

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

PRINTED: 12/16/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185146 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R-C 12/16/2015 |
| 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 000} | INITIAL COMMENTS An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 12/11/15 as alleged. | {F 000} | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/11/2015

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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Approved for 12/11/15

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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey investigating Complaint #KY00024002 was initiated on 11/04/15 and concluded on 11/05/15. Complaint #KY00024002 was substantiated with deficient practice identified at a Scope and Severity (S/S) of an "E".

F 323 483.25(h) FREE OF ACCIDENT
SS=E 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.

F323

12-11-15

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure the resident environment remained free of accident hazards for one (1) of six (6) sampled residents (Resident #1) and three Unsampled Residents (Unsampled Residents A, B, and C).

Resident #1 eloped from the facility on 11/01/15 through a fire door which failed to alarm sufficiently to alert staff on Unit B, and suffered a fall sustaining injuries. Unsampled Residents A, B, and C who resided on Unit B were assessed as a wandering risk and were wearing wanderguard bracelets at the time of Resident #1's elopement.

The findings include:

1 Resident #1 was assessed immediately on 11/01/15 by a facility charge nurse. EMS was called and the resident was sent to the hospital for further exam. Resident #1 returned to the facility at approximately 7:45 pm. Resident was reassessed for elopement risk and a wander guard was placed on resident's ankle along with 15 minute checks to be performed by staff. Resident #1's plan of care was updated to reflect the changes.

Unsampled Resident A, B, and C were reassessed for elopement risk and their plan of care was reviewed by the Director of Nursing and no

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TITLE

(X6) DATE

Silena M. Hudson

Administrator

12-11-15

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F 323 Continued From page 1

Review of the "Secure (Wandering) System on Doors" Policy, dated January 20015, revealed all exterior doors of the building shall be in compliance with all state and local codes for paths of egress. All doors will alarm when opened without the proper steps followed. This will ensure the safety of residents and staff members. These doors will be checked daily Monday through Friday. In the event of a door system failure, the following steps will be taken: the administrator and all staff will be notified of the problem, the repairs will be made as soon as possible, a staff member will monitor entrance and exit doors used by visitors and staff until repairs have been made, and all other exterior doors will be equipped with a temporary alarm system that will sound when the door is opened.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 01/22/15 with diagnoses which included Unspecified Dementia With Behavioral Disturbance, Difficulty in Walking, and History of Falling. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/03/15, revealed the facility assessed Resident #1 as severely cognitively impaired.

Review of the Elopement Risk Evaluation, dated 07/06/15, revealed the facility determined Resident #1 was not at risk for elopement.

Review of the Initial Investigation, dated 11/01/15, completed by the Administrator of the facility, revealed on 11/01/15 at approximately 3:40 PM, Resident #1 was located outside the facility doors in the parking lot. Resident was found by a staff member and a head to toe assessment was completed by charge nurse and resident safety

F 323

change was needed to Unsampld Resident A, B, or C plan of care.

The North Exit door was assessed by RF Technologies on 11/2/15. Minor adjustments were made to the door to sound loudly.

2 On 11/01/15 an assessment on all residents was started and completed by 11/02/15 for elopement risk. Assessments were completed by the Charge Nurses on each unit. One resident was found to not be at risk for elopement that had previously been assessed as at risk. The resident was monitored for 72 hours and the IDT team determined to remove the wander guard and that the resident was no longer at risk for elopement. The Resident's plan of care was updated to reflect the change.

Facility environmental rounds were completed by the Director of Nursing, Administrator, Staff Development Coordinator, and by Plant Operations on

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| F 323 | <p>Continued From page 2</p> <p>was ensured. Further review revealed the resident's family and Physician were notified and an investigation had been initiated.</p> <p>Interview with Resident #1 on 11/04/15 at 10:00 AM, revealed the resident was hard of hearing and did not appear to understand most questions asked, but did share he/she was doing well with no complaints.</p> <p>Interview with Resident #6, on 11/04/15 at 1:28 PM, revealed he/she observed Resident #1 on 11/01/15 at 4:40 PM, wheeling himself/herself down the C Wing hall. Resident #6 stated he/she knew what time it was as he/she had his/her electronic tablet with him/her. Resident #6 revealed a few minutes later a nurse was running down the hall saying Resident #1 was out on the sidewalk. Resident #6 stated he/she did not hear any alarms from his/her position in the lounge at that time.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 11/05/15 at 12:39 PM, revealed she had just looked at her watch and was heading outside of the facility for her fifteen (15) minute break when she heard a thump and someone yell "Oh" LPN #2 stated it was 3:42 PM when she discovered Resident #1 on the ground with his/her wheelchair on its side nearby. LPN #4 stated she did not hear the door alarm sounding at that time, and banged on the door with her fist to get staffs attention. LPN #4 revealed Resident #1 had a cut above his/her right eye and to his/her forehead, and the resident stated his/her head and right elbow were bothering him/her. LPN #1 revealed staff were quick to respond to her banging on the door.</p> | F 323 | <p>11/01/15 to ensure an environment free of accidents and hazards exist for the residents. Plant Operations checked all exterior doors to ensure proper function and no further concerns were found. All exit doors were also assessed by RF Technologies on 11/4/15 and minor adjustments were made as needed.</p> <p>3 On 11/01/15 additional door checks was started for staff to check the function of every exterior door every 2 hours. The door checks are documented on the door check form and is being completed by srna, charge nurse, plant operations, environmental services staff, or a member of the management staff, including but not limited to the Administrator, Director of Nursing, Nursing Supervisor, Assistant Administrator, HR Director, Admissions Coordinator, Central Supply, and Medical Records. The door checks are documented using</p> | |

