

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

2nd SOD

PRINTED: 03/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/06/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 106 HARMON HEIGHTS STANFORD, KY 40484
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(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
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F 000 INITIAL COMMENTS

—Amended—

An abbreviated standard survey (KY22684, KY22737) was initiated on 01/27/15 and concluded on 02/06/15. KY22684 was unsubstantiated with unrelated deficient practice identified at 42 CFR 483.13 Resident Behavior and facility Practices (F225) at a scope and severity of "E." KY22737 was substantiated and Immediate Jeopardy was identified on 01/28/15 at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) at a scope and severity of "J" with Substandard Quality of Care at 42 CFR 483.25 Quality of Care (F323). Immediate Jeopardy was determined to exist on 01/21/15. The facility was notified of the Immediate Jeopardy on 01/28/15.

On 01/21/15, Resident #1 exited from the facility without staff knowledge and was discovered by facility staff when a staff member exited the building to go on a routine break. Although the facility had identified Resident #1 to be at risk for elopement and implemented visual checks every 15 minutes and redirection as needed to ensure the resident's safety, the facility failed to provide the visual checks and redirection as required.

Additionally, the facility failed to ensure the exit doors were maintained in working order to minimize the risk of residents exiting the facility without staff knowledge. Although nine nursing staff members were working on 01/21/15 at the time Resident #1 exited the facility, only Registered Nurse (RN) #3 heard the emergency exit door alarm on the Unit 100 Hallway. RN #3 described the alarm as "faint" and at first

F 000

Preparation, submission and implementation of this plan of correction does not constitute an admission of agreement with thin facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a mean to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.

F225 E

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice:

3-13-15

Resident A- 9/10/14 Misplaced eyeglasses and remote control. Items were replaced by the facility.

Resident B- 10/6/14- Resident's "twenty one dollars" was located on unit and returned. Resident declines to secure money in Lock Box or place in Pt. Trust when offered.

11/7/14 Same resident with "fifteen dollars" misplaced from her blue change purse. Facility unable to locate and replaced "fifteen dollars" and Lock Box provided.

Resident C- 10/23/14- Resident with misplaced coat, gloves, and hat. Resident indicated she had a UK Hospital. Unable to locate and facility replaced.

Resident D- 11/1/14- Resident with misplaced pink sweatshirt was replaced.

12/3/14 Resident #3- with missing blanket- Discussion held with family and declined to have resident's blanket replaced.

OIG made aware of all above upon internal investigation beginning 1/27/15 and ended on 2/6/15. Adult Protective Services was notified of all above on 3/12/15.

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

Kevin McCann

TITLE

Administrator

(DATE)

3/12/2015

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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F 000	Continued From page 1 perceived the alarm to be an intravenous pump (IV) alarm sounding. Observations of the exit door alarm sounding on 01/27/15 revealed the alarm was not audible at the Unit 100 Nurses' Station or at the Unit 300 Nurses' Station. A partial extended survey was conducted on 02/05-08/15. An acceptable Allegation of Compliance was received on 02/04/15 which alleged removal of the Immediate Jeopardy on 02/04/15. The State Survey Agency determined the Immediate Jeopardy was removed on 02/04/15 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Interviews were conducted for all current interviewable residents beginning 2/18/15 and completed on 2/25/15 by the Department Managers. These interviews consist of questions around Abuse/Neglect, Missing Items, etc. No concerns were identified during these interviews. Interviews were conducted for all current non-interviewable residents beginning on 3/2/15 and completed on 3/4/15 by contacting the resident's families. These interviews consist of questions around Abuse/Neglect, Missing Items, etc. No concerns were identified during these interviews.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Re-In-services initiated on 2/18/15 and completed on 2/26/15 as relates to Abuse/Neglect, Misappropriation of resident property, etc., to Golden Living staff to include Administrator to include Aegia Therapy Staff, and HCS Staff. Re-In-services initiated on 2/24/15 and completed on 2/26/15 on the Grievance Process to Golden Living Nurses, and Department Managers to include Administrator. This in-service relates to Grievance Guideline to include completion of the Grievance Form. The staff member will complete Grievance Forms once made aware of any allegation. The ED/DNS/Designer will be notified of the Grievance for follow up at the time of any allegation. The ED will ensure all allegations are then reported to the state agencies as required according to the regulations.	3/3/15

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F 225	<p>Continued From page 2</p> <p>Immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policy it was determined the facility failed to ensure alleged violations of misappropriation of resident property were reported immediately to state agencies in accordance with state law for one (1) of six (6) sampled residents (Resident #3) and four (4) unsampled residents (Residents A, B, C, and D).</p> <p>Review of the facility's grievance log revealed incidents of possible allegations of misappropriation of residents' property were not reported to the State Survey and Certification agency as required. Although the grievance log identified that several articles of clothing and personal belongings were reported missing such as a coat, gloves, and eyeglasses, the</p>	F 225	<p>The ED/DNS/ADNS/Social Services/Designee will monitor Grievances to include follow up to include a complete facility investigation and ensure plans are developed to correct. The ED will review and discuss all Grievances during the daily morning meeting to ensure follow up has been completed.</p> <p>All Investigations such as, Abuse/Neglect, Misappropriation of resident property will be conducted by the ED/DNS/ADNS/Designee. The ED will be responsible to ensure all allegations as above are reported to the State Agencies as required by the Regulations within 24 hours of the time in which facility made aware of the allegation/s. The DNS/ADNS/Designee will ensure all allegations as above are reported to the State Agencies in the absence of the ED. All Investigations as above will be reported by the ED/DNS/Designee to the State Agency within the allotted time frame noted as per regulations initially and upon completion of the facility's investigation.</p> <p>4) Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and</p> <p>All Grievances/Investigations will be reviewed to ensure all allegations have been reported to state agencies as needed to include follow up with resolution to during the monthly Quality Assurance Process Improvement Meeting.</p> <p>Date of Compliance 3/13/15</p>	3-13-15

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F 225	<p>Continued From page 3</p> <p>Administrator stated the missing items were not reported as possible misappropriation of resident property because they were "not of significant monetary value."</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Reporting and Investigation of Alleged Violations of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property," last revised 10/24/13, revealed all alleged violations which involved mistreatment, neglect, abuse, injuries of unknown origin, and misappropriation of resident property would be reported to state agencies in accordance with existing state laws.</p> <p>1. Review of a grievance form for Resident A, dated 09/10/14, revealed the resident's eyeglasses and remote control were missing. Further review revealed the resident's property was never located. However, facility staff replaced the items.</p> <p>2. Review of a grievance form for Resident B, dated 10/06/14, revealed the resident had "misplaced" twenty-one dollars. Further review revealed the resident's missing money was later located and returned to the resident. Another grievance form for Resident B dated 11/07/14 revealed he/she was missing fifteen dollars. Continued review revealed the resident's missing money was never located, but was replaced by the facility.</p> <p>3. Review of a grievance form for Resident C, dated 10/23/14, revealed the resident reported to staff that he/she was unable to locate a winter</p>	F 225		

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F 225	Continued From page 4 coat, gloves, and a hat. Further review revealed the resident's property was never located, but was replaced by the facility. 4. Review of a grievance form for Resident D, dated 11/01/14, revealed the resident reported to staff that he/she was unable to locate a pink sweatshirt. Continued review revealed the resident's property was never located, but was replaced by the facility. 5. Review of a grievance form for Resident #3, dated 12/03/14, revealed the resident's personal blanket was missing. The form revealed the resident's property was never located and had not been replaced by the facility. An interview with the facility's Administrator on 01/27/15 at 6:50 PM revealed he reviewed and was responsible for reporting all allegations of misappropriation of resident property to state agencies. Continued interview revealed he had not reported the allegations of misappropriation of property for Resident #3 and Residents A, B, C, and D because the items had been replaced or were not of significant monetary value.	F 225	<u>Preparation, submission and implementation of this plan of correction does not constitute an admission of agreement with thin facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a mean to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review.	F 282	F323 D/F282D 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 was returned safely to the Living Center by 200 Wing staff- Charge Nurse and CNA. 3) 1/21/15- an assessment was completed to rule out injury, including vital signs by the 200 Wing Charge Nurse. 4) 1/21/15- Facility head count was completed for all residents on all 3 units by Charge Nurses.		

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F 282	<p>Continued From page 5</p> <p>review of the facility's investigation, and review of the facility's policies, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care for one (1) of six (6) sampled residents (Resident #1). Review of Resident #1's Comprehensive Care Plan effective 01/21/15, revealed the facility had assessed Resident #1 as being at risk for wandering and elopement and had initiated interventions including 15-minute visual checks and providing redirection as needed. However, on 01/21/15, staff failed to perform the visual checks as required and although at least three (3) staff members were aware Resident #1 was wandering around the facility and off his/her unit, staff failed to provide the resident with the required redirection. (Refer to F323.)</p> <p>On 01/21/15, Resident #1 exited the facility without staff knowledge. Resident #1 was discovered by a staff member, who was exiting the facility to go on break, at approximately 3:24 AM. Resident #1 was outside the facility in a wheelchair unattended in the parking lot adjacent to the facility's breezeway. Review of archived weather records revealed on 01/21/15, at 3:15 AM, the temperature in the vicinity of the facility was 41 degrees Fahrenheit with a wind chill index of 35 degrees Fahrenheit. The resident was wearing a polyester dress with tall socks and loafer-style shoes and a jersey cardigan with a sweatshirt-type lining. Staff assisted Resident #1 back into the facility and determined the resident had not sustained any injury.</p> <p>The facility's failure to have an effective system in place to ensure interventions on the care plan were provided as required to prevent elopement</p>	F 282	<p>5) 1/21/15- Immediate Investigation was initiated by ED/DNS.</p> <p>6) 1/21/15- Accutech Bracelet for Resident #1 was checked by 200 Wing Charge Nurse and was working properly.</p> <p>7) 1/21/15- Resident #1 Care Plan was reviewed by IDT and updated to reflect current event.</p> <p>8) 1/21/15- Maintenance Director checked all door alarms, accutech system: all doors and equipment were working correctly</p> <p>9) 1/21/15- Family & MD were notified, attending Physician's PA visited resident #1 on 1/21/15 with new orders noted (EKG, chest Xray, and Labs which were all WNL). Med review conducted and new med order noted. Resident #1 was currently on 15 minute checks at the time of event. Resident #1 visual checks were changed to every 10 minutes to include, update to the care plan/care sheets. CNA was assigned to complete 10 minute checks. If CNA was unable to complete the 10 minute checks, charge nurse was responsible. The 10 minutes checks ended on 2/2/15 when resident #1 was transferred to Ephraim McDowell Regional Medical Center-Behavioral Management Unit. 200 wing Nurses and CNA's were educated on the changes to the care plan/care sheets on 1/30/15 by IDT and Director of Nursing.</p> <p>2/2/15-Resident #1 was transported, per order from Dr. James, to Ephraim McDowell Regional Medical Center-Behavioral Management Unit due to increased behaviors with agitation.</p>		

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F 282	<p>Continued From page 8</p> <p>placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was determined to exist on 01/21/15 at 42 CFR 483.20 Resident Assessment (F282) and 483.25 Quality of Care (F323) with Substandard Quality of Care at 42 CFR 483.25 Quality of Care (F323). The facility was notified of the Immediate Jeopardy on 01/28/15.</p> <p>An acceptable Allegation of Compliance was received on 02/04/15 which alleged removal of the Immediate Jeopardy on 02/04/15. A partial extended survey was conducted on 02/05-08/15. The State Survey Agency determined the Immediate Jeopardy was removed on 02/04/15 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing Services on 02/05/15 at 12:16 PM revealed the facility did not have a policy and procedure related to the development of Comprehensive Care Plans; the facility utilized the Resident Assessment Instrument for guidance in completing resident care plans.</p> <p>Review of the facility's policy, "Elopement Guideline," revised 2013, revealed residents assessed to be at risk for elopement would be reassessed quarterly and as needed. The policy also stated the facility would implement a care plan that addressed the resident's potential to</p>	F 282	<p>Behaviors included: refusing care and medication and physical behaviors towards staff. When resident #1 is discharged from Ephraim McDowell Regional Medical Center-Behavioral Management Unit and returns to facility, a thorough assessment, including elopement risk, will be completed by Unit Manager and reviewed by DNS/ADNS.</p> <p>2/10/15- Resident returned to the facility. Resident was reassessed and noted to continue to be Risk for Elopement. The following measures were put into place:</p> <p>1) Multiple med changes upon return 2) Continued with Visual Checks, and Self release seat belt alarm. Continue with diversional activities as prior to Hospitalization.</p> <p>2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p><u>Immediate Actions:</u></p> <p>1.)1/21/15 All residents currently residing in the facility were reassessed for elopement risk with completion of the Elopement Section on the 24 Hour Clinical Assessment by the IDT/Social Services.</p> <p>2) 1/21/15- The facility Elopement binders were reviewed and updated if indicated by Social Service Staff. One additional resident was identified and added to the Elopement listing according to Elopement Guidelines. Elopement Binders are current and up to date and this was validated by the DNS/ADNS on 1/21/15.</p>		

