

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

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/10/2014
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220	
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated/Partial Extended Survey investigating complaint #KY21495 was conducted on 03/26/14 through 04/10/14 to determine the facility's compliance with Federal requirements. Complaint #KY21495 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 04/01/14 and determined to exist on 03/22/14 at CFR 483.20 Resident Assessment, F-281 and F282; and CFR 483.25 Quality of Care, F-323 at a scope and severity of a "J". Substandard Quality of Care was identified at 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 04/01/14.</p> <p>Resident #1 was readmitted to the facility on 03/22/14 at approximately 5:20 PM with a physician's order for a Secure Care bracelet to the left ankle on at all times; however, the facility failed to implement the physician's order to apply the Secure Care bracelet to the resident's left ankle and failed to provide adequate supervision to ensure the resident could not exit the facility without staff knowledge. On 03/22/14 at approximately 6:10 PM, a female called the facility to notify them she saw an elderly person walking on the road near the facility. The nurse exited the front of the building and saw Resident #1 walking down the road and approached the resident and was able to escort him/her back to the facility. Resident #1 had exited the front doors of the facility without staff knowledge and walked 0.4 miles from the facility on a two (2) lane road with a speed limit of forty-five (45) miles per hour.</p> <p>An acceptable Allegation of Compliance (AoC) was received on 04/08/14 alleging the removal of</p>	F 000	<p><i>Disclaimer:</i> The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts or conclusions set forth in support of the allegations of deficiency. Further, the facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. The facility also disputes that the circumstances constituted non-compliance to any resident. This plan of correction is prepared and execute solely because it is required by federal and state law.</p>	

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

*Diane Miller*

TITLE

*Intervenor Administrator*

(X6) DATE

*May 2, 2014*

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 000	Continued From page 1 Immediate Jeopardy on 04/05/14. The State Survey Agency validated, on 04/10/14, the Immediate Jeopardy was removed on 04/05/14, as alleged. The Scope and Severity was lowered to a "D" at 482.20 Resident Assessment, F-281 and F282 and 485.25 Quality of Care, F-323 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes.	F 000		
F 281 SS=J	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 interview, record review, and review of the facility's policy and procedure and Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, last revised 10/2010, it was determined the facility failed to provide services to meet professional standards of quality of care for one (1) of four (4) sampled residents (Resident #1) related to following the physician's order for a Secure Care bracelet.  Resident #1 was readmitted to the facility on 03/22/14 at approximately 5:20 PM with a physician's order for a Secure Care bracelet to the left ankle at all times. Licensed staff failed to follow the physician's order to apply the Secure Care bracelet when the resident returned to the facility. At 6:10 PM, a female called the facility and notified staff that an elderly person was walking down the road. The nurse exited the	F 281	<b>F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b> <b>The corrective actions accomplished for those residents found to have been affected by the deficient practice were:</b>  <ul style="list-style-type: none"> <li>• LPN #1 placed a Secure Care anklet on Resident #1's ankle 3/22/14.</li> <li>• LPN #1 completed a body audit, assessment, Unusual Occurrence Report, and documented the events of the incident in Resident #1's chart 3/22/14.</li> <li>• LPN #1 notified the DON, physician and POA of the incident 3/22/14. The DON notified the Administrator 3/22/14.</li> <li>• All staff working at the time of the incident were asked to write a statement or questioned about whether they saw Resident #1 exit the building or if they had any interaction with him by LPN #1.</li> <li>• Resident #1's care plan and Elopement Assessment were updated by the ADON on 3/22/14.</li> </ul>	4/26/14

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F 281	<p>Continued From page 2</p> <p>front of the building and saw Resident #1 walking down the road and approached the resident and was able to escort him/her back to the facility. Resident #1 had exited the front doors of the facility and walked 0.4 miles from the facility on a two (2) lane road with a speed limit of forty-five (45) miles per hour without the staff's knowledge.</p> <p>The facility's failure to follow the physician's order has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/01/14 and was determined to exist on 03/22/14. The facility was notified of the Immediate Jeopardy on 04/01/14. An acceptable Allegation of Compliance (AoC) was received on 04/08/14 alleging the removal of Immediate Jeopardy on 04/05/14. The State Survey Agency validated, on 04/10/14, the Immediate Jeopardy was removed on 04/05/14, as alleged. The Scope and Severity was lowered to a "D" at 482.20 Resident Assessment, F-281 and F282; and 485.25 Quality of Care, F-323 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's Physician Orders policy, last revised 10/16/11, revealed "Physician orders must be given and managed in accordance with applicable laws and regulations".</p> <p>Review of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, revised 10/2010, revealed Registered Nurses and Licensed Practical</p>	F 281	<p><b>The actions taken by the facility to identify other residents having the potential to be affected by the same alleged deficient practice were:</b></p> <ul style="list-style-type: none"> <li>• The ADON audited the care plans, risk assessments and elopement assessments of all residents wearing a Secure Care anklet to ensure they had a physician order for the anklet 3/22/14.</li> <li>• The ADON completed and audit of all Elopement Assessments for all residents 3/22/14.</li> <li>• All exit doors were checked for proper functioning by Administrator 3/22/14.</li> <li>• All resident assessed to be at risk for elopement and wearing a Secure Care anklets were checked for proper placement and functioning by the Staffing Coordinator 3/22/14.</li> <li>• The DON notified the Medical Director 3/22/14 of the incident and actions put into place.</li> <li>• The DON counseled LPN #1 for failing to keep Resident #1 safe upon return from the hospital 3/22/14.</li> <li>• A Point Click Care (electronic medical records) task audit was completed by Administrator and ADON 3/22/14 to ensure that a Secure Care tasks was in place for all residents at risk for elopement</li> </ul>	