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Interview with LPN #1, on 11/04/15 at 2:33 PM, revealed she last spoke with Resident #1 prior to the elopement on 11/01/15 at approximately 3:15 PM, when Resident #1 was at the nurses station while she was getting supplies together to test resident blood sugars. LPN #1 revealed Resident #1 wanted to watch television, and she pushed his/her wheelchair to the lounge area of the B Wing. LPN #1 stated she last observed Resident #1 prior to the elopement at approximately 3:30 PM in the lounge, and he/she appeared to be sleeping at that time as his/her eyes were closed. LPN #1 stated when coming back towards the nurses station after completing her work, she noticed Resident #1 was not in the lounge, and asked State Registered Nurse Aide (SRNA) #7 to try to locate him/her. LPN #1 further stated SRNA #7 came running back up the hall about a minute later alerting her Resident #1 was outside. Continued interview with LPN #1 revealed she did not recall hearing any alarms when running towards the North door exit, but did hear alarms when she went outside. LPN #1 stated she assisted in providing first aid to Resident #1 and called the ambulance.

Review of the Clinical Report Note dated 11/01/15 at 10:19 PM, revealed Resident #1 returned to the facility from the Hospital Emergency Room (ER) at 7:45 PM per ambulance and was noted to have two (2) abrasions to the right side of the forehead and one (2) abrasion to the right knee. Further review revealed a Wanderguard was placed on the resident's left ankle and every fifteen (15) minute checks was in place related to elopement.

Review of SRNA #7's Witness Statement, dated 11/01/15, revealed she last saw Resident #1

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the door check form. If a door was found to not be in proper function, the staff member was to stay with the door and notify plant operations of the faulty door. At this time, there have not been any issues with the door function of any exterior doors. Education was provided by the Staff Development Coordinator to the Charge Nurses on the floor on 11/01/15 on the door check form.

On 11/2/15 a second alarm was placed on exterior doors by Plant Operations Director that did not have the wander guard alarm on them. The second alarm sounds loudly when someone gets close to the exit door. Education was provided by the Plant Operations Director to sma's and charge nurses.

On 11/04/15, RF Technologies arrived at the facility to inspect all exterior doors and made minor adjustments as needed.

Staff education was started on 11/01/15 in regards to accidents and incidents investigating and reporting, elopement and

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sitting in the lounge at approximately 3:30 PM. No further information was provided regarding condition at the time of elopement, and SRNA #7 was not available for interview during the investigation.

Interview with SRNA #3, on 11/04/15 at 3:12 PM, revealed although she was uncertain of the frequency of elopement drills, overhead pages of "wander alert," along with the door designation, went off "all the time," and staff went to whatever door was indicated. SRNA #3 stated she had not heard the North exit door exit alarm and was not sure what it sounded like.

Interview with SRNA #4, on 11/04/15 at 3:23 PM, revealed she had worked with Resident #1 a lot and had never observed him/her attempting to exit or heard him/her talking about wanting to leave. She revealed the wander alarm went off multiple times each day, and she responded by going to whatever exit was designated and investigating.

Interview with Registered Nurse (RN) #1 on 11/04/15 at 3:28 PM revealed residents were assessed for elopement risk upon admission, quarterly, and any time there was a change of status. RN #1 stated Resident #1 didn't wheel him/herself around very often, and when she heard about the elopement she was shocked.

Interview with the Maintenance Director on 11/04/15 at 3:55 PM, revealed door alarms were checked daily, although he acknowledged if a person was more than ten (10) or fifteen (15) feet from the North door the fire alarm was difficult to hear. The Maintenance Director revealed, following the incident on 11/01/15 with Resident

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wandering, missing resident, and environment concerns and issues (including if there is an issue with an alarm on a door not sounding or not sounding loud enough). This education was provided to all staff, including the Plant Operations and Manager on Duty. Education was provided by the Staff Development Coordinator, Administrator, Charge Nurse, Director of Nursing, Dietary Manager, Environmental Services Director, Behavioral Health Manager, and Nursing Supervisors. Any staff that had not received the education by 11/3/15 had a certified letter mailed to them about the necessary education needed prior to returning to work.

