

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

PRINTED: 07/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/01/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203		
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY21876 was initiated on 06/25/14 and concluded on 07/01/14. The Division of Health Care substantiated the allegation with Immediate Jeopardy identified at 42 CFR 483.25 Quality of Care (F323 at S/S of "J") resulting in Substandard Quality of Care in F323. Immediate Jeopardy was identified on 07/01/14, and determined to exist on 06/17/14 through 06/23/14.</p> <p>Resident #1 was admitted to the facility, on 05/22/14 for short term rehabilitation. The facility assessed the resident with a Brief Mental Status (BIMS) score of three (3) of fifteen (15), indicating the resident was cognitively impaired, and also assessed the resident not at risk for elopement. On 06/17/14, the Social Worker assisted the resident off the elevator to his/her floor at approximately 8:30 AM. The resident stated "I want out of here". This comment was not communicated to the floor staff; however, was overheard by another nurse and no action was taken. On 06/17/14 at 9:04 AM, Resident #1 exited a locked unit door and left the facility without staff knowledge. He/she ambulated with a walker one hundred sixty-six (166) feet to a bus stop and got on a city transit bus at 9:24 AM. The resident exited the bus at 9:31 AM and walked eight (8) blocks to the last address where he/she lived. An acquaintance at this address called 911 (Emergency Services). The resident was taken to a local acute care hospital at approximately 12:27 PM. The National Weather Service temperature for the metropolitan city on this date was a high of 92 degrees Fahrenheit. The facility was notified, on 06/17/14 at 4:30 PM, by the local hospital emergency department they were</p>	F 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE **Senior Executive Director** (X6) DATE **7/31/14**

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

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If continuation sheet Page 1 of 27
JUL 31 2014
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE PROTECTION SERVICES

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

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F 000	Continued From page 1 returning the resident back to the facility. Interview and record review revealed the facility was unaware Resident #1 was not in the facility, on 06/17/14 from 9:04 AM until 4:30 PM (approximately 7.5 hours), when the facility was notified by the hospital. The resident was transferred back to the facility at 5:15 PM with no injury assessed. The State Survey Agency determined the facility completed corrective actions to remove the Immediate Jeopardy, prior to the investigation initiated on 06/25/14; therefore, the Immediate Jeopardy was determined to be Past Jeopardy. The Immediate Jeopardy was determined to be removed on 06/24/14.	F 000		
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 interview, record review, and review of the facility's policy and procedures, it was determined the facility failed to have an effective system to ensure one (1) of five (5) sampled	F 323	Past noncompliance: no plan of correction required.	

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F 323	<p>Continued From page 2</p> <p>residents (Resident #1) received adequate supervision to prevent elopement from the facility's grounds on 06/17/14 after stating he/she wanted to leave the facility.</p> <p>The facility admitted Resident #1 on 05/22/14 for rehabilitation. The facility assessed the resident with a Brief Mental Status (BIMS) score of three (3) of fifteen (15), indicating the resident was cognitively impaired, and also assessed the resident not at risk for elopement. On 06/17/14, the Social Worker assisted the resident off the elevator to his/her floor at approximately 8:30 AM. The resident stated "I want out of here". This comment was not communicated to the floor staff; however, was overheard by another nurse and no action was taken. On 06/17/14 at 9:04 AM, Resident #1 exited a locked unit door and left the facility without staff knowledge. He/she ambulated with a walker one hundred sixty-six (166) feet to a bus stop and got on a city transit bus at 9:24 AM. The resident exited the bus at 9:31 AM and walked eight (8) blocks to the last address where he/she lived. An acquaintance at this address called 911 (Emergency Services). The resident was taken to a local acute care hospital at approximately 12:27 PM. The National Weather Service temperature for the metropolitan city on this date was a high of 92 degrees Fahrenheit. The facility was notified, on 06/17/14 at 4:30 PM, by the local hospital emergency department they were returning the resident back to the facility. Interview and record review revealed the facility was unaware Resident #1 was not in the facility, on 06/17/14 from 9:04 AM until 4:30 PM (approximately 7.5 hours), when the facility was notified by the hospital. The resident was transferred back to the facility at 5:15 PM with no injury assessed.</p>	F 323			

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F 323	Continued From page 3 The facility's failure to provide adequate supervision placed Resident #1 in a situation that was likely to cause serious injury, harm, impairment or death. Immediate Jeopardy and Substandard Quality of Care was determined to exist, on 06/17/14 through 06/23/14, with the Immediate Jeopardy removed on 06/24/14. It was determined the facility completed corrective action prior to the State Survey Agency's (SSA) investigation on 06/25/14; therefore, the Immediate Jeopardy was determined to be Past Jeopardy. The findings include: Review of the facility's Elopement Policy, undated, revealed assessments were completed to identify residents at risk for elopement or unsafe wandering. The facility would enhance staff awareness of residents at risk and educate them in approaches and interventions for the identified residents. An elopement and wandering assessment would be completed on admission, readmission, quarterly and PRN (as needed). Review of the clinical record for Resident #1 revealed the facility admitted the resident on 05/22/14, to short term rehabilitation with diagnoses of Hypertension, Bipolar Disorder, Cerebrovascular Accident (CVA) and Senile Dementia. An initial comprehensive Minimum Data Set (MDS) was completed on 05/29/14. The facility assessed the resident using a Brief Mental Status (BIMS) assessment that revealed the resident was cognitively impaired with a score of three (3) out of fifteen (15). Record review revealed the resident was not assessed as an	F 323			

