

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

PRINTED: 05/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185194	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/05/2015
NAME OF PROVIDER OR SUPPLIER THE FORUM AT BROOKSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243	
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F 000	INITIAL COMMENTS	F 000	Responses to the cited deficiencies do Not Constitute an admission or agreement by the Facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and state law.	
F 323 SS=D	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, it was determined the facility failed to ensure the residents' received supervision and functional assistive devices to prevent an elopement. The facility failed to ensure an operable Wanderguard alarm system was in place for two (2) of five (5) sampled residents, Resident #1 and Resident #2. The findings include: Review of the facility's policy regarding Resident Safety Program: Wandering and Elopement, dated 10/31/07, revealed the purpose of the program was to provide a proactive program of interventions to minimize the risk of a resident elopement. Review of the facility's policy regarding	F 323	F 323 The Forum at Brookside ensures That each resident receives adequate supervision and assistive devices to prevent accidents. Corrective Action for Residents Cited by the Deficient Practice: The Wanderguard alert bracelet device for Resident #1 and Resident #2 was verified to be in place and functioning, by licensed nurses on 04/26/15. On 04/27/15 Resident #1 and Resident #2 were re-assessed, using the facility Wandering/Elopement Review Tool, and both residents assessed for Risk for Wandering/Elopement. Resident's #1 and #2 care plans were reviewed and updated to reflect appropriate interventions. Identification of Other Facility Residents that may Be affected by the Deficient Practice: All residents identified at risk for	05/12/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

X [Signature]

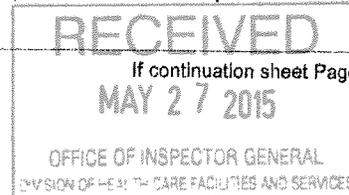
TITLE

X NHA

(X6) DATE

X 5/27/15

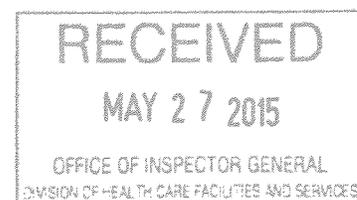
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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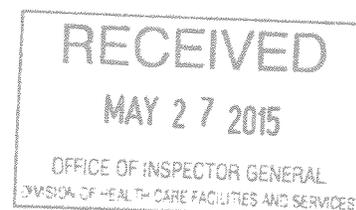
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F 323	<p>Continued From page 1</p> <p>Wandering and Elopement: Resident Security Systems and Devices, dated 10/31/07, revealed a security system (Wanderguard) was in place to enhance the safety of residents. The Wanderguard system was comprised of signaling devices (to be worn by residents assessed as at risk of elopement) and the door alarming system at the end of hall. The alarming system alerted staff when a resident left a secured area or the building by the sounding of an alarm activated by the signaling device worn by the resident. Further review of the policy revealed the signaling device on the doors was to be tested three (3) times per week, rotating shifts and times and the Executive Director was to be notified immediately if the door system was not working properly.</p> <p>Observation of the A Hall doors, on 04/27/15 at 5:00 PM, revealed those doors led to a lobby/sitting area with a keypad coded exit door (no Wanderguard security keypad) and to an accessible hallway for the Personal Care Unit. Further observation at that time revealed the A Hall doors were equipped with a keypad as part of the Wanderguard security system.</p> <p>Interview with a Housekeeper, on 04/29/15 at 12:30 PM, revealed she was aware there were some concerns with the Wanderguard alarm system on the A Hall doors working properly and she had seen some staff unplug the system from an electrical wall outlet in the hall on multiple occasions. She stated the staff unplugged the system to stop it from alarming and to reset the system; however, she had never seen it left unplugged.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/29/15 at 3:49 PM, revealed she had</p>	F 323	<p>elopement, based on the facility's Wandering/Elopement Risk Review Tool, were verified to be in place and functioning by licensed nurses on 4/26/15. All current residents were re-assessed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), and MDS Coordinators for potential elopement risk using the facility's Wandering/Elopement Risk Review Tool on 04/27/15. These Wanderguard bracelets will continue to be checked for placement and function by licensed nurses three (3) times each day ongoing, using the electronic transmitter testing device.</p> <p>These checks will continue to be documented by the licensed nurse on the MAR. All residents identified with increased risk of wandering/elopement have been placed on increased supervision with every 15 minute checks beginning 4/27/15 by facility staff, pending completion of in-service re-education. Care Plans were reviewed at this time and updated to reflect this new intervention. All new residents will be assessed at the time of admission with the facility's Wandering/Elopement Risk Review Tool. Any resident assessed</p>	



