

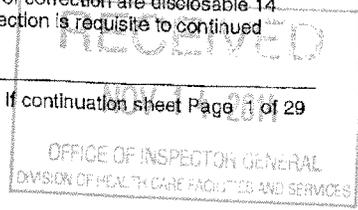
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2014
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(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)	(X6) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated and Partial Extended Survey to investigate complaint KY22318 was initiated on 10/08/14 and concluded on 10/15/14. The Division of Health Care substantiated the allegation and identified Immediate Jeopardy on 10/09/14 and determined the Immediate Jeopardy existed on 10/05/14 at 42 CFR 483.20 Resident Assessment (F281 at S/S of "J") and 42 CFR 483.25 Quality of Care (F323 at S/S of "J") resulting in Substandard Quality of Care in F323. The State Survey Agency verified Immediate Jeopardy was removed on 10/14/14.</p> <p>The facility was notified of the Immediate Jeopardy and Substandard Quality of Care at 42 CFR 483.25 Quality of Care (F323) on 10/09/14.</p> <p>Resident #1 was admitted to the facility on 09/29/14 and assessed as an elopement risk due to the resident's history of wandering tendencies and current behaviors of exit seeking and wandering. The facility failed to develop specific interventions on the interim care plan that would address the resident's risk for elopement.</p> <p>On 10/05/14, at approximately 8:30 PM, Resident #1 exited the facility without staff knowledge. The facility received a call from the local police at 8:47 PM, informing them a concerned citizen had found Resident #1 walking in the middle of a busy street, in the dark. The facility staff responded in a personal automobile to Resident #1's location, and returned the resident to the nursing facility at 9:00 PM. The investigation found that when the back exit door alarmed facility staff failed to open the door and look outside to search for residents;</p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 10/17/14

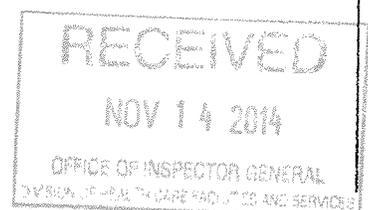
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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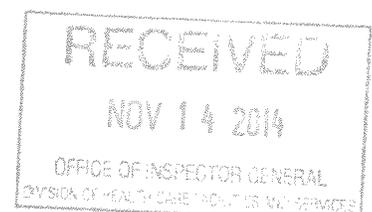
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F 000	Continued From page 1 and, failed to ensure all residents were present. In addition, facility staff failed to conduct the scheduled safety checks for Resident #1 at 8:15 PM, 8:30 PM, and 8:45 PM. The facility's failure to provide adequate supervision of a cognitively impaired resident with known elopement risks placed all residents who had been assessed at risk for elopement in a situation that has caused or was likely to cause serious injury, harm, impairment or death. At the time of the survey, the facility had assessed seventeen (17) residents to be at risk for elopement. The facility provided an acceptable Allegation of Compliance (AOC) on 10/14/14 that alleged removal of Immediate Jeopardy. The State Survey Agency verified Immediate Jeopardy was removed on 10/14/14; prior to exit on 10/15/14. The Scope and Severity was lowered to a "D" in 42 CFR 483.20 Resident Assessment (F281); and, 42 CFR 483.25 Quality of Care (F323) while the facility monitors the effectiveness of the Plan of Correction.	F 000		10/15/14	
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 observation, interviews, record review and review of the Lippincott Manual of Nursing Practice, the facility's investigation, and the facility's policy, it was determined the facility failed	F 281	F- 281 Meet professional standards 1. Resident was returned to the facility without difficulty on 10/05/14 at 9: 00 PM. Upon return, a head to toe skin assessment was completed by a licensed nurse and no skin issues were identified. Resident was placed on 1:1 on 10/05/14 and will remain on 1:1 until deemed safe per review by and Interdisciplinary Team (IDT) [to include the Executive Director (ED), Director of Clinical Services (DCS), Social Service Director (SSD) and Activities]and Primary Care Physician. The resident's Responsible Party (RP) and the Practitioner, on call for resident's Primary Care Physician (PCP), were notified on 10/05/2014. The Unit Manager notified the Advanced Practice Nurse Practitioner (APRN) on 10/05/14 at 10:28 PM. On 10/06/16 the PCP was notified by the ED. The		



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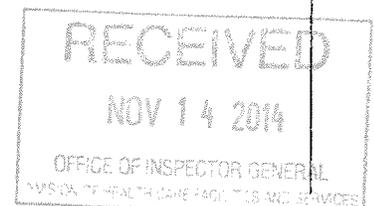
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F 281	<p>Continued From page 2</p> <p>to develop an interim care plan with specific interventions to address the elopement risk for one (1) of seven (7) sampled residents (Resident #1). The facility assessed Resident #1, upon admission, as at risk for elopement due to a history of wandering tendencies and exit seeking behaviors. The Admission Care Plan only listed a Wander Guard device as an intervention.</p> <p>On 10/05/14, at approximately 8:30 PM, Resident #1 exited the facility without staff knowledge. The facility received a call from the local Police at 8:47 PM, informing them a concerned citizen found Resident #1 walking in the middle of a busy street, in the dark. The resident was returned to the facility at 9:00 PM. Interviews revealed when responding to the alarming door, the staff saw another resident in front of the alarming exit door and assumed he/she was the cause of the alarm. The facility staff did not open the door and look outside; and did not ensure all residents were present. In addition, facility staff failed to conduct the scheduled safety checks for Resident #1 at 8:15 PM, 8:30 PM, and 8:45 PM.</p> <p>The facility's failure to develop an interim care plan that was sufficient to meet the needs of a cognitively impaired resident with known elopement risks placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 10/09/14 and was determined to exist on 10/05/14.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/14/14; and, the State Survey Agency verified Immediate Jeopardy was removed on 10/14/14, prior to exit on 10/15/14. The Scope and Severity was lowered to a "D"</p>	F 281	<p>resident was seen by the Psychiatrist on 10/06/2014. The admission/readmission data collection assessment was completed and the care plan was initiated on 9/29/14 by a licensed nurse. The resident was assessed to be at risk for elopement and an order for a wander guard was received, placed and the intervention was placed on the care plan by a licensed nurse on 9/29/14. The care plan was updated by a licensed nurse on 10/06/14 to include: the resident's successful elopement, to redirect with cues in native language (paradas acqui, detanges) and resident placed on 1:1 on 10/05/14. The care plan and kardex were reviewed and updated to include the location and expiration date of the wander guard by the IDT which included the SSD, the Assistant Activities Director, the Assistant Director of</p>		



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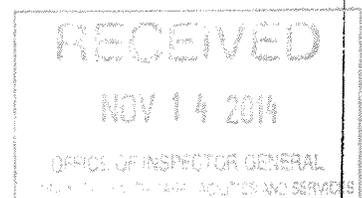
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F 281	Continued From page 3 while the facility monitors the effectiveness of the implemented Plan of Correction. The findings include: Review of the facility's policy titled, Care Plan, revised 02/27/14, revealed an interim care plan must be developed within twenty-four hours of admission to ensure the resident's needs were met appropriately. The Interdisciplinary Team would add minor changes in the resident's status on an "as needed" basis. All direct care staff must always know, understand, and follow the care plan. Review of the Lippincott Manual of Nursing Practice, 10th Edition, Chapter 2, page 15, "Advocacy" revealed the professional nurse had a duty to promote what was best for the patient and ensure the patient's needs were met. Review of Resident #1's clinical record revealed the facility admitted the resident on 09/29/14 with diagnoses which included Advanced Alzheimer's Disease. The facility assessed the resident as at risk for elopement; placed the resident in a secured unit; and, applied a Wander Guard device that would alarm when the resident attempted to exit the unit. Review of the Admission Minimum Data Set (MDS) assessment, completed on 10/10/14, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a six (6) out of fifteen (15) indicating a severe cognition impairment. The assessment identified the resident exhibited frequent wandering and at times became restless and exit-seeking. Upon admission, the resident was assessed to be	F 281	Clinical Services (ADCS) and the Minimum Data Set Coordinator on 10/09/14. 2. Newly admitted residents have the potential to be affect by insufficient assessment and care planning. Residents admitted in the last 30 days at risk for elopement have the potential to be at risk for unsafe exit from the facility. Current in-house residents had an elopement risk assessment completed by a licensed nurse on 10/09/2014. The care plans and kardexes for 17 residents were reviewed and updated, as indicated, by the IDT which included SSD, UM, Activity Director. (The revisions included validating that each resident had an individualized care plan for the potential for elopement, a goal for		