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F 281	<p>Continued From page 3</p> <p>Nurses were responsible for the administration of medication or treatment as authorized by a Physician, Physician Assistant, or Advanced Practice Registered Nurse.</p> <p>Record review revealed the facility readmitted Resident #1 on 03/22/14 with diagnoses which included Syncope secondary to Orthostatic Hypotension, Generalized Weakness, and Deconditioning.</p> <p>Review of the Admission Physician's Orders, dated 03/22/14, revealed an order for a Secure Care bracelet to the left ankle at all times, check placement to verify no tampering and functioning twice a day.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/29/14 at 7:30 PM, revealed Resident #1 was returned to the facility by ambulance on 03/22/14 at 5:20 PM. The LPN stated she signed the resident back in and looked in on him/her to let him/her know she would be back to perform an assessment. The LPN revealed she did not place the Secure Care bracelet or notify any other direct care staff that Resident #1 was back in the building. LPN #1 stated she should have notified LPN #2 that the resident was back in the building and the Secure Care bracelet needed to be applied to his/her left ankle per physician's order.</p> <p>Interview with LPN #2 (Medication Nurse, who had the bracelets in the medication cart), on 03/30/14 at 2:14 PM, revealed she was not notified Resident #1 was going to be returning to the facility or that he/she had arrived. LPN #2 stated the Secure Care bracelets were kept in the g-tube/medication cart and the Charge Nurse would have to come get a bracelet from her or</p>	F 281	<p>The measures or systemic changes made to ensure that the alleged deficient practice will not recur are:</p> <ul style="list-style-type: none"> <li>The Resident Discharge or Transfer section of the Secure Care Policy was revised 3/22/14 by the Administrator, DON and ADON. The Administrator typed the revisions and replaced the old Secure Care policy in the P &amp; P manual with the new copy. Per DON &amp; ADON input, the new copy now includes the following revisions: <i>"If the resident is sent to the hospital, discharged or leaves for a home visit, the charge nurse MUST cut the transmitter strap off the resident prior to the resident leaving. Affix the strap and transmitter on the rings in the resident's medical chart. When the resident returns, the Charge Nurse should replace the transmitter immediately. The Nurses' Notes should state that the transmitter was removed and another note stating when it was placed back on the resident."</i></li> <li>All nursing staff and Administrative staff were in-serviced by phone on the revised Secure Care Policy by ADON, DON, and Staffing Coordinator 3/22/14. A letter was mailed to a PRN licensed staff member and Administrator will ensure that other PRN nursing staff will be in-serviced prior to being scheduled to work again.</li> <li>The Licensed Nurses Orientation form was reviewed and revised by the Administrator and DON 3/22/14 to include detailed information pertaining to the Secure Care as follows:</li> </ul>	
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F 281	<p>Continued From page 4</p> <p>designate her to place the bracelet on the resident when a physician's order was received.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 03/28/14 at 11:13 AM, revealed her practice has been to follow the resident to the room during readmission and if a Secure Care bracelet was ordered by the physician, she would place it on the resident on arrival to the room. The ADON stated she would have expected the Charge Nurse to place the Secure Care bracelet on arrival or delegate someone to be with the resident one on one until the Secure Care bracelet was placed.</p> <p>Interview with the Director of Nursing (DON), on 03/28/14 at 3:33 PM, revealed he would have expected the Charge Nurse to have prepared for the admission when she received report by getting the supplies together and notifying the direct care staff of the readmission so they could get prepared for Resident #1's arrival.</p> <p>Interview with the Administrator, on 03/31/14 at 2:24 PM, revealed she expected the Charge Nurse or a designee to go to the room when the resident was readmitted to observe the transfer, implement the plan of care, assess the resident, initiate physician's orders, and notify direct care staff the resident had arrived, and of the interventions needed to be provided and monitored.</p> <p>Interview with the Medical Director, on 03/31/14 at 3:24 PM, revealed she expected residents with a physicians's order for a Secure Care bracelet to have the bracelet applied as soon as they entered the building.</p>	F 281	<ul style="list-style-type: none"> <li>o Having resident's room, equipment and all care needs ready prior to a new admission or readmission.</li> <li>o New Nursing Policy &amp; Procedure Manuals</li> <li>o Following and updating care plans</li> <li>o Removing and replacing a Secure Care Having resident's anklet when resident leaves the facility for LOA, hospitalization or discharge and document that the anklet was removed and attached to the resident's medical chart.</li> <li>o Location of the Secure Care Supplies.</li> <li>o Upon return from LOA, hospital, assigning staff one on one until Secure Care anklet is replaced.</li> <li>o Documenting that the anklet was replaced on resident for proper functioning, placement and expiration date.</li> <li>o When in charge nurse position, inform staff of admission or readmission to ensure resident's room and care needs are ready.</li> </ul> <ul style="list-style-type: none"> <li>• CQI tool N-29 "New Admission &amp; Hospital Return Review" was reviewed and revised 3/22/14 by Administrator, DON, ADON, QA team and Medical Director to include:             <ul style="list-style-type: none"> <li>o Was a Secure Care bracelet removed from the resident and affixed to his/her chart at discharge?</li> </ul> </li> </ul>		

