

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

PRINTED: 09/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/11/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY LOUISVILLE, KY 40299</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated/partial extended survey was initiated on 09/04/13 and concluded on 09/11/13 to investigate KY20644. The Division of Health Care substantiated the allegation with Immediate Jeopardy identified on 09/05/13 and determined to exist on 08/29/13 at 42 CFR 483.20 Resident Assessment (F280 S/S "J") and 42 CFR 483.25 Quality of Care (F323 at S/S of "J") resulting in Substandard Quality of Care at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 09/05/13.</p> <p>On 02/17/13, the facility re-admitted Resident #1, with multiple diagnoses which included Non-Alzheimer's Dementia Disease and assessed the resident at risk for elopement related to the resident's impaired cognition. The facility obtained a physician's order and implemented a WanderGuard device to alert facility staff should the resident attempt to exit the facility without staff knowledge. On 08/29/13, between 6:00 PM and 6:40 PM, Resident #1 exited the facility without staff knowledge. Interview revealed a visitor found Resident #1 alone in a wheelchair, self-propelling down the facility's driveway path, and notified a staff member that the resident was outside in the hot sun. Review of the National Weather Service archive temperature log revealed the afternoon high temperature on 08/29/13 was 94 degrees Fahrenheit. Interview with the staff revealed the resident's WanderGuard did not function when the resident was returned to the facility. Interview and record review revealed the WanderGuard battery life was 90-days and the resident's WanderGuard should have been changed on</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

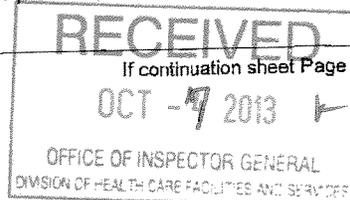
(X6) DATE

*A. Hammett RN*

*DHS*

*10/4/13*

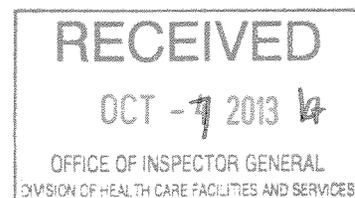
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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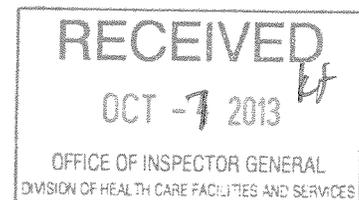
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F 000	Continued From page 1 07/25/13. The facility was unable to provide evidence that they had a system to monitor and replace the resident's WanderGuard after the ninety (90) days prior to Resident #1's elopement.  The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/10/13 alleging the Immediate Jeopardy was removed on 09/07/13. The State Survey Agency verified Immediately Jeopardy was removed as alleged on 09/07/13, prior to exit on 09/11/13, with remaining non-compliance at 42 CRF 483.20 Resident Assessment and 42 CRF 483.25 Quality of Care. The scope and severity of F280 and F323 was lowered to a "D", while the facility's Quality Assurance continues to monitor the Elopement Policies and protocols, review of alarms, and Care Plan development.	F 000			
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F 280 On 8/29/13 at 6:20 pm, Resident #1 was immediately returned to facility by the nursing staff. The nurse immediately assessed the resident and no injuries were noted. The family and physician was notified of the incident. Resident #1 was placed on 15 minute checks for increased observation as required by the facility policy. Resident #1 was assessed by the MDS nurse for continued elopement	10/2/13	



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F 280	Continued From page.2 each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have an effective system to ensure the comprehensive care plans were reviewed and revised to address the placement and function of a WanderGuard device for two (2) of nine (9) sampled residents (Resident #1 and #2). The facility failed to revise the care plans for Resident #1 and Resident #2 to ensure the resident's safety needs were met.  On 02/17/13, the facility re-admitted Resident #1, with multiple diagnoses which included Non-Alzheimer's Dementia Disease and assessed the resident at risk for elopement related to the resident's impaired cognition. The facility obtained a physician's order and implemented a WanderGuard device to alert facility staff should the resident attempt to exit the facility without staff knowledge. On 08/29/13, between 6:00 PM and 6:40 PM, Resident #1 exited the facility without staff knowledge. Interview revealed a visitor found Resident #1 alone in a wheelchair, self-propelling down the facility's driveway path, and notified a staff member that the resident was outside in the hot sun. Review of the National Weather Service archive temperature log revealed the afternoon high temperature on 08/29/13 was 94 degrees Fahrenheit. Interview with the staff revealed the resident's WanderGuard did not function when the resident was returned to the facility. Interview	F 280	potential and a new wandergaurd was applied on 8/29/13. A wanderguard with one year expiration date was applied on 9/6/13 The incident was documented on the 24-hour report and the Charge Nurse initiated an Exit Seeking Circumstance form. All residents in house were assessed for Elopement Potential by the Nurse Managers and Charge Nurses. No other residents were identified as elopement risks. Resident profiles for those at risk for elopement were reviewed on 8/30/13 by the Director of Health Services and Clinical Support and updated as needed. Elopement binders were reviewed by the Assistant Director of Health Services on 8/30/13 and updated as necessary These binders located at the the nurses stations, business office and receptionist desk and will be maintained and updated by the Assistant Director of Health Services. All resident care plans/profiles and treatment records were audited by the Nurse Managers and MDS Nurses on 9/5/13 to insure that behavior care plans are in place and reflect current status of resident and treatment records reflect current orders. These audits will continue weeklyx60 days by the DHS and ADHS, then monthly x90 days until such time that substantial compliance is achieved and indicated by the Quality Assurance	



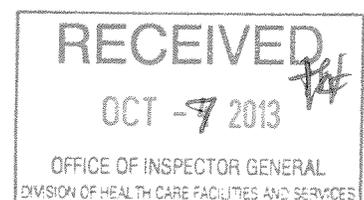
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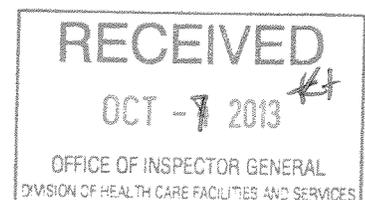
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F 280	<p>Continued From page 3</p> <p>and record review revealed the WanderGuard battery life was 90-days and the resident's WanderGuard should have been changed on 07/25/13. The facility was unable to provide evidence that they had a system to monitor and replace the resident's WanderGuard after the ninety (90) days prior to Resident #1's elopement. Review of Resident #1's care plan revealed a replacement date of 05/01/13 for the WanderGuard and the care plan had not been revised to replace the WanderGuard in July per the 90-day battery life.</p> <p>Record review revealed Resident #2's comprehensive care plan was not revised for wandering, for monitoring the function of the WanderGuard, or the life of the WanderGuard's battery after WanderGuard placement.</p> <p>The facility's failure to ensure the care plan was reviewed and revised, placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment or death to a resident. The facility was notified of the Immediate Jeopardy on 09/05/13.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/10/13 alleging Immediate Jeopardy was removed on 09/07/13. Immediate Jeopardy was verified to be removed on 09/07/13 as alleged, prior to exit on 09/11/13 with remaining non-compliance at 42 CFR 483.20 Resident Assessment F280 with the scope and severity lowered to a "D", while the facility develops and implements the quality assurance measures to establish and maintain an effective system to ensure residents receive care according to the plan of care.</p>	F 280	<p>Committee. A successful elopement drill was completed on 9/5/13.</p> <p>All nurses were educated by the Staff Development Nurse and Nurse Managers on 8/30/13. Education included but not limited to elopement protocols, checking wanderguard devices, and care plan development. A Quality Assurance Meeting was conducted by the Clinical Director and Medical Director on 9/6/13 to provide guidance to campus staff addressing the issue of Elopement and Behavior Changes. Systemic changes include ordering wanderguards that last one year. Expiration dates are imprinted on the devices by the manufacturer and Medical Records will track the expiration dates and insure the imprint remains legible. Charge nurses are responsible to check the devices each shift by using the control wand. Charge Nurses will document placement and function q shift. The door alarms are checked daily by Plant Operation and on the weekends by the weekend manager and documented that they are working. Residents identified who have been identified by the nurses that they have a change in condition, including exit seeking behavior, will have wandergurd placed and be monitored by the nursing staff for 72-hours and longer if needed.</p>	



