

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

PRINTED: 11/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/10/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON MANOR HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 LYNN WAY</b> <b>LOUISVILLE, KY 40222</b>
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>An onsite re-visit was conducted on 11/10/15 and found the facility in compliance on 10/13/15 as alleged in their PoC.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.

**Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

<b>(Y1) Provider / Supplier / CLIA / Identification Number</b> 185169	<b>(Y2) Multiple Construction</b> A. Building B. Wing	<b>(Y3) Date of Revisit</b> 11/10/2015
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<b>Name of Facility</b> JEFFERSON MANOR HEALTH & REHABILITATION CENTER	<b>Street Address, City, State, Zip Code</b> 1801 LYNN WAY LOUISVILLE, KY 40222
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0281</u> Reg. # <u>483.20(k)(3)(i)</u> LSC _____	Correction Completed <u>10/13/2015</u>	ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____	Correction Completed <u>10/13/2015</u>
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>MZ</u> State Agency	Reviewed By <u>VX</u>	Date: <u>11/10/15</u>	Signature of Surveyor: <u>Milke Zornstein</u>	Date: <u>11/10/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>9/10/2015</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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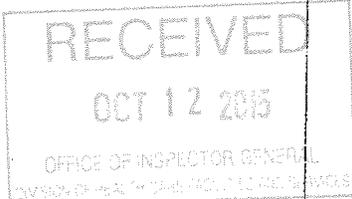
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F 000	INITIAL COMMENTS  Amended 10/07/15  A Recertification/Abbreviated/Extended Survey was initiated on 08/25/15 and concluded on 09/10/15. The Division of Health Care substantiated the allegation for complaint KY23736 with Immediate Jeopardy identified on 08/27/15 and determined to exist on 08/19/15 at 42 CFR 483.20 Resident Assessment (F281) and 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "J" with Substandard Quality of Care in 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 08/27/15.  On 08/19/15, Resident #7 eloped from the facility without staff knowledge. An employee of the facility was walking to the bus stop on a busy two-lane road after completing his shift and observed the resident sitting in a wheelchair and attempting to cross a busy two-lane road approximately 0.4 miles from the facility. The temperature was eighty-six (86) degrees Fahrenheit (F) with intermittent clouds and a breeze up to fourteen (14) miles per hour. The resident was wearing an orange shirt, bib overalls, a hat, and sneakers. The resident was returned to the facility at approximately 3:30 PM and assessed with no injuries identified.	F 000	"The preparation and execution of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement Of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."	
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	The facility provided an acceptable Allegation of Compliance (AOC) on 09/02/15 alleging removal of Immediate Jeopardy on 08/29/15. The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as alleged, prior to exit on 09/10/15. The Scope and Severity was lowered to a "D" for 42 CFR 483.20 Resident			
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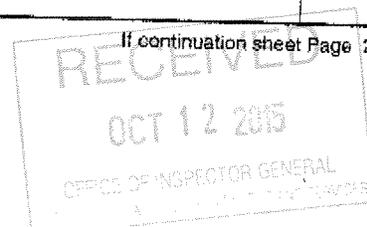
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Julie Blowski</i>	TITLE <i>X Administrator X</i>	(X6) DATE <i>10/9/15</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may 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 Assessment (F281) and 42 CFR 483.25 Quality of Care (F323) while the facility implements the Plan of Correction (POC) and the Quality Assurance (QA) Committee monitors the effectiveness of systemic changes.	F 000			
F 281 SS=J	<p>An additional deficiency was cited during the recertification survey at a scope and severity of an F.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review and review of the facility's incident report, it was determined the facility failed to have an effective system to ensure the development of an interim care plan to meet the needs of a newly admitted resident to reduce the risk of elopement for one (1) of nineteen (19) sampled residents, Resident #7.</p> <p>On 08/19/15, Resident #7 eloped from the facility without staff knowledge. An employee of the facility was walking to the bus stop on a busy two-lane road after completing his shift and observed the resident sitting in a wheelchair and attempting to cross a busy two-lane road approximately 0.4 miles from the facility. The temperature was eighty-six (86) degrees Fahrenheit (F) with intermittent clouds and a breeze up to fourteen (14) miles per hour. The resident was wearing an orange shirt, bib</p>	F 281	<p>Resident #7 was discharged home with wife on 8-27-15.</p> <p>On 8-27-15 all other current residents Elopement Risk Screens were audited by the Staff Development Coordinator, MDS Coordinators, ADON and Unit Managers to ensure that each resident was screened accurately, there were no residents that were screened 'not at risk' that were changed to 'at risk'. On 8-27-15 the care plans for the 12 residents that were determined to be 'at risk' were reviewed by the Staff Development Coordinator, MDS Coordinators, ADON and Unit Managers to ensure that they included the resident being at risk for elopement. On 8-27-15 the Administrator reviewed all exterior door functions checks for the last 60 days to ensure that the doors were checked on a weekly basis and functioning. On 8-27-15 the Unit Managers and Assist Unit Managers verified that a list of those residents at risk for elopement was at the reception area and on each MAR.</p>	10/13/15	