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F 281	<p>Continued From page 5</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <p>On 03/22/14, once Resident #1 was back in the building and in his/her room, the Charge Nurse assigned a nurse aide to stay with him/her until she returned with the Secure Care bracelet for him/her.</p> <p>The bracelet was replaced on Resident #1 by the Charge Nurse, on 03/22/14.</p> <p>The Charge Nurse completed a body audit/assessment on Resident #1 once he/she was back in the building with no injuries noted on 03/22/14.</p> <p>On 03/22/14, the Charge Nurse completed an Unusual Occurrence report for Resident #1.</p> <p>The Charge Nurse initiated a head count, on 03/22/14, to ensure the safety of all other residents in the building after receiving the phone call from the unidentified female about a person walking up the road.</p> <p>The Charge Nurse documented the events of the incident in Resident #1's Chart, on 03/22/14.</p> <p>On 03/22/14, the Charge Nurse, Treatment Nurse, Certified Medication Aide (CMT), State Registered Nurse Aide (SRNA), and Ward Clerk that were working at the time of the incident were either questioned or wrote a statement about whether they saw Resident #1 exit the building or if they had any interaction with him/her by the Director of Nursing (DON), Assistant Director of</p>	F 281	<ul style="list-style-type: none"> <li>o Is there documentation that the bracelet was removed and where it is located?</li> <li>o Was the Secure Care bracelet put back on the resident upon return from the hospital, LOA?</li> <li>o Is there documentation that the bracelet was put back on the resident when he/she returned to the facility?</li> </ul> <ul style="list-style-type: none"> <li>• DON counseled the Charge Nurse for failing to keep resident safe upon return from the hospital on 3/22/14.</li> <li>• All fulltime and part-time licensed staff were re-in-serviced on the revised Secure Care policy &amp; procedure during the March monthly staff meeting 3/28/14 by DON. Administrator will ensure that PRN staff are in-serviced prior to return to work.</li> <li>• Licensed staff and Department Directors reviewed and updated all care plans 4/4/14 to ensure that all residents were not at risk for elopement and physician orders were being followed.</li> <li>• All issues pertaining to the Resident #1's elopement and the events to date were discussed and reviewed during the monthly Quality Assurance meeting with the Medical Director and Interdisciplinary Team 4/10/14.</li> </ul>	

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F 281	<p>Continued From page 6 Nursing (ADON), and Staffing Coordinator.</p> <p>Resident #1's care plan and Elopement Assessment were updated by the ADON, on 03/22/14.</p> <p>The Administrator notified the Office of Inspector General (OIG), Department for Community Based Services (DCBS), and the local Police about the incident, on 03/22/14.</p> <p>The ADON audited the care plans, and elopement risk assessments of all residents wearing a Secure Care bracelet to ensure they had a physician order for the bracelet on 03/22/14.</p> <p>An Elopement Assessment audit was completed for all residents by the ADON, on 03/22/14, to ensure all Elopement Assessments were up to date.</p> <p>All exit doors were checked for proper functioning by Administrator, on 03/22/14.</p> <p>All residents' Secure Care anklets were checked for proper functioning by the Staffing Coordinator, on 03/22/14</p> <p>The DON counseled the Charge Nurse for failing to keep the resident safe upon return from the hospital, on 03/22/14.</p> <p>A task audit was completed in Point Click Care (electronic medical records) by the Administrator and ADON, on 03/22/14, to ensure Secure Care check tasks were in place for all residents at risk for elopement.</p>	F 281	<ul style="list-style-type: none"> <li>All licensed staff were in-serviced and received a copy of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, last revised 10/2010 during April's monthly staff meeting that included following care plans and physician orders 4/25/14 by the DON. Those licensed staff that were not present at the staff meeting were in-serviced by phone and mailed a copy of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, last revised 10/2010.</li> </ul> <p><b>The facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained by:</b></p> <ul style="list-style-type: none"> <li>The revised CQI tool N-29 "New Admission &amp; Hospital Return Review" was completed the weeks of 3/31/14, 4/7/14, 4/17/14, and 4/24/14 by the DON on all residents currently assessed to be at risk for elopement and currently wear a Secure Care anklet who have been discharged and/or returned to the facility</li> <li>CQI tool N-29 will now be completed monthly for 4 months, then per our regular CQI schedule by the DON or ADON.</li> </ul>		