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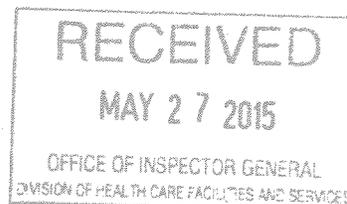
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F 323	<p>Continued From page 2</p> <p>worked on the evening shift of 04/26/15 and saw the electrical plug to the Wanderguard alarm system of the A Hall doors unplugged around 7:00 PM. She stated she immediately plugged the system back into an electrical outlet and checked to ensure it was working. She further stated she did not know how long it had been inactivated, but the residents with Wanderguard signaling bracelets would be at risk of elopement when the system was deactivated.</p> <p>Record review revealed the facility had assessed two (2) residents at risk for elopement and the residents had Wanderguards applied.</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 04/17/15 with diagnoses to include Aftercare Hip Fracture, Dementia and Toxic Encephalopathy (disease of the brain). The facility assessed Resident #1 as an elopement risk on 04/21/15 and placed a Wanderguard signaling device on his/her wrist on that date. Review of the plan of care for Resident #1, dated 04/21/15, revealed the facility identified the potential for safety issues related to wandering/elopement as a problem for the resident. Review of a Brief Interview for Mental Status (BIMS) document, dated 04/23/15, revealed Resident #1 had a score of thirteen (13) indicating the resident was cognitively intact.</p> <p>Interview with the Rehabilitation Director, on 05/05/15 at 3:24 PM, revealed Resident #1 was able to ambulate with contact guard assist when using a walker and he/she could self-propel a wheelchair.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident on 07/01/13 with</p>	F 323	<p>at risk for wandering/elopement will have appropriate interventions initiated and a Wanderguard bracelet placed, as needed. Individual interventions will be documented in the resident's care plan.</p> <p>Implementation of Systemic Measures: In-service training for Healthcare nursing staff on duty at the time of the elopement was immediately completed by the licensed nurse on ensuring that the Wanderguard alarm A/C Adapter remains plugged in and functioning, door alarm response. On the morning of 4/27/15 the Wanderguard alarm A/C Adapter (electrical plug) was moved above the ceiling by the facility's Maintenance Department, making it inaccessible for Anyone to unplug it or to accidentally Knock it out of the receptacle. The Wanderguard alarms on these doors were verified by Maintenance Department to be functioning appropriately at this time. A preventative maintenance check was performed by the facility's Maintenance Department on 4/28/15 To include proper functioning of the Wanderguard System, the Simplex Door security system and the secondary audible alarming mechanisms. The</p>		



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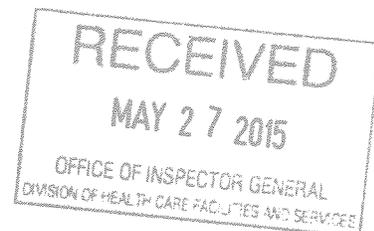
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F 323	<p>Continued From page 3</p> <p>diagnoses to include Aftercare Hip Fracture, Altered Mental Status and Chronic Obstructive Pulmonary Disease. The facility assessed Resident #2 as an elopement risk on 11/12/14 and placed a Wanderguard signaling device on his/her wrist at that time. Review of nursing notes dated 02/09/15 revealed Resident #2 could self-propel his/her wheelchair and moved about the facility freely. Review of the Minimum Data Set (MDS) assessment tool revealed Resident #2 was assessed as severely cognitively impaired with a score of three (3). Review of Resident #2's care plan revealed the facility indicated he/she had a problem of being at risk for leaving the facility unattended related to his/her cognitive impairment.</p> <p>Interview with a Maintenance Supervisor, on 04/28/15 at 2:00 PM, revealed he was informed on 04/27/15 of the Wanderguard alarm system at the doors to A Hall having been inactivated for an indeterminate length of time on 04/26/15 (the system was unplugged from an electrical source). He stated he was instructed by the Administrator to move the electrical outlet for the Wanderguard alarm system from an accessible electrical outlet in the hall wall up into the ceiling. He stated that was accomplished by 04/27/15 around 12:00 Noon and the Wanderguard security system was working at that time.</p> <p>Interview with the Director of Plant Operations, on 04/28/15 at 3:00 PM, revealed he had been informed on 04/20/15 of some problems with the A Hall alarm system by one of the nursing staff (could not recall name). He stated he was told the system would 'chirp' off and on and sometimes could not be reset at the keypad. The Director of Plant Operations also stated he</p>	F 323	<p>facility's contracted door alarm system (Simplex) was contacted on 4/28/15 to perform a backup check of the exit door monitoring system. This was completed by Simplex on 4/29/15. Beginning 4/27/15 Elopement Drills were conducted on each shift by the ADON and DON. Additional Elopement Drills were Conducted on the weekend shifts, 05/02/15 and 05/03/15. These Elopement Drills will continue to be conducted monthly for the next 3 months, then at least quarterly thereafter to reinforce staff's knowledge of the proper procedures to follow in the event an actual elopement occurs. An action plan will be developed by the DON for staff re-education and correction of an identified issue encountered during the drills. Re-education of all staff began on April 26, 2015 and was completed by May 12, 2015. Re-education included the facility's Wandering/Elopement policy – responding to alarms, redirecting residents with care planned interventions including initiating increased supervision up to and including every 15 min checks or 1:1 supervision at nurse's discretion; responding to an actual elopement and what to do if resident is found outside including staying with the resident,</p>		