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F 282	<p>Continued From page 7</p> <p>wander or exit the facility, and the measures which would be taken to prevent wandering/elopement.</p> <p>Review of the facility's investigation initiated on 01/21/15 revealed at approximately 3:15 AM, staff observed an emergency exit door to be alarming and ajar. Approximately nine minutes later, a staff member exited the facility for a routine break and discovered Resident #1 outside the facility unattended in the parking lot adjacent to the facility's breezeway. The facility's investigation determined the resident had exited the building from an emergency exit door located at the end of the Unit 100 second hallway, and traveled in the wheelchair approximately 155 feet to the area where the resident was found.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 11/30/12. The facility assessed the resident to be an elopement risk on 12/07/12, and placed the resident on visual checks every 30 minutes to ensure the resident's safety and whereabouts.</p> <p>Review of Resident #1's Comprehensive Care Plan dated 01/15/15, revealed the facility had identified that Resident #1 was exhibiting increased restlessness, wandering about the facility, going to exit doors and pushing on the handle, trying to open the doors, and making statements about leaving. As a result of the behavioral changes exhibited by Resident #1, the Care Plan directed staff to increase Resident #1's visual checks to every 15 minutes. The Care Plan also stated staff should provide redirection to Resident #1 as needed. Review of Resident #1's Minimum Data Set (MDS) assessment completed on 01/21/15 revealed the facility</p>	F 282	<p>3) 1/21/15- IDT/ADNS audited all residents noted at Risk for Elopement and had the following reviews completed: Care Plans, Care Sheets, CNA Documentation of Accutech Bracelets to ensure proper functioning, battery checks. All individual accutech devices/bracelets/tags were checked by the ADNS for functioning/placement/batteries 1/21/15. 1/22/15- Charge Nurses will document the accutech bracelets are in place and functioning. Nurses will document on the electronic MAR Q-shift. In addition, Charge Nurses on each unit will document weekly accutech battery checks to be placed on the electronic MAR.</p> <p>1/28/15- Care sheet/Care plan training initiated; and completed on 1/29/15. CNAs will review care sheet every shift to identify any resident for elopement. The CNA care sheets and nursing care plans training was conducted by the IDT/ADNS/DCE/Department Managers. This training was to ensure that CNA/Nurses are aware of resident care needs. CNA's were trained on Care Sheets and Post Test completed. Nurse's post test was over care sheets and care plans.</p> <p>4) 1/21/15- Immediate Education was initiated by the ED/DNS/ADNS/IDT/DCE on Elopement Guidelines. All Employees Includes: Dietary, Housekeeping (contract services), Therapy, Hospice. (See Attached Elopement Guidelines). Training completed 1/23/15. Employees will not work until receiving training.</p> <p>5) 1/21/15- The Activity Director conducted assessments on all current residents at Risk to Elopement for changes as indicated. Documentation completed to support this review.</p> <p>6) 1/21/2015- Contractor from Applied Audio Visual was in the facility to assess every door. Visual and operation checks were done on each door- *all doors were found to be working properly.</p>		

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F 282	<p>Continued From page 8</p> <p>assessed the resident to have moderate cognitive impairment with a Brief interview for Mental Status (BIMS) score of 8.</p> <p>Observation with Resident #1 on 01/27/15, at 3:05 PM revealed the resident was independently mobile in a wheelchair.</p> <p>Review of the facility's investigation and a written statement dated 01/21/15, signed by Certified Nursing Assistant (CNA) #1, revealed the CNA, who was assigned to care for Resident #1 on 01/21/15 during third shift, "followed" Resident #1 while the resident self-propelled in a wheelchair off Unit 200, where the resident resided. CNA #1 wrote in the statement, "I suspected (he/she) might try to leave the facility." However, CNA #1 failed to provide Resident #1 with redirection as required by the resident's plan of care, leaving the resident unattended on Unit 100. The statement stated that CNA #1 returned to Unit 200 and Informed Licensed Practical Nurse (LPN) #1 that Resident #1 was on Unit 100. The State Survey Agency was unable to contact CNA #1 for an interview.</p> <p>Interviews with LPN #1 on 01/27/15, at 2:20 PM and on 01/28/15, at 6:50 AM revealed she last observed Resident #1 on Unit 200 at approximately 3:00 AM; and at approximately 3:10 AM she recognized the resident was no longer on the unit or within sight. LPN #1 stated she instructed CNA #1 at that time to find Resident #1 and return the resident to the unit before the CNA left for her lunch break. LPN #1 stated CNA #1 never reported to her that she had observed Resident #1 on Unit 100, or that she suspected the resident would try to leave the facility.</p>	F 282	<p>7) 2/3/15 Charge Nurses will document visual checks every 30 minutes on residents that are at risk for elopement. If the charge nurse is unable to document the visual checks, the house supervisor will be responsible for visual checks and documentation. Unit Managers will audit charge nurse's logs every 3 hours per shift. 2/3/15 All charge nurses were in-serviced by the DNS/ADNS on importance of visual documentation: in service completed on 2/3/2015. Unit managers were in serviced by DNS/ADNS on reviewing charge nurse's logs every 3hrs. This in-service was completed 2/3/15. If unit managers see concerns with documentation corrective actions will take place immediately to include re education. This information will be monitored and audited by the DNS and/or House Supervisor. During the week, the information will be reviewed in clinical start up/morning managers meeting. On the weekends, the information will be reviewed by the house supervisor and reported to the DNS/ADNS, if any concerns are identified in the documentation. If any areas of concern are identified ED/DNS will take corrective actions which will include re education. The data will be brought to QA weekly to be analyzed, if trends are noted appropriate action will be taken, such as system revision and education or what is deemed necessary. Staff members that have not been in-serviced will not be allowed to return to work until in-service is completed.</p> <p>8) - Contractor from Applied Audin Visual was in the facility to assess every door. Visual and operation checks were done on each door- *all doors were found to be working properly.</p> <p>9) 1/27/15- Applied Audin Visual contractor returned to provide recommendations and bid to add additional accutech equipment. Bid was approved and equipment has been ordered to be installed on all doors that lead to the outside perimeters that give access to off the property grounds and have the delayed emergency egress function.</p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 108 HARMON HEIGHTS STANFORD, KY 40484		
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F 282	Continued From page 9 Interview with Registered Nurse (RN) #3 on 01/27/15, at 6:15 PM, revealed she was assigned to Unit 300 for third shift on 01/21/15. RN #3 stated she observed Resident #1 self-propelling in a wheelchair on Unit 100 attempting to enter a resident's room at approximately 3:00 AM on 01/21/15. RN #3 stated she redirected Resident #1 out of the room, and then alerted the Unit 100 Nurse that the resident was on the unit and "to keep an eye on (him/her)." However, according to RN #3 she provided no further redirection or supervision for Resident #3. An interview was conducted on 01/27/15, at 11:48 AM with LPN #2, who was the third shift nurse for Unit 100 on 01/21/15. LPN #2 stated that RN #3 had informed her that Resident #1 was on the unit and had been redirected out of another resident's room. However, LPN #2 stated she provided no further redirection or supervision for Resident #1 to ensure the resident's safety and she did not notify the Unit 200 staff that Resident #1 was on Unit 100. LPN #2 stated she was aware that Resident #1 was at risk for elopement, but it was not unusual to observe Resident #1 to be independently mobile in the wheelchair throughout the facility. Review of the "Visual Checks" documentation for Resident #1 dated 01/21/15, revealed the visual check required for Resident #1 at 3:15 AM had not been conducted. Interviews with LPN #1 on 01/27/15, at 2:20 PM and on 01/28/15, at 6:50 AM revealed she had conducted the visual checks for Resident #1 throughout the shift because the resident had been with her. LPN #1 stated when she realized Resident #1 was no longer visible at approximately 3:10 AM, she	F 282	The current alarm system includes Mag Locks and secondary alarms. This dual alarms system is found on the doors at the end of 200 Wing door, smoking door by conference room, first end hall on 100 Wing, 2nd end hall on 100Wing, end hall on 300 Wing, Dietary, Therapy door by the ramp in the back area of the building (new addition). Secondary alarms can be heard at all nursing stations and rooms on each unit. This was tested by posting staff members on each unit and by the nurses stations and sounding the alarms. These secondary alarms were originally installed as a back up because they produce a louder more distinctive sound that travels a greater distance. The replacement of the secondary alarms occurred on 1/29/15 due to an alarm test conducted by the ED and Maintenance Director on 1/28/15. The secondary alarms installed on 1/29/15 produce a louder more distinctive sound than the original secondary alarms. This was tested by posting staff members on each unit and by the nursing stations and rooms on each unit. Staff was educated and in serviced on how to react to sounding alarms and potential elopements on 1/29/15. (Elopement Guidelines). Staff must attend training before returning to work. Training/Education included Activation/Deactivation of Secondary Alarms on 1/30/15. Staff must be trained before returning to work. 1. All staff will respond immediately to any sounding alarms. 2. Door alarm should remain sounding and not turned off so additional staff can render help.		

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F 282	<p>Continued From page 10</p> <p>instructed CNA #1 to "find" the resident, but CNA #1 failed to locate the resident as LPN #1 had instructed her to do. LPN #1 stated she last visualized Resident #1 at approximately 3:00 AM, and did not observe the resident again until she was discovered outside the facility unattended at approximately 3:24 AM.</p> <p>Interview with the Executive Director and Director of Nursing Services on 01/28/15, at 10:55 AM, revealed the facility's investigation had identified that facility staff did not provide Resident #1 with the supervision and redirection required in accordance with the resident's plan of care on 01/21/15.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 02/04/15. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>1) Resident #1 was found outside of the facility at approximately 3:24 AM on 01/21/15. Resident #1 was assisted back into the facility safely. The Charge Nurse completed an assessment to rule out injury, including obtaining vital signs.</p> <p>2) A head count was completed on 01/21/15 for all residents on all three units by the Charge Nurses. All residents were accounted for at that time.</p> <p>3) The Executive Director and Director of Nursing Services immediately initiated an investigation of Resident #1's elopement.</p> <p>4) The Accutech Bracelet worn by Resident #1 was checked by the Charge Nurse and was found to be working properly when the resident was</p>	F 282	<p>WHAT TO DO WHEN ALARM SOUNDING:</p> <ul style="list-style-type: none"> • GO TO DOOR THAT IS ALARMING AND DO THE OUTSIDE PERIMETER CHECK - • IF NO RESIDENT IS NOTED TO BE OUTSIDE- GO BACK INSIDE THE DOOR- • DEACTIVATE THE ALARM- PAGE "GOLDEN ALERT" • THIS ALERTS THE UNITS TO CONDUCT A HEAD COUNT FOR ALL RESIDENTS. • IF ALL RESIDENTS ARE ACCOUNTED FOR THEN PAGE "ALL CLEAR" • IF A RESIDENT IS "MISSING" IMMEDIATELY PAGE "GOLDEN ALERT AND ANNOUNCE THE ROOM NUMBER." THIS ALERTS ALL STAFF THERE IS A "MISSING RESIDENT." • IF A RESIDENT IS "MISSING" THEN FOLLOW THE FACILITY ELOPEMENT GUIDELINE LOCATED IN THE ELOPEMENT BOOK. <p>1/23/15 Door alarm checks/drills conducted every hour for 24 hours by Maintenance Director. Logs were audited by the ED.</p> <p>1/24/15 Door Alarm Drills conducted every shift Monday thru Friday by Maintenance Director. Daily door checks will continue to be completed by Maintenance Director and/or ED. Logs will be audited by ED daily Monday - Friday and by the House Supervisor on Saturday and Sunday.</p>		