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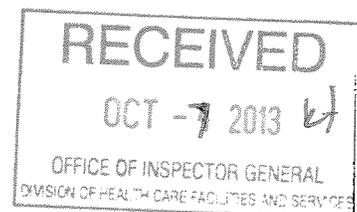
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F 280	<p>Continued From page 4 The findings include:</p> <p>Review of the facility's policy, Clinical Documentation System, undated, revealed the interdisciplinary team (IDT) would plan the resident's care and treatment to ensure appropriateness of service to meet the resident's needs. Review of the Assessment, Review, and Consideration policy, undated, revealed the purpose was to recognize risk factors identified upon admission during the nursing assessment and to provide interventions that impact the resident's condition. The team would care plan the risk factors with specific individualized interventions.</p> <p>Review of the facility's policy, Elopement Risk Reduction, undated, revealed the purpose was to implement preventive interventions in the comprehensive care plan to address the potential for elopement.</p> <p>Review of the manufacture's WanderGuard Departure Alert System, User Instruction/Manual for 90 day and one (1) year Signaling Device, revealed the date imprinted on the back of the WanderGuard device was the last date the device could be activated to permit approximately 90-days of use. Review of the WanderGuard Departure Alert System Manual pages 30 and 32 (section 4) revealed the signaling device should be tested and results recorded in the resident's records.</p> <p>1. Review of the facility's investigation dated 08/30/13, revealed on 08/29/13 Resident #1 exited the front door at the Health Center entrance. The resident was returned to the facility and was assessed with no injury. The physician</p>	F 280	<p>The Charge Nurse who identifies the exiting-seeking behavior will initiate the Circumstance Form, documenting behavior, adding new careplan interventions, as well as initiating follow-up.</p> <p>Those residents identified are reviewed in the morning Clinical Meeting. The DHS oversees the meeting with the ADHS, MDS, Medical Records, Staff Development, ED and Therapy Program Director in attendance. Any additional behavior changes or exit seeking behavior interventions will be addressed on Care Plans by the MDS Coordinator and Social Services at time of meeting. No Policy changes were made.</p> <p>Clinically "At Risk" residents who include behaviors are reviewed weekly in the CAR meeting. Residents remain on CAR until the condition stabilizes x4 weeks.</p> <p>The door alarms will continued to be checked daily by Plant Operations Monday - Friday using the transponder that is make by the manufacturer.</p> <p>Weekend managers will test on the weekends. Plant Operations will monitor this and maintain the documentation.</p> <p>Residents are assessed daily by Charge Nurse for safety under the Medicare Part A requirements and monthly by Charge Nurses for long term care residents, as well as indicated with a significant change in condition.</p>		



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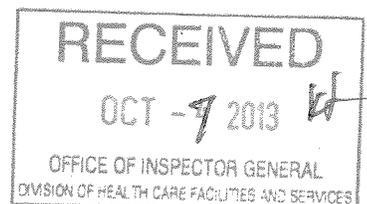
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F 280	<p>Continued From page 5</p> <p>and family were notified and elopement protocols were initiated. The root cause was determined to be the WanderGuard device was not functioning.</p> <p>Review of the clinical record for Resident #1 revealed the facility re-admitted the resident on 02/17/13, with multiple diagnoses including Dementia. On 02/17/13 and 03/24/13, the facility assessed Resident #1 as an elopement risk. On admission the facility assessed Resident #1 as cognitively impaired and at risk for elopement. A comprehensive care plan was developed on 03/01/13 addressing wandering. The interventions included: personal pressure alarm and a WanderGuard; to monitor the resident's whereabouts. On 03/24/13 an intervention was added for a WanderGuard in place and functional, and to replace the resident's WanderGuard on 05/01/13. The goal for the resident's wandering care plan stated the resident would have no unplanned exits or elopements. Review of the Treatment Record dated for 05/01/13 through 05/31/13 revealed a handwritten notation to replace the WanderGuard on 07/25/13 as an "FYI". However, there was no evidence the resident's plan of care was revised to include the 07/25/13 date.</p> <p>Phone interview, with Registered Nurse (RN) # 3, on 09/05/13 at 11:25 AM, revealed the care plan was used to detail the resident's needs. She stated the care plan should reflect the resident's current status. RN #3 continued to state the care plan and the TAR should reflect the same information regarding the date a WanderGuard would be changed. The TAR was where the nurses initialed/dated that the WanderGuard had been checked for placement and function. However, prior to the elopement she was unsure</p>	F 280	<p>New staff will continue to be educated to Elopement/Wandering protocols upon hire and every 6 months by the Staff Development Coordinator. Elopement Drills will be conducted by Plant Operations every 6 months. Quality Assurance Committee will review monthly for compliance. Elopement and Behavior information is part of QA process. This information is automatically pulled from weekly DHS report and will trigger for follow up during QA meeting. Any systems triggering from QA requires action plan with follow up until substantial compliance is achieved. The ED and DHS, along with Medical Director input will monitor on an ongoing basis.</p>		



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F 280	<p>Continued From page 6</p> <p>if changing the resident's WanderGuard was completed and was not aware if a change date was on the care plan. She further offered if the clinical record didn't show the WanderGuard was replaced as ordered, then the resident's safety could be compromised.</p> <p>Interview, on 09/05/13 at 1:30 PM, with RN #4 revealed the care plan directed staff on how to provide care. She stated she provided care to Resident #1 often and she did not recall ever changing the resident's WanderGuard and was not aware of any date on the care plan to change the WanderGuard. She stated if the care plan interventions for the WanderGuard were not followed the resident's safety would be in danger.</p> <p>Phone interview, on 09/05/13 at 2:00 PM, with License Practical Nurse (LPN) #2 revealed the care plan was used to inform staff of a resident's care needs. However, she stated the TAR and MAR were used more frequently to obtain what the care needs were. She further stated if the care plan was not revised or the TAR was not accurate to reflect the current care the resident's needs then the care could be altered.</p> <p>Interview, on 09/05/13 at 2:40 PM, with RN #2 the Minimum Data Set (MDS) Coordinator revealed being notified of Resident #1's elopement. She stated the resident's WanderGuard did not function at the time of the elopement. The MDS Coordinator reviewed the resident's care plan and verified the care plan had not been revised to replace the WanderGuard and there was no evidence the WanderGuard was changed on 07/25/13. The MDS Coordinator stated the nurse placed telephone orders on the TAR and 24-hour report sheet, then the DON or ADON transcribes</p>	F 280			



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F 280

Continued From page 7  
the information to the care plan. The MDS department along with the IDT were responsible to ensure the care plan remained accurate and the nurses were responsible for following the care plan. However, she was not aware of a WanderGuard change date on the care plan.

