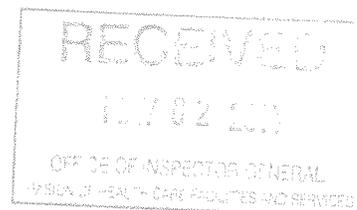


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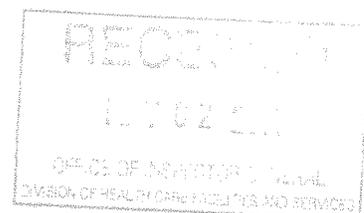
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
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F 282	Continued From page 30 trained on 03/09/14 by the UM. 19. Interview with the DON, on 03/27/14 at 2:10 PM, revealed she participated in review of the facility's elopement policy on 03/10/14 with no changes made. 20. Review of the care plans for residents at risk of elopement on 03/10/14 revealed six (6) residents with care plans for risk of elopement were updated by 03/14/14. Interview with the DON, on 03/27/14 at 2:01 PM, revealed she reviewed resident care plans for risk of elopement for all nine (9) residents and revised six (6) resident care plans, completed by 03/12/14. 21. A. Review of the Wanderguard Audit Tools, dated 03/10/14, 03/12/14, 03/13/14, 03/14/14, 03/18/14, 03/19/14, 03/20/14, 03/21/14, 03/22/14, 03/24/14 revealed they were completed by the DON and ADON. Interview with the DON, on 03/27/14 at 2:10 PM, revealed she completed WG audit checks of individual residents beginning 03/10/14 and at least five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, then weekly. B. Review of the eMAR/eTAR Medication Admin Audit Report revealed audits for missed documentation were conducted five (5) times a week beginning 03/12/14. Interview, on 03/27/14 at 2:10 PM, with the DON revealed eMAR/eTAR audits were begun on 03/12/14 and would be conducted five (5) times a week for four (4) weeks, then three (3) times a week for four (4) weeks, and then weekly. C. Review of the facility's Daily Maintenance Rounds and Weekend Manager Checklist, dated 03/08/14 through 03/23/14, revealed the exterior	F 282			



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F 282	<p>Continued From page 31</p> <p>doors were checked to ensure the doors were working daily by Maintenance or the Manager on Duty.</p> <p>22. Review of the facility's Medication Administration Audit Report, dated 03/10/14, revealed all residents eMARs/eTARS were reviewed for missing documentation by the DON. Interview with RN #5 on 03/27/14 at 8:52 AM; RN #3 on 03/27/14 at 9:02 AM; and LPN #3 on 03/27/14 at 9:28 AM, revealed the nurses were responsible to check the resident's WG placement and function each shift and document on the eMAR/eTAR.</p> <p>23. Review of the facility's education records revealed thirteen (13) staff participated in an elopement drill on 03/11/14. Interview, on 03/27/14 at 8:26 AM, with the Maintenance Director revealed he was responsible to conduct elopement drills quarterly, beginning 03/11/14.</p> <p>24. Review of the facility's Elopement Guidelines revealed the checklist included the elopement binder, care plans, staff able to verbalize elopement procedures, door alarms checked, and WG checked daily and documented. Review of six (6) resident care plans for residents at risk of elopement revealed care plans were updated by 03/14/14. Interview with the UM on 03/27/14 at 1:26 PM; the DON on 03/27/14 at 2:10 PM; the DCE 03/27/14 at 2:47 PM; the Social Worker on 03/27/14 at 3:16 PM; and the Social Service Director on 03/27/14 at 3:16 PM, revealed they participated in the IDT meetings and reviewed resident care plans for risk of elopement beginning 03/10/14 and would be reviewed by the IDT quarterly, with significant changes, or as needed using the checklist.</p>	F 282			



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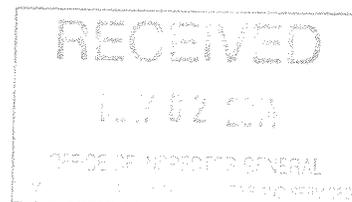
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F 282	Continued From page 32 25. Review of the facility's QAPI attendee signature sheet revealed an Ad Hoc QA&A meeting was held on 03/10/14. Interview with the Administrator, on 03/27/14 at 10:10 AM revealed she called the Medical Director for the QAPI meeting on 03/10/14. Interview with the Administrator on 03/27/14 at 10:10 AM; the UM on 03/27/14 at 1:26 PM; the DON on 03/27/14 at 2:10 PM; the DCE 03/27/14 at 2:47 PM; the Social Worker on 03/27/14 at 3:16 PM; and the Social Service Director on 03/27/14 at 3:16 PM, revealed they participated in the facility's QAPI meetings and attended a meeting on 03/10/14 to discuss the elopement, with meetings schedule weekly for four (4) weeks, then bi-weekly for four (4) weeks, then monthly. The UM stated a QAPI meeting was also held on 03/27/14 with the Medical Director on speaker phone. Review of the QAPI signature sheet, dated 03/20/14, revealed the Medical Director attended the meeting. The signature sheet, dated 03/27/14, indicated the Medical Director participated via conference call. 26. Review of the facility's QAPI signature sheet, dated 03/20/14, revealed an ADHOC QA&A meeting was conducted. A QAPI meeting held on 03/20/14 indicated the Medical Director was in attendance. Interview with the Administrator, on 03/27/14 at 10:10 AM revealed she called the Medical Director for the QAPI meeting on 03/20/14. Interview with the Administrator on 03/27/14 at 10:10 AM; the UM on 03/27/14 at 1:26 PM; the DON on 03/27/14 at 2:10 PM; the DCE 03/27/14 at 2:47 PM; the Social Worker on 03/27/14 at 3:16 PM; and the Social Service Director on 03/27/14 at 3:16 PM, revealed they participated in the facility QAPI meetings and	F 282		
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F 282 Continued From page 33
attended a meeting on 03/20/14 to discuss the elopement, with meetings schedule weekly for four (4) weeks, then bi-weekly for four (4) weeks, then monthly. The UM stated a QAPI meeting was also held on 03/27/14 with the Medical Director on speaker phone. Review of the QAPI signature sheet, dated 03/20/14, revealed the Medical Director attended the meeting. The signature sheet, dated 03/27/14, indicated the Medical Director participated via conference call.

F 323 SS=K 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 the facility's policy, investigation, WanderGuard List, and the manufacturer's Accutech Installation Manual, it was determined the facility failed to have an effective system in place to ensure supervision of residents at risk for elopement for five (5) of fourteen (14) sampled residents (Resident #4, #5, #6, #7, and #8).

Resident #4 was assessed by the facility to be at risk for elopement and was care planned to have a WanderGuard applied. On 03/09/14, Resident #4 was found by staff, at approximately 10:30 AM, with the WanderGuard (WG) device off.