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F 281	<p>Continued From page 2</p> <p>overalls, a hat, and sneakers. The resident was returned to the facility at approximately 3:30 PM and assessed with no injuries identified.</p> <p>The facility's failure to ensure a care plan was developed to direct staff in the monitoring of a newly admitted resident with exit seeking behavior has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 08/27/15 and determined to exist on 08/19/15. The facility was notified of the Immediate Jeopardy on 08/27/15.</p> <p>The facility provided an acceptable allegation of compliance (AOC) on 09/02/15 alleging compliance on 08/29/15. The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as alleged prior to exit on 09/10/15. The scope and severity was lowered to a "D" while the facility implements the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Elopement, dated 02/18/09, revealed the facility would assess all residents for elopement risk upon admission, between day three (3) and day seven (7), between day thirty (30) and day forty-five (45), quarterly and with any significant change in Activities of Daily Living (ADL) function or cognitive function. The facility would use the Elopement Risk Assessment. The elopement risk assessment would indicate a resident had an increased risk for elopement if the facility determined the answer to two (2) or more of the</p>	F 281	<p>On 8-28-15 the DON checked the MAR's and TAR's of all residents assessed to be at risk for elopement to ensure that placement and function checks were completed.</p> <p>No changes were made to the policy.</p> <p>All staff were re-educated by the House Supervisor, Staff Development Coordinator, MDS Coordinators, DON, Administrator, Unit Managers and Assistant Unit Managers on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behavior and Interventions to address exit seeking behavior. All staff were educated by 8-28-15 or not allowed to work until the education was completed. On 8-28-15 the education on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behaviors and interventions to address exit seeking behaviors were added to the new hire orientation by the Staff Development Coordinator, all newly hired staff will receive the education during orientation which is overseen by the Staff Development Coordinator. This education will be repeated for all facility staff not less than annually by administrative nurses, including the Staff Development Coordinator, DON, ADON, Administrator and Unit Managers.</p> <p>All newly admitted residents will have an Elopement Risk Screen completed by the admitting nurse.</p>		

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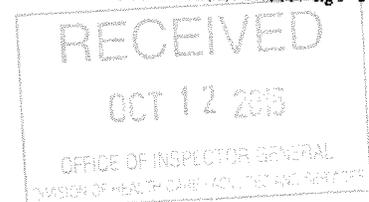
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F 281	Continued From page 3 five (5) questions on the assessment was a "YES." The assessment further stated if a resident had two (2) or more "Yes" answers and the facility determined the resident was not at risk for elopement, the facility would provide rationale. If the assessment determined the resident was at risk for elopement, the facility would develop a care plan to include interventions such as increased monitoring, use of one-on-one services, bed alarms, code alerts, and activity programs. The policy further stated the facility should develop a plan to eliminate or reduce the risk of elopement.  Interview with the Administrator, on 08/27/15 at 4:07 PM, revealed the facility used the Resident Assessment Instrument (RAI) Manual for the development and revision of initial and interim care plans. The Administrator provided a printout of a power point presentation the facility used to train staff on care plan development and updating.  Review of the Resident Assessment Instrument (RAI) manual, Minimum Data Set (MDS), Chapter 4, page revealed a good assessment is the starting point for good clinical problem solving, decision making, and for the creation of a sound care plan. The manual revealed the facility should have collected information that was needed to identify an individual's strengths and risks by obtaining a personal and medical history. The facility would identify the resident's prior wandering behaviors and determined whether those behaviors put the resident at significant risk of getting into potentially dangerous situations/places. The facility would identify any current consequences of the individual's situation and defined significant risk factors. The facility	F 281	The DON, ADON, Unit Manager, Assistant Manager or House Supervisor will complete the New Admit Elopement Risk Screen audit on all new admissions weekly for 2 months and then 25% of new admissions will be completed monthly for 3 months and then 25% quarterly to ensure accurate screening.  The Elopement Audit on Elopement Risk Screens, MAR, TAR, Care Plans and Nurse Aide Care Plans for residents assessed at being at risk for elopement will be completed by the DON, ADON, Unit Manager, Assistant Manager or House Supervisor monthly for 12 months to ensure accuracy and timeliness of the screens and placement and function checks.  Audits on the function of all exterior door checks will be completed weekly for 6 weeks then monthly for 12 months by the Administrator or DON.  New Employee Orientation Audits will be completed by the DON, ADON or Administrator weekly for 12 months to ensure that all newly hired staff have received education on elopement.  All audits to be reported to QA subcommittee by the DON or Administrator that will meet no less than monthly for 6 months then no less that quarterly to ensure sustained compliance. The findings from QA Subcommittee will be presented to the Quality Assurance Committee by the Administrator or DON which meets no less than quarterly.		

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F 281	Continued From page 4 would implement interventions to address the individual's concerns and risks.  Review of the facility's Power Point presentation titled Care Planning, 04/08/13, revealed the facility identified three (3) types of care plans: the initial care plan; the comprehensive care plan; and, the acute care plan. The facility would initiate the standard template with admission and complete it within twenty-four (24) hours. The standard template served as the initial care plan and the nurse aide care sheet. When building a care plan, the facility used assessments including the elopement assessment.  Review of the facility's Combined Incident Report/Final Report, dated 08/20/15, revealed on 08/19/15 the Administrator had observed	F 281			
	Resident #7 walking in the facility around 3:05 PM on 08/19/15. At approximately 3:30 PM, an employee walking toward the bus stop observed the resident headed toward the bus stop and brought the resident back to the facility. Review of the document further revealed on 08/20/15 the facility discovered Resident #7 had a history of elopement at home. On 08/20/15, the Director of Admissions spoke with the resident's POA. The POA informed the facility the resident had a history of elopement at home. The document stated the facility did not know about the elopement history at the time of admission.  Interview with the Admissions Director, on 08/27/15 at 1:35 PM, revealed she did not specifically ask Resident #7 or the resident's Power of Attorney (POA) if the resident had a history of elopement. She stated the facility had liaisons who conducted a pre-admission assessment with residents who moved to the				



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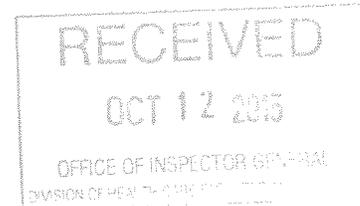
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F 281	Continued From page 5 facility directly from the hospital. However, the facility did not utilize a pre-admission assessment for residents moving from their homes. The Admissions Director stated she conducted the admission with Resident #7 and the resident's POA on the evening of 08/17/15. The Admissions Director explained to the POA that the facility had limitations concerning elopements in that the facility did not have a locked Memory Care Unit. The Admissions Director further stated she did not ask the POA if the resident had a history of elopement from another facility or from home. She stated the POA did not disclose any information regarding whether or not the resident had a history of elopement or of leaving the home or wandering.  Review of the clinical record for Resident #7 revealed the facility admitted the resident on 08/17/15 with diagnoses including Non-Alzheimer's Dementia, Coronary Artery Disease, and Difficulty in Walking.  Review of the Brief Interview for Mental Status (BIMS), dated 08/18/15, revealed the facility assessed the resident to have a BIMS score of six (6) of fifteen (15) indicating the resident was not interviewable and had moderate cognitive impairment.  Review of the Nursing Observations Assessment, dated 08/17/15 at 4:12 PM, revealed the facility admitted Resident #7 from home by wheelchair. The resident was accompanied by his/her spouse/POA. The resident had a history of a recent hospitalization due to a Syncope and Hemorrhagic Stroke. The resident was alert, but had impaired memory. The assessment stated the resident and the resident's POA stated the	F 281			

