

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

PRINTED: 05/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/03/2013
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey to investigate KY20101 was initiated on 04/29/13 through 04/30/13 and a partial extended survey was conducted 05/02/13 through 05/03/13. Immediate Jeopardy was identified on 04/30/13 and determined to exist on 04/27/13 in the areas of 42 CFR 483.20 (F280) S/S=J, 42 CFR 483.25 (F323) S/S=J, and 42 CFR 483.75 (F490) at S/S= J. Substandard Quality of Care was identified in 42 CFR 483.25 (F323). The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 04/30/13.</p> <p>On 04/27/13, Resident #1 exited the facility without staff knowledge. The resident was last seen by staff at 9:30 AM and was found by a visitor at 10:10 AM, ambulating on a sidewalk, past the facility's parking lot, toward a busy highway with six (6) lanes of traffic. The family member recognized the resident and informed facility staff of the resident's location. The resident was returned to the facility and assessed as having sustained no injuries. Interview and record review revealed the facility assessed Resident #1 to have a change in condition due to wandering behaviors, increased confusion, and removal of clothing from the closet with verbalization of a desire to go home on 02/07/13 and 03/06/13. However, the facility failed to reassess Resident #1 for elopement risk and did not revise the care plan to reflect those changes and implement increased supervision for Resident #1. On 04/26/13, Resident #1 was observed to exit the facility through the front entrance and was placed on fifteen (15) minute visual checks and a wander guard bracelet was applied to the resident's right wrist. However,</p>	F 000	<div data-bbox="950 1375 1299 1575" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>JUN 06 2013</p> <p>OFFICE OF INSPECTOR GENERAL CENTERS FOR MEDICARE & MEDICAID SERVICES</p> </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Exec. Dir.

(X6) DATE
5-24-13

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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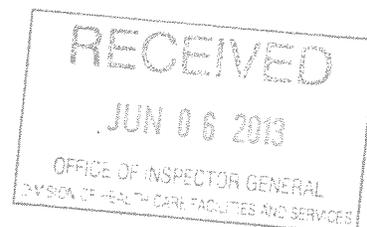
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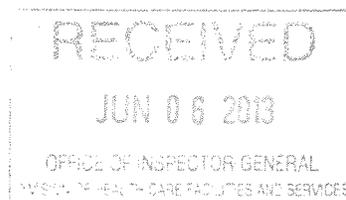
F 000	<p>Continued From page 1</p> <p>review of the log for the fifteen (15) minute checks revealed no documented evidence the visual checks were completed from 6:00 AM-11:00 AM on 04/27/13, the day the resident eloped from the facility. Staff interviews revealed the 15 minute checks were not conducted during that time because of a miscommunication between the night shift and day shift staff where another resident (not Resident #1) was being monitored. These facility failures resulted in Resident #1 exiting the building on 04/27/13 without staff knowledge.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 05/03/13 alleging Immediate Jeopardy was removed as of 05/02/13. The State Survey Agency verified the Immediate Jeopardy was removed prior to exit on 05/03/13, with remaining non-compliance at 42 CFR 483.20 Resident Assessments (F280), 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490) at a Scope and Severity of a "D" while the facility develops and implements a plan of correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p>	F 000		
F 280 SS-J	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an</p>	F 280		



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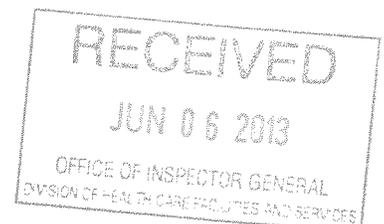
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F 280	<p>Continued From page 2</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's change in condition forms, it was determined the facility failed to have an effective system to ensure the review and revision of the care plan for one (1) of seven (7) sampled residents (Resident #1) when a change in condition occurred. The facility identified Resident #1 had experienced a change in condition on 02/07/13 and 03/06/13 when the resident was observed to have increased confusion and wandering behaviors. The facility failed to revise the care plan to reflect those changes. On 04/26/13, Resident #1 was witnessed to leave the facility through the main entrance doors. The resident was redirected back into the facility. On 04/27/13, Resident #1 exited the facility without staff knowledge, was discovered by another resident's family member, and was returned to the facility by staff. In addition, the care plan was not revised on 04/26/13 to reflect the elopement that occurred</p>	F 280	<ol style="list-style-type: none"> 1. Resident #1 was discharged from facility on 5/2/13 to a secured facility. 2. All resident care plans were audited by MDS nurses on April 30, 2013 to insure behavior care plans in place and reflected current resident status. Any further residents identified with behavior changes and/or elopement risk had profiles updated and care plans developed to reflect these changes. This affected four other residents. 	05-23-13



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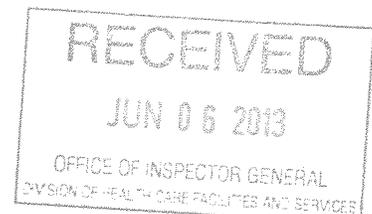
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F 280	<p>Continued From page 3</p> <p>and/or include preventive interventions and Resident #1 eloped again from the facility without staff knowledge on 04/27/13. (Refer to F-323)</p> <p>The facility's failure to ensure the Care Plan was revised to address residents' change in condition, and to include adequate supervision for residents assessed at risk for elopement placed residents at risk for serious harm, injury, impairment or death to a resident. Immediate Jeopardy was identified on 04/30/13 and determined to exist on 04/27/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 05/03/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 05/02/13 as alleged, prior to exit on 05/03/13. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's Change in Condition Form guidelines, revised January 8, 2008, revealed upon assessment of a resident's change in status, the Nurse shall initiate the Condition Change Form in order to fully reflect and document the nursing process. The care plan update section will be completed in its entirety. If the problem area is a new area, include measurable and time-specific goal(s), and realistic, individualized approaches, and the disciplines who will be involved in the care of the resident. If a problem has already been identified for this resident, check the appropriate box and</p>	F 280	<p>3. Staff education for nurses conducted on 4/30/13- 5/1/13 by Staff Development Nurse with emphasis on Change in Condition communication and documentation and care plan development, evaluation and revision. A Quality Assurance meeting was conducted by Clinical Director on 5/1/13 with Medical Director in attendance to provide guidance to campus staff on monitoring behavior changes and subsequent development of care plans to address resident needs.</p>		



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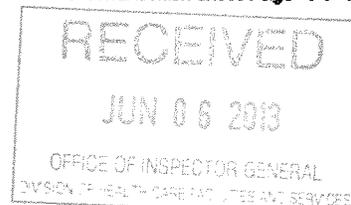
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F 280	<p>Continued From page 4 document the intervention to be added to the current care plan.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 11/15/12 with a diagnosis of Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) Admission assessment, dated 11/26/12, revealed the facility had assessed the resident as having a severe cognition impairment with no behaviors observed. The Quarterly MDS Assessment, dated 02/22/13, revealed the resident had no wandering behaviors.</p> <p>Continued review of the clinical record revealed a change in condition form was completed by Licensed Practical Nurse (LPN) #6, on 02/07/13 at 1:30 PM, that revealed Resident #1 had increased confusion, had been wandering for hours at night, and the resident was standing at the window in his/her room, asking to go home. Review of the Nurses' Note, dated for 02/07/13, revealed the facility obtained a urinalysis secondary to the resident's confusion and wandering. The urinalysis was positive and treatment was obtained. Review of the comprehensive care plan, revised on 02/07/13, revealed the care plan addressed the Urinary Tract Infection (UTI); however, the facility failed to revise the care plan to reflect the resident's wandering behaviors.</p> <p>Further review of Resident #1's clinical record revealed on 03/06/13, LPN #6 completed a change in condition form due to the resident's increased confusion, with the resident stating he/she had to pack their clothes and go home. The Nurses' Note, dated 03/06/13 at 9:00 AM,</p>	F 280	<p>4. Ongoing monitoring for compliance will be achieved by audits of care plans for residents with behavioral changes and/or elopement risks during morning CQI meetings by IDT to ensure care plans are updated with interventions based on identified risks and reflect current status. Any behavior changes and/or exit seeking behavior will be addressed at the time by MDS nurses and Social Services at the time of the meeting. These residents will also be monitored during Clinical At Risk meetings weekly until behavior is stable x 4 weeks. Random Care Plan audits of 5 residents will be conducted by DHS and MDS nurses weekly x 2 months, then monthly x 3 months. IDT will review care plans during resident first meetings and update/develop as needed. Monitoring will also take place during monthly QA meetings, which will require action plan development for non-compliance and through Home Office Peer Review Process. The Peer Review</p>		