2. Observation, on 09/04/13 during initial tour of the facility at 11:35 AM, revealed Resident #2 sitting in his/her room in the wheelchair with a WanderGuard device fastened to the right ankle.

Review of the clinical record for Resident #2, revealed the facility admitted the resident on 03/24/07, with multiple diagnoses including Alzheimer's Disease. Review of the resident's clinical record revealed the resident had a history of wandering and would go to the front door. The resident had a WanderGuard applied. However, review of the comprehensive care plan revealed no interventions to monitor placement or function of the WanderGuard. Continued review of the record revealed the Treatment Administration Record (TAR) from 03/01/13 through 08/29/13 revealed no monitoring system to verify placement or function of the WanderGuard.

Interview, with Certified Resident Care Assistant (CRCA) #1, on 09/04/13 at 2:00 PM, revealed she cared for Resident #2 often. She stated the resident had a WanderGuard for a long time; over a year. She continued to state the nurses were responsible to ensure the WanderGuard was working.

Interview, on 09/05/13 at 3:05 PM with Registered Nurse #2 the Minimum Data Set (MDS) Coordinator, revealed Resident #2's care plan did not indicate the WanderGuard would be checked

F 280

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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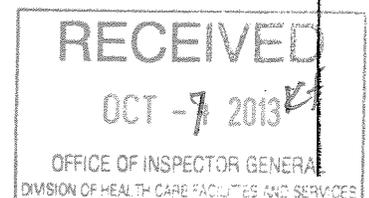
F 280	<p>Continued From page 8</p> <p>for placement/functioning. The MDS Coordinator stated the lack of revision was from consistent oversight because the resident had always had the WanderGuard and staff assumed they knew what the care needs were. Further interview revealed neither the clinical record or the care plan provided any evidence the care plan was revised to reflect the safety monitoring of the WanderGaurd. She further stated the record did not reflect when the WanderGuard was implemented or when the WanderGuard needed to be changed. She stated the purpose of the care plan was to guide staff on the needed care of the resident, and without an accurate care plan, the resident's care needs may not be met.</p> <p>Interview, on 09/05/13 at 1:30 PM, with RN #4 revealed she provided care to Resident #2 often. She further stated the resident's WanderGuard was probably checked out of habit. However, if the care plan interventions for the WanderGuard were not revised the resident's safety would be in danger.</p> <p>Phone interview with RN #3, on 09/05/13 at 11:25 AM, revealed on 08/29/13 when the resident's WanderGuard was assessed for functioning the device did not function. She further offered the care plan didn't show the WanderGuard was to be check and that the resident's safety could be compromised.</p> <p>Interview, on 09/11/13 at 4:10 PM, with the Executive Director (ED) and the Director Health Services, revealed the care plan was the tool used to inform staff of the resident's needed care and services. The MDS staff was responsible to update, revise, and develop the care plan as needed.</p>	F 280		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/11/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY LOUISVILLE, KY 40299</b>		
(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 280	Continued From page 9  Review of the acceptable Allegation of Compliance (AOC), dated 09/10/13, revealed the facility took the following actions:  1. Resident #1 was returned to the 200 Unit and was assessed on 08/29/13 and found no injury was sustained. Resident #1 was placed on every 15 minute checks to increase supervision. The Care Plan of Resident #1 was updated by the Clinical Support nurse on 08/29/13 identifying elopement risk and application of a new WanderGuard.  2. All exit doors in the facility were checked for function on 08/29/13 and found to be in working order by the Director of Plant Operations.  3. Resident #2, and #3 had WanderGuard devices changed on 08/29/13 based on risk assessments. Systematically the facility will use one year WanderGuards instead of 90-day devices. Staff Development education on the differences of the devices was completed on 09/06/13.  4. The facility initiated an investigation on 08/29/13 of the elopement and concluded on 08/30/13 with notification to the Office of Inspector General on 08/30/13 and a five day report on 09/04/13.  5. All residents were reassessed for elopement potential on 09/05/13. All applicable care plans were updated to include wandering behavior. One resident (Resident #5 who was a new admit) was identified as at risk for elopement with the care plan revised to reflect this.	F 280			



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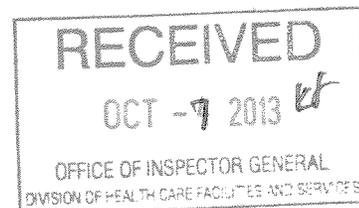
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F 280	<p>Continued From page 10</p> <p>6. The Elopement binders were reviewed by the Assistant Director Health Services on 08/30/13 and were placed at all the Nurses Station and Business Office and Reception Desk (Resident #1, #2, #3, and #5). The facility verified the Treatment Administration Record (TAR) to reflect the current status of the resident and current orders with change dates for the devices.</p> <p>7. Staff education initiated by Staff Development Nurse on 08/29/13 and completed on 09/06/13. Staff Education included elopement, WanderGuard including the one (1) year device, alarm and missing residents policies.</p> <p>8. An Elopement Drill was conducted, on 09/05/13 at 6:15 PM, by the Director of Plant Operations.</p> <p>9. A QA monitoring tool was implemented on 09/05/13 which included review of alarms and Care Plan development. These audit would be completed by the MDS nurse and Nurse Managers. Then the Director of Health Services and Assistant Director of Health Services would complete this audit weekly times 60 days and then monthly times 90 days. All audits would be reviewed during the Quality Assurance Meeting monthly.</p> <p>10. A QA meeting was held on 09/06/13 that included the Medical Director with discussion of the Immediate Jeopardy, elopement and behavioral changes.</p> <p>The State Survey Agency (SSA) validated the AOC on 09/11/13 as follows:</p> <p>1. Review of the care plan and the every 15</p>	F 280		
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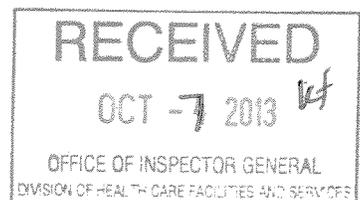
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F 280	<p>Continued From page 11</p> <p>minute checks for Resident #1 revealed they were completed and updated.</p> <p>2. Observation, on 09/11/13 at 1:40 PM -1:50 PM of the main entrance door revealed Residents #1, #2, #3 and #5 all had WanderGuards. The facility's main door activated the alarm and locked the door with each resident. Observation, on 09/11/13 at 1:20 PM, of RN #6 revealed she placed the tester 2" above Resident #3's WanderGuard and the tester flashed green.</p> <p>3. The SSA validated through observation that all residents who utilized a WanderGuard had the new WanderGuard with a one year battery life. Observation during the extended survey, on 09/11/13 at 9:20 AM - 9:30 AM, revealed the residents currently assessed to be an elopement risk ( Resident #1, #2, #3 and #5) had a WanderGuard applied. Each device was imprinted with Do Not Use past 09/29/14. Interview, on 09/11/13 at 1:25 PM, with RN #6 revealed the writing indicated the day the facility applied the one year WanderGuard plus one year to indicate the date it was to be changed. The RN continued to state the TAR would also have the date the device was applied. She further stated they do not use past date indicated when the manufacturer designated the battery was no longer functional. Interview, on 09/11/13 at 2:40 PM with LPN #1 (Medical Records) revealed all 90-day WanderGuards were removed from stock on 09/06/13 when the one year devices were stocked.</p> <p>4. Review of the facility's investigation revealed the completion of the investigation on 08/30/13.</p>	F 280			