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F 323	<p>Continued From page 4 elopement risk.</p> <p>Review of the facility's investigation, dated 06/17/14, revealed Resident #1 successfully exited the building without primary staff knowledge on 06/17/14. The investigation provided to the SSA indicated at 9:15 AM an ancillary worker on the campus helped the resident out an exit door. The worker recognized the resident as a neighbor of his from the apartment complex where they both lived and assumed the resident was there to visit his/her sister. The worker did not know the resident actually lived at the facility and when the worker was going out the door, the resident went out the door with the him. The investigation further indicated the bus company confirmed the bus stop was scheduled for a pick-up every ten minutes and was on a short-loop that included the resident's old apartment building. Interview with the resident confirmed he/she went to the apartment building because someone owed him/her some money.</p> <p>Interview with the Associate Executive Director (AED), on 06/25/14 at 11:00 AM, revealed the facility received notification from a local hospital, on 06/17/14 at 4:30 PM, that Resident #1 was in the emergency room and being returned to the facility. He stated, the facility was not aware the resident had left the campus prior to the hospital notification. He also stated, upon notification he began an investigation and corrective actions immediately. The facility's cameras were reviewed and identified Resident #1 exited the facility at 9:04 AM with an ancillary worker. The ancillary worker had known the resident prior to the resident's admittance to the facility, and only knew the resident as a neighbor where the two</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>had lived previously, and did not realize the resident had moved to the facility to receive services. The AED, stated the distance from the exiting door to the bus stop was one hundred and sixty-six (166) feet, where the resident boarded a city bus. Resident #1 rode the bus for seven (7) minutes per the pictures provided by the bus company. He stated, Resident #1 was picked up by the ambulance service at his/her former residence (a living unit complex), on 06/17/14. Resident #1 was received by the Emergency Department at 12:27 PM. He/she arrived back to the facility from the local hospital at 5:15 PM.</p> <p>Review of the Emergency Department (ED) triage record, dated 06/17/14, revealed he/she arrived by ambulance to the ED and was registered, at 12:27 PM. The resident was discharged from the ED with a diagnosis of Changed Mental Status, on 05/17/14 at 17:13 hours (5:00 PM), and returned to the facility by ambulance.</p> <p>Review of the pictures provided by the local bus company, identified the bus as BUS 2002, on 06/17/14 at 9:24 AM, and revealed Resident #1 getting on the bus, while lifting his/her walker. The background at the bus stop appeared to be located next to the facility's fence. Review of a second picture provided by the local bus station, revealed Resident #1 exited BUS 2002, at 9:31 AM. Although the pictures provided a date and time, they did not have the location printed on the pictures.</p> <p>Interview with the Ancillary Worker, on 06/25/14 at 1:42 PM, revealed he was working on 06/17/14 when Resident #1 followed him out the door at approximately 9:10 AM. He stated he knew the resident as a neighbor where they both lived. He</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>stated he knew he/she had a family member that lived at the facility. He was aware the resident rode the city bus back and forth to visit with the family member. He had seen him/her sitting across from the nurses station with his/her walker. He/she always used a walker and got around slow. They greeted each other and Resident #1 stated he/she was visiting his/her family member at the center. Resident #1 went out the door as he went out. He then saw Resident #1 at the bus stop shelter and later he/she was gone from the bus stop. He did not know the resident was now living at the facility.</p> <p>Interview with the Executive Director, on 06/26/14 at 2:35 PM, revealed the location of where Resident #1 exited the bus, on 06/17/14 at 9:34 AM (per pictures captured by bus camera), was more or less eight (8) busy city blocks away in distance from his/her former residence where he/she was picked up by an ambulance and arrived at the hospital at 12:27 PM. The resident's travels were unaccounted for during the time period from 9:34 AM upon exiting the bus until the ambulance transported him/her to the Emergency Department at 12:27 PM.</p> <p>Review of the National Weather Service temperatures for the metropolitan city on this date revealed a high of 92 degrees Fahrenheit (F) and a low of 72 degrees (F).</p> <p>Interview with Social Worker #1, on 06/27/14 at 10:40 AM, revealed on the morning of 06/17/14 at approximately 8:30 AM, when she and another staff member (Social Worker #2) entered the elevator on the lower level, Resident #1 was standing in the elevator. She stated Social Worker #2 for the Rehabilitation Unit assisted</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>Resident #1 back to the second floor and toward his/her room.</p> <p>Interview with Social Worker #2, on 06/27/14 at 1:05 PM, revealed she saw Resident #1 on the elevator at the lower level on the morning of 06/17/14. She and the other Social Worker rode the elevator to the second floor with the resident. She stated he/she got off the elevator and started going the opposite direction of his/her room and she redirected him/her in the right direction. The resident stated he/she wanted out of there.</p> <p>Interview, on 06/27/14 at 1:30 PM, with Registered Nurse (RN) #2 revealed she was in her office the morning of 06/17/14 and saw the Social Workers exit the elevator with Resident #1. She heard someone tell the resident to go to his/her room and the resident replied he/she "wanted out of here". RN #2 further stated she thought the resident may be exit seeking; however, did not intervene through assessment. Further interview, on 06/30/14 at 4:20 PM, revealed at the 11:30 AM RUG (Medicare) meeting on 06/17/14 they were discussing moving the resident to the first floor, and at that time she told the group she did not think it was a good idea because of his/her earlier comment of wanting "out of here".</p> <p>Further interview with Social Worker #2, on 06/27/14 at 1:05 PM, revealed at 11:30 AM in the Medicare meeting, the morning of 06/17/14, there was a discussion of Resident #1's behaviors and his/her mention of asking to go home every time Social Worker #2 was around. She further stated the Interim Director of Nursing (I-DON) talked to the nurses in the meeting about possible elopement behaviors.</p>	F 323			

