

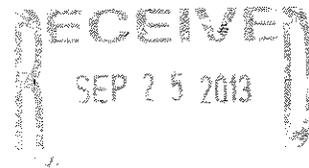
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

*Accepted
PDC
9/25/13*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2013
NAME OF PROVIDER OR SUPPLIER BRIDGE POINT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 WOODSPOINT DRIVE FLORENCE, KY 41042	

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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 09/19/13</p> <p>An Abbreviated/Partial Extended Survey Investigating KY# 00020593 was Initiated on 08/21/2013, and concluded on 08/30/13. KY#00020593 was substantiated with deficiencies identified. Immediate Jeopardy was identified on 08/23/13, and was determined to exist on 07/30/13, with deficiencies cited at 42 CFR 483.20 Resident Assessment F-280; 42 CFR 483.25 Quality of Care F-323; and, 42 CFR 483.75 Administration F-490, at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care F-323. The facility was notified of the Immediate Jeopardy on 08/23/13.</p> <p>Based on interview, record review and review of the facility's policies it was determined the facility failed to implement it's Elopement Policies by failing to assess and evaluate Resident #1 for elopement/wandering. On 07/30/13, at approximately 3:00 PM, Resident #1 left the facility premises without staff knowledge, and was found at approximately 3:10 PM, approximately 0.2 miles from the facility on a busy two (2) lane highway. The resident was returned to the facility by the Administrator. However, the facility failed to consider this an elopement; therefore, no assessment or care plan revision was completed. On 08/17/13, Resident #1 left the premises after 4:30 PM, without staff knowledge and was found by the local Police Department on Interstate 75 (an 8 lane Interstate) at 5:09 PM. The resident was given a ride by the Police to the resident's mothers old address approximately 24.4 miles from the facility. The Police notified the resident's</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, BridgePoint Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	9/25/13



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

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
daughter when the people living at the address did not know the resident. The facility was not aware the resident had left the premises until approximately 5:30 PM, when the resident's daughter called the facility. The resident's daughter picked the resident up and returned the resident to the facility at approximately 6:30 PM.

An acceptable credible Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 08/28/13, alleging the removal of Immediate Jeopardy on 08/24/13. On 08/30/13, the State Survey Agency verified the Immediate Jeopardy was removed on 08/24/13, as alleged, with remaining non-compliance at 42 CFR 483.20 Resident Assessment F-280; 42 CFR 483.25 Quality of Care F-323; and, 42 CFR 483.75 Administration F-490, at a Scope and Severity (S/S) of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic change.

F 280 SS=J 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

F 000

F280 (Care Plans)

1. Resident #1 was returned to the center by his daughter and placed on 1:1 monitoring by nursing staff on August 17, 2013. *9/29/13*

F 280 A head to toe assessment and Wander Risk/Elopement assessment was completed on Resident #1 and the MD notified on August 17, 2013 by a licensed nurse. An order was obtained by the MD for Resident #1 to have a UA, CBC, BMP, and a wanderguard device, which was tested for functionality and then placed on resident by the licensed nurse. This resident's family was notified of the event on August 17, 2013 and the

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F 280	Continued From page 2 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to have an effective system to ensure the comprehensive plan of care was reviewed and revised to address the risk factors of elopement, and implement interventions to provide adequate supervision to prevent elopement for one (1) of seven (7) sampled residents (Resident #1). Resident #1 was assessed and identified at risk for wandering/elopement per the resident care plan on 05/20/12 with interventions to keep the resident safe which included a wander guard. On 07/26/13, the resident's Physician noted in a Progress Note the resident's wander guard could be removed due to the resident not exhibiting exit seeking behavior. On 07/29/13, the resident's wander guard was removed and the resident's elopement care plan was discontinued. On 07/30/13, at approximately 3:00 PM, Resident #1 left the facility premises without staff knowledge, and was found at approximately 3:10 PM, approximately 0.2 miles from the facility on a busy two (2) lane highway. The resident was returned to the facility by the Administrator. However, the facility failed to consider this an elopement; therefore, no assessment or care plan revision was completed.	F 280	care plan and Care Card updated by a licensed nurse. Resident #1's care plan and nurse aide Care Card was updated on 8/23/13 to include supervision during outdoor activities by the licensed nurse. 2. Current residents residing in the center were reviewed by the licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans and C.N.A Care cards to address risk of elopement on August 17, 2013. Current residents residing in the center were assessed by the licensed nurses using "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement and identified current residents to either require supervision for outdoor activities or not to require supervision for outdoor activities on 8/23/13 and updated the resident care plans and C.N.A Care Cards. 3. Re- education of all staff was initiated on August 17, 2013 and completed on August 21, 2013. The topics reviewed were the Elopement		

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F 280	<p>Continued From page 3</p> <p>On 08/17/13, Resident #1 left the premises after 4:30 PM, without staff knowledge and was found by the local Police Department on Interstate 75 (an 8 lane interstate) at 5:09 PM. The resident was given a ride by the Police to the resident's mother's old address approximately 24.4 miles from the facility. The Police notified the resident's daughter when the people living at the address did not know the resident. The facility was not aware the resident had left the premises until approximately 5:30 PM, when the resident's daughter called the facility. The resident's daughter picked the resident up and returned the resident to the facility at approximately 6:30 PM. (Refer to F323)</p> <p>Based on the above findings the facility's failure to revise the Comprehensive Care Plan to include supervision and monitoring for residents with a history and/or at risk for elopement/wandering behaviors was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 08/23/13, and was determined to exist on 07/30/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/28/13, and alleged removal of the Immediate Jeopardy on 08/24/13. The state survey agency determined the Immediate Jeopardy was removed on 08/24/13, prior to exit, which lowered the scope/severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plan:</p>	F 280	<p>Management Program to include resident assessments to identify elopement potential, and updating resident care plans/nurse aide care cards with identified risk and interventions as indicated. This education was provided by the Administrator Director of Nursing, and/or Assistant Director of Nursing. The Medical Director was notified by the Administrator of the event on August 17, 2013. An ad hoc Performance Improvement Meeting was held with the Administrator, Director of Nursing and Medical Director on August 20, 2013 to discuss the events of the elopement and begin a root cause analysis and plan of action. A follow up ad hoc Performance Improvement meeting was held on 8-30-13 for review of the plan of action.</p> <p>4. The Director of Nursing and/or Assistant Director of Nursing will review nursing assessments, care plans, and nurse aide Care Cards of new/re-admissions within 72 hours, and current residents upon new exit seeking/wandering behavior, quarterly and with any significant change to validate that resident assessments are</p>		