4 The door checks (for all exterior doors) was continued for 2 weeks every 2 hours by staff for proper function. Plant Operations continue to monitor the door systems daily Monday thru Friday and will be monitored by the Manager on Duty on the weekends. The Door Check form will be used to complete the audit on the

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#1, all doors were rechecked, with the North door being checked repeatedly, and found to alarm, although not loudly, each time.

Review of the Final Investigation, undated, completed by the Administrator, revealed staff members working the floor on the unit Resident #1 resided did not hear the alarm when Resident #1 exited the building on 11/01/15, and when they approached the door Resident #1 went out, they could barely hear the alarm. All the facility exit doors were checked by plant operations and an extra loud alarm was placed at the door in which Resident #1 exited.

2. Review of Unsampled Resident A's medical record revealed the facility admitted the resident on 03/09/15 with diagnoses which included Dementia, Depression, and Diabetes Mellitus. Review of the Quarterly MDS Assessment dated 10/21/15 revealed the facility assessed the resident as severely cognitively impaired.

Review of the Elopement Risk Evaluation dated 11/01/15, revealed the resident was determined to be at risk for elopement related to being cognitively impaired, was independently mobile, poor decision making skills, has demonstrated exit seeking behavior, and had the ability to exit the building.

Review of the Treatment Administration Record (TAR) dated November 2015, revealed an intervention for a wanderguard to the ankle due to wander risk.

3. Review of Unsampled B's medical record revealed the facility re-admitted the resident on 06/09/15 with diagnoses which included

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doors. If a door is found to not be in proper function, a staff member will stay with the door and contact plant operations of the issue with the door.

Environmental safety rounds will be completed daily by department managers, not limited to but including: Human Resource Director, Admissions Coordinator, Environmental Services, Supply Coordinator, Nursing Supervisor, Assistant Administrator, Social Services, Chaplain, and Quality of Life. The monitoring tool will be completed daily for one month, then, 3 times per week for one month, then weekly. The monitoring tool will be reviewed monthly in the Quality Assurance meeting for 3 months.

All accidents/incident reports will be reviewed by the DON, ADON, and/or Nursing Supervisor daily, Monday thru Friday to ensure proper interventions are put in place and investigations are complete.

The elopement risk assessments will be completed as needed

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| F 323 | <p>Continued From page 6</p> <p>Psychotic Disorder, Coronary Artery Disease, and Cerebrovascular Accident. Review of the Annual MDS Assessment dated 09/10/15 revealed the facility assessed the resident as severely cognitively impaired.</p> <p>Review of the Elopement Risk Evaluation dated 11/01/15, revealed the resident was determined to be at risk for elopement related to being cognitively impaired, was independently mobile, had poor decision making skills, demonstrated exit seeking behavior, wandered oblivious to safety needs, and had the ability to exit the building.</p> <p>Review of the TAR dated November 2015, revealed an intervention for a wanderguard to the ankle due to decreased safety awareness.</p> <p>4. Review of Unsampled C's medical record revealed the facility re-admitted the resident on 06/26/15 with diagnoses which included Alzheimer's Disease, and a Hip Fracture. Review of the Quarterly MDS Assessment dated 09/07/15, revealed the facility assessed the resident as severely cognitively impaired.</p> <p>Review of the Elopement Risk Evaluation dated 11/01/15, revealed the resident was determined to be at risk for elopement related to being cognitively impaired, was independently mobile, had poor decision making skills, demonstrated exit seeking behavior, wandered oblivious to safety needs, and had the ability to exit the building.</p> <p>Review of the TAR dated November 2015, revealed an intervention for a wanderguard to the ankle to alert staff of exit seeking.</p> | F 323 | <p>based upon each residents behavior and at least quarterly. The assessments will be completed by a Charge Nurse, Nursing Supervisor, or MDS Coordinator.</p> <p>The ongoing processes will be discussed in the Quality Assurance committee meeting monthly for three months, for recommendations and for further follow up as indicated. The members of the Quality Assurance committee include, but not limited to the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, SDC, Social Services Director, Dietician, Quality of Life Director, and Unit Managers.</p> | |
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Interview with the Administrator on 11/05/15 at 1:50 PM, revealed it was her understanding the door alarm was alarming on 11/01/15 when Resident #1 exited the building but was too quiet to hear unless staff was close by. The Administrator revealed her expectation was for door alarms to be checked weekly by maintenance, which was happening, and be properly functioning meaning the alarms should be loud enough for staff to hear them at a distance. She stated, if alarms were not properly functioning anyone could have gotten out through the doors and injured themselves, which is what happened to Resident #1. Further interview revealed although Resident #1 was not assessed as an elopement risk at the time of the incident, three (3) other residents on Unit B were at risk for elopement and wearing wanderguard bracelets at the time of Resident #1's elopement.