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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED
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OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185227		C 11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUPERIOR CARE HOME	3100 CLAY STREET PADUCAH, KY 42001

(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	INITIAL COMMENTS An Abbreviated Survey investigating Complaint #KY22394 was conducted on 10/29/14 through 11/05/14 to determine the facility's compliance with Federal requirements. KY #22394 was substantiated with deficiencies cited at a Scope and Severity of a "D".	F 000	**Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.**	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to provide services to meet professional standards of quality for one (1) of four (4) sampled residents (Resident #1). The facility failed to assess Resident #1 to determine if the resident was at risk for elopement due to the resident's wandering behavior. Resident #1 was able to exit the facility on 10/02/14 without the staff's knowledge. The findings include: Review of the facility's Secure Care Policy, not dated, revealed the staff will identify residents who are at risk for harm because of unsafe wandering. Once a resident has been identified as someone who wanders, a secure care bracelet will be applied and family will be notified. The resident's care plan will indicate the resident is at risk for wandering. Interview with the DON, on 11/04/14 at 3:20 PM, revealed it was not their policy to complete Elopement Risk assessments.	F 281	F281 1) On 10/2/14, the LPN charge nurse placed a Secure Care bracelet on resident to alert staff of further attempts to exit seek. Staff was made aware of Secure Care bracelet placement through the use of the nursing shift report. 2) On 11/1/14, current residents were assessed by DON and the MDS Coordinator by using a newly implemented exit seeking assessment to determine if other residents could be identified. No new residents were identified at that time. New admissions will be assessed upon admission for exit seeking behavior. If exit seeking behavior is identified, a Secure Care Bracelet will be placed and staff will be notified through the nursing shift report. 3) New residents will be assessed at the time of admission. After the initial assessment, the assessments will be completed quarterly and as needed for change in resident condition. The MDS Coordinator will in-service necessary LPN/RN staff and Social Services staff on the proper use of the assessment. The in-services will be completed by 11/24/14. Until 11/24/14, the Assistant Administrator will be completing the assessments. If a resident is identified as a possible exit seeker a Secure Care bracelet will be placed and a care plan will developed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11-21-14

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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F 281	Continued From page 1 Record review revealed the facility admitted Resident #1 on 09/12/14 with diagnosis which included Non-Alzheimer's Dementia. Review of the initial Minimum Data Assessment (MDS) assessment, dated 09/23/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental status (BIMS) score of six (6) which indicated the resident was non-interviewable. Review of the Resident Data Collection sheet, dated 09/12/14 revealed Resident #1 did not know what town he/she was in. Review of the Nurses Notes on admission, dated 9/12/14 at 6:45 PM, revealed Resident #1 was alert with confusion. Review of the Comprehensive Care Plan, dated 09/23/14, revealed the resident had Alteration in Cognitive skills for daily decision making and Alteration in short term memory. Review of the Behavior and Mood flow sheet, revealed Resident #1 was identified as having wandering behavior on 09/20/14 at 3:18 AM and 09/25/14 at 9:09 AM; however, there was no evidence the resident was assessed to determine if the resident was at risk for elopement. Interview with MDS Staff #1, on 10/29/14 at 4.46 PM, revealed there was no elopement risk assessment on Resident #1 and the facility does not do elopement risk assessments. Review of the Completed Care Task flow sheet, revealed on 10/02/14 at 5:06 AM CNA #5 documented Resident #1 was awake most of the	F 281	4) The facilities performance will be monitored thru the QA process to ensure the exit seeking assessment is being completed at the time of admission, quarterly and as needed for change in resident condition. The QA committee is comprised of the Administrator, Asst. Administrator, DON, MDS Coordinator, Clinical Directors, Social Services, Dietitian, Activity Director, Staff Development Nurse and the Human Resource Manager. The resident charts will be audited to check for the timely completion and proper implementation of the exit seeking assessment according to the MDS schedule. A sampling of five residents will be chosen to audit weekly. This audit will be performed by the Assistant Administrator and will be performed for three months If the QA process identifies a concern, procedures will be amended to ensure proper implementation for the safety of the residents. 5) 11/25/14	11/25/14

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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001	