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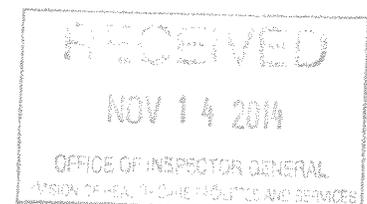
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F 281	<p>Continued From page 4 independent with ambulation.</p> <p>Review of the Interim Care Plan, dated 09/29/14, revealed under the title "Goal", that a Wander Guard device to the resident's right wrist was documented. The Interim Care Plan had no other goals or interventions to address the resident's identified behaviors of wandering and exit seeking.</p> <p>Review of the Nurse's Note, dated 09/30/14, for the 11:00 PM-7:00 AM shift, revealed the resident was awake all night and wandering into other residents' rooms. The resident became combative toward staff when they attempted to redirect him/her. The nurse documented the resident continued with exit seeking behaviors. An additional Note, not timed, revealed the nurse documented the resident had been wandering the unit and going to the exit doors (four) and pushing on the doors causing the alarms to activate. The nurse documented the resident was difficult to redirect. The resident's Primary Physician visited him at that time and ordered medications.</p> <p>Continued review of the Daily Skilled Nurse's Notes revealed, on 10/02/14, the resident was noted wandering all four (4) halls attempting to open the exit doors. Review of the Daily Skilled Nurse's Note for 10/03/14 revealed the resident wandered about the unit. The facility did not provide a Skilled Nurse's Note for 10/04/14. Further review of the Skilled Nurse's Notes revealed on 10/05/14 at approximately 8:30 PM, Resident #1 exited the facility without staff knowledge.</p> <p>Review of the facility's investigation revealed the egress #1 exit door (back door) alarmed at</p>	F 281	<p><i>safety, target date, and individualized goals revisions included items such as wander guard, location of bracelet, and placement of picture ID in wander book. These revisions were completed on 10/9/14). On 10/09/14, ten residents were identified as being at risk for elopement; all of whom had a wander guard in place, a physician's order for the wander guard and had been care planned as being at risk for elopement. Wander guard placement will be checked every shift and function daily by a licensed nurse to be signed on the Medication Administration Record (MAR). The DCS/ADCS/Nurse Manager will monitor for compliance daily. Resident safety checks can be initiated every 15 minutes, 30 minutes or hourly by a physician or clinical nurse who deems the resident to be a risk. Residents</i></p>		



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F 281	<p>Continued From page 5</p> <p>approximately 8:30 PM. Certified Nursing Assistant (CNA) #1 responded and found Resident #5 standing in front of the door. The CNA "assumed" this resident was the cause of the alarm activation. The CNA redirected Resident #5 away from the door. At 8:47 PM, the Weekend Supervisor received a call from the local police stating there was an elderly person on the street and he thought he/she might reside at the nursing facility. The facility staff went and brought Resident #1 back to the facility at 9:00 PM. The facility's investigation found that staff did not open the door and look outside when the door alarmed, as per facility policy, because they assumed Resident #5 activated the alarm. In addition, the Weekend Supervisor did not ensure all residents were present, as per facility policy. Refer to F323.</p> <p>Observation of Resident #1, on 10/08/14 at 2:45 PM, revealed the resident was awake, sitting in a recliner in the resident's room. A Wander Guard device was on the resident's right wrist. CNA #2 was sitting with the resident. Interview with the resident (through an interpreter) revealed the resident did not recall the elopement and did not remember he/she was outside the facility.</p> <p>Observation of the resident on 10/09/14 at 10:00 AM, revealed the resident was ambulating independently throughout the unit. Staff was providing 1:1 supervision.</p> <p>Interview with CNA #2, on 10/08/14 at 2:47 PM, revealed the resident had a cognition impairment and did not recall anything about the elopement. He stated the resident ambulated independently without any assistive device. He confirmed he was on duty when Resident #1 left the facility, but</p>	F 281	<p>who require additional supervision will have documentation on the Resident Safety Check form by a Certified Nurses' Assistant (CNA), Licensed Practical Nurse (LPN), Registered Nurse (RN), Unit Manager (UM), Medical Records Director, Maintenance Director, Maintenance Assistant, Activities Director, Activities Assistant, Central Supply Clerk, ED, ADCS, Receptionist, Business Office Manager (BOM), Assistant Business Office Manager, and Human Resources (HR). Licensed nurses are responsible for validating the completion of the Resident Safety Check form. The DCS/ADCS/Nurse Manager will monitor for compliance daily.</p> <p>3. On 10/09/2014 the Corporate Administrative Registered Nurse re-educated the Interdisciplinary Team consisting of SSD, ADCS, Unit Manager (UM), Activities</p>		



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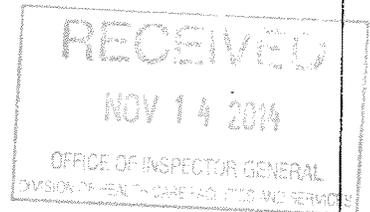
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F 281	<p>Continued From page 6</p> <p>he was not assigned to the resident that day. He said he was working another section of the unit, when he heard the door alarm and went to see what caused the alarm to activate. He stated he saw another resident (Resident #5) standing in front of the exit door and thought that was the reason the alarm was sounding.</p> <p>Telephone interview with the Weekend Supervisor, on 10/09/14 at 10:58 AM, revealed she received a call from the local police around 8:47 PM, on 10/05/14, telling her Resident #1 was outside the facility. She stated she found the resident with the Police Officer, off facility property, on a sidewalk, beside a very busy street. It was dark. She said the resident was returned to the facility and a physical assessment was conducted that found the resident had sustained no injuries. She said the Wander Guard device was on the resident and alarmed upon the resident's return to the secure unit.</p> <p>Continued interview revealed the Weekend Supervisor was not on the 200 Unit when she heard the alarm sounding. Upon her arrival on the 200 Unit, she found CNA #1 redirecting Resident #5 from the exit door. She was told that was the cause of the alarm activation. She indicated she asked the staff if everyone was present, but did not validate the presence of all residents. She stated it was an oversight and she should have ensured all residents were present after the alarm sounded. She revealed all residents who utilized a Wander Guard device were placed on fifteen (15) minutes safety checks where staff had to visualize and document they saw the resident. She stated the last safety check conducted for Resident #1 was at 8:00 PM.</p>	F 281	<p>Director, Dietary Manager, and MDS Coordinator on the facility's care plan policy. On 10/10/14 the Corporate Administrative Registered Nurse educated the IDT including the SSD, Therapy Program Director, Registered Dietitian, ADCS, ED, UM and MDS on the regulation F281 with emphasis placed on evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and comprehensive care plan. On 10/11/14 the Corporate Administrative Registered Nurse educated the DCS on the regulation F281 with emphasis placed on evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to completion of</p>		