F 282

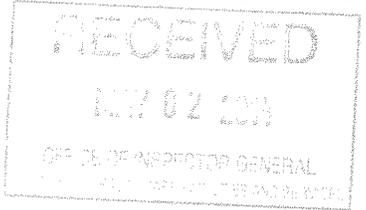
F 323 F323

Criteria I
3/9/14

- Returned safely to Living Center by the Licensed Nurse.
- Assessment completed to rule out injury by the Licensed Nurse.

3/9/14
The Unit Manager was immediately notified of the incident and initiated the investigation. Verbal instructions were given to the Licensed Nursing Staff per Unit Manager. The DNS and ED were notified per Unit Manager.

- Immediate investigation was initiated by the Unit Manager.
- WanderGuard was replaced by the Licensed Nurse. The device was verified to be in working order by the flashing light as indicated by manufacturer's directions per the Licensed Nurse. The Licensed Nurse documented incident with interventions on the DQI per policy.
- Care plan was reviewed by the Unit Manager. No revisions were needed.
- System review, i.e., the Unit Manager manually checked all doors to ensure they were locking properly. All doors were working correctly. The Unit Manager checked the WanderGuard system by taking each resident with a device to an exit door. The system was working properly Per manufacturers instructions the flashing light



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F 323	<p>Continued From page 34</p> <p>However, staff failed to replace the WG, and the resident exited the building without staff knowledge. The resident was observed by staff outside the facility on the sidewalk propelling self in the wheelchair at approximately 1:00 PM. The resident was returned to the facility and assessed to have no injury. The facility identified the resident did not have the WG on upon return to the facility.</p> <p>The facility failed to ensure Resident #7's WG was checked for placement and function each shift when initially applied and failed to ensure care plans were revised for Resident #5, #6, #7, and #8 to indicate the WG should be checked for placement, function, and/or how often. In addition, the facility failed to have a system to ensure the WG bracelets were monitored for length of use in relation to the WG battery's twelve (12) month warranty period for Resident #4, #5, #6, #7, and #8.</p> <p>The facility's failure to have an effective system in place to ensure residents were adequately supervised for risk of elopement placed residents in a situation that has caused or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/17/14 and determined to exist on 03/09/14. The facility was notified of the Immediate Jeopardy on 03/17/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 03/24/14 alleging the IJ was removed on 03/15/14 and the State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 03/15/14, as alleged. The scope and severity was lowered to an "E" while the facility develops and implements the Plan of</p>	F 323	<p>on the devise ensures the battery is working properly. All wanderguards in use was checked for the flashing light. A flashing light was not visible on one wanderguard and the device was immediately replaced by the Unit Manager. The License Nurse checked all 7 Elopement binders to ensure this resident was included. The resident was included in all 7 binders.</p> <ul style="list-style-type: none"> Family and MD were immediately notified by the Licensed Nurse. <p>A physician order for checking Wanderguard placement and functioning was obtained and implemented on the EMAR per Unit Manager for Resident #7 on 3/12/14. The DNS verified that resident # 5, 6, 7 & 8 had a functioning wanderguard in place, order present for checking placement and functioning and care plans were in place by 3/12/14.</p> <p>Criteria 2</p> <p>All residents have a potential to be affected.</p> <p>Criteria 3</p> <p>3/9/14:</p> <p>The Unit Manager initiated immediate education for the Licensed Staff and Nursing Assistants:</p> <p>The Licensed Nurse is responsible to ensure:</p> <ul style="list-style-type: none"> Wanderguards are in place every shift or more often if care plan indicates the need for more frequent checks. Documentation occurs every shift on MARS/TARS or according to care plan. Care plan updated quarterly, with significant change or as needed on an ongoing basis. <p>3/10/14:</p> <p>The Director of Clinical Education (DCE) continued education initiated by the Unit Manager. All licensed staff excluding PRN did receive education by 3/13/14. PRN staff will be in-serviced prior to working. The center does not use agency staff.</p>	

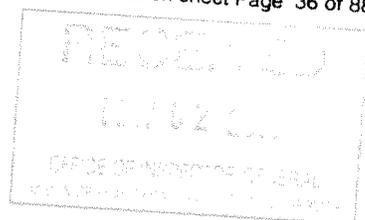


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F 323	<p>Continued From page 35</p> <p>Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Elopement Guidelines, revised 2013, revealed elopement occurred when a resident with impaired decision making, was unaware of his/her own safety needs, and was at risk for injury outside the confines of the facility had left the facility without staff knowledge. Staff would observe each resident's WG bracelet to ensure it was in place each shift and a process would be established to check the WG batteries. A roster of bracelet battery expiration dates would be maintained and WG's replaced prior to expiration. The charge nurse would be responsible to test the resident's WG.</p> <p>The facility did not provide a policy regarding resident supervision.</p> <p>1. Review of the facility's investigation, dated 03/09/14, revealed the Speech Therapist saw Resident #4 in her wheelchair slowly moving on the sidewalk. She immediately brought it to the attention of the nurse. The nurse brought the resident back in to the facility. The investigation included employee statements and employee counseling form to the nurse for not replacing the WG in a timely fashion. Corrective action to be taken is extra bands are to be kept in the medication cart, WGs are to be replaced immediately. Review of the Verification of Investigation, dated 03/09/14, revealed the resident was seen outside the building, no injury sustained, resident wanted to go home and the</p>	F 323	<p>3/10/14: The Executive Director and Director of Nursing reviewed the Elopement Policy and Procedures and determined to be in plan and without need for revision.</p> <p>3/10/14: The Executive Director and/or the Director of Nursing will monitor the education daily, until all staff receive re-education, by reviewing the in-service sign in sheets with the Director of Clinical Education. A review of the in-service attendance roster reflected 12 completed on 3/9/14, 28 completed on 3/10/14, 18 completed on 3/11/14, 31 completed on 3/12/14, 7 completed on 3/13/14 and 26 completed on 3/14/14. 100% of all working staff including PRN were educated by the end of the day, 3/14/14. One employee is on Medical Leave of Absence and will receive training prior to returning to work.</p> <p>All staff received written elopement policy with verbal in-service and an elopement drill was performed per the DCE by 3/14/14. Upon questioning, staff verbalized elopement policy, after completion of training.</p> <p>The DCE will continue to educate new hires during orientation and re-educate staff as needed on an on-going basis.</p> <p>Criteria 4</p> <p>3/11/14: The Director of Nursing is response to ensure the wanderguards and MAR/TARS are completed, initiated 3/12/14. The audits will be reviewed in QA meeting by members of the QA committee.</p> <ul style="list-style-type: none"> Audit placement of wanderguard devices on individual residents 5 times a week x 4 weeks starting 3/10/14, 3 times a week x 4 weeks and once a week ongoing by Director of Nursing or Assistant Director of Nursing. Audit MARS/TARS to ensure elopement documentation is complete 5 times a week x 4 weeks, starting 3/12/14, 3 times a week x 4 weeks, once a week ongoing by Director of Nursing or Assistant Director of Nursing. 	