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F 281	Continued From page 6 resident was able to ambulate independently without the assistance of any device. The assessment further stated the resident's POA was present during the admission process.  Review of the Elopement Risk Screen, dated 08/17/15, revealed the facility assessed Resident #7 as not at risk for elopement. The facility completed the Elopement Risk Screen upon admission of the resident to the facility. The screen consisted of five (5) questions. The nurse marked the assessment with three (3) yes answers and two (2) no answers. The assessment stated the resident did not wander and did not have a history of elopement. The screen stated at the bottom of the assessment that two (2) or more "YES" answers indicated possible risk for elopement. It further stated if a resident had two (2) or more "YES" answers and nursing determined the resident was not at risk, nursing would provide a rationale. The nurse completing the assessment documented, the resident was currently alert and oriented, was here to get stronger, for return to home with the spouse and there was no risk for elopement at this time.  Interview with the MDS Coordinator, on 08/27/15 at 1:50 PM, revealed the Unit Managers were responsible for completing the initial one page care plan when a resident was admitted to the facility. MDS reviewed the initial care plan and created the hand written interim care plan for the resident. Afterwards, any Nurse or Nurse Manager could update the interim care plan.  Interview with the Green House Supervisor, on 8/27/15 at 2:40 PM, revealed she did not include elopement risk on the interim care plan for	F 281			



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F 281	<p>Continued From page 7</p> <p>Resident #7. The Green House Supervisor completed the intake assessments, including the elopement screen, and the interim care plan. She did not assess Resident #7 as an elopement risk and therefore did not place elopement risk on the interim care plan. The Green House Supervisor completed the initial elopement evaluation and did not ask Resident #7 or the resident's POA if the resident had a history of elopement or of leaving the home.</p> <p>Review of the Interim Care Plan for Resident #7, dated 08/17/15, revealed the facility placed no interventions identifying or reducing the elopement risk on the resident's Interim Care Plan.</p> <p>Review of the Physician's Telephone Orders for Resident #7, dated 08/19/15, revealed the facility received an order to place a code alert to the resident's ankle. The order included instruction for staff to check the placement of the code alert bracelet every hour.</p> <p>However, review of the Interim Care Plan for Resident #7, dated 08/18/15, revealed an interim care plan for elopement was not developed until 08/20/15, three (3) days after admission and two (2) days after the elopement. Interventions in the care plan included staff to check placement of the code alert per physician's orders, staff to check the function of the code alert per physician's orders, monitor resident's whereabouts, redirect the resident as needed, and provide activities for diversion.</p> <p>Interview with RN #1, on 08/26/15 at 11:05 AM, revealed the morning of 08/19/15, RN #1 observed the resident gathering his/her</p>	F 281			

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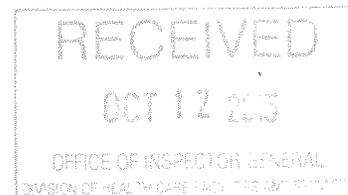
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F 281	<p>Continued From page 8</p> <p> belongings. She also observed the resident walking throughout the facility with no walker and the resident stated he/she was looking for their truck. RN #1 stated she consulted with the Assistant Unit Manager and placed a code alert bracelet on Resident #7's wrist; but did not develop an interim care plan for elopement.</p> <p>Interview with the Blue Assistant Unit Manager, on 08/26/15 at 3:20 PM, revealed RN #1 informed her of Resident #7's increased exit seeking behaviors. RN #1 placed a code alert bracelet on the resident due to the resident wandering the facility and looking for his/her truck. The Assistant Unit Manager stated she was the acting supervisor for the nurses on the floor, but did not ensure the RN for Resident #7 developed an interim care plan for elopement. The Assistant Unit Manager stated she did not communicate the increased exit seeking behaviors with other staff and did not add any increased supervision to ensure the safety of the resident.</p> <p>Interview with the Director of Nursing (DON), on 08/27/15 at 2:18 PM, revealed the facility did not develop and interim care plan for Resident #7 after becoming aware of an increased elopement risk. The DON stated because nursing had already placed the code alert on the resident, she assumed the nursing staff had completed other requirements, such as placing it on the care plan. The DON stated she did not check until after the resident eloped later on that afternoon.</p> <p>Interview with the Administrator, on 08/27/15 at 4:07 PM, revealed the facility did not care plan Resident #7 for increased risk for elopement due to not performing a thorough assessment to determine Resident #7 was at increased risk for</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>elopement. Part of completing the elopement assessment included staff asking family about elopement risk. The facility did not identify Resident #7 as an elopement risk until 08/19/15. Admissions addressed elopement risks with the family; however, they were not required to ask the family if the resident had a history of elopement. Per interview, it is part of the Elopement Risk Screen for nursing to ask the resident's family if the resident had a history of elopement.</p> <p>Interview with Resident #7's POA, on 08/25/15 at 1:45 PM, revealed the facility did not ask the POA about elopement concerns, precautions, or interventions prior to the resident eloping from the facility.</p> <p>The facility took the following actions to remove the Immediate Jeopardy:</p> <p>1. The Elopement Policy was reviewed by the Administrator, Director of Nursing (DON), Unit Managers, Corporate staff and Medical Director on 08/28/15. The Elopement Policy required: residents to be screened upon admission/readmission, between day three (3) and seven (7), between day thirty (30) and forty-five (45), quarterly and with any significant change. Residents identified at risk for elopement would have a care plan developed to eliminate or reduce the risk of elopement. The facility would maintain a list of all residents identified at risk for elopement at the reception area and in each Medication Administration Record (MAR). If a Code Alert bracelet was utilized, placement was checked every shift and function was checked no less than weekly. All monitored doors would be checked not less than weekly for function.</p>	F 281			