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F 281	<p>Continued From page 7</p> <p>The Administrator, DON, and ADON had direct input into the revision of the Resident Discharge or Transfer section of the Secure Care policy, on 03/22/14. The revision pertained to changing the location of where to put the bracelet once it was removed from a resident. The Administrator typed the revisions and replaced the old Secure Care policy in the P &amp; P manual with the new copy. Per the DON's and ADON's input, the new copy now includes the following revisions: "If the resident is sent to the hospital, discharged or leaves for a home visit, the Charge Nurse MUST cut the bracelet strap off the resident prior to the resident leaving. Affix the bracelet on the rings in the resident's medical chart. When the resident returns, the Charge Nurse should replace the bracelet immediately. The Nurses' Notes should state that the bracelet was removed and another Note stating when it was placed back on the resident."</p> <p>All nursing staff and Administrative staff were in-serviced by phone on the revised Secure Care Policy by the ADON, DON, and Staffing Coordinator, on 03/22/14, to include: the Charge Nurse's responsibility to remove the bracelet when the resident leaves the facility for the hospital, Leave of Absence (LOA) or discharged, and document in the Nurse's Notes that it was removed and fastened to the rings inside the resident's chart. Also it is the Charge Nurse's responsibility to apply the Secure Care bracelet upon admission and readmission and document in the Nurse's Notes that it was reapplied and checked for proper functioning.</p> <p>The DON notified the Medical Director, on 03/22/14, of the incident; Resident #1's condition once back in the building; the counseling of the</p>	F 281			

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F 281	<p>Continued From page 8</p> <p>Charge Nurse for failing to follow physicians orders; the revisions made to the Secure Care policy; the notification of the Power of Attorney (POA), physician, Office of Inspector General (OIG), Department for Community Based Services (DCBS), and local police; the checking of the physician orders; updates to elopement assessments and care plans; checking the exit doors and the resident's bracelets for proper functioning; review of revisions to the CQI tool N-29 "New Admission &amp; Hospital Return Review"; nursing orientation updates; staff in-service training; and audits of Point Click Care tasks.</p> <p>The Administrator and DON reviewed the current Licensed Nurses Orientation form and revised it to include detailed training information pertaining to the Secure Care program and other issues, on 03/22/14. All new hire licensed staff will receive orientation on the revised Licensed Nurses Orientation by the DON. The information included pertaining to the Secure Care program is:</p> <ul style="list-style-type: none"> <li>i. Having resident's room, equipment and all care needs ready prior to a new admission or readmission.</li> <li>ii. New Nursing Policy &amp; Procedure Manuals.</li> <li>iii. Removing and replacing a Secure Care bracelet when resident leaves the facility for LOA, hospitalization or discharge and document that the bracelet was removed and attached to the resident's medical chart.</li> <li>v. Location of the Secure Care supplies.</li> <li>vi. Upon return from LOA, hospital, assigning staff one on one until Secure Care bracelet is replaced. Documenting that the bracelet was replaced on resident for proper functioning, placement and expiration date.</li> </ul>	F 281			

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F 281	<p>Continued From page 9</p> <p>vii. When functioning in the Charge Nurse position, inform staff of admission or readmission to ensure resident's room and care needs are ready.</p> <p>The Care plans were reviewed and updated, on 04/04/14, by licensed staff and Department Directors for all residents who were not assessed to be at risk for elopement to ensure that physician orders were being followed.</p> <p>Licensed Nurses, Certified Medication Aides (CMA), State Registered Nurse Aides (SRNA), Ward Clerks, Activity Director, Activity Assistant, Social Service Director, Maintenance, Dietary Manager, Office Manager, and Medical Records Coordinator were called, on 03/22/14, and informed about the details surrounding the elopement and the nurse's failure to follow the physician orders and put the Secure Care bracelet back on to keep the resident safe upon return from the facility and inform the staff of his/her return. The staff was in-serviced, on 03/22/14, by phone by the DON, ADON, and Staffing Coordinator on the revisions made to the Secure Care policy to include: The Charge Nurse's responsibility to remove the bracelet when the resident leaves the facility for the hospital, LOA or discharged and document in the Nurse's Notes that it was removed and fastened to the ring inside the resident's chart. Also the Charge Nurse's responsibility to apply the Secure Care bracelet upon admission and readmission and document in the Nurse's Notes that it was reapplied and checked for proper functioning. All PRN staff, staff on Federal Medical Leave Act (FMLA), and any potential agency staff will be educated on the Secure Care policy prior to working again by the DON, ADON, or Staffing</p>	F 281			

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F 281	<p>Continued From page 10 Coordinator.</p> <p>The Administrator and DON reviewed the current Licensed Nurses Orientation form and revised it to include detailed training information pertaining to the Secure Care program and other issues, on 03/22/14. All new hire licensed staff will receive orientation on the revised Licensed Nurses Orientation by the DON. Information included pertaining to the Secure Care program is:</p> <ul style="list-style-type: none"> <li>i. Having resident's room, equipment and all care needs ready prior to a new admission or readmission.</li> <li>ii. New Nursing Policy &amp; Procedure Manuals.</li> <li>iii. Removing and replacing a Secure Care bracelet when resident leaves the facility for LOA, hospitalization or discharge and document that the bracelet was removed and attached to the resident's medical chart.</li> <li>v. Location of the Secure Care supplies.</li> <li>vi. Upon return from LOA, hospital, assigning staff one on one until Secure Care bracelet is replaced. Documenting that the bracelet was replaced on resident for proper functioning, placement and expiration date.</li> <li>vii. When acting in the Charge Nurse position, inform staff of admission or readmission to ensure resident's room and care needs are ready.</li> </ul> <p>CQI tool N-29 "New Admission &amp; Hospital Return Review" was reviewed, on 03/22/14, by the Administrator, DON, and ADON. Together, we decided to add the following four (4) questions to monitor after reviewing with QA team and the Medical Director:</p> <ul style="list-style-type: none"> <li>i. Was a Secure Care bracelet removed</li> </ul>	F 281			