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F 280	<p>Continued From page 4</p> <p>Patient", revised 05/01/11, revealed the purpose was to provide necessary care and services to attain or maintain the patient's highest practicable, physical, mental and psychosocial well being. Further review revealed that per the policy (section 2.2) care plans were developed based on Nursing Assessments, subsequent assessments and other observations. Continued review of the policy (section 2.4) revealed care plans were reviewed and revised a minimum of quarterly and as needed to reflect response to care and changing needs and goals.</p> <p>Record review revealed the facility admitted Resident #1 on 05/07/12, with diagnoses which include Dementia, Anemia, Tobacco use disorder, and Palliative Care Stage 4 lung cancer. Review of Resident #1 Annual Minimum Data Set (MDS) Assessment, dated 05/15/13, revealed the facility assessed the resident as being severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of three (3) out of fifteen (15) and Independent with activities of daily living (ADL's).</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 05/20/13, revealed the facility assessed and identified Resident #1 at risk for wandering/elopement. Interventions were put in place to keep the resident safe which included a wander guard.</p> <p>Record review revealed on 07/26/13, Resident #1's Physician wrote a Progress Note stating "OK to remove wander guard since resident is coherent and does not display exit seeking behaviors". On 07/29/13, the wander guard was removed from the resident, and review of the Comprehensive Care Plan revealed the</p>	F 280	<p>complete, to include the "Resident Elopement Risk Screen and Assessment Tool" and any identified elopement potential has a corresponding care plan and nurse aide Care Card addressing this potential. This review will also include validating any need for supervision during outdoor activities and appropriate care plans and nurse aide Care Card updates have been completed. Results of these reviews will be submitted by the Director of Nursing or Administrator to the Performance Improvement Committee monthly for further review and recommendation.</p>		

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F 280	<p>Continued From page 5</p> <p>elopement care plan was discontinued on 07/29/13, with no interventions to monitor Resident #1 without the wander guard.</p> <p>On 07/30/13, Resident #1 was sitting unsupervised on the front porch of the facility. Resident #1 exited the facility premises without staff knowledge, walked down the facility driveway to a busy, two (2) lane highway, crossed the highway and was walking on the side walk approximately 0.2 miles from the facility when staff located the resident.</p> <p>Further record review revealed no Elopement Risk Assessment was completed on 07/30/13, when the resident was returned to the facility. Record review revealed no documentation of an Interdisciplinary Team (IDT) Assessment of Resident #1 and no documented care plan to monitor Resident #1 after the resident left the facility grounds on 07/30/13.</p> <p>Interview with the Administrator on 08/22/13 at 4:10 PM, revealed the facility administration and/or Interdisciplinary team (IDT) never considered elopement when Resident #1 left the facility on 07/30/13, as the resident had a motive for leaving and knew the date. He further stated "We let our residents go and come as they please", therefore there was no reason to revise the care plan.</p> <p>Interview with the Assistant Director of Nursing (ADON) and Administrator on 08/29/13 at 1:00 PM, revealed that when the resident went for his/her "walk" it was never considered an elopement by anyone at the facility. There was no change so there was no need to complete an assessment or complete a care plan.</p>	F 280			

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F 280	Continued From page 6 Interview with the Director of Nursing (DON), on 08/22/13 at 3:35 PM, revealed that she was on vacation on 07/30/13, and had not been told about any elopement. Further interview revealed that she felt that she would have considered the resident's exit without staff knowledge an elopement and would have reassessed the resident and updated the care plan. Review of the quarterly MDS Assessment, dated 08/15/13, revealed a BIMS score of three (3) out of fifteen (15) for cognition, indicating Resident #1 was severely Impaired In cognition and Independent with ADL's. Review of the care plan revealed there was no update/revision of the care plan to include the resident's exit from the facility on 07/30/13, when the resident had left the facility without staff knowledge. In addition, there was no documentation was found in the record that the resident had left the facility property on 07/30/13, without staff knowledge. Record review of "Change of Condition Documentation" revealed that on 08/17/13, Resident #1 was last seen at about 4:30 PM sitting on the facility's front porch; left the facility property without staff knowledge; was found by Police at 5:09 PM; and, was returned to the facility by the resident's daughter at approximately 6:30 PM. Interview with ADON, on 08/22/13 at 2:00 PM, revealed Resident #1 returned to the facility on 08/17/13, at approximately 6:30 PM, upon return the resident was reassessed for elopement, and interventions for elopement risk was initiated including 1:1 supervision, and placement of a wander guard. The resident's care plan was	F 280			

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F 280	Continued From page 7 reviewed and revised on 08/17/13. The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/28/13, that alleged removal of the IJ effective 08/24/13. Review of the AOC revealed the facility implemented the following: 1) On 08/17/13, Resident #1 was placed on 1:1 supervision, a head to toe assessment was completed by licensed nurse, no injuries were identified, wander guard was tested for functionality and then placed on the resident. 2) A head count of residents residing in the facility was completed on 08/17/13, by the licensed nurse to validate all residents were accounted for. 3) The Administrator and ADON validated that all doors and alarms were working properly on 08/17/13. 4) Residents residing in the facility were reviewed by licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans to address risk of elopement on 08/17/13. 5) One hundred percent (100%) of residents in the facility were assessed by the licensed nurse using the "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement on 08/23/13. Using this assessment tool the licensed nurse updated the resident care plan, care card and also identified each resident to either require or not require supervision for outdoor activities. 6) Administrator, DON, and ADON initlated	F 280			