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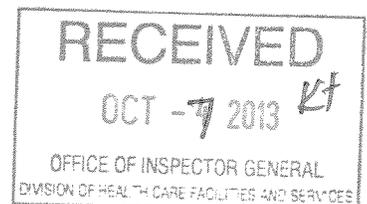
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F 280	Continued From page 12 5. Review of the audit for reassessment of all residents revealed the audit identified one new resident (Resident #5) as a new resident with a potential for elopement and the care plan was updated to reflect that risk. Observation revealed one resident who was found to be at risk for elopement, had a WanderGuard bracelet applied and was working properly. This was validated through observation of the tester and door alarm. Through record review of four recent admissions since 09/07/13 - 09/11/13 found elopement risk assessments were performed and found not to be at risk. In addition, the SSA validated re-assessments of all residents were completed on 09/05/13.  6. Review of the elopement binders revealed they were located in the Business Office, the Skilled Unit, the 400 Unit and the 500 Unit. The binders contained resident information and pictures of the four residents identified as at risk for elopement.  7. The State Agency validated through record review and evidence of education provided to staff which included policies for: elopement, alarm checks, missing residents, WanderGuards and care plan development completed on 09/06/13. Interview with CRCA #6, on 09/10/13 at 5:05 PM, CRCA #7, on 09/10/13 at 5:10 PM, CRCA #8, on 09/11/13 at 1:40 PM, RN #7, on 09/10/13 at 4:40 PM, RN #6, on 09/11/13 at 9:30 AM, LPN #4, on 09/10/13 at 5:00 PM, LPN #3, on 09/11/13 at 9:10 AM, LPN #5, on 09/11/13 at 12:20 PM, Housekeeper #8, on 09/11/13 at 8:59 AM, and Dietary Director, on 09/11/13 at 8:50 AM revealed all staff members were trained and knowledgeable on the elopement policy. The RNs and LPNs revealed knowledge of the WanderGuard 1 year procedure.	F 280			



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F 280	Continued From page 13  8. Review of the elopement drill and sign sheets, dated 09/05/13 at 6:15 PM by the Director of Plant Operations.  9. Review of the QA monitoring tool revealed the tool was initiated and completed on 09/05/13 by the MDS nurse.  10. Interview with the Medical Director, on 09/11/13 at 2:20 PM, and record review of the sign sheet revealed the facility conducted a Quality Assurance meeting with the Medical Director on 09/06/13. The facility notified him on 08/29/13 between 6 PM - 7 PM of the elopement. He stated he was present at the facility during the Quality Assurance Meeting on 09/05/13. He further stated no concerns with the facility's elopement policy, but staff needed to follow the policy.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy and manufacturer guidelines it was determined the facility failed to have an effective system to provide adequate	F 323		



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185461

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED  
  
C  
09/11/2013

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE  
6415 CALM RIVER WAY  
LOUISVILLE, KY 40299

GLEN RIDGE HEALTH CAMPUS

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F 323	<p>Continued From page 14</p> <p>supervision to prevent accidents for one (1) of nine (9) sampled residents. (Resident #1) The facility failed to follow their Elopement Risk Reduction Policy/Alarm Check Policy.</p> <p>On 02/17/13, the facility re-admitted Resident #1, with multiple diagnoses which included Non-Alzheimer's Dementia Disease and assessed the resident at risk for elopement related to the resident's impaired cognition. The facility obtained a physician's order and implemented a WanderGuard device to alert facility staff should the resident attempt to exit the facility without staff knowledge. On 08/29/13, between 6:00 PM and 6:40 PM, Resident #1 exited the facility without staff knowledge. Interview revealed a visitor found Resident #1 alone in a wheelchair, self-propelling down the facility's driveway path, and notified a staff member that the resident was outside in the hot sun. Review of the National Weather Service archive temperature log revealed the afternoon high temperature on 08/29/13 was 94 degrees Fahrenheit. Interview with the staff revealed the resident's WanderGuard did not function when the resident was returned to the facility. Interview and record review revealed the WanderGuard battery life was 90-days and the resident's WanderGuard should have been changed on 07/25/13. The facility was unable to provide evidence that they had a system to monitor and replace the resident's WanderGuard after the ninety (90) days prior to Resident #1's elopement. The facility was notified on the Immediate Jeopardy on 09/05/13.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/10/13 alleging Immediate Jeopardy was removed on</p>	F 323	<p>F 323</p> <p>On 8/29/13 at 6:20 pm, Resident #1 was immediately returned to the facility by the nursing staff. The nurse immediately assessed the resident and no injuries were noted. The family and physician was notified of the incident. Resident #1 was placed on 15 minute checks fro 24- hours for observation as required by the facility policy. Resident #1 was assessed by the MDS nurse for continued elopement potential and a new wanderguard was applied on 8/29/13. The incident was documented on the 24-hour report and the Charge Nurse initiated an Exit Seeking Circumstance form. A wanderguard with one year expiration date was applied on 9/6/13.</p> <p>All residents in house were assessed for Elopement Potential by the Nurse Managers and Charge Nurses. No other residents were identified as elopement risks. Resident profiles for those at risk for elopement were reviewed on 8/30/13 by the Director of Health Services and Clinical Support and updated as needed. Elopement binders were reviewed by Assistant Director of Health Services on 8/30/13 and updated as necessary. These binders located at the the nurses stations, business office and receptionist desk will be maintained and updated by the Assistant Director of Health Services.</p>	10/2/13