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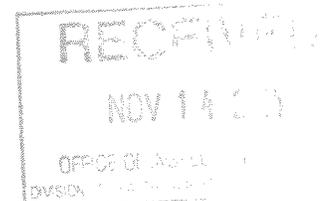
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F 281	<p>Continued From page 7</p> <p>A telephone call was placed to the local police dispatch, on 10/09/14 at 3:59 PM. The Dispatcher revealed she was the person who received the call regarding Resident #1 on 10/05/14. She stated she received a call, on 10/05/14 at 8:33 PM, from a female citizen driving a car on the street in front of the facility. She said the caller told her they had to stop their car because Resident #1 was walking in the middle of the street and appeared to be disoriented. The caller was concerned the resident was going to be hit because it was dark outside. She stated officers were dispatched at 8:35 PM and were on the scene shortly thereafter.</p> <p>Interview with CNA #1, on 10/09/14 at 4:30 PM, revealed he was assigned to Resident #1 on the night the resident eloped. He revealed Resident #1 frequently went to the exit doors and had to be redirected. He said the resident had exhibited wandering behaviors since admission. CNA #1 stated he recalled seeing Resident #1 at 8:00 PM on 10/05/14, then he got busy caring for other residents. When the back exit door alarmed, he responded and saw Resident #5 at the door pushing. He removed the resident and pushed the reset button to reactivate the alarm. He stated the Wander Guard alarm was sounding as well as the exit door alarm and Resident #5 had a Wander Guard also. CNA #1 revealed he did not go outside and look around for any residents and did not check on each of his residents to ensure they were all present. He stated he was in the process of doing incontinent rounds and was very busy. He acknowledged he did not conduct safety checks at 8:15 PM, 8:30 PM, and 8:45 PM because he was too busy.</p> <p>Review of the safety check form for Resident #1,</p>	F 281	<p>the first comprehensive assessment and comprehensive care plan. On 10/09/2014-10/12/2013, the IDT (ED, DCS, ADCS, SSD& UM) re-educated the licensed nursing staff on care plans and care plan updates to be conducted when a resident is identified to be at risk for elopement. Thirty-three of 45 licensed nurses working full time, part time and per diem have been re-educated. All 20 of the 20 nurses receiving the post test initiated on 10/13/14, successfully completed the test. Remaining nurses will receive the exam prior to the start of next scheduled shift. Staff members who have not been re-educated will not be allowed to work until the education has been completed prior to the start of their next scheduled shift. On 10/09/2014 the Corporate Administrative Registered Nurse re-educated IDT</p>		



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F 281	<p>Continued From page 8 dated 10/05/14, revealed no documented evidence a safety check was conducted between 8:00 PM-9:00 PM.</p> <p>Interview with the 200 Unit Manager, on 10/15/14 at 8:30 AM, revealed she was the nurse who admitted the resident on 09/29/14 and identified the resident was at risk for elopement and placed a Wander Guard device on the resident. She stated the resident exhibited exit seeking behaviors from admission and could ambulate independently. She stated she developed the interim care plan but failed to develop specific interventions related to the resident's known wandering and exit seeking behaviors. She said the facility used a standardized care plan with preprinted goals and interventions. The Unit Manager stated she failed to distinguish between risk for falls and elopement and did not write in any interventions to prevent the elopement. She stated she was now aware to make the Interim Care Plan more specific to address the resident's specific needs. She revealed the nurse who admits the resident would be the person who developed the Interim Care Plan and the Interdisciplinary Team would develop the Comprehensive Care Plan.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) alleging removal of Immediate Jeopardy on 10/14/14. The facility took the following steps:</p> <p>1. Resident #1 was returned to the facility on 10/05/14 at 9:00 PM. A head to toe assessment was completed by a licensed nurse and no skin issues were identified. Resident #1 was placed on 1:1 supervision and will remain on 1:1 until deemed "safe" per review by the Interdisciplinary</p>	F 281	<p>consisting of SSD, ADCS, Unit Manager (UM), Activities Director, Dietary Manager, and MDS Coordinator on the Elopement Risk Evaluation, Resident Safety Checks and the Elopement Skills Checklist. Competency was determined by the completion to the Elopement Skills Checklist. Any employees not educated as of 10/13/14 have been removed from the schedule and will not be scheduled until competency validation completed. The facility does not use agency staff at this time. New nurses will receive the education by a licensed nurse during the orientation process and competency will be established by successful completion the post test. The interim care plans and assessments of residents admitted in the last 30 days were reviewed and updated by the IDT on 10/10/14.</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281

Continued From page 9
Team. The resident was seen by the Psychiatrist on 10/06/14. The care plan and Kardex were reviewed and updated to include the location expiration date of the Wander Guard on 10/09/14 by the Interdisciplinary Team.

2. All exit doors were checked and verified to have a functional alarm device by the Executive Director (ED) and Maintenance Director on 10/06/14 and 10/09/14. Exit doors and alarm key pads will be checked daily by Maintenance/Department Manager to ensure proper function. The windows were checked by the Executive Director and Maintenance to ensure regulatory compliance with open egress on 10/06/14.

3. Current in-house residents had an elopement risk assessment completed by a licensed nurse on 10/09/14. Ten (10) residents were identified on 10/09/14 as being at risk for elopement. Elopement risk binders were updated by Medical Records Director on 10/06/14 and 10/09/14.

4. Wander Guard placement will be checked every shift and function daily by a licensed nurse to be signed on the Medication Administration Record (MAR). Licensed nurses are responsible for validating Wander Guard placement. The Director of Clinical Services (DCS)/Assistant Director of Clinical Services (ADCS)/Nurse Manager will monitor for compliance daily. Resident safety checks can be initiated every fifteen (15) minutes, thirty (30) minutes or hourly by a physician or clinical nurse who deems the resident at risk.

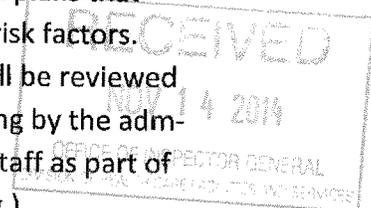
5. On 10/06/14 through 10/07/14 the ED, the DCS and Unit Managers re-educated the staff on

F 281

(A systemic change was initiated by the ED on 11/7/14 that includes a revision to the Admission Audit Tool. The tool was revised by the ED to include an audit of initials care plans for any new admission. The Medical Records Coordinator and ED are responsible for validating that all new admission charts and care plans are reviewed during the daily clinical meetings. The Medical Records Coordinator was educated regarding this process on 11/7/14 by the ED. The Admission Audit tool is required to be completed within 72 hours of an admission by the Medical Records Coordinator. The DCS/ADCS/Unit Manager are required to correct all identified concerns listed on the admission audit tool. The ED/DCS are responsible for oversight of this process).

(The ED developed the quality improvement tool on 10/7/14.)

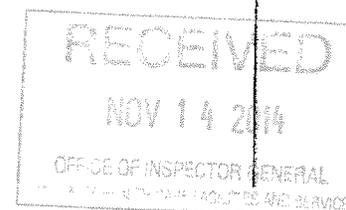
(The licensed nursing staff are Responsible for implementing New admission care plans that Address individual risk factors. These care plans will be reviewed The morning meeting by the administrative nursing staff as part of The clinical meeting.)