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F 282	Continued From page 11 returned inside the facility on 01/21/15. 5) On 01/21/15, the Interdisciplinary Team reviewed Resident #1's Care Plan which was updated to reflect the resident's elopement on 01/21/15. 6) The Maintenance Director checked all door alarms and the Accutech system on 01/21/15. All doors and equipment were found to be operating correctly. 7) Resident #1's family and physician were notified of Resident #1's elopement on 01/21/15. 8) The attending Physician Assistant visited Resident #1 on 01/21/15 and wrote orders for Resident #1 to have an echocardiogram performed, a chest x-ray, and laboratory tests completed. 9) A medication review was conducted for Resident #1 on 01/21/15 by the facility's consulting pharmacist and new medications were ordered by the physician. 10) Resident #1 was on visual checks every 15 minutes at the time the resident eloped from the facility. Resident #1's visual checks were increased to every 10 minutes on 01/30/15. 11) Resident #1's Comprehensive Care Plan and Certified Nursing Assistant Care Sheets were updated to reflect the 10-minute visual checks implemented on 01/30/15 for Resident #1. 12) Certified Nursing Assistants were assigned to complete the 10-minute visual checks for Resident #1. If a Certified Nursing Assistant was	F 282	Alarm door drills have been conducted starting 1/21/15 and are on-going Q shift by Maintenance Director. Alarm door drills will include how to react to a sounding door alarm. Door alarm drills consist of placing staff members on each unit and at each nurses station. The Maintenance Director activates an alarm at a specific door. Employees answering the alarm are timed by how long it takes them from the time the alarm sounds until they get to the door. Employees that do not answer the alarm are immediately re-educated on the correct procedure when a door alarm is activated. Alarm door drills were completed on 1/28/15. 1/29/15 Door Alarm Drills and Door Checks will be conducted on Saturdays and Sundays every shift by the Manager on Duty and/or the House Supervisor. 1/29/15 Door Check training was also provided to all staff by Maintenance Director which covered Activating/Deactivating secondary alarms, How to perform door checks on Maglocks/Accutech doors. ED will audit weekend checks every Monday. The Executive Director is responsible to ensure QAPI meetings are held. 1/30/15- 1st week QAPI meeting held post Elopement Event. Reviewed ADHOC Plans. Continue to follow plans. Dr. Miller present. Plans reviewed with no new recommendations.		

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F 282	<p>Continued From page 12</p> <p>unable to complete the 10-minute visual checks, the Charge Nurse would then complete the visual checks for Resident #1. Nurses and CNAs were educated on the changes to the care plan/care sheets on 01/30/15 by the Interdisciplinary Team and Director of Nursing Services.</p> <p>13) Resident #1 was transferred to a behavioral unit on 02/02/15.</p> <p>14) All residents residing in the facility on 01/21/15 were reassessed for elopement risk by the Interdisciplinary Team and Social Services.</p> <p>15) Facility Elopement Binders were reviewed and updated as indicated on 01/21/15 by Social Services staff. One additional resident was identified as an elopement risk and added to the Elopement Binders. The Director of Nursing Services and the Assistant Director of Nursing Services verified the Elopement Binders were current and up to date on 01/21/15.</p> <p>16) On 01/21/15, the Interdisciplinary Team and the Assistant Director of Nursing Services audited all residents at Risk for Elopement and completed the following resident reviews: Care Plans, Care Sheets, and Certified Nursing Assistant Documentation of Accutech Bracelets, and ensured all Accutech bracelets were functioning properly.</p> <p>17) The Interdisciplinary Team will continue to monitor and revise care sheets, care plans, and Accutech Bracelets daily during Clinical Start Up Meetings to ensure revisions are made as needed. The Director of Nursing Services and the Assistant Director of Nursing Services or House Supervisor will conduct the monitoring on</p>	F 282	<p>3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>1) Residents will continue to be assessed and ongoing at a minimum of New admission/readmissions, Quarterly, upon significant change, and annually for risk for elopement by completion on the twenty four hour clinical assessment by the Charge Nurses/designee. Residents identified Risk for Elopement will have measures put in place following the facility's Elopement Policy/Procedures. DNS/ADNS/Designee will monitor daily for completion.</p> <p>2) The facility Elopement Binders will continue to be updated ongoing monthly and as needed by Social Services Director/Designee. Upon identification of Resident/s to be at Risk for Elopement the Elopement Binders will be updated by Social Services Director/Designee. Residents Risk for Elopement will be reviewed weekly by the IDT in the Behavior Management meeting and documentation will be completed by the Social Services/Designee post this review related to status/changes of Risk for Elopement.</p>		

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F 282	Continued From page 13 weekends. 18) The Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, and Interdisciplinary Team initiated education related to elopement guidelines to all employees, including contracted services, on 01/21/15. The training was completed on 01/23/15. Employees who have not received the training will not be permitted to work until they have received the training. 19) The Activity Director conducted assessments on 01/21/15 for all residents at risk for elopement. 20) An "Applied Audio Visual" contractor was in the facility on 01/21/15 to assess all doors in the facility. A visual and operational check was conducted for each door; all doors were found to be working properly. 21) Beginning 01/22/15, Charge Nurses will document that Accutech bracelets are in place and functioning for each resident who utilizes the device. The documentation will be done on the electronic Medication Administration Record every shift. 22) Charge Nurses will check and document weekly on the electronic Medication Administration Record that the Accutech batteries are functioning properly utilizing activation/deactivation boxes. 23) The Director of Nursing Services and/or Assistant Director of Nursing Services will audit the Medication Administration Records daily, and the House Supervisor will conduct the audits on weekends to ensure the Charge Nurses are	F 282	3) The facility will continue to monitor and revise Care Sheets, Care Plans, accutech bracelets daily during daily Clinical Start Up by the IDT (DNS/ADNS/Designee/Social Services, Dietary Manager, RNAs) as needed. The DNS/ADNS/Designee or House Supervisor will monitor daily to include weekends to ensure Care Sheets, Care Plans are revised as needed. Nurses were trained/educated on how to put resident's Risk for Elopement once identified to be at Risk to include applying an Accutech Bracelet. The Accutech Bracelets will be monitored and electronic documentation will be on the Medication Administration Sheet by the Nurses on each shift. This documentation includes checking placement of accutech bracelets, and functioning which is indicated by the flashing light on the tags and weekly as a secondary check for placement and functioning. Documentation will be monitored by DNS/ADNS/Designee/House Supervisor daily. Activation/Deactivation boxes will be used to test resident's bracelets weekly. Flashing red light indicates proper functioning battery. MAR's will be audited daily by the DNS/ADNS/Designee/House Supervisor daily and on weekends. The Director of Clinical Educator (DCE) or Designee will continue to train/educate Nursing Staff on use of Care Sheets/Care Plans as needed. New hires will have training/education as indicated Nurse and/or CNA during orientation process as above. 4) Training/Education on Elopement Guidelines will be ongoing and conducted at a minimum of twice a year and/or as needed. New Hires will receive training/education on Elopement Guidelines during their orientation process. 5) The Activity Director will continue to conduct ongoing assessments/reassessments at a minimum of New Admissions/Re-admissions, Quarterly, Significant Change, and Annually for Residents to determine specific Diversional Activities as needed.		

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F 282	<p>Continued From page 14</p> <p>monitoring the functioning of the Accutech Bracelets daily and battery function weekly.</p> <p>24) The Interdisciplinary Team, Assistant Director of Nursing Services, and Department Managers initiated education related to Care Sheets and Care Plans on 01/28/15 and completed the trainings on 01/29/15. Certified Nursing Assistants will review care sheets every shift to identify any resident for elopement. The training was to ensure that Certified Nursing Assistants and Nurses were aware of residents' care needs. Post tests were completed.</p> <p>25) When Resident #1 is readmitted to the facility the Unit Manager will conduct a thorough assessment, including elopement risk, and the Director of Nursing Services and/or Assistant Director of Nursing Services will review the assessment.</p> <p>26) Beginning 02/03/15, Charge Nurses will document visual checks every 30 minutes on residents that are at risk for elopement. If the Charge Nurse is unable to document the visual checks, the House Supervisor will be responsible for the visual checks and documentation.</p> <p>27) Unit Managers will audit the Charge Nurse 30-minute Visual Check Logs every three hours per shift to ensure the visual checks are being conducted.</p> <p>28) On 02/03/15, all Charge Nurses were educated by the Director of Nursing Services and/or Assistant Director of Nursing Services on the importance of conducting and documenting the 30-minute visual checks.</p>	F 282	<p>6) Charge Nurses will continue to conduct visual checks according to the resident specific needs. If visual checks are to be conducted the Charge Nurse will continue to conduct as per Care Plan and document on the Visual Check form and sign upon completion as indicated. completion. Care Sheets will be updated by the Restorative/MDS Nurse daily as needed. The DNS/ADNS/Designee will monitor daily to ensure updates as needed have been completed.</p> <p>7) Door Alarm checks will be conducted twice daily by the Maintenance Director Monday thru Friday and by Manager on Duty on Saturday and Sunday. This Door Alarm System check will validate proper functioning of the doors listed. This audit will be conducted on a Door Check Log that list all doors to include the Secondary Alarms. These door alarm checks will be monitored daily by the ED/DNS/ADNS/Designee.</p> <p>These secondary alarms will be in place until the new Accutech equipment is installed. Elopement/Alarm Drills will be conducted monthly ongoing by the Maintenance Director/Designee.</p> <p>4) Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>A QAPI Committee meeting will be held weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly thereafter. The committee will review compliance with education related to door Alarms, Elopement P/P, Accutech bracelets, and care plan training. If the Medical Director is unavailable in person on a weekly basis, he will review progress by telephone with Executive Director and/or DNS</p> <p>Date of Compliance: 3/6/15</p>	
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3-6-15

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F 282	<p>Continued From page 15</p> <p>29) Education by the Director of Nursing Services and/or the Assistant Director of Nursing Services with the Unit Managers related to reviewing the Charge Nurse 30-minute Visual Check Log every three hours was completed on 02/03/15. If Unit Managers see concerns with documentation, corrective action will take place immediately, including re-education.</p> <p>30) Reviews conducted by the Unit Managers of the Charge Nurse 30-minute Visual Check Logs will be monitored and audited by the Director of Nursing Services and/or House Supervisor daily during the Clinical Start Up meeting. On weekends the House Supervisor will review the Logs.</p> <p>31) Identified concerns related to the Charge Nurse 30-minute Visual Check Logs will be reported to the Director of Nursing Services and/or the Assistant Director of Nursing Services. The Executive Director and/or the Director of Nursing Services will take corrective actions which will include re-education.</p> <p>32) On 01/27/15, an "Applied Audio Visual" contractor returned to the facility and provided recommendations and presented a monetary bid to add additional Accutech equipment. The monetary bid made by "Applied Audio Visual" was approved by the facility and equipment has been ordered which will be installed on all exit doors in the facility that currently utilize the delayed emergency egress function, lead to the outside perimeter, and give residents access to off-grounds property.</p> <p>33) The current alarm system includes magnetic Locks and secondary alarms. This dual alarm</p>	F 282			