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F 280	Continued From page 8 re-education to all staff on 08/17/13, and completed on 08/21/13. The topics reviewed were Elopement Management Program to include procedure for missing resident, response to door alarm, that facility door codes were changed, new facility policy to not give door codes to any resident or visitor. 7) The Maintenance Director changed all door codes on 08/19/13. 8) The Administrator, DON, and ADON, was re-educated on 08/23/13 by the Manager of Clinical Operations to the facility's Elopement Policy and Procedures. 9) The Administrator, DON, ADON, and/or Maintenance Director will conduct missing resident/elopement drills three (3) times weekly on varied shifts, and report results to QA Committee monthly for further review and recommendations. 10) The Administrator and/or Maintenance will conduct observations of facility exit doors five (5) times weekly, at varied times, to validate that residents nor visitors are aware of the door codes, and will report findings to the QA Committee monthly for further review and recommendations. 11) The DON/ADON will audit elopement assessments on admision, readmision, annual, quarterly and significant change assessments, to ensure care plans, care cards and elopement assessments are complete. The State Agency validated the implementation of the facility's AOC as follows:	F 280			

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F 280	Continued From page 9 1) Review of the resident record revealed that 08/17/13, Resident #1 was placed on 1:1 supervision, a head to toe assessment was completed by licensed nurse, no injuries were identified, wander guard was tested for functionality and then placed on the resident. 2) Review of the facility investigation binder revealed a head count was conducted on all residents residing in the facility on 08/17/13, by the licensed nurse to validate all residents were accounted for. 3) Review of the facility's investigation binder revealed the Administrator and ADON validated that all doors and alarms were working properly on 08/17/13. 4) Review of Residents elopement assessments revealed that all residents residing in the facility were reviewed by licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans to address risk of elopement on 08/17/13. 5) Review of random residents records revealed all residents in the facility were assessed by the licensed nurse using the "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement on 08/23/13. Using this assessment tool the licensed nurse updated the resident care plan, care card and also identified each resident to either require or not require supervision for outdoor activities 6) Review of the facility's investigation binder revealed that the Administrator, DON, and ADON	F 280		

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F 280	<p>Continued From page 10</p> <p>initiated re-education to all staff on 08/17/13, and completed on 08/21/13. The topics reviewed were Elopement Management Program to include procedure for missing resident, response to door alarm, that facility door codes were changed, new facility policy to not give door codes to any resident or visitor.</p> <p>Interviews on 08/30/13 at 9:32 AM, with Licensed Practical Nurse (LPN) #1, at 9:32 AM with LPN #2, at 10:10 AM with LPN #3 at 9:40 AM with Registered Nurse (RN) #1, at 8:20 AM with RN #2, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors and when to complete elopement assessments.</p> <p>Interviews on 08/30/13 at 9:25 AM with SRNA #1, at 9:10 AM with SRNA #2, at 10:40 AM with SRNA #3, at 10:30 AM with SRNA #5, at 10:50 with SRNA #4, and at 8:30 AM with SRNA #6, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors.</p> <p>Interviews with other facility staff on 08/30/13, at 9:35 AM with Occupational Therapist, at 9:00 AM with House Keeping (HK) #1, at 10:45 AM with HK #2, at 8:15 AM with HK #3, at 9:05 AM with Activities/SRNA, at 9:20 AM with Cook #1, at 9:25 am with Cook #2, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors.</p> <p>7) Review of the facility's investigation binder revealed that the Maintenance Director changed</p>	F 280			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2013
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F 280	Continued From page 11 all door codes on 08/19/13, and will change the codes anytime it is determined that a resident or visitor knows the code. 8) Review of the facility's investigation binder revealed that the Administrator, DON, and ADON, was re-educated by the Manager of Clinical Operations to the facility's Elopement Policy and Procedures on 08/23/13. 9) Review of the facility's investigation binder revealed that the Administrator, DON, ADON, and/or Maintenance Director conducted missing resident/elopement drills on 08/18/13, 08/19/13, and 08/20/13 on all three shifts. 10) Review of the facility's investigation binder revealed that the Administrator and/or Maintenance conducted observations of facility exit on 08/18/13, 08/19/13, 08/20/13, and 08/21/13, at varied times, and the door codes have been changed due to a visitor was aware of the door codes. The findings will be reported to the QA Committee monthly for further review and recommendations. 11) Interview with the DON, on 08/30/2013 at 11:10 AM, revealed that the DON/ADON will audit all elopement assessments on admission, readmission, annual, quarterly and significant change assessments during the daily Clinical Meeting, to ensure care plans, care cards and elopement assessments are complete.	F 280			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 12</p> <p>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 interview, record review, and review of the facility's policy it was determined the facility failed to have an effective system to ensure resident safety through monitoring and supervision for one (1) of seven (7) sampled residents (Resident #1). The facility failed to ensure adequate interventions were in place to prevent resident elopement.</p> <p>The facility assessed and identified Resident #1 as at risk for wandering/elopement per the resident care plan on 05/20/12. Interventions were put into place to keep the resident safe which included a wander guard. On 07/26/13, the resident's Physician noted in a Progress Note the resident's wander guard could be removed due to the resident not exhibiting exit seeking behavior. On 07/29/13, the resident's wander guard was removed and the resident's elopement care plan was discontinued. On 07/30/13 at approximately 3:00 PM, Resident #1 left the facility premises without staff knowledge, and was found at approximately 3:10 PM, approximately 0.2 miles from the facility on a busy two (2) lane highway. The resident was returned to the facility by the Administrator. However, the facility failed to consider this an elopement; therefore, no assessment or care plan revision was completed. (Refer to F-280)</p>	F 323	<p>F 323 (Accidents/Prevention)</p> <p>1. Resident #1 was returned to the center by his daughter and placed on 1:1 monitoring by nursing staff on August 17, 2013. <i>9/25/13</i></p> <p>A head to toe assessment and Wander Risk/Elopement assessment was completed on Resident #1 and the MD notified on August 17, 2013 by a licensed nurse. An order was obtained by the MD for Resident #1 to have a UA, CBC, BMP, and a wanderguard device, which was tested for functionality and then placed on resident by the licensed nurse. This resident's family was notified of the event on August 17, 2013 and the care plan and Care Card updated by a licensed nurse. Resident #1's care plan and nurse aide Care Card was updated on 8/23/13 to include supervision during outdoor activities by the licensed nurse.</p>	