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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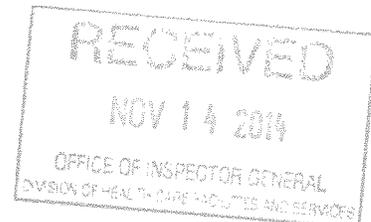
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F 281	<p>Continued From page 10</p> <p>elopement prevention and action procedure which included: Definition of Elopement; Exit Seeking Verbalizations and Actions to Monitor/Watch for and Report Immediately; Individual Identifier Information; Reporting Suspected Elopement/Missing Resident; Missing Resident Search-internal and external; and, Elopement Drills. Competency was determined by a successful completion of the post test. As of 10/12/14 ninety-four (94) of one hundred and forty (140) employees have completed the elopement post test. As of 10/12/14, one hundred and eighteen (118) employees working full time, part time and per diem employees have been re-educated and have successfully completed skills checklists. Any employees not educated as of 10/13/14 have been removed from the schedule and will not be scheduled until competency validations have been completed.</p> <p>6. An Ad-Hoc QAPI Committee meeting held with ED, DCS, Activities Director, Unit Managers, and Medical Director (by phone) on 10/06/14 to discuss elopement and plan to correct. An additional meeting was held on 10/09/14 to discuss the need for additional oversight and monitoring and the revisions needed to correct.</p> <p>7. Elopement Drills were initiated on 10/06/14 by the ED/DCS to ensure staff knowledge and proficiency including competency completion. Proficiency skills checklist was initiated on 10/09/14 by the Corporate Administrative Registered Nurse to ensure staff knowledge and proficiency.</p> <p>Through observation, interview and record review the State Survey Agency validated the corrective actions on 10/15/14 prior to exit as follows:</p>	F 281	<p>4. An Ad Hoc QAPI committee meeting held with the ED, DCS, Activities Director, Unit Manager, and Medical Director (by phone) on 10/06/14 to discuss elopement and plan to correct. An Ad Hoc QAPI committee meeting held with the ED, DCS (by phone), Dietary Manager, Unit Managers, Medical Records Director, Business Office Manager, Activities Director, ADCS, SSD, and the Medical Director (by phone) on 10/09/14 to discuss the need for additional oversight and monitoring and the revisions needed to correct. The facility's policies and procedures for Care Plans, Resident Safety Checks, the Guide to Elopement Risk Evaluation, and the Elopement Skills Checklist were read and adopted by the facility without changes. The DCS/Nurse Manager will conduct Quality Improvement Monitoring of this process</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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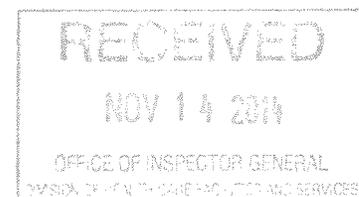
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F 281	Continued From page 11 1. Record review revealed, after the resident was returned, the facility assessed Resident #1 on 10/05/14 and he/she was found to be without injury and was placed on one to one (1:1) supervision. Observation during the survey validated the resident continued with 1:1 supervision. The resident was seen by a Psychiatrist on 10/06/14 with some medication changes. The Admssion Care Plan and Kardex were reviewed and updated on 10/06/14. 2. Review of the door alarm work history report revealed door alarms were checked weekly prior to the elopement. The door alarms were checked on the day after the elopement on 10/08/14, and daily since the elopement. Observation during a test of all exit door alarms on 10/08/14 revealed all alarms were working properly. 3. All in-house residents had an elopement risk assessment completed by a licensed nurse on 10/09/14. Ten (10) residents were identified as being at risk for elopement; all of whom already had a Wander Guard device. The care plan and Kardex for these residents were revised. These residents' pictures were placed in the elopement book at each nurses' station and the front lobby. Two (2) other residents were assessed and placed in the elopement book on 10/12/14. Validation of the elopement book on 10/15/14 revealed all twelve (12) residents were included in the books and the elopement books were located at the front lobby and all four (4) nursing units. 4. Review of the Treatment Administration Record (TAR) revealed documentation of checking for placement of the Wander Guard devices every shift and it was determined the devices were	F 281	reviewing the assessment and care planning of newly admitted residents to ensure evidence of sufficient to meet the needs 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months or until substantial compliance is achieved. The DCS/ED will report findings to the Quality Assurance/Performance Improvement Committee 1 x monthly for 6 months for continued improvement or until substantial compliance is achieved. Date of Compliance 11-15-14		



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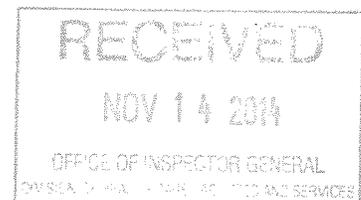
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F 281	<p>Continued From page 12</p> <p>working. No omissions were found on 10/15/14. Review of the safety checks documentation revealed staff performed the scheduled checks. Observation on 10/14/14 at 4:30 PM, revealed all twelve (12) residents were utilizing the Wander Guard devices.</p> <p>5. Interviews and review of Sign in Sheets and agendas, revealed all staff were trained on the facility's policy for Elopement, missing person, and door alarms. Nurses and the Interdisciplinary Team were trained on admission care plans and revision. Training consisted of elopement education, elopement competency exam and elopement skills checklist. Interview with the Director of Nursing, on 10/08/14 at 3:49 PM, revealed re-training on elopements began immediately after the elopement occurred. The staff competency was validated by a post-test and skills checklist. Review of the staff attendance roster for the staff training revealed all regular facility staff had been trained prior to returning to work. Employees on leave or vacation were notified the training must occur prior to returning to work. Interview with CNA #1, on 10/09/14 at 4:30 PM, revealed he had been re-trained on elopements after Resident #1 was returned to the facility. Interview with CNAs #2, #3, #4, #5, #6, #7, and #8 validated they had been retrained. Interview with LPNs #1 and #2 and RN #1, #2, and #3 validated they had been retrained.</p> <p>6. Interview with the ED, on 10/08/14 at 4:45 PM, and the Medical Director, on 10/09/14 at 9:05 AM, revealed an Ad Hoc QAPI meeting was held on 10/06/14. Another QAPI meeting was held on 10/09/14. The Executive Director revealed she was in the process of developing audits tools for QAPI to ensure ongoing compliance.</p>	F 281			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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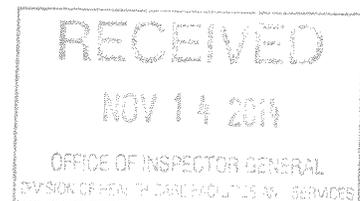
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F 281	Continued From page 13				
F 323 SS=J	<p>7. Review of the elopement drills revealed they were occurring daily. Observation of an elopement drill, on 10/08/14 at 3:00 PM, revealed staff responded promptly. Staff went outside and searched and every resident was counted to ensure all were present and none were missing.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews and review of the facility's policy, it was determined the facility failed to have an effective system to provide adequate supervision of cognitively impaired residents with known exit seeking behaviors for one (1) of seven (7) sampled residents (Resident #1). The facility admitted Resident #1 on 09/29/14 and assessed the resident as an elopement risk due to the resident's history of wandering tendencies and current behaviors of exit seeking and wandering. The facility placed a Wander Guard device on the resident on 09/29/14, and safety checks were to be conducted every fifteen (15) minutes.</p> <p>On 10/05/14, at approximately 8:30 PM, Resident #1 exited the facility without staff knowledge. The</p>	F323	<p>1. The identified Resident was returned to the facility without difficulty on 10/05/14 at 9:00 PM. Upon return, a head to toe skin assessment was completed by a licensed nurse and no skin issues were identified. Resident was placed on 1:1 on 10-05-14 and will remain on 1:1 until deemed safe per review by and Interdisciplinary Team (IDT) [to include the Executive Director (ED), Director of Clinical Services (DCS), Social Service Director (SSD) and Activities and Primary Care Physician. The resident's Responsible Party (RP) and the Practitioner, on call for resident's Primary Care Physician (PCP), were notified on 10/05/2014 by the licensed practical nurse. (On 10/13/14, the clinical ambassador, RN, spoke to the residents responsible party and validated that he did receive the</p>	11/13/14	