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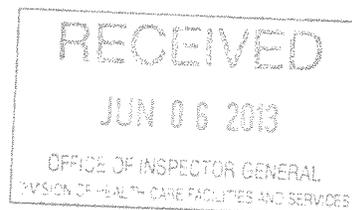
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F 280	Continued From page 5 revealed the resident removed an Incontinent brief and started walking in the hallway stating he/she was going home. Review of the care plan section on the form revealed nothing had been checked to indicate a care plan had been revised according to the facility's policy. Interview with LPN #6, on 04/30/13 at 3:45 PM, revealed she had completed the change in condition forms dated 02/07/13 and 03/06/13. She stated whenever Resident #1 became more confused and started to wander, it was usually indicative the resident had a UTI. She stated the night shift Nurse had reported to her that on 02/07/13, the resident had wandered for hours in the hallway outside the resident's room and this was a new behavior for Resident #1 because the resident usually stayed in his/her room. On 03/06/13, she was working on the floor when a Certified Nursing Assistant (CNA) came to her and told her the resident had removed his/her clothing from the closet and was saying he/she was going home. Per interview, she went into the room and asked the resident where he/she was going and the resident responded, "packing to go home." LPN #6 stated she did not complete the care plan revision section (on the change in condition form) and usually did not fill out that section. She indicated the forms were reviewed during the morning meetings (Monday-Friday) and during this meeting, the care plan was usually revised. However, review of the comprehensive care plan, dated 02/07/13, revealed only the UTI had been addressed with clinical interventions to treat and prevent UTI's. The resident's new behaviors of wandering, removal of clothing from the closet, and the resident stating he/she wanted to go home had	F 280	is conducted twice a year with an Interdisciplinary Team from other Trilogy campuses. This review evaluates systems implementation and requires Action Plans to be completed for non-compliance. Home Office Support follows up on these action plans for correction during their routine visits.		



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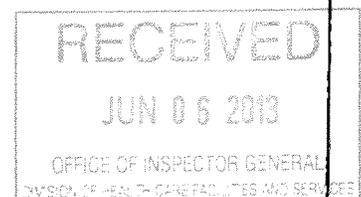
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F 280	<p>Continued From page 6 not been addressed on the care plan.</p> <p>Further record review revealed on 04/26/13 at 6:00 PM, Resident #1 was observed by staff to exit the facility through the main entrance doors. The Executive Director witnessed the resident leaving and redirected the resident back into the facility. The resident was placed on visual checks every fifteen (15) minutes and a wander guard device was placed on the resident. Further review of the record revealed the resident's care plan was not revised to include the resident's attempt to exit the facility nor any preventive interventions the facility had implemented.</p> <p>On 04/27/13 at 10:10 AM, Resident #1 exited the facility without staff knowledge and was found by a visitor ambulating on a sidewalk, past the facility's parking lot, toward a busy highway.</p> <p>Review of the comprehensive care plan revealed the facility did not revise the care plan to address the resident's wandering behaviors that occurred on 02/07/13 and 03/06/13 or the elopement that occurred on 04/26/13 until after the resident had exited from the facility on 04/27/13.</p> <p>Interview with the Social Service Director, on 04/30/13 at 2:00 PM, revealed she knew Resident #1 well and sometime during the week of 04/22/13 - 04/26/13 the resident was wandering more. She stated the resident normally stayed in his/her room and watched TV (loves Price is Right game show). However, last week (Tuesday, 04/23/13 or Wednesday, 04/24/13) she observed the resident wandering throughout the hallways, on the unit. She stated she was unaware of the change in condition regarding the</p>	F 280			



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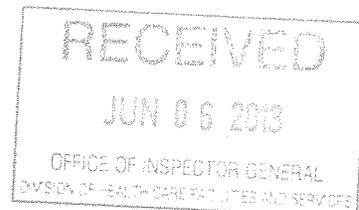
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F 280	<p>Continued From page 7</p> <p>behaviors exhibited on 02/07/13 and 03/06/13. She stated the only changes that were discussed in the morning stand up meetings was that the resident had a UTI. No behaviors were discussed. Therefore, she did not document in her notes about the wandering behaviors and did not revise the care plan. She stated when the resident exited the building on 04/26/13, the care plan should have been revised to reflect this new behavior of exit seeking and the interventions the facility implemented.</p> <p>Interview with the Director of Nursing Services, on 04/30/13 at 11:00 AM, revealed staff should have completed the care plan section on the Change in Condition form. She stated the care plan should have been revised during the morning meetings and interventions implemented. She stated the staff was focused on the UTI and the clinical aspects and did not consider the behaviors. Although the resident had exhibited wandering behaviors prior to the attempt to exit the building on 04/26/13, she considered the wandering behaviors different from exit seeking.</p> <p>Observation of Resident #1, on 04/29/13 at 3:00 PM, revealed the resident sitting in a recliner in his/her room, dressed with a wander guard device pinned to the back of the resident's shirt. Interview with the resident revealed he/she could not answer any questions or converse in conversation.</p> <p>Review of the acceptable Allegation of Compliance (AOC), dated 05/03/13, revealed the facility took the following immediate actions:</p>	F 280		



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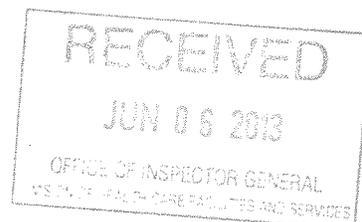
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F 280	<p>Continued From page 8</p> <ol style="list-style-type: none"> All residents in the facility were assessed for indicators of elopement risk, wandering, and unsafe wandering, completed on 04/30/13. All residents were reassessed for elopement potential and Care Plans were updated to include staff interventions to manage unsafe wandering and exit seeking behaviors. Four additional residents were identified as elopement risk. These residents were placed on every fifteen (15) minute checks. These checks were also documented on the 24 hour report and CNA assignment sheets. These actions were completed on 04/30/13. Elopement binders on each Nurses' stations were updated, by the Unit Managers on 04/30/13, with residents' photographs and profile information specific to that resident. Specific demographic information was included for each resident who demonstrated unsafe wandering and exit seeking behaviors. A mandatory in-service was provided for all staff on 04/29/13-05/01/13 that included the elopement policy and procedures, missing resident procedure, door alarms, to ensure staff was competent to identify, report, react effectively to elopements, and document wandering and exit seeking behaviors as well as revision of care plans. <p>The State Survey Agency validated the AOC on 05/03/13 prior to exit as follows:</p> <p>*The State Survey Agency validated through review of the facility's incident/accident reports titled Exit Seeking Circumstance, assessment,</p>	F 280		