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F 323	<p>Continued From page 4</p> <p>ordered a new keypad for the Wanderguard on 04/20/15 and installed it at the A Hall doors on the afternoon of 04/27/15. He indicated the system was working then and was continuing to work. However, he did indicate there were some "problems" with the A Hall door alarm system in February 2015 and March 2015, but he thought they were fixed and the preventive maintenance tests had all been okay since that time. The Director of Plant Operations stated the residents with a Wanderguard signaling device would be at risk of elopement if the door alarm system was inactivated. He further stated he checked the operation of the alarming systems weekly and he reported verbally to the Executive Director any problems with the system.</p> <p>Interview with the Administrator, on 05/05/15 at 4:21 PM, revealed she was aware some of the staff were unplugging the Wanderguard alarm system at the doors of A Hall on 04/20/15. She stated she understood the staff unplugged the system on occasion to reset the alarm, but thought they always plugged it back in. She further stated she was made aware the Director of Plant Operations had ordered a new keypad for the system on 04/20/15 and she thought the installation of the new keypad would correct any problems with the system. The Administrator stated she had not been made aware of problems with the Wanderguard alarming system on the A Hall doors prior to 04/20/15. The Administrator stated the residents with Wanderguard signaling devices could elope from the facility and/or be seriously harmed if the system was not activated.</p> <p>Interview with the Executive Director, on 05/05/15 at 4:51 PM, revealed the Director of Plant Management reported verbally to him any</p>	F 323	<p>calling for assistance, assisting back into the facility, and immediate notification of the DON and/or Administrator; Steps to take in the event a door alarm is not working appropriately that include posting a staff member at the door immediately, notification of the DON and Administrator, submission of a work order, and conducting a head count if an alarm sounds with no indication of triggering factor. All new staff members, upon hire and at least annually, will receive educational training on the facility's Wandering/Elopement policy.</p> <p>Monitoring of Corrective Action: The DON/ADON will complete a weekly ongoing Quality Assurance Performance Improvement (QAPI) audit to ensure that the Wanderguard alert bracelet checks are completed for all residents identified at risk for wandering/elopement and documented appropriately. Any discrepancies identified will be addressed by the DON as indicated. A copy of these audits and any discrepancies will be reported to the Administrator for additional follow up, as needed. Results of the weekly QAPI audit will be reviewed with the QAPI committee</p>		



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F 323	Continued From page 5 maintenance concerns at the facility, but he could not remember any specific concerns with the operation of the Wanderguard system. He further stated residents would be at risk of elopement and/or serious harm if the Wanderguard system was not operational.	F 323	on a quarterly basis. Maintenance staff will continue to perform the weekly verification of the functioning of the exit door alarm system and Wanderguard system as part of the facility's preventative maintenance plan. This will be documented by the maintenance employee performing the verification in the TELS (Facilities Maintenance Work Order System) System. The facility will review/assess all residents at risk for wandering/elopement, weekly, to ensure proper interventions are in place to reduce the risk of elopement.	05/12/2015	