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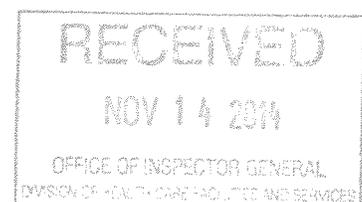
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F 323	<p>Continued From page 14</p> <p>facility received a call from the local police at 8:47 PM, informing them a concerned citizen found Resident #1 walking in the middle of a busy street, in the dark. The investigation found when the alarm on the back exit door of the secure unit activated at approximately 8:30 PM, the facility staff responded, but failed to look outside the door and ensure all residents were present. In addition, facility staff failed to conduct the scheduled safety checks for Resident #1 at 8:15 PM, 8:30 PM, and 8:45 PM.</p> <p>The facility's failure to provide adequate supervision of cognitively impaired individuals with known elopement risks placed residents at risk for elopement in a situation that has caused or was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was identified on 10/09/14 and determined to exist on 10/05/14.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/14/14 and the State Survey Agency verified Immediate Jeopardy was removed on 10/14/14; prior to exit on 10/15/14. The Scope and Severity was lowered to a "D" while the facility monitors the effectiveness of the implemented Plan of Correction.</p> <p>The findings include:</p> <p>Review of the facility's policy for elopement risk, revised 09/01/11, revealed all residents would be assessed for elopement risk upon admission and quarterly by nursing. If the resident was identified as an elopement risk, the care plan would reflect interventions (Wander Guard or Code alert) and desired outcomes. Residents identified as at risk for elopement would require nursing to check the</p>	F 323	<p>notification.) The Unit Manager notified the Advanced Practice Nurse Practitioner (APRN) on 10/05/14 at 10:28 PM. The ED notified the PCP on 10/06/14. The resident was seen by the Psychiatrist on 10/06/2014. The Resident had an elopement risk assessment completed by a licensed nurse on 9/29/14, 10/06/14, and 10/09/14. The resident was assessed to be at risk for elopement and an order for a wander guard was received and placed by a licensed nurse on 9/29/14. The care plan was updated by a licensed nurse on 10/06/14 to include: the resident's successful elopement, to redirect with cues in native language (paradas acqui, detanges) and resident placed on 1:1 on 10/05/14. The care plan and kardex were reviewed and updated to include the location and expiration date of the wander</p>		



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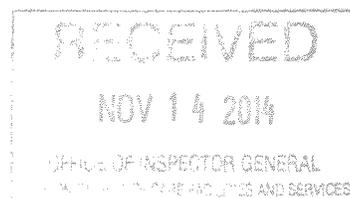
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F 323	<p>Continued From page 15</p> <p>resident regularly and document on the safety check form.</p> <p>Review of the facility's policy titled Door Alarms, revised 09/01/14, revealed when a door alarm was activated, staff would quickly proceed to the door and investigate the cause. If the cause could not be determined, the staff would exit through the door and search the surrounding area. If the search revealed no cause for the alarm, an immediate count of all residents would be conducted by licensed staff. Door alarm function would be checked daily.</p> <p>Review of the facility's investigation revealed the egress #1 exit door (back door) alarmed at approximately 8:30 PM. Certified Nursing Assistant (CNA) #1 responded and found Resident #5 standing in front of the door. The CNA assumed this resident was the cause of the alarm activation. The CNA redirected Resident #5 away from the door. At 8:47 PM, the Weekend Supervisor received a call from the local police stating there was an elderly person on the street and thought they might live at the nursing facility. The facility staff went and brought Resident #1 back to the facility at 9:00 PM. The facility's investigation found the staff did not open the door and look outside because they assumed Resident #5 activated the alarm. In addition, the Weekend Supervisor did not ensure all residents were present.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 09/29/14 with a diagnosis of Advanced Alzheimer's Disease. The facility assessed the resident as at risk for elopement, placed the resident in a secured unit, and applied a Wander Guard device. The facility</p>	F 323	<p>guard by the IDT which included the SSD, the Assistant Activities Director, the Assistant Director of Clinical Services (ADCS) and the Minimum Data Set Coordinator on 10/09/14.</p> <p>2. All residents at risk for elopement have the potential to be at risk for unsafe exit from the facility. Current in-house residents had an elopement risk assessment completed by a licensed nurse on 10/09/2014. The care plans and kardexes for 17 residents were reviewed and updated, as indicated, by the IDT which included SSD, UM, Activity Director. <i>(The revisions included validating that each resident had an individualized care plan for the potential for elopement, a goal for safety, target date, and individualized goals revisions)</i></p>		