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F 323	Continued From page 8 Interview with the Interim Director of Nursing (I-DON), on 06/27/14 at 10:20 AM, revealed the RUG (Medicare) Meeting was held on 06/17/14 at 11:30 AM and it was suggested that Resident #1 be moved from the second floor to the first floor since he/she had been discharged from therapy services. Upon hearing Resident #1 was to be moved, RN #2 then told the group that she thought Resident #1 could be an elopement risk if he/she was moved from the second to first floor; however, an assessment was not completed to determine if the resident was indeed an elopement risk as addressed in the policy. Per interview and record review, Resident #1 had already left the facility at the time of the 11:30 AM Medicare meeting. The resident had expressed his/her desire to leave to staff at approximately 8:30 AM that morning; however, the facility failed to implement increased supervision and/or re-assess the resident for elopement risk. Interview with the Associate Executive Director, on 06/26/14 at 3:30 PM, revealed the facility did not have a policy specifically for resident supervision; however, it was the practice of the facility for staff to see each resident every two (2) hours. However, staff interviews revealed they did not visualize Resident #1 every two hours. Interview with Certified Nursing Assistant (CNA) #3, on 06/30/14 at 10:15 AM, revealed he was assigned to be the CNA caregiver for Resident #1 on 06/17/14. Resident #1 was up and dressed before breakfast and ate 100% of his/her breakfast meal in his/her room. After breakfast, CNA #3 did not see Resident #1 on the unit. When the lunch trays were delivered he put Resident #1's tray on the bedside table. The	F 323			

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F 323	Continued From page 9 resident was not in the room and CNA #3 stated he failed to locate or look for Resident #1 to ensure he/she ate his/her lunch. However, review of the resident meal intake for lunch on 06/17/14, revealed CNA #3 documented Resident #1 consumed 100% of the lunch meal. Per interview and record review Resident #1 was not in the facility during the noon meal. Interview with Licensed Practical Nurse (LPN) #3, on 06/27/14 at 2:55 PM, revealed she would do a walk through making rounds at the beginning of her shift (first shift). She stated she had not been told by CNA #3, who had been assigned to Resident #1, that the resident had not been seen, and that his/her whereabouts were unknown. Further interview revealed the Interim Director of Nursing (I-DON) stated to her that Resident #1 could be an elopement risk, but the I-DON did not ask her to reassess Resident #1 for a wander guard. She stated she asked the I-DON if she wanted a wander guard placed on Resident #1 and was told it was not necessary. Interview with LPN #4, on 06/28/14 at 10:00 AM, revealed she was present when the I-DON conversed with LPN #3. She stated the I-DON told LPN #3 that it was not necessary to place a WanderGuard on Resident #1 and then she left the unit. Interview with CNA #7, on 06/27/14 at 3:50 PM, revealed he arrived at work around 2:30 PM and made rounds at the beginning of the shift. He stated rounds took him about two (2) hours because as he rounded, he toileted the residents and provide other care as needed. He further stated residents on the Rehabilitation Unit were mobile and were often off the unit for activities	F 323		