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F 282	<p>Continued From page 16</p> <p>system is in place on the door at the end of the Unit 200 Wing, the smoking exit door, the first hall Unit 100 door, the second hall Unit 100 door, the door at the end of the hall on Unit 300, and the Therapy door in the new building addition.</p> <p>34) The secondary alarms were installed on 01/29/15 and produce a loud distinctive sound when an exit door is opened. The secondary alarms can be heard at all nursing stations and rooms on each unit. This was tested by posting staff members on each unit and by the Nurses' Stations and sounding the alarms. These alarms will be in place until the new Accutech equipment is installed. The new Accutech system will sound alarms at the Nurses' Stations as well as at the door.</p> <p>35) On 01/29/15, staff was educated on Elopement Guidelines and how to react to sounding alarms and potential elopements. Any staff not attending the training must receive education before returning to work.</p> <p>36) Education on responding to alarms, which included activation/deactivation of secondary alarms, was conducted on 01/30/15. All staff is required to receive the training and will not be permitted to work in the facility until they have been trained on the procedures as follow:</p> <p>A. All staff will respond immediately to any sounding alarms.</p> <p>B. The door alarm should remain sounding and not turned off so additional staff can render help.</p> <p>C. Go to the door that is alarming and conduct an outside perimeter check.</p> <p>D. If no resident is noted to be outside, go back inside the door.</p>	F 282	

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F 282	<p>Continued From page 17</p> <p>E. Deactivate the alarm and page "golden alert"; this alerts the units to conduct a head count for all residents.</p> <p>F. If all residents are accounted for then page "all clear."</p> <p>G. If a resident is "missing" immediately page "golden alert" and announce the room number. This alerts all staff there is a "missing resident."</p> <p>H. If a resident is "missing" then follow the facility's elopement guideline located in the elopement book.</p> <p>37) Door alarm drills were initiated on 01/21/15 and were conducted every shift by the Maintenance Director. The door alarm drills included how to react to a sounding door alarm. The drills consist of placing staff members on each unit and at each Nurses' Station. The Maintenance Director activates an alarm at a specific door. Employees answering the alarm are timed as to how long it takes them to respond to the alarming door. Employees that do not answer the alarm are immediately re-educated on the correct procedure when a door alarm is activated.</p> <p>38) On 01/23/15, door alarm checks and drills were conducted and documented hourly from 8:00 AM through 11:00 PM. The Logs were audited by the Executive Director to ensure they had been completed.</p> <p>39) Beginning 01/24/15 door alarm drills and door checks will be conducted every shift Monday through Friday by the Maintenance Director and/or Executive Director. The Manager on duty and/or House Supervisor will complete the door checks and alarm drills on the weekend.</p>	F 282		
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F 282	Continued From page 18 40) Logs to ensure the daily door drills and door alarm checks were conducted will be audited by the Executive Director daily Monday through Friday and by the House Supervisor on weekends. 41) The Maintenance Director provided training to all staff on 01/29/15 related to activating/deactivating secondary alarms and performing door checks on the magnetic locking doors and the Accutech doors. 42) All reviews and audits will be taken to the weekly Quality Assurance Committee meetings for four weeks, then monthly, to be analyzed for trends. If concerns are identified appropriate action will be taken including system revision and education as deemed necessary. ***The SSA validated the Immediate Jeopardy was removed as follows: 1) Review of Nursing documentation dated 01/21/15, revealed Resident #1 required no treatment after the elopement and was assessed to have sustained no injury when returned inside the facility. Vital signs were obtained and documented; they were within normal limits. 2) Review of the facility's documentation, dated 01/21/15 and interview with Licensed Practical Nurse (LPN) #1 on 01/27/15, at 2:20 PM, LPN #2 on 01/27/15 at 11:48 AM, and RN #3 on 01/27/15 at 6:15 PM, revealed head counts were conducted on all three units and each resident was accounted for at that time. 3) Review of the facility's investigation and interview with the Executive Director (ED) on	F 282			

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F 282	<p>Continued From page 19</p> <p>02/06/15 at 11:50 AM and the Director of Nursing Services (DNS) on 02/06/15, revealed the investigation was initiated on 01/21/15.</p> <p>4) Review of documentation, dated 01/21/15, revealed Resident #1's Accutech bracelet was in place and functioning appropriately when the resident was returned inside the facility on 01/21/15.</p> <p>5) Review of Resident #1's Comprehensive Care Plan dated 01/21/15, revealed the Care plan had been updated to reflect the resident's elopement on 01/21/15.</p> <p>6) Review of a Door Audit dated 01/21/15, and signed by the Maintenance Director revealed all locking mechanisms on each door in the facility were examined with no concerns noted.</p> <p>7) Review of the facility's documentation revealed Resident #1's Physician and Responsible Party were notified that Resident #1 had eloped from the facility on 01/21/15.</p> <p>8) Review of documentation made by the Physician Assistant (PA) revealed the PA examined Resident #1 on 01/21/15, and ordered an electrocardiogram, chest x-ray, and laboratory tests for the resident. Review of Resident #1's medical record on 01/28/15 revealed the tests had been conducted with no significant abnormalities noted.</p> <p>9) Review of a Clinical Pharmacist Medication Regimen Review Summary dated 01/21/15, revealed a medication review was conducted on 01/21/15 for Resident #1, with recommendations made and approved by Resident #1's Physician.</p>	F 282			

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F 282	Continued From page 20 10) Review of Visual Checks documentation revealed the facility had been conducting 15-minute visual checks on Resident #1 since 01/15/15. Documentation of Visual Checks revealed the 15-minute visual checks were increased to every 10 minutes on 01/30/15. 11) Review of Resident #1's Comprehensive Care Plan revealed it was updated on 01/30/15, to reflect the increase in visual checks to every 10 minutes for Resident #1. Review of a Certified Nursing Assistant (CNA) Care Sheet dated 01/30/15 also revealed staff was to perform visual checks for Resident #1 every 10 minutes. 12) Review of Visual Checks documented by staff for Resident #1 from 01/30/15 through 02/01/15, revealed the visual checks were documented as conducted every 10 minutes. Interviews on 02/08/15 at 10:18 AM with CNA #7, 10:42 AM with CNA #10, and 11:19 AM with RN #8 and the Unit 200 Manager, revealed they had conducted visual checks for Resident #1 from 01/30/15 through 02/01/15 every 10 minutes, and were aware of the procedures for performing the visual checks. Interview on 02/08/15 at 12:00 PM with the Director of Nursing Services revealed she had performed staff training related to conducting visual checks for Resident #1 on 01/30/15. 13) Review of nursing documentation dated 02/02/15, revealed Resident #1 was transferred to a behavioral unit on 02/02/15. Resident #1 remained out of the facility on 02/08/15. 14) Review of Risk Elopement assessments, dated 01/21/15 revealed all residents in the facility had been re-evaluated for elopement risks.	F 282			

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F 282	<p>Continued From page 21</p> <p>Interviews on 01/28/15, at 3:23 PM with MDS (Minimum Data Set) Coordinators #1 and #2; and at 4:25 PM with the Social Services Director revealed reassessments of all residents in the facility were conducted on 01/21/15.</p> <p>15) Review of the Elopement Binders located on each Nursing Unit, in the Dietary Department, Business Office, Housekeeping Area, and Therapy Department revealed the binders contained information on all residents identified to be at risk for elopement and the Elopement Guidelines and procedures.</p> <p>16) Review of Clinical Audits dated 01/21/15 and interviews on 01/28/15, at 3:23 PM with MDS Coordinators #1 and #2; at 4:25 PM with the Social Services Director; and on 02/08/15, at 11:45 AM with the Assistant Director of Nursing Services revealed audits of all residents at Risk for Elopement had been completed and they had also conducted reviews of Comprehensive Care Plans, Care Sheets, Certified Nursing Assistant documentation of Accutech Bracelets, and ensured all Accutech bracelets were functioning properly on 01/21/15.</p> <p>17) Review of Clinical Start Up Meeting documentation dated 02/05/15 and interviews on 02/08/15 at 12:00 PM with the Director of Nursing Services, at 11:45 AM with the Assistant Director of Nursing Services, and at 10:12 AM with RN #4, the Weekend Supervisor, revealed the Care Sheets, Care Plans, and Accutech bracelets were monitored daily during the Clinical Start Up meeting and as needed, and would also be performed on weekends by the House Supervisor.</p>	F 282			

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F 282	Continued From page 22 18) Review of In-service Training "Elopement Guidelines" dated 01/21/15-01/23/15, revealed the training had been conducted by staff including the Executive Director and Director of Nursing Services. Interviews on 02/06/15 at 11:19 AM with RN #8, 10:58 AM with RN #5, 10:36 AM with LPN #5, 11:06 AM with LPN #7, 10:50 AM with LPN #8, 10:18 AM with CNA #7, 10:24 AM with CNA #8, 10:30 AM with CNA #9, 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, and on 02/05/15, at 4:15 PM with LPN #7, at 4:06 PM with CNA #12, at 4:30 PM with CNA #13, at 4:58 PM with the Business Office Manager, at 4:26 PM with PTA (Physical Therapy Assistant) #1, at 4:28 PM with the Rehabilitation Manager, at 4:40 PM with the Dietary Manager, and at 4:10 PM with Housekeeping Staff #1 revealed all the staff interviewed had attended the training and were knowledgeable related to the locations of the Elopement Binders and the Elopement Guidelines. Staff interviewed was able to verbally state the steps to take if an exit door was found alarming and/or a resident had eloped from the facility. 19) Review of Activity assessments for residents identified to be at risk for elopement revealed assessments were conducted on 01/21/15. 20) Review of documentation revealed "Applied Audio Visual" was in the facility on 01/21/15, and found no concerns with exit doors. 21) Interviews on 02/06/15, at 10:36 AM with LPN #5, 11:06 AM with LPN #7, and 10:50 AM with LPN #8, and review of Medication Administration Records for Residents #1, #2, #3, #5, #6, and #7 revealed documentation by nurses that the Accutech bracelets were in place and functioning	F 282			

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F 282	Continued From page 23 every shift was contained on the Medication Administration Records. 22) Interviews on 02/06/15, at 10:36 AM with LPN #5, 11:06 AM with LPN #7, and 10:50 AM with LPN #8, and review of Medication Administration Records for Residents #1, #2, #3, #5, #6 and #7 revealed documentation by nurses that the Accutech bracelet batteries worn by the residents were checked weekly for functioning utilizing the activation/deactivation boxes. Interview with Resident #6 on 02/05/15, at 3:08 PM revealed staff had brought a device to the resident's room and checked the bracelet's functioning. 23) Review of the Accutech Bracelets Medication Administration Record Audits dated 01/22/15 through 02/06/15, and interviews with the Director of Nursing Services on 02/06/15 at 12:00 PM, at 11:45 AM with the Assistant Director of Nursing Services, and at 10:12 AM with RN #4, the Weekend Supervisor, revealed they had conducted audits of the Medication Administration Records for residents at risk for elopement to ensure the bracelet functioning and battery functioning had been conducted by the nurses as required. 24) Review of in-service training "Care Sheets and Care Plans" dated 01/28-29/15, and Post Tests also dated 01/28/15 and 01/29/15, revealed the training had been conducted and staff had been administered the test. Interviews on 02/05/15 at 4:08 PM with CNA #12, at 4:30 PM with CNA #13, and on 02/06/15 at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11 revealed the staff had received the training and taken the post test.	F 282			

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F 282	<p>Continued From page 24</p> <p>Staff interviewed was knowledgeable on how to obtain the care sheets, what information was contained on the care sheets, and their responsibility to review the care sheets to ascertain each resident's care needs.</p> <p>25) Resident #1 remained out of the facility on 02/08/15.</p> <p>26) Review of Visual Checks dated 02/03/15 through 02/05/15 for Residents #2, #3, #5, #6 and #7 revealed nurses had documented they had visualized the residents every thirty (30) minutes. Interviews on 02/08/15 at 10:36 AM with LPN #5, at 11:08 AM with LPN #7, and at 10:50 AM with LPN #6 revealed they were knowledgeable regarding the visual checks and had conducted the checks as required. Interview on 02/08/15, at 10:12 AM with RN #4, the Weekend Supervisor, revealed she was knowledgeable regarding that if the Charge Nurses were unable to perform and document the visual checks for residents identified to be at risk for elopement it would be the House Supervisor's responsibility to conduct and document the visual checks.</p> <p>27) Review of the Unit Manager Visual Check Audits dated 02/03-05/15, and interviews on 02/08/15 at 11:19 AM with RN #8, the Unit 200 Manager; and at 10:58 AM with RN #5, the Unit 300 Manager, revealed the Unit Managers had been conducting audits every three (3) hours to ensure Charge Nurses were completing the visual checks as required.</p> <p>28) Review of documentation revealed in-service training was conducted on 02/03/15 by the Director of Nursing Services and Assistant Director of Nursing Services related to Charge</p>	F 282			