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F 323 Continued From page 36
family and MD were notified. the causal factor was determined to be resident had dementia.

Review of the clinical record for Resident #4 revealed the facility admitted the resident on 08/11/11 with diagnoses of Senile Dementia and Alzheimer's disease. The facility completed a quarterly Minimum Data Set (MDS) assessment on 12/28/13 and assessed the resident with a Brief Interview Mental Status (BIMS) score of five (5). A nurse's note, dated 01/24/14, revealed Resident #4 exhibited exit seeking behavior and was observed by staff to attempt to open the front door of the facility. A WG was then placed on the resident's ankle. The facility developed an elopement care plan, dated 01/25/14, which stated the resident looked for people and things that were not there, was unable to make good safety decisions, and had attempted to open the front door to get a ride to go home. The care plan, dated 01/25/14, stated staff was to find something on the unit the resident would like to do to divert attention from the door; remind the resident the family would be visiting soon; talk to the resident to try and find out what they were looking for; and test the WG alarm to make sure it was working properly. Review of the CNA care sheet revealed the resident had a WG. There was no direction to the CNA in regards to the interventions listed in the care plan. Review of the electronic Treatment Administration Record (eTAR), dated March 2014, revealed the resident's WG should be checked every shift for placement and function. A nurse's note, dated 03/09/14, revealed Resident #4 exited the facility and was found outside. The resident had stated he/she wanted to go home.

Interview, on 03/13/14 at 1:18 PM, with Certified

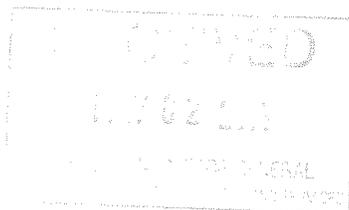
F 323 The DNS will report any issues identified from these audits to the IDT/Start up team at the next meeting. Re-education will be provided by the DCE or DNS on a one on one basis.

3/9/14:
The Maintenance Director was and is responsible to ensure door audits are completed daily. This process was in place prior to 3/9/14 and is ongoing. The Executive Director will review the log weekly, started 3/12/14.

3/10/14:
The Executive Director is responsible to ensure QA meetings are held and members sign in. QA members include: Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Managers, Director of Clinical Education, MDS Coordinator, Social Services, Dietary, Activities, Business Office, Consultant Pharmacy and Medical Director.

The Elopement binders will be reviewed weekly by Social Services on an ongoing basis to ensure residents at elopement risk are identified.

03/12/14 The DNS created and initiated an audit tracking form. Information included on audit form: resident name with tag, date wander guard tag applied, site, weekly check of battery using the hand held device, date of last assessment, IPOC/care plan, MD order, and is resident information in the Elopement Nook. The use of this audit form is ongoing. 3/12/14 spare wander guard tags, bands, and the hand held device used for activation of the wander guard tang have been placed in the North med caret to facilitate access for nursing. Social Services created and continues to review and update the Elopement Binder weekly and as needed. Social Services created and continues to utilize an audit tool. Information included: resident name, serial number for ID tag, and where tag is placed. Maintenance or Manager on Duty continues to monitor all doors and Wander Guard System for proper functioning daily. The DCE continues to complete education with all newly hired staff related to the Wander Guard System and care Plans. The DNS will re-educate staff as needed.



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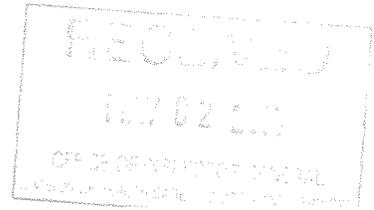
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F 323	Continued From page 37 Nursing Assistant (CNA) #4 revealed she assisted the resident, on 03/09/14 at 10:30 AM, to get ready for exercise group and noticed the WG was not on the resident's ankle. The aide stated she saw the WG on the resident's dresser and immediately informed Registered Nurse (RN) #3 the resident's WG was off the resident. She indicated she finished assisting the resident and took the resident to the West dining room for the 11:00 AM exercise group. The CNA further indicated after exercise group Resident #4 would usually go to the North dining room for lunch around 11:40 AM. She stated after she took the resident to exercise group she did not see the resident again until after lunch while she was passing ice in the resident's room. CNA #4 stated during ice pass, around 1:00 PM, she observed the resident at the 200 Unit nurse's station and called to the resident; however, the resident was unable to hear her. She indicated about one (1) to two (2) minutes later she placed the resident's water pitcher back in his/her room and when she (CNA #4) came out of the resident's room she could no longer see the resident; however, Licensed Practical Nurse (LPN) #3 informed her that Resident #4 was outside the building. The aide further indicated she followed LPN #3 out the front doors and saw Resident #4 self-propel in his/her wheelchair on the sidewalk toward the parking lot. The CNA stated the resident was redirected back into the facility and the resident stated he/she was going home. She indicated the resident did not have a WG in place when she and the nurse went outside to the resident. The aide stated the front doors were unlocked during the day; however, when a WG was nearby the device would trigger the doors to lock automatically. She indicated the nurses were responsible to put the WG on the	F 323	QA Committee meeting will be held weekly x4 weeks, then bi-weekly x 4 wks then monthly thereafter. QA meetings were held weekly. No problems identified. Elopement Binders, Door & Wander Guard System Audits, and Nursing Audits are reviewed at each meeting. The QA meeting held on 3/27/14 recommended creation of an Elopement Emergency Kit. 4/3/14 the DNS created the emergency kit as recommended. 4/3/14 the committee recommended to the removal of wander guard tags for two residents due to change of condition and were removed per Nursing. 4/10/14 QA meeting was held. No issues were identified. 4/17/14 No issues were identified. The QA Committee will review compliance with education related to care plan training. The DCE will monitor and report percentages of training completed to the QA Committee quarterly. 3/17/14 the DCE reported that all nursing staff have completed Care Plan training. IF the Medical Director is unavailable in person on a weekly basis, he will review progress by telephone with the Executive Director and/or DNS. To date the Medical Director has been either present for all meetings or on phone conference line during the meeting.	F323 5/10/2014
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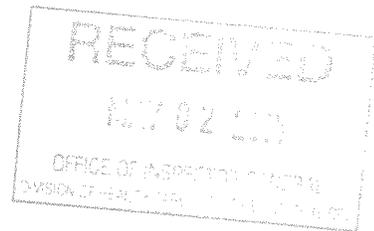
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F 323 Continued From page 38
resident, ensure the WG was in place, and working. CNA #4 further indicated if the resident did not have the WG in place, the resident could leave the building and get hurt, lost, or killed.

