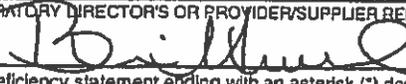


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE 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)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An Abbreviated Survey was initiated on 09/24/14 and concluded on 10/03/14 to investigate KY 22267. The Division of Health Care substantiated the allegation and identified Immediate Jeopardy on 09/25/14. The Immediate Jeopardy was determined to exist on 09/19/14 at a scope and severity of a "J" at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) with Substandard Quality of Care at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>On 09/19/14 at 6:44 PM, Resident #1 exited the facility without staff knowledge. Interview and review of the facility's video surveillance revealed Resident #1 was near the exit door to the 100 Unit when staff entered the code to the exit door for two visitors to leave the facility, and Resident #1 exited the facility with the two (2) visitors. At approximately 6:52 PM, the Maintenance Director was returning to the facility and saw Resident #1 on the sidewalk of the two (2) lane street moving towards the intersection of a six (6) lane street. The Maintenance Director stopped to retrieve the resident when he saw the resident with Certified Occupational Therapy Assistant (COTA) #1. The Maintenance Director returned to the facility and called a Code Green to alert staff of the elopement of Resident #1. Staff was not aware Resident #1 had eloped until the code was called. The resident was returned to the facility at 6:58 PM and assessed with no injuries.</p> <p>The facility provided an acceptable Allegation of</p>	F 000	<p>Signature HealthCARE of East Louisville does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>Immediate Jeopardy Concern Stated: Facility was notified on 10/28/14, that the previously cited 221 at a "D" level was being changed to a 221 at an Immediate Jeopardy level with the scope not identified. Facility was instructed to complete an Allegation of Completion and turn in as soon as possible.</p> <p>Resident(s) affected by the IJ and actions taken to remove IJ:</p> <p>The only resident identified as being affected the immediate jeopardy is the resident that was reported in the elopement (Resident #1). The facility took the following actions to remove the IJ:</p> <p>Facility was notified by the two surveyors on 9/30/14 that they had witnessed Resident #1's wheelchair brakes in a locked position on 2 occasions on 9/29/14. Resident #1's high back reclining wheelchair had brakes installed in the rear of the chair. On 9/30/14, the facility Maintenance Director conducted an audit of all high back reclining wheelchairs with no other chairs identified as having the breaks out of the residents reach.</p>	11/17/14	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 			TITLE Administrator		(X6) DATE

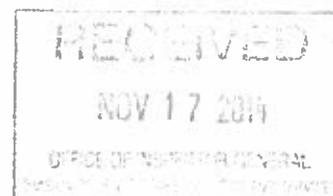
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF SUPERVISOR
INSPECTION

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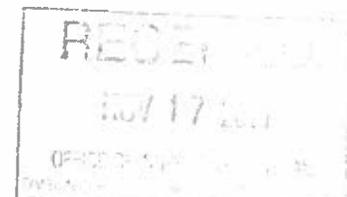
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F 000	Continued From page 1 Compliance (AOC) on 09/30/14 that alleged removal of Immediate Jeopardy on 09/23/14. However, the State Survey Agency (SSA) verified Immediate Jeopardy was removed on 10/03/14; after training of facility staff was verified completed on 10/02/14, at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) with the scope and severity lowered to a "D" while the facility monitors the effectiveness of the implemented plan of correction. An additional deficiency was cited at 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) at a scope and severity of a "D". After supervisory review and consultation with the Centers for Medicare and Medicaid Services (CMS), the scope and severity for 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) was changed to a "J". The facility was notified on 10/28/14 and the SSA reopened the survey on 10/28/14. The facility provided a second acceptable credible Allegation of Compliance (AOC) to address the Immediate Jeopardy at 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) on 10/31/14 alleging removal of Immediate Jeopardy on 10/29/14. The SSA verified Immediate Jeopardy was removed on 10/29/14 prior to exit on 11/07/14 at 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) with the scope and severity lowered to a "D" while the facility monitors the effectiveness of the implemented plan of correction.	F 000	Resident was assessed by the Psych APRN on 9/22/14 for any psychosocial effects related to his high back reclining chair. Resident voiced to the APRN that he recognized he was in a different chair, but voiced that his chair was switched because his new chair is more comfortable for him. APRN notes indicated that he was sitting in the wheelchair, reading at the bedside and that he was engaged in the conversation. APRN notes indicate no recommendations as resident was of his normal cognition with no noted negative effects of the new wheelchair. Quality of Life director assessed resident on 9/20/14. QOL director notes indicated that she will provide 1:1 visits twice weekly during his transition period to ensure adequate activity programming. The goals of these visits were to provide sensory stimulation and socialization. On 10/01/14, the facility held a QA meeting with the Medical Director, Administrator, Director of Nursing, Social Worker, Rehab, Maintenance Director, MDS nurse, ADON and Nurse Consultant. In this meeting, we discussed Resident #1 and the placement of the brakes on his chair, therapy interventions which consisted of working on upper body strength, manual chair mobility and positioning. We also reviewed therapy's assessment from 9/30/14, of his ability to maneuver the manual chair independently throughout the facility and from unit to unit and the determination was made to schedule a safety assessment with the power chair. The QA team also discussed any additional interventions needed in addition to activities and therapy involvement and no other interventions were initiated at this time. QA team determined to review resident comprehensively every 30 days x3 months, then quarterly to determine his psychosocial needs, alternative activities and nursing interventions for any needed changes. We also reviewed Restraint and Resident Rights policy. No Policy and Procedure changes were made.	
F 221 SS=J	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any	F 221		



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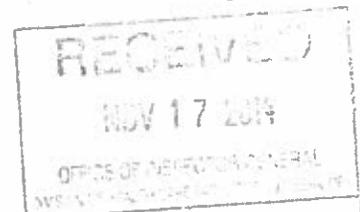
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F 221	<p>Continued From page 2</p> <p>physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's investigation and policy and procedures, and the Centers for Medicare and Medicaid (CMS) RAI Manual 3.0, it was determined the facility failed to assess the use of a high back, reclining wheelchair as a potential restraint for one (1) of seven (7) sampled residents, Resident #1. The facility staff replaced Resident #1's electric wheelchair with a manual operating, high back, reclining seat, wheelchair (w/c) after the resident eloped from the facility on 09/19/14. Additionally, the w/c locks on the manual w/c were located on the back of the w/c, out of the reach of the resident, and observed in the locked position on 09/29/14.</p> <p>The facility's failure to ensure restraint assessment and interventions were implemented placed Resident #1 and other residents at risk in a situation that has caused or is likely to cause serious injury, harm, impairment or even death to a resident.</p> <p>The Immediate Jeopardy was determined to exist on 09/19/14 at a scope and severity of a "J" at 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) with Substandard Quality of Care at 42 CFR 483.13 Resident Behaviors and Facility Practice and the facility was notified of the Immediate Jeopardy on 10/28/14. The facility provided a second acceptable credible Allegation of Compliance (AOC) to address the Immediate</p>	F 221	<p>On 10/01/14, after the QA meeting, the Maintenance Director relocated the brakes that were previously located in the back to the front of the wheelchair. After the brakes were moved, the resident was assessed for restraints by the DON and it was determined that the wheelchair does not constitute a restraint as resident is able to use the brakes on command and he is able to propel the wheelchair independently from one unit to the next. The DON also made an observation on 10/1/14 of the resident correctly using the wheelchair brakes 5 out of 5 times. Resident is being observed 5 times weekly to ensure his consistent ability to use the wheelchair brakes by the DON, ADON and RN's. This will be documented on a calendar form and will be reviewed by the Administrator or DON weekly.</p> <p>On 10/1/14, after the Maintenance Director relocated the brakes to the front of the wheelchair, resident was assessed for restraints by the DON and it was determined at that time that the resident was able to propel his wheelchair freely around the facility.</p> <p>Therapy attempted to complete an Electric Wheelchair motorized scooter assessment on 10/01/14 with the resident and family. At that time the family was not able to come in, but did schedule for 10/2/14. This was again attempted on 10/02/14 with the family and resident declining the assessment. The assessment was completed on 10/03/14 with the family present. As of the assessment on 10/3/14, it was determined by the therapist that the resident exhibited inconsistent performance with the chair placing him and others at risk. He complained of back pain while in the power chair and reports that he does better in the manual chair. A pain assessment was completed on 10/3/14 by the ADON and resident denied any discomfort, once he was back in his high back reclining chair.</p>		



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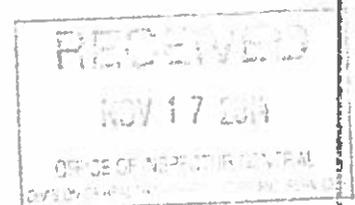
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F 221	<p>Continued From page 3</p> <p>Jeopardy at 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) on 10/31/14 alleging removal of Immediate Jeopardy on 10/29/14. The State Survey Agency verified Immediate Jeopardy was removed on 10/29/14 as alleged at 42 CFR 483.13 Resident Behaviors and Facility Practice (F221) with the scope and severity 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 Federal Resident/Patient Rights, reviewed August 2009, revealed the resident had the right to be free from any physical restraints that were not required to treat the resident's medical symptoms and were not administered for the purpose of discipline or convenience.</p> <p>Review of the facility's policy Restraints/Emergency Application, effective December 2010, revealed safety devices were used as a temporary emergency device to provide safety and prevent injury to a resident. Documentation should include the reason for use and other alternative interventions that had been used with outcomes.</p> <p>Review of the facility's policy Physical Restraint Reduction Program, effective December 2010, revealed residents should be free of any physical restraints imposed for the purpose of discipline or staff convenience. The facility would not use restraints except when other alternatives were not appropriate. Use of physical restraints would only be considered to treat a medical symptom/condition and as a last resort after a trial period where alternative, less restrictive measures had</p>	F 221	<p>On 10/6/14, 10/13/14, 10/20/14 and 10/27/14 the DON, ADON, Social Services and MDS reviewed residents care plan for any needed changes and to address any concerns identified specific to Resident #1. It was determined that resident's care plan is current and appropriate. He is continuing to improve his mobility in his wheelchair, continues to work with therapy, still attending dining room for meals as well as activities of choice. It was determined by the DON that care plan reviews would occur monthly x3 then quarterly thereafter.</p> <p>120 residents were assessed for restraints on 10/27/14 by the DON, ADON and RN's. Considerations were made to different types of restraints which included standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, broda chairs, geri chairs, seat belts and side rails. Only one resident was identified as having a restraint. This resident had previously been identified and currently has an existing care plan for her restraint. This resident's care plan was reviewed on 10/28/14 by the MDS coordinator and no changes were made to the care plan. The MDS coordinator was educated on Resident rights, restraint application and care plans on 10/28/14.</p> <p>The Administrator, DON, SDC and MDS coordinator was educated on 10/28 by the Signature Nurse Consultant on Restraint application and Residents Rights.</p> <p>Training:</p> <p>On 9/30/14, immediate education of all staff members working in the facility was completed by the Staff Development Coordinator on the wheelchair brake placement as well as not locking of wheelchair brakes except for transfers and for patient safety. By 10/28/14, 135 staff members have been trained with 63 employees to be trained. On 10/28/14, the facility was informed the level of deficiency has changed from a "D" level to an "U" level. As a result of this change, the facility has changed its training and this education will be ongoing with no staff member being allowed to work their shift prior to the education being completed. This education</p>		



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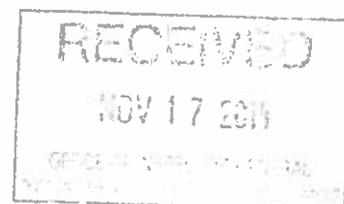
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F 221	<p>Continued From page 4</p> <p>been used and proven unsuccessful. Also, restraints would be used with informed consent of the resident or legal representative. A physical restraint was any mechanical device which restricted the resident's freedom of movement. The facility would evaluate the resident's condition prior to the use of a restraint for potential concerns using the pre-restraint assessment. The restraint would be explained in advance to the resident and family and an informed consent for use of the restraint should be obtained. A restraint would be care planned with a goal to reduce the use of the restraint. The facility should use other nursing measures, diversion programs, activity programs, and supervision to control behavior when possible.</p> <p>Review of the CMS RAI Version 3.0 Manual, dated 05/13, Section P-1, revealed physical restraint was defined as any manual, physical, or mechanical device the resident could not remove easily and restricted freedom of movement. Restraints should be used as a short-term, temporary intervention to treat a resident's medical symptoms and should not be used for discipline or convenience. Before a resident was restrained the facility must determine the presence of a medical symptom that required the restraint and how the restraint would treat the medical symptom, protect the resident's safety, and assist the resident to attain or maintain his/her highest practicable level of physical and psychosocial well-being. The assessment should be used to identify specific reasons for the restraint. The resident care plan based on the conclusions of the assessment should address the underlying physical or psychological condition that led to the restraint with a goal to eliminate the restraints use by employing alternatives.</p>	F 221	<p>covers restraint policy and procedure to include the types of restraints, when to utilize the restraints, assessing restraints, obtaining physician orders and updating care plans. This education will be provided to all employees in all departments including administration, LPNs, RNs, CNAs, Dietary, Housekeeping, therapy, laundry, activities and social services. The training was provided by DON, ADON, RNs, Admin and dept. heads. This will continue until all staff members receive the education. Staff development coordinator will ensure that all remaining staff members receive their training before working and will educate all new hires prior to starting orientation.</p> <p>This facility does not utilize agency staff.</p> <p>Monitoring:</p> <p>The facility began monitoring on 10/01/14 and has been performing 10 observations per week of Resident #1's wheelchair brakes to make sure that they are not locked by staff and that resident is able to propel his wheelchair throughout facility. These audits are being completed by Admin, DON, dept head team and RN supervisors. An audit of all standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, broda chairs, geri chairs, seatbelts and side rails will be conducted on each unit weekly to determine if residents' movements are restricted by their wheelchair by DON, ADON or RN x12 weeks. These audits are being collected weekly by the administrator and reviewed for tracking/trending. The monitoring will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p> <p>Alleged removal of LJ:</p> <p>The facility feels that the removal of the jeopardy occurred on 10/29/14.</p>		



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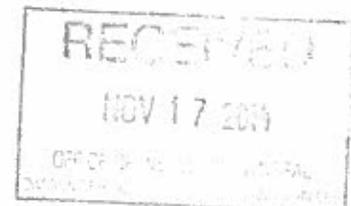
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F 221	Continued From page 5 Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/27/11. The admission Minimum Data Set (MDS) assessment for Resident #1 was completed on 06/03/11, and the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of six (6). The facility re-admitted the resident on 11/26/13 with diagnoses of Dementia, General Muscle Weakness, and Above Knee Amputation. The facility completed an annual MDS assessment on 02/03/14 with a BIMS score of eight (8). The facility completed a quarterly MDS on 09/06/14 with a BIMS score of four (4). The facility assessed the resident's functional status as independent for locomotion to other areas of the facility and self-sufficient in his/her electric w/c. Record review revealed, on 09/19/14, Resident #1 exited the facility without staff knowledge and was found off the facility property, propelling his/her electric wheelchair towards the intersection of a six (6) lane highly traveled street. Review of Resident #1's elopement risk assessment, dated 09/19/14, revealed the facility and Medical Director (MD) chose to allow Resident #1 only the use of the electric w/c when one to one (1:1) with family, when they were available in the facility. Review of the facility's Pre-Restraining Assessment form, dated 09/19/14 for Resident #1, revealed the form should be completed to adequately assess all aspects of a resident's well-being prior to the use of physical restraints in order to identify the least restrictive intervention. The facility assessed the resident with no	F 221	What corrective action will be accomplished for those residents found to have been affected? Resident #1's brakes were moved to the front position of his chair within his reach on 9/30/14 by the maintenance director. Resident was assessed for restraints by the DON, Admin, ADON, social services and therapy on 10/1/14. How will the facility identify other residents that have the potential to be affected? All residents were assessed for restraints on 10/27/14 by the DON, ADON. Considerations were made to different types of restraints which included standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, broad chairs, geri chairs, seatbelts and side rails. Only one resident was identified as having a restraint. This resident had previously been identified and currently has an existing care plan for her restraint. This resident's care plan was reviewed by the MDS coordinator on 10/28/14 and no changes were made to the care plan. All residents' wheelchairs were assessed for proper brake placement by maintenance director and assistant on 10/24/14. No additional residents were identified. What measures will be put into place to ensure that the deficient practice will not recur? All staff has been educated on the use restraints, types of restraints, residents rights, restraint elimination, care plans, locking of wheelchair brakes and brake placement by the staff development coordinator, DON, ADON or RN's on 10/2/14. An audit of all standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, broad chairs, geri chairs, seatbelts and side rails will be conducted on each unit weekly to determine if residents' movements are being restricted by DON, ADON or RN x12 weeks. Wheelchair brake audits will be completed weekly x12 weeks by social services, housekeeping director, maintenance director and department heads to ensure that staff is not locking brakes inappropriately.	11/28/14	



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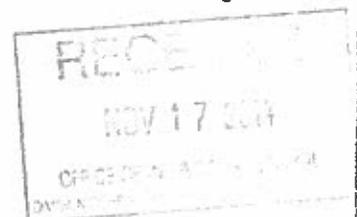
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F 221	<p>Continued From page 6</p> <p>concerns of falling forward or sideways, the resident did not slide down, or slump, all while seated due to the resident being a double amputee. The facility assessment also revealed no medical factors affected the resident's behavior; however, a recent elopement in the power w/c was added. The assessment recommendation stated to allow the resident to only use the power chair when family visited due to the need for 1:1 supervision when in the power chair.</p> <p>Review of Resident #1's care plan revealed the care plan was revised on 09/19/14 after the resident's elopement, with an intervention to encourage the resident to use the regular w/c versus the motorized w/c, schedule a family care plan meeting, and refer to Occupational Therapy for w/c positioning. Additionally, the resident could be up in the power chair when family visited; otherwise, the resident should use the high back reclining w/c for safety and positioning. The care plan did not specify how long to use the manual wheelchair, a plan to assess Resident #1 for reduction of the high back w/c; the location of the manual w/c locks; or if any other alternative interventions were used with the outcomes. The updated facility care plan for self-care, on 09/19/14, specified to use a manual w/c with the electric w/c discontinued. The care plan for activities, revised 09/19/14 per physician (MD) order, revealed the facility would provide 1:1 activity visits twice per week for socialization. A Care Plan Conference Summary, dated 09/22/14, revealed Resident #1's family was present for the meeting, and they had concerns for Resident #1's quality of life since the use of the electric w/c would be limited; however, the resident would be able to use the electric w/c when he/she had</p>	F 221	<p>How the facility will monitor its performance to ensure solutions are sustained.</p> <p>The administrator will review the results of the audits weekly and forward the results of the audits to the monthly Quality Assurance Committee for further review and recommendation. The audits will be presented by the Admin and DON weekly for 3 months, then monthly x3 months to the QAPI team for review and recommendation based upon the results.</p>		



