

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS An abbreviated survey investigating KY20333 was initiated on 06/17/13 and concluded on 06/18/13. The Division of Health Care substantiated the allegation with Immediate Jeopardy determined to exist on 06/12/13. Immediate Jeopardy was identified at 42 CFR 483.25 Quality of Care (F323 at S/S of "J") resulting in Substandard Quality of Care in F323. The facility completed corrective actions prior to the initiation of the State Survey Agency's investigation on 06/17/13; therefore, the Jeopardy was determined to be Past Jeopardy. Resident #1 was admitted to the facility on 03/05/13 and assessed as an elopement risk due to the resident's history of wandering tendencies and current behaviors of pacing and wandering. The facility initiated the Comprehensive Care Plan to address the resident's risk for elopement with the goal the resident would not elope from the facility. On 06/12/13, between 3:45 PM and 4:00 PM, Resident #1 exited the facility without staff knowledge. The resident was present for an every fifteen (15) minute check at 3:45 PM and prior to the 4:00 PM check the resident was escorted in the front door by a female, who lived in the apartments next to the facility. The facility's failure to provide adequate supervision of a cognitively impaired individual with known elopement risks placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment or death.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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

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

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 1</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have an effective system to ensure adequate supervision of cognitively impaired residents with known wandering behaviors for one (1) of four (4) sampled residents (Resident #1). The facility admitted Resident #1 on 03/05/13 and assessed him/her as having wandering tendencies due to the resident's history of wandering. The facility initiated an Interim Care Plan and then the Comprehensive Care Plan to address the resident's risk for elopement with the goal the resident would not elope from the facility and the resident would be observed for exit seeking behaviors.</p> <p>On 06/12/13, between 3:45 PM and 4:00 PM, Resident #1 exited the facility without staff knowledge. The resident was present at a fifteen (15) minute check for 3:45 PM and was returned to the building prior to the 4:00 PM check. The resident was placed on 1:1 supervision until bedtime and then placed on every fifteen (15) minute checks until 06/18/13.</p>	F 323	Past noncompliance: no plan of correction required.		

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 2</p> <p>The facility's failure to provide adequate supervision of cognitively impaired individuals with known elopement risk placed residents at risk for elopement 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 06/12/13 with corrective actions completed on 06/17/13, prior to the State Survey Agency's investigation; therefore, the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Elopement Risk Assessment, dated January 2007, revealed a resident's potential for elopement would be determined by risk factors at the time of admission, quarterly and more often if deemed necessary. Risk factors would be documented in the medical record. Interventions would be developed and entered on the plan of care.</p> <p>Record review revealed the facility admitted Resident #1 on 03/05/13, with diagnoses of Encephalopathy and Dementia. On 03/05/13, the facility assessed Resident #1 as an elopement risk based on the resident's history of dementia and wandering. A care plan was developed on 03/21/13 addressing the elopement risk with interventions directing staff to observe for exit seeking behaviors, use diversion when exit seeking, and placement of a wander guard. The goal stated would not leave the facility unattended.</p> <p>Review of Resident #1 Nurse's Notes revealed</p>	F 323			

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 3</p> <p>the resident exhibited exit seeking behavior on 04/11/13 and 05/03/13. The Nurse's Notes dated 05/11/13, 05/18/13 and 06/04/13 documented Resident #1 was wandering on the unit but no mention of exit seeking behavior.</p> <p>Review of Resident #1's Social Service Note dated 04/02/13 revealed, the resident was pleasant and cooperative, cognitively impaired related to dementia and was oriented to self only. Further review revealed the facility assessed the resident with a Brief Interview Mental Status score of four (4), with a score of fifteen (15) indicating cognition intact.</p> <p>Record of the clinical record revealed Resident #1 successfully exited the building without staff knowledge on 06/12/13.</p> <p>Interview, on 06/18/13 at 10:50 AM, with the Nurse Manager revealed every fifteen minute checks on all residents had been initiated on all residents with wander guards. She stated Resident #1 was present for a visual check at 3:45 PM on 06/12/13. The Nurse Manager stated she did not witness the resident leave or attempt to leave the building. She stated she was paged at 4:00 PM and was informed Resident #1 was returned to the building through the front door. She went to the front hallway, assessed the resident and escorted Resident #1 back to the unit. The Nurse Manager stated once the resident was back on the unit, she did a complete head to toe assessment and found no injuries. A full head count was completed immediately on all the units. The physician and family were then notified of the elopement. She stated she never saw Resident #1 try to get out of the door prior to</p>	F 323			