On 03/13/14 at 1:52 PM and 03/17/14 at 9:55 AM, interview with RN #3 revealed she was Resident #4's nurse on 03/09/14 at the time the resident left the facility. The RN stated she had checked Resident #4's WG that morning during med pass, around 8:15 AM, and the WG was in place and functioning. She stated later that morning CNA #4 reported to her the resident's WG had been removed from the resident; however, the RN was unsure of the time. She indicated she intended to place the WG back on the resident; however, she was busy doing other things and got distracted. The nurse further indicated the WG was not placed back onto the resident until after Resident #4 was returned to the facility. RN #3 stated the resident had in the past attempted to leave the facility and stated he/she wanted to go home. She further stated she had been trained by the facility to use and check the WG before the incident occurred. The nurse indicated the purpose of the WG was to maintain the resident's safety. She indicated Resident #4 was confused with Dementia and if the resident left the facility the resident could get hurt.

Interview, on 03/13/14 at 2:14 PM, with the Health Information Manager (HIM)/Weekend Manager on duty revealed she assisted in the dining room on 03/09/14 and had last seen Resident #4 in the dining room at 12:30 PM. The HIM/Weekend Manager stated after assisting residents from the dining room she sat down at the receptionist desk at 1:00 PM and LPN #3 immediately entered the building with Resident #4. She stated additional

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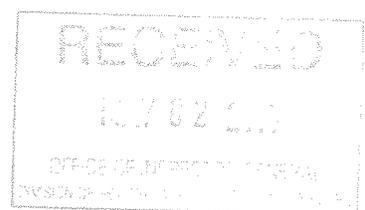
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F 323 Continued From page 39
duties of the Weekend Manager on duty included testing the doors and alarms and when she checked the doors and alarms on 03/09/14, everything was functioning the way it should. She indicated the door would alarm if it was held open; however, she did not check the doors with a WG to ensure the doors would lock when the device was in range. She stated the nurses were responsible to check the WG. She indicated if a resident at risk of elopement had left the facility something could happen to the resident, including the resident could become dehydrated.

Interview with LPN #3, on 03/13/14 at 5:01 PM and 03/14/14 at 9:29 AM, revealed she was the nurse on the 200 Unit and was working at the medication cart. The LPN stated she saw Resident #4 at the 200 Unit nurse's station and CNA #4 down the 300 hallway, calling to the resident, around 1:00 PM. She stated Unsampled Resident A and the Speech Therapist were working in that resident's room and reported a resident was outside about twenty (20) seconds later. She further indicated she observed Resident #4 outside Unsampled A's bedroom window and saw Resident #4 self-propel on the sidewalk. The nurse stated she immediately went outside to the resident, who had further propelled toward the parking lot. LPN #3 stated Resident #4 had said he/she was going home. She indicated CNA #4 had followed her (the nurse) outside to the resident and assisted to return the resident to the facility. The nurse stated Resident #4 did not have a WG on when she went to the resident outside. LPN #3 indicated when a resident wearing a WG approached doors, the doors would automatically lock. The nurse stated an alarm did not sound in the facility when Resident #4 eloped. LPN #3 further indicated she

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F 323	<p>Continued From page 40</p> <p>assisted with placement of the WG on the resident after she redirected the resident back into the facility. She stated the nurses were responsible to check that the WG was in place and functioning every shift. The LPN indicated if the resident was at risk of elopement the resident should have a WG on to protect the resident from leaving the facility which could be unsafe if the resident was mentally confused. She indicated the WG system would not work if the resident did not have on the WG.</p> <p>Interview, on 03/17/14 at 9:31 AM, with the Social Service Director (SSD) revealed Resident #4 did not have good safety awareness if he/she left the facility. The SSD indicated the resident's care plan included an intervention for the WG. She further indicated if the resident did not have the WG on and staff did not observe the resident as the resident left the facility the resident would be unsafe once he/she left the building.</p> <p>Interview with the Maintenance Director, on 03/13/14 at 2:44 PM, revealed when a resident had on a WG, the doors automatically lock when the WG was within a certain range. He indicated the doors were checked every day by maintenance during the week and by the weekend manager on duty on the weekends. The Maintenance Director stated he was called to the facility, on 03/09/14 after Resident #4 had eloped from the facility. He stated he checked all of the doors around 2:30 PM and found the doors to be functioning properly. He indicated the purpose of the WG was to alert staff a resident was attempting to leave the facility or had already exited the building.</p> <p>Interview with the interim Director of Nursing</p>	F 323		

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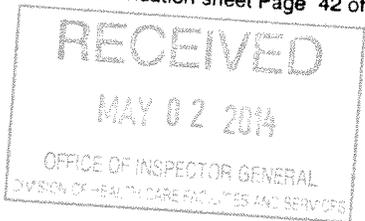
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F 323 Continued From page 41
(DON), on 03/17/14 at 10:15 AM, revealed the nurses were responsible to check the resident's WG every shift. She indicated the March 2014 eTAR check of Resident #4's WG had been checked by the nurse; however, there was no time documented and was unable to determine what time the WG had been checked. She further indicated if the WG was not on the resident, the resident could leave the facility without staff knowledge. The DON stated if Resident #4 needed a WG the resident did not have safety awareness. Additionally, the DON stated the WG did not replace supervision of residents and the WG system would not work if the resident was not wearing the WG. She indicated all staff was responsible to visually supervise residents; however, there was no scheduled times to visualize residents.

Interview, on 03/17/14 at 1:33 PM and 2:47 PM, with the Administrator revealed Resident #4 was confused and his/her judgment was altered. She stated the WG was an additional tool; however, the WG did not replace staff supervision. The Administrator indicated a WG did not mean the resident was safe, but was to assist the facility to keep the resident safe. She further indicated the resident's WG should be checked every shift by the nurse. She stated if a resident needed a WG and did not have it on, the resident had the potential to leave the facility. The Administrator indicated Resident #4 was able to leave the facility as the WG was not on the resident.

2. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/05/14 with a diagnosis of Dementia with Behavioral Disturbance. The facility completed an initial MDS assessment on 01/10/14 and

F 323



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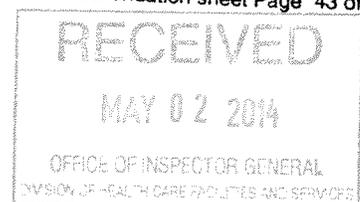
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F 323	<p>Continued From page 42</p> <p>assessed the resident to have a BIMS score of two (2). The facility initiated a care plan, on 02/14/14, for risk of elopement related to the resident self-propelling to the doors and attempting to open the doors. The care plan included an intervention for the use of a WG on the resident's left ankle. However, the facility could not confirm the WG was placed on 02/14/14 and review of the physician orders and eTAR, dated February 2014, revealed no physician order to check the WG each shift. The physician orders and eTAR for March 2014 revealed an order, dated 03/12/14, to check Resident #7's WG for placement and function each shift. The eTAR for March 2014 revealed the facility began to check the resident's WG for placement and function on 03/12/14.</p> <p>On 03/13/14 at 5:01 PM, 03/14/14 at 9:29 AM, and 03/24/14 at 10:22 AM, interview with LPN #3 revealed the facility had to have a physician's order for use of the WG in order for the WG checks to show on the eTAR. The nurse stated the only place to document the WG was checked for placement and function by the nurse was on the eTAR. She indicated if the WG checks were not listed on the eTAR then there was no way to know if the WG was being checked each shift. The LPN further indicated the purpose of the WG was to protect the resident from leaving the facility on their own if the resident was mentally confused, as it was unsafe for the resident.</p> <p>Interview with RN #3, on 03/24/14 at 10:44 AM, revealed the facility did not need a physician's order to place a WG on a resident; however, a physician order was required for the WG checks to transcribe onto the eTAR. She stated if there was not a physician's order for the WG checks</p>	F 323		
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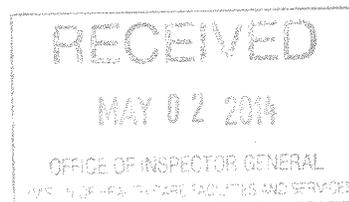


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F 323	<p>Continued From page 43</p> <p>the order would not show on the eTAR. The nurse indicated the eTAR was the only record of the WG checks. She further indicated if the WG was not being checked for placement and function the resident was at risk for elopement.</p> <p>Interview, on 03/24/14 at 11:15 AM, with LPN #6 revealed the use of a WG for residents was nursing judgment and did not require a physician's order; however, an order was needed for the WG checks to be listed on the eTAR. The LPN indicated the eTAR for March 2014 documentation began 03/12/14 to check the resident's WG for placement and function each shift. She further indicated she had worked with Resident #7 in the past; however, could not remember if she had checked the resident's WG for placement and function prior to the order and eTAR update on 03/12/14. LPN #6 stated if the WG was not checked each shift the resident could wander out of the facility and could become lost, or hurt. She stated she had been trained by the facility how to enter physician's orders into the computer and the use of the WGs.</p> <p>On 03/24/14 at 1:57 PM, interview with the Unit Manger for the 100 Unit revealed the nurse who placed the WG on Resident #7 was responsible to ensure the WG checks were on the resident's eTAR. She stated use of the WG was nursing judgment and did not require a physician's order; however, the facility would get a physician's order for the WG so the WG checks would carry over onto the eTAR. The Unit Manager indicated if the WG checks were not listed on the eTAR there was the potential the WG was not being checked for placement and function each shift. Additionally, she stated if the WG was not checked each shift, the WG had the potential of</p>	F 323		



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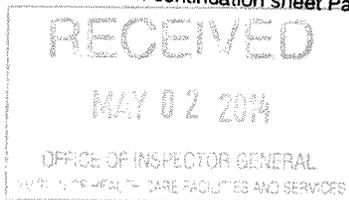
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F 323 Continued From page 44
not working. She further indicated the facility was unable to manually enter the WG checks onto the eTAR without a physician order. The Unit Manager stated the nurses were responsible for physician's orders. She indicated she attended the morning clinical meeting and would have discussed new orders, including the WG, in that meeting. She further indicated she was unaware how Resident #7's eTAR for 02/14/14 through 03/12/14 for WG checks was not updated to include the WG checks each shift. The Unit Manager stated it was not possible to determine if the WG was checked for placement and function each shift from 02/14/14 through 03/12/14. She indicated if the WG checks were not documented then they were not completed.

Interview, on 03/24/14 at 2:23 PM, with the Assistant Director of Nursing (ADON) revealed use of the WG was nursing judgment; however, a physician's order was necessary to ensure the WG checks were on the eTAR. She stated it was not possible to enter the WG checks directly onto the eTAR without a physician's order. The ADON indicated when the facility placed a WG on a resident the resident's need for the WG would be discussed in the morning clinical meeting. She further indicated she was unable to recall if Resident #7's WG placement was discussed in the meeting. The ADON stated if the WG checks were not listed on the eTAR it was not possible to know if the nurses were checking the WG each shift for placement and function. Additionally, the ADON stated if the WG was not listed on the eTAR the nurse would not know a resident had a WG on unless the nurse visually saw the WG. She indicated the DON was responsible to ensure the WG order was in place and on the eTAR. The ADON further indicated she was

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F 323	<p>Continued From page 45</p> <p>unaware Resident #7 had a WG and had not been informed of the placement of the WG on the resident and did not have record of the WG placement. She stated because she was unaware of Resident #7's WG, she had not followed up to ensure the physician's order was completed.</p> <p>Interview with the interim DON, on 03/24/14 at 2:46 PM, revealed although the use of a WG was nursing judgment, the resident's nurse was responsible to obtain a physician's order for the WG. She stated the purpose of the physician's order for the WG was to ensure the WG printed onto the eTAR and ensure the physician was aware the resident had a WG placed by the facility. She indicated if there was not an order entered into the computer the morning clinical meeting would not be aware of the new placement of the WG on the resident. The DON further indicated there was no way to know if Resident #7's WG was checked for placement and function each shift by the nurses prior to the physician order dated 03/12/14. She stated there was no other documentation of the WG checks. She also stated if the WG checks were not listed on the eTAR it was unknown if the nurses were aware the resident had a WG and the WG may not be checked for placement and function each shift. The DON indicated if the WG was not checked, the resident could remove the WG or the WG could stop working and staff would not be aware.</p> <p>On 03/25/14 at 9:33 AM, an interview with the Administrator revealed use of a WG for a resident was nursing judgment and did not require a physician's order to use the WG; however, a physician order was necessary to generate on the eTAR. She stated the nurse would document on</p>	F 323		
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F 323	<p>Continued From page 46</p> <p>the eTAR if the WG was being checked for placement and function each shift. The Administrator indicated Resident #7 was cognitively impaired and self-propelled around the facility in his/her wheelchair independently. She further indicated without the WG check listed on the eTAR, there was no way to know the nurses were checking the resident's WG unless she visually observed the nurse doing so. She stated resident behaviors were discussed in the morning clinical meeting, which she did not usually attend. The Administrator stated she could not recall if Resident #7 was discussed in the morning meeting for placement of the WG in February.</p> <p>3. Review of the manufacturer's Accutech Installation Manual, not dated, revealed the electronic security system should be considered a supplemental deterrent. The Accutech Tag's (referred to as a bracelet per facility policy and WG per facility records) internal battery was not replaceable and would eventually lose battery power, requiring the WG to be replaced. The manufacturer recommended as an option that the WG be tested weekly with a Secure Tag Activator/Deactivator (S-TAD) to determine if the WG had enough battery power to respond to an activated signal. The S-TAD contained an LED indicator for low battery that would require the WG to be replaced.</p> <p>Additional review of a facility email from Accutech Security, dated 03/13/14, revealed the S-TAD device was used to turn the WG device on or off and check the device for a low battery. A blinking red light indicated the WG was on. No light indicated the WG was either turned off or the battery was dead. The WG should have over twelve (12) months of use. The manufacturer</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
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F 323	<p>Continued From page 47</p> <p>recommended as one of the options for testing was to test the WG on a weekly basis with the S-TAD device to provide an indication if the battery was low.</p> <p>Interview with the Accutech Representative (Rep), on 03/25/14 at 9:08 AM, revealed he partnered with Direct Supply to complete the installation of the Accutech system in the facility. He stated the current system was installed around December 2013. The Rep indicated the WG was working if there was a red blinking light and if there was no light it was not working. He stated the WG device (tag) could be turned on and off to save the battery life beyond the one (1) year warranty. He stated once the S-TAD battery low indicator lighted, the WG should be replaced immediately. He indicated there was no percentage or time left on the battery given. The Rep further indicated Accutech recommended to check the WG batteries once a week. He stated if the battery was not checked weekly, the WG (tag) would eventually fail and no longer lock the doors.</p> <p>However, interviews with staff revealed they only visualized the function of the WG by a blinking red light and did not know there was a device to check for a low battery.</p> <p>On 03/13/14 at 5:01 PM and 03/14/14 at 9:29 AM, interview with LPN #3 revealed when the nurse placed a WG on a resident, the bracelet number was documented in a Nurse's Note. She stated the WG was obtained from administration, who was responsible to record the bracelet number being used for the resident. She stated if the WG was blinking a red light it was functioning and if the WG did not blink then the battery would be low. However, LPN #3 indicated there was no</p>	F 323			