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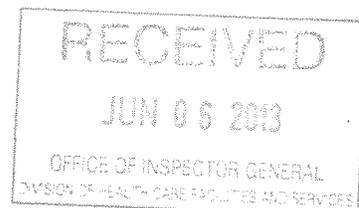
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F 280	<p>Continued From page 9</p> <p>and intervention forms, used by the facility to document and identify residents at risk for elopement, that the facility had identified four (4) residents to be at risk for elopement on 04/30/13. Interview, on 05/03/13, with the Director of Nursing Services revealed the facility had reassessed all residents for elopement risk and placed four residents (Residents #4, #5, #6, and #7) on every fifteen (15) minute checks. Validated through observation and review of the documented scheduled checks.</p> <p>*The State Survey Agency validated through record review of the residents identified to be at risk for elopement that the care plans were updated and CNA assignment sheets were updated with patient information.</p> <p>*The State Survey Agency validated through record review of Elopement binders, on the nursing stations, that all residents identified by the facility to be at risk of elopement were documented by photograph, and included documentation of specific behaviors and demographic information.</p> <p>*The State Survey Agency validated through record review and staff sign in sheets for mandatory staff in-services that the appropriate content was provided to ensure staff were competent to identify, report, react effectively to elopements, and document wandering and exit seeking behaviors as well as revision of care plans.</p> <p>*Interview, on 05/03/13 at 1:35 PM, with the Staff Development Nurse, revealed all staff including himself had attended a mandatory inservice that</p>	F 280		



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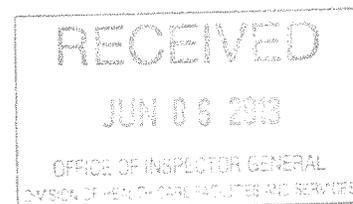
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F 280	Continued From page 10 focused on elopement procedures, missing resident procedures, identification of elopement risks, door alarms, and revision of care plans. *Interviews with the facility staff, on 05/03/13 on TCU-1 at 2:00 PM with RN #1 and CNA #4; on TCU-2 at 2:15 PM with LPN #5; on TCU-3 at 2:05 PM with LPN #4; on 200 unit at 2:10 PM with LPN #1; on Bell unit at 2:25 PM with RN #2, CNA #5, and CNA 6; and, on 300 unit (Derby City) at 2:40 PM with LPN #2 and CNA # 7 revealed they had been in-serviced on the elopement policy and procedure, proper function of the door alarm system, and missing person procedures. The Nurses were in-serviced on the change in condition forms and care plan updates. All the staff had been informed of which residents were on every fifteen (15) minute checks and completion of those forms. All staff had good knowledge of the material presented in the training.	F 280			
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy for elopement,	F 323	1. Resident # 1 was discharged on May 2, 2013 to a secured facility. 2. All residents reassessed for Behavioral changes and elopement risks on 4/30/13 by Nurse Managers. Any residents identified at risks had care plans developed on 4/30/13 by MDS	5-23-13	



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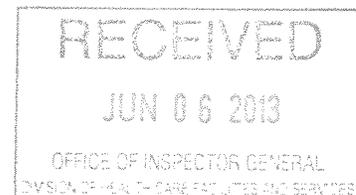
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F 323	<p>Continued From page 11</p> <p>facility investigation, and the log for fifteen (15) minute visual checks, it was determined the facility failed to have an effective system to ensure the provision of adequate supervision to prevent accidents for one (1) resident (Resident #1) of seven (7) sampled residents. The facility failed to follow their Elopement Risk Reduction policy in regard to assessing residents' risk factors for elopement and implementing appropriate measures. On 02/07/13 and 03/06/13, Resident #1 exhibited a change in condition related to increased wandering behaviors, increased confusion, and removal of clothing from the closet with verbalization of wanting to go home. The facility failed to identify the potential elopement risk related to the resident's increased wandering and verbalizations of wanting to go home and failed to implement interventions for increased supervision. (Refer to F280)</p> <p>On 04/26/13 at 6:00 PM, Resident #1 was observed to exit the facility through the front entrance. The facility implemented fifteen (15) minute visual checks to monitor the resident's whereabouts; however, record review and staff interview revealed the fifteen (15) minute checks were not completed on 04/27/13 from 6:00 AM-11:00 AM due to a miscommunication between the night shift and day shift staff. On 04/27/13, Resident #1, who had exhibited wandering and exit seeking behaviors, exited the facility without staff knowledge. The resident was last seen by staff at 9:30 AM. The resident was found by a visitor at 10:10 AM, ambulating on a sidewalk, past the facility's parking lot, toward a busy highway with six (6) lanes of traffic.</p>	F 323	<p>nurses and CRCA assignment sheets were updated by Medical Records Nurse. After reassessments, there were four additional residents identified as elopement risks. These residents were placed on q 15 minute checks and information was communicated during change of shift between nurses, then communicated to CRCA's by nurses. The checks were documented on 24 hour reports and CRCA Assignment sheets. Resident Profiles updated and Elopement Binders updated as well. Plant Operations checked all alarms on day of elopement and found them to be functioning properly.</p>		



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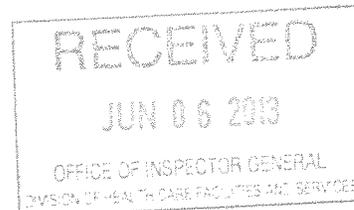
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F 323	<p>Continued From page 12</p> <p>The facility's failure to have an effective system in place to provide supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Immediate Jeopardy was identified on 04/30/13 and determined to exist on 04/27/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 05/03/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 05/02/13, as alleged, prior to exit on 05/03/13. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Elopement Risk Reduction, revision date of 09/16/11, revealed each resident would be assessed upon admission, monthly, and with a change in condition to determine the supervision required to leave facility grounds. A plan of care would be developed and implemented for each resident identified as having the potential to leave the facility unauthorized, requiring supervision for off ground privileges, or wandering to an unsafe area. An album would be kept at a secure location, known to staff, that contains a photograph and identification information about each resident who may be at risk for elopement.</p> <p>Review of facility's Change in Condition form guidelines, revised January 2008, revealed this form was to be utilized to document the change in the resident's status, physician's response,</p>	F 323	<p>3. Staff Education was conducted by Staff Development Nurse and Nurse Managers on 4/30/13-5/1/13 with emphasis on Elopement protocol and alarms. The code on the affected door was changed on 5/1/13 and staff will have to input for visitors who are leaving through that exit. All Health Center residents will be escorted and remained under supervision during activities conducted on Assisted Living by a volunteer and/or staff member. Stop signs were placed at each exit to notify families and visitors to</p>	