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F 281	Continued From page 2 night. There was no further documentation noted. Review of the Nurses Note, dated 10/02/14 at 6:50 AM, revealed Resident #1 went out the front door looking for his/her wife's car and was redirected back in the building by Certified Nursing Assistants (CNA). Interviews with CNA #5 on 10/30/14 at 4:25 PM and CNA #3 on 10/31/14 at 7:10 AM, revealed they were returning from taking out the trash around 6:30 AM when they saw Resident #1 in his/her wheelchair across the street from the facility in the employee parking lot. CNA #5 stated she did not know how long Resident #1 had been outside. They stated they ran across the street and took Resident #1 back into the facility. They stated the incident was reported to Licensed Practical Nurse (LPN) #4 and LPN #3. CNA #5 revealed Resident #1 had been trying to get up all night and was awake all night. Interviews on 10/30/14 with LPN #3 at 3:10 PM and LPN #4 at 3:30 PM, revealed CNA #3 and CNA #5 reported that Resident #1 was in the parking lot and they had brought the resident back inside the facility. They stated the incident was reported to the Director of Nursing (DON). Interview with the DON, on 11/04/14 at 3:20 PM, revealed Resident #1 had no prior exit seeking behavior. She stated Resident #1 was brought up to the dining room for breakfast and he/she got up and walked out the front door. She stated there was no monitoring until breakfast; however, residents come up to the dining room to drink coffee and read the newspaper. Interview with the Owner, on 11/05/14 at 10:40	F 281		

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F 281	Continued From page 3 AM, revealed she had never heard of a policy for supervision of residents. She stated the front doors are unlocked at 5:30 AM and they do not monitor the dining room/lobby area that time of day.	F 281	F323 1) On 10/2/14, the LPN charge nurse placed a Secure Care bracelet on resident to alert staff of further attempts to exit seek. Staff was made aware of Secure Care bracelet placement through the use of the nursing shift report.	
F 323 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide adequate supervision and assistive devices for one (1) of four (4) residents (Resident #1). Resident #1 was able to exit the facility without the staff's knowledge. The findings include: Interview with the Owner and the Director of Nursing, on 11/05/14 at 10:40 AM, revealed there was no policy for supervision of residents. They stated the front doors were unlocked at 5:30 AM and the staff do not monitor the dining room/lobby area that time of day. The DON stated checking on the residents every two hours was a nursing protocol. The DON revealed the staff check on the residents; however, we don't instruct them to check on the residents at any specific time. The	F 323	2) Current residents were assessed by DON and the MDS Coordinator on 11/1/14 by using a newly implemented exit seeking assessment to determine if other residents could be identified. No new residents were identified at that time. New residents will be assessed upon admission for exit seeking behavior. If exit seeking behavior is identified a Secure Care bracelet will be placed. 3) New residents will be assessed at the time of admission. After the initial assessment, the assessments will be completed quarterly and as needed for change in resident condition. The MDS Coordinator will in-service necessary LPN/RN staff and Social Services staff on the proper use of the assessment. The in-services will be completed by 11/24/14. If a resident is identified as a possible exit seeker a Secure Care bracelet will be placed and a care plan will be developed. To ensure adequate resident supervision, the front door will not be unlocked until 7:15am daily. At this time, a nurse aide will be present daily in the dining area to provide adequate supervision until the breakfast meal begins.	

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F 323	Continued From page 4 DON stated the facility does not utilize a check off sheet and staff round every two hours or more frequently. The DON revealed revealed there was oversight with the residents at all times and there was always someone on the floor and available for the residents. Review of the facility's Secure Care Policy, not dated, revealed the staff will identify residents who are at risk for harm because of unsafe wandering. Once a resident has been identified as someone who wanders, a secure care bracelet will be applied and family will be notified. The resident's care plan will indicate the resident is at risk for wandering. Record review revealed the facility admitted Resident #1 on 09/12/14 with diagnosis which included Non-Alzheimer's Dementia. Review of the Initial Minimum Data Assessment (MDS) assessment, dated 09/23/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) indicating the resident was not interviewable. In addition, the resident was assessed as not having any wandering behavior. Review of the Behavior and Mood flow sheet, revealed Resident #1 was identified as having wandering behavior on 09/20/14 at 3:18 AM and 09/25/14 at 9:09 AM. Interview with MDS staff #1, on 10/29/14 at 4:46 PM, revealed there was no elopement risk assessment on Resident #1 and the facility does not do elopement risk assessments. Review of the Comprehensive Care Plan, dated 09/23/14, revealed there was no care plan to	F 323	4) The facilities performance will be monitored thru the QA process to ensure the exit seeking assessment is being completed at the time of admission, quarterly and as needed for change in resident condition. The QA committee is comprised of the Administrator, Asst. Administrator, DON, MDS Coordinator, Clinical Directors, Social Services, Dietitian, Activity Director, Staff Development Nurse and the Human Resource Manager. The resident charts will be audited to check for the timely completion and proper implementation of the exit seeking assessment according to the MDS schedule. A sampling of five residents will be chosen to audit weekly. This audit will be performed by the Assistant Administrator and will be performed for three months If the QA process identifies a concern, procedures will be amended to ensure proper implementation for the safety of the residents. Monitoring of the morning dining area supervision will be done by the Administrator five days a week for the duration of the stay in the current facility. 5) 11/25/14	11/25/14

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F 323	Continued From page 5	F 323		

address wandering and/or exit seeking behaviors.