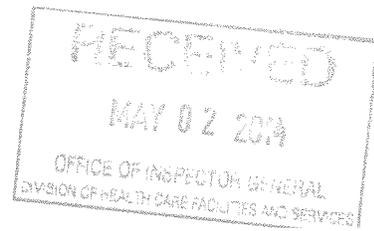
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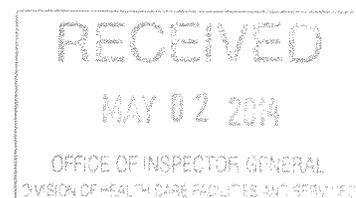
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F 323	<p>Continued From page 48</p> <p>device to check the WG system to ensure the battery was not too low which would require the WG be replaced.</p> <p>On 03/17/14 at 3:05 PM, interview with the Second Shift Supervisor revealed when the nurses check the WG to ensure it was functioning they look for the red blinking light on the device. He stated even if the light was blinking, if the door did not lock when the WG was by the door then the WG was not functioning. He indicated he was unaware of any way to check the WG battery status and the facility did not have a device to check the battery. He further indicated there was no way to know if a battery was dying except if there was no blinking light on the WG. The Supervisor stated the WG should be checked during each shift and agreed it was possible the battery could fail between checks by the nurses. He stated if the battery did not have enough charge the doors would not lock when the WG was in range. He stated per the manufacturer the battery life of the WG was over one (1) year.</p> <p>Interview with LPN #4, on 03/18/14 at 4:08 PM, revealed when she checked a resident's WG she looked for the red blinking light. She stated she did not check the WG battery; however, if the light was on the device the device was working. She also stated it was possible for the WG light to blink; however, still not be fully operational.</p> <p>Interview with LPN #6, on 03/24/14 at 11:15 AM, revealed the WG was checked for function if there was a red blinking light. She stated the nurses had a machine to turn the WG on and off. She indicated if the WG light was not blinking it would need to be replaced. She also indicated if the facility assessed the resident to be a risk for</p>	F 323		



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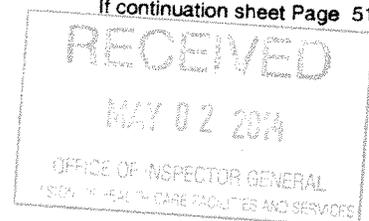
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F 323	<p>Continued From page 49</p> <p>elopement, the nurse would place a WG on the resident and add the resident's name and bracelet number to the elopement list. The date of placement of the WG would be documented in the clinical record in the physician's orders and nurses notes. She further stated if the WG needed to be replaced the information would be in the nurse's notes of the resident's clinical record.</p> <p>Interview with the Unit Manager (UM) for the 100 unit, on 03/14/14 at 12:46 PM and 03/17/14 at 3:05 PM, revealed the WG battery should last at least one (1) year. The WGs were verified they were functioning by looking at the blinking light. She indicated the battery could go dead after the nurse had checked it for the shift and prior to the nurse checking it on the next shift. She stated if the WG was not functioning a resident could leave the facility unobserved by staff. She indicated the staff would not know a battery had failed until it was visualized or a resident attempted to leave the facility. In addition, she stated the company representative for the WG system conducted inservice training at the facility and had stated the WGs should last between one (1) and one half (1/2) years. She stated the facility WG list included the WG bracelet device number. The WG number was submitted to the ADON or DON to add the resident to the WG list. She further stated the documentation of the date the bracelet was placed on a resident would be the date the facility updated the resident care plan and the eTAR for monitoring.</p> <p>On 03/19/14 at 10:27 AM, interview with the Assistant Director of Nursing (ADON) revealed when the nurses check the resident WGs for placement and function they do not check the</p>	F 323			



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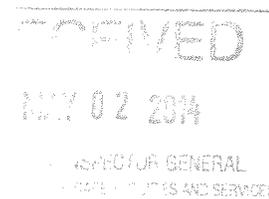
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F 323	<p>Continued From page 50</p> <p>battery status. She stated the WG battery could not be replaced and the entire WG device would have to be replaced. She further indicated if the battery status was not checked the WG may not function. Continued interview with the ADON, on 03/24/14 at 2:23 PM, revealed no one at the facility kept track of the date the WG was placed on a resident. She indicated a WG could be re-used on another resident at a later date as long as the battery was functioning. The ADON indicated there was no way to know how long a used WG had been in use prior to placing it on another resident, because she did not track the date the WG was placed on a resident. She stated if the time of use of the WG was not monitored, it was possible the battery may not function.</p> <p>Interview with the Interim DON, on 03/19/14 at 10:14 AM, revealed the WG devices did not have an expiration date and she contacted Accutech after Resident #4 had eloped from the facility and was informed there were no expiration dates for the WG devices. She indicated the WG light would blink as long as the device was working; however, the number of times a resident's WG set off the alarms would affect how quickly the battery was used up. She indicated if the WG battery was low and had not been tested the WG could quit functioning and the facility would not be aware. She further stated a resident could leave the facility without staff knowledge.</p> <p>Continued interview, on 03/24/14 at 2:46 PM, with the Interim DON revealed she was not aware of tracking dates for placement of a WG on a resident other than the physician's order or the resident's care plan. She stated the facility would re-use WGs on other residents as needed. The</p>	F 323			