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

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F 323	<p>Continued From page 13</p> <p>On 08/17/13, Resident #1 left the premises after 4:30 PM, without staff knowledge and was found by the local Police Department on Interstate 75 (an 8 lane Interstate) at 5:09 PM. The resident was given a ride by the Police to the resident's mother's old address approximately 24.4 miles from the facility. The police notified the resident's daughter when the people living at the address did not know the resident. The facility was not aware the resident had left the premises until approximately 5:30 PM, when the resident's daughter called the facility. The resident's daughter picked the resident up and returned the resident to the facility at approximately 6:30 PM.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents with a history and/or at risk for elopement/wandering behaviors was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 08/23/13, and was determined to exist on 07/30/13. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, Quality of Care F-323.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/28/13, and alleged removal of the Immediate Jeopardy on 08/24/13. The state survey agency determined the Immediate Jeopardy was removed on 08/24/13, prior to exit, which lowered the scope/severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility "Elopement" Policy, dated 01/2008, revealed the intent of the facility was to</p>	F 323	<p>2. A head count of current residents residing in the center was completed on August 17, 2013 by the licensed nurse to validate center residents were accounted for with no other concerns noted. The Administrator and Director of Nursing were notified of the resident exiting the building on 8-17-13. The Administrator and Assistant Director of Nursing came to the building, without delay on 8-17-13, to initiate the investigation of events and to ensure resident safety. The Administrator and Assistant Director of Nursing validated that all doors and alarms were working properly on August 17, 2013.</p>	

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

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F 323	<p>Continued From page 14</p> <p>provide a safe environment and that residents who were at risk for elopement were identified. The policy further noted "upon return of resident to the facility, an Elopement Risk Evaluation would be completed and/or updated and the resident care plan would be reviewed and updated as necessary".</p> <p>Record review revealed the facility admitted Resident #1 on 05/07/12, with diagnoses which include Dementia, Anemia, Tobacco use disorder, Palliative Care, Stage 4 lung cancer. Further review revealed on admission the resident was assessed as an elopement/wander risk. The care plan dated 05/20/12, revealed interventions were put in place to keep the resident safe, which included a wander guard.</p> <p>Review of Resident #1 Annual Minimum Data Set (MDS) Assessment, dated 05/15/13, revealed the facility assessed the resident as being severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of three (3) out of fifteen (15), indicating severe cognitive impairment and the resident was assessed as independent with activities of daily living (ADL's). Review of the elopement risk assessment for the assessment period of 05/15/13, revealed the resident was at risk for elopement. Review of the care plan dated 05/30/13, revealed the resident was at risk for elopement and interventions were put in place to keep the resident safe which included a wander guard.</p> <p>Record review revealed on 07/26/13, the resident's Physician saw Resident #1 and wrote a Progress Note stating "OK to remove wander guard since resident is coherent and does not display exit seeking behaviors". However, record</p>	F 323	<p>The Elopement Risk Evaluations for current at risk residents, Care plans, and Care Cards were reviewed and updated as indicated by the licensed nurse on 8-17-13. Current residents residing in the center were assessed by the licensed nurse using "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement and whether or not the resident required supervision or not for outdoor activities and care plans updated as indicated on 8/23/13. The Maintenance Director changed door codes to center doors on 8/19/13. The Medical Director was notified by the Administrator of the event on August 17, 2013.</p> <p>An ad hoc Performance Improvement Meeting was held with the Administrator, Director of Nursing and Medical Director on August 20, 2013 to discuss the events of the elopement and begin a root cause analysis and plan of action. A follow up ad hoc Performance Improvement meeting was held on 8-30-13 for review of the plan of action.</p>	

3. The Administrator, Director of Nursing and Assistant Director of

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

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F 323	<p>Continued From page 15</p> <p>review revealed no documentation of an Interdisciplinary Team (IDT) Assessment of Resident #1 for removal of the wander guard. The wander guard was removed and the resident's elopement care plan was discontinued on 07/29/13. Furthermore, there was no documented plan to monitor Resident #1 after the removal of the wander guard on 07/29/13.</p> <p>Interview with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON), on 08/22/13 at 12:00 PM, revealed that the clinical team had made the decision to remove the wander guard, after the resident's Physician had assessed the resident and said it was okay to remove the wander guard. They further stated they just never thought about monitoring the resident for elopement when the wander guard was removed.</p> <p>Interview with House Keeper #1, on 08/22/13, at 3:05 PM, revealed Resident #1 had exited the facility without staff knowledge near the end of July.</p> <p>Interview with the House Keeping Assistant Supervisor, on 08/22/13 at 3:25 PM, revealed Resident #1 did leave the facility at the end of July. He further stated staff was down stairs when a code was called and they all started looking for the resident. He stated Resident #1 was up the street by the two matching buildings almost to the home improvement store. The Administrator brought the resident back to the facility. He further stated the resident was always saying he/she wanted to go home.</p> <p>Interview with Resident #1's daughter, Power of Attorney (POA), on 08/22/13 at 2:20 PM, revealed</p>	F 323	<p>Nursing re- educated all staff as of August 21, 2013 to the Elopement Policy and Procedure including the identification of residents that require supervision with outdoor activities.</p> <p>4. The Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and/or Maintenance Director will conduct missing resident/elopement drills, monthly x12 months on varied shifts, and report results to Performance Improvement Committee monthly for further review and recommendations. The Administrator and/or Maintenance will conduct observations of center exit doors five times weekly x4 weeks and then monthly x11 months, at varied times, to validate that residents nor visitors are aware of center door codes, and report results to the Performance Improvement Committee monthly for further review and recommendations. The Director of Nursing and/or Assistant Director of Nursing will review nursing assessments, care plans, and nurse aide Care Cards of new/re-admissions within 72 hours, and current residents upon new exit seeking/wandering behavior, quarterly and with any significant change to validate that resident assessments are complete, to include the "Resident Elopement Risk Screen and</p>		