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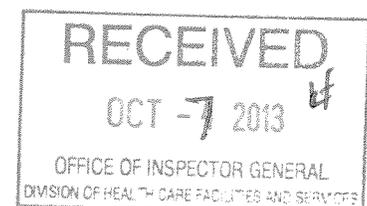
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F 323	Continued From page 15 09/07/13. Immediate Jeopardy was verified to be removed on 09/07/13 as alleged, prior to exit on 09/11/13 with remaining non-compliance at 42 CFR 483.25 Quality of Care F323 with the scope and severity lowered to a "D", while the facility develops and implements quality assurance measures to establish and maintain an effective system to ensure residents receive adequate supervision to prevent accidents.  The findings include:  Review of the facility's Elopement Risk Reduction/Alarm Check policies (revised 10/19/07)-revealed the purpose was to prevent elopements by appropriately observing resident patterns, and to implement preventive interventions. The facility's procedure to prevent elopement was to place a WanderGuard bracelet on the resident and the alarms would be activated at all times. The alarm checks would ensure the resident's WanderGuard and door alarms were properly functioning. The batteries should be scheduled for replacement on a routine basis, and alarms should be replaced per the manufacturer's recommendations.  Review of the manufacturer's WanderGuard Departure Alert System, User Instruction/Manual for 90-day and one (1) year Signaling Device, revealed the date imprinted on the back of the WanderGuard device was the last date the device could be activated to permit approximately 90-days of use. The date would include the month, day, and year. Review of the WanderGuard Departure Alert System Manual, pages 30 and 32, revealed the reasons a device would fail were the signaling device would be inoperable if beyond the 90-days and poorly	F 323	All resident care plans/profiles and treatment records were audited by the Nurse Managers and MDS Nurses on 9/5/13 to insure that behavior care plans are in place and reflect current status of resident and treatment records reflect current orders. These audits will continue weeklyx60 days by the DHS and ADHS, then monthly x90 days until such time that substantial compliance is achieved indicated by the Quality Assurance Committee. A successful elopement drill was completed on 9/5/13.  All nurses were educated by the Staff Development Nurse and Nurse Managers on 8/30/13. Education included but not limited to elopement protocols, checking wondergard devices, and care plan development. A Quality Assurance Meeting was conducted by the Clinical Director and Medical Director on 9/6/13 to provide guidance to campus staff addressing the issue of Elopement and Behavior Changes. Wonderguards ordered for the campus have changed to last 1 year. Expiration dates are imprinted on the devices by the manufacturer and Medical Records will track the expiration dates and insure the imprint remains legible.	



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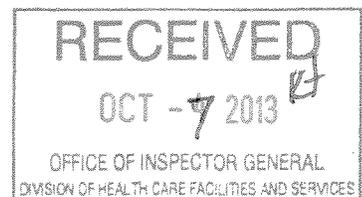
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F 323	Continued From page 16 trained staff. The manufacturer's instructions revealed the signaling device should be tested and results recorded in the residents' records; and all staff members involved in the care of wanderers should read and understand all of the information contained within the manual, particularly the warnings and cautions. In addition, staff should develop and carry out a Wanderer Management Protocol that outlined correct procedures and assigned staff responsibilities. The manufacturer provided a WanderGuard Protocol Guide (in the WanderGuard E Program Manual) to assist the facility in developing the Wanderer Management Protocol Guide. Failure to comply with the manufacturers warning could result in injury or death to a resident.  Review of the Exit Seeking Circumstance, Assessment, and Intervention record revealed Resident #1 successfully exited the building without staff knowledge on 08/29/13. The resident was found by a visitor and notified staff. The resident was located by staff at 6:20 PM in the front parking lot. The assessment form further stated the exit was not witnessed by anyone. The resident had a WanderGuard on and it was not functioning, as well as, the door did not alarm. The assessment form further stated the resident had impaired safety judgement; had a history of exit seeking behavior; was independent with w/c mobility; and, had a diagnosis of Dementia. The prevention update included: WanderGuard and 15 minute checks for whereabouts. The Interdisciplinary Team (IDT) reviewed the assessment determinations and indicated they agreed on 08/30/13. The assessment form included a 72 hour follow-up dated 08/29/13, 10p-6a, that indicated the resident had no	F 323	Charge nurses are responsible to check the devices each shift by using the control wand. The door alarms are checked daily by Plant Operation and on the weekends by the weekend manager and documented that they are working. Residents identified who have been identified by the nurses that they have a change in condition, including exit seeking behavior, will have wondergurd placed and be monitored by the nursing staff for 72-hours and longer if needed. The Charge Nurse who identifies the exiting seeking behavior will initiate the Circumstance Form documenting behavior and initiated follow-up. Those residents identified are reviewed in the morning Clinical Meeting. The DHS oversees the meeting with the ADHS, MDS, Medical Records, Staff Development, ED and Therapy Program Director in attendance. Any behavior changes or exit seeking behavior will be addressed on the Care Plans by the MDS Coordinator and Social Services.		



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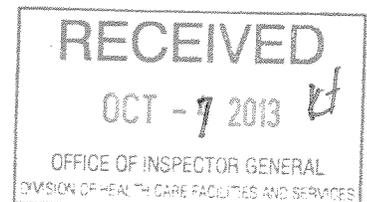
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F 323	Continued From page 17 episodes of exit seeking, exit prevention interventions were in place and effective, and WanderGuard was changed, tested and did sound the alarm, as well as, lock the door. Review revealed this was the only follow-up documented. Review of the incident/accident form dated 08/29/13 revealed the resident was located in the front parking lot at 6:20 PM after supper and indicated the WanderGuard did not alarm.  Review of the facility's investigation dated 08/30/13, revealed on 08/29/13 Resident #1 exited the front door at the Health Center entrance. The resident was returned to the facility and was assessed with no injury. The physician and family were notified and elopement protocols were initiated. The root cause was determined to be the WanderGuard device was not functioning. Review of a written statement by the staff person, Registered Nurse (RN #5), who went outside and retrieved the resident revealed she was working in the computer room when a man stated to her a resident was outside. She went outside and found Resident #1 in the parking lot where the drive starts to curve around the building. The resident was about 15-20 feet from the curb. The RN brought the resident back inside the facility and reported the event to another nurse. Review of the Director of Health Services's hand written statement, not dated, revealed she spoke with the male visitor, who stated he arrived at the facility around 6:15 PM, parked his car, and then noticed the resident sitting in a wheelchair in the front lot. He immediately came inside and reported it to staff person. Per the investigation, all door alarms and WanderGuards were checked for proper functioning and the necessary corrections were made. Further review revealed two other	F 323	Residents with potential exit seeking behavior will be assessed on admission and required interventions to keep safe will be implemented at that time., as well as with significant changes in behavior. Systemic changes will include assessment of room placement for these residents. This will provide greater opportunity for staff observation. Potential admissions with behavior/exit seeking will be reviewed prior to acceptance. Behavior will also be monitored during Resident First meetings quarterly and with significant changes. Weekend managers will test on the weekends. Plant Operations will monitor this and maintain the documentation. Residents are assessed daily for safety under the Medicare Part A requirements and monthly for long term care residents, as well as indicated with a significant change in condition. New staff will continue to be educated to Elopement/Wandering protocols upon hire and every 6 months by the Staff Development Coordinator. Elopement Drills will be conducted by Plan Operations every 6 months. Quality Assurance Committee will review monthly for compliance..		



