) were answered yes there had to be a Code Alert applied to the resident. Interview with the Administrator further revealed the Elopement policy did not give the nurse the latitude to not follow the policy and there was no nursing judgment outside of following the policy.</p> <p>Interview with the Maintenance Director, on 10/23/13 at 10:45 AM, revealed the front doors stayed opened between the hours of six (6) AM and six (6) PM every day and were equipped with a code alert system. The Maintenance Director stated when a resident with a code alert device on, walked up within six (6) feet of the front door, an alarm would sound to alert staff.</p> <p>Review of the acceptable Allegation of Compliance (AOC), dated 10/25/13, revealed the facility took the following actions:</p> <p>1. Resident #1 was returned to the facility by the Police Officer and was assessed on 10/19/13 and found no injury was sustained. Resident #1 was</p>	F 323			



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F 323	<p>Continued From page 14</p> <p>placed on 1-on-1 supervision until transfer to the hospital that evening due to an escalation in behaviors. The Care Plan for Resident #1 was updated on 10/19/13 identifying elopement risk and application of a new code alert device.</p> <p>2. The Weekend House Supervisor conducted a head count immediately when it was learned of the elopement on 10/19/13 and all residents were safe and accounted for. The Supervising Nurse checked all thirteen (13) code alert transmitters and found them in place and working properly on 10/19/13. The DON re-checked all devices for placement and proper functioning and checked all code alert transmitters to ensure all were within expiration dates on 10/21/13. In addition, on 10/21/13, the DON and Quality Assurance Nurse reviewed all code alert transmitter check documentation to ensure all were performed in accordance with policy and procedures.</p> <p>3. The DON completed an audit on 10/21/13, to confirm all residents at risk for elopement had physician orders for the device, that placement of device was on the Treatment Administration Records (TARs), care plans addressed the elopement risk with interventions in place and the elopement binders were accurate and available.</p> <p>4. The Weekend House Supervisor checked all doors for proper functioning on 10/19/13 and found all were working properly. The Maintenance Director re-checked to ensure all exit doors were properly functioning and changed access codes for each key pad on 10/21/13.</p> <p>5. The Administrator reviewed the results of the resident audits, transmitter and door audits, and physician order, TAR and care planning audits to</p>	F 323			



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F 323	<p>Continued From page 15</p> <p>ensure all charts were audited and no more residents were identified at risk and that all systems were working properly on 10/21/13</p> <p>6. All floor nurses, supervisors, administrative nurses and Social Services Directors were re-educated by the Weekend House Supervisor on 10/20/13 and by the DON and Staff Development Coordinator on 10/21/13 on elopement policy and procedures, the assessment process and the implementation of interventions.</p> <p>7. All other staff in the facility were re-educated by the Staff Development Coordinator on the elopement policy and procedures on 10/24/13 and 10/25/13.</p> <p>8. The Elopement Assessment form was amended on 10/22/13 by the Administrator, DON and QA Nurse, to require two (2) nurses to assess all at-risk residents upon admission or re-admission to verify accurate assessment and appropriate interventions were in place.</p> <p>9. The Maintenance Director changed the door lock down times to 4:30 PM to 8:00 AM, Monday through Friday and all doors were locked down twenty-four (24) hours a day on Saturday and Sunday on 10/24/13. During Business hours Monday through Friday a staff member would monitor the front door.</p> <p>10. Social Services would update the elopement binder immediately when a change in cognitive status required elopement precautions, and would review the binder weekly for accuracy.</p> <p>11. The Administrator developed a QA agenda</p>	F 323			



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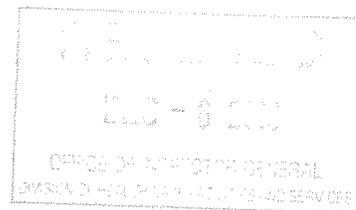
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F 323	<p>Continued From page 16</p> <p>and schedule in conjunction with the Director of Nursing and Nurse Consultant. Initial QA meeting was held on 10/21/13, with meetings on 10/22/13 and 10/24/13, then weekly from that date. The Medical Director attended QA on 10/24/13 and will attend not less than monthly thereafter.</p> <p>The State Survey Agency (SSA) validated the AOC on 10/30/13 as follows:</p> <p>1. Review of the initial care plan revealed it had been updated on 10/19/13 to identify the resident as an elopement risk and the 1-to-1 checks for Resident #1 revealed they were completed and dated until the resident's discharge to the hospital on 10/19/13. Review of the nurses' notes confirmed the assessment of the resident.</p> <p>2. Interview with the Weekend House Supervisor, on 10/23/13 at 3:40 PM, revealed she had conducted a head count to ensure all residents were safe. The Weekend House Supervisor also checked the thirteen (13) residents who were identified as elopement risks to ensure transmitters were in place and functioning properly on 10/19/13. Interview with the DON and Quality Assurance (QA) Nurse, on 10/30/13 at 4:00 PM, revealed on 10/21/13, the DON and QA Nurse checked all devices for placement and functioning.</p> <p>3. Review of five (5) if eight (8) residents at risk for elopement, revealed Residents #1, #3, #4, #6 and #7 had physician orders for the code alert device, placement on TAR for checking placement, every shift and that care plans were developed and addressed elopement precautions and code alert function. Interview with the DON, on 10/30/13 at 4:00 PM, revealed she had</p>	F 323			