Review of the Nurses Note, dated 10/02/14 at 6:50 AM, revealed Resident #1 went out the front door looking for his/her wife's car and was redirected back in the building by Certified Nursing Assistants (CNA). At 7:15 AM, a wander bracelet was placed on the resident; and, at 7:20 AM, a call was placed to a friend to make them aware a wander bracelet was placed on the resident to alert staff when the resident was close to door.

Review of the 11:00 PM to 7:00 AM Nurse Aide Assignment Sheet, dated 10/02/14, revealed CNA #5 was assigned Resident #1's room. Review of the Completed Care Task flow sheet, revealed on 10/02/14 at 5:06 AM CNA #5 documented Resident #1 was awake most of the night. There was no further documentation noted.

Interview with CNA #5, on 10/30/14 at 4:25 PM, revealed she was unsure if she took care of Resident #1 the morning he/she got out the front door. She stated all the CNAs work together. CNA #5 revealed CNA #3 and her were returning from taking out the trash around 6:30 AM when they saw Resident #1 in his/her wheelchair across the street from the facility in the employee parking lot. CNA #5 stated she did not know how long Resident #1 had been outside. She revealed she ran across the street and took Resident #1 back into the facility. She stated she reported Resident #1 being outside the facility to Licensed Practical Nurse (LPN) #4 and the nurse called the DON. CNA #5 revealed Resident #1 had been trying to get up all night and was awake all night.

Interview with CNA #3, on 10/31/14 at 7:10 AM,

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F 323	Continued From page 6 revealed CNA #5 and her were returning from taking the laundry and the trash out when she noticed Resident #1 in a wheelchair in the employee parking lot across the street from the front entrance of the facility. CNA #3 revealed CNA #5 and her ran over there and brought Resident #1 back into the facility. She stated they report it to LPN #4 and LPN #3. Interview with LPN #3, on 10/30/14 at 3:10 PM, revealed CNA #3 and CNA #5 reported that Resident #1 was in the parking lot and they had brought the resident back inside the facility. LPN #3 stated she did not know where in the parking lot Resident #1 was or how long he/she had been outside. She stated she called the Director of Nursing (DON) and told her what happened. Interview with LPN #4, on 10/30/14 at 3:30 PM, revealed she does not how Resident #1 got out of the facility. She stated two (2) of the night CNAs brought Resident #1 back in to the facility, however, she did not know who they were. She stated she did not know how the CNAs knew the resident was outside of the facility. She stated the incident was reported to the DON. Interview with Therapist #2, on 11/01/14 at 7:03 PM, revealed she was coming to work sometime before 7:00 AM and saw nursing staff attending to Resident #1 in the employee parking lot across the street from the facility. Resident #1 was in a wheelchair. Therapist #2 stated she reported it to her supervisor. Interview with CNA #8, on 11/04/14 at 3:26 PM, revealed each staff member was given a certain number of rooms and the DON makes out the assignment daily. The assignment sheet has the	F 323		

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F 323	Continued From page 7 names of staff and what wing their working and who was responsible to obtain vital signs and pass out water. She stated the CNAs do rounding every two (2) hours and more often in the process of doing bed checks and answering call lights. She revealed they were always going around to make sure residents were okay and the staff work as a group on midnight shift. She stated she did not know if she had been assigned to Resident #1's room on 10/02/14. She revealed the staff take care of of the resident and can document at any time. She stated she does not remember the last time she saw Resident #1 and does not know how he got out of the facility that morning. Interview with the DON, on 10/31/14 at 1:00 PM, 11/04/14 at 3:20 PM and 11/05/14 at 3:20 PM, revealed she was aware Resident #1 got out the door on 10/02/14. The DON stated she was told Resident #1 went out the front door and the CNAs re-directed him/her back in to the facility. She stated Resident #1 was looking for his/her spouse in the parking lot in front of the building. She revealed Resident #1 just walked out the door and was still on the facility property and did not exit off. She stated she does not know who brought Resident #1 back in to the facility. She stated from the phone conversation with the nurse it was very quick and was at the time the CNAs went out to put their personal items in their cars on their last break. Further interview revealed Resident #1 had no prior exit seeking behavior. She stated Resident #1 was brought up to the dinning room for breakfast and he/she got up and walked out the front door. She stated there was no monitoring in the area until breakfast, however, residents come up to the dining room to drink coffee and read the newspaper. She stated staff was assigned a	F 323		

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F 323	Continued From page 8 group of rooms that they chart on and they work together as a team. Interview with the Administrator, on 10/31/14 at 1:30 PM, revealed she was not made aware Resident #1 got out of the facility when he/she got out. She stated she doesn't know the date the resident went out of the facility or the date she was made aware Resident #1 got out of the facility. She revealed she had understood that Resident #1 had exited and was brought back in by the staff and he/she did not leave outside the front door. She stated she supposed if Resident #1 had not been right there at the front door and someone had not been with him/her there was a potential for harm and any resident could have the potential for something to happen to them.	F 323		