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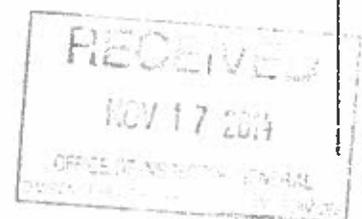
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F 221	<p>Continued From page 7 visitors.</p> <p>Review of the quarterly Social Services notes for Resident #1, dated 05/05/14, 06/07/14, revealed the resident used an electric w/c for mobility. A quarterly Social Service Review on 09/06/14 revealed the resident was at risk for elopement and he/she used an electric w/c. On 09/20/14, a Social Services note revealed the resident's family was informed that Resident #1 would use a manual w/c and could only use the electric w/c when he/she had visitors. The family member was informed the resident would be given a high back reclining w/c and was referred to therapy for positioning.</p> <p>Review of the facility's therapy screening form, dated 09/20/14, completed by Certified Occupational Therapy Assistant (COTA) #2 revealed Resident #1 had been referred for therapy due to an incident report, related to Resident #1's elopement on 09/19/14. The resident was identified with difficulty using the manual w/c and had been previously in a power w/c. Resident #1 required assessment for w/c positioning and safety with a speech therapy evaluation for cognition.</p> <p>Review of the Occupation Therapy Evaluation and Plan of Treatment, completed on 09/22/14, revealed Resident #1 had a diagnosis of Generalized Muscle Weakness. A short term goal included to increase the ability to self-propel twenty (20) feet to increase functional mobility throughout the facility, with a long term goal of one hundred (100) feet. The resident was assessed to have intact fine motor and gross motor coordination. The facility assessed the resident with total dependence for w/c mobility</p>	F 221			



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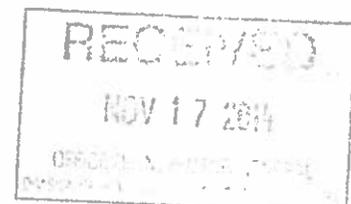
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F 221	<p>Continued From page 8 and management in the manual w/c. The assessment noted the resident had run into doors and walls when using the electric w/c.</p> <p>A Speech Therapy Evaluation and Plan of Treatment, dated 09/22/14, revealed the resident was referred due to a recent elopement. The assessment determined the resident appeared at baseline cognitively.</p> <p>Review of a blank facility Electric Wheelchair/ Motorized Scooter Assessment form, not dated, revealed an assessment would include cognition, physical, and functional areas to determine if the resident had demonstrated an acceptable or unacceptable ability to safely operate the electric w/c. The facility did not provide any completed Electric Wheelchair Assessments for Resident #1 since the facility initially admitted the resident on 05/27/11.</p> <p>Review of the Psychiatrist note, dated 09/22/14, revealed Resident #1 recognized he/she was in a different chair. The resident was quite mobile in the electric w/c and the facility was concerned about the resident's ability to travel within the facility quickly which was the incentive for moving the resident to a manual w/c when he/she did not have visitors.</p> <p>Upon request, the facility did not provide a resident or family consent for the use of a restraint.</p> <p>Observation, on 09/24/14 at 7:52 AM, revealed the resident was sitting in a manual, high back, reclining seat, wheelchair in the dining room for breakfast.</p>	F 221			



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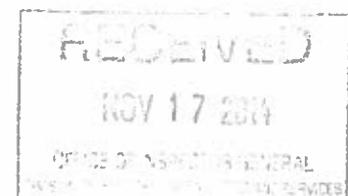
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F 221	<p>Continued From page 9</p> <p>Interview with Resident #1, on 09/25/14 at 3:45 PM, revealed he/she was "scolded" for leaving the facility and the facility "took his/her chair away".</p> <p>Observation, on 09/26/14 at 3:38 PM, of Resident #1's electric w/c revealed the chair was stored in the 200 Unit's locked medication room.</p> <p>On 09/26/14 at 3:48 PM and 09/29/14 at 11:46 AM, observations of Resident #1 revealed he/she was in bed with eyes closed. A manual high back reclining w/c with anti-tippers was next to the bed. The w/c was partially hidden by the privacy curtain.</p> <p>Observation, on 09/29/14 at 12:00 PM, of Resident #1 revealed staff wheeled the resident to the dining room. At 1:20 PM the resident was sitting in a manual w/c next to his/her bed watching TV. At 2:25 PM the resident was sitting in the hallway at the double doors. At 2:50 PM the resident was outside smoking. The w/c locks were located behind the resident and the resident could not reach the locks to release them.</p> <p>Observation of Resident #1, on 09/29/14 at 12:04 PM, revealed the resident was in the manual w/c on the 200 Unit hallway. The resident was a bilateral above the knee amputee. The resident's w/c was pushed by staff to the dining room.</p> <p>Observation, on 09/29/14 at 2:23 PM, Resident #1 was in the manual w/c in the 200 Unit hallway. At 2:26 PM the Assistant Director of Nursing (ADON) for the 200 Unit pushed the resident's w/c toward the dining room and out to the smoking patio. The ADON locked the resident's w/c once the resident was pushed out to the</p>	F 221		



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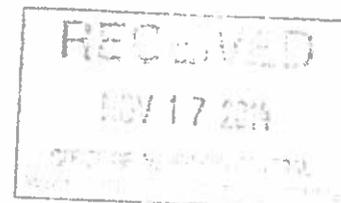
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F 221	<p>Continued From page 10</p> <p>smoking patio. The w/c locks were located behind the resident at the back of the w/c. Observation at 2:46 PM of the smoking patio revealed Resident #1 was independently smoking and the w/c locks were in the locked position.</p> <p>On 09/29/14 at 3:23 PM, observation of Resident #1 revealed the resident was unable to reach the locks at the back of the w/c.</p> <p>Observation of Resident #1, on 09/29/14 at 4:04 PM, revealed the resident was in the assisted dining room for a movie activity and was talking with the Activities Director (AD). The AD then unlocked the w/c locks and pushed the resident to the 200 Unit nurse's station for the resident to speak with the unit ADON.</p> <p>On 09/30/14 at 9:12 AM, interview with CNA #7 revealed the resident was in a manual w/c and she was unaware of the resident using an electric w/c when the family visited. Additionally, the aide stated she did not know where Resident #1's electric w/c was kept. The CNA stated the manual w/c locks were located at the back of the resident's w/c and the resident would not be able to reach the locks. She indicated if the w/c locks were used and the resident could not reach the locks, the resident would not be able to go anywhere, or get around the facility.</p> <p>Continued interview, on 09/29/14 at 3:23 PM, with Resident #1 revealed he/she did not get around very well since he/she was no longer in the electric w/c. The resident stated when the electric w/c was taken away he/she felt "naked". Additionally, Resident #1, stated the facility "scolded" him/her for leaving the building. Resident #1 indicated he/she was unable to</p>	F 221			



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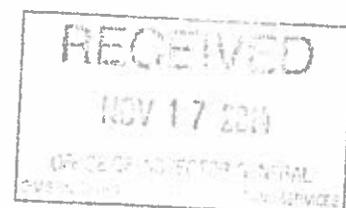
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F 221	<p>Continued From page 11</p> <p>unlock the w/c when the locks were used. The resident stated he/she missed his/her electric w/c.</p> <p>Interview, on 09/26/14 at 3:02 PM, with the Social Services Director (SSD) revealed Resident #1 had eloped from the facility on 09/19/14. She stated the resident displayed safety concerns in the electric w/c as he/she was able to roll around and get out of the building as quickly as he/she did. The SSD indicated she was unaware if staff placed the resident in the electric w/c when the family visited. She further indicated she had viewed the facility video which showed how quickly Resident #1 had moved from the unit and out the door. The SSD stated the facility took the resident's electric w/c and would provide it when the resident would have 1:1 supervision when the family visited. She further stated the resident was safer in the manual w/c as he/she was not able to get around the facility as quickly. The SSD further indicated she was unsure if Resident #1 was still as mobile as he/she had been in the electric w/c.</p> <p>On 09/26/14 at 3:35 PM, interview with the 200 Unit ADON revealed Resident #1's family visited the resident earlier in the week; however, the family was not offered the use of the electric w/c and the family would need to request it. The ADON indicated Resident #1 was not as quick in the manual w/c as he/she was in the electric w/c.</p> <p>Interview, on 09/26/14 at 3:50 PM, with COTA #1 revealed Occupational Therapy (OT) Services had started for Resident #1 after the elopement. She stated there was a difference in mobility for Resident #1 in the manual w/c. The resident was not able to go everywhere in the building like</p>	F 221			



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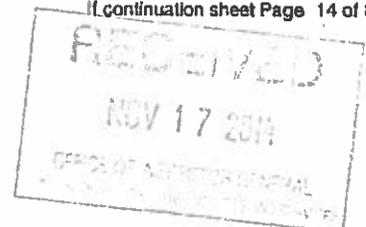
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F 221	<p>Continued From page 12</p> <p>when he/she had been in the electric w/c. The COTA further indicated the resident could self-propel in the manual w/c twenty-five (25) feet. She stated the resident's mobility was limited and she was unsure if the resident would be able to propel an entire hall.</p> <p>On 09/29/14 at 3:05 PM, interview with Registered Nurse (RN) #5 revealed she had not seen Resident #1 on the 300 Unit as much as she used to see him/her when he/she was in the electric w/c.</p> <p>Interview with RN #2, on 09/24/14 at 3:10 PM, revealed Resident #1 was constantly roaming the facility before the electric w/c was taken away.</p> <p>Interview with COTA #1, on 09/25/14 at 4:24 PM, revealed Resident #1, constantly, during waking hours, roamed the facility and frequently sat in front of exit doors before the electric w/c was taken away.</p> <p>On 09/26/14 at 4:18 PM, interview with the Assistant Dietary Manager revealed he supervised the scheduled 2:30 PM smoke time for residents. He stated Resident #1 would normally attend the 2:30 PM smoke break, and would arrive around 1:30 PM. The Assistant Dietary Manager revealed he had not seen Resident #1 smoke at the 2:30 PM smoke time since the resident's electric w/c had been replaced with the manual w/c.</p> <p>Interview, on 09/29/14 at 2:31 PM, with the Therapy Director revealed she was unaware who made the decision to place Resident #1 in a</p>	F 221			



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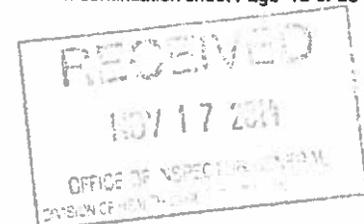
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F 221	<p>Continued From page 13</p> <p>manual w/c; however, the Director of Nursing (DON) made a referral after Resident #1 eloped from the facility on 09/19/14 for therapy to evaluate the resident. The Therapy Director indicated the therapy assessment for Resident #1 was completed on 09/22/14. She further indicated the resident could use the electric w/c when a family member was with him/her. She stated it was unsafe for Resident #1 to leave the building without staff and unsupervised.</p> <p>Interview, on 09/29/14 at 3:44 PM, with the Activities Director (AD) revealed after Resident #1 eloped from the facility the facility staff put the resident on 1:1 visits from the Activity Department for socialization. She indicated she participated in the care plan meeting with the resident's family on 09/22/14. The AD further indicated if the resident remained in the power chair, he/she would need someone to be with him 1:1 so he/she would not elope from the facility again. The AD revealed the manual w/c helped to prevent elopement as the resident was slower in the manual w/c.</p> <p>Interview with RN #1, on 09/30/14 at 9:37 AM, revealed Resident #1 needed to be in a high back w/c unless the family visited and requested the motorized w/c. She further revealed the facility did not want the resident to access the electric w/c or try to get to it. RN #1 stated Resident #1 was faster in the electric w/c and his/her mobility in the manual w/c was slow. She indicated the resident did not go to the places he/she used to and wandered less. The RN stated the resident used to take him/herself to smoke and activities; however, staff now had to escort him/her. She indicated with the locks on the back of the w/c the resident would not be able to unlock the w/c.</p>	F 221		



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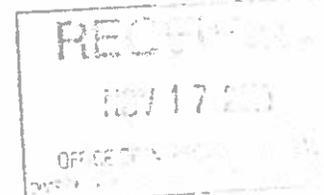
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F 221	<p>Continued From page 14</p> <p>Additionally, the nurse stated if the resident could not unlock the w/c then the w/c would be a restraint.</p> <p>Continued interview with the SSD, on 09/30/14 at 12:35 PM, revealed Resident #1's family did not initially agree to the change in the w/c. She also stated when a family visited a resident and took the resident outside, the family was responsible to supervise the resident. The SSD indicated the manual w/c prevented elopement as the w/c reduced the resident's speed. She further indicated the resident got around quickly in the electric w/c and the manual w/c slowed him/her down.</p> <p>On 09/30/14 at 1:34 PM, interview with COTA #1 revealed Resident #1 was not in a position to lock the w/c as he/she did not transfer independently. She stated if staff locked the w/c the resident would need to ask someone to unlock the w/c. The COTA indicated Resident #1's manual w/c was the only chair available at the time. She further indicated when an assessment was completed the assessment would include use of the w/c locks. She stated the resident had not been assessed after the elopement for continued use of the electric w/c. The COTA further stated when the w/c was locked it could be a restraint, as well as anything that could limit or inhibit the resident's ability to move. She stated Resident #1's manual w/c was structurally different from the other reclining w/cs in the facility.</p> <p>Interview with the 200 Unit ADON, on 09/30/14 at 2:53 PM, revealed the facility intervention after Resident #1 eloped was to take away his/her electric w/c, although the resident moved around well in the electric w/c. He stated the resident</p>	F 221			



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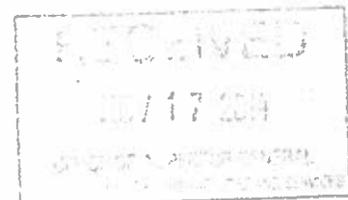
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F 221	<p>Continued From page 15</p> <p>was not as mobile or as quick in the manual w/c. The ADON indicated the manual w/c locks were located on the back of the w/c and he was unaware of the resident attempting to self-transfer. He further indicated the resident's mobility was less in the manual w/c when compared to the electric w/c. The ADON stated the manual w/c was safer for the resident as the electric w/c was so fast. He further indicated he was unaware of a plan by the facility for the resident to return to the electric w/c. The ADON stated he had not asked Resident #1 to try to un-lock the manual w/c locks located at the back of the w/c. He indicated if the locks were used and the resident could not reach the locks, the resident would be immobile and restrained.</p> <p>On 10/01/14 at 8:56 AM, interview with the Director of Nursing (DON) revealed that on 09/19/14 Resident #1 had gone from one end of the building to the other end and exited the facility within four (4) to five (5) minutes. She stated the facility considered fifteen (15) minute checks and 1:1 supervision; however, the facility decided to give the resident a manual w/c to use instead of the electric w/c. The DON indicated on 09/20/14 therapy was asked to see the resident to determine positioning, maneuvering, and if the resident was safe in the manual w/c. She further indicated a therapy assistant completed a screen of Resident #1 on 09/20/14; however, a therapist was not at the facility until 09/22/14. The DON indicated the resident's electric w/c was changed to a manual w/c due to Resident #1 having moved so quickly from one end of the building to the other. It was determined a high back reclining w/c would slow down the resident and help prevent the resident from eloping from the facility. She further indicated the electric w/c contributed</p>	F 221			



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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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F 221	Continued From page 18 to the resident's elopement. The DON indicated the facility would encourage the resident to use the manual w/c; however, the resident did not have to use it. She further indicated the electric w/c was stored in the medication room and the resident did not have access to it. She stated the resident could use the electric w/c when the family visited as the resident would need 1:1 due to his/her ability to go anywhere in the facility. The DON could not state why the resident could not use the electric w/c when 1:1 with activities, when the resident could use the electric w/c when 1:1 with family. The DON indicated Resident #1 was the only resident in the facility with locks at the back of the w/c and this was the only w/c available at the time. She indicated if the resident could not reach the locks at the back of the w/c, and the locks were applied, the resident's movement would be restricted. She also indicated any device that restricts movement would be considered a restraint. The DON had completed a pre-restraint assessment for the high back reclining w/c; however, she did not consider the locks at the back of the w/c as part of the assessment and did not determine if the high back reclining w/c was or was not a restraint. She stated she knew the manual w/c would slow the resident down. She further indicated the change to the manual w/c was the only intervention put into place after Resident #1 eloped from the facility. She stated Resident #1 had reported to her he/she liked the new w/c, but if the resident wanted the electric w/c, then therapy would need to assess the resident for safety and maneuverability. The DON further indicated she was unsure if Resident #1 was aware he/she had the option to use the electric w/c.	F 221			



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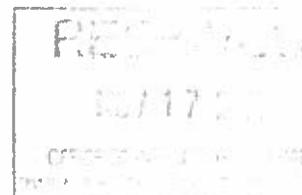
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F 221	<p>Continued From page 17</p> <p>Interview, on 10/01/14 at 10:42 AM, with the Administrator revealed the Interdisciplinary Team (IDT) met on 09/19/14 after the elopement and determined Resident #1's electric w/c would be changed to a manual w/c for safety. He further indicated the safety need of the manual w/c was due to the facility video showed the resident had moved from one (1) end of the building to the other in approximately four (4) minutes and would require 1:1 at all times in the electric w/c to ensure the resident's safety. The Administrator indicated he was unsure of the reason the facility chose to replace the resident's electric w/c with a manual w/c instead of using 1:1 supervision. He further indicated the care plan for Resident #1 to encourage use of the manual w/c meant to recommend the manual w/c and did not mean the resident had to use it. He stated he was unaware if Resident #1 was aware he/she could request the electric w/c. The Administrator further stated he was unaware if Resident #1 was able to use the manual locks located at the back of the w/c, and indicated he, the Administrator, would not be able to use the locks in their location. He indicated if the locks were used and the resident could not reach the locks, then they would be considered a restraint as they would limit his/her mobility. He stated the type of w/c Resident #1 used affected his/her ability to exit the facility. The Administrator indicated Resident #1 had a quicker ability to exit in the electric w/c than in the manual w/c. He stated if the resident wanted his/her electric w/c back, the facility would need to complete an electric w/c assessment.</p> <p>Interview with the Nurse Consultant (NC), on 09/26/14 at 4:30 PM, revealed Resident #1's family was not happy with the change to a manual w/c and was not in agreement to use it. She</p>	F 221			