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F 282	<p>Continued From page 25</p> <p>Nurses conducting the visual checks for residents identified to be at risk for elopement. Interviews on 02/05/15 at 4:15 PM with LPN #7; and on 02/08/15 at 10:36 AM with LPN #5, at 11:08 AM with LPN #7; and at 10:50 AM with LPN #8, revealed the Charge Nurses received the training and were knowledgeable regarding the process for conducting and documenting visual checks for residents identified to be at risk for elopement.</p> <p>29) Review of documentation revealed in-service training was conducted on 02/03/15 by the Director of Nursing Services and Assistant Director of Nursing Services for Unit Managers related to Charge Nurses conducting the visual checks for residents identified to be at risk for elopement. Interviews on 02/08/15 at 11:19 AM with RN #8, the Unit 200 Manager and at 10:58 AM with RN #5, the Unit 300 Manager, revealed they had attended the training and were knowledgeable regarding auditing the Charge Nurse's visual check and if concerns were identified to take immediate corrective action including re-education.</p> <p>30) Review of Audits performed by the Director of Nursing Services and House Supervisors and interview on 02/06/15 at 12:00 PM with the Director of Nursing Services, and at 10:12 AM with RN #4, the Weekend House Supervisor, revealed they had conducted daily reviews to ensure visual checks were being performed as required for residents in the facility identified to be at risk for elopement.</p> <p>31) Interviews on 02/08/15 at 12:00 PM with the Director of Nursing Services, at 11:45 AM with the Assistant Director of Nursing Services; and at 11:50 AM with the Executive Director revealed no</p>	F 282			

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F 282	Continued From page 26 identified concerns had been identified with staff performing the visual checks as required for residents identified to be at risk for elopement. 32) Review of documentation dated 01/27/15 revealed an "Applied Audio Visual" contractor submitted a bid to the facility for installation of equipment to doors in the facility. Interview on 02/06/15 at 11:50 AM with the Executive Director of the facility revealed all exit doors in the facility currently utilizing a delayed emergency egress function and leading to the outside perimeter which gives residents access to off-grounds property will be equipped to function with the Accutech system was already in place at the facility. 33) Observations on 02/05/15 revealed magnetic alarms and secondary alarms were in place on the seven (7) exit doors accessible to residents in the facility which lead to unsecured outdoor areas of the facility and which were not equipped to operate with the Accutech system 34) Observations on 02/05/15 revealed the secondary alarms could be heard at the Unit 100 Nurses' Station and at the Unit 300 Nurses' Station. Interviews on 02/06/15 at 11:19 AM with RN #8, at 10:56 AM with RN #5, at 10:36 AM with LPN #5, at 11:08 AM with LPN #7, at 10:50 AM with LPN #8, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, revealed all the staff had participated in door drills. Interviews revealed the secondary alarms were loud and distinctive and could be heard in all areas of the facility. 35) Review of the "Elopement Guidelines"	F 282			

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F 282	Continued From page 27 in-service documentation dated 01/29/15 and interviews on 02/06/15 at 11:19 AM with RN #8, at 10:58 AM with RN #5, at 10:38 AM with LPN #5, at 11:08 AM with LPN #7, at 10:50 AM with LPN #8, at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, and on 02/05/15, at 4:15 PM with LPN #7, at 4:06 PM with CNA #12, at 4:30 PM with CNA #13, at 4:58 PM with the Business Office Manager, at 4:28 PM with PTA #1, at 4:28 PM with the Rehabilitation Manager, at 4:40 PM with the Dietary Manager, and at 4:10 PM with Housekeeping Staff #1, revealed staff had received training on the Elopement Guidelines. 36) Review of the in-service training "Responding to Alarms," dated 01/30/15; and interviews on 02/06/15 at 11:19 AM with RN #8, at 10:58 AM with RN #5, at 10:38 AM with LPN #5, at 11:08 AM with LPN #7, at 10:50 AM with LPN #8, at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, and on 02/05/15, at 4:15 PM with LPN #7, at 4:06 PM with CNA #12, at 4:30 PM with CNA #13, at 4:58 PM with the Business Office Manager, at 4:28 PM with PTA #1, at 4:28 PM with the Rehabilitation Manager, at 4:40 PM with the Dietary Manager, and at 4:10 PM with Housekeeping Staff #1, revealed each staff member could verbally state the facility's procedure when an exit door alarmed and/or a resident in the facility was determined to be missing. Each staff member interviewed was knowledgeable regarding their expected duties during an elopement in the facility or when an exit door alarmed. 37) Review of the Door Alarm drill audits dated	F 282			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 108 HARMON HEIGHTS STANFORD, KY 40484		
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F 282	<p>Continued From page 28</p> <p>01/21/15, and interview on 02/08/15, at 12:10 PM with the Maintenance Director revealed audits had been conducted every shift by the Maintenance Director beginning on 01/21/15. They included how to react to a sounding door alarm and timing staff on their response. Interviews on 02/05/15, at 4:15 PM with LPN #7, at 4:08 PM with CNA #12, and at 4:30 PM with CNA #13, and on 02/08/15 at 11:19 AM with RN #8, at 10:58 AM with RN #5, at 10:36 AM with LPN #5, at 11:08 AM with LPN #7, at 10:50 AM with LPN #8, at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, revealed they had participated in door alarm drills conducted in the facility.</p> <p>38) Review of the Door Alarm Audits dated 01/23/15, revealed audits and door drills were documented hourly from 8:00 AM through 11:00 PM. Review of the audits and interview on 02/08/15 at 11:50 AM with the Executive Director revealed he had audited the logs to ensure the door audits and drills had been conducted as required.</p> <p>39) Review of the Door Alarm Drills and Door Check Audits, dated 01/24/15 through 02/05/15, and interview on 02/08/15 at 12:10 PM with the Maintenance Director and at 10:12 AM with RN #4, the Weekend Supervisor, revealed the audits had been conducted on every shift Monday through Friday by the Maintenance Director or Executive Director, and on the weekends by the House Supervisor.</p> <p>40) Review of the Daily Door Drills and Door Alarm Logs, dated 02/05-08/15 and interview on 02/08/15 at 11:50 AM with the Executive Director</p>	F 282		

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F 282	Continued From page 29 revealed the Executive Director had audited the Logs to ensure the drills had been conducted. 41) Review of in-service training dated 01/29/15, and interview on 02/08/15 at 11:45 AM with the Assistant Director of Nursing Services, at 11:19 AM with RN #8, and at 10:58 AM with RN #5 revealed they had attended in-services and were aware of the procedures required to activate/deactivate secondary alarms and perform door checks on the magnetic locking doors and the doors equipped with Accutech alarms. 42) Review of Quality Assurance meeting documentation dated 01/30/15 and 02/05/15 revealed all data collected and performance audits, conducted related to the facility's response to Resident #1's elopement from the facility on 01/21/15, were reviewed during the meetings. Interview with the Executive Director on 02/08/15 at 11:50 AM revealed no significant changes in the facility's implemented plan were determined to be necessary during the meetings.	F 282		
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:	F 323		

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F 323	<p>Continued From page 30</p> <p>Based on observation, interview, record review, review of the facility's investigation and review of the facility's policy and procedures, it was determined the facility failed to have an effective system in place to ensure that one (1) of six (6) sampled residents (Resident #1) received adequate supervision and monitoring to prevent accidents. The facility assessed Resident #1 to be an elopement risk on 12/07/12, and placed the resident on elopement precautions including "30 minute visual checks" which required staff to visually observe Resident #1 to ensure the resident was safe and that staff was aware of the resident's whereabouts. The precautions also included providing Resident #1 with an Accutech bracelet (an electronic device worn by the resident which elicits an audible alarm when a resident is within a certain range of any exit door equipped with the system, and also prevents the door from immediately opening).</p> <p>On 01/15/15, the facility identified Resident #1 to be exhibiting an increase in exit-seeking behaviors; and at that time the facility increased the resident's visual checks to every 15 minutes. However, the facility failed to ensure the visual checks were performed as required, and Resident #1 exited the facility on 01/21/15 at approximately 3:15 AM, without staff knowledge, and was discovered outside the facility unattended at approximately 3:24 AM when a staff member exited the facility while on a break. Resident #1 was escorted back into the facility by staff and assessed to have sustained no injuries. Additionally, the facility failed to ensure that the exit doors in the facility were maintained and functioning appropriately to effectively minimize the risk of residents exiting the facility without staff knowledge.</p>	F 323			

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F 323	Continued From page 31 The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who were at risk for elopement was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was determined to exist on 01/21/15 at 42 CFR 483.20 Resident Assessment (F282) and 483.25 Quality of Care (F323) with Substandard Quality of Care at 42 CFR 483.25 Quality of Care (F323). The facility was notified of the Immediate Jeopardy on 01/28/15. An acceptable Allegation of Compliance was received on 02/04/15 which alleged removal of the Immediate Jeopardy on 02/04/15. A partial extended survey was conducted on 02/05-06/15. The State Survey Agency determined the Immediate Jeopardy was removed on 02/04/15 as alleged, which lowered the scope and severity to "D" at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy, "Elopement Guidelines," revised 2013, revealed the facility would assess each resident upon admission, quarterly, and as needed to establish elopement risks. The guidelines directed staff to perform eight specific steps to locate a missing resident; however, the guidelines did not address specific steps for staff to follow when an exit door was found alarming and/or open and it was unknown if, or specifically which, if any, resident had exited the facility. The policy also indicated the facility	F 323			

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F 323	Continued From page 32 would identify environmental hazards such as entrances/exits "that pose a foreseeable danger to residents who wander or have an exit seeking behavior," and implement interventions to minimize the risks as appropriate. Record review revealed the facility admitted Resident #1 on 11/30/12, with diagnoses that included Alzheimer's Disease, Extrinsic Asthma, and Anxiety. The facility assessed Resident #1 to be at risk for elopement on 12/07/12. Elopement precautions initiated for Resident #1 on 12/07/12, included placing the resident on "30 minute visual checks" which required staff to visually observe Resident #1 to ensure the resident was safe and that staff was aware of the resident's whereabouts. Review of a "Risk for Elopement" assessment for Resident #1 dated 01/04/15, revealed the facility assessed Resident #1 to continue to be a risk for elopement. Review of Behavior Charting for Resident #1 and the resident's Comprehensive Care Plan both dated 01/15/15 revealed staff had identified that Resident #1 was exhibiting increased restlessness and exit-seeking behaviors. The facility increased the resident's visual checks to every 15 minutes on 01/15/15. Review of Resident #1's Minimum Data Set (MDS) assessment completed 01/21/15 revealed the facility assessed the resident to have moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 8. Review of the facility's investigation initiated on 01/21/15 revealed at approximately 3:15 AM on 01/21/15, Registered Nurse (RN) #3, who was working on Unit 300 heard an alarm and discovered the Unit 100 second hall emergency exit door was alarming and open. RN #3 looked	F 323			