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F 323	<p>Continued From page 10</p> <p>and meals. However, Resident #1 was normally always on the unit. He stated he asked CNA #2 if she had seen Resident #1 and she responded "no". Upon further interview, he stated he did not report to the nurse when he did not see Resident #1 on the unit because the residents were free to go about the units.</p> <p>Interview, on 06/27/14 at 4:05 PM, with CNA #2 revealed she did not see Resident #1, on 06/17/14, on the second shift. She further stated if she could not find a resident on her assignment she would tell the nurse and look for the resident on the first floor and lower level. However, CNA #2 did not report to the nurse that she could not find Resident #1.</p> <p>Interview with the Director of Clinical Support, on 06/29/14 at 2:20 PM, revealed the facility missed an opportunity to locate Resident #1 during lunch. However, CNA #3 did not report to the nurse Resident #1 was not present for lunch.</p> <p>On 06/17/14 the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. The I-DON completed a head-to-toe assessment of Resident #1 upon return to the facility, on 06/17/14 and determined the resident sustained no injuries. 2. Resident #1 was placed on physical (visual) checks, by a licensed nurse, every fifteen (15) minutes, on 06/17/14 at 5:30 PM through 06/19/14 at 10:30 AM. On 06/19/14 at 10:30 AM through 06/23/14 at 6:30 PM, Resident #1 was increased to visual checks every thirty (30) minutes. Resident #1's visual checks were increased to every one (1) hour on 06/23/14 at 	F 323			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/01/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203		
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F 323	<p>Continued From page 11</p> <p>7:00 PM through 06/27/14 at 10:00 AM. On 06/27/14 at 10:00 AM, the resident's visual checks increased to every two (2) hours.</p> <p>3. The facility completed an elopement risk re-assessment for Resident #1, on 06/17/14 after his/her return and identified him/her as an elopement risk. The facility immediately placed a WanderGuard device on the resident. Resident #1 was added to the at-risk for elopement system which included the picture placement in the Code Green Binder and the elopement pictures by the exit doors.</p> <p>4. The facility notified the resident's physician and responsible party on 06/17/14 of the elopement. The facility received new physician orders to place a WanderGuard on the resident, check placement and function on Sunday, and every fifteen (15) minute checks. The responsible party was notified of this on 06/17/14.</p> <p>5. The facility updated the elopement care plan for Resident #1, on 06/17/14 that included interventions of wander system bracelet applied; ensure wander system bracelet placement every shift; observe for elopement behavior; photo taken and added to elopement file; check every one hour; activities for diversion; offer snack and drink as needed; and a psych evaluation as ordered.</p> <p>6. The facility developed an action plan, dated 06/17/14, to do an accounting of each resident to make sure all residents were accounted for and present in the building, The Unit Managers initiated and completed the accounting on 06/17/14 under the direction of the Associate Executive Director.</p>	F 323			

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F 323	Continued From page 12 7. The Interim DON, three (3) RNs and two (2) LPNs initiated one hundred and fourteen (114) elopement assessments, after all of the residents in the facility were accounted for, on 06/17/14. Two residents were identified as needing changes to their elopement status. Resident #1 was identified as at risk for elopement and added to the at-risk elopement system. A second resident was identified as no longer at risk for elopement and was removed from the at risk for elopement system and their care plans updated, accordingly. 8. The I-DON and RN Unit Manager completed Quality Assurance (QA) Audits of the one hundred fourteen (114) at risk elopement assessments completed on 06/17/14 and finalized on 06/18/14 to ensure all were completed. Refer to #7. 9. The Elopement, Missing Resident, Abuse Prevention, Smoking and Fall Prevention policies and procedures were reviewed by the Associate Executive Director, Clinical Support Specialist and I-DON, on 06/17/14. The Elopement policy section titled Wander Monitoring System was revised to indicate employees only will be given the access code to exit/entry doors. Volunteers will not be considered an employee at any time. Staff are not to give the code to anyone. Staff found giving the code to families/vendors will be subject to disciplinary action. Maintenance will change the door codes monthly. 10. The Staff Development Coordinators (SDC) initiated on 06/17/14, an all staff education on policies and procedures for Elopement, Missing Resident Response, Abuse Prevention, Smoking	F 323			