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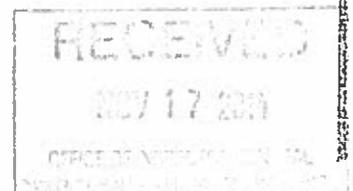
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F 221	<p>Continued From page 18</p> <p>stated the facility felt it was a good move to place the resident in a manual w/c. The NC indicated the resident could use the electric w/c when the family was at the facility and the family requested it.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 10/31/14 alleging removal of Immediate Jeopardy on 10/29/14. The facility took the following steps:</p> <ol style="list-style-type: none"> 1. Resident #1's high back reclining wheelchair had brakes installed in the rear of the chair. On 09/30/14, the facility Maintenance Director conducted an audit of all high back reclining wheelchairs with no other chairs identified as having the breaks out of the residents' reach. 2. Resident was assessed by the Psychiatric Advanced Practice Registered Nurse (APRN) on 09/22/14 for any psychosocial effects related to his/her high back reclining chair. APRN notes indicated that he/she was sitting in the wheelchair, reading at the bedside and that he/she was engaged in the conversation. APRN notes indicated no recommendations as resident was of his/her normal cognition with no noted negative effects of the new wheelchair. 3. Quality of Life Director (QOL) assessed Resident #1 on 09/20/14. QOL Director's notes indicated that she would provide 1:1 visits twice weekly during his/her transition period to ensure adequate activity and programming. The goal of these visits were to provide sensory stimulation and socialization. 4. On 10/01/14, the facility held a QA meeting with the Medical Director, Administrator, Director 	F 221			



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F 221	<p>Continued From page 19</p> <p>of Nursing, Social Worker, Rehab, Maintenance Director, MDS nurse, ADON and Nurse Consultant. In this meeting, Resident #1 was discussed regarding the placement of the brakes on his/her chair, therapy interventions which consisted of working on upper body strength, manual chair mobility and positioning. Resident #1's therapy assessment was reviewed from 09/30/14, regarding his/her ability to maneuver the manual chair independently throughout the facility and from unit to unit and the determination was made to schedule a safety assessment with the power chair. The QA team also discussed any additional interventions needed in addition to activities and therapy involvement and no other interventions were initiated at this time. QA team determined to review Resident #1 comprehensively every 30 days x 3 months, then quarterly to determine his/her psychosocial needs, alternative activities and nursing interventions for any needed changes. The Restraint and Resident Rights policy was also reviewed and no Policy and Procedure changes were made.</p> <p>5. On 10/01/14, after the QA meeting, the Maintenance Director relocated the brakes that were previously located in the back to the front of the wheelchair. After the brakes were moved, the resident was assessed for restraints by the DON, dated 10/01/14, and it was determined that the wheelchair did not constitute a restraint as resident was able to use the brakes on command and he/she was able to propel the wheelchair independently from one unit to the next. The DON also made an observation on 10/01/14 of the resident correctly using the wheelchair brakes 5 out of 5 times. Resident was being observed 5 times weekly to ensure his/her consistent ability</p>	F 221			



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F 221	<p>Continued From page 20</p> <p>to use the wheelchair brakes by the DON, ADON and RN's. This would be documented on a calendar form and would be reviewed by the Administrator or DON weekly.</p> <p>6. Therapy attempted to complete an Electric Wheelchair motorized scooter assessment on 10/01/14 with the resident and family. At that time the family was not able to come in, but did schedule for 10/02/14. This was again attempted on 10/02/14 with the family and resident declining assessment. The assessment was completed on 10/03/14 with the family present. As of the assessment on 10/03/14, it was determine by the therapist that the resident exhibbled inconsistent performance with the electric chair placing him/her and others at risk.</p> <p>7. On 10/06/14, 10/13/14, 10/20/14, and 10/27/14 the DON, ADON, Social Services and the Minimum Data Set (MDS) Coordinator reviewed resident's care plan for any needed changes and to address any concerns identified specific to Resident #1. It was determined that resident's care plan was current and appropriate. He/she was continuing to improve his/her mobility in his/her wheelchair, continued to work with therapy, still attended dining room for meals as well as activiles of choice. It was determined by the DON that care plan reviews would occur monthly x 3 then quarterly thereafter.</p> <p>8. On 10/27/14, one hundred and twenty (120) residents were assessed for restraints by the DON, ADON and RN's. Considerations were made to the different types of restraints which included standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, Broda chairs, geri chairs, seat belts and side rails.</p>	F 221		



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F 221	<p>Continued From page 21</p> <p>Only one (1) resident was identified as having a restraint. This resident previously had been identified and currently had an existing care plan for his/her restraint. This resident's care plan was reviewed on 10/28/14 by the MDS Coordinator and no changes were made to the care plan. The MDS Coordinator was educated on Resident Rights, restraint application and care plans on 10/28/14 by the Corporate Consultant.</p> <p>9. On 09/30/14, immediate education of all staff members working in the facility was completed by the Staff Development Coordinator on the wheelchair brake placement as well as not locking of wheelchair brakes except for transfers and for patient safety. On 10/28/14, the facility was informed the level of deficiency has changed from "D" level to and "I" level. As a result of the change in scope and severity, the facility has changed its training and this education would be ongoing with no staff member being allowed to work their shift prior to the education being completed. This education covered restraint policy and procedure and included the types of restraints, when to utilize the restraints, assessing restraints, obtaining physician orders and updating care plans. This education would be provided to all employees in all departments including Administration, LPNs, RNs, CNAs, Dietary, Housekeeping, Therapy, Laundry, Activities, and Social Services. The training was provided by the DON, ADON, RNs, Administration and Department Heads. By 10/28/14, one hundred and thirty-five (135) staff members had been trained with sixty-three (63) employees to be trained. This would continue until all staff members received the education. The Staff Development Coordinator would ensure that all remaining staff members received their</p>	F 221			



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F 221	<p>Continued From page 22</p> <p>training before working and would educate all new hires during orientation. The facility does not utilize agency staff.</p> <p>10. The facility began monitoring on 10/01/14 and has been performing ten (10) observations per week of Resident #1's wheelchair brakes to make sure that they are not locked by staff and that resident is able to propel his/her wheelchair throughout facility. These audits are being completed by Administration, DON, Department Head team and RN Supervisors. An audit of all standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, Broda chairs, geri chairs, seatbelts and side rails will be conducted on each unit weekly to determine if residents' movements are restricted by their wheelchair by DON, ADON, or RN x 12 weeks. These audits are being collected weekly by the administrator and reviewed for tracking/trending. The monitoring will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will reevaluate the effectiveness of the interventions.</p> <p>Through observation, interview and record review the State Survey Agency validated the corrective actions on 11/07/14 prior to exit as follows:</p> <p>1. Observations, on 11/05/14 at 8:00 AM, revealed Resident #1 was sitting in the dining room in a manual, high back, reclining wheelchair (w/c) with the brakes located at the front of the w/c and the resident was able to lock and unlock the brakes. Review of the Maintenance Director's audit, 09/30/14, revealed there were eight (8)</p>	F 221			



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F 221	<p>Continued From page 23</p> <p>residents in reclining w/cs on 09/30/14. Seven (7) of the residents' had brakes in the front of the w/cs. Resident #1's brakes were in the back. Interview with the Maintenance Director, on 11/05/14 at 7:42 AM, revealed he had completed a reclining w/c audit on 09/30/14 and identified Resident #1's brakes had been located in the rear of the chair out of his/her reach at that time.</p> <p>2. Record review, on 11/05/14, of the requested assessment/evaluation for Dementia, elopement, and medication review completed by the APRN, revealed Resident #1 was found sitting in a manual w/c at his/her bedside reading. He/she was easily engaged in superficial conversation. The APRN made no recommendations. Interview with the APRN, on 11/05/14 at 3:40 PM, revealed Resident #1 had no concerns at the time of her assessment on 09/22/14. She had no concerns related to Resident #1 being in a manual w/c. In addition, she stated Resident #1 had said, he/she was doing better in the manual w/c and cognitively she felt Resident #1 was safer in the manual w/c.</p> <p>Observations of Resident #1, on 11/05/14 at 10:45 AM, revealed he/she was self propelling in a high back reclining w/c towards the dining room for a smoke break. At 11:30 AM, Resident #1 was observed wheeling down the 100 hallway for lunch. At 2:40 PM Resident #1 was observed wheeling down the 300 hallway in his/her high back, reclining w/c talking to another resident.</p> <p>3. Review of the Quality of Life (QOL) entry, on 09/20/14, revealed the Activity Progress Notes stated Resident #1 would be provided one to one (1:1) visits by staff and Resident #1 would be encouraged to attend group activities. Review of</p>	F 221			



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F 221	Continued From page 24 the Participation Log revealed Resident #1 received 1:1 visits on 10/01/14, 10/03/14, 10/07/14, 10/11/14, 10/12/14, 10/13/14, 10/25/14, and 10/29/14. The log also identified those activities Resident #1 had attended. Interview with the QOL Director, on 11/05/14 at 10:50 AM, revealed a second One on One Needs Guideline Assessment had been completed on 10/15/14 and Resident #1 scored a seven (7) indicating that he/she now was self-initiating his/her activities. The goals for Resident #1 was to stimulate and socialize him/her during the transition from the electric to the manual w/c. She felt the stimulation and socialization goals had been met. Review of the One on One Needs Assessment, dated 10/15/14, revealed the resident scored a seven (7) and was self initiating activities. 4. Interview with the Administrator, on 11/05/14 at 12:40 PM, revealed on 10/01/14 in the Quality Assessment meeting (QA) it was discussed to move Resident #1's brakes from the back to the front of his/her high back, reclining w/c. Review of the QA sign in sheet on 11/05/14, revealed the following were present at the meeting on 10/01/14: two Minimum Data Set (MDS) nurses, QOL Director, Human Resources, Assistant Director of Nurses (ADON), The Therapy Director, Respiratory Therapist, Staff Development Nurse, Social Services, Administrator, House Keeping Director, Dietary Director, Medical Records, and the DON. Minutes from the Comprehensive Review meeting, dated 10/01/14, were reviewed on 11/06/14 and it was documented no changes were needed for Resident #1's Care Plan or the Restraint Reduction and Resident Rights policies. The COTA had been asked to assess and	F 221			



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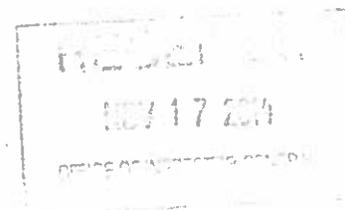
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F 221	<p>Continued From page 25</p> <p>Implement therapy to improve Resident #1's strength and mobility. The COTA assessment completed 09/30/14 was reviewed and it indicated Resident #1 had an increase in strength and mobility since changing to the manual, high back, reclining w/c. The QA team, on 10/01/14, discussed and decided no additional interventions were needed at that time. The Resident Rights and the Restraint Reduction Policies were reviewed on 10/01/14 and no changes had been needed. Resident #1's Care plan was also reviewed and no changes were needed.</p> <p>5. Interview with the Maintenance Director, on 11/05/14 at 1:45 PM, revealed on 10/01/14 he had moved the brakes on Resident #1's high back, reclining w/c to the front of the chair. Review of a signed statement by the Maintenance Director that the brakes were moved from the back to the front of Resident #1's high back, reclining w/c. Observations, on 11/05/14 at 8:00 AM, revealed Resident #1 was able to lock and unlock the high back, reclining w/c brakes located on the front of the chair. Interview with the Director of Nursing (DON), on 11/05/14 at 3:00 PM, revealed on 10/01/14 she had observed five (5) times Resident #1 lock and unlock his/her high back, reclining w/c and independently propel the chair. It was deemed at that time the high back, reclining w/c was not a restraint. In addition the DON stated, Resident #1 would be observed five (5) times weekly to ensure his/her ability to propel and lock and unlock the high back, reclining w/c. Interview with the DON, on 11/05/14 at 2:06 PM, revealed she was reviewing and monitoring the log records for Resident #1's ability to lock and unlock the high back, reclining w/c and propel himself/herself throughout the facility. The DON documented on the log, on</p>	F 221			

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F 221	<p>Continued From page 26</p> <p>10/01/14, that the resident had been able to lock and unlock the brakes and propel his/her high back, reclining w/c five (5) times upon command. Interview with the Administrator, on 11/05/14 at 2:08 PM, revealed he is also reviewing and monitoring the logs for Resident #1's ability to lock and unlock his/her high back, reclining w/c. Record review of the log revealed Resident #1 will be monitored through December 2014 for his/her ability to lock and unlock the high back, reclining w/c and propel himself/herself throughout the facility. The ability to lock and unlock the high back, reclining w/c was documented five (5) times through 11/06/14 and the ability to propel the high back, reclining w/c was documented eight (8) times through 11/06/14. The monitor began 10/04/14.</p> <p>6. On 11/05/14, review of the electric wheel chair assessment, dated 10/03/14, revealed the Certified Occupation Therapy Assistant (COTA) assessed Resident #1 for the use of his/her electric wheel chair on 10/03/14. Review of the documentation by the Social Services Director, on 10/01/14, revealed she had contacted the spouse of Resident #1, on 10/01/14, to schedule a time for his/her electric w/c assessment. The spouse requested the assessment be 10/02/14. On 10/02/14 at 10:08 AM when the spouse arrived, Resident #1 was resting and he/she requested the assessment be the next day on 10/03/14. The Electric Wheelchair/Motorized Scooter Assessment was completed on 10/03/14 by the COTA and it was determined Resident #1 was unsafe in the electric w/c without close supervision. Review of the COTA assessment documented 09/30/14 revealed Resident #1 had demonstrated increased strength and endurance. The COTA correlated this to increased quality of</p>	F 221			



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F 221	Continued From page 27 life and his/her ability to roam the halls. Review of the electric W/C assessment dated 10/03/14, revealed Resident #1 was awake, alert, and oriented, but at times disoriented and he/she hit a table in the dining room during the assessment. The COTA concluded Resident #1 needed constant supervision to operate the electric W/C. 7. On 11/06/14, review of the Care Plan for Resident #1 revealed it had been reviewed by the DON, ADON, Social Services and MDS. All four had signed the care plan on 10/06/14, 10/13/14, 10/20/14, and 10/27/14 that the care plan had no changes necessary. Interview with the DON, on 11/05/14 at 3:35 PM, revealed the care plan had been reviewed for accuracy, appropriateness, and changes if needed. In addition, she stated a comprehensive review had been completed in October and would also be done in November and December of 2014, after which the reviews would be quarterly. Review of the care plan interventions on 11/06/14 revealed, interventions dated 10/06/14 were in place to address mobility, therapy, dining room for meals, and activities. Interview with Social Services, on 11/06/14 at 4:00 PM, revealed during the care plan meeting on 10/06/14 for Resident #1 her focus had been psychological issues, mood/behaviors, and comfort in the manual high back, reclining w/c. Interview with the ADON, on 11/06/14 at 4:05 PM, revealed during the care plan meeting his focus had been comfort in the high back, reclining w/c, mobility, and psychological needs. Interview with the MDS Coordinator, on 11/06/14 at 4:10 PM, revealed during the care plan meeting her focus had been ensuring the elopement policy guidelines were followed in the care plan, interventions were accurate, and the care plan was current.	F 221			



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F 221	<p>Continued From page 28</p> <p>8. On 11/06/14 review of one hundred and twenty (120) restraint assessments revealed total census had been assessed for any manual, physical, mechanical device/material or equipment attached to a resident's body that would restrict freedom of movement on 10/27/14. During the assessment of the residents, one (1) resident continued to be identified in a Broda Chair and it was deemed a restraint due to thigh straps. The resident had a diagnosis of Huntington's Chorea leading to loss of muscle control. The assessment also questioned if the device restricted movement and if the device could be removed by the resident upon command. Interview with the DON, on 11/05/14 at 4:10 PM, revealed standard wheelchairs, high back wheelchairs, high back reclining wheelchairs, Broda chairs, seat belts, and side rails had been assessed to see if they would be considered a restraint. The one (1) resident identified in a Broda chair on 10/27/14 had his/her care plan reviewed by the DON, on 10/27/14, and it was determined the resident had an existing restraint. In addition, the DON stated the resident in the Broda chair would be assessed monthly for three (3) months. Review of the physical restraint care plan on 11/06/14 revealed the care plan had been reviewed on 10/28/14 by MDS also. The Nurses Noted dated 11/03/14 had a restraint assessment note. Interview with the MDS Coordinator, on 11/07/14 at 8:20 AM, revealed she reviewed the care plan of the resident in the Broda chair and determined no changes were needed.</p> <p>9. Review on 11/07/14 of the Train the Trainer In-service sign in sheet revealed the MDS Coordinator, Staff Development, the DON, the</p>	F 221			



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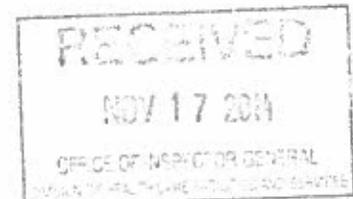
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F 221	<p>Continued From page 29</p> <p>Administrator, and the Assistant MDS were in-serviced on 10/28/14 on Resident Rights, Restraint Application, and Care Plans by the facility's consultant. A post-test was administered after the in-service. Interview with the MDS Coordinator, on 11/07/14 at 8:20 AM, revealed she had attended the in-service prior to assessing the care plan of the resident in the Broda chair.</p> <p>Interview with the Staff Development nurse, on 11/07/14 at 8:23 AM, revealed she had been in-serviced on 10/28/14 by the consultant. Interview with the Administrator, on 11/07/14 at 8:29 AM, revealed he had been in-serviced on 10/28/14 by the consultant. Interview with the DON, on 11/07/14 at 8:40 AM, revealed she had been in-serviced on 10/28/14 by the consultant.</p> <p>On 11/07/14 review of the Wheel Chair in-service presented on 09/30/14 by the Staff Development Nurse revealed the education provided to staff included to not lock wheelchair brakes for any reason except to safely transfer a resident. The facility had 183 staff of which the Administrator estimated 97% had been trained. Staff not trained were one (1) staff member on Leave of Absence and six (6) PRN staff. The deadline before disciplinary action was 11/04/14. Review of a certified letter, dated 10/28/14, had been sent to the PRN staff on 10/28/14. Review of the Restraint in-service post education quiz revealed the in-service covered the Restraint Policy (that identified the types of restraints, when to use restraints, obtaining a physician order, assessing the restraint, and updating the care plan). Staff was to be trained before leaving the facility on 10/28/14 or before working their shift.</p> <p>Interview with the Dietary Manager, on 11/06/14</p>	F 221			