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F 323	<p>Continued From page 33</p> <p>outside the door without exiting the facility, and observed no resident. However, when CNA #1 exited the facility during her lunch break on 01/21/15, at approximately 3:24 AM she discovered Resident #1 outside the facility in a wheelchair, unattended, in the parking lot adjacent to the facility's breezeway. Facility staff assisted Resident #1 back into the facility and assessed the resident to have sustained no injury.</p> <p>Observation of Resident #1 on 01/27/15, at 10:50 AM, revealed the resident to be independently mobile in a wheelchair.</p> <p>Review of a written statement dated 01/21/15, provided by Certified Nursing Assistant (CNA) #1, who was caring for Resident #1 on 01/21/15, revealed at approximately 2:50 AM she observed Resident #1 self-propelling in a wheelchair on Unit 200 where the resident resided. CNA #1 stated she "suspected (Resident #1) might try to leave the facility" so she "followed" Resident #1 to Unit 100, then returned to Unit 200 to inform Licensed Practical Nurse (LPN) #1 that Resident #1 was on Unit 100. She did not redirect the resident and left the resident unattended.</p> <p>Interviews with LPN #1 on 01/27/15, at 2:20 PM and on 01/28/15, at 6:50 AM revealed she was caring for Resident #1 on 01/21/15. LPN #1 stated Resident #1 had been awake and self-propelling in a wheelchair, following her as she performed her duties, since the beginning of the shift on 01/20/15 at 10:30 PM. LPN #1 stated she last visualized Resident #1 at approximately 3:00 AM, prior to her leaving Unit 200. LPN #1 stated upon returning to Unit 200 at approximately 3:10 AM she noticed Resident #1</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>was not on the unit or within sight. LPN #1 stated at that time she instructed CNA #1 to locate Resident #1 before she (CNA #1) want to lunch and return the resident to Unit 200. LPN #1 stated at no time did CNA #1 inform her that Resident #1 was on Unit 100 or that CNA #1 suspected Resident #1 would attempt to leave the facility. Review of the "Visual Checks" documentation dated 01/21/15, revealed staff failed to perform the 3:15 AM visual check to identify the resident's whereabouts and ensure the resident's safety.</p> <p>Interviews with RN #3 on 01/27/15, at 8:15 PM, and on 01/28/15, at 10:34 AM, 2:38 PM and 4:43 PM revealed she was the third shift nurse assigned to Unit 300 on 01/21/15. RN #3 stated at approximately 3:00 AM she observed Resident #1 self-propelling on Unit 100, attempting to enter another resident's room. RN #3 stated at that time she redirected Resident #1 out of the other resident's room, and alerted the Unit 100 nurse that Resident #1 was on the unit and to "keep an eye on (him/her)." RN #3 stated she went back to Unit 300 to count medications with Pharmacy staff that had arrived at the facility. RN #3 stated as she was signing the last pharmacy receipt dated 01/21/15 and timed 3:15 AM, she heard a "faint" alarm sounding and discovered it was the Unit 100 second hall emergency exit door alarming and that the door was "ajar." RN #3 stated she looked through the glass of the door and "opened it (the door) just a little," but did not step out, and did not see anyone in the vicinity. RN #3 stated she then silenced the alarm, shut the door, and proceeded to attempt to locate other facility staff to notify them she had discovered the door ajar and the alarm sounding. However, according to RN #3, by the time she</p>	F 323		

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F 323	Continued From page 35 located staff Resident #1 had already been located outside of the facility, nine minutes after she first heard the door alarming. RN #3 stated she had planned to search the perimeter of the facility once she had located other staff and notified them of what had transpired. However, RN #3 stated she was not aware of the facility's specific sequential steps for staff to follow when an exit door was found to be alarming and/or open to make a timely determination if or which resident had exited the facility. Interview on 01/27/15 at 11:48 AM, with LPN #2, who was the Unit 100 Nurse on 01/21/15 for third shift, revealed she did recall RN #3 stating to her that Resident #1 was on Unit 100, but it was not uncommon for the resident to self-propel in the facility, and she took no action to redirect the resident or notify Unit 200 staff of the resident's whereabouts. Review of a written statement dated 01/21/15 and signed by CNA #1, and review of the facility's "time punch" records, revealed CNA #1 clocked out for lunch break at 3:24 AM, and upon exiting the facility discovered Resident #1 outside in a wheelchair unattended in the parking lot adjacent to the facility's breezeway. According to the facility's investigation and CNA #1's statement, she went back into the facility to notify LPN #1 that she had found the resident outside the facility, again leaving the resident outside unattended without supervision. Review of archived weather records revealed the temperature in the facility's area at 3:15 AM on 01/21/15, was 41 degrees Fahrenheit with a wind chill index of 35 degrees Fahrenheit. The resident was wearing a polyester dress with tall socks and loafer-style shoes and a jersey	F 323			

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F 323	Continued From page 36 cardigan with a sweatshirt-type lining. Facility staff assisted Resident #1 back into the facility and assessed the resident to have sustained no injuries. Further review of the "Risk for Elopement" assessment dated 01/04/15, for Resident #1 revealed staff assessed the resident to continue to be an elopement risk, indicating the resident self-propels in a wheelchair "but does wear wrist alarm which triggers outside doors." Observation of exit doors in the facility conducted with the Executive Director on 01/27/15, at 3:05 PM revealed seven exit doors in the facility were accessible to residents, including the Unit 100 second hall emergency exit door, and were not equipped to operate with the facility's Accutech system. Observations revealed the exit doors that were not equipped with the Accutech system would emit an audible alarm three seconds after the push bar was engaged when attempting to open the door. The alarm continued to sound when the magnetic locks released the door after fifteen seconds of continued pressure being applied, and could not be silenced until a numerical sequence was entered into a keypad adjacent to the door which reset the door alarm. Observation of the Unit 100 second hall emergency exit door also revealed a small device secured to the upper part of the door along the inside hinge. According to the Executive Director, the device had been in place on the door prior to his employment at the facility. However, the Executive Director explained the device functioned as a "secondary" alarm which also emitted an audible alarm when the door was open, and operated independently of the magnetic door lock alarm utilized to alert staff	F 323			

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F 323	Continued From page 37 when the door was open. A "key" device used to silence the secondary alarm was located on the medication cart keys for staff to utilize if the alarm sounded. The facility was not utilizing the "secondary" alarm and it was inoperable at the time of the door observation on 01/27/15. Demonstration of the audible alarm emitted by the Unit 100 second hall emergency exit door on 01/27/15, at 3:10 PM revealed the sound of the alarm became very faint at the end of the Unit 100 hallway and was undetectable at the Unit 100 Nurses' Station located approximately 159 feet from the exit door and at the 300 Unit Nurses' Station located approximately 150 feet from the exit door. Interview with RN #3 on 01/27/15, at 8:15 PM, and on 01/28/15, at 10:34 AM, 2:38 PM, and 4:43 PM revealed when she first detected the sounding alarm on 01/27/15, the sound was faint and she first perceived it to be an intravenous (IV) medication pump alarming. RN #3 stated the alarm was "not very loud" and was "hard to hear," indicating the alarm could have been sounding prior to 3:15 AM, but she failed to hear it. RN #3 stated it was the first time she had heard the door alarm and "thought it would have been louder." RN #3 stated that she silenced the alarm by entering the numerical sequence into the keypad, but did not have to use the "key" for the secondary alarm, because "it was not alarming." Interviews conducted on 01/27/15 at 11:48 AM with LPN #2, at 2:00 PM with CNA #4, at 2:20 PM with LPN #1, at 2:50 PM with CNA #2, at 5:00 PM with CNA #3, on 01/28/15 at 7:08 AM with CNA #5, and on 01/29/15 at 2:21 PM with CNA #8, and review of a written statement dated 01/21/15 by	F 323			

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F 323	Continued From page 38 CNA #1, who were all working in the facility during third shift on 01/21/15, and interview on 01/28/15 at 2:45 PM with Pharmacy staff delivering medications in the facility on 01/21/15 from approximately 3:00 AM until 3:30 AM revealed none of the staff interviewed, including the Pharmacy staff, heard an exit door alarm sound on 01/21/15. Interview with the Maintenance Director on 01/28/15, at 3:45 PM, revealed he conducted daily door audits which included the Unit 100 second hall emergency exit door. Review of the Door Audit documentation for January 2015 revealed the magnetic locks, keypad, and alarm on all the doors were all included in the daily door audits; however, the documentation did not indicate how each of the three identified components were "audited." The Maintenance Director stated that he checked the magnetic locks to ensure the door was locked by applying pressure to the push bar, and the alarm was checked by visually observing a light which flashed within the three seconds prior to the audible alarm sounding which indicated the system was working, and therefore the audible alarm was not always engaged during the daily door audit. The Maintenance Director stated he visually observed the keypad to ensure the lights indicated it was functioning properly and that no keys were "stuck" on the keypad. The Maintenance Director stated the daily door audits had been conducted primarily on first shift and he had never conducted any testing related to how far from the door the alarm was audible or how easily detectable the alarms were for staff to hear at various times and in various locations in the facility. The Maintenance Director stated that staff had voiced to him "things like it (the door	F 323			

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F 323	Continued From page 39 alarm) is not very loud," but he could not recall if they had made the statements before or after 01/27/15. The Maintenance Director stated the secondary alarm was not required to be on the door and thought "it was working" on 01/27/15, but he "can't be sure" because he did not check the "secondary" alarm at regular intervals for functioning. Continued interview with the Maintenance Director revealed he was also required to perform Monthly Door Alarm Drills on all doors equipped with a security system. Review of the Monthly Door Alarm Drill form revealed ten steps were required to be followed which included activating the door alarm, timing staff response to the alarm, and questioning staff on proper procedures. However, the Maintenance Director stated that although he had been conducting the monthly audits, he was not performing the audits in any sequential manner to ensure each door was tested within a certain timeframe. The Maintenance Director further stated he was not recording the monthly audits, and therefore was unable to state if or when the Unit 100 second hall emergency exit door had undergone a monthly door alarm audit. Interview with the Executive Director on 01/28/15 at 5:00 PM revealed he was unaware of any problems related to the functioning of the facility door alarms, and conducted no oversight related to the door audits performed by the Maintenance Director prior to 01/21/15. The Executive Director stated since he had been employed at the facility there had not been a resident elopement, and he had identified no areas of concern related to the elopement policies or procedures utilized by the facility.	F 323			

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F 323	<p>Continued From page 40</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 02/04/15. The facility implemented the following actions to remove the immediate Jeopardy:</p> <p>1) Resident #1 was found outside of the facility at approximately 3:24 AM on 01/21/15. Resident #1 was assisted back into the facility safely. The Charge Nurse completed an assessment to rule out injury, including obtaining vital signs.</p> <p>2) A head count was completed on 01/21/15 for all residents on all three units by the Charge Nurses. All residents were accounted for at that time.</p> <p>3) The Executive Director and Director of Nursing Services immediately initiated an investigation of Resident #1's elopement.</p> <p>4) The Accutech Bracelet worn by Resident #1 was checked by the Charge Nurse and was found to be working properly when the resident was returned inside the facility on 01/21/15.</p> <p>5) On 01/21/15, the Interdisciplinary Team reviewed Resident #1's Care Plan which was updated to reflect the resident's elopement on 01/21/15.</p> <p>6) The Maintenance Director checked all door alarms and the Accutech system on 01/21/15. All doors and equipment were found to be operating correctly.</p> <p>7) Resident #1's family and physician were notified of Resident #1's elopement on 01/21/15.</p>	F 323		

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F 323	Continued From page 41 8) The attending Physician Assistant visited Resident #1 on 01/21/15 and wrote orders for Resident #1 to have an echocardiogram performed, a chest x-ray, and laboratory tests completed. 9) A medication review was conducted for Resident #1 on 01/21/15 by the facility's consulting pharmacist and new medications were ordered by the physician. 10) Resident #1 was on visual checks every 15 minutes at the time the resident eloped from the facility. Resident #1's visual checks were increased to every 10 minutes on 01/30/15. 11) Resident #1's Comprehensive Care Plan and Certified Nursing Assistant Care Sheets were updated to reflect the 10-minute visual checks implemented on 01/30/15 for Resident #1. 12) Certified Nursing Assistants were assigned to complete the 10-minute visual checks for Resident #1. If a Certified Nursing Assistant was unable to complete the 10-minute visual checks, the Charge Nurse would then complete the visual checks for Resident #1. Nurses and CNAs were educated on the changes to the care plan/care sheets on 01/30/15 by the Interdisciplinary Team and Director of Nursing Services. 13) Resident #1 was transferred to a behavioral unit on 02/02/15. 14) All residents residing in the facility on 01/21/15 were reassessed for elopement risk by the Interdisciplinary Team and Social Services. 15) Facility Elopement Binders were reviewed	F 323			