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F 323	<p>Continued From page 13</p> <p>and Fall prevention. Scheduled staff education was completed on 06/19/14. The remaining staff on leave of absence or vacation will be educated prior to returning to their shift. One hundred thirty-nine (139) of one hundred sixty (160) staff were educated on 06/17/14 and 06/19/14. There are twenty-one (21) staff on vacation, sick or on leave of absence.</p> <p>11. On 06/18/14 the Unit Managers checked the individual WanderGuard devices for placement and function, for the thirteen (13) residents identified at risk for elopement.</p> <p>12. On 06/18/14 the Receptionist posted pictures of the thirteen (13) residents with elopement risk at her desk and by the exit door.</p> <p>13. The Maintenance Director completed a checklist of the door alarms and locks on 06/18/14 through 06/24/14. The door access codes would be changed on a monthly basis or as necessary by the Maintenance Director. WanderGuard door checks would be daily for a week and then twice a week compared to the old standard of twice a month. The door key pads would be checked twice a week and the codes changed monthly. All exits were to have a picture frame without names posted of the residents with WanderGuards.</p> <p>14. The I-DON and the Clinical Support Specialist trained the grounds keeper, on 06/18/14, regarding door precautions, to look at the WanderGuard pictures posted at the exit doors and if he had a volunteer worker with him to be sure they knew not to allow any person to exit the building with them. The facility reinforced with the grounds keeper, as well as the other</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>volunteers, he could not provide the door codes to the volunteers. The ancillary worker involved in the exiting of Resident #1 was re-educated on 06/18/14 and again on 06/23/14 on Elopement, Missing Resident, Abuse Policies & Procedures, Door Alarm and Smoking Policies by the I-DON and the Clinical Support Specialist.</p> <p>15. The Director of Maintenance trained his staff with the nursing staff on elopement and WanderGuards on 06/17/14 through 06/19/14.</p> <p>16. The Department Directors (with the exception of those on leave of absence (LOA) or on vacation were educated on the regulatory standards associated with F323 related to Accident and Incident Prevention by the Clinical Support Specialist on 06/19/14. The staff identified on vacation or on LOA would be educated before returning to their duties.</p> <p>17. On 06/20/14, the AED, Clinical Support Services, Staff Development Coordinator (SDC) and (I-DON) reviewed and revised the Certified Nursing Assistant (CNA) orientation checklist to include the clinical standard of physically visualizing their assigned residents every two hours. They also educated staff that only staff members may know the door access code for the entrance doors to the facility. Education was initiated by the Registered Nurse (RN), and SDC, on 06/20/14 for all nursing staff (with the exception of those on leave of absence (LOA). All staff would be educated prior to working their next assigned shift.</p> <p>18. Ten percent (10%) of residents' elopement assessments would be audited weekly by a nurse manager. This 10% was to be initiated on</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>06/23/14 and would include new admissions and readmissions during that week. If a resident was found to be at risk for elopement, the corresponding care plan would be reviewed and revised as needed.</p> <p>19. The code green binder and pictures would be audited weekly for accuracy by the Social Services Director. This was to be initiated on 06/23/14.</p> <p>20. A Quality Assurance (QA) meeting was held with the Medical Director, on 06/18/14, to review the preliminary findings and actions taken to date. In addition, a QA meeting was held 06/24/14 to update the committee on actions taken and audits were reviewed.</p> <p>The State Survey Agency validated the facility's corrective action through record review, observation, and interview, on 07/01/14, prior to exit as follows:</p> <ol style="list-style-type: none"> 1. Review of the clinical record for Resident #1 revealed he/she was readmitted to the facility, on 06/17/14 at 5:15 PM. Resident #1 returned to the facility via ambulance transfer from the local emergency department. The record further revealed the I-DON completed a head-to-toe assessment upon the resident's return to the facility, on 06/17/14, and determined the resident sustained no injuries. 2. Review of the visual checks dated 06/17/14 through 06/27/14 revealed the documentation of observations were complete. 3. Review of the elopement risk re-assessment for Resident #1, dated 06/17/14, completed after 	F 323		

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F 323	<p>Continued From page 16</p> <p>the resident's return, identified him/her as an elopement risk. The clinical record revealed the facility immediately placed a WanderGuard device on the resident and Resident #1 was added to the at-risk for elopement system which included the picture placement in the Code Green Binder and the elopement pictures by the exit doors.</p> <p>4. Continued review of the clinical record revealed the facility notified the resident's physician and responsible party on 06/17/14 of the elopement. The nursing staff obtained new orders from the physician regarding placement of a WanderGuard, checking placement and function and every fifteen (15) minute checks. The facility notified the responsible party of the new orders.</p> <p>5. Review of the elopement care plan for Resident #1, revealed it had been updated on 06/17/14 with new interventions of wander system bracelet applied; ensure wander system bracelet placement every shift; observe for elopement behavior; photo taken and added to elopement file; check every one hour; activities for diversion; offer snack and drink as needed; and a psych evaluation as ordered.</p> <p>6. Review of the facility's action plan, dated 06/17/14, revealed an accounting of each resident was initiated and completed on 06/17/14 under the direction of the Associate Executive Director. The census was one hundred and fourteen (114). Upon notification from the local hospital the facility identified 113 of 114 residents were accounted for by the facility. In addition, Resident #1 was identified as missing and remained at the hospital. All residents were accounted for at that time.</p>	F 323			