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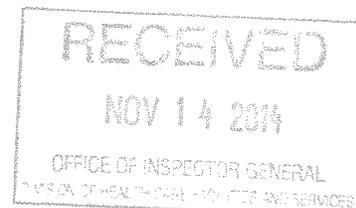
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F 323	<p>Continued From page 16</p> <p>placed the resident on fifteen (15) minute safety checks. Review of the Admission Minimum Data Set (MDS) assessment, completed on 10/10/14, revealed a Brief Interview Mental Status (BIMS) exam was conducted and the resident scored a six (6) out of fifteen (15) indicating a severe cognition impairment. The facility documented the resident only spoke Spanish. The assessment identified the resident exhibited frequent wandering and at times became restless and exit-seeking. Upon admission, the resident was assessed as independent with ambulation. The admission interim care plan, developed 09/29/14, had no interventions except the placement of the Wander Guard device. Refer to F281.</p> <p>Observation of Resident #1, on 10/08/14 at 2:45 PM, revealed the resident was awake, sitting in a recliner in his/her room. A Wander Guard device was placed on the resident's right wrist. CNA #2 was sitting with the resident providing 1:1 supervision. Interview with the resident (through an interpreter) revealed the resident did not recall the elopement and didn't remember he/she was outside the facility.</p> <p>Interview with CNA #2, on 10/08/14 at 2:47 PM, revealed the resident had cognitive impairment and did not recall anything about the elopement. He stated the resident ambulated independently without any assistive devices. He confirmed he was working at the time the resident left the facility, but he was not assigned to the resident that day. He said when the back door alarmed, he responded and found Resident #5 was standing in front of the exit door and thought that was the reason the alarm was sounding.</p>	F 323	<p><i>included items such as wander guard, location of bracelet, and placement of picture ID in wander book. These revisions were completed on 10/9/14). Ten residents were identified on 10/09/14 as being at risk for elopement; all of whom already had a wander guard, a physician's order for the wander guard and had been care planned as being at risk for elopement. Wander guard placement will be checked every shift and function daily by a licensed nurse to be signed on the Medication Administration Record (MAR). Licensed nurses are responsible for validating wander guard placement. The DCS/ADCS/Nurse Manager will monitor for compliance daily. Resident safety checks can be initiated every 15 minutes, 30 minutes or hourly by a physician or clinical nurse who deems the</i></p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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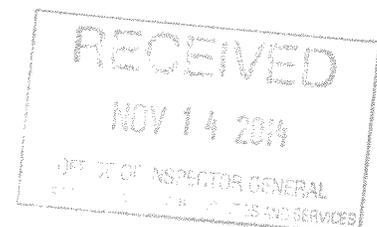
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F 323	<p>Continued From page 17</p> <p>Observation of the back exit door (where the resident eloped), on 10/08/14 at 3:00 PM, in the presence of the Executive Director (ED), revealed the exit door was equipped with a Wander Guard alarm and a door alarm that activated when the door was opened. A test was performed by the Maintenance Director and the Wander Guard alarmed and the door alarm was activated when the door bar was pushed for greater than fifteen (15) seconds. Observation revealed the door lead to the back parking lot. Observation of the "assumed" path the resident took on the day of elopement revealed the resident had to walk around the building, toward the front of the facility, then off the facility's property. The location where the resident was found by the local police was off the facility's property and out of sight. It was approximately one hundred and fifty (150) feet from the facility's property beside a very busy street.</p> <p>Interview with the ED, during the tour, revealed the facility's investigation found Resident #1 left the unit through the same door that was alarming. She stated the staff responded to the alarm to find another resident (Resident #5) pushing on the door. The staff redirected the resident away from the door and reactivated the alarm. She stated the staff failed to look outside the door and did not conduct a head count. The staff assumed the alarm was activated by the other resident. She stated the investigation revealed Resident #1 was last seen around 8:00 PM. She indicated the Weekend Supervisor received a telephone call from the local police at 8:47 PM questioning if they had a resident missing. She said the supervisor told her the resident was found on the sidewalk beside the street. She said two (2) staff members got into a car and picked up the</p>	F 323	<p>resident to be a risk. Residents who require additional supervision will have documentation on the Resident Safety Check form by a Certified Nurses' Assistant (CNA), Licensed Practical Nurse (LPN), Registered Nurse (RN), Unit Manager (UM), Medical Records Director, Maintenance Director, Maintenance Assistant, Activities Director, Activities Assistant, Central Supply Clerk, ED, ADCS, Receptionist, Business Office Manager (BOM), Assistant Business Office Manager, and Human Resources (HR). Licensed nurses are responsible for validating the completion of the Resident Safety Check form. The DCS/ADCS/Nurse Manager will monitor for compliance daily.</p> <p>3. Elopement risk binders, which include current pictures and identifying information, located at the nurses' station and front office</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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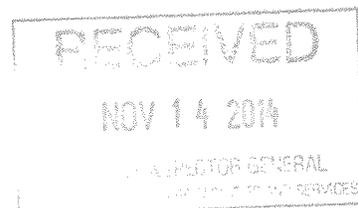
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F 323	<p>Continued From page 18</p> <p>resident and brought the resident back into the facility. The Wander Guard device was still on the resident and when tested it was found to be working properly.</p> <p>Interview with the Director of Nursing (DON), on 10/08/14 at 3:49 PM, revealed she received a call from the Weekend Supervisor informing her that Resident #1 had left the building and staff was unaware the resident was gone until the Police called. She stated she began an investigation, interviewed staff that was working that evening and began training. She stated the staff heard the door alarm, responded, and found Resident #5 standing in front of the exit door. The staff assumed the resident had activated the alarm because Resident #2 had a Wander Guard device too. She stated staff told her nobody was in the hallway when the door alarmed and no staff saw Resident #1 leave the building. She said she interviewed CNAs #1 and #2 and they told her they had responded to the door alarm and had redirected Resident #5 away from the door. They told her they thought Resident #5 was the reason the alarm sounded. She stated no staff opened the exit door and looked outside and the staff failed to conduct a search for missing residents, as per the facility's policy requires. She stated it was the job of the nurses working when the alarm activated to ensure all residents were present.</p> <p>Interview with Register Nurse (RN) #1, on 10/08/14 at 5:05 PM, revealed the nurse was passing medications on the same hall where the exit door the resident eloped from was located. She stated she did not recall any residents standing at the door prior to the elopement. However, she stated residents wander about the unit and she had observed Resident #1 go to the</p>	F 323	<p>were updated by Medical Records Director/ Executive Director (ED) on 10/06/2014 and 10/09/2014. All exit doors were checked and verified to have a functional alarm device by the ED / Maintenance Director on 10/06/14 and 10/09/2014. Exit doors and alarm key pads will be checked daily by Maintenance/ Department Manager to ensure proper function. The windows were checked by the ED/ Maintenance to ensure regulatory compliance with open egress on 10/06/2014. On 10/06/14-10/07/14 the ED, the DCS and Unit Managers re-educated the staff on elopement prevention and action procedure which includes: Definition of Elopement, Exit Seeking Verbalizations and Actions to Monitor/Watch for and Report Immediately, Individual Identifier Information, Reporting Suspected</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 19</p> <p>exit doors (4) in the unit and push against the door activating the alarms. She stated the resident was new to the unit and wandered independently. She indicated the resident had to be redirected from the exit doors often. She recalled the resident was wandering about that night. The last time she saw the resident was around 8 PM in the unit's dining room. She said she was in another resident's room administering medications when she heard the alarm sound. She went into the hallway and saw CNAs #1 and #2 and the Weekend Supervisor at the door working on the alarm. She said she did not see any residents. She stated that a resident count was not conducted.</p> <p>Telephone interview with the Weekend Supervisor, on 10/09/14 at 10:58 AM; revealed she received a call from the local police around 8:47 PM, telling her an elderly person was found outside on the street that may be a resident at the Nursing Facility. The Police Officer described the person to be Resident #1 and told her the location of the resident. She said she requested CNA #3 to check Resident #1's room and found the resident was not in his/her room. She revealed she ran outside and found the resident off facility property, on a sidewalk with the Police Officer. The sidewalk was beside a very busy street. She said the resident was about 100-150 feet away from the property. Further interview with the Weekend Supervisor, revealed the resident was returned to the facility and a physical assessment was conducted that found the resident had sustained no injuries. She said the Wander Guard device was on the resident and alarmed when the resident was returned to the secured unit.</p>	F 32	<p>Elopement/Missing Resident, Missing Resident Search- internal and external, Elopement Drills. Competency was determined by a successful completion of the post test. As of 10/12/14, ninety-four of 140 employees have completed the elopement post test. On 10/09/2014 the Corporate Administrative Registered Nurse re-educated IDT consisting of SSD, ADCS, Unit Manager (UM), Activities Director, Dietary Manager, and MDS Coordinator on the Elopement Risk Evaluation, Resident Safety Checks and the Elopement Skills Checklist. Competency was determined by the completion to the Elopement Skills Checklist. On 10/09/2014-10/12/2013, the IDT (which included the Unit Managers, SSD, ADCS, ED, and DCS) re-educated the licensed nursing staff on care plans and care plan updates to be conducted when a resident is</p>		



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F 323

Continued From page 20
Continued interview, with the Weekend Supervisor, revealed she was not on the 200 Unit when she heard the alarm activate. Upon her arrival, CNA #2 was reactivating the alarm to the back exit door that leads to the parking lot. The CNA told her Resident #5 was found at the door pushing on the bar and RN #1 told her everything was fine. The resident was redirected from the door and the alarm was reactivated. She did not instruct anyone to go outside and look around and she did not go out to look for residents either. She stated she asked the staff if everyone was present, but she did not validate all residents were present. She stated it was an oversight and she should have ensured all residents were present after the alarm sounded. She revealed all residents who utilize Wander Guard devices were placed on fifteen (15) minute safety checks where staff had to visualize and document they saw the resident. She stated she did rounds every hour on all units. She revealed the last safety check conducted for Resident #1 was at 8:00 PM.