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 4</p> <p>the day of elopement. He/she would sometimes walk up to the door and push on the key pad but never attempted to push open the door. He/she did wander on the unit, but was always easily redirected. She stated she did not know how the resident got out of the facility.</p> <p>Interview, on 06/18/13 at 3:53 PM, with Certified Nursing Assistant (CNA) #1 revealed Resident #1 had exhibited exit seeking behavior in the past. She was unaware of the elopement until another staff member informed her and by then, the resident was already back on the unit. She stated after Resident #1 was returned to the facility, a head count was done on her unit. The staff also received education on elopement that same day.</p> <p>Interview, on 06/18/13 at 4:10 PM, with Registered Nurse (RN) #1 revealed she saw Resident #1 sitting near the nurse's station at 3:45 PM and the next thing she knew someone was returning the resident to the unit. She stated they immediately conducted a head count and the Assistant Director of Nursing came and did another head count. Within the hour staff was re-educated on elopement. Resident #1 was placed on one to one (1:1) supervision. Someone (she was not sure who) came in and checked the door alarms.</p> <p>Interview with the Executive Director, on 06/17/13 at 4:25 PM, revealed she was near the front entrance on 06/12/13, a little before 4:00 PM, when she heard the door alarm sound. She went to the front door and a female was escorting Resident #1 into the building. She checked the resident and made sure he/she was safe and then called the unit and all the supervisors. She</p>	F 323			

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 5</p> <p>stated she checked her cell phone and those calls were initiated at 4:00 PM, so she knows the resident was back in the building prior to 4:00 PM. A head count was initiated immediately and all residents were located. Staff working on the day of the elopement was immediately re-educated on elopement. All staff, except those on vacation, were re-educated on elopement, a competency exam was taken and elopement drills were conducted. There was a plan in place to educate the staff on vacation or leave, to be educated prior to their return to work. Staff not present, was notified by phone that the education was necessary. She stated, as a new administrator, on 06/10/13, she had initiated every fifteen (15) minute visual checks for all residents with wander guards. Because of the fifteen (15) minute checks, it was known the resident was in the building at 3:45 PM.</p> <p>The State Survey Agency validated the corrective actions on 06/18/13 prior to exit as follows:</p> <ol style="list-style-type: none"> 1. Record review revealed, after the resident was returned, the facility assessed Resident #1 on 06/12/13 and he/she was found to be without injury and was placed on one to one (1:1) supervision for the remainder of the day and then placed on every fifteen (15) minute visual checks which remained in effect until 06/18/13. 2. Review of the maintenance log revealed the door alarms were checked weekly prior to the elopement. The door alarms were checked on the day of the elopement (06/12/13), after the resident was returned, and daily since the elopement. 3. Review of an invoice from from the facility's 	F 323			

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 6</p> <p>contracted door, locks and alarm service provider, revealed all doors alarms and closures were checked by the company on 06/14/13 with no problems found.</p> <p>4. Interview and review of sign in sheets and agendas, revealed staff was trained on the facility's policy for Elopement. Training consisted of elopement education, elopement competency exam and elopement skills checklist. Interview with the Interim Director of Nursing, on 06/17/13 at 4:25 PM, revealed re-training on elopements began immediately after the elopement occurred. The staff competency was validated by a post-test and skills checklist. Review of the staff attendance roster for the staff training revealed all regular facility staff had been trained prior to returning to work. Employees on leave or vacation were notified the training must occur prior to returning to work. Interview with CNA #1, on 06/18/13 at 3:53 PM, revealed she had been re-trained on elopements after Resident #1 was returned to the facility. Interview with RN #1, on 06/18/13 at 4:10 PM, revealed within an hour of Resident #1 returning to the facility she was re-educated on elopements.</p> <p>5. Review of the attendance roster validated staff attended a Quality Assurance Ad Hoc meeting on 06/13/13. Interview with the Executive Director, on 06/17/13 at 4:25 PM, revealed the purpose of the Ad Hoc meeting was to review the elopement of 06/12/13, review assigned tasks and to ensure the facility's response and interventions were complete.</p> <p>6. Observation of staff on 200 Unit, on 06/17/13 and 06/18/13, revealed staff redirecting residents</p>	F 323			

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/18/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 7 if they approached exit doors or exhibited restless wandering. 7. Record reviews on 06/17 - 18/13, of residents identified at risk for elopement, determined those residents were reassessed and care plans were reviewed for appropriateness. 8. Placement of signs posted at exit door were confirmed on 06/18/13.	F 323			