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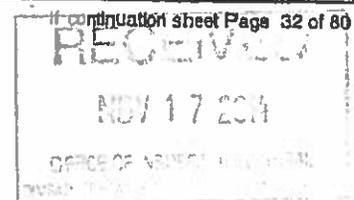
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F 221	<p>Continued From page 30</p> <p>at 10:20 AM, RN #7, on 11/07/14 at 10:23 AM, and RN #2, on 11/06/14 at 10:25 PM, revealed 100% of their staff had been trained.</p> <p>Interview with the Social Services Director, on 11/06/14 at 11:00 AM, the Dietary Manager, on 11/06/14 at 11:06 AM, and the Physical Therapy Department Director, on 11/08/14 at 11:10 AM, revealed they had assisted with the staff training.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 11/07/14 at 10:45 AM, LPN #8, on 11/07/14 at 10:50 AM, RN #2, on 11/06/14 at 10:25 AM, CNA #12, on 11/03/14 at 11:05 AM, Restorative Aide #1, on 11/03/14 at 11:03 AM, RN #9, on 11/07/14 at 11:12 AM, Environmental Services staff member, on 11/07/14 at 11:26 AM, and Dietary Cook #2, on 11/07/14 at 11:29 AM, revealed they were trained on 10/28/14. Interview with LPN #9, on 11/07/14 at 11:00 AM, revealed she had been on vacation on 10/28/14 and was trained by the night supervisor before her shift upon return to work. Interview with Restorative Aide #2, on 11/07/14 at 11:05 AM, and Laundry staff #2, on 11/07/14 at 11:08 AM, revealed they had been trained on 10/29/14 before starting work.</p> <p>Interview with the Staff Development Coordinator, on 11/07/14 at 1:24 PM, revealed all new hires had been and would continue to be trained on Restraints before working in their departments. Interview with the Administrator, on 11/07/14 at 1:26 PM, revealed the facility did not use agency staff.</p> <p>10. On 11/06/14, review of the audit sheet, initiated 09/28/14, revealed ten (10) observations a week were completed of Resident #1 for his/her ability to lock and unlock his/her high back,</p>	F 221			



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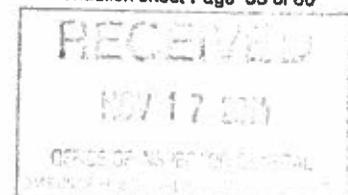
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F 221	Continued From page 31 reclining w/c and propel the chair around the facility. Review of the nurses notes, dated 10/01/14, revealed the DON documented five (5) observations of the resident being able to lock and unlock the brakes upon command and propel the chair. Interview with the DON, on 11/07/14 at 11:55 AM, revealed the audits were weekly and she and the Administer were reviewing the audits weekly. On 11/07/14 review of the audits revealed: 09/28/14 - 10/04/14 thirteen (13) observations had been completed, 10/05/14 - 10/11/14 twelve (12) observations had been completed, 10/12/14 - 10/18/14 twelve observations had been completed, 10/19/14 - 10/25/14 eleven (11) observations had been completed, 10/26/14 - 11/01/14 eleven (11) observations had been completed, and 11/02/14 - Thursday 11/07/14 eight (8) observations had been completed. Interview with the Administer, on 11/07/14 at 11:55 AM, revealed he reviewed the restraint audits for Resident #1 weekly. The audits are part of the daily morning meeting. A weekly audit that began 09/30/14 was completed weekly for restrictive devices for all residents. Review of the facility's resident audit conducted on 11/03/14 revealed it included all the residents. This was a continuance of the wheelchair audit. This audit would continue for twelve (12) weeks. The audits were collected weekly by the Administrator for tracking and trending and would be presented at the morning meeting and Quality Assurance (QA). Review of the wheelchair audits revealed no concerns. Audits would continue through November and December 2014. The QA would evaluate this intervention in three months. The next QA would be 11/19/14.	F 221			
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	<p>Immediate Jeopardy Concern Stated: After assessment of ongoing interventions the facility did not update care plan to reflect the resident's repeated attempts of exit seeking so that approaches could have been put into place to prevent elopement or provide adequate supervision to prevent elopement.</p> <p>Resident(s) affected by the IJ and actions taken to remove IJ:</p> <p>The only resident identified as being affected the immediate jeopardy is the resident that was reported in the elopement (Resident #1). The incident in question occurred on 9/19/2014 at 6:52 pm. The resident was witnessed approximately 172 yards off campus by the maintenance director and a COTA from the facility. Action items to remove the jeopardy are as follows:</p>		



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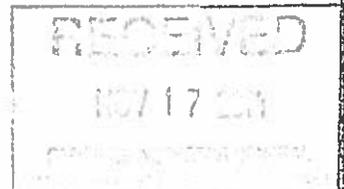
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F 282	Continued From page 32 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation, facility's policy and procedures, it was determined the facility failed to have an effective system in place to ensure care plan interventions were implemented related to monitoring one (1) of three (3) residents identified at risk for elopement of the seven (7) sampled residents, (Resident #1). (Refer to F323) On 09/19/14 at 6:44 PM, Resident #1 exited the facility without staff knowledge. Interview and review of the facility's video surveillance revealed Resident #1 was near the exit door to the 100 Unit when staff entered the code to the exit door for two visitors to leave the facility, and Resident #1 exited the facility with the two (2) visitors. At approximately 6:52 PM, the Maintenance Director was returning to the facility and saw Resident #1 on the sidewalk of the two (2) lane street moving towards the intersection of a six (6) lane street. The Maintenance Director stopped to retrieve the resident when he saw the resident with Certified Occupational Therapy Assistant (COTA) #1. The Maintenance Director returned to the facility and called a Code Green to alert staff of the elopement of Resident #1. Staff was not aware Resident #1 had eloped until the code was called. The resident was returned to the facility at 6:58 PM and assessed with no injuries.	F 282	<ul style="list-style-type: none"> At approximately 6:52 pm on 9/19/14, COTA immediately went to the resident and assured his safety by observing for any obvious signs of injury and staying with him until another staff member arrived. The Maintenance Director (MD) went back to the facility to notify staff and activate the elopement protocols. All other residents were accounted for during the head count. MD returned to assist the COTA and Resident #1 back to the facility. A skin assessment and vital signs were completed by Resident #1's LPN and were within normal limits. Resident #1 was assisted to bed per his choice. Assessment did not reveal any signs of injury or trauma. Resident #1's wife was contacted by LPN on 9/19/14 to inform her of the event of her husband exiting the facility. Physician and facility Medical Director was notified by Director of Nursing on 9/19/14 of the event. Upon review of the security camera footage by the Administrator and Director of Nursing on 9/19/14, it was determined that Resident #1 was helped outside by a visiting family member. The visitor's son was called by the DON, on 9/19/14 and asked him about the incident. The visitor stated that he did hold the door for the resident to exit, but he was unaware the the resident was not able to exit without staff assistance. Education was also provided to the family member regarding assisting residents outside of secure doors. Information from the interview with the son also identified the CNA that punched the code to release the maglock. The CNA was interviewed by 		



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F 282	<p>Continued From page 33</p> <p>The facility's failure to ensure care plan interventions were implemented placed Resident #1 and other residents at risk in a situation that has caused or is likely to cause serious injury, harm, impairment or even death to a resident. The Immediate Jeopardy was identified 09/25/14 and determined to exist on 09/19/14. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 09/30/14 that alleged removal of Immediate Jeopardy on 09/23/14. However, the State Survey Agency verified Immediate Jeopardy was removed on 10/03/14, after training of facility staff was verified completed on 10/02/14, at 42 CFR 483.20 Resident Assessment (F282) with the scope and severity 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 Safety and Supervision of Residents, revised 2007, revealed resident supervision was a core component of the systems approach to safety. The type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment. The policy further stated implementation of the interventions to reduce accident risks and hazards shall include ensuring that interventions are implemented and documented.</p> <p>Review of the facility's policy Elopement/Wandering Residents, effective December 2010, revealed any resident displaying</p>	F 282	<p>the Administrator on 9/19/14 and education on elopement policy and procedures provided by the DON on 9/19/14. This education included staying observant of the surrounding area to ensure no resident exits when assisting visitor in or out of the door. A review of Elopement books was completed on 9/19/14, by the DON and Staff Development Coordinator to ensure that the elopement risk forms for each resident identified at risk for elopement were accurate. 3 total residents were reviewed.</p> <ul style="list-style-type: none"> On 9/19/14, Maintenance Director and assistant checked all exterior doors for proper function with no issues identified. Proper signage was in place at all doors. The sign reads "Visitors: Please see a nurse before assisting any resident out of the facility." On 9/19/14, Administrator called in a vendor to check overall operation of all exterior doors with no issues identified. This inspection was completed on 9/19/14. ADIIOC QAPI meeting regarding resident's elopement and plan of care that included MDS, DON, Admin, SS, SDC and Medical Director occurred on 9/19/14. Resident's care plan was updated to reflect new interventions. Each resident was discussed to determine if they were affected by the elopement or if changes need to be made to their elopement risk status. No additional residents were identified and the 2 other "at risk" residents' care plans were reviewed with no changes. No changes were made to the policies reviewed. Policies reviewed were elopement and missing persons. 		



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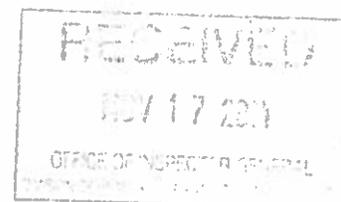
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F 282	<p>Continued From page 34</p> <p>significant wandering behaviors would be assessed for elopement/wandering risk and care planned appropriately. Care plans and individual behavior plans would address wandering as a specific problem.</p> <p>Review of the facility's investigation revealed Resident #1 exited the 100 Unit door, on 09/19/14 at 6:44 PM, with a male family member and a phlebotomist technician when Certified Nursing Assistant (CNA #3) entered the exit door code. The Maintenance Director was returning to the facility at approximately 6:52 PM when he observed Resident #1 in his/her electric wheelchair (w/c) on the sidewalk down the street from the facility. He parked his vehicle and saw COTA #1 with the resident. The Maintenance Director proceeded to the facility and called a Code Green and then went to Resident #1 and the COTA. The resident was returned to the facility at approximately 6:58 PM without injury.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 11/25/13 with diagnoses of Chronic Respiratory Failure, Symbolic Dysfunction, Dysphagia, Dementia with Behaviors, DMII, and Bilateral above the knee amputees, Muscle Weakness, and Psychosis.</p> <p>Review of the Minimum Data Set (MDS), dated 09/06/14, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) with a cognitive score of a four (4). The resident's functional status for mobility was assessed by the facility as non-ambulatory and requiring supervision on the unit and independent off the unit once in the electric wheelchair.</p>	F 282	<ul style="list-style-type: none"> • Dr. Pelligrini, Psychiatry, was informed of the event by ADON on 9/22/14. His NP, evaluated resident on 9/22/14 for any psychosocial needs related to the event. No recommendations were made. • In addition to Resident #1's wife being notified of the event on 9/19/14, his care plan was reviewed with her on the morning of 9/20/14 by the social services director, and a subsequent care plan meeting held was held on 9/22/14 with the IDT and DON. • Care plans for 2 other residents previously identified as elopement risk were reviewed by the IDT on 9/19/14 to assess for any necessary changes. No changes were made to these care plans. • 125 residents were reviewed by the IDT and DON on 9/19/14 to ensure no risk related to this particular event. No additional risk was identified. • A letter was added by the Director of Sales and Marketing on 9/20/14 to the admission packet for all new admissions and families. No new admissions until 9/22/14. This letter addresses reminding visitors not to assist residents out of the facility without the knowledge of staff. • Review of resident #1's record revealed that care plan interventions were followed related to redirecting resident when he would navigate towards exit doors and these interventions had been effective up until the actual event on 9/19/2014 		



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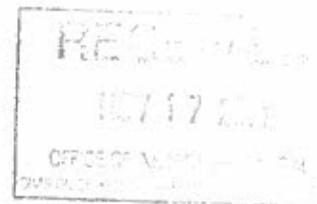
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/07/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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F 282	<p>Continued From page 35</p> <p>Review of Resident #1's Elopement Risk/Exit Seeking Care Plan, dated 04/12/13 and last reviewed on 09/04/14, revealed Resident #1's care plan had been initiated for elopement evidenced by the resident wandering the facility. The resident exhibited behaviors such as gravitating towards exit doors and asking staff to go outside. The goal of the care plan was for the resident not to elope the facility and the resident would be monitored for his/her whereabouts on an ongoing basis. Approaches listed were: monitor for talking; use verbal/physical cues for redirection; seek mental health referral; refer to social services as needed; reassess elopement risk at least quarterly; and, provide direct staff supervision when attending out-of-facility activities. The care plan noted on 03/15/14 Resident #1 had been placed on every fifteen (15) minute check observations for forty-eight hours and on 03/18/14 the resident had been placed on every thirty (30) minute check observations for twenty-four hours related to exit seeking behavior. On 04/12/13 Resident #1 had been added to the Elopement Binder per facility policy.</p> <p>Staff interviews revealed staff was to monitor Resident #1; however, there was no guidance as to the frequency. Interview with CNA #7, on 09/30/14 at 9:12 AM, revealed if a resident was an elopement risk the staff would monitor the resident and keep the resident from exiting the facility. The CNA further indicated all residents were supervised all the time and residents at risk of elopement were supervised constantly; however, there were no specific time frames to monitor residents. She stated staff would keep their eyes on the residents.</p>	F 282	<p>Training:</p> <p>On 9/19/14, immediate education of all staff members working in facility was educated by AIDON, Director of Clinical Education, Social Worker, LPN or RN on the elopement policy, care plans and to be aware of the area around the doors to make sure that everyone entering and exiting the building is appropriate. Post-test competencies are also being administered with the training. By 9/22/14, 135 staff members were trained with 65 employees to be trained. Of the remaining 65, 15 are PRN therapy staff that are on our payroll, but work in other Signature locations other than East Louisville. This education has been ongoing with no staff member being allowed to work their shift prior to the education. This education will be provided to all employees in all departments including administration, LPNs, RNs, CNAs, Dietary, Housekeeping, therapy, laundry, activities and social services. This will continue until all staff members receive the education. Staff development coordinator will ensure that all remaining staff members receive their training before working and will educate all new hires prior to starting orientation. This facility does not utilize agency staff.</p> <p>On 9/19/14, a letter was drafted by the DON and Admin to educate family members and residents on being aware of those going in and out of the facility and to please check with nursing staff before assisting residents in out of the facility. This letter was placed in all resident rooms on 9/19/14 and placed in the outgoing mail on 9/19/14 to all family representatives.</p>		



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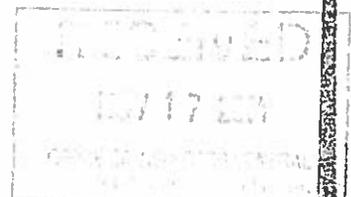
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F 282	<p>Continued From page 36</p> <p>Interview with Registered Nurse (RN) #1, on 09/30/14 at 9:37 AM, revealed the facility did not have a standard to supervise residents and the supervisions were not documented. Additionally, there were no standards to visualize residents at risk for elopement unless the resident was placed on fifteen (15) minute checks. The RN stated the facility prevented resident elopement through frequent monitoring, the locked exit doors, and use of re-direction and activities.</p> <p>Interview with the SSD, on 09/30/14 at 12:35 PM, revealed a resident at risk of elopement should be supervised by all staff and the resident should not exit the facility without staff supervision.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/30/14 at 2:53 PM, revealed he expected staff to visualize residents every two (2) hours, although that was not a facility policy. The ADON stated staff did not document when they made the two (2) hour rounds. He indicated if a resident was at risk for elopement, supervision was at the discretion of the DON.</p> <p>Interview with the Director of Nursing (DON), on 09/24/14 at 1:26 PM, revealed the facility had a general policy for resident supervision and all staff were responsible to supervise residents. She stated she was unsure if the policy specified specific times residents should be visualized and staff did not document when residents had been seen. The DON stated she monitored staff supervision of residents through general observations of staff when she conducted rounds of the facility at least once a day and throughout the day. The DON indicated she did not document when she completed daily rounds.</p>	F 282	<p>Post education competencies were completed by all staff when the education was completed. This has been completed by all staff who has worked to date. No staff will be permitted to work until training has occurred.</p> <p>Monitoring:</p> <p>The facility began monitoring on 9/19/14 at 8:45 p.m. and are performing 3 observations every 12 hour shift by Admin, DON, dept head team, IDT and RN supervisors of staff monitoring the area around the doors when letting families in/out. These audits will be collected daily by the administrator and reviewed for tracking/trending. The monitoring will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p> <p>Alleged removal of IJ:</p> <p>The facility feels that this is past non-compliance and as of 9/23/14 we took all of the necessary steps to abate the jeopardy.</p>		



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F 282	<p>Continued From page 37</p> <p>Interview with the Administrator, on 10/01/14 at 10:42 AM, revealed he could not recall if the facility policy specified how frequently staff should visualize any resident or residents at risk for elopement.</p> <p>The facility provided an Allegation of Compliance (AOC) on 09/30/14 alleging the Immediate Jeopardy was removed on 09/23/14; however, the State Survey Agency verified that staff training was completed on 10/02/14. The facility took the following immediate steps to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> At approximately 6:52 PM on 09/19/14, a COTA immediately went to the resident and assured his/her safety by observing for any obvious signs of injury and staying with him/her until another staff member arrived. The Maintenance Director went back to the facility to notify staff and activate the elopement protocols. All other residents were accounted for during the head count. Maintenance Director returned to assist the COTA and Resident #1 was returned to the facility at 6:58 PM. A skin assessment and vital signs were completed by Resident #1's LPN and were within normal limits. Assessment did not reveal any signs of injury or trauma. Resident #1's husband/wife was contacted by the LPN on 09/19/14 to inform him/her that his/her spouse had exited the facility. Physician and facility Medical Director was notified by the Director of Nursing (DON) on 09/19/14 of the event. Upon review of the security camera footage by 	F 282	<p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Resident #1's care plan was reviewed and updated on 9/19/2014 by the DON. Care plan was again reviewed on 10/1/14 by the DON, ADON, Admin, Medical director, social worker and therapy. CNA care plan was reviewed and updated on 9/19/14 by the DON, MDS, Social Services and staff development coordinator. CNA care plan as also reviewed and updated on 10/1/14 by the DON, ADON, Admin, Medical Director, social worker and therapy.</p> <p>How will the facility identify other residents that have the potential to be affected?</p> <p>All residents were reviewed on 9/19/14, by DON, MDS, Social services and Staff Development coordinator to identify other residents that may have been affected. Facility had previously identified 2 other residents that were at risk for elopement and those care plans and CNA plans were reviewed on 9/19/14 by the DON, MDS, Social services and Staff Development coordinator.</p> <p>No additional residents were identified as being affected.</p> <p>What measures will be put into place to ensure that the deficient practice will not recur?</p> <p>All staff has been educated on 10/2/14, by the SDC, DON, ADONs and RNs on care plan development, care plan revisions and following the care plans. This training also addressed the CNA care plans as well.</p> <p>Care plan audits to review Elopement interventions will be completed by the DON, ADONs, MDS, RN's, and Dept heads 3 x's weekly x12 weeks.</p> <p>Door observation audits will continue 3x weekly x12 weeks by the DON, Admin, ADON, RNs and department heads.</p>	11/14/14	