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F 323	Continued From page 17 7. Review of the one hundred and fourteen (114) elopement assessments revealed they were completed on 06/18/14. Two residents were identified as needing changes to their elopement status. A second resident was identified as no longer at risk for elopement and was removed from the at risk for elopement system. Their care plans were reviewed and updated, accordingly. Record review revealed the elopement assessments were completed by the unit managers, MDS Coordinators, Clinical Support Specialist and the Interim Director of Nursing on 06/18/14. Interview with the Interim Director of Nursing (I-DON), on 06/25/14 at 11:25 AM, revealed staff was called in, on 06/17/14, initiating the one hundred and fourteen (114) elopement risk assessments with completion on 06/18/14. The care plans were updated. One resident was removed from the at risk for elopement system related to the progression of his/her disease and no longer at risk for elopement. 8. Record review of the QA Audit revealed one hundred fourteen (114) at risk elopement assessments were initiated on 06/17/14 and finalized on 06/18/14 by the I-DON and a second RN. 9. The updated Elopement, Missing Resident, Abuse Prevention, Smoking and Fall Prevention policies and procedures were compared to the original policies to confirm changes were made by the Associate Executive Director, Clinical Support Specialist and I-DON, on 06/17/14. 10. Review of the Department Directors'	F 323			

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F 323	<p>Continued From page 18</p> <p>in-service rosters, dated 06/19/14 at 8:45 AM, revealed they were educated on F323 Accidents and Supervision. Fifteen (15) of nineteen (19) Department Directors attended. The remaining four (4) were on vacation and re-educated prior to return of their duties. The F323 presentation was provided by the Clinical Support Specialist.</p> <p>11. Review of the residents identified as at risk for elopement had their WanderGuards checked for placement and function by the Unit Managers, on 06/18/14. All WanderGuards were appropriately placed and functioned properly.</p> <p>12. Interview with the Receptionist, on 06/26/14 at 4:08 PM, revealed she had posted the residents with elopement risk at her desk and by the exit door. She stated she also had the Code Green Binder at her desk. The Receptionist further stated she was to monitor at the reception desk seven (7) different locations and had a sign in/out log at the facility's main door desk. The monitors at the reception desk provided a view of the three (3) entry/exit doors, the patio on hallway B, the ambulance hallway, the delivery and staff entry hallway, and the drive way and parking lot. In addition there were two picture frames without identifying names of the residents posted on the backboard of her desk.</p> <p>Observations of exits at the facility, on 06/26/14 at 4:08 PM, revealed there were three (3) exit doors on the first floor. Each of the doors had a group picture posted in a green frame of the current residents with WanderGuards. Each of the doors had camera surveillance with monitors at the receptionist desk and at the first floor nursing station. The cameras monitor: the entry/exit doors, patio on the "B" hallway,</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>ambulance hallway, delivery and staff hallway, entry driveway, and the parking lots.</p> <p>13. Review of the door alarm and door lock checklists, dated 06/03/14 through 06/24/14, revealed they were completed and no concerns were identified by the Maintenance Director. Door codes were changed on 06/17/14, 06/18/14 and 06/19/14. Review of the facility's action plan revealed the Maintenance Director would continue to check the entrance doors and alarms for proper function weekly for four weeks. After the four week period, the doors and alarms would be checked twice monthly.</p> <p>Interview, on 06/30/14 at 11:43 AM, with the Director of Maintenance revealed he checked the facility key pads for function twice a week now versus twice a month. The door key pad codes were changed once a month.</p> <p>Interview with the I-DON, on 06/27/14 at 10:20 AM, revealed the nursing staff check weekly for function of the WanderGuards and daily from shift to shift the placement of the WanderGuards. She also stated, maintenance staff check the exit door alarms twice a week. This was a change from twice a month.</p> <p>14. Interview, on 06/30/14 at 11:40 AM, with the grounds keeper revealed he had been trained in door precautions, to look at the WanderGuard pictures posted at the exit doors and if he had a volunteer worker with him to be sure they knew not to allow any person to exit the building with them. He stated he could not provide the door codes to the volunteers. Additional interview, on 06/25/14 at 1:42 PM, with the ancillary worker involved in the exit of Resident #1 revealed he</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>was re-educated on 06/18/14 and again on 06/23/14 on Elopement, Missing Resident, Abuse Policies & Procedures, Door Alarm and Smoking Policies by the I-DON and the Clinical Support Specialist. He further stated he had been trained that if the alarm (WanderGuard) went off, then he must let the nurse know.</p> <p>15. Interview, on 06/30/14 at 11:43 AM, with the Director of Maintenance revealed his staff had been trained the same as nursing on elopement and WanderGuards.</p> <p>16. Review of the education material revealed all staff re-education was initiated on 06/17/14 and completed on 06/19/14, by the Staff Development Coordinators (SDC) on policies and procedures for Elopement, Missing Resident Response, Abuse Prevention, Smoking and Fall Prevention. The remaining staff on LOA or vacation are to be re-educated prior to returning to their shift. Review of the staff rosters revealed one hundred thirty nine (139) of one hundred sixty (160) staff were educated on 06/17/14 and 06/19/14. The remaining twenty-one (21) staff identified were on vacation, sick or leave of absence. The facility stated the staff would be trained prior to working their next assigned shift.</p> <p>17. Review of the revised CNA Orientation Skills checklist compared to the previous CNA Orientation checklist revealed an added component included physically laying eyes on your team of residents approximately every two (2) hours. Review of the education rosters revealed they educated on 06/20/14 that the staff was the only ones that may have the access code for the entrance doors to the facility. The education was initiated by the Registered Nurse</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>(RN), and SDC, on 06/20/14 for all nursing staff with the exception of those on leave of absence (LOA). All staff will be educated prior to working their next assigned shift.</p> <p>Review of the Standards of Care (resident two hour checks) and door codes inservice roster, dated 06/20/14, revealed sixty-nine (69) of seventy-nine (79) nursing staff were educated. Ten (10) of the seventy-nine (79) nursing staff were on LOA, vacation or family medical leave and will be educated prior to returning to their duties.</p> <p>Review of the every two (2) hour visual checks for Resident #1, dated 06/23/14, revealed they were completed by two staff members.</p> <p>Interview with RN #1, on 06/26/14 at 3:25 PM, revealed staff was supposed to check on residents every two (2) hours. If a resident went off site for an appointment or visit there was a log book that the resident was signed out of the facility and then signed back in when they returned. At this time the nurse visualizes the resident. Staff was aware when a resident returned because there were two (2) doors that staff must buzz to allow entry into the facility. The third door has a greeter and also a sign out/in book.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/26/14 at 3:48 PM, revealed, she was to check the presence of her assigned residents every two hours. She added if a resident was off campus they were signed out in a log book which she was also to check if she could not visualize the resident.</p>	F 323			