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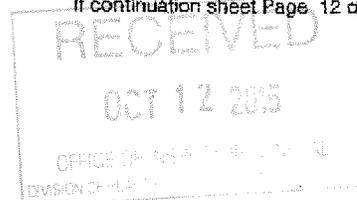
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F 281	<p>Continued From page 10</p> <p>2. All current ninety-four (94) residents' Elopement Risk Screens were reviewed to ensure accurate and timely assessments and the care plans and nurse aide care plans for the twelve (12) residents identified at risk for elopement were reviewed to ensure all appropriate interventions were in place, on 08/27/15 by the Staff Development Nurse, the Minimum Data Set (MDS) nurse, the Assistant Director of Nursing (ADON) and Unit Mangers. All were determined to be correct with exception of one care plan. It was determined all newly admitted residents would have an Elopement Risk Screen completed by the admitting nurse and the Elopement Risk Screen would be reviewed by the Director of Nursing, Unit Manager or House Supervisor to ensure accurate screening to begin 08/27/15 and continue for three (3) months. In addition, the Unit Managers and Assistant Managers verified the list of residents identified at risk for elopement was on each MAR and at the reception area on 08/27/15. On 08/28/15, the MARs and Treatment Administration Records (TARs) were checked by the DON retroactively to 08/01/15 for the twelve (12) residents identified as at risk for elopement to ensure all placement and function checks were completed.</p> <p>3. The Administrator completed a review of all exterior door function checks on 08/27/15 for the past sixty (60) days to ensure the policy was followed.</p> <p>4. On 08/28/15 a Quality Assurance (QA) meeting was held with the Medical Director, Corporate Consultant, Vice President of Operations, Administrator, DON and Unit Managers to review the Immediate Jeopardy (IJ)</p>	F 281			

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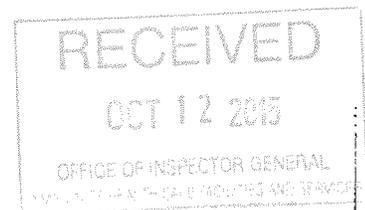
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F 281	Continued From page 11 notification and the process and interventions to remove the IJ, review of facility policy and actions currently underway in regards education and audits. All in attendance at the meeting voiced understanding and agreement with the plan with no additional recommendations made. It was determined at the meeting all audits would be reported to a QA subcommittee that would meet no less than monthly for six (6) months and then no less than quarterly to ensure sustained compliance.  5. Re-education on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behavior and interventions to address exit seeking behavior was initiated on 08/27/15 and concluded on 08/28/15 for staff. No staff would be allowed to work until re-educated. The re-education included a pre and post test and was completed by the Administrator, DON, and Administrative Nurses to include MDS, Staff Development, House Supervisor, Unit Managers and Assistant Unit Managers. The facility did not utilize agency staff but did utilize contract therapy staff. All regular contract therapy staff had been trained on 08/28/15 and no as needed (prn) contract staff would be allowed to work until re-educated.  6. On 08/28/15 education on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behavior and Interventions to address exit seeking behaviors was added to the new hire orientation by the Staff Development Coordinator and that education would be repeated no less than annually by administrative nurses including Staff Development, the Administrator, DON, ADON and Unit Managers.	F 281			



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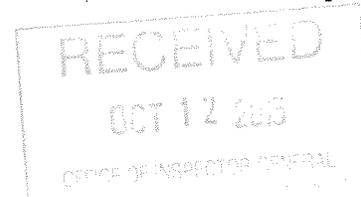
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F 281	Continued From page 12  7. Audits on Elopement Risk Screens, MAR, TAR, Care Plans and Nurse Aide Care Plans were to be done daily for seven (7) days, then weekly for three (3) weeks, then monthly for twelve (12) months to ensure accuracy and timeliness of the screens and placement and function checks with audits initiated on 08/28/15. Audits of all exterior door checks initiated on 08/28/15 are to be done weekly for three (3) months then monthly for twelve (12) months. Audit of review of new Elopement Risk Screens to be done weekly for three (3) months and was initiated on 08/28/15. Audits of education for newly hired employees to be completed weekly for twelve (12) months were initiated on 08/28/15. Audit of list at reception area and on MAR of all residents at risk for elopement to be completed weekly for three (3) weeks and then monthly for twelve (12) months were initiated on 08/28/15.  The State Survey Agency validated the implementation of the acceptable AOC as follows:  1. Review of the facility Elopement Policy on 09/10/15 revealed it contained all points as alleged. Interview with the Administrator, on 09/10/15 at 8:58 AM, the Director of Nursing (DON), on 09/10/15 at 9:25 AM, the Unit Manager, on 09/10/15 at 9:40 AM, the Blue Unit Manager, on 09/10/15 at 10:04 AM, the Vice President of Operations, on 09/10/15 at 10:25 AM via telephone, the Corporate Consultant, on 09/10/15 at 10:35 AM and the Medical Director, on 09/10/15 at 8:45 AM revealed they had reviewed the facility's Elopement Policy as alleged on 08/28/15.	F 281			