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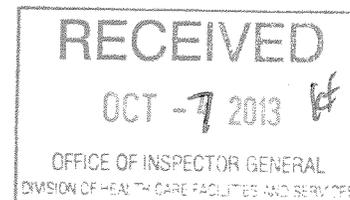
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NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY</b> <b>LOUISVILLE, KY 40299</b>		
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F 323	Continued From page 18 residents were identified as likely to have the same risk that required an assessment and an action plan implemented, as deemed appropriate.  Phone interview, with the visitor who found the resident, on 09/04/13 at 6:30 PM, revealed when they arrived at the facility at approximately 6:15 PM - 6:30 PM they drove up to the main entrance, and observed the resident in a wheel chair self propelling down the driveway path. The family member voiced concern for the resident due to the hot weather. Review of the National Weather Service archived temperature log revealed the afternoon high temperature on 08/29/13 was 94 degrees Fahrenheit. Further interview revealed there was no visible staff upon entering the facility. The family member informed the first staff member they encountered of the resident's whereabouts.  Interview, on 09/05/13 at 2:10 PM, with RN #5 revealed she was working in the workroom, when a gentleman entered the doorway, and stated a resident was outside. RN #5 stated she went outside and observed the resident in a wheelchair, off the sidewalk, self propelling down the driveway path between the front and the corner of the building. RN #5 revealed upon transporting the resident back into the facility she noted the WanderGuard did not trigger the door to alarm. RN #5 added the resident was taken to the unit and the resident's nurse was notified. She also notified RN #2, the MDS Coordinator, due to being a part of management. RN #5 stated she, RN #2 and RN #3 observed the resident with the WanderGuard at the main entrance door and it did not function.  Interview, with the Plant Operations Director, on	F 323			



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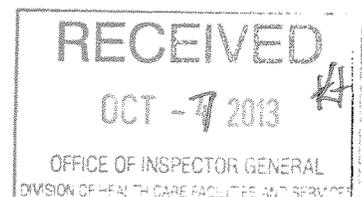
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F 323	<p>Continued From page 19</p> <p>09/04/13 at 4:15 PM, revealed the entrance door remained open till 9 PM. He further stated when a resident wearing a WanderGuard come close to the door it would activate the door to alarm and lock. He stated the alarm would trigger staff that a resident was attempting to exit. He continued to state a non-functioning WanderGuard would not alarm the door and after the elopement he assessed all exits doors on 08/29/13 and found all in working condition.</p> <p>Review of the clinical record for Resident #1 revealed the facility re-admitted the resident on 02/17/13, with multiple diagnoses including Dementia. On 02/17/13 the facility assessed Resident #1 as cognitively impaired and at risk for elopement. A comprehensive care plan was developed on 03/01/13 addressing wandering. The interventions included: personal pressure alarm and a WanderGuard; to monitor the resident's whereabouts. On 03/24/13, Resident #1 was observed by the facility attempting to exit the front entrance door. Review of the resident's care plan revealed a goal that the resident would have no unplanned exits or elopements. The facility added an intervention on the comprehensive care plan to ensure the WanderGuard was in place and functional and to replace the resident's WanderGuard on 05/01/13. However, there was no documented evidence that the WanderGuard was replaced on 05/01/13.</p> <p>Review of the resident's August 2013 Treatment Administration Record (TAR) revealed the WanderGuard alarm was to be checked for placement and functioning every shift. This was noted as being completed by staff initials. Review of the TAR for the month of 05/01/13 through</p>	F 323			



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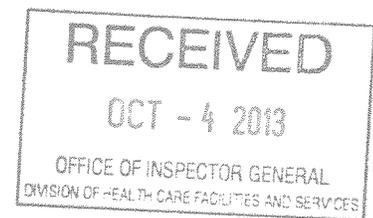
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F 323	<p>Continued From page 20</p> <p>05/31/13 revealed a handwritten notation to replace the WanderGuard on 07/25/13 as an "FYI". However, this was not noted on the resident's TAR for June and July 2013 and the facility provided no evidence the WanderGuard was ever changed.</p> <p>Phone interview, on 09/05/13 at 2:00 PM, with Licensed Practical Nurse (LPN) #2 revealed on 08/29/13 Resident #1's WanderGuard was assessed for functioning and placement between 2 PM - 6 PM. She stated the WanderGuard was assessed to be properly working. The LPN stated the WanderGuard/tester training was provided verbally. She stated she was unsure if she used the tester correctly to determine if WanderGuard was functional. She further stated she did not notify the facility of her uncertainty of how to use the tester. LPN #2 stated the resident's WanderGuard was assessed with the tester on 08/29/13 during the resident's treatment and stated it was working. She could not offer any explanation as to how the resident's functioning WanderGuard alarms allowed the resident to exit the facility with the door properly working. She further stated she had only received training during orientation and no testing of knowledge was completed prior to the incident.</p> <p>Phone interview, with Registered Nurse (RN) #3, on 09/05/13 at 11:25 AM, revealed she was trained on elopement and WanderGuard activation, checking the function, and the placement. She stated the nurse was responsible for ensuring the WanderGuard was functioning properly. The function of the WanderGuard may be performed by two (2) methods: the tester device which would flash green (ensures it was working) when placed over</p>	F 323			