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F 323	<p>Continued From page 42</p> <p>and updated as indicated on 01/21/15 by Social Services staff. One additional resident was identified as an elopement risk and added to the Elopement Binders. The Director of Nursing Services and the Assistant Director of Nursing Services verified the Elopement Binders were current and up to date on 01/21/15.</p> <p>16) On 01/21/15, the Interdisciplinary Team and the Assistant Director of Nursing Services audited all residents at Risk for Elopement and completed the following resident reviews: Care Plans, Care Sheets, and Certified Nursing Assistant Documentation of Accutech Bracelets, and ensured all Accutech bracelets were functioning properly.</p> <p>17) The Interdisciplinary Team will continue to monitor and revise care sheets, care plans, and Accutech Bracelets daily during Clinical Start Up Meetings to ensure revisions are made as needed. The Director of Nursing Services and the Assistant Director of Nursing Services or House Supervisor will conduct the monitoring on weekends.</p> <p>18) The Executive Director, Director of Nursing Services, Assistant Director of Nursing Services, and Interdisciplinary Team initiated education related to elopement guidellnes to all employees, including contracted services, on 01/21/15. The training was completed on 01/23/15. Employees who have not received the training will not be permitted to work until they have received the training.</p> <p>19) The Activity Director conducted assessments on 01/21/15 for all residents at risk for elopement.</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>20) An "Applied Audio Visual" contractor was in the facility on 01/21/15 to assess all doors in the facility. A visual and operational check was conducted for each door; all doors were found to be working properly.</p> <p>21) Beginning 01/22/15, Charge Nurses will document that Accutech bracelets are in place and functioning for each resident who utilizes the device. The documentation will be done on the electronic Medication Administration Record every shift.</p> <p>22) Charge Nurses will check and document weekly on the electronic Medication Administration Record that the Accutech batteries are functioning properly utilizing activation/deactivation boxes.</p> <p>23) The Director of Nursing Services and/or Assistant Director of Nursing Services will audit the Medication Administration Records daily, and the House Supervisor will conduct the audits on weekends to ensure the Charge Nurses are monitoring the functioning of the Accutech Bracelets daily and battery function weekly.</p> <p>24) The Interdisciplinary Team, Assistant Director of Nursing Services, and Department Managers initiated education related to Care Sheets and Care Plans on 01/28/15 and completed the trainings on 01/29/15. Certified Nursing Assistants will review care sheets every shift to identify any resident for elopement. The training was to ensure that Certified Nursing Assistants and Nurses were aware of residents' care needs. Post tests were completed.</p> <p>25) When Resident #1 is readmitted to the facility</p>	F 323			

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F 323	Continued From page 44 the Unit Manager will conduct a thorough assessment, including elopement risk, and the Director of Nursing Services and/or Assistant Director of Nursing Services will review the assessment. 26) Beginning 02/03/15, Charge Nurses will document visual checks every 30 minutes on residents that are at risk for elopement. If the Charge Nurse is unable to document the visual checks, the House Supervisor will be responsible for the visual checks and documentation. 27) Unit Managers will audit the Charge Nurse 30-minute Visual Check Logs every three hours per shift to ensure the visual checks are being conducted. 28) On 02/03/15, all Charge Nurses were educated by the Director of Nursing Services and/or Assistant Director of Nursing Services on the importance of conducting and documenting the 30-minute visual checks. 29) Education by the Director of Nursing Services and/or the Assistant Director of Nursing Services with the Unit Managers related to reviewing the Charge Nurse 30-minute Visual Check Log every three hours was completed on 02/03/15. If Unit Managers see concerns with documentation, corrective action will take place immediately, including re-education. 30) Reviews conducted by the Unit Managers of the Charge Nurse 30-minute Visual Check Logs will be monitored and audited by the Director of Nursing Services and/or House Supervisor daily during the Clinical Start Up meeting. On weekends the House Supervisor will review the	F 323			

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F 323	Continued From page 45 Logs. 31) Identified concerns related to the Charge Nurse 30-minute Visual Check Logs will be reported to the Director of Nursing Services and/or the Assistant Director of Nursing Services. The Executive Director and/or the Director of Nursing Services will take corrective actions which will include re-education. 32) On 01/27/15, an "Applied Audio Visual" contractor returned to the facility and provided recommendations and presented a monetary bid to add additional Accutech equipment. The monetary bid made by "Applied Audio Visual" was approved by the facility and equipment has been ordered which will be installed on all exit doors in the facility that currently utilize the delayed emergency egress function, lead to the outside perimeter, and give residents access to off-grounds property. 33) The current alarm system includes magnetic Locks and secondary alarms. This dual alarm system is in place on the door at the end of the Unit 200 Wing, the smoking exit door, the first hall Unit 100 door, the second hall Unit 100 door, the door at the end of the hall on Unit 300, and the Therapy door in the new building addition. 34) The secondary alarms were installed on 01/29/15 and produce a loud distinctive sound when an exit door is opened. The secondary alarms can be heard at all nursing stations and rooms on each unit. This was tested by posting staff members on each unit and by the Nurses' Stations and sounding the alarms. These alarms will be in place until the new Accutech equipment is installed. The new Accutech system will sound	F 323			

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F 323	Continued From page 46 alarms at the Nurses' Stations as well as at the door. 35) On 01/29/15, staff was educated on Elopement Guidelines and how to react to sounding alarms and potential elopements. Any staff not attending the training must receive education before returning to work. 36) Education on responding to alarms, which included activation/deactivation of secondary alarms, was conducted on 01/30/15. All staff is required to receive the training and will not be permitted to work in the facility until they have been trained on the procedures as follow: A. All staff will respond immediately to any sounding alarms. B. The door alarm should remain sounding and not turned off so additional staff can render help. C. Go to the door that is alarming and conduct an outside perimeter check. D. If no resident is noted to be outside, go back inside the door. E. Deactivate the alarm and page "golden alert"; this alerts the units to conduct a head count for all residents. F. If all residents are accounted for then page "all clear." G. if a resident is "missing" immediately page "golden alert" and announce the room number. This alerts all staff there is a "missing resident." H. If a resident is "missing" then follow the facility's elopement guideline located in the elopement book. 37) Door alarm drills were initiated on 01/21/15 and were conducted every shift by the Maintenance Director. The door alarm drills	F 323			

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F 323	Continued From page 47 included how to react to a sounding door alarm. The drills consist of placing staff members on each unit and at each Nurses' Station. The Maintenance Director activates an alarm at a specific door. Employees answering the alarm are timed as to how long it takes them to respond to the alarming door. Employees that do not answer the alarm are immediately re-educated on the correct procedure when a door alarm is activated. 38) On 01/23/15, door alarm checks and drills were conducted and documented hourly from 8:00 AM through 11:00 PM. The Logs were audited by the Executive Director to ensure they had been completed. 39) Beginning 01/24/15 door alarm drills and door checks will be conducted every shift Monday through Friday by the Maintenance Director and/or Executive Director. The Manager on duty and/or House Supervisor will complete the door checks and alarm drills on the weekend. 40) Logs to ensure the daily door drills and door alarm checks were conducted will be audited by the Executive Director daily Monday through Friday and by the House Supervisor on weekends. 41) The Maintenance Director provided training to all staff on 01/29/15 related to activating/deactivating secondary alarms and performing door checks on the magnetic locking doors and the Accutech doors. 42) All reviews and audits will be taken to the weekly Quality Assurance Committee meetings for four weeks, then monthly, to be analyzed for	F 323			

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F 323	<p>Continued From page 48</p> <p>trends. If concerns are identified appropriate action will be taken including system revision and education as deemed necessary.</p> <p>***The SSA validated the Immediate Jeopardy was removed as follows:</p> <p>1) Review of Nursing documentation dated 01/21/15, revealed Resident #1 required no treatment after the elopement and was assessed to have sustained no injury when returned inside the facility. Vital signs were obtained and documented; they were within normal limits.</p> <p>2) Review of the facility's documentation, dated 01/21/15 and interview with Licensed Practical Nurse (LPN) #1 on 01/27/15, at 2:20 PM, LPN #2 on 01/27/15 at 11:48 AM, and RN #3 on 01/27/15 at 6:15 PM, revealed head counts were conducted on all three units and each resident was accounted for at that time.</p> <p>3) Review of the facility's investigation and interview with the Executive Director (ED) on 02/08/15 at 11:50 AM and the Director of Nursing Services (DNS) on 02/08/15, revealed the investigation was initiated on 01/21/15.</p> <p>4) Review of documentation, dated 01/21/15, revealed Resident #1's Accutech bracelet was in place and functioning appropriately when the resident was returned inside the facility on 01/21/15.</p> <p>5) Review of Resident #1's Comprehensive Care Plan dated 01/21/15, revealed the Care plan had been updated to reflect the resident's elopement on 01/21/15.</p>	F 323		

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F 323	<p>Continued From page 49</p> <p>6) Review of a Door Audit dated 01/21/15, and signed by the Maintenance Director revealed all locking mechanisms on each door in the facility were examined with no concerns noted.</p> <p>7) Review of the facility's documentation revealed Resident #1's Physician and Responsible Party were notified that Resident #1 had eloped from the facility on 01/21/15.</p> <p>8) Review of documentation made by the Physician Assistant (PA) revealed the PA examined Resident #1 on 01/21/15, and ordered an electrocardiogram, chest x-ray, and laboratory tests for the resident. Review of Resident #1's medical record on 01/28/15 revealed the tests had been conducted with no significant abnormalities noted.</p> <p>9) Review of a Clinical Pharmacist Medication Regimen Review Summary dated 01/21/15, revealed a medication review was conducted on 01/21/15 for Resident #1, with recommendations made and approved by Resident #1's Physician.</p> <p>10) Review of Visual Checks documentation revealed the facility had been conducting 15-minute visual checks on Resident #1 since 01/15/15. Documentation of Visual Checks revealed the 15-minute visual checks were increased to every 10 minutes on 01/30/15.</p> <p>11) Review of Resident #1's Comprehensive Care Plan revealed it was updated on 01/30/15, to reflect the increase in visual checks to every 10 minutes for Resident #1. Review of a Certified Nursing Assistant (CNA) Care Sheet dated 01/30/15 also revealed staff was to perform visual checks for Resident #1 every 10 minutes.</p>	F 323		

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F 323	Continued From page 50 12) Review of Visual Checks documented by staff for Resident #1 from 01/30/15 through 02/01/15, revealed the visual checks were documented as conducted every 10 minutes. Interviews on 02/06/15 at 10:18 AM with CNA #7, 10:42 AM with CNA #10, and 11:19 AM with RN #8 and the Unit 200 Manager, revealed they had conducted visual checks for Resident #1 from 01/30/15 through 02/01/15 every 10 minutes, and were aware of the procedures for performing the visual checks. Interview on 02/06/15 at 12:00 PM with the Director of Nursing Services revealed she had performed staff training related to conducting visual checks for Resident #1 on 01/30/15. 13) Review of nursing documentation dated 02/02/15, revealed Resident #1 was transferred to a behavioral unit on 02/02/15. Resident #1 remained out of the facility on 02/06/15. 14) Review of Risk Elopement assessments, dated 01/21/15 revealed all residents in the facility had been re-evaluated for elopement risks. Interviews on 01/28/15, at 3:23 PM with MDS (Minimum Data Set) Coordinators #1 and #2; and at 4:25 PM with the Social Services Director revealed reassessments of all residents in the facility were conducted on 01/21/15. 15) Review of the Elopement Binders located on each Nursing Unit, in the Dietary Department, Business Office, Housekeeping Area, and Therapy Department revealed the binders contained information on all residents identified to be at risk for elopement and the Elopement Guidelines and procedures. 16) Review of Clinical Audits dated 01/21/15 and	F 323			