Telephone interview with CNA #3, on 10/09/14 at 11:51 AM, revealed she was working the 200 Unit the night of Resident #1's elopement. She revealed she had not responded to the alarm, but a short time after that she was walking past the nurses' station and noticed the Weekend Supervisor was on the telephone. She said the Weekend Supervisor asked her to go check Resident #1's room to see if the resident was present. She went to Resident #1's room and found the resident was not there. She told the Weekend Supervisor and they went outside to find the resident. The resident was found on a sidewalk beside a busy street with the Police. She said CNA #1, put the resident in his car and brought the resident back to the facility. CNA #3

F 323

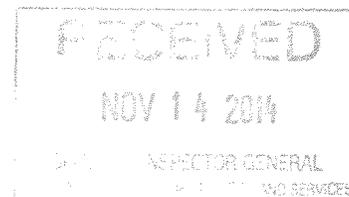
identified to be at risk for elopement. Competency was determined by the completion of the Elopement Skills Checklist. As of 10/12/14, 118 employees working full time, part time and per diem employees have been re-educated and have a successfully completed skills checklist. Any employees not educated as of 10/13/14 have been removed from the schedule and will not be scheduled until competency validation completed. The facility does not use agency staff at this time. There are two unlicensed employees out on extended leave with no date of return at this time. Upon return to the facility, the employees will be trained by ED. New employees will receive the education by a licensed nurse/ED/Human Resources during the orientation process and competency will be established by successfully completing the skills checklist.

(The ED developed the quality improvement tool on 10/7/14.)

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

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F 323	<p>Continued From page 21</p> <p>revealed Resident #1 would wander to the exit doors often. She said nobody asked her to conduct a head count of her residents.</p> <p>Telephone interview with the local Police, on 10/09/14 at 3:42 PM, revealed when the first officer arrived on scene, Resident #1 was standing in the middle of the street and the Officer assisted the resident to the sidewalk. The resident could not speak English and seemed confused. The Police Officer revealed he spoke Spanish and tried to speak with the resident, but he could not get the resident to understand. The nursing facility was called with a description of the resident and was informed the resident did reside there. The facility's staff came immediately and returned the resident to the nursing facility. The Officer did not know the time of arrival and suggested he call the police station dispatch for more information.</p> <p>A telephone call was placed to the local Police Dispatch on 10/09/14 at 3:59 PM. The Dispatcher stated she was the person who received the call regarding Resident #1 on 10/05/14. The Dispatcher stated she received a call, on 10/05/14 at 8:33 PM, from a female citizen driving a car down the street in front of the facility. She said the caller told her they had to stop their car because Resident #1 was walking in the middle of the street and appeared to be disoriented. The caller was concerned the resident was going to be hit because it was dark outside. Officers were dispatched at 8:35 PM and were shortly on the scene.</p> <p>Interview with CNA #1, on 10/09/14 at 4:30 PM, revealed he was assigned to Resident #1 on the night the resident eloped. He stated Resident #1</p>	F 323	(Systemic change- all residents with a wander guard will have the wander guard listed on the treatment/medication record. Each licensed nurse is responsible for signing the treatment/medication record q shift to validate placement and daily function of the alarm, licensed nursing staff were notified of this process change during the elopement education listed above) The administrator developed a quality improvement tool for F323 to validate that appropriate documentation occurs on the treatment/medication record. The ED educated the DCS/ADCS/Unit Managers regarding the F323 Quality Improvement Audit Tool on 10/20/14. The ED/DCS will		



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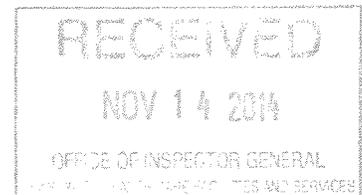
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F 323	<p>Continued From page 22</p> <p>frequently went to the exit doors and had to be redirected. CNA #1 stated the resident had exhibited wandering behaviors since admission. CNA #1 stated he recalled seeing Resident #1 at 8:00 PM on 10/05/14, then he got busy caring for other residents. When the exit door alarm activated, he responded and saw Resident #5 at the door pushing. He removed the resident and pushed the reset button to reactivate the alarm. He stated the Wander Guard alarm was sounding as well as the exit door alarm and Resident #5 had a Wander Guard too. CNA #1 revealed he did not go outside and look around for any residents and did not check on each of his residents to ensure they were all present. He stated he was in the process of doing incontinent rounds and was very busy. He acknowledged he did not conduct safety checks at 8:15 PM, 8:30 PM, and 8:45 PM because he was too busy. He stated sometime later, the Weekend Supervisor came running down the hallway and asked him if he knew Resident #1 was out of the building and he informed her that he did not the resident was out of the building. He revealed the resident frequently wandered about the unit until 8:00 PM. He stated the resident should have been on 1:1 supervision since admission because of the exit-seeking behaviors. CNA #1 stated Resident #1 had been exit seeking since day one. He validated again that he did not conduct safety checks for Resident #1 between 8 PM to 9 PM-the time the resident was out of the building.</p> <p>Review of the Safety Check Form for Resident #1, dated 10/05/14, revealed no documented evidence safety checks were conducted between 8:00 PM-9:00 PM.</p> <p>Review of the 200 Unit Treatment Administration</p>	F 323	<p>conduct Quality Improvement Monitoring using this tool 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months or until substantial compliance is achieved. Any concerns identified will be addressed immediately by the Ed/DCS with the licensed nurse responsible for the documentation.)</p> <p>4. Elopement drills were initiated on 10/06/14 by the ED/ Director of Clinical Services (DCS) to ensure staff knowledge and proficiency including competency completion. Elopement Skills Checklist initiated on 10/09/2014 by Corporate Administrative Registered Nurse to ensure staff knowledge and proficiency. Drills will continue daily until all current working staff is educated and has successfully completed the competency. Drills will then be</p>		

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F 323	<p>Continued From page 23</p> <p>Record (TAR), on 10/09/14, for residents identified at risk for elopement (14), revealed the Wander Guard checks for placement and function were not conducted on 10/08/14 for the 3-11 shift. In addition, validation of Resident #2's Wander Guard device on 10/09/14 at 9:45 AM, revealed the resident had removed the device and staff was not aware.</p> <p>Interview with the 200 Unit Manager, on 10/15/14 at 8:30 AM, revealed she was the nurse who admitted the resident on 09/29/14 and identified the resident was at risk for elopement and placed a Wander Guard device on the resident. She stated the resident exhibited exit seeking behaviors from admission and could ambulate independently. The Unit Manager stated she was responsible for ensuring the Wander Guard Checks were completed and the staff nurses were to ensure the safety checks were conducted every fifteen (15) minutes. She stated she was doing weekly checks of the TARs before the elopement but now she checked them daily. She also checked several times a day to ensure the safety checks were conducted and staff were conducting visual checks of those resident every fifteen (15) minutes.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) alleging removal of Immediate Jeopardy on 10/14/14. The facility took the following steps:</p> <p>1. Resident #1 was returned to the facility on 10/05/14 at 9:00 PM. A head to toe assessment was completed by a licensed nurse and no skin issues were identified. Resident #1 was placed on 1:1 supervision and will remain on 1:1 until deemed "safe" per review by the Interdisciplinary</p>	F 323	<p>conducted monthly on rotating shifts by the ED/DCS to ensure one drill on each shift per quarter to maintain proficiency of facility staff. Results of Elopement Drills will be brought through Quality Assurance Performance Improvement (QAPI) committee monthly by the ED/DCS for further review and recommendations ongoing. An Ad Hoc QAPI committee meeting held with the ED, DCS, Activities Director, Unit Manager, and Medical Director (by phone) on 10/06/14 to discuss elopement and plan to correct. An Ad Hoc QAPI committee meeting held with the ED, DCS (by phone), Dietary Manager, Unit Managers, Medical Records Director, Business Office Manager, Activities Director, ADCS, SSD, and the Medical Director (by phone) on 10/09/14 to discuss the need for additional oversight and monitoring and the revisions</p>		