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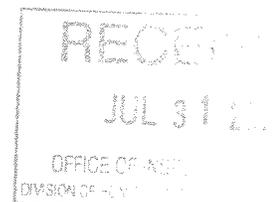
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F 323	<p>Continued From page 22</p> <p>Interview with CNA # 2, on 06/27/14 at 4:05 PM, revealed she was to check her residents every two hours and had received re-training on elopement.</p> <p>Interviews with CNA's #5, #8, #9, #10, and #11 on 06/30/14 from 4:45 PM until 5:15 PM revealed all had been trained in elopement and every two (2) hour rounding on residents. In addition, CNA's #5, #8, and #9 stated that if a resident wanted to go on the elevator a staff member must be with them.</p> <p>18. Review of the Elopement Assessment Audit revealed for the week of 06/23/14, it was completed by the I-DON on twelve (12) residents.</p> <p>19. Review of the Code Green Elopement System audit, completed on 06/23/14, revealed it was completed and signed off by the Senior Executive Director (SED).</p> <p>20. Interview with the AED, on 06/25/14 at 11:20 AM, revealed the policies on Missing Residents, Elopement, Abuse, Door Alarms, Falls and Smoking were reviewed on the night of 06/17/14 in detail with Clinical Support Services, Staff Development Coordinator (SDC) and the I-DON. The orientation skills checklist was revised to add a component that included the visualization of the assigned residents approximately every two (2) hours. This was also reviewed and approved by the Quality Assurance (QA) Committee during the meeting on 06/18/14. The policies were discussed in QA, the actions plans were already in place and the chart audits, the elopement risk assessments, the care plan reviews, the findings of the audits were all reviewed at QA. They also, held a second QA meeting on 06/24/14 to review</p>	F 323			

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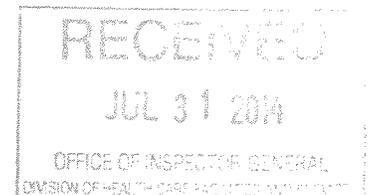
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/01/2014
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F 323	Continued From page 23 additional audits. All of the above audits would be reviewed by the Associate Executive Director (AED) and be presented to the Senior Executive Director (SED) on a monthly basis. The SED will present the audit results to the QA committee for review and recommendations for a period of twelve (12) months. Review of the QA meeting attendance roster, dated 06/18/14 revealed the Medical Director attended, the I-DON and eight (8) additional staff members attended. The topics included the review of the incident and investigation status, review of the immediate actions to ensure resident safety, review of identification of other residents with elopement potential, review of measures to prevent re-occurrence, review of education on policies of abuse/neglect, elopement, smoking, falls and door codes, and review of the Code Green Book audit. Review of the QA meeting attendance roster, dated 06/24/14 revealed the I-DON and ten (10) additional staff members attended. The topics included the review Code Green Book audits, WanderGuard Bracelet audits, and door alarm checks. Interview with the facility's Medical Director, on 06/30/14 at 11:15 AM, revealed he was notified on 06/17/14 of Resident #1's elopement from the facility. He stated they had a Quality Assurance meeting on 06/18/14. He stated policies were reviewed along with staffing. He stated a weak link was identified as the staff was not supervising the residents.	F 323	1) The record for Resident #1 was corrected to reflect that he did not have a lunch meal on June 17, 2014. Resident #1's electronic medical record was corrected by Kristen Walden, RN, Clinical Support Specialist. 2) To determine if any other residents were affected by this practice, the interim DON completed an assessment of weights obtained in July to assess if there were any unexpected resident weight changes that occurred and, if any unexpected weight changes were identified, assess if the resident's weight change occurred due to inaccurate meal documentation. The Registered Dietitian (RD) reviewed the residents identified by the interim DON and determined that no residents had unexpected weight change. Thus, no other residents were affected by this practice. 3) All nursing staff was educated on June 27, 2014 on the standard related to the completion of	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		