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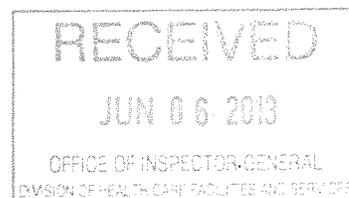
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F 323	<p>Continued From page 13</p> <p>notification of change, and the care plan updated. The policy instructed the staff to complete the care plan section in its entirety. If a problem area is new, the care plan was to include measurable and time-specific goals. The date on the care plan section must be completed and reflective of the date the care plan update was made.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 11/15/12 with a diagnosis of Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) Admission assessment, dated 11/26/12 and the Quarterly MDS Assessment, dated 02/22/13, revealed the facility had assessed the resident as having a severe cognition impairment. Neither MDS assessments identified the resident as having wandering behaviors.</p> <p>Continued review of the clinical record revealed a change in condition form was completed by Licensed Practical Nurse (LPN) #6, on 02/07/13 at 1:30 PM, that revealed the resident was confused, had been wandering for hours at night, and was standing at the window in his/her room, asking to go home. Review of the Nurses' Note, dated for 02/07/13, revealed the facility obtained a urinalysis secondary to the resident's confusion and wandering. On 03/06/13, the same nurse completed a change in condition form due to the resident's increased confusion, with the resident stating he/she had to pack their clothes and go home. The Nurses' Note, dated 03/06/13 at 8:00 AM, revealed the resident removed an incontinent brief and started walking in the hallway stating he/she was going home. Review of the care plan section on the change in condition forms revealed the care plan section had not been checked to</p>	F 323	<p>seek staff assistance before allowing residents out. Volunteer staff were educated by Resident Activities Director. A successful Elopement Drill was conducted by Plant Operations on 4/30/13. This drill was monitored for compliance by DHS and evaluated by Executive Director.</p> <p>4. Systemically, all changes in condition, including exit seeking behavior will be monitored for 72 hours and longer if indicated. They will be reviewed in Morning Clinical Meeting. Residents displaying exit seeking behavior will be initially placed on q 15 minute checks, then wanderguard applied after 72 hours based on Elopement Protocol policy in place. Functioning and placement of the device is checked q shift. Door alarms will continue to be checked by Plant Operations and/or Weekstart Manager daily to insure operational. Residents are assessed daily for safety under Medicare Part A requirements and monthly for Long Term Residents. Elopement Drills will be conducted every 6 months at a minimum</p>		



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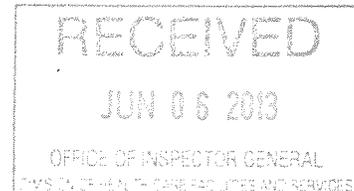
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F 323	Continued From page 14 indicate a care plan had been revised for either incident. Interview with LPN #6, on 04/30/13 at 3:45 PM, revealed she was the Unit Manager where Resident #1 resided. She revealed she had completed the change in condition forms dated 02/07/13 and 03/06/13. After the nurse reviewed the forms, she stated whenever Resident #1 became more confused and started to wander, it was usually indicative the resident had a Urinary Tract Infection (UTI). She stated the night shift nurse had reported to her that on 02/07/13, the resident had wandered for hours in the hallway outside the resident's room. She indicated this was a new behavior for this resident because the resident usually stayed in his/her room. On 03/06/13, LPN #6 was working as a floor nurse when a Certified Nursing Assistant (CNA) came to her and told her the resident had removed his/her clothing from the closet and was saying he/she was going home. The nurse went into the room and asked the resident where he/she was going and the resident responded, "packing to go home." LPN #6 revealed she had failed to complete the care plan revision section on the change in condition form; however, indicated she did not usually fill out that section. She stated the change in condition forms are reviewed during the morning meetings (Monday-Friday) and the care plans are usually revised if needed. Review of the comprehensive care plan, dated 02/07/13, revealed only the UTI had been addressed with clinical interventions to treat and prevent UTI's. The resident's new behaviors of wandering, removal of clothing from the closet, and the resident stating he/she wanted to go home had not been addressed on the care plan.	F 323	every 6 months at a minimum based on requirements. Elopement Binders will be updated and maintained by ADHS. There were no Policy Changes implemented, but current policies addressed and reemphasized during Quality Assurance meeting conducted on 5/1/13 with Medical Director in attendance.		



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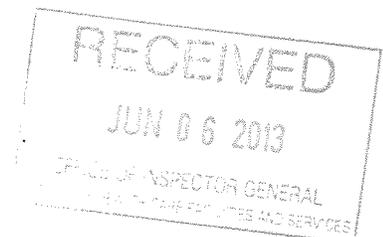
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F 323	Continued From page 15 Review of the record revealed, on 04/26/13 at 6:00 PM, Resident #1 was observed to exit the facility through the main entrance doors. The Executive Director witnessed the resident leaving and redirected the resident back into the facility. The resident was placed on visual checks for every fifteen (15) minutes and a wander guard device was applied. However, review of the log for the fifteen (15) minute checks, dated 04/27/13, revealed no documented evidence the checks were conducted between 6:00 AM through 11:00 AM. Interview with LPN #1, on 04/29/13 at 5:00 PM, revealed she had received the wrong information regarding which resident was to be on the fifteen (15) minute visual checks. She said the night shift nurse had given her another resident's name and that was the resident she was watching, not Resident #1. Review of the facility's incident report revealed the resident was found outside the facility at 10:10 AM, on 04/27/13. Resident #1 exited the facility without staff knowledge and was found by a visitor ambulating on a sidewalk, past the facility's parking lot, toward a busy highway with six (6) lanes of traffic. The resident was assessed to have no injuries. On 04/29/13 at 4:10 PM, an interview with the family members who observed Resident #1 in the parking lot, revealed they (couple) were driving down the driveway to the nursing facility when they had almost reached the parking lot, they saw Resident #1 with his/her walker ambulating alone toward the busy highway. They knew the resident	F 323			



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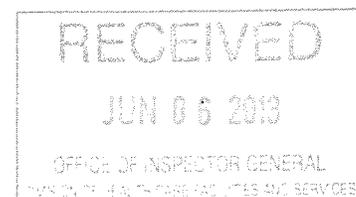
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F 323	<p>Continued From page 16</p> <p>well and knew the resident should not be out alone. They ran into the facility and reported what they saw to the staff. Two staff members went out and retrieved the resident. They stated they had not seen the resident outside alone before, but had over heard staff redirecting the resident often.</p> <p>Interview with CNA #1, on 04/29/13 at 4:30 PM, revealed a family member came into the facility on 04/27/13 and reported Resident #1 was outside and pointed where. The CNA and a housekeeper ran outside and found the resident at the end of the parking lot. When she asked the resident where he/she was going, the resident replied, "home." The CNA brought the resident back into the building through the Assisted Living facility. CNA #1 stated she asked the resident if those where the doors where he/she had exited the facility and the resident nodded their head to indicate yes.</p> <p>Interview with LPN #1, on 04/29/13 at 5:00 PM, revealed she remembered Resident #1 wandering about the hallways the morning of 04/27/13. She stated after breakfast, the resident would usually stay in his/her room and watch the Price is Right (game show). However, he/she did not the morning of 04/27/13, the day the resident eloped. She stated the resident had been more agitated lately and the resident had tried the Assisted Living door earlier. She redirected the resident away from the door. She revealed the resident would wander when the resident had a UTI; however, the wandering appeared to be worse that day. She stated she was conducting the medication pass and did not see the resident exit the building on 04/27/13. She did not hear</p>	F 323		



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F 323	<p>Continued From page 17</p> <p>any door alarm sound and did not know the resident was missing until the family member reported seeing the resident outside the facility.</p> <p>Interview with CNA #3, on 04/30/13 at 9:00 AM, revealed she was assigned to Resident #1 on 04/27/13. She stated she last saw the resident approximately 9:30 AM when she assisted the resident from the dining room to her/his room. She indicated she had toileted the resident and assisted the resident to sit in a recliner in the resident's room. She then left to assist other residents from the dining room. She stated she did not hear any door alarm sound. She revealed the resident was up and down a lot that day and the resident liked to walk all the time, even in the hallways. This was a new behavior for him/her that started about a month ago. She stated after family visits, the resident would walk the halls searching for them. The resident routinely walked family members to the main entrance and gave them good-bye kisses. CNA #3 stated she was busy with other residents when Resident #1 was found outside. The nurses were suppose to document the visual checks, not the aides.</p> <p>Interview with CNA #2, on 04/30/13 at 10:30 AM, per telephone, revealed she was working the day the resident eloped from the facility. She stated she was not responsible for Resident #1 that day, but had provided care for the resident many times and knew the resident well. She revealed Resident #1 was observed to be wandering in the hallways and stated the resident walked fast and went everywhere. The resident had talked about going home before. Recently, the resident was observed with clothes in his/her hands walking down the hallway saying he/she was going home.</p>	F 323		



Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185132	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/24/2013
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Name of Facility FRANCISCAN HEALTH CARE CENTER	Street Address, City, State, Zip Code 3625 FERN VALLEY ROAD LOUISVILLE, KY 40219
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 05/23/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 05/23/2013	ID Prefix F0490 Reg. # 483.75 LSC	Correction Completed 06/15/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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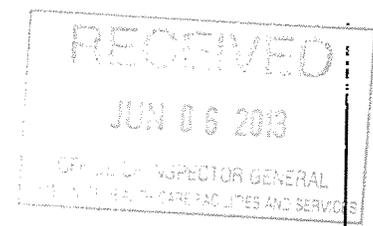
Reviewed By <i>JM</i>	Reviewed By <i>J. Mayo</i>	Date: 7.25.13	Signature of Surveyor: <i>Betty J. Brennan</i>	Date: 7/25/13
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/3/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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NAME OF PROVIDER OR SUPPLIER FRANCISCAN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3626 FERN VALLEY ROAD LOUISVILLE, KY 40219		
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F 323	<p>Continued From page 18</p> <p>CNA #2 observed the resident sitting in the area beside the door that leads to the Assisted Living Facility before. The resident waited until someone opened the door and then the resident grabbed the door and tried to go through to the Assisted Living Facility. When she tried to redirect the resident, he/she got mad at her. She indicated the resident had wandered the hallways before, but it appeared to increase last week. The CNA stated it appeared the resident was waiting for someone to open the door. She just knew the resident left the building through the Assisted Living exit door and when the resident was brought back into the building, the resident had pointed toward the Assisted Living exit door when asked which door he/she had exited. When asked if she had reported the resident had attempted to leave through the Assisted Living exit door, this CNA stated LPN #3 had been present. However, interview with LPN #3, on 04/30/13 at 1:30 PM, revealed the nurse denied she ever saw the resident attempt to go through the door that leads to the Assisted Living Facility.</p> <p>Observation of Resident #1, on 04/29/13 at 3:00 PM, revealed the resident sitting in a recliner in his/her room with a wander guard device pinned to the back of the resident's shirt. Interview with the resident revealed the resident could not answer questions regarding the elopement. The resident's daughter was visiting and interview at this time with the daughter revealed the resident had been at the nursing facility for about five months. She stated whenever the resident had a UTI, the resident became more confused, restless, and would wander. The daughter stated last Wednesday (04/24/13), LPN #1 called her and told the daughter the resident was restless</p>	F 323			



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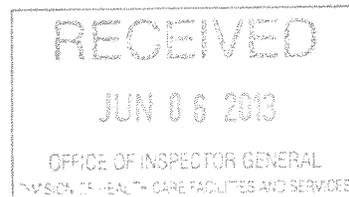
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F 323	<p>Continued From page 19</p> <p>and wandering. The nurse requested the daughter to come to the facility and sit with the resident. She said a facility nurse called again on Thursday, 04/25/13 and reported to the daughter the resident was agitated and wanted to leave the facility. On Friday, 04/26/13, the nursing facility called her and told her she needed to come to the nursing facility and sit with the resident because the resident had attempted to leave the building. On Saturday morning, 04/27/13, the nursing facility called the daughter to informed her the resident had gotten out of the facility. The daughter stated recently the resident appeared to be more determined to get out than before.</p> <p>Interview with the Director of Nursing Services, on 04/29/13 at 3:45 PM, in the presence of the Director of Clinical Operations, revealed she had received a telephone call on Saturday morning from the House Supervisor reporting Resident #1 had gotten out of the building. She stated the resident was observed by another resident's family member to be at the end of the parking lot. She indicated she had just begun the investigation of the incident and had not interviewed all staff working that day. She had spoken with the staff (CNA #1 and a housekeeper) who went outside and brought the resident back into the facility. The resident was assessed and found the resident had not sustained any injuries. The alarm system was checked and it was found to be working properly. She stated the resident was observed to leave the facility on Friday, 04/26/13, through the main entrance doors. The resident was redirected back into the facility and a wander guard alarming device was placed on the resident. In addition, the resident was placed on fifteen (15) minute</p>	F 323			

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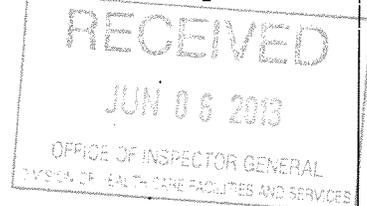
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F 323	<p>Continued From page 20</p> <p>visual checks. She stated the facility was investigating to determine if the resident exited through the door that leads to the Assisted Living facility because that door was not equipped with a wander guard alarm. She revealed a Mass service was being held in the Assisted Living chapel at the time the resident was found outside.</p> <p>Observation of the door between the Nursing Facility and the Assisted Living Facility, on 04/29/13 at 8:30 AM, revealed the door was located on the unit where Resident #1 resided. The door required a code to the key pad before the door would unlock. This door was not equipped with a wander guard alarm. Observation revealed staff, volunteer, and visitors had the code to the door. Observation through the door revealed the Assisted Living chapel was located about fifty feet from the door. Once inside the Assisted Living Facility, the front entrance doors (unlocked) are located around the corner from the chapel. There are no staff positioned at those exit doors. Through the exit doors, there is a straight pathway to where Resident #1 was found on 04/27/13 by a visitor.</p> <p>Further interview with the Director of Nursing Services and Director of Clinical Operations on 04/30/13 at 11:00 AM, revealed the nursing staff had knowledge the resident became more confused and increased wandering behaviors when the resident was experiencing a UTI. However, they could not say any additional safety measures or increased supervision had been implemented during those times. The Director of Nursing Services said the nursing staff had been focused on treating the UTI and missed the new behavior for Resident #1. When the change in</p>	F 323			



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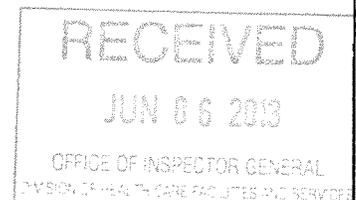
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F 323	<p>Continued From page 21</p> <p>condition forms for 02/07/13 and 03/06/13 were reviewed with the surveyor, they stated the focus had been on the UTI and not the behaviors. In addition, the care plan section had not been completed per policy. The Director of Nursing Services said the staff supervised the resident when the resident was experlencing a UTI, with all eyes on the resident and the staff redrect the resident, but did not answer how often or when.</p> <p>Review of the AOC revealed the facility implemented the following measures: 04/26/13-05/01/13. The immediate actions taken were:</p> <ol style="list-style-type: none"> 1. The facility performed a physical assessment on Resident #1 and found no injuries. 2. Resident #1 was placed on every fifteen (15) minute visual checks on 04/26/13. 3. A wander guard device was placed on the resident on 04/26/13. 4. An elopement risk assessment was completed for Resident #1 and the resident's picture and profile was placed in the elopement binder on 04/27/13. 5. Resident #1's care plan was revised to address the wandering behaviors on 04/27/13. 6. The Plant Operation Director checked all exit door alarms and found they were operational on 04/27/13. 7. Stop signs were placed on each exit door to 	F 323			