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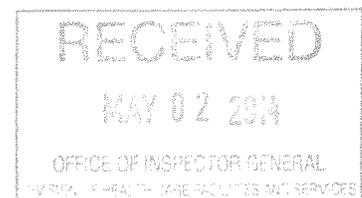
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F 323	<p>Continued From page 51</p> <p>DON indicated the WG device could be turned on and off. She further indicated if a WG was re-used and the dates of use were not maintained by the facility there was no way to know how long a WG had been in use for a total amount of time. The DON stated if the WG light was blinking it was functioning.</p> <p>On 03/17/14 at 1:33 PM and 2:47 PM, interview with the Administrator revealed the WG should have a red blinking light and the battery should last about one (1) year.</p> <p>Continued interview with the Administrator, on 03/19/14 at 10:42 AM, revealed the facility had a device to check the battery status of the WG; however, it was not used for that purpose. She stated the facility chose not to use the device and had directed the nurses to check the WG every shift, looking for the red blinking light to ensure it was functioning. She also stated when a resident with a WG was near the door the door could be heard to automatically lock. She indicated the facility did not have record when the doors were triggered by a WG or how often a resident's WG triggered the doors. The Administrator stated the WGs were supposed to last between one (1) to two (2) years. She stated if a WG battery failed it was possible for a resident to leave the facility.</p> <p>Continued interview with the Administrator, on 03/24/14 at 11:03 AM and 03/25/14 at 9:33 am, revealed she had been told by the WG representative to look for the red blinking light as an indicator if the WG was functioning. She stated the light on the WG was the indicator the battery was working. Additionally, the Administrator stated a WG would be turned off when removed from a resident and could be</p>	F 323			



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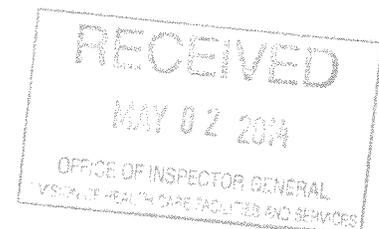
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F 323	<p>Continued From page 52</p> <p>re-used at another time or for another resident. She indicated when a WG was re-activated, the battery status would indicate at that time if the battery was low and the WG needed to be replaced.</p> <p>Review of the facility's WanderGuard List, not dated, revealed the list included the resident's name, where the WG was placed on the resident, and the device number. The list did not contain a date of activation or placement of the WG on the resident.</p> <p>Review of the clinical records for Resident #4, #5, #6, #7 and #8 revealed the facility the January, February, and March 2014 eTAR indicated the WG to the resident's ankle and check placement and function each shift. However, the eTAR did not direct staff to check the actual battery status, and the facility did not provide evidence of monitoring the dates of use for resident WGs.</p> <p>On 04/23/14 at 10:42 AM, post survey interview with the Social Service Director (SSD) revealed she would be notified when the facility placed a WG on a resident. She stated she would update the elopement binder with the resident's information. She indicated the ADON or DON was responsible to update the WG list of residents with the location of the WG, and the bracelet number.</p> <p>Post survey interview, on 04/23/14 at 10:53 AM, with the ADON revealed she was educated when the WG system was first installed the battery would last about twelve (12) months. She stated at that time she was not responsible to maintain the WG list. Additionally, she indicated the DON at that time, and the current interim DON, were</p>	F 323		



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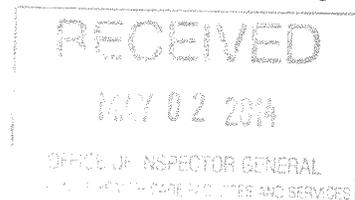
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F 323	<p>Continued From page 53</p> <p>responsible to maintain the WG List for the facility. The ADON stated she was unaware of the process to maintain the list at that time.</p> <p>Post survey interview with the interim DON, on 04/23/14 at 11:22 AM, revealed she was not at the facility when the current WG system was installed and did not receive training on the WG system when she began employment at the facility. She indicated the WG List had the resident name and where the WG was located, in addition to the bracelet number, it did not include the dates of use. The DON further indicated there was no tracking of how long a WG had been in use. She stated if the WG was still good, the facility could re-use the WG on another resident. She indicated she was unaware who was responsible to monitor the WG List before the elopement.</p> <p>Post survey interview with the Administrator, on 04/23/14 at 11:41 AM, revealed she was aware the WG battery would last twelve (12) months when the system was installed by the Accutech Rep. She stated the batteries could last up to two (2) years and depended on how frequently a WG would trigger the doors to lock. The Administrator indicated the WGs could be re-used. She stated Social Services was responsible to update the WG List and she monitored the List was updated and accurate when she would review the elopement book periodically. She indicated since the elopement occurred, the facility had begun to track the bracelet numbers and dates of use to improve the tracking system.</p> <p>The facility provided an Allegation of Compliance (AOC) on 03/24/14 alleging the Immediate Jeopardy (IJ) was removed on 03/15/14; the</p>	F 323		



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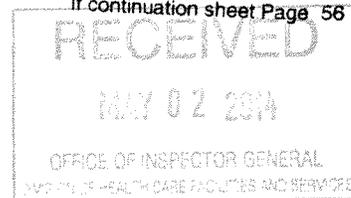
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F 323	Continued From page 54 facility took the following immediate steps to remove the IJ: 1. The resident was immediately returned to the facility on 03/09/14. 2. An assessment was completed on 03/09/14 by LPN #3 with no injuries reported. 3. An investigation was started on 03/09/14 by the Unit Manager. 4. The WG was replaced by LPN #3 on 03/09/14. The device was verified to be working by the flashing red light and documented the incident on the incident report (DQI). 5. The care plan was reviewed by the Unit Manager (UM) on 03/09/14. 6. The UM checked all doors to ensure they were locking properly on 03/09/14. The UM checked the WG system taking each resident with a WG to an exit door and found the system to work properly. All WG in use were checked for the red flashing light. The red flashing light was not visible on one (1) WG device and was immediately replaced by the UM. All elopement binders were checked by the UM to ensure the resident was included. 7. The resident's family and physician were notified by RN #3 on 03/09/14. 8. All residents were assessed on 03/09/14 for risk of elopement with nine (9) residents currently at risk and WG verified in place and working. 9. All residents were confirmed in the facility by	F 323			