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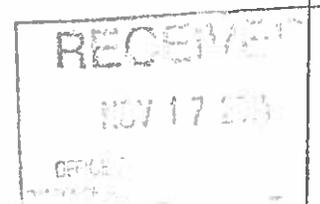
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F 282	<p>Continued From page 38</p> <p>the Administrator and DON on 09/19/14, it was determined that Resident #1 was helped outside by a visiting family member. The visitor was called by the DON, on 09/19/14 and asked him about the incident. The visitor stated that he did hold the door for the resident to exit, but he was unaware the resident was not able to exit without staff assistance. Education was also provided to the family member regarding assisting residents outside of secured doors.</p> <p>5. Information from the interview with visitor also identified the CNA that entered the code to release the maglock. The CNA was interviewed by the Administrator on 09/19/14 and education on elopement policy and procedures provided by the DON on 09/19/14. This education included staying observant of the surrounding area to ensure no resident exited when assisting a visitor in or out of the door.</p> <p>6. A review of the Elopement books were completed on 09/19/14, by the DON and Staff Development Coordinator (SDC) to ensure the elopement risk forms for each resident identified at risk for elopement were accurate. Three (3) total residents were reviewed.</p> <p>7. On 09/19/14, the Maintenance Director and Maintenance Assistant checked all exterior doors for proper function with no issues identified. Proper signage was in place at all doors. The sign read "Visitors: Please see a nurse before assisting any resident out of the facility."</p> <p>8. On 09/19/14, the Administrator called in the door vendor to check overall operation of all exterior doors with no issues identified. This inspection was completed on 09/19/14.</p>	F 282	<p>How the facility will monitor its performance to ensure solutions are sustained.</p> <p>The administrator will review the results of the audits weekly and forward the results of the audits to the monthly Quality Assurance Committee for further review and recommendation. The audits will be presented by the Admin and DON weekly for 3 months, then monthly x3 months to the QAPI team for review and recommendation based upon the results.</p>		

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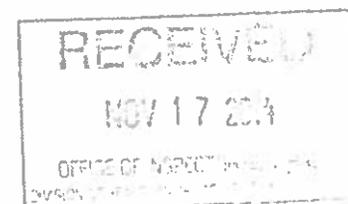
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F 282	Continued From page 39 9. An ADHOC-QAPI meeting regarding resident's elopement and plan of care that included MDS, Director of Nursing, Administrator, Social Services, Staff Development Coordinator and Medical Director occurred on 09/19/14. Resident's care plan was updated to reflect new interventions. Each resident was discussed to determine if they were affected by the elopement or if changes were needed to their elopement risk status. No additional residents were identified and the two (2) other "at risk" residents' care plans were reviewed with no changes. No changes were made to the policies reviewed. Policies reviewed were Elopement and Missing Persons. 10. Psychiatry, was informed of the event by the ADON on 09/22/14. The Nurse Practitioner (APRN), evaluated Resident #1 on 09/22/14 for any psychosocial needs related to the event. No recommendations were made. 11. In addition to Resident #1's spouse being notified of the event on 09/19/14, the resident's care plan was reviewed with the spouse on the morning of 09/20/14 by the Social Services Director (SSD), and a care plan meeting was held on 09/22/14 with the Interdisciplinary Team (IDT) and the DON. 12. Care plans for two (2) other residents previously identified as elopement risk were reviewed by the IDT on 09/19/14 to assess for any necessary changes. No changes were made to these care plans. 13. One hundred twenty-five (125) residents were reviewed by the IDT and DON on 09/19/14	F 282			



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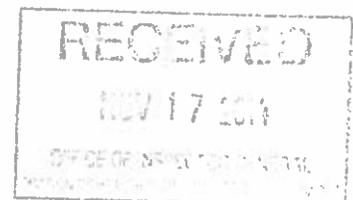
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F 282	Continued From page 40 to ensure no risk related to this particular event. No additional risk was identified. 14. A letter was added by the Director of Sales and Marketing on 09/20/14 to the admission packet for all new admissions and families. There were no new admissions until 09/22/14. The letter addressed reminding visitors not to assist residents out of the facility without the knowledge of staff. 15. A review of Resident #1's record revealed that care plan interventions were followed related to redirecting resident when he/she would navigate towards exit doors and these interventions had been effective up until the actual event on 09/19/14. 16. On 09/19/14, immediate education of all staff members working in facility was provided by the ADON, SDC, SSD, LPN or RN on the elopement policy, care plans and to be aware of the area around the doors to make sure that everyone entering and exiting the building were appropriate. Post-test competencies are also being administered with the training. By 09/22/14, 135 staff members were trained with 65 employees to be trained. This education would be provided to all employees in all departments including Administration, LPNs, RNs, CNAs, Dietary, Housekeeping, Therapy, Laundry, Activities and Social Services. This would continue until all staff members received the education. Post education competencies were completed by all staff when education was completed and had been completed by all staff who had worked to date. No staff would be permitted to work until training had occurred.	F 282		



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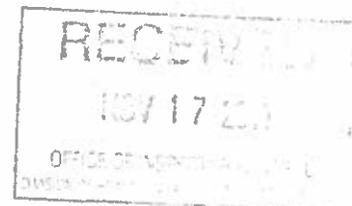
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F 282	<p>Continued From page 41</p> <p>17. Of the remaining 65 employees as stated in the AOC, fifteen (15) are PRN therapy staff on the payroll, but work in other Signature locations other than East Louisville. This education had been ongoing with no staff member being allowed to work their shift prior to the education.</p> <p>18. The SDC would ensure that all remaining staff members receive their training before they worked and would educate all new hires prior to starting orientation. The facility did not utilize agency staff.</p> <p>19. On 09/19/14, a letter from the DON and Administration educated family members and residents to be aware of others who entered or exited the facility and check with nursing staff before they assisted residents in or out of the facility. The letter was placed in all resident rooms on 09/19/14 and placed in outgoing mail on 09/19/14 to all family representatives.</p> <p>20. The facility began monitoring, on 09/19/14 at 8:45 PM, and had perform three (3) observations every 12 hour shift by the Administrator, DON, Department Head team, IDT and RN supervisors of staff monitor the area around the doors when they let families in or out. These audits would be collected daily by the Administrator and reviewed for tracking/trending in the next QA meeting.</p> <p>Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 10/03/14, with a compliance date of 10/03/14 prior to exit as follows:</p> <p>1. Review of the facility's investigation revealed COTA #1 was driving down the street and observed Resident #1 in his/her electric</p>	F 282			



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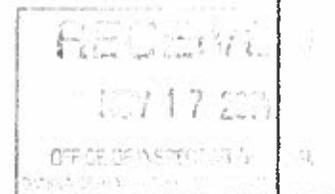
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F 282	Continued From page 42 wheelchair (w/c) on the sidewalk. The COTA parked her vehicle and stayed with the resident until other staff arrived. The Maintenance Director had been driving to the facility and saw Resident #1 on the sidewalk in his/her electric wheelchair (w/c). Interview with COTA #1, on 10/01/14, revealed she was leaving the facility at approximately 6:50 PM on 09/19/14 and saw Resident #1 on the sidewalk headed toward a busy intersection. She stated she parked her vehicle and stayed with the resident until another staff member arrived. She stated the Maintenance Director arrived and they assisted Resident #1 back to the facility. Interview with the Maintenance Director, on 10/01/14, revealed on 09/19/14 at approximately 6:52 PM, he saw Resident #1 in his/her electric wheelchair on the sidewalk moving in the direction of a busy intersection. He stated he parked his vehicle and saw COTA #1 with the resident and then entered the facility and called a Code Green. In response to the Code Green, interviews with Licensed Practical Nurse (LPN) #4, on 10/02/14 at 7:40 PM, revealed he did a head count of residents on the 300 unit on 09/19/14 and all residents were accounted for and reported to the Maintenance Director. Interview with LPN #5, on 10/02/14 at 7:45 PM, revealed he completed a head count of residents on the 200 unit on 09/19/14 with all residents accounted for except Resident #1, and reported to the Maintenance Director. Interview with the Maintenance Director, on 10/03/14 at 8:45 AM, revealed the nurse on the 100 Unit had completed a head count and reported to him all residents were accounted for. Review of the facility head count revealed on 09/19/14 the elopement code was called at approximately 6:53 PM and a head count was completed on the 100, 200, and 300 Units with all residents accounted	F 282			



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F 282	<p>Continued From page 43 except Resident #1.</p> <p>2. Review of the clinical record for Resident #1 revealed, on 09/19/14 a skin assessment and vital signs were completed by LPN #3 upon his/her return to the facility with no concerns noted. Interview with LPN #3, on 10/02/14 at 8:20 AM and 8:48 AM, revealed she completed a skin assessment on 09/19/14 of Resident #1 with no new injuries and the resident's vital signs were within normal limits. She indicated the resident went to bed upon return to the facility.</p> <p>3. Review of Resident #1's clinical record revealed LPN #3 notified Resident #1's family member on 09/19/14. Interview with LPN #3, on 10/02/14 at 8:20 AM and 8:48 AM, revealed she notified Resident #1's family member on 09/19/14. Review of the clinical record for Resident #1 revealed the Director of Nursing (DON) notified Resident #1's physician (MD), who was also the facility Medical Director, on 09/19/14 of Resident #1's elopement. Interview with the MD, on 10/03/14 at 8:11 AM, revealed she was notified on 09/19/14 by the DON that Resident #1 had eloped. Interview, on 10/03/14 at 10:15 AM, with the DON revealed she notified the MD on 09/19/14 of Resident #1's elopement.</p> <p>4. Review of the video revealed, on 09/19/14 at approximately 6:42 PM, of an exit door revealed Resident #1 exited the inner doors first in his/her electric w/c and was followed by a male visitor, then a female visitor. Review of facility record revealed the DON spoke to the male visitor, who was another resident's family member, and was educated regarding assisting residents out of the facility. Interview with the DON, on 10/03/14 at 10:15 AM, revealed she had seen the video and</p>	F 282			



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F 282	Continued From page 44 spoke to the male visitor and educated him regarding assisting residents out of the facility. 5. Review of a typed statement by the DON revealed when the DON spoke with the male visitor, and CNA #3 had been identified as the staff member who had entered the door code. The Administrator spoke with the CNA on 09/19/14 and education was provided to the CNA by the DON to ensure residents did not exit when assisting visitors in or out of the building. Interview with CNA #3, on 10/01/14 at 11:02 PM, revealed she had received elopement education on 09/19/14 to ensure proper closure of the exit doors. Interview with the DON, on 10/03/14 at 10:15 AM, revealed she had spoken to the aide and provided education on 09/19/14 to stay in the area when she entered the door code. 6. Review of a written statement by the Staff Development Coordinator (SDC) revealed the SDC reviewed the elopement binders on all three (3) unit nurse's stations and the front desk. The binders were accurate and up to date with the three (3) residents that had been identified at risk of elopement prior to 09/19/14. Interview with the Staff Development Coordinator, on 10/02/14 at 9:59 AM, revealed she reviewed all of the elopement binders and found the binders were accurate and up to date. Observation, on 10/01/14 at 4:10 PM, of the 100 Unit, on 10/01/14 at 4:20 PM of the 200 Unit, on 10/01/14 at 4:29 PM, of the 300 Unit and on 10/10/02/14 at 3:00 PM of the front desk elopement binders revealed they were accurate and up to date with the three (3) residents identified at risk for elopement listed in the binders. 7. Review of a typed statement by the	F 282			



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F 282	<p>Continued From page 45</p> <p>Maintenance Director revealed the Maintenance Director checked all exit doors in the facility on 09/19/14 at approximately 7:15 PM. The doors were all functioning and the door codes changed. A sign requested visitors to see a nurse before assisting any resident out of the facility. Interview, on 10/01/14 at 3:21 PM, with the Maintenance Assistant revealed he assisted to check all exterior doors for function and reset the door codes. He stated each door had the visitor sign to see a nurse and the doors all functioned properly. Interview with the Maintenance Director, on 10/01/14, revealed he also checked the exterior door for function and the door codes had been changed. He stated the doors all functioned properly. Observation of the exterior doors, on 01/01/14 at 4:10 PM, revealed all exterior doors were locked and visitor signs posted. Observation of all facility exit doors, on 10/01/14 from 4:10 PM to 4:29 PM, revealed all doors were locked with a sign posted for visitors to see a nurse before assisting any resident out of the facility.</p> <p>8. Review of a vendor letter revealed on 09/19/14 the security company's vendor conducted a check of all the exterior doors and determined they were functioning properly and the door code had been changed. Interview with the Maintenance Assistant, on 10/01/14 at 3:21 PM, revealed the vendor was called and checked the doors on 09/19/14. Interview with the Maintenance Director, on 10/01/14, revealed the professional company checked the doors for function and the code had been changed.</p> <p>9. Review of facility records revealed a Quality Assurance (QA) meeting was held on 09/19/14 with the following members signed in: SDC, MDS Assistant, Maintenance Assistant, DON, MD (by</p>	F 282			



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F 282	Continued From page 46 phone), and the Administrator. Resident #1's care plan was reviewed with interventions added on 09/19/14. A facility census sheet, with each resident of the facility listed, was reviewed with specific questions asked to determine if any other resident was at risk for elopement with no additional residents identified at risk. The other two (2) residents who were previously identified and in the elopement binder were reviewed with no changes made. Policies reviewed included Elopement/ Wandering Residents and Missing Resident. Interviews with SDC on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed and updated Resident #1's care plan, reviewed all facility residents for risk of elopement, reviewed the care plans for the other two (2) residents previously identified at risk of elopement with no changes made, and reviewed the policies for Elopement and Missing Resident with no changes made. Observation of Resident #1, on 10/01/14 at 4:27 PM, Resident #5, on 10/02/14 at 3:30 PM, and Resident #6, on 10/02/14 at 3:35 PM, revealed the three (3) identified residents made no attempts at exit seeking behavior and staff was supervising. 10. Review of the psychiatric note, dated 09/22/14, revealed Resident #1 was seen by the APRN on 09/22/14 related to the elopement with no changes made to the resident's current medications. Interview with the APRN, on 10/02/14 at 2:33 PM, revealed she saw Resident #1 on 09/22/14 with no issues identified. Interview with the Psychiatrist, on 10/02/14 at 3:38 PM,	F 282			



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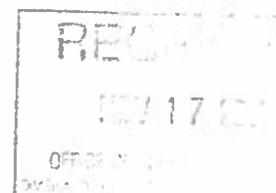
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F 282	<p>Continued From page 47</p> <p>revealed he was notified on 09/22/14 of Resident #1's elopement by the DON and he requested the APRN to see the resident. The Psychiatrist had no concerns and medications were not changed.</p> <p>11. Review of a social service note, dated 09/20/14, revealed social services contacted Resident #1's family member to review the resident's care plan and schedule a care plan meeting for 09/22/14. Review of the care plan conference summary revealed a care plan meeting was conducted on 09/22/14 with the family member present. Interview with the Social Services Director (SSD), on 10/02/14 at 1:40 PM, revealed she contacted Resident #1's family member to schedule a care plan meeting, which was 09/22/14. Interview with the Assistant Director of Nursing (ADON) for the 200 Unit, on 10/02/14 at 2:20 PM, revealed he attended the care plan meeting on 09/22/14 with Resident #1's family member.</p> <p>12. Review of nurse's notes revealed the QA meeting on 09/19/14 reviewed the care plans for the other two (2) residents previously identified at risk of elopement with no changes made. Review of the two (2) resident care plans revealed no new interventions after the 09/19/14 elopement by Resident #1. Interviews with Staff Development Coordinator, on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed the care plans for the other two (2) residents previously identified at risk of elopement with no changes made.</p>	F 282			



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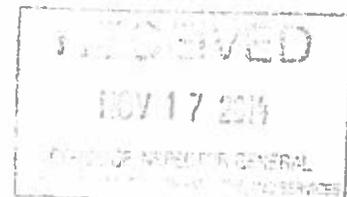
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F 282	<p>Continued From page 48</p> <p>13. Review of the facility census sheet for 09/19/14 and a list of questions used as the assessment tool revealed all residents were reviewed in the QA meeting on 09/19/14 for risk of elopement with no additional residents identified. Interviews with Staff Development Coordinator, on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed all residents of the facility with no new residents identified at risk of elopement.</p> <p>14. Review of a facility admission packet revealed a letter that requested visitors not assist any resident out of the facility. The Director of Sales and Marketing was unreachable for interview. Interview with the DON, on 10/03/14 at 10:15 AM, revealed the letter had been included in the admission packet for new residents. Review of the facility daily census sheet for 09/20/14 and 09/21/14 revealed the facility had no new admissions. Interview, on 10/03/14 at 2:25 PM, with the Administrator revealed the facility no new admissions after the elopement until 09/22/14.</p> <p>15. Review of Resident #1's care plan revealed new interventions were implemented after his/her elopement during the QA meeting on 09/19/14. Interviews with SDC, on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting</p>	F 282			



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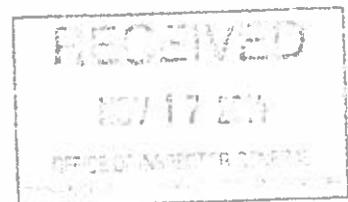
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F 282	Continued From page 49 held on 09/19/14 and reviewed and updated Resident #1's care plan to include the use of the manual wheelchair and a therapy referral. The DON stated she had reviewed Resident #1's clinical record on 09/19/14 to determine what change needed to be made to the care plan, and decided by the QA meeting that night. 16. Review of the facility staff roster and education post-tests revealed the facility began education of staff on 09/19/14 on the elopement policy. A total of two hundred (200) employees in all departments were being educated, with 154 staff trained by 09/22/14. The most recent employee was trained on 10/02/14, with thirty-two (32) PRN staff and one (1) full time employee on medical leave who needed to be trained. Review of employee schedules across departments compared to post-tests revealed staff were trained prior to or upon return to work. Interviews with thirty-one (31) staff: CNA #8 on 10/01/14 at 2:10 PM, Laundry Aide on 10/01/14 at 2:17 PM, CNA #9 on 10/01/14 at 2:24 PM, Assistant Dietary Manager on 10/01/14 at 2:27 PM, Activities Director on 10/01/14 at 2:32 PM, Physical Therapy (PT) #2 on 10/01/14 at 2:36 PM, Maintenance Director on 10/1/14 at 3:35 PM, COTA #1 on 10/01/14 at 4:24 PM, CNA #10 on 10/01/14 at 2:11 PM, CNA # 11 on 10/01/14 at 2:17 PM, Registered Nurse (RN) #1 on 10/01/14 at 2:24 PM, Licensed Practical Nurse (LPN) #6 on 10/01/14 at 2:27 PM, Cook on 10/01/14 at 2:32 PM, LPN #7 on 10/01/14 at 2:36 PM, Dietary Aide on 10/1/14 at 2:40 PM, PT #3 on 10/01/14 at 3:00 PM, Maintenance Assistant on 10/01/14 at 3:21 PM, CNA #1 on 10/01/14 at 3:37 PM, CNA #2 on 10/01/14 at 3:58 PM, Evening Supervisor #1 on 10/1/14 at 8:15 PM, CNA #3 on 10/01/14 at 11:02 PM, LPN #3 on 10/02/14 at 8:20 AM,	F 282			