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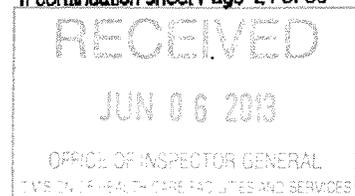
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F 323	<p>Continued From page 22</p> <p>notify families and visitors to seek staff assistance before allowing residents out the exit door on 04/26/13.</p> <p>Additional measures taken by the facility were:</p> <p>8. The code to the affected door (entrance to the Assisted Living Facility from the nursing facility) was changed on 05/01/13. Only staff are allowed to have the code and must input for visitors. All nursing facility residents are to be escorted and remain under supervision during activities conducted in the Assisted Living Facility.</p> <p>9. All residents were reassessed for elopement potential on 04/30/13 and found there were four (4) additional residents identified as elopement risk. These residents were placed on every fifteen (15) minute visual checks to increase observation. These checks will be communicated between ongoing and outgoing nurses during shift change and then communicated to the nursing aides by the nurse. These checks will be documented on the 24 hour report and CNA assignment sheets. Audits will be performed by the the Unit Manager, Director and Assistant Director of Nursing Services.</p> <p>10. The care plan for the four residents were revised to include elopement risk on 04/30/13.</p> <p>11. Pictures of the four (4) residents identified at risk for elopement were placed in the elopement binder located at each nurses station. (Resident #4, #5, #6, and #7) on 04/30/13.</p> <p>12. Training of staff (all departments) on the elopement policy, alarm policy and procedures,</p>	F 323		



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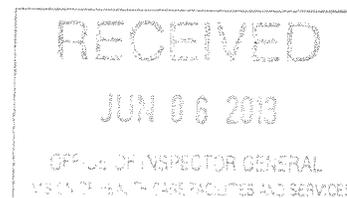
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F 323	<p>Continued From page 23</p> <p>missing resident procedure, and elopement binder was conducted on 04/29/13 through 05/01/13. The nurses were reeducated on the change in condition form and revision of care plan on 05/01/13.</p> <p>13. A Quality Assurance (QA) meeting was conducted on 05/01/13 with the Medical Director in attendance. All audits will be reviewed during the monthly QA meetings.</p> <p>14. An Elopement drill was conducted on 04/30/13. Monthly drills will be conducted for the next six (6) months.</p> <p>The State Survey Agency validated the AOC on 05/03/13 prior to exit as follows:</p> <p>*Observation of Resident #1, on 04/29/13 at 3:00 PM, revealed the resident sitting in a recliner with a wander guard device pinned to the resident's top. Review of the treatment record (April and May) revealed the wander guard device had been checked every shift to ensure placement and operational.</p> <p>*Review of the exit seeking risk form completed by the facility on 04/30/13 revealed all residents had been reassessed for elopement risk. The additional four (4) residents identified by the facility to be at elopement risk had individualized care plans developed to address the risk.</p> <p>*Observation of all exit doors (B) with the Plant Operation Director, on 04/30/13 at 8:50 AM, revealed all alarms were operational. Only the main entrance door and the Rehab entrance were equipped with a wander guard alarm system.</p>	F 323		



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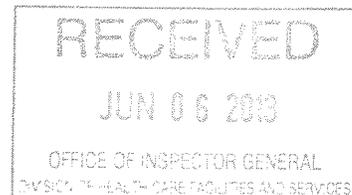
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F 323	<p>Continued From page 24</p> <p>There was documented evidence the exit alarm doors were checked daily. An elopement drill was performed on 04/30/13 with staff signatures to validate. Observation revealed all exit doors had Stop signs applied to instruct visitors to seek staff assistance before allowing residents out the door. These stop signs were applied prior to initiation of the survey.</p> <p>*Observation and interview validated the code to the Assisted Living door had been changed. Observation, on 05/02/13 at 10:30 AM, revealed the staff put the code into the key pad for visitors and the volunteer was observed to escort residents to and from the Mass church services held in the Assisted Living chapel. Interview with the volunteer revealed she had been instructed to stay with the nursing facility residents during the entire activity and assist them back and forth.</p> <p>*Validated each Nurses' station (6 total) and the front desk had the elopement risk binder with Resident #1, #2, #4, #5, #6 and #7 pictures and profile included.</p> <p>*Review of the every fifteen (15) minute visual checks for the dates of 04/30/13 through 05/03/13 validated the staff had completed the visual checks as scheduled for Residents #1, #3, #5, #6, and #7. Resident #4 was in the hospital. Review of audits conducted on 04/30/13-05/03/13 validated completion.</p> <p>*Validation of staff training 04/29/13-05/01/13 via sign-in roster checked against staffing roster. Validated all staff had been trained by 05/01/13 except for those on vacation, medical leave, or had not worked yet. Validated a PRN (as needed)</p>	F 323		



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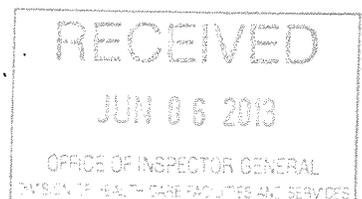
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F 323	Continued From page 25 nurse received training prior to working on 05/02/13. *Interviews with the facility staff, on 05/03/13 on TCU-1 at 2:00 PM with RN #1 and CNA #4; on TCU-2 at 2:15 PM with LPN #5; on TCU-3 at 2:05 PM with LPN #4; on 200 unit at 2:10 PM with LPN #1; on Bell unit at 2:25 PM with RN #2, CNA #5 and CNA #6; and, on 300 unit (Derby City) at 2:40 PM with LPN #2 and CNA #7 revealed they had been in-serviced on the elopement policy and procedure, proper function of the door alarm system, and missing person procedures. The Nurses were in-serviced on the change in condition forms and all had been informed of which residents were on every fifteen (15) minute checks and completion of those forms. All staff had good knowledge of the material presented in the training. *Interview with the Medical Director, on 05/02/13 at 11:00 AM, revealed she had been notified of the elopement and spoke with the Executive Director on 04/30/13, the day the facility was notified of the Immediate Jeopardy. She came to the nursing facility on 05/01/13 for a QA meeting. This was validated by the QA signature sheet. The Medical Director revealed the facility requested her input and she assisted with the development of the AOC. She stated she would be attending monthly QA meetings and would be reviewing audit tools to determine if additional education or actions were required. *Interview with the Executive Director, on 05/03/13 at 3:00 PM, revealed the AOC implementation will continue with morning meetings, audits, and monthly QA meetings to	F 323			