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

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F 323	<p>Continued From page 16</p> <p>on 07/30/13, the resident had left the facility without staff knowledge. Resident #1's daughter further stated that when the Administrator called her on 07/30/13 about the incident, he told her the resident was allowed to go for walks.</p> <p>Interview with the Administrator, on 08/22/13 at 4:10 PM, revealed Resident #1 was sitting on the front porch on 07/30/13, at about 2:30 PM to 3:00 PM. He said he took a phone call that lasted about two (2) minutes and when he looked out the window the resident wasn't on the porch. He checked to see if the resident had come back into the facility and then started looking for the resident. He stated Resident #1 was across the street on the sidewalk, walking towards a grocery store. The Administrator drove the resident back to the facility. He further stated he did not consider the resident's exit an elopement as the resident had a motive to go to grocery store to buy a soda, and could also tell him the date. Furthermore, the Administrator stated "we let the residents go and come as they please, based on the resident's response I didn't feel it was an elopement". Even though Resident #1 was assessed by the facility on 05/15/13, with severe cognitive impairment.</p> <p>Further record review revealed no Elopement Risk Assessment was completed on 07/30/13, when the resident was returned to the facility. This failure prevented the facility from establishing effective interventions to prevent future elopement recurrence for this resident. Further record review revealed the resident's Comprehensive Plan of Care was not revised related to the incident on 07/30/13.</p> <p>Review of the resident's quarterly MDS</p>	F 323	<p>Assessment Tool" and the determination for the need of supervision with outdoor activities. Results of these reviews will be submitted by the Director of Nursing or Administrator to the Performance Improvement Committee monthly for further review and recommendation.</p>		

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

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F 323	<p>Continued From page 17</p> <p>Assessment, dated 08/15/13, revealed the facility assessed no change in the resident's cognition with a BIMS score of three (3) for cognition and the resident remained independent with ADL's.</p> <p>Record review of "Change of Condition Documentation" revealed that on 08/17/13 Resident #1 left the facility premises without staff knowledge. Staff reported that Resident #1 was last seen by nursing staff at about 4:30 PM, sitting on the facility's front porch.</p> <p>Review of the Police run sheet on 08/17/13, revealed the local Police received a call from a motorist at 4:55 PM, that an older person was sitting Indian style on the side of Interstate 75 (a high traffic, 8 lane Interstate) before the exit. The Police Officer arrived at 5:09 PM, at which time Resident #1 told him that his/her car was broken down and that he/she was trying to get home. The resident gave the Police his/her mother's old address, as his/her address. The Police Officer took the resident to the address which was approximately 24.4 miles from the facility. When they arrived at the address, the person living at the address did not know the resident; however, the people across the street from the address did know the resident and told the police officer the resident's daughter's name and phone number. The Police Officer contacted the daughter who was also the resident's Power of Attorney (POA). The daughter went and picked Resident #1 up and returned him/her to the facility at approximately 6:30 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/22/13 at 2:30 PM, revealed she had received a phone call on 08/17/2013, sometime after 5:00 PM, from Resident #1 daughter. The</p>	F 323			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 18</p> <p>daughter ask where the resident was and she replied in his/her room or on smoke break and stated she would check and placed the phone on hold. She stated she was unable to locate the resident so she called a code yellow and returned to the phone to tell the resident's daughter. Resident #1's daughter told her the resident was with the police in Verona and she was going to get him/her and bring him/her back to the facility. LPN #1 further stated she did not know how long it would have been before the staff would have known the resident was not in the facility. She further stated she did notify the DON and Administrator. She stated Resident #1's daughter returned the resident to the facility at approximately 6:30 PM.</p> <p>Interview with State Registered Nursing Assistant SRNA #4, on 08/22/13 at 3:17 PM, revealed she was assigned to care for Resident #1 on 08/17/13, 3-11 shift. She stated that she had done her rounds when she arrived for work at approximately 3:06 PM. Resident #1 was not in his/her room so she asked her co-workers if they had seen Resident #1 and a nurse told her he/she was on the front porch at 3:40 PM, so she completed her work. She further stated she didn't know that Resident #1 was not at the facility until they got the call from his/her daughter sometime after 5:00 PM.</p> <p>Interview with ADON, on 08/22/13 at 2:00 PM, revealed Resident #1 returned to the facility on 08/17/13, at approximately 6:30 PM, upon return the resident was reassessed for elopement, a head to toe assessment completed for injuries, interventions for elopement risk were initiated including 1:1 supervision, and placement of a wander guard. She stated the resident's care plan</p>	F 323			

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

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FORM APPROVED
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F 323	<p>Continued From page 19 was reviewed and revised on 08/17/13.</p> <p>Interview with the Administrator, on 08/22/13 at 1:30 PM, revealed Resident #1 knew the code on the door. He stated a lot of the residents knew the code because the one's that were safe to be outside unsupervised could come and go as they pleased. Interview revealed Resident #1 could come and go as he/she pleased. Even though the facility had assessed the resident with severe cognitive impairment. He further stated visitors knew the code as well.</p> <p>Interview with Unit Manager #1, on 08/23/13 at 11:00 AM, revealed she was unaware of any system in place to identify the residents that were safe to sit outside unsupervised. She stated as a nurse if she felt a resident was not safe to be outside unsupervised she would apply a wander guard.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/28/13, that alleged removal of the IJ effective 08/24/13. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1) On 08/17/13, Resident #1 was placed on 1:1 supervision, a head to toe assessment was completed by licensed nurse, no injuries were identified, wander guard was tested for functionality and then placed on the resident. 2) A head count of residents residing in the facility was completed on 08/17/13, by the licensed nurse to validate all residents were accounted for. 3) The Administrator and ADON validated that all doors and alarms were working properly on 	F 323			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 20 08/17/13. 4) Residents residing in the facility were reviewed by licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans to address risk of elopement on 08/17/13. 5) One hundred percent (100%) of residents in the facility were assessed by the licensed nurse using the "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement on 08/23/13. Using this assessment tool the licensed nurse updated the resident care plan, care card and also identified each resident to either require or not require supervision for outdoor activities. 6) Administrator, DON, and ADON Initiated re-education to all staff on 08/17/13, and completed on 08/21/13. The topics reviewed were Elopement Management Program to include procedure for missing resident, response to door alarm, that facility door codes were changed, new facility policy to not give door codes to any resident or visitor. 7) The Maintenance Director changed all door codes on 08/19/13. 8) The Administrator, DON, and ADON, was re-educated on 08/23/13 by the Manager of Clinical Operations to the facility's Elopement Policy and Procedures. 9) The Administrator, DON, ADON, and/or Maintenance Director will conduct missing resident/elopement drills three (3) times weekly on varied shifts, and report results to QA	F 323		