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F 282	<p>Continued From page 50</p> <p>ADON 300 Unit on 10/02/14 at 1:02 PM, SSD on 10/02/14 at 1:40 PM, ADON 200 Unit on 10/02/14 at 2:20 PM, LPN #4 on 10/02/14 at 7:40 PM, LPN #5 on 10/02/14 at 7:45 PM, Business Office Manager (BOM) on 10/03/14 at 8:45 AM, HR Director on 10/03/14 at 8:50 AM, Receptionist on 10/03/14 at 8:54 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they were trained prior to working their scheduled shift on the elopement policy, what to do if there was an elopement, to stay at the exit door when they assisted anyone to enter or exit the facility and completed a post test.</p> <p>17. Review of the staff roster and education post tests revealed thirty-two (32) PRN staff needed to be trained. Review of a letter sent to the remaining staff that needed to be trained, on 09/30/14, by certified mail revealed staff needed to complete the training by 10/10/14. Review of a list of staff that needed to be trained revealed thirty-two (32) employees required training. Interview with SDC, on 10/02/14 at 9:59 AM, revealed training for staff began on 09/19/14 of the elopement policy with care plan and to stay at the door until the door was closed. Interview with the DON, on 10/03/14 at 10:15 AM, and the Administrator, on 10/03/14 at 2:25 PM, revealed a letter was sent by certified mail to remaining staff that education needed to be completed by 10/10/14. The DON stated the employee schedules were compared with the list of remaining staff daily for the following day to ensure staff were trained as they came to work. Review of a list of staff that needed to be trained revealed thirty-two (32) employees required training. Interview with SDC, on 10/02/14 at 9:59 AM, revealed she had tracked who needed to be trained and monitored daily, along with the DON.</p>	F 282		



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F 282	Continued From page 51 She stated the facility did not use agency staff. 18. Review of a letter by the DON, dated 09/20/14, revealed visitors were asked not to assist any resident out of the facility and seek assistance from a nurse. Interview with the DON, on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM, revealed the letter was placed in all resident rooms on 09/20/14 and was also mailed to all resident families. 19. Review of the facility staff roster, employee schedules across departments, and post-tests, revealed staff were trained prior to or upon return to work. All but thirty-two (32) PRN and one (1) full time employee on medical leave had been trained prior to working their next scheduled shift. Interviews with thirty-one (31) staff CNA #8 on 10/01/14 at 2:10 PM, Laundry Aide on 10/01/14 at 2:17 PM, CNA #9 on 10/01/14 at 2:46 PM, Assistant Dietary Manager on 10/01/14 at 2:27 PM, Activities Director on 10/01/14 at 2:32 PM, Physical Therapy (PT) #2 on 10/01/14 at 2:36 PM, Maintenance Director on 10/01/14 at 3:35 PM, COTA #1 on 10/01/14 at 4:27 PM, CNA #10 on 10/01/14 at 2:11 PM, CNA # 11 on 10/01/14 at 2:17 PM, Registered Nurse (RN) #1 on 10/01/14 at 2:24 PM, Licensed Practical Nurse (LPN) #6 on 10/01/14 at 2:27 PM, Cook on 10/01/14 at 2:32 PM, LPN #7 on 10/01/14 at 2:36 PM, Dietary Aide on 10/1/14 at 2:40 PM, PT #3 on 10/01/14 at 3:00 PM, Maintenance Assistant on 10/01/14 at 3:21 PM, CNA #1 on 10/01/14 at 3:37 PM, CNA #2 on 10/01/14 at 3:58 PM, Evening Supervisor #1 on 10/1/14 at 8:15 PM, CNA #3 on 10/1/14 at 11:02 PM, LPN #3 on 10/02/14 at 8:20 AM, ADON 300 Unit on 10/02/14 at 1:02 PM, SSD on 10/02/14 at 1:40 PM, ADON 200 Unit on 10/02/14 at 2:20 PM, LPN #4 on 10/02/14 at 7:40 PM, LPN	F 282			



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F 282	Continued From page 52 #5 on 10/02/14 at 7:45 PM, BOM on 10/03/14 at 8:45 AM, HR Director on 10/03/14 at 8:50 AM, Receptionist on 10/03/14 at 8:54 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they were trained prior to working their scheduled shift on the elopement policy, what to do if there was an elopement, to stay at the exit door when they assisted anyone to enter or exit the facility and completed a post test. 20. Review of daily monitoring sheets for observation of staff who let visitors in or out of the building began on 09/19/14 at 8:45 PM revealed observations were conducted daily with a minimum of three (3) observations every twelve (12) hours and reviewed by the DON. Interview with the DON, on 10/03/14 at 10:15 AM, revealed the monitoring forms were completed daily for observations of any staff that had let a visitor in or out at the exit doors every twelve (12) hours from 6:00 AM, and 6:00 PM shifts, to ensure the staff remained at the door and the door had closed. She stated the monitoring of the doors would be reviewed in QA; however, no concerns had been identified. Interview with the Administrator, on 10/03/14 at 2:25 PM, revealed the exit doors would be monitored every twelve (12) hours shifts, from 6:00 AM - 6:00 PM, and 6:00 PM - 6:00 AM, to observe staff who would let visitors out of the building and ensure the door was closed before they left the area. He stated the DON and he both reviewed the monitoring and would discuss this in QA.	F 282	Immediate Jeopardy Concern Stated: After assessment of ongoing interventions the facility did not update care plan to reflect the resident's repeated attempts of exit seeking so that approaches could have been put into place to prevent elopement or provide adequate supervision to prevent elopement. Resident(s) affected by the IJ and actions taken to remove IJ: The only resident identified as being affected the immediate jeopardy is the resident that was reported in the elopement (Resident #1). The incident in question occurred on 9/19/2014 at 6:52 pm. The resident was witnessed approximately 172 yards off campus by the maintenance director and a COTA from the facility. Action items to remove the jeopardy are as follows: • At approximately 6:52 pm on 9/19/14, COTA immediately went to the resident and assured his safety by observing for any obvious signs of injury and staying with him until another staff member arrived. The Maintenance Director (MD) went back to the facility to notify staff and activate the elopement protocols. All other residents were accounted for during the head count. MD returned to assist the COTA and Resident #1 back to the facility. • A skin assessment and vital signs were completed by Resident #1's LPN and were within normal	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		



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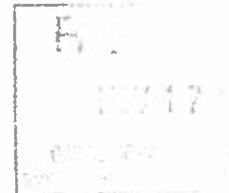
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F 323	<p>Continued From page 53</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation, policy and procedures, and video surveillance it was determined the facility failed to have an effective system in place to ensure supervision of residents at risk for elopement. This failure affected one (1) of three (3) residents identified at risk for elopement out of the seven (7) sampled residents, (Resident #1).</p> <p>On 09/19/14 at 6:44 PM, Resident #1 exited the facility without staff knowledge. Interview and review of the facility's video surveillance revealed Resident #1 was near the exit door to the 100 Unit when staff entered the code to the exit door for two visitors to leave the facility, and Resident #1 exited the facility with the two (2) visitors. At approximately 6:52 PM, the Maintenance Director was returning to the facility and saw Resident #1 on the sidewalk of the two (2) lane street moving towards the intersection of a six (6) lane street. The Maintenance Director stopped to retrieve the resident when he saw the resident with Certified Occupational Therapy Assistant (COTA) #1. The Maintenance Director returned to the facility and called a Code Green to alert staff of the elopement of Resident #1. Staff was not aware Resident #1 had eloped until the code was called. The resident was returned to the facility at 6:58</p>	F 323	<p>limits. Resident #1 was assisted to bed per his choice. Assessment did not reveal any signs of injury or trauma.</p> <ul style="list-style-type: none"> Resident #1's wife was contacted by LPN on 9/19/14 to inform her of the event of her husband exiting the facility. Physician and facility Medical Director was notified by Director of Nursing on 9/19/14 of the event. Upon review of the security camera footage by the Administrator and Director of Nursing on 9/19/14, it was determined that Resident #1 was helped outside by a visiting family member. The visitor's son was called by the DON, on 9/19/14 and asked him about the incident. The visitor stated that he did hold the door for the resident to exit, but he was unaware the the resident was not able to exit without staff assistance. Education was also provided to the family member regarding assisting residents outside of secure doors. Information from the interview with the son also identified the CNA that punched the code to release the maglock. The CNA was interviewed by the Administrator on 9/19/14 and education on elopement policy and procedures provided by the DON on 9/19/14. This education included staying observant of the surrounding area to ensure no resident exits when assisting visitor in or out of the door. A review of Elopement books was completed on 9/19/14, by the DON and Staff Development Coordinator to ensure that the elopement risk forms for each resident identified at risk for elopement were accurate. 3 total residents were reviewed. On 9/19/14, Maintenance Director and assistant checked all exterior doors for proper function with no issues identified. Proper signage was in place at all doors. The sign reads "Visitors: Please see a nurse before assisting any resident out of the facility." On 9/19/14, Administrator called in a vendor to check overall operation of all exterior doors with no issues identified. This inspection was completed on 9/19/14. 		



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F 323	<p>Continued From page 54 PM and assessed with no injuries.</p> <p>The facility's failure to ensure appropriate supervision of residents at elopement risk placed Resident #1 and other residents at risk in a situation that has caused or is likely to cause serious injury, harm, impairment or even death to a resident. The Immediate Jeopardy was identified 09/25/14 and determined to exist on 09/19/14. The facility was notified of the Immediate Jeopardy on 09/25/14.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 09/30/14 that alleged removal of Immediate Jeopardy on 09/23/14. However, the State Survey Agency verified Immediate Jeopardy was removed on 10/03/14, after training of facility staff was verified completed on 10/02/14, at 42 CFR 483.25 Quality of Care (F323) with the scope and severity 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 titled Safety and Supervision of Residents, revised December 2007, revealed resident supervision was a core component of the systems approach to safety. The type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. Unsafe wandering was identified as a resident risk and environmental hazard.</p>	F 323	<ul style="list-style-type: none"> ADHOC QAPI meeting regarding resident's elopement and plan of care that included MDS, DON, Admin, SS, SDC and Medical Director occurred on 9/19/14. Resident's care plan was updated to reflect new interventions. Each resident was discussed to determine if they were affected by the elopement or if changes need to be made to their elopement risk status. No additional residents were identified and the 2 other "at risk" residents' care plans were reviewed with no changes. No changes were made to the policies reviewed. Policies reviewed were elopement and missing persons. Dr. Pelligrini, Psychiatry, was informed of the event by ADON on 9/22/14. His NP, evaluated resident on 9/22/14 for any psychosocial needs related to the event. No recommendations were made. In addition to Resident #1's wife being notified of the event on 9/19/14, his care plan was reviewed with her on the morning of 9/20/14 by the social services director, and a subsequent care plan meeting held was held on 9/22/14 with the IDT and DON. Care plans for 2 other residents previously identified as elopement risk were reviewed by the IDT on 9/19/14 to assess for any necessary changes. No changes were made to these care plans. 125 residents were reviewed by the IDT and DON on 9/19/14 to ensure no risk related to this particular event. No additional risk was identified. A letter was added by the Director of Sales and Marketing on 9/20/14 to the admission packet for all new admissions and families. No new admissions until 9/22/14. This letter addresses reminding visitors not to assist residents out of the facility without the knowledge of staff. 		



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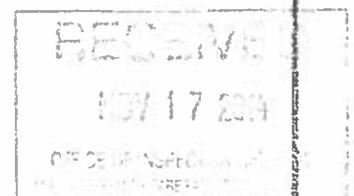
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F 323	<p>Continued From page 55</p> <p>Review of the facility's policy titled Elopement/Wandering Residents, effective December 2010, revealed it was the intent of the facility to determine which residents had significant wandering behavior and enhance staff awareness as well as educate them on how to deal with such residents. Any resident displaying significant wandering behavior would be assessed for elopement/wandering risk and care planned appropriately.</p> <p>Review of Resident #1's Minimum Data Set (MDS), dated 09/06/14, revealed the facility assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of a four (4). The resident's functional status for mobility was assessed by the facility as non-ambulatory and requiring supervision on the unit and independent off the unit once in the electric wheelchair.</p> <p>Review of Resident #1's Elopement Risk Assessments dated 05/27/11, 07/08/13, 09/24/13, 10/30/13, and 01/08/14 revealed the facility assessed the resident wandered aimlessly; would leave the facility without informing staff; and, verbally expressed the desire to go home or stay near a exit door. Review of the Elopement Assessments, dated 05/30/14, 06/11/14, and 09/05/14, revealed the facility assessed Resident #1 had the ability to exit the building and was at risk for elopement.</p> <p>Review of the elopement risk/exit seeking care plan, initiated on 04/12/13 and last reviewed on 09/04/14, revealed the resident wandered the facility in his/her wheelchair and would often gravitate to exit doors. The interventions were to monitor for tail gaiting when visitors were in the building; use verbal and physical cues for</p>	F 323	<ul style="list-style-type: none"> Review of resident #1's record revealed that care plan interventions were followed related to redirecting resident when he would navigate towards exit doors and these interventions had been effective up until the actual event on 9/19/2014 <p>Training:</p> <p>On 9/19/14, immediate education of all staff members working in facility was educated by ADON, Director of Clinical Education, Social Worker, LPN or RN on the elopement policy, care plans and to be aware of the area around the doors to make sure that everyone entering and exiting the building is appropriate. Post-test competencies are also being administered with the training. By 9/22/14, 135 staff members were trained with 65 employees to be trained. Of the remaining 65, 15 are PRN therapy staff that are on our payroll, but work in other Signature locations other than East Louisville. This education has been ongoing with no staff member being allowed to work their shift prior to the education. This education will be provided to all employees in all departments including administration, LPNs, RNs, CNAs, Dietary, Housekeeping, therapy, laundry, activities and social services. This will continue until all staff members receive the education. Staff development coordinator will ensure that all remaining staff members receive their training before working and will educate all new hires prior to starting orientation. This facility does not utilize agency staff.</p> <p>On 9/19/14, a letter was drafted by the DON and Admin to educate family members and residents on being aware of those going in and out of the facility and to please check with nursing staff before assisting residents in out of the facility. This letter was placed in all resident rooms on 9/19/14 and placed in the outgoing mail on 9/19/14 to all family representatives.</p>		

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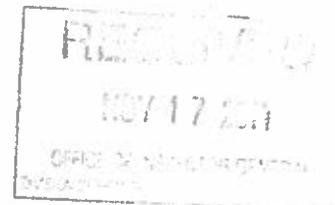
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F 323	<p>Continued From page 56</p> <p>redirection; diversional activities for exit seeking behavior; picture in elopement binder; and to monitor resident per facility policy.</p> <p>Review of the care plan meeting, dated 02/28/14, revealed Resident #1 had been identified as having exit seeking behaviors. Review of the care plan note, dated 09/04/14, revealed Resident #1's exiting seeking behaviors were because he/she wanted his/her spouse.</p> <p>Review of the facility's investigation revealed Resident #1 exited the 100 Unit door, on 09/19/14 at 6:44 PM, with a male family member and a phlebotomist technician when Certified Nursing Assistant (CNA) #3 entered the exit door code. The Maintenance Director was returning to the facility at approximately 6:52 PM when he observed Resident #1 in his/her electric wheelchair (w/c) on the sidewalk down the street from the facility. He parked his vehicle and saw COTA #1 with the resident. The Maintenance Director proceeded to the facility and called a Code Green and then went to Resident #1 and the COTA. The resident was returned to the facility at approximately 6:58 PM without injury.</p> <p>Observations, on 09/24/14 at 8:10 AM, of the route taken by Resident #1 upon exit from the facility revealed when the resident exited the facility property he/she propelled his/her electric wheelchair onto the sidewalk located at the right side of the facility front parking lot. This placed the resident parallel to the frontage road heading towards the intersection of a main road with six (6) lanes and a speed limit of forty-five (45) miles per hour. There was a traffic light at the intersection.</p>	F 323	<p>Post education competencies were completed by all staff when the education was completed. This has been completed by all staff who has worked to date. No staff will be permitted to work until training has occurred.</p> <p>Monitoring:</p> <p>The facility began monitoring on 9/19/14 at 8:45 p.m. and are performing 3 observations every 12 hour shift by Admin, DON, dept head team, IDT and RN supervisors of staff monitoring the area around the doors when letting families in/out. These audits will be collected daily by the administrator and reviewed for tracking/trending. The monitoring will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p> <p>Alleged removal of IJ:</p> <p>The facility feels that this is past non-compliance and as of 9/23/14 we took all of the necessary steps to abate the jeopardy.</p> <p>F 323</p> <p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>On 9/19/14, Resident #1's care plan and CNA care plan was reviewed and updated by the DON, MDS, Social service, and staff development coordinator. Resident #1 was referred to therapy by DON on 9/19/14 for proper positioning and work on mobility in manual wheelchair.</p>	11/14/14	