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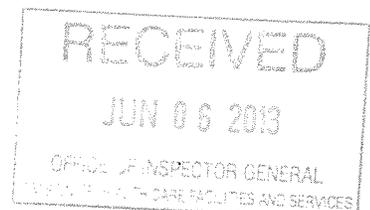
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F 323 F 490 SS=J	Continued From page 26 ensure ongoing compliance. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record and policy review, it was determined the facility failed to be administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, psychosocial well being for one (Resident #1) of seven (7) sampled residents. The Administration failed to have an effective system to ensure policies and procedures were implemented to provide adequate supervision to prevent accidents related to residents who were identified at risk for elopement/wandering, and care plans were revised to include effective interventions. (Refer to F-280 and F-323). On 04/27/13, Resident #1 exited the facility without staff knowledge. The resident was last seen by staff at 9:30 AM and was found by a visitor at 10:10 AM, ambulating on a sidewalk, past the facility's parking lot, toward a busy highway with six (6) lanes of traffic. The family member recognized the resident and informed facility staff of the resident's location. The	F 323 F 490	1. Resident #1 was discharged to a secured facility on May 2, 2013. 2. All residents reassessed for elopement risk on April 30, 2013 by Nurse Managers. Any residents identified at risk (4) had care plans developed on 4/30/13 by MDS Nurses and CRCA Assignment sheets updated by Medical Records nurse. Residents identified were placed on q 15 minute checks, placed on 24 hour reports, communicated between shifts, CRCA assignment sheets updated. Resident Profiles were developed for Elopement Binders on 4/30/13 by DHS and Resident Activities Director and placed at each nursing unit, main entrance desk and assisted living desk.	05-23-13



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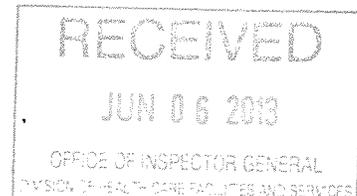
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F 490	Continued From page 27 resident was returned to the facility and assessed as having sustained no injuries. Interview and record review revealed the facility assessed Resident #1 to have a change in condition due to wandering behaviors, increased confusion, and removal of clothing from the closet with verbalization of a desire to go home on 02/07/13 and 03/06/13. However, the facility failed to reassess Resident #1 for elopement risk and did not revise the care plan to reflect those changes and implement increased supervision for Resident #1. On 04/26/13, Resident #1 was observed to exit the facility through the front entrance and was placed on fifteen (15) minute visual checks and a wander guard bracelet was applied to the resident's right wrist. However, review of the log for the fifteen (15) minute checks revealed no documented evidence the visual checks were completed from 6:00 AM-11:00 AM on 04/27/13, the day the resident eloped from the facility. Staff interviews revealed the 15 minute checks were not conducted during that time because of a miscommunication between the night shift and day shift staff where another resident (not Resident #1) was being monitored. These facility failures resulted in Resident #1 exiting the building on 04/27/13 without staff knowledge. The facility's failure to administer the facility effectively and efficiently, to provide adequate supervision of cognitively impaired individuals with known elopement risk, and failure to implement policy and procedures placed residents with potential elopement risk in a situation that was likely to cause serious injury, harm, impairment or death. The immediate Jeopardy was identified on 04/30/13 and	F 490	3. Facility staff were educated by Staff Development Nurse beginning on April 29,2013 and completed on May 1, 2013 related to Elopement Protocols and alarms. Topics included procedure and guidelines, risk factors, plan of care, missing resident guidelines and Elopement Binder, alarms policies and procedures.A Quality Assurance Meeting was conducted by Clinical Director on 5/1/13 with Medical Director in attendance to provide guidance to campus staff addressing the issue of elopement and behavioral changes, as well as any action plans, audits implemented and systemic monitoring that will be implemented to decrease further elopement events. The meeting discussion included guidance related to the Elopement event, Investigation and follow up. The Executive Director and Director of Health Services were educated by Clinical Director on Administrative responsibility for conducting and oversight of the Quality Assurance Program on 5/1/13. Discussion with		



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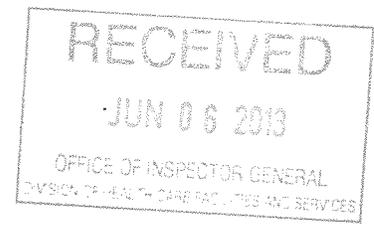
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F 490	<p>Continued From page 28 determined to exist on 04/27/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 05/03/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 05/02/13 as alleged, prior to survey exit on 05/03/13. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Elopement Risk Reduction", revision date of 09/16/11, revealed each resident would be assessed upon admission, monthly, and with a change in condition to determine the supervision required to leave facility grounds. A plan of care would be developed and implemented for each resident identified as having the potential to leave the facility unauthorized, requiring supervision for off ground privileges, or wandering to an unsafe area. An album would be kept at a secure location, known to staff, that contains a photograph and identification information about each resident who may be at risk for elopement.</p> <p>Review of the facility's policy titled "Change In Condition Form Guidelines", revised January 2008, revealed this form was to be utilized to document the change in the resident's status, physician's response, notification of change, and the care plan updated. The policy instructed the staff to complete the care plan section in its entirety. If a problem area was new, the care plan was to include measurable and time-specific</p>	F 490	<p>the team also centered on Administrative responsibility for Quality Assurance oversight for these systems. Educational topics included review of Elopement Policies and Protocols, review of alarm systems, condition change documentation, care plan development, elopement drills and communication with staff and volunteers related to these issues. A successful elopement drill was conducted by Plant Operations on 4/30/13. The drill was monitored for compliance by DHS and evaluated by Executive Director. Stop signs were placed at each exit to notify families and visitors to seek staff assistance before allowing residents out. The code on the affected door was changed on 5/1/13 and staff will have to input for visitors who are leaving through that exit. All Health Center residents will be escorted and remained under supervision during activities conducted on Assisted Living by a volunteer and/or staff member.</p>		



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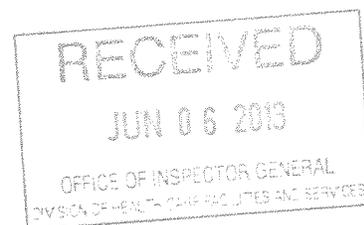
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F 490	<p>Continued From page 29</p> <p>goals. The date on the Care Plan section must be completed and reflective of the date the care plan was updated.</p> <p>Record review and interview revealed the facility completed a change in condition form on 02/07/13 and 03/06/13 when Resident #1 was observed to have increased confusion, wandering behaviors, and with the resident stating she/he had to pack their clothes and go home. However, staff interviews revealed this change in condition/behavior was contributed to the resident's diagnosis of a Urinary Tract Infection (UTI). The facility failed to reassess Resident #1 for elopement risk after the change in condition to determine if supervision was required according to facility policy and failed to revise the resident's comprehensive care plan to address the resident's increased wandering behaviors.</p> <p>On 04/26/13, Resident #1 was observed leaving the facility through the main entrance and was placed on fifteen (15) minute visual checks. However, documentation on the log revealed the facility failed to conduct the 15 minute checks on 04/27/13 from 6:00 AM to 11:00 AM. Staff interview revealed the wrong information was received regarding which resident was to be on the fifteen minute visual checks and the visual checks were conducted on the wrong resident.</p> <p>On 04/27/13 at 10:10 AM, a family member reported Resident #1 was outside ambulating toward a busy highway. The resident had eloped from the facility without staff knowledge and was last seen at 9:30 AM.</p> <p>Interview with the Director of Nursing Services</p>	F 490	<p>4. Ongoing monitoring for compliance will be achieved by review of these items in monthly Quality Assurance Meetings. Clinical Director will be present during these monthly meetings for 3 consecutive months and then quarterly times 6 months to insure oversight and correction of issues are being completed. The Medical Director will also be in attendance as required quarterly. Quality Assurance activities will also be monitored by Home Office Staff during Peer Review two times per year. Action Plan Development will be determined by Executive Director for any noncompliance identified during these meetings. Coaching, counseling as well as any disciplinary measures will be addressed by Executive Director related to noncompliance with effective implementation of systems.</p>		