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2013
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F 323	<p>Continued From page 21</p> <p>Committee monthly for further review and recommendations.</p> <p>10) The Administrator and/or Maintenance will conduct observations of facility exit doors five (5) times weekly, at varied times, to validate that residents nor visitors are aware of the door codes, and will report findings to the QA Committee monthly for further review and recommendations.</p> <p>11) The DON/ADON will audit elopement assessments on admission, readmission, annual, quarterly and significant change assessments, to ensure care plans, care cards and elopement assessments are complete.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1) Review of the resident record revealed that 08/17/13, Resident #1 was placed on 1:1 supervision, a head to toe assessment was completed by licensed nurse, no injuries were identified, wander guard was tested for functionality and then placed on the resident.</p> <p>2) Review of the facility investigation binder revealed a head count was conducted on all residents residing in the facility on 08/17/13, by the licensed nurse to validate all residents were accounted for.</p> <p>3) Review of the facility's investigation binder revealed the Administrator and ADON validated that all doors and alarms were working properly on 08/17/13.</p> <p>4) Review of Residents elopement assessments</p>	F 323			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 22 revealed that all residents residing in the facility were reviewed by licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans to address risk of elopement on 08/17/13. 5) Review of random residents records revealed all residents in the facility were assessed by the licensed nurse using the "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement on 08/23/13. Using this assessment tool the licensed nurse updated the resident care plan, care card and also identified each resident to either require or not require supervision for outdoor activities 6) Review of the facility's investigation binder revealed that the Administrator, DON, and ADON initiated re-education to all staff on 08/17/13, and completed on 08/21/13. The topics reviewed were Elopement Management Program to include procedure for missing resident, response to door alarm, that facility door codes were changed, new facility policy to not give door codes to any resident or visitor. Interviews on 08/30/13 at 9:32 AM, with Licensed Practical Nurse (LPN) #1, at 9:32 AM with LPN #2, at 10:10 AM with LPN #3 at 9:40 AM with Registered Nurse (RN) #1, at 8:20 AM with RN #2, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors and when to complete elopement assessments. Interviews on 08/30/13 at 9:25 AM with SRNA #1, at 9:10 AM with SRNA #2, at 10:40 AM with	F 323			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/30/2013
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F 323	<p>Continued From page 23</p> <p>SRNA #3, at 10:30 AM with SRNA #5, at 10:50 with SRNA #4, and at 8:30 AM with SRNA #6, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors.</p> <p>Interviews with other facility staff on 08/30/13, at 9:35 AM with Occupational Therapist, at 9:00 AM with House Keeping (HK) #1, at 10:45 AM with HK #2, at 8:15 AM with HK #3, at 9:05 AM with Activities/SRNA, at 9:20 AM with Cook #1, at 9:25 am with Cook #2, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors.</p> <p>7) Review of the facility's investigation binder revealed that the Maintenance Director changed all door codes on 08/19/13, and will change the codes anytime it is determined that a resident or visitor knows the code.</p> <p>8) Review of the facility's investigation binder revealed that the Administrator, DON, and ADON, was re-educated by the Manager of Clinical Operations to the facility's Elopement Policy and Procedures on 08/23/13.</p> <p>9) Review of the facility's investigation binder revealed that the Administrator, DON, ADON, and/or Maintenance Director conducted missing resident/elopement drills on 08/18/13, 08/19/13, and 08/20/13 on all three shifts.</p> <p>10) Review of the facility's investigation binder revealed that the Administrator and/or Maintenance conducted observations of facility exit on 08/18/13, 08/19/13, 08/20/13, and</p>	F 323			

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

PRINTED: 09/19/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 24 08/21/13, at varled times, and the door codes have been changed due to a visitor was aware of the door codes. The findings will be reported to the QA Committee monthly for further review and recommendations. 11) Interview with the DON, on 08/30/2013 at 11:10 AM, revealed that the DON/ADON will audit all elopement assessments on admission, readmission, annual, quarterly and significant change assessments during the daily Clinical Meeting, to ensure care plans, care cards and elopement assessments are complete.	F 323		
F 490 SS-J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facillty must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policies, it was determined facility Administration failed to have an effective system to ensure its resources, including policies related to resident assessment and care plan, were used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being for one (1) of seven (7) sampled residents (Resident #1). The Administrator failed to ensure assessment and care plan policies and procedures were implemented by failing to assess and evaluate Resident #1 for elopement/wandering. On	F 490	<u>F 490 (Administration)</u> 1. . Resident #1 was returned to the center by his daughter and placed on 1:1 monitoring by nursing staff on August 17, 2013. A head to toe assessment and Wander Risk/Elopement assessment was completed on Resident #1 and the MD notified on August 17, 2013 by a licensed nurse. An order was obtained by the MD for Resident #1 to have a UA, CBC, BMP, and a wanderguard device, which was tested for functionality and then placed on resident by the licensed nurse. This resident's family was notified of the event on August 17, 2013 and the	9/25/13