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F 323	Continued From page 21 the resident's WanderGuard; or actually transporting the resident to the door to ensure the door would alarm and lock. RN #3 stated the TAR was where the nurses initialed and dated that the WanderGuard had been checked for placement and function. She indicated her method of checking placement and function was during the 7-8 PM medication pass. Upon review of the 05/01/13 TAR with a replacement date of 07/25/13 she stated if the WanderGuard was to be changed on 07/25/13 then it should have been changed on that date. She continued to state the WanderGuard should be replaced on the date that it appeared on the TAR. She revealed she worked the day Resident #1 exited and stated she last saw the resident at the nurses station prior to receiving shift change report around 6:00 PM. RN #3 continued to state the next time she was aware of the resident's whereabouts was when RN #5 informed her that the resident was outside unsupervised. She assessed the resident for injuries and WanderGuard placement and function. She stated she assessed the function of the WanderGuard by using the tester, which did not function and then took the resident back to the entrance door, which did not appear to function either. RN #3 stated the WanderGuard had an imprinted activation date of 04/2013. She further stated that on 08/29/13 she was instructed to assess all residents with WanderGuards, by using the same two methods. The facility had identified two other residents with WanderGuards. Resident #2, who was identified as a long standing resident of the facility, had a WanderGuard that did not function by either method also. Resident #3, identified as a recent new admit, had a WanderGuard that functioned by both methods. The RN stated both residents with non-functioning WanderGuards had	F 323			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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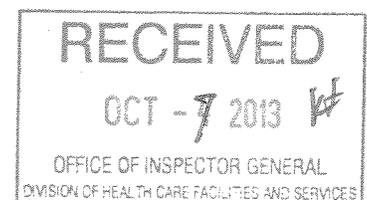
F 323	<p>Continued From page 22</p> <p>imprinted dates to activate by 04/2013. She stated the WanderGuard was replaced and rechecked for functioning by the two methods for both Resident #1 and Resident #2. RN #3 continued to state both of the replaced WanderGuards worked properly. She added the only solution to why the two residents' WanderGuards did not work was the battery life had expired. Those WanderGuards had a 90-day battery life. Based on the two (2) residents' activation dates of 04/2013, she revealed the WanderGuard would have expired 07/2013. RN #3 stated by not having a functioning WanderGuard the residents were at risk for unsupervised exit or injury. However, even though RN #3 knew the WanderGuards had a 90-day battery life, there was no evidence she took action to ensure the WanderGuards were replaced timely.</p> <p>Interview, with Certified Resident Care Assistant (CRCA) #2, on 09/05/13 at 5:55 PM, revealed she cared for Resident #1 often. The CRCA stated the nurses were responsible for the function of the WanderGuard and stated the CRCAs were to notify the nurses if the WanderGuard was observed not to alarm when a resident was near an exit door, if the WanderGuard was off, or if a resident was exit seeking. She further stated she had not reported any WanderGuard concerns. The CRCA stated she worked the day of the elopement, and last saw Resident #1 around 5:45 PM - 6:00 PM, sitting in front of the nurses station prior to starting other residents' evening showers. She stated she was aware of the resident's elopement by report from the nurse. The CRCA indicated she had only previously received training during the orientation with a preceptor and had not been</p>	F 323		
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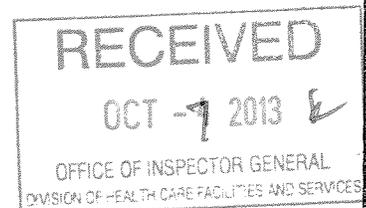
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F 323	<p>Continued From page 23</p> <p>tested to determine any knowledge of the WanderGuard system.</p> <p>Interview, on 09/05/13 at 2:40 PM, with RN #2 (MDS Coordinator) revealed she was notified of the elopement between 6:30 PM - 6:45 PM. She stated after being notified she went to the unit and observed the nurse who assessed the resident for injuries. RN #2 stated that RN #3, and RN #5 along with herself took the resident with the WanderGuard back to the entrance door to assess the door function. She further added the resident's WanderGuard did not function at the main entrance door. Upon not knowing the root cause for Resident #1's WanderGuard not functioning, she had all the residents in the facility with WanderGuards to be assessed to ensure proper function. RN #2 stated Residents' #2 and #3 WanderGuards were assessed with the tester and at the door. She stated Resident #2, a long standing resident, had a WanderGuard that did not function; whereas Resident #3, a newly admitted resident, had a WanderGuard that alarmed and functioned. She stated the 90-day WanderGuard activation date on Residents #1 and #2 were 04/24/13. RN #2 continued to state after new WanderGuards were placed, both residents' WanderGuards were retested for function and both functioned appropriately. RN #2 further stated the clinical record did not reflect the WanderGuard change date for Resident #1 and #2. However, even though RN #2 knew the WanderGuards had a 90-day battery life, there was no evidence she took action to ensure the WanderGuards were replaced timely.</p> <p>Interview, on 09/05/13 at 1:30 PM, with RN #4 revealed she cared for Resident #1 often. She stated she was not formally trained on the</p>	F 323		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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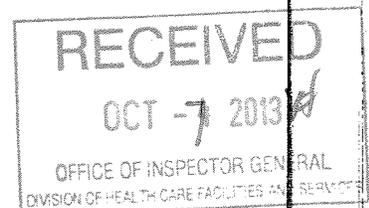
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F 323	<p>Continued From page 24</p> <p>facility's WanderGuard system. The RN continued to state she had no knowledge of the WanderGuard's 90-day battery life. She stated she was not sure of how to correctly use the WanderGuard tester. RN #4 stated the normal system preferred to test the WanderGuard was by physically taking the resident to the entrance door and see if it locked and alarmed.</p> <p>Interview with the Staff Development Coordinator LPN #6, on 09/11/13 at 4:30 PM, revealed staff training on the WanderGuard system occurred during orientation with a preceptor who discussed safety measures of the WanderGuard system door locations, codes, and residents with a potential for elopement, as well as missing residents. She further stated the staff was not tested to assess their knowledge base or the need for further education regarding the WanderGuard system.</p> <p>Review of the Preceptor/Job Specific Orientation Checklist under safety measures revealed it did not cover the life of the battery to be 90-days.</p> <p>Interview, on 09/05/13 at 4:00 PM, with the Executive Director (ED) revealed the facility notified her of the elopement on 08/29/13. She stated she notified the newly hired Director of Health Service (DHS) on 08/29/13. The ED stated the facility had only used the 90-day WanderGuard devices and the staff was trained upon hire and annually regarding elopement policies and how to use the WanderGuard devices. The ED stated she had no system to monitor the 90-day usage of the WanderGuards and the responsibility of calculating the 90-day battery life would be the nurse who placed the WanderGuard on the resident. She revealed</p>	F 323			



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F 323	<p>Continued From page 25</p> <p>through their investigation the WanderGuard 90-day battery had expired at some point, but could not specify the date.</p> <p>Phone interview, with the manufacturer's Compliance Manager, on 09/05/13 at 9:40 AM, revealed a WanderGuard would not function if the bracelet was out of date or not tested properly. He stated the 90-day WanderGuard days start to count down at the time of activation. He stated the battery life will last 90-days and it was highly doubtful it would last past 94 days. He stated, for example, if the resident's activation date happened on 04/24/13 the last battery usage date would be 07/27/13 and 07/27/13 to 08/29/13 (the day of elopement) would have been 37 days without the battery functioning.</p> <p>Continued interview, with the Executive Director (ED), on 09/05/13 at 4:10 PM, revealed the nurses were responsible to ensure the placement and functioning of the WanderGuard. She continued to state the nurse should have visually seen the WanderGuard and checked the function by using the tester or physically taking the resident to the door to ensure it alarmed and locked. She further stated the bracelet must have stopped functioning before the elopement.</p> <p>Review of the acceptable Allegation of Compliance (AOC), dated 09/10/13, revealed the facility took the following actions:</p> <p>1. Resident #1 was returned to the 200 Unit and was assessed on 08/29/13 and found no injury was sustained. Resident #1 was placed on every 15 minute checks to increase supervision. The Care Plan of Resident #1 was updated by the</p>	F 323			