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F 323	<p>Continued From page 51</p> <p>interviews on 01/28/15, at 3:23 PM with MDS Coordinators #1 and #2; at 4:25 PM with the Social Services Director; and on 02/06/15, at 11:45 AM with the Assistant Director of Nursing Services revealed audits of all residents at Risk for Elopement had been completed and they had also conducted reviews of Comprehensive Care Plans, Care Sheets, Certified Nursing Assistant documentation of Accutech Bracelets, and ensured all Accutech bracelets were functioning properly on 01/21/15.</p> <p>17) Review of Clinical Start Up Meeting documentation dated 02/05/15 and interviews on 02/06/15 at 12:00 PM with the Director of Nursing Services, at 11:45 AM with the Assistant Director of Nursing Services, and at 10:12 AM with RN #4, the Weekend Supervisor, revealed the Care Sheets, Care Plans, and Accutech bracelets were monitored daily during the Clinical Start Up meeting and as needed, and would also be performed on weekends by the House Supervisor.</p> <p>18) Review of In-service Training "Elopement Guidelines" dated 01/21/15-01/23/15, revealed the training had been conducted by staff including the Executive Director and Director of Nursing Services. Interviews on 02/06/15 at 11:19 AM with RN #8, 10:58 AM with RN #5, 10:38 AM with LPN #5, 11:08 AM with LPN #7, 10:50 AM with LPN #6, 10:18 AM with CNA #7, 10:24 AM with CNA #8, 10:30 AM with CNA #9, 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, and on 02/05/15, at 4:15 PM with LPN #7, at 4:08 PM with CNA #12, at 4:30 PM with CNA #13, at 4:58 PM with the Business Office Manager, at 4:28 PM with PTA (Physical Therapy Assistant) #1, at 4:28 PM with the Rehabilitation Manager, at 4:40 PM</p>	F 323		
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F 323	<p>Continued From page 52</p> <p>with the Dietary Manager, and at 4:10 PM with Housekeeping Staff #1 revealed all the staff interviewed had attended the training and were knowledgeable related to the locations of the Elopement Binders and the Elopement Guidelines. Staff interviewed was able to verbally state the steps to take if an exit door was found alarming and/or a resident had eloped from the facility.</p> <p>19) Review of Activity assessments for residents identified to be at risk for elopement revealed assessments were conducted on 01/21/15.</p> <p>20) Review of documentation revealed "Applied Audio Visual" was in the facility on 01/21/15, and found no concerns with exit doors.</p> <p>21) Interviews on 02/06/15, at 10:38 AM with LPN #5, 11:08 AM with LPN #7, and 10:50 AM with LPN #8, and review of Medication Administration Records for Residents #1, #2, #3, #5, #6, and #7 revealed documentation by nurses that the Accutech bracelets were in place and functioning every shift was contained on the Medication Administration Records.</p> <p>22) Interviews on 02/06/15, at 10:38 AM with LPN #5, 11:08 AM with LPN #7, and 10:50 AM with LPN #8, and review of Medication Administration Records for Residents #1, #2, #3, #5, #6 and #7 revealed documentation by nurses that the Accutech bracelet batteries worn by the residents were checked weekly for functioning utilizing the activation/deactivation boxes. Interview with Resident #8 on 02/05/15, at 3:08 PM revealed staff had brought a device to the resident's room and checked the bracelet's functioning.</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-STANFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 108 HARMON HEIGHTS STANFORD, KY 40484		
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F 323	<p>Continued From page 53</p> <p>23) Review of the Accutech Bracelets Medication Administration Record Audits dated 01/22/15 through 02/08/15, and interviews with the Director of Nursing Services on 02/08/15 at 12:00 PM, at 11:45 AM with the Assistant Director of Nursing Services, and at 10:12 AM with RN #4, the Weekend Supervisor, revealed they had conducted audits of the Medication Administration Records for residents at risk for elopement to ensure the bracelet functioning and battery functioning had been conducted by the nurses as required.</p> <p>24) Review of in-service training "Care Sheets and Care Plans" dated 01/28-29/15, and Post Tests also dated 01/28/15 and 01/29/15, revealed the training had been conducted and staff had been administered the test. Interviews on 02/05/15 at 4:08 PM with CNA #12, at 4:30 PM with CNA #13, and on 02/06/15 at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11 revealed the staff had received the training and taken the post test. Staff interviewed was knowledgeable on how to obtain the care sheets, what information was contained on the care sheets, and their responsibility to review the care sheets to ascertain each resident's care needs.</p> <p>25) Resident #1 remained out of the facility on 02/08/15.</p> <p>26) Review of Visual Checks dated 02/03/15 through 02/05/15 for Residents #2, #3, #5, #8 and #7 revealed nurses had documented they had visualized the residents every thirty (30)minutes. Interviews on 02/08/15 at 10:36 AM with LPN #5, at 11:08 AM with LPN #7, and at 10:50 AM with</p>	F 323			

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F 323	Continued From page 54 LPN #8 revealed they were knowledgeable regarding the visual checks and had conducted the checks as required. Interview on 02/06/15, at 10:12 AM with RN #4, the Weekend Supervisor, revealed she was knowledgeable regarding that if the Charge Nurses were unable to perform and document the visual checks for residents identified to be at risk for elopement it would be the House Supervisor's responsibility to conduct and document the visual checks. 27) Review of the Unit Manager Visual Check Audits dated 02/03-05/15, and interviews on 02/08/15 at 11:19 AM with RN #8, the Unit 200 Manager; and at 10:56 AM with RN #5, the Unit 300 Manager, revealed the Unit Managers had been conducting audits every three (3) hours to ensure Charge Nurses were completing the visual checks as required. 28) Review of documentation revealed in-service training was conducted on 02/03/15 by the Director of Nursing Services and Assistant Director of Nursing Services related to Charge Nurses conducting the visual checks for residents identified to be at risk for elopement. Interviews on 02/05/15 at 4:15 PM with LPN #7; and on 02/06/15 at 10:36 AM with LPN #5, at 11:06 AM with LPN #7; and at 10:50 AM with LPN #8, revealed the Charge Nurses received the training and were knowledgeable regarding the process for conducting and documenting visual checks for residents identified to be at risk for elopement. 29) Review of documentation revealed in-service training was conducted on 02/03/15 by the Director of Nursing Services and Assistant Director of Nursing Services for Unit Managers related to Charge Nurses conducting the visual	F 323			

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F 323	<p>Continued From page 55</p> <p>checks for residents identified to be at risk for elopement. Interviews on 02/08/15 at 11:19 AM with RN #8, the Unit 200 Manager and at 10:58 AM with RN #5, the Unit 300 Manager, revealed they had attended the training and were knowledgeable regarding auditing the Charge Nurse's visual check and if concerns were identified to take immediate corrective action including re-education.</p> <p>30) Review of Audits performed by the Director of Nursing Services and House Supervisors and interview on 02/08/15 at 12:00 PM with the Director of Nursing Services, and at 10:12 AM with RN #4, the Weekend House Supervisor, revealed they had conducted daily reviews to ensure visual checks were being performed as required for residents in the facility identified to be at risk for elopement.</p> <p>31) Interviews on 02/08/15 at 12:00 PM with the Director of Nursing Services, at 11:45 AM with the Assistant Director of Nursing Services; and at 11:50 AM with the Executive Director revealed no identified concerns had been identified with staff performing the visual checks as required for residents identified to be at risk for elopement.</p> <p>32) Review of documentation dated 01/27/15 revealed an "Applied Audio Visual" contractor submitted a bid to the facility for installation of equipment to doors in the facility. Interview on 02/08/15 at 11:50 AM with the Executive Director of the facility revealed all exit doors in the facility currently utilizing a delayed emergency egress function and leading to the outside perimeter which gives residents access to off-grounds property will be equipped to function with the Accutech system was already in place at the</p>	F 323	

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F 323	Continued From page 58 facility. 33) Observations on 02/05/15 revealed magnetic alarms and secondary alarms were in place on the seven (7) exit doors accessible to residents in the facility which lead to unsecured outdoor areas of the facility and which were not equipped to operate with the Accutech system 34) Observations on 02/05/15 revealed the secondary alarms could be heard at the Unit 100 Nurses' Station and at the Unit 300 Nurses' Station. Interviews on 02/06/15 at 11:19 AM with RN #8, at 10:56 AM with RN #5, at 10:38 AM with LPN #5, at 11:06 AM with LPN #7, at 10:50 AM with LPN #8, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, revealed all the staff had participated in door drills. Interviews revealed the secondary alarms were loud and distinctive and could be heard in all areas of the facility. 35) Review of the "Elopement Guidelines" in-service documentation dated 01/29/15 and interviews on 02/06/15 at 11:19 AM with RN #8, at 10:56 AM with RN #5, at 10:36 AM with LPN #5, at 11:06 AM with LPN #7, at 10:50 AM with LPN #8, at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, and on 02/05/15, at 4:15 PM with LPN #7, at 4:06 PM with CNA #12, at 4:30 PM with CNA #13, at 4:58 PM with the Business Office Manager, at 4:26 PM with PTA #1, at 4:28 PM with the Rehabilitation Manager, at 4:40 PM with the Dietary Manager, and at 4:10 PM with Housekeeping Staff #1, revealed staff had received training on the Elopement Guidelines.	F 323			

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F 323	<p>Continued From page 57</p> <p>38) Review of the in-service training "Responding to Alarms," dated 01/30/15; and Interviews on 02/06/15 at 11:19 AM with RN #8, at 10:58 AM with RN #5, at 10:36 AM with LPN #5, at 11:08 AM with LPN #7, at 10:50 AM with LPN #6, at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, and on 02/05/15, at 4:15 PM with LPN #7, at 4:08 PM with CNA #12, at 4:30 PM with CNA #13, at 4:58 PM with the Business Office Manager, at 4:28 PM with PTA #1, at 4:28 PM with the Rehabilitation Manager, at 4:40 PM with the Dietary Manager, and at 4:10 PM with Housekeeping Staff #1, revealed each staff member could verbally state the facility's procedure when an exit door alarmed and/or a resident in the facility was determined to be missing. Each staff member interviewed was knowledgeable regarding their expected duties during an elopement in the facility or when an exit door alarmed.</p> <p>37) Review of the Door Alarm drill audits dated 01/21/15, and interview on 02/06/15, at 12:10 PM with the Maintenance Director revealed audits had been conducted every shift by the Maintenance Director beginning on 01/21/15. They included how to react to a sounding door alarm and timing staff on their response. Interviews on 02/05/15, at 4:15 PM with LPN #7, at 4:08 PM with CNA #12, and at 4:30 PM with CNA #13, and on 02/06/15 at 11:19 AM with RN #8, at 10:58 AM with RN #5, at 10:36 AM with LPN #5, at 11:08 AM with LPN #7, at 10:50 AM with LPN #6, at 10:18 AM with CNA #7, at 10:24 AM with CNA #8, at 10:30 AM with CNA #9, at 10:42 AM with CNA #10, and at 11:35 AM with CNA #11, revealed they had participated in door</p>	F 323	

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F 323	Continued From page 58 alarm drills conducted in the facility. 38) Review of the Door Alarm Audits dated 01/23/15, revealed audits and door drills were documented hourly from 8:00 AM through 11:00 PM. Review of the audits and interview on 02/06/15 at 11:50 AM with the Executive Director revealed he had audited the logs to ensure the door audits and drills had been conducted as required. 39) Review of the Door Alarm Drills and Door Check Audits, dated 01/24/15 through 02/05/15, and interview on 02/06/15 at 12:10 PM with the Maintenance Director and at 10:12 AM with RN #4, the Weekend Supervisor, revealed the audits had been conducted on every shift Monday through Friday by the Maintenance Director or Executive Director, and on the weekends by the House Supervisor. 40) Review of the Daily Door Drills and Door Alarm Logs, dated 02/05-08/15 and interview on 02/06/15 at 11:50 AM with the Executive Director revealed the Executive Director had audited the Logs to ensure the drills had been conducted. 41) Review of in-service training dated 01/29/15, and interview on 02/06/15 at 11:45 AM with the Assistant Director of Nursing Services, at 11:19 AM with RN #8, and at 10:56 AM with RN #5 revealed they had attended in-services and were aware of the procedures required to activate/deactivate secondary alarms and perform door checks on the magnetic locking doors and the doors equipped with Accutech alarms. 42) Review of Quality Assurance meeting	F 323			

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F 323	Continued From page 59 documentation dated 01/30/15 and 02/05/15 revealed all data collected and performance audits, conducted related to the facility's response to Resident #1's elopement from the facility on 01/21/15, were reviewed during the meetings. Interview with the Executive Director on 02/06/15 at 11:50 AM revealed no significant changes in the facility's implemented plan were determined to be necessary during the meetings.	F 323		
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