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F 281	<p>Continued From page 13</p> <p>2. Review of the clinical records for sampled Residents' #20, #21, #22 and #23, who were assessed as elopement risks, revealed all had accurate, timely Elopement Risk Screens and appropriate interventions in place on their care plans and nurse aide care plans. Review of the MARs and TARs for Residents #20, #21, #22 and #23 revealed they had all placement and function checks completed for their Code Alert Bracelets documented back to 08/01/15.</p> <p>Interview with the Staff Development Nurse, on 09/10/15 at 9:45 AM, the Green Unit Nurse Manager, on 09/10/15 at 9:40 AM, and the Blue Unit Nurse Manager, on 09/10/15 at 10:04 AM, revealed they were all involved in an audit of the ninety-four (94) residents' (census as of 08/27/15) Elopement Risk Screens on 08/27/15 to ensure accurate and timely assessments.</p> <p>In addition, the Staff Development nurse, the Green Unit Nurse Manager, the Blue Unit Nurse Manager, the Green Unit Assistant Manager, on 09/10/15 at 9:10 AM and the Blue Unit Assistant Manager, on 09/10/15 at 9:58 AM, all revealed they participated in reviewing the care plans and the nurse aide care plans to ensure appropriate interventions were in place on 08/27/15 for risk of elopement.</p> <p>Further interview with the Green Unit Nurse Manager, the Blue Unit Nurse Manager, the Green Unit Assistant Manager, on 09/10/15 at 9:10 AM and the Blue Unit Assistant Manager, on 09/10/15 at 9:58 AM, all revealed they verified the list of residents identified at risk for elopement was on each MAR and at the reception area on 08/27/15.</p>	F 281			



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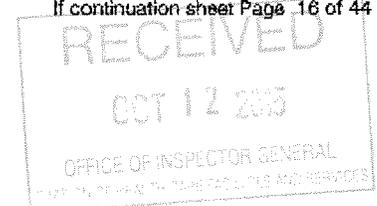
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F 281	<p>Continued From page 14</p> <p>Interview with the DON, on 09/10/15 at 9:25 AM, the Green Unit Nurse Manager, on 09/10/15 at 9:40 AM, the Blue Unit Nurse Manager, on 09/10/15 at 10:04 AM, and an RN Supervisor, on 09/10/15 at 12:30 PM, revealed they understood they were to review the Elopement Risk Screen completed for all newly admitted residents. No residents had been newly admitted.</p> <p>3. Review of exterior door function checks revealed they had been completed for sixty (60) days prior to 8/27/15 per the facility policy. Interview with Maintenance Staff #1 and Maintenance Staff #2, on 09/10/15 at 10:15 AM, revealed they had been completing the door function checks per the facility policy for the sixty (60) days prior to 08/27/15 and were continuing to do so. They indicated they had and would continue to provide computer generated print-outs of the door checks to the Administrator. Interview with the Administrator, on 09/10/15 at 9:10 AM, revealed she did receive and was continuing to receive the door function checks from the Maintenance personnel and she was conducting an audit of those function checks as evidenced by her signature and date reviewed on the computer print-outs for the door checks. Observation of the exterior doors on the Blue Unit, the 600 hallway, the Blue Unit dining room, the main dining room, the back door by the kitchen, the Green Unit dining room, the 300 hallway and the 200 hallway, on 09/10/15 from 8:25 AM - 9:15 AM, revealed all alarms operational per policy.</p> <p>4. Review of the Quality Assurance (QA) Meeting signature sheet revealed a meeting was held on 08/28/15 to review the Immediate Jeopardy (IJ) Notification, the process to remove the IJ, review</p>	F 281			

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F 281	Continued From page 15 of the facility Elopement Policy and actions to be taken in regard education and audits.  Telephone interview with the Vice President of Operations, on 09/10/15 at 10:25 AM, and the Corporate Consultant, on 09/10/15 at 10:35 AM revealed they had been present in the QA Meeting held on 08/27/15 at the facility and it was decided all audits would be reported to a QA subcommittee which would meet no less than monthly for six (6) months and then no less than quarterly to ensure sustained compliance.  Interview with the Administrator, on 09/10/15 at 8:58 AM, revealed she had been present in the QA Meeting held on 09/10/15 to discuss the U. Interview with the Director of Nursing (DON), on 09/10/15 at 9:25 AM, revealed she had been present in the QA Meeting held on 09/10/15 to discuss the IJ and interview with the Blue and Green Unit Managers, on 09/10/15 at 9:40 AM and 10:04 AM, revealed they had also been present in that QA Meeting. Interview with the Medical Director, on 09/10/15 at 8:45 AM, revealed he had been present at the QA Meeting to review the IJ Notification, the process to remove the I.), review of the facility Elopement Policy and actions to be taken in regard education and audits.  5. Telephone interview with the Vice President of Operations, on 09/10/15 at 10:25 AM, and the Corporate Consultant, on 09/10/15 at 10:35 AM revealed they held a meeting on 08/27/15 to re-educate the administrative staff of the facility on the Elopement Policy, the Elopement Risk Screen, behavioral indicators for exit seeking behavior and interventions to address exit seeking behaviors.	F 281			