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F 281	<p>Continued From page 11</p> <p>from the resident and affixed to his/her chart at discharge?</p> <p>ii. Is there documentation that the bracelet was removed and where it is located?</p> <p>iii. Was the Secure Care bracelet put back on the resident upon return from the hospital, LOA?</p> <p>iv. Is there documentation that the bracelet was put back on the resident when he/she returned to the facility?</p> <p>The CQI tool N-29 "New Admission &amp; Hospital Return Review" will be completed weekly for four (4) weeks, monthly for four (4) months, then per CQI schedule by the DON or ADON.</p> <p>ADON completed CQI N-29 "New admission &amp; Hospital Return Review" for Resident #1, on 03/22/14.</p> <p>CQI N-29 was completed, on 04/04/14, by the DON on all residents who have been discharged, LOA or hospitalized and those who have returned to the facility since 03/22/14 with 100% accuracy.</p> <p><b>**The State Agency validated the corrective action taken by the facility as follows:</b></p> <p>Review of Nurse's Notes, dated 03/22/14 at 6:30 PM, validated Resident #1 returned to the facility, complete body audit/assessment completed, SRNA assigned to monitor Resident #1 one to one until Secure Care bracelet replaced, and Secure Care bracelet applied by the Charge Nurse. The Charge Nurse initiated a head count to ensure the safety of all other residents in the building after receiving the phone call from the unidentified female about a person walking up the</p>	F 281			

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F 281	<p>Continued From page 12</p> <p>road and documentation of all notifications and events related to the incident were documented.</p> <p>Review of Resident #1's "Elopement Assessment" and "Elopement/Wandering" care plan validated, on 03/22/14, those documents were updated by ADON.</p> <p>Review of Residents' #2-#20 physicians' orders, elopement assessments and care plans revealed the residents had orders for the Secure Care bracelets and the residents were assessed and care planned for elopement. Observation of Residents #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #14, #15, #17, #18, #19 and #20 revealed the Secure Care bracelets were in place on each resident. Resident #13 and Resident #16 were in the hospital and observation revealed their Secure Care bracelets were in the ring of their charts.</p> <p>Interview with the Administrator, on 04/10/14 at 11:00 AM, verified that the ADON also audited all residents charts to ensure the "Elopement Risk Assessment" was up to date and she had checked for proper functioning of all exits with the Secure Care system, on 03/22/14. She stated a task audit in Point Click Care (electronic medical records) was performed to ensure the Secure Care tasks were in place for all residents with Secure Care bracelets, on 03/22/14.</p> <p>Interview with the Staffing Coordinator, on 04/10/14 at 12:11 PM, validated she had checked for proper functioning of all residents' Secure Care bracelets.</p> <p>Review of the counseling form revealed the DON counseled the Charge Nurse for not keeping</p>	F 281			

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F 281	<p>Continued From page 13</p> <p>Resident #1 safe on return from the hospital, on 03/22/14.</p> <p>Review of inservice records, dated 03/22/14, revealed all nursing staff and Administrative staff that could be contacted were in-serviced in person or inserviced by phone on the revisions in the Secure Care policy by the ADON, DON, and Staffing Coordinator. Those that could not be contacted on 03/22/14 were inserviced before they were allowed to return to work either by phone or in person when they arrived for work on their next scheduled day.</p> <p>Interview with the Staffing Coordinator, on 04/10/14 at 12:11 PM, revealed she had used the call list to ensure all staff was in-serviced on the Secure Care policy revision before they returned to work.</p> <p>Interview with the Administrator, on 04/10/14 at 11:00 AM, verified that care plans were reviewed and updated by licensed staff and Department Directors, on 04/04/14, to ensure that residents were not at risk of elopement, forty-one (41) residents, were having their physicians orders followed.</p> <p>Interviews with RN #4 and #5, LPN #5, #6, and #7, and SRNA #1, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14 on 04/10/14 at 11:00 AM, 11:04 AM, 11:08 AM, 11:12 AM, 11:16 AM, 11:20 AM, 11:24 AM, 11:31 AM, 11:36 AM, 11:39 AM, 11:42 AM, 11:46 AM, 11:50 AM, 11:55 AM, 12:02 PM, and 12:06 PM respectively, revealed they received an inservice on the changes to the Secure Care policy in person and by phone starting on 03/22/14 and all of the staff had been inserviced before they returned to work on their</p>	F 281			

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F 281	Continued From page 14 next scheduled day. All interviews revealed the inservice was related to the Charge Nurse being responsible to ensure the Secure Care bracelet was placed immediately on admission and readmission to the facility, the Secure Care bracelet was removed just before the resident goes out of the facility, documentation of the removal of the bracelet, how the bracelet was stored in the resident's chart until the resident returned to the facility, placement of the Secure Care bracelet, function of the bracelet, expiration date of the bracelet, and location of Secure Care supplies.  Review of the CQI tool N-29, "New Admission & Hospital Return Review", dated 03/22/14, compared to CQI tool N-29, undated, validated the changes made on the CQI tool N-29.  Review of the CQI tool N-29 and interview with the Administrator, on 04/10/14, revealed the ADON completed the CQI tool N-29 form on Resident #1, on 03/22/14, and on all residents who have been out of facility or hospitalized from 03/22/14 through 04/03/14 with 100% accuracy. The monitoring was going to continue weekly for a total of 4 weeks, monthly for a total of 4 months, then per CQI schedule by the DON or ADON.	F 281			
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The corrective actions accomplished for those residents found to have been affected by the deficient practice were:	4/26/14	