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F 323	<p>Continued From page 17</p> <p>checked the physician orders, TARs and care plans on 10/21/13.</p> <p>4. Interview with the Weekend House Supervisor, on 10/23/13 at 3:40 PM, revealed all six (6) doors were functioning appropriately on 10/19/13. Record Review of the log book, for the door checks revealed the doors were functioning properly on 10/18/13 and the doors were rechecked and functioning properly on 10/22/13. Interview with the Assistant Maintenance Director, on 10/30/13 at 2:20 PM, revealed he checked the doors weekly and assisted the Maintenance Director with changing the access codes for each key pad on 10/21/13. Observation of all six (6) doors, on 10/22/13 at 3:20 PM, revealed five (5) doors had to utilize a key pad to exit and the front door was open to residents to come and go without a key pad. Observation of a resident walking up to the front door, with a code alert bracelet on, on 10/23/13 at 10:50 AM, revealed the front door functioned properly.</p> <p>5. Record review for Resident #1, #2, #3, #4, #5, #6, #7 and #8, found elopement assessments were completed and assessed per policy and procedure. Review of the auditing tools dated 10/21/13 utilized by the Administrator revealed the transmitter and door audits were completed, physician orders contained code alert orders, TARs contained documentation of placement and function and care planning audits confirmed wandering and elopement risk were addressed with interventions per policy and procedure, and no other residents were identified as at risk for elopement.</p> <p>6. Interview with LPN #3, on 10/30/13 at 2:28 PM, revealed she was in-serviced on the elopement</p>	F 323		



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F 323	Continued From page 18 policy and elopement assessment, on 10/20/13 by the Weekend House Supervisor. Interview with Registered Nurse (RN) #2, on 10/30/13 at 2:18 PM, revealed she was educated on the elopement policy and assessment, on 10/20/13 by the Weekend House Supervisor. RN #2 stated two nurses were to now sign the elopement assessment to ensure proper decision was made for the resident. Interview with the Weekend House Supervisor, on 10/23/13 at 3:40 PM, revealed she started the education on the elopement policy and elopement assessment on Sunday 10/20/13 and the Staff Development Nurse finished the education. Record Review of the In-service training dated 10/20/13 through 10/25/13 revealed the subject was elopement education on the elopement policy and assessment. Interview with the Staff Development Coordinator, on 10/30/13 at 3:22 PM, revealed she educated nursing staff on the elopement policy and elopement assessment on 10/21/13.  7. All other staff in the facility was re-educated on elopement policy and procedures on 10/24/13 and 10/25/13. Interview with CNA #8, on 10/30/13 at 2:42 PM, revealed she was educated about what to do when the door alarms and how to keep residents safe when an elopement has occurred. CNA #8 stated she was educated by Staff Development on 10/25/13. Interview with Housekeeper, on 10/30/13 at 2:02 PM, revealed she was in-serviced by the Staff Development Coordinator, on 10/25/13, on what to do when the alarm sounded at the door and who to inform if a resident was observed to leave the building. Interview with the Bookkeeper, on 10/30/13 at 3:16 PM, revealed she was in-serviced by the Staff Development Coordinator on what to do	F 323			



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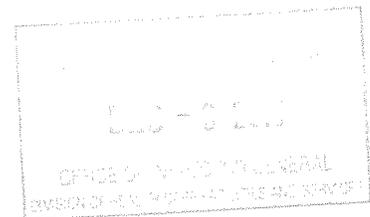
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F 323	<p>Continued From page 19</p> <p>when the alarm sounded at the doors and who to report to when a resident was trying to leave the building. Interview with the Staff Development Coordinator, on 10/30/13 at 3:22 PM, revealed she educated everyone in the building by 10/25/13. Record review of the signatures for the training between the days of 10/20/13 through 10/25/13 revealed all staff were in-serviced.</p> <p>8. Record review of the elopement assessment, revealed there was a space added for two nurses to sign that the elopement assessment was completed accurately. Interview with RN #2, on 10/30/13 at 2:18 PM, revealed two nurses were to now sign the elopement assessment and if the resident was identified to not be at risk for elopement the nurses must give a rationale as to why.</p> <p>9. Interview with the Administrator, on 10/24/13 at 11:03 AM, revealed on 10/24/13 he had the Maintenance Director change the locks on the front door, to be closed between the hours of 4:30 PM to 8:00 AM. The front door was also set to be locked for twenty-four (24) hours on the weekend. Interview with the Weekend House Supervisor on Saturday 10/26/13 at 3:20 PM, revealed the front doors were locked and someone was present at the front desk to ensure no resident could get out without supervision.</p> <p>10. Interview with the Social Services Director, on 10/24/13 at 2:35 PM, revealed she completed the elopement binder. She finds out about changes in the morning meeting and changes the binder accordingly. The Social Services Director stated she changed the binder daily as needed. The State Survey Agency reviewed the elopement binder that revealed all thirteen (13) residents</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/30/2013
NAME OF PROVIDER OR SUPPLIER  GREEN VALLEY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 20 were included with updated information.  11. Review of the QA binder revealed there were QA meetings on 10/21/13, 10/22/13 and 10/24/13. The Medical Director attended on 10/24/13. Interview with the Medical Director, on 10/30/13 at 3:50 PM, revealed he was notified of the elopement on 10/19/13. The Medical Director stated he attended a QA meeting on 10/24/13 and would attend weekly there after and had no concerns.	F 323			