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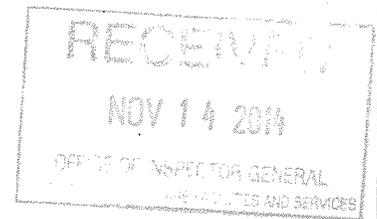
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F 323	<p>Continued From page 24</p> <p>Team. The resident was seen by the Psychiatrist on 10/06/14. The care plan and Kardex were reviewed and updated to include the location expiration date of the Wander Guard on 10/09/14 by the Interdisciplinary Team.</p> <p>2. All exit doors were checked and verified to have a functional alarm device by the Executive Director (ED) and Maintenance Director on 10/06/14 and 10/09/14. Exit doors and alarm key pads will be checked daily by Maintenance/Department Manager to ensure proper function. The windows were checked by the Executive Director and Maintenance to ensure regulatory compliance with open egress on 10/06/14.</p> <p>3. Current in-house residents had an elopement risk assessment completed by a licensed nurse on 10/09/14. Ten (10) residents were identified on 10/09/14 as being at risk for elopement. Elopement risk binders were updated by Medical Records Director on 10/06/14 and 10/09/14.</p> <p>4. Wander Guard placement will be checked every shift and function daily by a licensed nurse to be signed on the Medication Administration Record (MAR). Licensed nurses are responsible for validating Wander Guard placement. The Director of Clinical Services (DCS)/Assistant Director of Clinical Services (ADCS)/Nurse Manager will monitor for compliance daily. Resident safety checks can be initiated every fifteen (15) minutes, thirty (30) minutes or hourly by a physician or clinical nurse who deems the resident at risk.</p> <p>5. On 10/06/14 through 10/07/14 the ED, the DCS and Unit Managers re-educated the staff on</p>	F 323	<p>needed to correct. The facility's policies and procedures for Care Plans, Resident Safety Checks, the Guide to Elopement Risk Evaluation, and the Elopement Skills Checklist were read and adopted by the facility without changes. The ED/DCS will conduct Quality Improvement Monitoring of this process 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 3 months or until substantial compliance is achieved. The ED/DCS will report findings to the Quality Assurance/Performance Improvement Committee 1 x monthly for 6 months for continued improvement or until substantial compliance is achieved.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2014
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
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F 323	<p>Continued From page 25</p> <p>elopement prevention and action procedure which included: Definition of Elopement; Exit Seeking Verbalizations and Actions to Monitor/Watch for and Report Immediately; Individual Identifier Information; Reporting Suspected Elopement/Missing Resident; Missing Resident Search-internal and external; and, Elopement Drills. Competency was determined by a successful completion of the post test. As of 10/12/14 ninety-four (94) of one hundred and forty (140) employees have completed the elopement post test. As of 10/12/14, one hundred and eighteen (118) employees working full time, part time and per diem employees have been re-educated and have successfully completed skills checklists. Any employees not educated as of 10/13/14 have been removed from the schedule and will not be scheduled until competency validations have been completed.</p> <p>6. An Ad-Hoc QAPI Committee meeting held with ED, DCS, Activities Director, Unit Managers, and Medical Director (by phone) on 10/06/14 to discuss elopement and plan to correct. An additional meeting was held on 10/09/14 to discuss the need for additional oversight and monitoring and the revisions needed to correct.</p> <p>7. Elopement Drills were initiated on 10/06/14 by the ED/DCS to ensure staff knowledge and proficiency including competency completion. Proficiency skills checklist was initiated on 10/09/14 by the Corporate Administrative Registered Nurse to ensure staff knowledge and proficiency.</p> <p>Through observation, interview and record review the State Survey Agency validated the corrective actions on 10/15/14 prior to exit as follows:</p>	F 323	<p>(The ED developed the quality improvement tool on 10/7/14.)</p> <p>(The licensed nursing staff are Responsible for implementing New admission care plans that Address individual risk factors. These care plans will be reviewed The morning meeting by the administrative nursing staff as part of The clinical meeting.)</p>	



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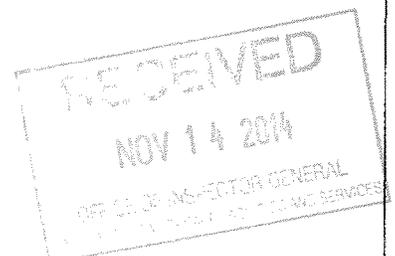
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F 323	Continued From page 26 1. Record review revealed, after the resident was returned, the facility assessed Resident #1 on 10/05/14 and he/she was found to be without injury and was placed on one to one (1:1) supervision. Observation during the survey validated the resident continued with 1:1 supervision. The resident was seen by a Psychiatrist on 10/06/14 with some medication changes. The Admission Care Plan and Kardex were reviewed and updated on 10/06/14. 2. Review of the door alarm work history report revealed door alarms were checked weekly prior to the elopement. The door alarms were checked on the day after the elopement on 10/06/14, and daily since the elopement. Observation during a test of all exit door alarms on 10/08/14 revealed all alarms were working properly. 3. All in-house residents had an elopement risk assessment completed by a licensed nurse on 10/09/14. Ten (10) residents were identified as being at risk for elopement; all of whom already had a Wander Guard device. The care plan and Kardex for these residents were revised. These residents' pictures were placed in the elopement book at each nurses' station and the front lobby. Two (2) other residents were assessed and placed in the elopement book on 10/12/14. Validation of the elopement book on 10/15/14 revealed all twelve (12) residents were included in the books and the elopement books were located at the front lobby and all four (4) nursing units. 4. Review of the Treatment Administration Record (TAR) revealed documentation of checking for placement of the Wander Guard devices every shift and it was determined the devices were	F 323			

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F 323	<p>Continued From page 27</p> <p>working. No omissions were found on 10/15/14. Review of the safety checks documentation revealed staff performed the scheduled checks. Observation on 10/14/14 at 4:30 PM, revealed all twelve (12) residents were utilizing the Wander Guard devices.</p> <p>5. Interviews and review of Sign in Sheets and agendas, revealed all staff were trained on the facility's policy for Elopement, missing person, and door alarms. Nurses and the Interdisciplinary Team were trained on admission care plans and revision. Training consisted of elopement education, elopement competency exam and elopement skills checklist. Interview with the Director of Nursing, on 10/08/14 at 3:49 PM, revealed re-training on elopements began immediately after the elopement occurred. The staff competency was validated by a post-test and skills checklist. Review of the staff attendance roster for the staff training revealed all regular facility staff had been trained prior to returning to work. Employees on leave or vacation were notified the training must occur prior to returning to work. Interview with CNA #1, on 10/09/14 at 4:30 PM, revealed he had been re-trained on elopements after Resident #1 was returned to the facility. Interview with CNAs #2, #3, #4, #5, #6, #7, and #8 validated they had been retrained. Interview with LPNs #1 and #2 and RN #1, #2, and #3 validated they had been retrained.</p> <p>6. Interview with the ED, on 10/08/14 at 4:45 PM, and the Medical Director, on 10/09/14 at 9:05 AM, revealed an Ad Hoc QAPI meeting was held on 10/06/14. Another QAPI meeting was held on 10/09/14. The Executive Director revealed she was in the process of developing audits tools for QAPI to ensure ongoing compliance.</p>	F 323			



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F 323	Continued From page 28 7. Review of the elopement drills revealed they were occurring daily. Observation of an elopement drill, on 10/08/14 at 3:00 PM, revealed staff responded promptly. Staff went outside and searched and every resident was counted to ensure all were present and none were missing.	F 323			