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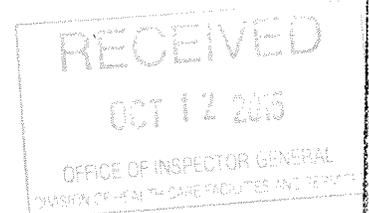
F 281	<p>Continued From page 16</p> <p>Interview with the Administrator, on 09/10/15 at 8:58 AM, the DON, on 09/10/15 at 9:25 AM, the Green Unit Manager, on 09/10/15 a 9:40 AM, the Blue Unit Manager, on 09/10/15 at 10:04 AM, the Staff Development Nurse, on 09/10/15 at 9:45 AM, the Blue Unit Assistant Nurse Manager, on 09/10/15 at 9:58 AM, the Green Unit Assistant Nurse Manager, on 09/10/15 at 9:10 AM, and the RN Supervisor, on 09/10/15 at 12:30 PM, revealed they had received re-education on the Elopement Policy, the Elopement Risk Screen, behavioral indicators for exit seeking behaviors and interventions to address exit seeking behaviors by the Vice President of Operations and the Corporate Consultant on 08/27/15 and prior to the administrative staff giving any re-training to the other facility staff. They all indicated they participated in re-training the other facility staff ending on 08/28/15 and indicated no staff would be allowed to work until they had received the re-training.</p> <p>6. Interview with the Staff Development Nurse, on 09/10/15 at 9:45 AM, revealed she had done most of the staff re-training beginning on 08/27/15 and ending on 08/28/15 and she had added training on the Elopement Policy, the Elopement Risk Screen, behavioral indicators for exit seeking behavior and interventions to address exit seeking behaviors to the new hire orientation and that training would be repeated for facility staff no less than annually by administrative nurses.</p> <p>Review of the new hire orientation documents revealed the training had been added to the content by the Staff Development Nurse as alleged.</p>	F 281		
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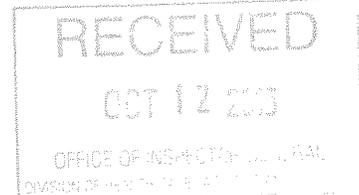
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F 281	Continued From page 17  7. Audits on Elopement Risk Screens, MARs, TARs, Care Plans and Nurse Aide Care Plans, exterior door checks, education of newly hired employees, and the audit of the list of residents at risk of elopement kept at the reception area and on the MARs for those residents completed by 09/10/15 were reviewed and were completed as alleged.  Interview with the DON, on 09/10/15 at 9:25 AM, the Green Unit Manager, on 09/10/15 at 9:40 AM, the Blue Unit Manager, on 09/10/15 at 10:04 AM, the Staff Development Nurse, on 09/10/15 at 9:45 AM, the Blue Unit Assistant Nurse Manager, on 09/10/15 at 9:58 AM, the Green Unit Assistant Nurse Manager, on 09/10/15 at 9:10 AM, revealed they were involved in doing audits of the list of residents at risk of elopement kept at the reception area and on the MARs and TARs and of their Elopement Risk Assessments, care plans and nurse aide care plans and submit those audits to the Administrator.  Interview with Maintenance #1 and Maintenance #2, on 09/10/15 at 10:15 AM, revealed they had been completing the door function checks per the facility policy and submit those checks to the Administrator as alleged.  Interview with the Administrator, on 09/10/15 at 8:58 AM, revealed she received all audits to date and reviewed them and will continue to do so to ensure sustained compliance.	F 281		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident	F 323	Resident #7 was discharged home with wife on 8-27-15.	10/13/15



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F 323	<p>Continued From page 18</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review and review of the facility's incident reports, it was determined the facility failed to have an effective system to provide adequate supervision to prevent the elopement of one (1) of nineteen (19) sampled residents, Resident #7.</p> <p>On 08/19/15, Resident #7 eloped from the facility without staff knowledge. An employee of the facility was walking to the bus stop on a busy two-lane road after completing his shift and observed the resident sitting in a wheelchair and attempting to cross a busy two-lane road approximately 0.4 miles from the facility. The temperature was eighty-six (86) degrees Fahrenheit (F) with intermittent clouds and a breeze up to fourteen (14) miles per hour. The resident was wearing an orange shirt, bib overalls, a hat, and sneakers. The resident was returned to the facility at approximately 3:30 PM and assessed with no injuries identified.</p> <p>The facility's failure to ensure adequate supervision was provided to prevent the elopement of a newly admitted resident with a history of elopement has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 08/27/15 and determined to exist on 08/19/15.</p>	F 323	<p>On 8-27-15 all other current residents Elopement Risk Screens were audited by the Staff Development Coordinator, MDS Coordinators, ADON and Unit Managers to ensure that each resident was screened accurately, there were no residents that were screened 'not at risk' that were changed to 'at risk'. On 8-27-15 the care plans for the 12 residents that were determined to be 'at risk' were reviewed by the Staff Development Coordinator, MDS Coordinators, ADON and Unit Managers to ensure that they included the resident being at risk for elopement. On 8-27-15 the Administrator reviewed all exterior door functions checks for the last 60 days to ensure that the doors were checked on a weekly basis and functioning. On 8-27-15 the Unit Managers and Assist Unit Managers verified that a list of those residents at risk for elopement was at the reception area and on each MAR. On 8-28-15 the DON checked the MAR's and TAR's of all residents assessed to be at risk for elopement to ensure that placement and function checks were completed.</p> <p>No changes were made to the policy.</p> <p>All staff were re-educated by the House Supervisor, Staff Development Coordinator, MDS Coordinators, DON, Administrator, Unit Managers and Assistant Unit Managers on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behavior and Interventions to address exit seeking behavior.</p>	



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F 323	<p>Continued From page 19</p> <p>The facility was notified of the Immediate Jeopardy on 08/27/15.</p> <p>The facility provided an acceptable allegation of compliance (AOC) on 09/02/15 alleging compliance on 08/29/15. The State Survey Agency validated the removal of Immediate Jeopardy on 08/29/15 as alleged prior to exit on 09/10/15. The scope and severity was lowered to a "D" while the facility implements the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Elopement, dated 02/18/09, revealed the facility would assess all residents for elopement risk upon admission and with any significant change in Activities of Daily Living (ADL) function or cognitive function. The facility would use the Elopement Risk Assessment. The Elopement Risk Assessment would indicate a resident had an increased risk for elopement if the facility determined the answer to two (2) or more of the five (5) questions on the assessment was a "Yes". The assessment further stated if a resident had two (2) or more "Yes" answers and the facility determined the resident was not at risk for elopement, the facility would provide a rationale. If the assessment determined the resident was at risk for elopement, the facility would develop a care plan to include interventions such as increased monitoring, use of one-on-one services, bed alarms, code alerts, and activity programs. The policy further stated the facility should develop a plan to eliminate or reduce the risk of elopement.</p>	F 323	<p>All staff were educated by 8-28-15 or not allowed to work until the education was completed. On 8-28-15 the education on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behaviors and interventions to address exit seeking behaviors were added to the new hire orientation by the Staff Development Coordinator, all newly hired staff will receive the education during orientation which is overseen by the Staff Development Coordinator. This education will be repeated for all facility staff not less than annually by administrative nurses, including the Staff Development Coordinator, DON, ADON, Administrator and Unit Managers.</p> <p>All newly admitted residents will have an Elopement Risk Screen completed by the admitting nurse. The DON, ADON, Unit Manager, Assistant Manager or House Supervisor will complete the New Admit Elopement Risk Screen audit on all new admissions weekly for 2 months and then 25% of new admissions will be completed monthly for 3 months and then 25% quarterly to ensure accurate screening.</p> <p>The Elopement Audit on Elopement Risk Screens, MAR, TAR, Care Plans and Nurse Aide Care Plans for residents assessed at being at risk for elopement will be completed by the DON, ADON, Unit Manager, Assistant Manager or House Supervisor monthly for 12 months to ensure accuracy and timeliness of the screens and placement and function checks.</p>	