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

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F 490	<p>Continued From page 25</p> <p>07/30/13, at approximately 3:00 PM, Resident #1 left the facility premises without staff knowledge, and was found at approximately 3:10 PM, approximately 0.2 miles from the facility on a busy two (2) lane highway. The resident was returned to the facility by the Administrator. However, the facility failed to consider this an elopement; therefore, no assessment or care plan revision was completed. On 08/17/13, Resident #1 left the premises after 4:30 PM, without staff knowledge and was found by the local Police Department on Interstate 75 (an 8 lane Interstate) at 5:09 PM. The resident was given a ride by the Police to the resident's mothers old address approximately 24.4 miles from the facility. The Police notified the resident's daughter when the people living at the address did not know the resident. The facility was not aware the resident had left the premises until approximately 5:30 PM, when the resident's daughter called the facility. The resident's daughter picked the resident up and returned the resident to the facility at approximately 6:30 PM. (Refer to F-280 and F-323)</p> <p>The Administration's failure to ensure facility policies/procedures related to resident assessment and care plan were implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents at the facility. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 07/30/13. The facility was notified of the Immediate Jeopardy on 08/23/2013.</p> <p>An acceptable Allegation of Compliance was received on 08/28/13, and alleged removal of the Immediate Jeopardy on 08/24/13. The state survey agency determined the Immediate</p>	F 490	<p>care plan and Care Card updated by a licensed nurse. Resident #1's care plan and nurse aide Care Card was updated on 8/23/13 to include supervision during outdoor activities by the licensed nurse. Center Administrator notified OIG and APS of resident exiting center on 8/18/13.</p> <p>2. A head count of current residents residing in the center was completed on August 17, 2013 by the licensed nurse to validate center residents were accounted for with no other concerns noted. The Administrator and Director of Nursing were notified of the resident exiting the building on 8-17-13. The Administrator and Assistant Director of Nursing came to the building, without delay on 8-17-13, to initiate the investigation of events and to ensure resident safety. The Administrator and Assistant Director of Nursing validated that all doors and alarms were working properly on August 17, 2013. The Elopement Risk Evaluations for current at risk residents, Care plans, and Care Cards were reviewed and updated as indicated by the licensed nurse on 8-17-13. Current residents residing in the center were assessed by the licensed nurse using "Resident</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490 Continued From page 26
Jeopardy was removed on 08/24/13, which lowered the scope/severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.

The findings include:

Review of the facility's policy and procedure related to "Elopement", dated 01/2008, revealed the intent of the facility was to provide a safe environment and that residents who were at risk for elopement were identified. The policy further noted "upon return of resident to the facility, an Elopement Risk Evaluation would be completed and/or updated and the resident care plan would be reviewed and updated as necessary".

Review of the facility's policy titled "Care Plan: Patient", revised 05/01/11, revealed the purpose was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental and psychosocial well being. Further review revealed that per policy (section 2.2) care plans were developed based on Nursing Assessments, subsequent assessments and other observations. Continued review of the policy (section 2.4) revealed care plans were reviewed and revised a minimum of quarterly and as needed to reflect response to care and changing needs and goals.

Interview and record review revealed the facility admitted Resident #1 on 05/07/12, with diagnoses which include Dementia. Further review revealed on admission the resident was assessed as an elopement/wander risk. The care plan dated 05/20/12, revealed interventions were put in place to keep the resident safe, which included a wander guard; however, this care plan

F 490 Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement and whether or not the resident required supervision or not for outdoor activities and care plans updated as indicated on 8/23/13. The Maintenance Director changed door codes to center doors on 8/19/13. The Medical Director was notified by the Administrator of the event on August 17, 2013.

An ad hoc Performance Improvement Meeting was held with the Administrator, Director of Nursing and Medical Director on August 20, 2013 to discuss the events of the elopement and begin a root cause analysis and plan of action. A follow up ad hoc Performance Improvement meeting was held on 8-30-13 for review of the plan of action.

3. The Administrator, Director of Nursing and Assistant Director of Nursing re- educated all staff as of August 21, 2013 to the Elopement Policy and Procedure including the identification of residents that require supervision with outdoor activities. On August 23, 2013, center Administrator, Director of Nursing and Assistant Director of Nursing

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

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F 490	<p>Continued From page 27</p> <p>was discontinued on 07/29/13, when the wander guard was discontinued. The resident was assessed to be severely cognitive impaired by the facility. Record review revealed on 07/30/13, Resident #1 left the facility premises without staff knowledge; however, upon return to the facility, the facility failed to assess the resident for elopement risk and failed to implement interventions to keep Resident #1 safe. On 08/17/13, Resident #1 left the facility premises again without staff knowledge and was located by local Police on a busy eight (8) lane Interstate.</p> <p>Interview with the Administrator, Director of Nursing (DON), and Assistant director of Nursing (ADON), on 08/22/13 at 12:00 PM, revealed that the clinical team had made the decision to remove the wander guard on 07/29/13 and never thought about monitoring the resident for elopement when the wander guard was removed.</p> <p>Interview with the Administrator, on 08/22/13 at 4:10 PM, revealed that he did not consider the resident's exit on 07/30/13, an elopement as the resident had a motive to go to grocery store to buy a soda, and the resident could also tell him the date. Furthermore, the Administrator stated "we let the residents go and come as they please", based on the resident's response, "I don't feel it was an elopement". Interview also revealed Resident #1 and other residents knew the code on the door and were safe to be outside unsupervised and could come and go as they pleased. Even though the facility had assessed Resident #1 with severe cognitive impairment and the resident was not his own responsible party.</p> <p>In addition, the facility's policy and procedure "Elopement", dated 01/2008, revealed "upon</p>	F 490	<p>have been re-educated by the Manager of Clinical Operations to the center Elopement Policy and Procedures.</p> <p>4. The Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and/or Maintenance Director will conduct missing resident/elopement monthly x12 months on varied shifts, and report results to Performance Improvement Committee monthly for further review and recommendations. The Administrator and/or Maintenance will conduct observations of center exit doors five times weekly x4 weeks and then monthly x11 months, at varied times, to validate that residents nor visitors are aware of center door codes, and report results to the Performance Improvement Committee monthly for further review and recommendations. The Director of Nursing and/or Assistant Director of Nursing will review nursing assessments, care plans, and nurse aide Care Cards of new/re-admissions within 72 hours, and current residents upon new exit seeking/wandering behavior, quarterly and with any significant change to validate that resident assessments are</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 28</p> <p>return of resident to the facility, an Elopement Risk Evaluation would be completed and /or updated and the resident care plan would be reviewed and updated as necessary'. However, record review revealed no Elopement Risk Assessment was completed on 07/30/13, when the resident was returned to the facility. This failure prevented the facility from revising the resident's care plan to establish effective interventions to prevent future elopement recurrence for this resident and the resident left the facility premises again on 08/17/13.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 08/28/13, that alleged removal of the IJ effective 08/24/13. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1) On 08/17/13, Resident #1 was placed on 1:1 supervision, a head to toe assessment was completed by licensed nurse, no injuries were identified, wander guard was tested for functionality and then placed on the resident. 2) A head count of residents residing in the facility was completed on 08/17/13, by the licensed nurse to validate all residents were accounted for. 3) The Administrator and ADON validated that all doors and alarms were working properly on 08/17/13. 4) Residents residing in the facility were reviewed by licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans to address risk of elopement on 08/17/13. 	F 490	<p>complete, to include the "Resident Elopement Risk Screen and Assessment Tool" and the determination for the need of supervision with outdoor activities. Results of these reviews will be submitted by the Director of Nursing or Administrator to the Performance Improvement Committee monthly for further review and recommendation</p>	