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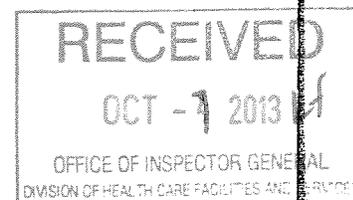
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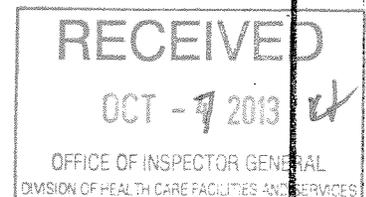
F 323	<p>Continued From page 26</p> <p>Clinical Support nurse on 08/29/13 identifying elopement risk and application of a new WanderGuard.</p> <p>2. All exit doors in the facility were checked for function on 08/29/13 and found to be in working order by the Director of Plant Operations.</p> <p>3. Resident #2, and #3 had WanderGuard devices changed on 08/29/13 based on risk assessments. Systematically the facility will use one year WanderGuards instead of 90-day devices. Staff Development education on the differences of the devices was completed on 09/06/13.</p> <p>4. The facility initiated an investigation on 08/29/13 of the elopement and concluded on 08/30/13 with notification to the Office of Inspector General on 08/30/13 and a five day report on 09/04/13.</p> <p>5. All residents were reassessed for elopement potential on 09/05/13. All applicable care plans were updated to include wandering behavior. One resident (Resident #5 who was a new admit) was identified as at risk for elopement with the care plan revised to reflect this.</p> <p>6. The Elopement binders were reviewed by the Assistant Director Health Services on 08/30/13 and were placed at all the Nurses Station and Business Office and Reception Desk (Resident #1, #2, #3, and #5). The facility verified the Treatment Administration Record (TAR) to reflect the current status of the resident and current orders with change dates for the devices.</p> <p>7. Staff education initiated by Staff Development</p>	F 323		
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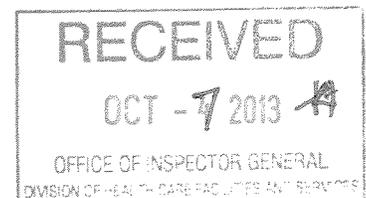
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/11/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLEN RIDGE HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6415 CALM RIVER WAY LOUISVILLE, KY 40299</b>		
(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 323	<p>Continued From page 27</p> <p>Nurse on 08/29/13 and completed on 09/06/13. Staff Education included elopement, WanderGuard including the one (1) year device, alarm and missing residents policies.</p> <p>8. An Elopement Drill was conducted, on 09/05/13 at 6:15 PM, by the Director of Plant Operations.</p> <p>9. A QA monitoring tool was implemented on 09/05/13 which included review of alarms and Care Plan development. These audit would be completed by the MDS nurse and Nurse Managers. Then the Director of Health Services and Assistant Director of Health Services would complete this audit weekly times 60 days and then monthly times 90 days. All audits would be reviewed during the Quality Assurance Meeting monthly.</p> <p>10. A QA meeting was held on 09/06/13 that included the Medical Director with discussion of the Immediate Jeopardy, elopement and behavioral changes.</p> <p>The State Survey Agency (SSA) validated the AOC on 09/11/13 as follows:</p> <p>1. Review of the care plan and the every 15 minute checks for Resident #1 revealed they were completed and updated.</p> <p>2. Observation, on 09/11/13 at 1:40 PM-1:50 PM of the main entrance door revealed Residents #1, #2, #3 and #5 all had WanderGuards. The facility's main door activated the alarm and locked the door with each resident. Observation, on 09/11/13 at 1:20 PM, of RN #6 revealed she placed the tester 2" above Resident #3's</p>	F 323			



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

PRINTED: 09/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 28 WanderGuard and the tester flashed green.  3. The SSA validated through observation that all residents who utilized a WanderGuard had the new WanderGuard with a one year battery life. Observation during the extended survey, on 09/11/13 at 9:20 AM - 9:30 AM, revealed the residents currently assessed to be an elopement risk ( Resident #1, #2, #3 and #5) had a WanderGuard applied. Each device was imprinted with Do Not Use past 09/29/14. Interview, on 09/11/13 at 1:25 PM, with RN #6 revealed the writing indicated the day the facility applied the one year WanderGuard plus one year to indicate the date it was to be changed. The RN continued to state the TAR would also have the date the device was applied. She further stated they do not use past date indicated when the manufacturer designated the battery was no longer functional. Interview, on 09/11/13 at 2:40 PM with LPN #1 (Medical Records) revealed all 90-day WanderGuards were removed from stock on 09/06/13 when the one year devices were stocked.  4. Review of the facility's investigation revealed the completion of the investigation on 08/30/13.  5. Review of the audit for reassessment of all residents revealed the audit identified one new resident (Resident #5) as a new resident with a potential for elopement and the care plan was updated to reflect that risk. Observation revealed one resident who was found to be at risk for elopement, had a WanderGuard bracelet applied and was working properly. This was validated through observation of the tester and door alarm. Through record-review of four recent admission	F 323			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 29</p> <p>since 09/07/13 - 09/11/13 found elopement risk assessments were performed and found not to be at risk. In addition, the SSA validated re-assessments of all residents were completed on 09/05/13.</p> <p>6. Review of the elopement binders revealed they were located in the Business Office, the Skilled Unit, the 400 Unit and the 500 Unit. The binders contained resident information and pictures of the four residents identified as at risk for elopement.</p> <p>7. The State Agency validated through record review evidence of education provided to staff which included policies for: elopement, alarm checks, missing residents, WanderGuards and care plan development completed on 09/06/13. Interview with CRCA #6, on 09/10/13 at 5:05 PM, CRCA #7, on 09/10/13 at 5:10 PM, CRCA #8, on 09/11/13 at 1:40 PM, RN #7, on 09/10/13 at 4:40 PM, RN #6, on 09/11/13 at 9:30 AM, LPN #4, on 09/10/13 at 5:00 PM, LPN #3, on 09/11/13 at 9:10 AM, LPN #5, on 09/11/13 at 12:20 PM, Housekeeper #8, on 09/11/13 at 8:59 AM, and Dietary Director, on 09/11/13 at 8:50 AM revealed all staff members were trained and knowledgeable on the elopement policy. The RNs and LPNs revealed knowledge of the WanderGuard 1 year procedure.</p> <p>8. Review of the elopement drill and sign sheets, dated 09/05/13 at 6:15 PM by the Director of Plant Operations.</p> <p>9. Review of the QA monitoring tool revealed the tool was initiated and completed on 09/05/13 by the MDS nurse.</p> <p>10. Interview with the Medical Director, on</p>	F 323			



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F 323	Continued From page 30 09/11/13 at 2:20 PM, and record review of the sign sheet revealed the facility conducted a Quality Assurance meeting with the Medical Director on 09/06/13. The facility notified him on 08/29/13 between 6 PM - 7 PM of the elopement. He stated he was present at the facility during the Quality Assurance Meeting on 09/05/13. He further stated no concerns with the facility's elopement policy, but staff needed to follow the policy.	F 323		