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F 323	Continued From page 20 Review of the clinical record for Resident #7 revealed the facility admitted the resident on 08/17/15 with diagnoses including Non-Alzheimer's Dementia, Coronary Artery Disease, and Difficulty in Walking.  Review of the Nursing Observations Assessment, dated 08/17/15 at 4:12 PM, revealed the facility admitted Resident #7 from home by wheelchair. The resident was accompanied by his/her spouse/Power of Attorney (POA). The resident had a history of recent hospitalization due to a Syncope and Hemorrhagic Stroke. The resident was alert, but had impaired memory. The assessment stated the resident and the resident's POA said Resident #7 was able to ambulate independently without the assistance of any device.	F 323	Audits on the function of all exterior door checks will be completed weekly for 6 weeks then monthly for 12 months by the Administrator or DON.  New Employee Orientation Audits will be completed by the DON, ADON or Administrator weekly for 12 months to ensure that all newly hired staff have received education on elopement.  All audits to be reported to QA subcommittee by the DON or Administrator that will meet no less than monthly for 6 months then no less that quarterly to ensure sustained compliance. The findings from QA Subcommittee will be presented to the Quality Assurance Committee by the Administrator or DON which meets no less than quarterly.		
	Review of the Elopement Risk Screen, dated 08/17/15, revealed the Green House Unit Supervisor completed the Elopement Risk Screen upon admission of Resident #7 to the facility. The screen consisted of five (5) questions. The nurse marked "YES" to the first question stating the resident was physically able to leave the facility on his/her own. The nurse marked "YES" to the second question stating the resident was a new admission. The nurse marked "YES" to the third question stating the resident exhibited periods of confusion. The nurse marked "NO" to the fourth question indicating the resident did not have a history of leaving the facility or the home. The nurse marked "NO" to the last question indicating the resident did not exhibit periods of pacing, agitation, or wandering. The screen stated at the bottom of the assessment that two (2) or more "YES" answers indicated possible risk for				

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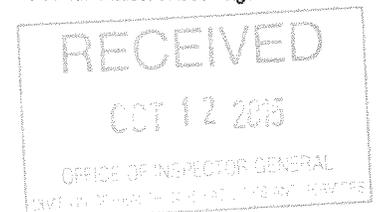
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F 323	<p>Continued From page 21</p> <p>elopement. It further stated if a resident had two (2) or more "YES" answers, and nursing determined the resident was not at risk, nursing would provide a rationale. The nurse completing the assessment documented, "Resident is currently alert and oriented, states that [he/she] is here to get stronger, so that he/she can return home with spouse. 0 risk for elopement at this time."</p> <p>Interview with the Green House Unit Supervisor, on 08/27/15 at 2:40 PM, revealed she completed the initial elopement evaluation and did not ask Resident #7 or the resident's POA if the resident had a history of elopement or leaving the home. The Green House Unit Supervisor stated she did ask the resident if he was planning to leave the facility. The resident replied saying he/she was there to get better. The Green House Unit Supervisor also stated the resident was able to say where he/she was and what day it was. Therefore, despite the three (3) "YES" answers on the Elopement Risk Screen, the Green House Unit Supervisor stated at the time she did not believe the resident was at risk for elopement. The Green House Unit Supervisor stated she did not directly ask the resident or his/her POA if the resident had any prior history of elopement.</p> <p>Review of the Initial Care Plan for Resident #7, dated 08/17/15, revealed the facility placed no interventions identifying or reducing the elopement risk on the resident's Initial Care Plan.</p> <p>Review of the Brief Interview for Mental Status (BIMS), 08/18/15, revealed the facility assessed the resident to have a BIMS score of six (6) of fifteen (15) indicating the resident was not interviewable and had moderate cognitive</p>	F 323			

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F 323	<p>Continued From page 22 impairment.</p> <p>Review of the facility's Combined Incident Report/Final Report, dated 08/20/15, revealed the Administrator observed Resident #7 walking down the 400 Hall of the facility around 3:05 PM on 08/19/15. At approximately 3:30 PM, an employee walking toward the bus stop observed the resident headed toward the bus stop and brought the resident back to the facility.</p> <p>Interview with the Dietary Aid, on 08/26/15 at 2:15 PM, revealed the Dietary Aid discovered Resident #7 crossing a busy two-lane road unattended on 08/19/15 a little after 3:00 PM. The Dietary Aid stated his shift ended at 3:00 PM and he was heading toward the bus stop when he realized he had forgotten something and returned to the facility. Then he proceeded to the bus stop where he observed an elderly person sitting in a wheelchair and self-propelled across the two-lane road. The Dietary Aid approached the elderly person and recognized him/her as Resident #7. He told the resident that he had to take him/her back to the facility. The resident resisted some by placing his/her hands on the armrests as if to stand-up and by pushing back into the chair. The Dietary Aid told the resident that he/she must sit down and the resident stopped resisting. Resident #7 told the Dietary Aid that he/she just wanted to go outside and get some fresh air. He stated the resident was wearing an orange shirt, bib overalls, a hat, and sneakers.</p> <p>Interview with the Physical Therapist Assistant (PTA), on 08/26/15 at 2:45 PM, revealed the resident had exhibited exit-seeking behaviors prior to 08/19/15. The PTA stated Resident #7 packed up his/her belongings every day as if to</p>	F 323			