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F 282	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide a Secure Care bracelet in accordance to the written plan of care, for one (1) of four (4) sampled residents (Resident #1).</p> <p>On 03/06/14, the facility assessed and care planned Resident #1 as an elopement risk requiring supervision to include a Secure Care bracelet. Resident #1 was transferred to the hospital on 03/17/14 and readmitted to the facility on 03/22/14 at approximately 5:20 PM. Staff failed to apply the Secure Care bracelet according to the care plan when the resident returned to the facility. At approximately 6:10 PM, a female called the facility and notified staff she saw an elderly person walking on the road near the facility. Resident #1 had exited the front doors of the facility and walked 0.4 miles from the facility on a two (2) lane road with a speed limit of forty-five (45) miles per hour without the staff knowledge.</p> <p>The facility's failure to provide care according to each resident's written plan of care related to a Secure Care bracelet has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/01/14 and was determined to exist on 03/22/14. The facility was notified of the Immediate Jeopardy on 04/01/14. An acceptable Allegation of Compliance (AoC) was received on 04/08/14 alleging the removal of Immediate Jeopardy on 04/05/14. The State Survey Agency validated, on 04/10/14, the Immediate Jeopardy was removed on 04/05/14, as alleged. The Scope</p>	F 282	<ul style="list-style-type: none"> <li>A Secure Care anklet was placed on Resident #1 by LPN #1 3/22/14.</li> <li>LPN #1 completed a body audit and physical assessment on Resident #1 3/22/14.</li> <li>LPN #1 completed an Unusual Occurrence Report for Resident #1 3/22/14.</li> <li>LPN #1 documented the details of the 3/22/14 event in Resident #1's medical chart on 3/22/14.</li> <li>Resident #1's care plan and Elopement Assessment were updated by the ADON on 3/22/14.</li> <li>LPN #1 notified the DON, physician and POA of the incident 3/22/14. The DON notified the Administrator 3/22/14.</li> <li>All staff working at the time of the incident were asked to write a statement or questioned about whether they saw Resident #1 exit the building or if they had any interaction with him by LPN #1.</li> </ul> <p>The actions taken by the facility to identify other residents having the potential to be affected by the same alleged deficient practice were:</p> <ul style="list-style-type: none"> <li>The ADON audited the care plans, risk assessments and elopement assessments of all residents wearing a Secure Care anklet to ensure they had a physician order for the anklet 3/22/14.</li> <li>The ADON completed and audit of all Elopement Assessments for all residents 3/22/14.</li> <li>All exit doors were checked for proper functioning by Administrator 3/22/14.</li> </ul>		

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F 282	<p>Continued From page 16</p> <p>and Severity was lowered to a "D" at 482.20 Resident Assessment, F-281 and 485.25 Quality of Care, F-323 while the facility develops and implements the Plan of Correction (PoC) and the facility's Performance Improvement Committee monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's Elopement Nursing Facility policy and procedure, last revised 12/02/13, if a resident is identified as a potential wanderer he/she will be issued a Secure Care bracelet, as appropriate.</p> <p>Record review revealed the facility admitted Resident #1 on 03/06/14 with diagnosis of Depression with anxiety. Review of the Elopement Risk Assessment, dated 03/06/14, revealed the facility assessed Resident #1 as an elopement risk because the resident had expressed a desire to go home and exhibited signs that would indicate he/she would act on that desire to go home and leave the facility unattended.</p> <p>Review of the Comprehensive Care Plan for Elopement/Wandering, dated 03/06/14, revealed interventions to obtain an order for Secure Care placement, apply Secure Care bracelet, verify Secure Care bracelet placement, verify no tampering, and verify functioning twice daily, allow resident to ambulate throughout the facility freely, divert attention when resident becomes insistent on leaving facility, check promptly when alarm system sounds to ensure resident whereabouts/safety, and redirect resident's attention as needed.</p>	F 282	<ul style="list-style-type: none"> <li>All resident assessed to be at risk for elopement and wearing a Secure Care anklets were checked for proper placement and functioning by the Staffing Coordinator 3/22/14.</li> <li>The DON notified the Medical Director 3/22/14 of the incident and actions put into place.</li> <li>A Point Click Care (electronic medical records) task audit was completed by Administrator and ADON 3/22/14 to ensure that a Secure Care tasks was in place for all residents at risk for elopement</li> </ul> <p><b>The measures or systemic changes made to ensure that the alleged deficient practice will not recur are:</b></p> <ul style="list-style-type: none"> <li>Licensed staff and Department Directors reviewed and updated all care plans 4/4/14 to ensure that all residents were not at risk for elopement and physician orders were being followed.</li> </ul>	
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F 282	Continued From page 17  Interview with Licensed Practical Nurse (LPN) #1, on 03/29/14 at 7:30 PM, revealed Resident #1 was returned to the facility by ambulance about 5:20 PM. She stated she signed the resident back in and looked in on him/her to let him/her know she would be back to perform an assessment. LPN #1 revealed she did not place the Secure Care bracelet on the resident, as per care plan, because she was trying to talk to another resident's physician and complete the paperwork to send the other resident to the hospital when Resident #1 returned to the facility. She revealed she should have told LPN #2 Resident #1 had returned so LPN #2 could have applied the Secure Care bracelet. LPN #1 revealed at approximately 6:10 PM she received a call from a female stating she had seen an elderly person in a blue shirt and gray pants walking on the road near the facility. LPN #1 stated when they reached the resident, the resident stated he/she was going home and she asked him/her to come back to the facility so they could assist him/her.  Interview with Resident #1, on 03/27/14 at 11:15 AM, revealed he/she remembered leaving the building and was walking home.  Interview with the Director of Nursing (DON), on 03/28/14 at 3:33 PM, revealed he would have expected the Charge Nurse to ensure the plan of care was in place before the resident left in the room.  Interview with the Administrator, on 03/31/14 at 2:24 PM, revealed she expected the Charge Nurse or a designee to go to the room when the resident was readmitted to observe the transfer,	F 282	<ul style="list-style-type: none"> <li>The Resident Discharge or Transfer section of the Secure Care Policy was revised 3/22/14 by the Administrator, DON and ADON. The Administrator typed the revisions and replaced the old Secure Care policy in the P &amp; P manual with the new copy. Per DON &amp; ADON input, the new copy now includes the following revisions: <i>"If the resident is sent to the hospital, discharged or leaves for a home visit, the charge nurse MUST cut the transmitter strap off the resident prior to the resident leaving. Affix the strap and transmitter on the rings in the resident's medical chart. When the resident returns, the Charge Nurse should replace the transmitter immediately. The Nurses' Notes should state that the transmitter was removed and another note stating when it was placed back on the resident."</i></li> <li>All nursing staff and Administrative staff were in-serviced by phone on the revised Secure Care Policy by ADON, DON, and Staffing Coordinator 3/22/14. A letter was mailed to a PRN licensed staff member and Administrator will ensure that other PRN nursing staff will be in-serviced prior to being scheduled to work again.</li> <li>The Licensed Nurses Orientation form was reviewed and revised by the Administrator and DON 3/22/14 to include detailed information pertaining to the Secure Care as follows: <ul style="list-style-type: none"> <li>Having resident's room, equipment and all care needs ready prior to a new admission or readmission.</li> <li>New Nursing Policy &amp; Procedure Manuals</li> </ul> </li> </ul>		