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F 323	<p>Continued From page 57</p> <p>Interview with the Maintenance Director, on 09/24/14 at 8:18 AM, revealed he was returning to the facility at approximately 6:44 PM on 09/19/14 when he saw Resident #1 on the sidewalk in an electric wheelchair rolling towards the busy main road. He parked his truck and began to walk towards the resident when he saw the COTA with the resident. He then got back in his truck continued to the facility, and once he entered the facility, he called a Code Green. Per interview, staff was not aware Resident #1 had eloped until the code was called. He estimated the resident was approximately 75 yards from the entrance to the facility's property. Driving measurement to the location was a tenth (10th) of a mile from the facility.</p> <p>Interview with COTA #1, on 09/25/14 at 6:50 PM, revealed as she left work and took a right onto the two lane road, the resident was in the electric wheelchair moving slowly. She stated she started to call her boss when the resident came to her with no problem. She started to push the resident when Maintenance arrived. She revealed the battery on the resident's chair was running down. She got the resident to her car and back to the facility.</p> <p>Observations during a facility tour, on 09/24/14 at 8:10 AM, revealed the facility had entrance doors at the main entrance, which had a vestibule, on the 100 Unit that had a vestibule also, and on the 300 Unit. The 200 Unit only had emergency exit doors. Each of the exit doors including the emergency exits had exit code panels. An exit door located in the main dining room had an exit code panel allowing access to the smoking patio which was a fenced area. In addition, each exit door on a window panel next to the door had a</p>	F 323	<p>How will the facility identify other residents that have the potential to be affected?</p> <p>On 9/19/14, all residents were reviewed for potential elopement risk by the DON, MDS, social services and staff development coordinator. The facility had previously identified 2 additional residents at risk for elopement. No additional residents were identified as being affected.</p> <p>Care plans for resident #1 and the 2 previously identified residents were reviewed and updated on 9/19/14 by DON, MDS, social services and staff development coordinator.</p> <p>What measures will be put into place to ensure that the deficient practice will not recur?</p> <p>CNA #1 was educated on 9/19/2014 by Administrator and DON regarding remaining observant of the area when assisting family members in or out of the facility. All staff has been educated on 10/2/14, by the SDC, DON, ADONs and RNs on the Elopement and Missing Persons policy and procedure, Disaster code for Elopement, ensuring environment is secure when letting customers in or out, how to identify residents at risk for elopement, possible interventions for residents that have been identified at risk for elopement, care plan development, care plan revisions and following the care plans. This training also addressed the CNA care plans as well. All staff also received post testing related to the above information.</p> <p>Door observation audits that include ensuring appropriate supervision by staff of exit areas when assisting customers in and out, will continue 15x weekly x12 weeks by the DON, Admin, ADON, RNs and department heads.</p>		



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F 323	<p>Continued From page 58</p> <p>sign which read: "Please see a nurse before assisting any visitor out of the building." Each of the exit doors except on the 200 Unit had cameras.</p> <p>Review of the facility's video surveillance of the exit doors on the 100 Unit hallway revealed the inner door being pushed by Resident #1 in an electric wheelchair with his/her left hand on the door in front of a male visitor with the visitor's left hand on the door behind Resident #1's. They both appeared to be pushing the door at the same time. Once the resident and the now visualized male visitor entered the vestibule between the inside and outside door a third person, a female, was seen entering the vestibule before the outside exit door. The male visitor, once the inner door had been cleared, walked past Resident #1 and held open the outside door, allowing Resident #1 access to the outside into the parking area. After Resident #1 exited the facility he/she was not seen any more, time stamped on the video was 6:44 PM. The video did not show any staff in the area.</p> <p>Interview with Family Member #1, on 09/24/14 at 4:25 PM, revealed he had been at the facility visiting a relative. When he went to the 100 Unit exit door, Resident #1 was sitting in front of the door in his/her electric wheelchair. He stated he had asked a female who he thought was a staff member if she could open the door for him. However, she did not work for the facility. She joined him at the door and they stood behind Resident #1. When the staff member who was passing in the hallway punched the exit code Resident #1 pushed the unlocked inside door. He stated he did walk around Resident #1 and held the outside door open for him/her to exit. He did</p>	F 323	<p>How the facility will monitor its performance to ensure solutions are sustained.</p> <p>The administrator will review the results of the audits weekly and forward the results of the audits to the monthly Quality Assurance Committee for further review and recommendation. The audits will be presented by the Admin and DON weekly for 3 months, then monthly x3 months to the QAPI team for review and recommendation based upon the results.</p>		

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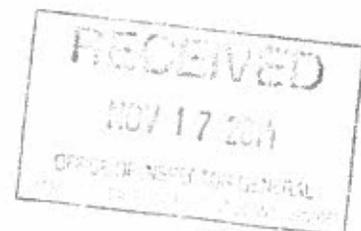
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F 323	<p>Continued From page 59</p> <p>not think this was inappropriate since the facility staff member had punched the code with Resident #1 sitting in front of the locked door. He stated during his visits to the facility, persons he thought were residents were always entering and exiting the facility through the 100 Unit hallway doors.</p> <p>Interview on 09/25/14 at 9:20 AM, with the Phlebotomist who was identified as the female at the door with the visitor, revealed she had been at the facility obtaining laboratory specimens when a male visitor approached her and asked if she could open the 100 Unit exit door. She replied she could not open the door and joined him in front of the door, both of them standing behind Resident #1 who was sitting in front of the door. She further stated when the facility staff member punched in the door exit code, Resident #1 was the first person to exit into the vestibule before exiting the outside door. She further stated she was at the facility several times a week and there were always residents entering and exiting the facility from the 100 Unit hallway door. She had had no concerns related to Resident #1 exiting the facility for that reason.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 09/24/14 at 11:30 PM, revealed she entered the exit code disarming the alarm on the 100 Unit exit door on the evening of 09/19/14. She further stated she did not see Resident #1 at the door when she deactivated the alarm and walked away.</p> <p>Interview with CNA #7, on 09/30/14 at 9:12 AM, revealed she was aware Resident #1 had been at risk for elopement prior to the elopement on 09/19/14. She indicated Resident #1 liked to go to</p>	F 323		

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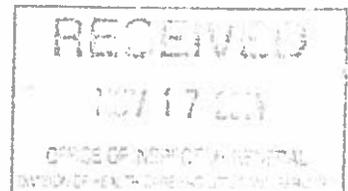
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F 323	<p>Continued From page 60</p> <p>the 100 Unit doors and believed the resident wanted to leave the facility. The aide indicated the resident's spouse would frequently visit and took Resident #1 outside. Additionally, the aide stated Resident #1 would only attempt to leave the facility through the 100 Unit doors. She indicated only staff had the door code and a staff member would have had to enter the code that allowed the resident to elope. The CNA further indicated staff were responsible to supervise residents, even if the visiting family were present.</p> <p>Interview with Registered Nurse (RN) #2, on 09/24/14 at 3:10 PM, revealed Resident #1 was constantly roaming the facility. He/she was seen approaching the exit doors. To his knowledge Resident #1 had not pushed on a door, but he acknowledged if a door was open Resident #1 was likely to go through it.</p> <p>Interview with COTA #1, on 09/25/14 at 4:24 PM, revealed Resident #1, constantly, during waking hours, roamed the facility and frequently sat in front of exit doors.</p> <p>Interview, on 09/29/14 at 3:05 PM, with RN #5 revealed a resident was at risk for elopement if the resident frequently sat at the doors, and stated he/she wanted to go home, what was the resident BIMS score, and if the resident was confused. She stated Resident #1 had a history of going to all three (3) units in the facility. The nurse indicated Resident #1 was at risk for elopement due to his/her level of cognition. She stated if a resident with cognitive impairment left the facility the resident was at risk for an accident. The RN indicated only staff members had the exit door code, and family or visitors were not given the codes. The nurse further indicated a staff</p>	F 323			



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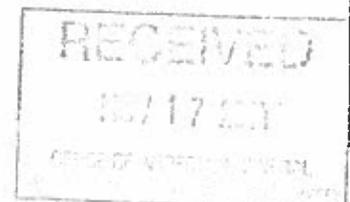
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F 323	<p>Continued From page 61</p> <p>member would have had to enter the door code in order for Resident #1 to have exited the facility.</p> <p>On 09/29/14 at 3:44 PM, interview with the Activities Director (AD) revealed Resident #1 enjoyed looking out of the windows and doors. She stated the resident would ask for his/her spouse often and looked out of the 100 Unit door often for him/her. The AD indicated Resident #1 would go through any open door. She further indicated Resident #1 had eloped due to the resident left the facility unsupervised. The AD stated if a resident eloped, horrible things could happen to the resident or the resident could be hit by a car. She indicated all staff were responsible to supervise residents and visitors were not responsible for supervision of residents.</p> <p>On 09/29/14 at 2:31 PM, interview with the Therapy Director revealed it was unsafe for Resident #1 to leave the facility unsupervised. She stated he/she could have come across uneven terrain in the wheelchair, or among the vehicles driving down the street. The Therapy Director indicated the resident eloped as he/she had left the facility without staff knowledge and was cognitively impaired. She further indicated a resident that was cognitively impaired and left the facility without staff knowledge could be injured or killed.</p> <p>Interview with the Director of Nursing (DON), on 09/24/14 at 1:26 PM, revealed Resident #1 was constantly roaming the facility and he/she liked to sit in front of the exit door on the 100 Unit. She did not consider the behavior exit seeking, but stated Resident #1 would go through any opened door.</p>	F 323			



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F 323	<p>Continued From page 62</p> <p>Interview with the Administrator (ADM), on 09/24/14 at 1:30 PM, revealed when he interviewed CNA #3, she stated she did not see Resident #1 when she deactivated the 100 Unit door alarm. The ADM was aware Resident #1's left hand was seen on the video in front of the visitors. The ADM stated Resident #1 was constantly propelling his electric wheelchair to all areas of the facility, but to his knowledge he had never pushed a door open. He also acknowledged Resident #1 would go through any opened door.</p> <p>Interview and record review revealed the resident had exhibited exit seeking behaviors in March 2014. Interview with Licensed Practical Nurse (LPN) #2, on 09/25/14 at 10:00 AM, revealed she had placed Resident #1 on every fifteen (15) minute observations on 03/15/14 for agitation and exit seeking. The resident had been overheard to ask persons to let him/her out of the building. However, she felt ongoing observations of the resident were not necessary.</p> <p>Interview with RN #3, on 09/25/14 at 10:05 AM, revealed on 03/18/14 she had placed Resident #1 on every thirty (30) minute observations for agitation and exit seeking. However, she felt no other interventions were needed.</p> <p>Interview, on 09/26/14 at 3:02 PM, with the Social Services Director (SSD) revealed on 03/15/14 Resident #1 had exhibited exit seeking behavior in the past and had been sitting by a locked door in March 2014. She stated the resident's care plan was updated at that time with intervention of fifteen (15) minute checks for two (2) days, with no additional interventions added. She indicated the resident exhibited exit seeking behaviors</p>	F 323			



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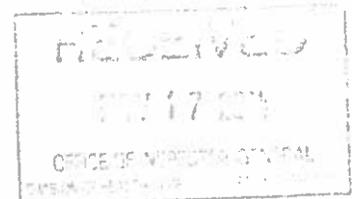
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F 323	<p>Continued From page 63 often and roamed throughout the facility.</p> <p>Further interview with the DON, on 10/01/14 at 8:56 AM, revealed she had viewed the video of Resident #1's elopement on 09/19/14. She indicated she was unsure who had entered the exit door code as that portion of the doorway was not visible in the video. She stated visitors and residents were not given the exit door code and the root cause of Resident #1's elopement was determined the CNA had entered the door code and then left the area without ensuring the area was secured. The DON stated if the aide had stayed at the exit door until the door was closed the resident might not have eloped. She indicated the aide was distracted when she entered the door code that allowed Resident #1 and the visitors to exit the facility. She further stated if staff entered the door code and did not stay at the door, then any resident with the physical capability to exit the door would be able to leave the facility. She stated if staff remained at the door until the door was closed, then residents would not be able to exit.</p> <p>Further interview with the Administrator, on 10/01/14 at 10:42 AM, revealed the root cause of Resident #1's elopement determined the CNA had entered the door code at the exit door and did not stay at the door to ensure the door was secured. He stated visitors were not responsible to supervise residents. The Administrator stated he was aware of Resident #1's previous exit seeking behaviors as the resident would go to the exit doors. He indicated a resident determined at risk of elopement would have poor safety awareness or poor judgment. He further indicated if a resident at risk for elopement left the facility the resident could get lost or hit by a car.</p>	F 323		



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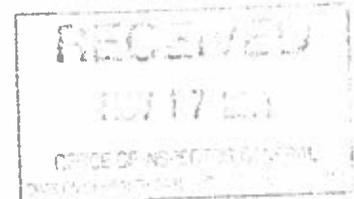
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F 323	Continued From page 64 The facility provided an Allegation of Compliance (AOC) on 09/30/14 alleging the Immediate Jeopardy was removed on 09/23/14; however, the State Survey Agency verified that staff training was completed on 10/02/14. The facility took the following immediate steps to remove the Immediate Jeopardy: 1. At approximately 6:52 PM on 09/19/14, a COTA immediately went to the resident and assured his/her safety by observing for any obvious signs of injury and staying with him/her until another staff member arrived. The Maintenance Director went back to the facility to notify staff and activate the elopement protocols. All other residents were accounted for during the head count. Maintenance Director returned to assist the COTA and Resident #1 was returned to the facility at 6:58 PM. 2. A skin assessment and vital signs were completed by Resident #1's LPN and were within normal limits. Assessment did not reveal any signs of injury or trauma. 3. Resident #1's husband/wife was contacted by the LPN on 09/19/14 to inform him/her that his/her spouse had exited the facility. Physician and facility Medical Director was notified by the Director of Nursing (DON) on 09/19/14 of the event. 4. Upon review of the security camera footage by the Administrator and DON on 09/19/14, it was determined that Resident #1 was helped outside by a visiting family member. The visitor was called by the DON, on 09/19/14 and asked him about the incident. The visitor stated that he did	F 323			



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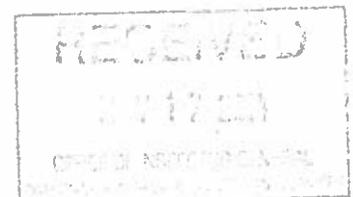
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F 323	<p>Continued From page 65</p> <p>hold the door for the resident to exit, but he was unaware the resident was not able to exit without staff assistance. Education was also provided to the family member regarding assisting residents outside of secured doors.</p> <p>5. Information from the interview with visitor also identified the CNA that entered the code to release the maglock. The CNA was interviewed by the Administrator on 09/19/14 and education on elopement policy and procedures provided by the DON on 09/19/14. This education included staying observant of the surrounding area to ensure no resident exited when assisting a visitor in or out of the door.</p> <p>6. A review of the Elopement books were completed on 09/19/14, by the DON and Staff Development Coordinator (SDC) to ensure the elopement risk forms for each resident identified at risk for elopement were accurate. Three (3) total residents were reviewed.</p> <p>7. On 09/19/14, the Maintenance Director and Maintenance Assistant checked all exterior doors for proper function with no issues identified. Proper signage was in place at all doors. The sign read "Visitors: Please see a nurse before assisting any resident out of the facility."</p> <p>8. On 09/19/14, the Administrator called in the door vendor to check overall operation of all exterior doors with no issues identified. This inspection was completed on 09/19/14.</p> <p>9. An ADHOC-QAPI meeting regarding resident's elopement and plan of care that included MDS, Director of Nursing, Administrator, Social Services, Staff Development Coordinator and</p>	F 323			



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F 323	<p>Continued From page 66</p> <p>Medical Director occurred on 09/19/14. Resident's care plan was updated to reflect new interventions. Each resident was discussed to determine if they were affected by the elopement or if changes were needed to their elopement risk status. No additional residents were identified and the two (2) other "at risk" residents' care plans were reviewed with no changes. No changes were made to the policies reviewed. Policies reviewed were Elopement and Missing Persons.</p> <p>10. Psychiatry, was informed of the event by the ADON on 09/22/14. The Nurse Practitioner (APRN), evaluated Resident #1 on 09/22/14 for any psychosocial needs related to the event. No recommendations were made.</p> <p>11. In addition to Resident #1's spouse being notified of the event on 09/19/14, the resident's care plan was reviewed with the spouse on the morning of 09/20/14 by the Social Services Director (SSD), and a care plan meeting was held on 09/22/14 with the Interdisciplinary Team (IDT) and the DON.</p> <p>12. Care plans for two (2) other residents previously identified as elopement risk were reviewed by the IDT on 09/19/14 to assess for any necessary changes. No changes were made to these care plans.</p> <p>13. One hundred twenty-five (125) residents were reviewed by the IDT and DON on 09/19/14 to ensure no risk related to this particular event. No additional risk was identified.</p> <p>14. A letter was added by the Director of Sales and Marketing on 09/20/14 to the admission</p>	F 323			



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F 323	<p>Continued From page 67</p> <p>packet for all new admissions and families. There were no new admissions until 09/22/14. The letter addressed reminding visitors not to assist residents out of the facility without the knowledge of staff.</p> <p>15. A review of Resident #1's record revealed that care plan interventions were followed related to redirecting resident when he/she would navigate towards exit doors and these interventions had been effective up until the actual event on 09/19/14.</p> <p>16. On 09/19/14, immediate education of all staff members working in facility was provided by the ADON, SDC, SSD, LPN or RN on the elopement policy, care plans and to be aware of the area around the doors to make sure that everyone entering and exiting the building were appropriate. Post-test competencies are also being administered with the training. By 09/22/14, 135 staff members were trained with 65 employees to be trained. This education would be provided to all employees in all departments including Administration, LPNs, RNs, CNAs, Dietary, Housekeeping, Therapy, Laundry, Activities and Social Services. This would continue until all staff members received the education. Post education competencies were completed by all staff when education was completed and had been completed by all staff who had worked to date. No staff would be permitted to work until training had occurred.</p> <p>17. Of the remaining 65 employees as stated in the AOC, fifteen (15) are PRN therapy staff on the payroll, but work in other Signature locations other than East Louisville. This education had been ongoing with no staff member being allowed</p>	F 323			



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F 323	<p>Continued From page 68 to work their shift prior to the education.</p> <p>18. The SDC would ensure that all remaining staff members receive their training before they worked and would educate all new hires prior to starting orientation. The facility did not utilize agency staff.</p> <p>19. On 09/19/14, a letter from the DON and Administration educated family members and residents to be aware of others who entered or exited the facility and check with nursing staff before they assisted residents in or out of the facility. The letter was placed in all resident rooms on 09/19/14 and placed in outgoing mail on 09/19/14 to all family representatives.</p> <p>20. The facility began monitoring, on 09/19/14 at 8:45 PM, and had perform three (3) observations every 12 hour shift by the Administrator, DON, Department Head team, IDT and RN supervisors of staff monitor the area around the doors when they let families in or out. These audits would be collected daily by the Administrator and reviewed for tracking/trending in the next QA meeting.</p> <p>Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 10/03/14, with a compliance date of 10/03/14 prior to exit as follows:</p> <p>1. Review of the facility's investigation revealed COTA #1 was driving down the street and observed Resident #1 in his/her electric wheelchair (w/c) on the sidewalk. The COTA parked her vehicle and stayed with the resident until other staff arrived. The Maintenance Director had been driving to the facility and saw Resident #1 on the sidewalk in his/her electric wheelchair</p>	F 323			