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F 514 LE	<p>Continued From page 24</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to ensure the clinical record was accurately documented for one (1) of five (5) sampled residents (Resident #1). The lunch meal was documented for one hundred per cent (100%) intake; however, Resident #1 was not in the facility and did not eat the lunch meal.</p> <p>The findings include:</p> <p>Review of the facility's Documentation-General Policy, written July 2011, revealed all entries made in the medical record would be in accordance with state law, facility policy and in accordance with the Board of Nursing.</p> <p>Review of the computer generated Nutritional Intake form located in the clinical record for</p>	F 514	<p>accurate clinical documentation and the importance of why clinical documentation must be complete and accurate. This education was provided by the interim DON or licensed nurse. In addition, the Administrator, interim DON, Staff Development Coordinator and other management positions (except those on vacation or LOA) were educated July 25, 2014 by Rev. Jackie Ward, M.Div (Master of Divinity), BCC (Board Certified Chaplain with Association of Professional Chaplains), Director of Pastoral Care and Chaplaincy for Christian Care Communities on ethics to include accurate documentation. This education included the definition of ethics, principles used for ethical decision-making and specific expectations for staff related to accurate and complete clinical documentation. The Administrator trained the remaining department directors</p>		



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F 514	<p>Continued From page 25</p> <p>Resident #1, dated 06/17/14 at 12:05 PM, revealed CNA #3 documented the resident's lunch intake as one hundred per cent (100%) consumed.</p> <p>Interview with the Associate Executive Director, on 06/25/14 at 11:30 AM, revealed Certified Nursing Assistant (CNA) #3 documented Resident #1 had eaten 100% of his/her lunch. He stated, during interviews with CNA #3, the CNA claimed to have seen Resident #1 during lunch. However, upon review of the camera footage, Resident #1 was off campus during lunch, which was unknown information to the CNA.</p> <p>Interview with CNA #3, on 06/30/14 at 10:15 AM, revealed he was assigned to care for Resident #1 on 06/17/14. CNA #3 stated he delivered Resident #1's breakfast tray and the resident ate 100%. CNA #3 further stated he delivered Resident #1 his/her lunch tray; however, was not sure who collected the lunch tray after the meal. When he went to document Resident #1's breakfast intake in the computer, he accidentally documented the resident's breakfast intake as the resident's lunch intake. Per interview, when he realized what he had done, he also documented 100% intake for breakfast. He stated he could not delete the intake for lunch; however, failed to tell the nurse about the error. Review of the Nutritional Intake form printed from the electronic record revealed the breakfast and lunch meal intakes for Resident #1 were both documented by CNA #3 for 100% at 12:05 PM.</p> <p>Interview, on 06/30/14 at 12:30 PM, with the Interim Director of Nursing (I-DON) revealed she could look at nurses notes and CNA documentation in the record. However, she did</p>	F 514	<p>or managers through July 30, 2014. All of the facility's staff (except those on vacation, PRN or leave of absence for whom must be trained before working) was educated from July 25, 2014 through July 30, 2014 by the Administrator, Staff Development Coordinator or management staff member on ethics related to the importance of caring for the residents and documenting accurately and completely in the resident's clinical record. Moreover, the facility developed a quality assurance indicator to audit 15 meal trays weekly to assure the resident's approximate meal intake is accurately documented in the resident's clinical record. This audit will be completed by a licensed nurse and submitted to the DON weekly. Lastly, a quality assurance indicator was initiated to validate the completion and accuracy of care being provided to the residents by auditing the documentation of</p>	

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F 514	Continued From page 26 not routinely look at CNA documentation. Currently, Quality Assurance (QA) only monitored the care plan and care plan documentation, not CNA documentation. Interview with the facility's Executive Director (ED), on 06/30/14 at 3:20 PM, revealed the resident's clinical record was to be documented accurately and concisely.	F 514	15 residents weekly on ADL performance and showers. This audit will also be completed by a licensed nurse and submitted to the DON weekly. 4) The DON will review the audit reports and submit the report findings for review by the Quality Assurance Committee on a monthly basis for 12 months. The Medical Director reviewed the education and quality assurance indicators and recommended approval of these items to the Quality Assurance Committee on July 30, 2014. The Administrator will be responsible for assuring the quality assurance committee completes the required monitoring of follow-up audits and actions implemented to ensure compliance on a monthly basis. The Medical Director attends and participates in the quality assurance meeting on a monthly basis. Compliance Date: July 31, 2014		