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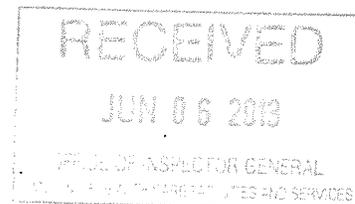
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F 490	<p>Continued From page 30</p> <p>and Director of Clinical Operations, on 04/30/13 at 11:00 AM, revealed oversight had not been provided to ensure the visual checks had been completed on Resident #1. Per interview, nursing staff had knowledge the resident became more confused and increased wandering behaviors when the resident was experiencing a UTI; however, additional safety measures or increased supervision had not been implemented.</p> <p>Review of the AOC revealed the facility implemented the following measures: 04/26/13-05/01/13. The immediate actions taken were:</p> <ol style="list-style-type: none"> 1. The facility performed a physical assessment on Resident #1 and found no injuries. The resident had been placed on every fifteen (15) minute visual checks and a wander guard device was placed on the resident on 04/26/13. 2. An elopement risk assessment was completed for Resident #1 and the resident's picture and profile was placed in the elopement binder. 04/27/13 3. Resident #1's care plan was revised to address the wandering behaviors. 04/27/13 4. The Plant Operation Director checked all exit door alarms and found they were operational. 04/27/13 5. Stop signs placed on each exit doors to notify families and visitors to seek staff assistance before allowing residents out the exit door. 04/26/13 	F 490		



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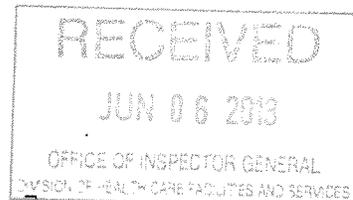
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F 490	Continued From page 31 Additional actions taken were: 6. The code to the affected door (entrance to the Assisted Living Facility from the nursing facility) was changed on 05/01/13. Only staff are allowed to have the code and must input for visitors. All nursing facility residents are to be escorted and remained under supervision during activities conducted in the Assisted Living Facility. 7. All residents were reassessed for elopement potential on 04/30/13 and found there were four (4) additional residents identified as elopement risk. These residents were placed on every fifteen (15) minute visual checks to increase observation. These checks will be communicated between ongoing and outgoing Nurses during shift change and then communicated to the nursing aides by the Nurse. These checks will be documented on the 24 hour report and CNA assignment sheets. Audits will be performed by the the Unit Manager, Director and Assistant Director of Nursing Services. 8. The care plan for the four (4) residents were revised to include elopement risk on 04/30/13. 9. Pictures of the four (4) residents identified at risk for elopement were placed in the elopement binder located at each Nurses' station. (Resident # 4, #5, #6, and #7). 04/30/13 10. Training of staff (all departments) on the elopement policy, alarm policy and procedures, missing resident procedure, and elopement binder was conducted on 04/29/13 through 05/01/13. The Nurses were reeducated on the	F 490			



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F 490	<p>Continued From page 32 change in condition form on 05/01/13.</p> <p>11. A Quality Assurance (QA) meeting was conducted on 05/01/13 with the Medical Director in attendance. All audits will be reviewed during the monthly QA meetings.</p> <p>12. Elopement drill was conducted on 04/30/13. Monthly drills will be conducted for the next six (6) months.</p> <p>The State Survey Agency validated the AOC on 05/03/13 prior to exit as follows:</p> <p>*Observation of Resident #1, on 04/29/13 at 3:00 PM, revealed the resident sitting in a recliner with a wander guard device pinned to the resident's top. Review of the treatment record (April and May) revealed the wander guard device had been checked every shift to ensure placement and operational.</p> <p>*Review of the exit seeking risk form completed by the facility on 04/30/13 revealed all residents had been reassessed for elopement risk. The additional four (4) residents identified by the facility to be at elopement risk had individualized care plans developed to address the risk.</p> <p>*Observation of all exit doors (8) with the Plant Operation Director, on 04/30/13 at 8:50 AM, revealed all alarms were operational. Only the main entrance door and the Rehab entrance were equipped with a wander guard alarm system. There were documented evidence the exit alarm doors were checked daily. An elopement drill was performed on 04/30/13 with staff signatures to validate. Observation revealed all exit doors have</p>	F 490			



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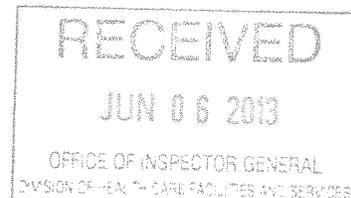
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F 490	<p>Continued From page 33</p> <p>Stop signs applied to instruct visitors to seek staff assistance before allowing residents out the door. These stop signs were applied prior to initiation of the survey.</p> <p>*Through observation and interview validated the code to the Assisted Living door had been changed. Observation, on 05/02/13 at 10:30 AM, revealed the staff put the code into the key pad for visitors and the volunteer was observed to escort residents to and from the Mass church services held in the Assisted Living chapel. Interview with the volunteer revealed she had been instructed to stay with the nursing facility residents during the entire activity and assist them back and forward.</p> <p>*Validated each Nurses' station (6) and the front desk had the elopement risk binder with Resident #1, #2, #4, #5, #6 and #7 pictures and profile included. 05/02/13</p> <p>*Review of the every fifteen (15) minute visual checks for the dates of 04/30/13 through 05/03/13 validated the staff had completed the visual checks as scheduled for Residents #1, #3, #5, #6, and #7. Resident #4 was in the hospital. Review of audits conducted on 04/30/13-05/03/13 validated completion.</p> <p>*Validation of staff training 04/29/13-05/01/13 via sign-in roster checked against staffing roster. Validated all staff had been trained by 05/01/13 except for those on vacation, medical leave, or had not worked yet. Validated a PRN (as needed) Nurse received training prior to working on 05/02/13.</p>	F 490			

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F 490	<p>Continued From page 34</p> <p>*Interviews with the facility staff, on 05/03/13 on TCU-1 at 2:00 PM with RN #1 and CNA #4; on TCU-2 at 2:15 PM with LPN #5; on TCU-3 at 2:05 PM with LPN #4; on 200 unit at 2:10 PM with LPN #1; on Bell unit at 2:25 PM with RN #2, CNA #5 and CNA #6; and, on 300 unit (Derby City) at 2:40 PM with LPN #2 and CNA #7 revealed they had been in-serviced on the elopement policy and procedure, proper function of the door alarm system, and missing person procedures. The Nurses were in-serviced on the change in condition forms and all had been informed of which residents were on every fifteen (15) minute checks and completion of those forms. All staff had good knowledge of the material presented in the training.</p> <p>*Interview with the Medical Director, on 05/02/13 at 11:00 AM revealed she had been notified of the elopement and spoke with the Executive Director on 04/30/13, the day the facility was notified of the Immediate Jeopardy. She came to the nursing facility on 05/01/13 for a QA meeting. This was validated by the QA signature sheet. The Medical Director revealed the facility requested her input and she assisted with the development of the AOC. She stated she would be attending monthly QA meetings and would be reviewing audit tools to determine if additional education or actions were required.</p> <p>*Validated the Divisional Vice President was in attendance of the QA meeting on 05/01/13 to provide guidance to the related Elopement events, investigation, reviewed the Elopement Policies and Procedures, Condition change forms, and documentation with emphasis on behavioral changes. There were no policy</p>	F 490		



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F 490	Continued From page 35 changes. *Interview with the Executive Director, on 05/03/13 at 3:00 PM, revealed the AOC implementation would continue with morning meetings, audits, and monthly QA meetings to ensure ongoing compliance.	F 490		
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