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(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
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F 282	<p>Continued From page 18</p> <p>implement the plan of care, assess the resident, initiate physician's orders and notify direct care staff the resident had arrived and the interventions that needed to be provided and monitored.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <p>On 03/22/14, once Resident #1 was back in the building and in his/her room, the Charge Nurse assigned a nurse aide to stay with him/her until she returned with the Secure Care bracelet for him/her.</p> <p>The bracelet was replaced on Resident #1 by the Charge Nurse, on 03/22/14.</p> <p>The Charge Nurse completed a body audit/assessment on Resident #1 once he/she was back in the building with no injuries noted on 03/22/14.</p> <p>On 03/22/14, the Charge Nurse completed an Unusual Occurrence report for Resident #1.</p> <p>The Charge Nurse initiated a head count, on 03/22/14, to ensure the safety of all other residents in the building after receiving the phone call from the unidentified female about a person walking up the road.</p> <p>The Charge Nurse documented the events of the incident in Resident #1's Chart, on 03/22/14.</p> <p>On 03/22/14, the Charge Nurse, Treatment Nurse, Certified Medication Aide (CMT), State</p>	F 282	<ul style="list-style-type: none"> <li>o Following and updating care plans.</li> <li>o Removing and replacing a Secure Care Having resident's ankle when resident leaves the facility for LOA, hospitalization or discharge and document that the ankle was removed and attached to the resident's medical chart.</li> <li>o Location of the Secure Care Supplies.</li> <li>o Upon return from LOA, hospital, assigning staff one on one until Secure Care ankle is replaced.</li> <li>o Documenting that the ankle was replaced on resident for proper functioning, placement and expiration date.</li> <li>o When in charge nurse position, inform staff of admission or readmission to ensure resident's room and care needs are ready.</li> <li>• CQI tool N-29 "New Admission &amp; Hospital Return Review" was reviewed and revised 3/22/14 by Administrator, DON, ADON, QA team and Medical Director to include:             <ul style="list-style-type: none"> <li>o Was a Secure Care bracelet removed from the resident and affixed to his/her chart at discharge?</li> <li>o Is there documentation that the bracelet was removed and where it is located?</li> <li>o Was the Secure Care bracelet put back on the resident upon return from the hospital, LOA?</li> </ul> </li> </ul>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 04/10/2014
NAME OF PROVIDER OR SUPPLIER  HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220		
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F 282	<p>Continued From page 19</p> <p>Registered Nurse Aide (SRNA), and Ward Clerk that were working at the time of the incident were either questioned or wrote a statement about whether they saw Resident #1 exit the building or if they had any interaction with him/her by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Staffing Coordinator.</p> <p>Resident #1's care plan and Elopement Assessment were updated by the ADON, on 03/22/14.</p> <p>The Administrator notified the Office of Inspector General (OIG), Department for Community Based Services (DCBS), and the local Police about the incident, on 03/22/14.</p> <p>The ADON audited the care plans, and elopement risk assessments of all residents wearing a Secure Care bracelet to ensure they had a physician order for the bracelet 03/22/14.</p> <p>An Elopement Assessment audit was completed for all residents by the ADON, on 03/22/14, to ensure all Elopement Assessments were up to date.</p> <p>All exit doors were checked for proper functioning by Administrator, on 03/22/14.</p> <p>All residents' Secure Care anklets were checked for proper functioning by the Staffing Coordinator, on 03/22/14</p> <p>The DON counseled the Charge Nurse for failing to keep the resident safe upon return from the hospital, on 03/22/14.</p> <p>A task audit was completed in Point Click Care</p>	F 282	<ul style="list-style-type: none"> <li>o Is there documentation that the bracelet was put back on the resident when he/she returned to the facility?</li> <li>• DON counseled the Charge Nurse for failing to keep resident safe upon return from the hospital on 3/22/14.</li> <li>• All fulltime and part-time licensed staff were re-in-serviced on the revised Secure Care policy &amp; procedure during the March monthly staff meeting 3/28/14 by DON. Administrator will ensure that PRN staff are in-serviced prior to return to work.</li> <li>• All issues pertaining to the Resident #1's elopement and the events to date were discussed and reviewed during the monthly Quality Assurance meeting with the Medical Director and Interdisciplinary Team 4/10/14.</li> <li>• All licensed staff were in-serviced and received a copy of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, last revised 10/2010 during April's monthly staff meeting that included following care plans and physician orders 4/25/14 by the DON. Those licensed staff that were not present at the staff meeting were in-serviced by phone and mailed a copy of the Kentucky Board of Nursing Advisory Opinion Statement (AOS) #14 Patient Care Orders, last revised 10/2010.</li> </ul>		