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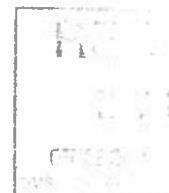
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F 323	Continued From page 69 (w/c). Interview with COTA #1, on 10/01/14, revealed she was leaving the facility at approximately 6:50 PM on 09/19/14 and saw Resident #1 on the sidewalk headed toward a busy intersection. She stated she parked her vehicle and stayed with the resident until another staff member arrived. She stated the Maintenance Director arrived and they assisted Resident #1 back to the facility. Interview with the Maintenance Director, on 10/01/14, revealed on 09/19/14 at approximately 6:52 PM, he saw Resident #1 in his/her electric wheelchair on the sidewalk moving in the direction of a busy intersection. He stated he parked his vehicle and saw COTA #1 with the resident and then entered the facility and called a Code Green. In response to the Code Green, interviews with Licensed Practical Nurse (LPN) #4, on 10/02/14 at 7:40 PM, revealed he did a head count of residents on the 300 unit on 09/19/14 and all residents were accounted for and reported to the Maintenance Director. Interview with LPN #5, on 10/02/14 at 7:45 PM, revealed he completed a head count of residents on the 200 unit on 09/19/14 with all residents accounted for except Resident #1, and reported to the Maintenance Director. Interview with the Maintenance Director, on 10/03/14 at 8:45 AM, revealed the nurse on the 100 Unit had completed a head count and reported to him all residents were accounted for. Review of the facility head count revealed on 09/19/14 the elopement code was called at approximately 6:53 PM and a head count was completed on the 100, 200, and 300 Units with all residents accounted except Resident #1. 2. Review of the clinical record for Resident #1 revealed, on 09/19/14 a skin assessment and vital signs were completed by LPN #3 upon	F 323			



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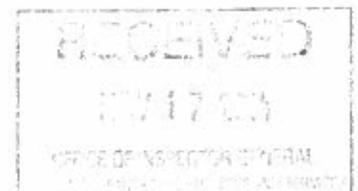
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F 323	<p>Continued From page 70</p> <p>his/her return to the facility with no concerns noted. Interview with LPN #3, on 10/02/14 at 8:20 AM and 8:48 AM, revealed she completed a skin assessment on 09/19/14 of Resident #1 with no new injuries and the resident's vital signs were within normal limits. She indicated the resident went to bed upon return to the facility.</p> <p>3. Review of Resident #1's clinical record revealed LPN #3 notified Resident #1's family member on 09/19/14. Interview with LPN #3, on 10/02/14 at 8:20 AM and 8:48 AM, revealed she notified Resident #1's family member on 09/19/14. Review of the clinical record for Resident #1 revealed the Director of Nursing (DON) notified Resident #1's physician (MD), who was also the facility Medical Director, on 09/19/14 of Resident #1's elopement. Interview with the MD, on 10/03/14 at 8:11 AM, revealed she was notified on 09/19/14 by the DON that Resident #1 had eloped. Interview, on 10/03/14 at 10:15 AM, with the DON revealed she notified the MD on 09/19/14 of Resident #1's elopement.</p> <p>4. Review of the video revealed, on 09/19/14 at approximately 6:42 PM, of an exit door revealed Resident #1 exited the inner doors first in his/her electric w/c and was followed by a male visitor, then a female visitor. Review of facility record revealed the DON spoke to the male visitor, who was another resident's family member, and was educated regarding assisting residents out of the facility. Interview with the DON, on 10/03/14 at 10:15 AM, revealed she had seen the video and spoke to the male visitor and educated him regarding assisting residents out of the facility.</p> <p>5. Review of a typed statement by the DON revealed when the DON spoke with the male</p>	F 323			



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F 323	<p>Continued From page 71</p> <p>visitor, and CNA #3 had been identified as the staff member who had entered the door code. The Administrator spoke with the CNA on 09/19/14 and education was provided to the CNA by the DON to ensure residents did not exit when assisting visitors in or out of the building. Interview with CNA #3, on 10/01/14 at 11:02 PM, revealed she had received elopement education on 09/19/14 to ensure proper closure of the exit doors. Interview with the DON, on 10/03/14 at 10:15 AM, revealed she had spoken to the aide and provided education on 09/19/14 to stay in the area when she entered the door code.</p> <p>6. Review of a written statement by the Staff Development Coordinator (SDC) revealed the SDC reviewed the elopement binders on all three (3) unit nurse's stations and the front desk. The binders were accurate and up to date with the three (3) residents that had been identified at risk of elopement prior to 09/19/14. Interview with the Staff Development Coordinator, on 10/02/14 at 9:59 AM, revealed she reviewed all of the elopement binders and found the binders were accurate and up to date. Observation, on 10/01/14 at 4:10 PM, of the 100 Unit, on 10/01/14 at 4:20 PM of the 200 Unit, on 10/01/14 at 4:29 PM, of the 300 Unit and on 10/10/02/14 at 3:00 PM of the front desk elopement binders revealed they were accurate and up to date with the three (3) residents identified at risk for elopement listed in the binders.</p> <p>7. Review of a typed statement by the Maintenance Director revealed the Maintenance Director checked all exit doors in the facility on 09/19/14 at approximately 7:15 PM. The doors were all functioning and the door codes changed. A sign requested visitors to see a nurse before</p>	F 323			



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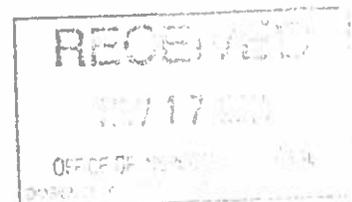
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F 323	<p>Continued From page 72</p> <p>assisting any resident out of the facility. Interview, on 10/01/14 at 3:21 PM, with the Maintenance Assistant revealed he assisted to check all exterior doors for function and reset the door codes. He stated each door had the visitor sign to see a nurse and the doors all functioned properly. Interview with the Maintenance Director, on 10/01/14, revealed he also checked the exterior door for function and the door codes had been changed. He stated the doors all functioned properly. Observation of the exterior doors, on 01/01/14 at 4:10 PM, revealed all exterior doors were locked and visitor signs posted. Observation of all facility exit doors, on 10/01/14 from 4:10 PM to 4:29 PM, revealed all doors were locked with a sign posted for visitors to see a nurse before assisting any resident out of the facility.</p> <p>8. Review of a vendor letter revealed on 09/19/14 the security company's vendor conducted a check of all the exterior doors and determined they were functioning properly and the door code had been changed. Interview with the Maintenance Assistant, on 10/01/14 at 3:21 PM, revealed the vendor was called and checked the doors on 09/19/14. Interview with the Maintenance Director, on 10/01/14, revealed the professional company checked the doors for function and the code had been changed.</p> <p>9. Review of facility records revealed a Quality Assurance (QA) meeting was held on 09/19/14 with the following members signed in: SDC, MDS Assistant, Maintenance Assistant, DON, MD (by phone), and the Administrator. Resident #1's care plan was reviewed with interventions added on 09/19/14. A facility census sheet, with each resident of the facility listed, was reviewed with specific questions asked to determine if any other</p>	F 323			



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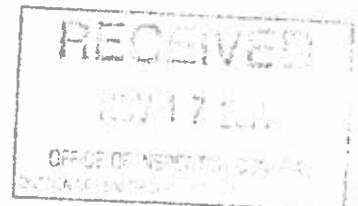
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F 323	<p>Continued From page 73</p> <p>resident was at risk for elopement with no additional residents identified at risk. The other two (2) residents who were previously identified and in the elopement binder were reviewed with no changes made. Policies reviewed included Elopement/ Wandering Residents and Missing Resident. Interviews with SDC on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed and updated Resident #1's care plan, reviewed all facility residents for risk of elopement, reviewed the care plans for the other two (2) residents previously identified at risk of elopement with no changes made, and reviewed the policies for Elopement and Missing Resident with no changes made. Observation of Resident #1, on 10/01/14 at 4:27 PM, Resident #5, on 10/02/14 at 3:30 PM, and Resident #6, on 10/02/14 at 3:35 PM, revealed the three (3) identified residents made no attempts at exit seeking behavior and staff was supervising.</p> <p>10. Review of the psychiatric note, dated 09/22/14, revealed Resident #1 was seen by the APRN on 09/22/14 related to the elopement with no changes made to the resident's current medications. Interview with the APRN, on 10/02/14 at 2:33 PM, revealed she saw Resident #1 on 09/22/14 with no issues identified. Interview with the Psychiatrist, on 10/02/14 at 3:38 PM, revealed he was notified on 09/22/14 of Resident #1's elopement by the DON and he requested the APRN to see the resident. The Psychiatrist had no concerns and medications were not changed.</p>	F 323			



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F 323	Continued From page 74 11. Review of a social service note, dated 09/20/14, revealed social services contacted Resident #1's family member to review the resident's care plan and schedule a care plan meeting for 09/22/14. Review of the care plan conference summary revealed a care plan meeting was conducted on 09/22/14 with the family member present. Interview with the Social Services Director (SSD), on 10/02/14 at 1:40 PM, revealed she contacted Resident #1's family member to schedule a care plan meeting, which was 09/22/14. Interview with the Assistant Director of Nursing (ADON) for the 200 Unit, on 10/02/14 at 2:20 PM, revealed he attended the care plan meeting on 09/22/14 with Resident #1's family member. 12. Review of nurse's notes revealed the QA meeting on 09/19/14 reviewed the care plans for the other two (2) residents previously identified at risk of elopement with no changes made. Review of the two (2) resident care plans revealed no new interventions after the 09/19/14 elopement by Resident #1. Interviews with Staff Development Coordinator, on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed the care plans for the other two (2) residents previously identified at risk of elopement with no changes made. 13. Review of the facility census sheet for 09/19/14 and a list of questions used as the assessment tool revealed all residents were reviewed in the QA meeting on 09/19/14 for risk of elopement with no additional residents	F 323			



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F 323	Continued From page 75 identified. Interviews with Staff Development Coordinator, on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed all residents of the facility with no new residents identified at risk of elopement. 14. Review of a facility admission packet revealed a letter that requested visitors not assist any resident out of the facility. The Director of Sales and Marketing was unreachable for interview. Interview with the DON, on 10/03/14 at 10:15 AM, revealed the letter had been included in the admission packet for new residents. Review of the facility daily census sheet for 09/20/14 and 09/21/14 revealed the facility had no new admissions. Interview, on 10/03/14 at 2:25 PM, with the Administrator revealed the facility no new admissions after the elopement until 09/22/14. 15. Review of Resident #1's care plan revealed new interventions were implemented after his/her elopement during the QA meeting on 09/19/14. Interviews with SDC, on 10/02/14 at 9:59 AM, MDS Assistant on 10/02/14 at 2:12 PM, Maintenance Assistant on 10/02/14 at 1:10 PM, MD on 10/03/14 at 8:11 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they attended a QA meeting held on 09/19/14 and reviewed and updated Resident #1's care plan to include the use of the manual wheelchair and a therapy referral. The DON stated she had reviewed Resident #1's clinical record on 09/19/14 to determine what	F 323			



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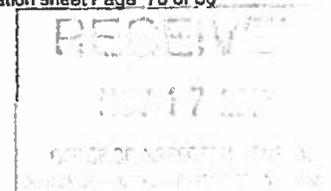
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F 323	Continued From page 76 change needed to be made to the care plan, and decided by the QA meeting that night. 16. Review of the facility staff roster and education post-tests revealed the facility began education of staff on 09/19/14 on the elopement policy. A total of two hundred (200) employees in all departments were being educated, with 154 staff trained by 09/22/14. The most recent employee was trained on 10/02/14, with thirty-two (32) PRN staff and one (1) full time employee on medical leave who needed to be trained. Review of employee schedules across departments compared to post-tests revealed staff were trained prior to or upon return to work. Interviews with thirty-one (31) staff: CNA #8 on 10/01/14 at 2:10 PM, Laundry Aide on 10/01/14 at 2:17 PM, CNA #9 on 10/01/14 at 2:24 PM, Assistant Dietary Manager on 10/01/14 at 2:27 PM, Activities Director on 10/01/14 at 2:32 PM, Physical Therapy (PT) #2 on 10/01/14 at 2:36 PM, Maintenance Director on 10/1/14 at 3:35 PM, COTA #1 on 10/01/14 at 4:24 PM, CNA #10 on 10/01/14 at 2:11 PM, CNA # 11 on 10/01/14 at 2:17 PM, Registered Nurse (RN) #1 on 10/01/14 at 2:24 PM, Licensed Practical Nurse (LPN) #6 on 10/01/14 at 2:27 PM, Cook on 10/01/14 at 2:32 PM, LPN #7 on 10/01/14 at 2:36 PM, Dietary Aide on 10/1/14 at 2:40 PM, PT #3 on 10/01/14 at 3:00 PM, Maintenance Assistant on 10/01/14 at 3:21 PM, CNA #1 on 10/01/14 at 3:37 PM, CNA #2 on 10/01/14 at 3:58 PM, Evening Supervisor #1 on 10/1/14 at 8:15 PM, CNA #3 on 10/01/14 at 11:02 PM, LPN #3 on 10/02/14 at 8:20 AM, ADON 300 Unit on 10/02/14 at 1:02 PM, SSD on 10/02/14 at 1:40 PM, ADON 200 Unit on 10/02/14 at 2:20 PM, LPN #4 on 10/02/14 at 7:40 PM, LPN #5 on 10/02/14 at 7:45 PM, Business Office Manager on 10/03/14 at 8:45 AM, HR Director on	F 323			



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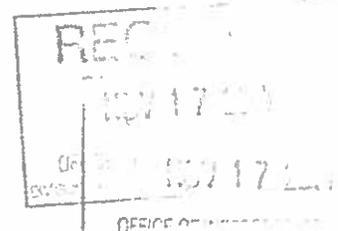
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F 323	<p>Continued From page 77</p> <p>10/03/14 at 8:50 AM, Receptionist on 10/03/14 at 8:54 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they were trained prior to working their scheduled shift on the elopement policy, what to do if there was an elopement, to stay at the exit door when they assisted anyone to enter or exit the facility and completed a post test.</p> <p>17. Review of the staff roster and education post tests revealed thirty-two (32) PRN staff needed to be trained. Review of a letter sent to the remaining staff that needed to be trained, on 09/30/14, by certified mail revealed staff needed to complete the training by 10/10/14. Review of a list of staff that needed to be trained revealed thirty-two (32) employees required training. Interview with SDC, on 10/02/14 at 9:59 AM, revealed training for staff began on 09/19/14 of the elopement policy with care plan and to stay at the door until the door was closed. Interview with the DON, on 10/03/14 at 10:15 AM, and the Administrator, on 10/03/14 at 2:25 PM, revealed a letter was sent by certified mail to remaining staff that education needed to be completed by 10/10/14. The DON stated the employee schedules were compared with the list of remaining staff daily for the following day to ensure staff were trained as they came to work. Review of a list of staff that needed to be trained revealed thirty-two (32) employees required training. Interview with SDC, on 10/02/14 at 9:59 AM, revealed she had tracked who needed to be trained and monitored daily, along with the DON. She stated the facility did not use agency staff.</p> <p>18. Review of a letter by the DON, dated 09/20/14, revealed visitors were asked not to assist any resident out of the facility and seek</p>	F 323			



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F 323	Continued From page 78 assistance from a nurse. Interview with the DON, on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM, revealed the letter was placed in all resident rooms on 09/20/14 and was also mailed to all resident families. 19. Review of the facility staff roster, employee schedules across departments, and post-tests, revealed staff were trained prior to or upon return to work. All but thirty-two (32) PRN and one (1) full time employee on medical leave had been trained prior to working their next scheduled shift. Interviews with thirty-one (31) staff CNA #8 on 10/01/14 at 2:10 PM, Laundry Aide on 10/01/14 at 2:17 PM, CNA #9 on 10/01/14 at 2:46 PM, Assistant Dietary Manager on 10/01/14 at 2:27 PM, Activities Director on 10/01/14 at 2:32 PM, Physical Therapy (PT) #2 on 10/01/14 at 2:36 PM, Maintenance Director on 10/01/14 at 3:35 PM, COTA #1 on 10/01/14 at 4:27 PM, CNA #10 on 10/01/14 at 2:11 PM, CNA # 11 on 10/01/14 at 2:17 PM, Registered Nurse (RN) #1 on 10/01/14 at 2:24 PM, Licensed Practical Nurse (LPN) #6 on 10/01/14 at 2:27 PM, Cook on 10/01/14 at 2:32 PM, LPN #7 on 10/01/14 at 2:36 PM, Dietary Aide on 10/1/14 at 2:40 PM, PT #3 on 10/01/14 at 3:00 PM, Maintenance Assistant on 10/01/14 at 3:21 PM, CNA #1 on 10/01/14 at 3:37 PM, CNA #2 on 10/01/14 at 3:58 PM, Evening Supervisor #1 on 10/1/14 at 8:15 PM, CNA #3 on 10/1/14 at 11:02 PM, LPN #3 on 10/02/14 at 8:20 AM, ADON 300 Unit on 10/02/14 at 1:02 PM, SSD on 10/02/14 at 1:40 PM, ADON 200 Unit on 10/02/14 at 2:20 PM, LPN #4 on 10/02/14 at 7:40 PM, LPN #5 on 10/02/14 at 7:45 PM, BOM on 10/03/14 at 8:45 AM, HR Director on 10/03/14 at 8:50 AM, Receptionist on 10/03/14 at 8:54 AM, DON on 10/03/14 at 10:15 AM, and the Administrator on 10/03/14 at 2:25 PM revealed they were trained	F 323			



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F 323	Continued From page 79 prior to working their scheduled shift on the elopement policy, what to do if there was an elopement, to stay at the exit door when they assisted anyone to enter or exit the facility and completed a post test. 20. Review of daily monitoring sheets for observation of staff who let visitors in or out of the building began on 09/19/14 at 8:45 PM revealed observations were conducted daily with a minimum of three (3) observations every twelve (12) hours and reviewed by the DON. Interview with the DON, on 10/03/14 at 10:15 AM, revealed the monitoring forms were completed daily for observations of any staff that had let a visitor in or out at the exit doors every twelve (12) hours from 8:00 AM, and 6:00 PM shifts, to ensure the staff remained at the door and the door had closed. She stated the monitoring of the doors would be reviewed in QA; however, no concerns had been identified. Interview with the Administrator, on 10/03/14 at 2:25 PM, revealed the exit doors would be monitored every twelve (12) hours shifts, from 6:00 AM - 6:00 PM, and 6:00 PM - 6:00 AM, to observe staff who would let visitors out of the building and ensure the door was closed before they left the area. He stated the DON and he both reviewed the monitoring and would discuss this in QA.	F 323			