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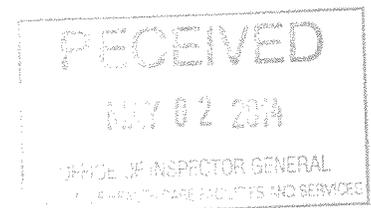
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F 323	Continued From page 55 the UM on 03/09/14. 10. All elopement binders were reviewed by the nursing staff on 03/09/14 to ensure all identified residents were in the binder. 11. The Maintenance Director checked all doors on 03/09/14. 12. The Maintenance Director checked the WG system on 03/09/14. 13. All resident WGs were checked by the UM on 03/09/14 for the red flashing light. 14. The DON assessed all residents on 03/10/14 for risk of elopement with no new residents added. 15. The DON and Social Services staff verified elopement binders were correct on 03/10/14. 16. The Director of Clinical Education (DCE) initiated an elopement drill on 03/11/14. 17. Education was initiated by the UM on 03/09/14 for nurses and CNAs that included: A. Care plans were to ensure resident safety B. Care plans were followed as developed for each resident and monitored every shift or more frequent if indicated with documentation on the eMAR/eTAR. Care plans were updated quarterly, with significant changes, or as needed. CNA assignment sheets were updated daily and as needed. C. WG devices in place if indicated and monitored each shift and more frequent if indicated with documentation on the eMAR/eTAR or according to the care plan.	F 323			



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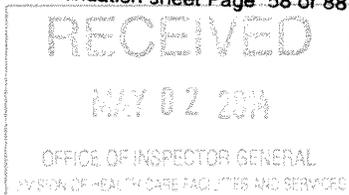
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F 323	Continued From page 56 18. The DCE continued education on 03/10/14 initiated by the UM. All licensed staff except PRN staff received education by 03/13/14. PRN staff will be in-serviced prior to working. 19. The Administrator and DON reviewed the Elopement Policy and Procedures on 03/10/14 with no changes made. 20. The DON verified on 03/10/14 the resident care plans were in place for residents at risk for elopement. The care plans were reviewed for accuracy 03/10/14 through 03/12/14 with six (6) of nine (9) revised. 21. The DON, ADON, and/or UM will: A. Audit placement of the WG on individual residents five (5) times a week for four (4) weeks to begin 03/10/14, followed by three (3) times a week for four (4) weeks, and weekly ongoing. B. Audit of eMARs/eTARs to ensure elopement documentation is complete five (5) times a week for four (4) weeks beginning 03/12/14, followed by three (3) times a week for four (4) weeks, and weekly ongoing. C. Check doors daily and ongoing by Maintenance or Manager on Duty to ensure the system was working. 22. Licensed staff are responsible to check WG placement and function each shift or as stated on the resident care plan with the device identified as functioning by evidence of a flashing red light on the resident's individual WG device. 23. The Maintenance Director will be responsible	F 323			



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F 323	<p>Continued From page 57 to conduct elopement drills quarterly, beginning 03/11/14.</p> <p>24. The Interdisciplinary Team (IDT) will monitor all care plans quarterly, with significant changes, or as needed and will utilize the checklist with the elopement policy.</p> <p>25. A QAPI meeting was held on 03/10/14 to discuss the incident on 03/09/14 and develop a plan to prevent re-occurrence. The plan included re-education of all staff regarding the elopement policy. All staff re-education was completed on 03/14/14. Elopement binders were reviewed 03/09/14; all care plans for resident with WGs were reviewed on 03/10/14; audit of eMARs/eTARs was completed 03/10/14; WG placement and function was completed 03/09/14; an elopement drill was completed 03/11/14 and will be quarterly thereafter. Details were discussed with the Medical Director by phone on 03/10/14.</p> <p>26. A QAPI meeting will be held weekly x4, then bi-weekly x4, then monthly. The committee will review compliance with education related to care plan training. If the Medical Director was not available, he would receive progress by telephone from the Administrator or DON. QAPI members include the Administrator, DON, ADON, UM, DCE, MDS Coordinator, Social Services, Dietary, Activities, Business Office, Consultant Pharmacist, and Medical Director.</p> <p>Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 03/26/14 through 03/27/14 prior to exit as follows:</p>	F 323			



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

PRINTED: 04/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
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F 323	Continued From page 58 1. Review of the clinical record for Resident #4 and the DQI revealed the resident was last seen at 12:35 PM leaving the north dining room. The resident was seen at 12:45 PM outside the building by the steps. Interview with RN #3, on 03/27/14 at 9:02 AM, revealed Resident #4 was returned to the facility at 12:45 PM. 2. Review of Resident #4's clinical record revealed a head to toe assessment was completed on 03/09/14 with no injuries noted. Interview with RN #3, on 03/27/14 at 2:01 PM, revealed she conducted a head to toe assessment for Resident #4 upon return to the facility with no injuries found. 3. Review of the facility DQI, dated 03/09/14, revealed an investigation was begun on 03/09/14. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she initiated the elopement investigation immediately after Resident #4 was returned to the facility. 4. Review of the clinical record revealed RN #3 completed the DQI on 03/09/14. Interview, on 03/27/14 at 2:01 PM, with RN #3 revealed she placed the WG back on the resident and verified the WG was functioning, and completed the DQI after Resident #4 was returned to the facility. Review of the facility's Daily Maintenance Rounds, dated Monday 03/03/14 through Friday 03/07/14, revealed all the exit doors were checked and operating correctly. Review of the Weekend Manager Checklist, dated 03/08/14 and 03/09/14, revealed door alarms and the WG system were working. Duties completed on 03/09/14 by the Weekend Manager included a tour for potential customers, assist to monitor call lights, dining room oversight during meals, seek	F 323			

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F 323	<p>Continued From page 59</p> <p>out and interact with residents and families, and assist with answering the telephone.</p> <p>5. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she reviewed Resident #4's care plan on 03/09/14. Review of the risk for elopement care plan for Resident #4 revealed the care plan was revised on 03/09/14.</p> <p>6. Review of the facility's Daily Maintenance Rounds and the Wanderguard List revealed the UM checked all exit doors and individual resident WG devices on 03/09/14. One (1) WG was replaced for Resident #7 by the UM. The UM reviewed all seven (7) elopement binders. Review of the elopement binder revealed all nine (9) residents with a WG were listed with a picture and informational face sheet. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she checked all the doors after the elopement and found all doors to be working. The UM stated she checked all the residents with a WG and found Resident #7's WG was not working and immediately replaced the WG. She indicated she also checked all the elopement binders and verified all residents at risk of elopement were in the binders.</p> <p>7. Review of Resident #4's clinical record revealed the physician and family were notified of the elopement on 03/09/14. Interview, on 03/27/14 at 2:01 PM, with RN #3 revealed she notified the physician and family about the elopement on 03/09/14.</p> <p>8. Review of the facility's Elopement Assessments revealed all residents were assessed 03/10/14 and 03/11/14 by the DON. Interview with the UM, on 03/27/14 at 1:26 PM,</p>	F 323		