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F 282	<p>Continued From page 20</p> <p>(electronic medical records) by the Administrator and ADON, on 03/22/14, to ensure Secure Care check tasks were in place for all residents at risk for elopement.</p> <p>The Administrator, DON, and ADON had direct input into the revision of the Resident Discharge or Transfer section of the Secure Care policy, on 03/22/14. The revision pertained to changing the location of where to put the bracelet once it was removed from a resident. The Administrator typed the revisions and replaced the old Secure Care policy in the P &amp; P manual with the new copy. Per the DON's and ADON's input, the new copy now includes the following revisions: "If the resident is sent to the hospital, discharged or leaves for a home visit, the Charge Nurse MUST cut the bracelet strap off the resident prior to the resident leaving. Affix the bracelet on the rings in the resident's medical chart. When the resident returns, the Charge Nurse should replace the bracelet immediately. The Nurses' Notes should state that the bracelet was removed and another Note stating when it was placed back on the resident."</p> <p>All nursing staff and Administrative staff were in-serviced by phone on the revised Secure Care Policy by the ADON, DON, and Staffing Coordinator, on 03/22/14, to include: the Charge Nurse's responsibility to remove the bracelet when the resident leaves the facility for the hospital, Leave of Absence (LOA) or discharged, and document in the Nurse's Notes that it was removed and fastened to the rings inside the resident's chart. Also it is the Charge Nurse's responsibility to apply the Secure Care bracelet upon admission and readmission and document in the Nurse's Notes that it was reapplied and</p>	F 282	<p>The facility plans to monitor its performance to ensure that solutions for the alleged deficient practice are sustained by:</p> <ul style="list-style-type: none"> <li>The revised CQI tool N-29 "New Admission &amp; Hospital Return Review" was completed the weeks of 3/31/14, 4/7/14, 4/17/14, and 4/24/14 by the DON on all residents currently assessed to be at risk for elopement and currently wear a Secure Care anklet who have been discharged and/or returned to the facility</li> <li>CQI tool N-29 will now be completed monthly for 4 months, then per our regular CQI schedule by the DON or ADON.</li> </ul>		

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F 282	<p>Continued From page 21 checked for proper functioning.</p> <p>The DON notified the Medical Director, on 03/22/14, of the incident; Resident #1's condition once back in the building; the counseling of the Charge Nurse for failing to follow physicians orders; the revisions made to the Secure Care policy; the notification of the Power of Attorney (POA), physician, Office of Inspector General (OIG), Department for Community Based Services (DCBS), and local police; the checking of the physician orders; updates to elopement assessments and care plans; checking the exit doors and the resident's bracelets for proper functioning; review of revisions to the CQI tool N-29 "New Admission &amp; Hospital Return Review"; nursing orientation updates; staff in-service training; and audits of Point Click Care tasks.</p> <p>The Administrator and DON reviewed the current Licensed Nurses Orientation form and revised it to include detailed training information pertaining to the Secure Care program and other issues, on 03/22/14. All new hire licensed staff will receive orientation on the revised Licensed Nurses Orientation by the DON. The information included pertaining to the Secure Care program is:</p> <ul style="list-style-type: none"> <li>i. Having resident's room, equipment and all care needs ready prior to a new admission or readmission.</li> <li>ii. New Nursing Policy &amp; Procedure Manuals.</li> <li>iii. Removing and replacing a Secure Care bracelet when resident leaves the facility for LOA, hospitalization or discharge and document that the bracelet was removed and attached to the resident's medical chart.</li> <li>v. Location of the Secure Care supplies.</li> </ul>	F 282			