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

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F 490	Continued From page 29 5) One hundred percent (100%) of residents in the facility were assessed by the licensed nurse using the "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement on 08/23/13. Using this assessment tool the licensed nurse updated the resident care plan, care card and also identified each resident to either require or not require supervision for outdoor activities. 6) Administrator, DON, and ADON initiated re-education to all staff on 08/17/13, and completed on 08/21/13. The topics reviewed were Elopement Management Program to include procedure for missing resident, response to door alarm, that facility door codes were changed, new facility policy to not give door codes to any resident or visitor. 7) The Maintenance Director changed all door codes on 08/19/13. 8) The Administrator, DON, and ADON, was re-educated on 08/23/13 by the Manager of Clinical Operations to the facility's Elopement Policy and Procedures. 9) The Administrator, DON, ADON, and/or Maintenance Director will conduct missing resident/elopement drills three (3) times weekly on varied shifts, and report results to QA Committee monthly for further review and recommendations. 10) The Administrator and/or Maintenance will conduct observations of facility exit doors five (5) times weekly, at varied times, to validate that residents nor visitors are aware of the door codes, and will report findings to the QA	F 490			

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

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F 490	<p>Continued From page 30 Committee monthly for further review and recommendations.</p> <p>11) The DON/ADON will audit elopement assessments on admission, readmission, annual, quarterly and significant change assessments, to ensure care plans, care cards and elopement assessments are complete.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <p>1) Review of the resident record revealed that 08/17/13, Resident #1 was placed on 1:1 supervision, a head to toe assessment was completed by licensed nurse, no injuries were identified, wander guard was tested for functionality and then placed on the resident.</p> <p>2) Review of the facility investigation binder revealed a head count was conducted on all residents residing in the facility on 08/17/13, by the licensed nurse to validate all residents were accounted for.</p> <p>3) Review of the facility's investigation binder revealed the Administrator and ADON validated that all doors and alarms were working properly on 08/17/13.</p> <p>4) Review of Residents elopement assessments revealed that all residents residing in the facility were reviewed by licensed nurses to determine that residents with elopement potential had appropriate assessments, devices as necessary, care plans to address risk of elopement on 08/17/13.</p> <p>5) Review of random residents records revealed</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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	
F 490	Continued From page 31 all residents in the facility were assessed by the licensed nurse using the "Resident Elopement Risk Screen and Assessment Tool" to further identify residents at risk for elopement on 08/23/13. Using this assessment tool the licensed nurse updated the resident care plan, care card and also identified each resident to either require or not require supervision for outdoor activities 6) Review of the facility's investigation binder revealed that the Administrator, DON, and ADON initiated re-education to all staff on 08/17/13, and completed on 08/21/13. The topics reviewed were Elopement Management Program to include procedure for missing resident, response to door alarm, that facility door codes were changed, new facility policy to not give door codes to any resident or visitor. Interviews on 08/30/13 at 9:32 AM, with Licensed Practical Nurse (LPN) #1, at 9:32 AM with LPN #2, at 10:10 AM with LPN #3 at 9:40 AM with Registered Nurse (RN) #1, at 8:20 AM with RN #2, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors and when to complete elopement assessments. Interviews on 08/30/13 at 9:25 AM with SRNA #1, at 9:10 AM with SRNA #2, at 10:40 AM with SRNA #3, at 10:30 AM with SRNA #5, at 10:50 AM with SRNA #4, and at 8:30 AM with SRNA #6, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors. Interviews with other facility staff on 08/30/13, at	F 490			

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F 490	Continued From page 32 9:35 AM with Occupational Therapist, at 9:00 AM with House Keeping (HK) #1, at 10:45 AM with HK #2, at 8:15 AM with HK #3, at 9:05 AM with Activities/SRNA, at 9:20 AM with Cook #1, at 8:25 am with Cook #2, revealed they were all aware of the Elopement Management Program, procedure for missing resident, facility door codes changed and not to give codes to residents or visitors. 7) Review of the facility's investigation binder revealed that the Maintenance Director changed all door codes on 08/19/13, and will change the codes anytime it is determined that a resident or visitor knows the code. 8) Review of the facility's investigation binder revealed that the Administrator, DON, and ADON, was re-educated by the Manager of Clinical Operations to the facility's Elopement Policy and Procedures on 08/23/13. 9) Review of the facility's investigation binder revealed that the Administrator, DON, ADON, and/or Maintenance Director conducted missing resident/elopement drills on 08/18/13, 08/19/13, and 08/20/13 on all three shifts. 10) Review of the facility's investigation binder revealed that the Administrator and/or Maintenance conducted observations of facility exit on 08/18/13, 08/19/13, 08/20/13, and 08/21/13, at varied times, and the door codes have been changed due to a visitor was aware of the door codes. The findings will be reported to the QA Committee monthly for further review and recommendations. 11) Interview with the DON, on 08/30/2013 at 11:10 AM, revealed that the DON/ADON will audit	F 490			

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F 490	Continued From page 33 all elopement assessments on admission, readmission, annual, quarterly and significant change assessments during the dally Clinical Meeting, to ensure care plans, care cards and elopement assessments are complete.	F 490			