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F 323	<p>Continued From page 23</p> <p>leave the facility. This behavior started the first day the resident was at the facility. The resident also talked about needing to get to his/her truck on the first day at the facility. However, per interview she did not report these behaviors to nursing staff. The PTA stated she did not identify these actions as elopement risks because the actions were similar to other residents at the facility who would often discuss their past lives as if it were the present.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 08/26/15 at 3:05 PM, revealed Resident #7 had been exit seeking on 08/18/15, the day before he/she eloped from the facility. CNA #1 stated on the morning of 08/18/15 Resident #7 met her at the door and asked the CNA to help find his/her truck. The CNA stated she did inform the nurse of the resident's exit seeking behaviors, but was unaware of what actions nursing took to protect the resident.</p> <p>Interview with Blue House Unit Manager, on 08/26/15 at 3:30 PM, revealed Resident #7 discussed wanting to leave the facility prior to 08/19/15. The Blue House Unit Manager stated Resident #7 began saying he/she needed to go home and cut the grass on 08/18/15, the day prior to the elopement. The Blue House Unit Manager stated he did not consider these statements as exit seeking and did not report the statements about wanting to leave the facility.</p> <p>Interview with Registered Nurse (RN) #1, on 08/26/15 at 11:05 AM, revealed on the morning of 08/19/15, RN #1 observed the resident gathering his/her belongings. She also observed the resident walking throughout the facility with no walker. The resident told the RN that he/she was</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>looking for their truck. RN #1 stated she consulted with the Assistant Unit Manager and placed a code alert bracelet on Resident #7's wrist the morning of 08/19/15. RN #1 stated she did not remember documenting the placement of the code alert bracelet in the nurses' notes. RN #1 also stated she did not call the physician for an order for the bracelet because she assumed the Assistant Unit Manager would call for the order. After placing the code alert bracelet, RN #1 informed the CNA, but did not put in place a specific increment of time or check-list in which to increase supervision. She stated the resident was out of the room and walking around the facility more that day, however, she did not notify staff about the resident's increased walking. RN #1 did not update the Care Plan to address elopement risk or include elopement risk interventions. She stated she thought the supervisor would update the care plan after completing an elopement risk assessment. RN #1 revealed she last observed Resident #7 when she provided care between 1:00 PM and 1:30 PM on 08/19/15.</p> <p>Continued interview with CNA #1, on 08/26/15 at 3:05 PM, revealed on 08/19/15, RN #1 informally and verbally told the CNA to check on Resident #7 more often and that the resident had a code alert bracelet. The CNA stated she was not told how often to check on the resident. CNA #1 stated her last observation of Resident #7 on 08/19/15 was approximately 2:30 PM when she gave the resident a soda.</p> <p>Interview with Assistant Unit Manager (AUM), on 08/26/15 at 11:20 PM, revealed she was the acting supervisor for the nurses on the floor on 08/19/15. She did not notify staff, document, or</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>increase supervision of Resident #7 after RN #1 reported the resident exhibited increased exit seeking behaviors on the morning of 08/19/15. Pre interview, RN #1 placed a code alert bracelet on the resident due to the resident wandering the facility and looking for his/her truck. The Assistant Unit Manager stated for the safety of the resident, a nurse might place a code alert bracelet on a resident first, and then obtain a physician's order and either the nurse or the Unit Manager (UM) may obtain the Physician's Order. She did not ensure the RN for Resident #7 made a notation on the care plan or in the nurse's notes of the addition of the code alert bracelet. Additionally, the Assistant Unit Manager on duty was responsible for completing a new Elopement Risk Assessment, however, she did not complete the assessment during the shift.</p> <p>Interview with the Director of Nursing (DON), on 08/27/15 at 2:18 PM, revealed Resident #7 had walked out of the facility on the morning of 08/19/15 while wearing a code alert bracelet. Per interview, at 7:30 AM on the morning of 08/19/15 she observed Resident #7 pushing his/her wheelchair with his/her belongings in the seat of the wheelchair. She stated the resident was wearing the code alert, walked out the front door, and, met a facility manager, who then walked around outside with the resident. However, the facility did not increase supervision or complete an elopement assessment at that time.</p> <p>Further interview with the AUM, on 08/26/15 at 11:20 PM revealed she went to the morning meeting, Interdisciplinary Team (IDT) meeting; however, she did not discuss Resident #7's new alarm or the exit seeking behaviors with staff in the IDT meeting. The AUM stated she had left</p>	F 323		

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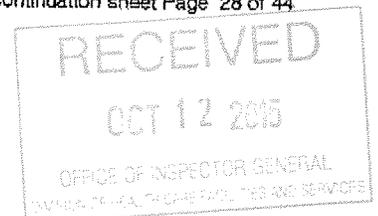
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F 323	<p>Continued From page 26</p> <p>the floor to attend meetings and returned to the floor around noon. At that time, she stated she was doing several other tasks and did not return to the subject of Resident #7's elopement risk.</p> <p>Further interview with the Blue Unit Manager, on 08/27/15 at 9:50 AM, revealed she attended the morning meeting and discussed Resident #7's exit seeking behaviors. However, in the meeting, nursing did not state they had placed the code alert bracelet on the resident just that morning. The facility did not discuss increasing supervision for Resident #7 at this meeting.</p> <p>Further interview with the DON, on 08/27/15 at 2:18 PM, revealed in the morning meeting on 08/19/15, staff discussed the resident's exit seeking behaviors; that the resident was wearing a code alert bracelet; and, that nursing would monitor the resident. However, interviews with staff said this was not discussed during the meeting.</p> <p>Review of the Nursing Notes, dated 08/19/15 at 3:46 PM, revealed an employee found Resident #7 by a bus stop. In the note, the nurse stated the resident was not wearing the code alert bracelet. Nursing found the bracelet in one of the resident's bags. The facility informed the Physician and the resident's family. At the time of the resident's return to the facility, the resident was stating he/she was looking for their truck.</p> <p>Interview with the Blue House Unit Manager, on 08/27/15 at 9:50 AM, revealed she was at the facility when the Dietary Aid returned Resident #7 to the facility. The resident was not wearing a code alert bracelet when he/she returned. Nursing staff found the bracelet in the resident's</p>	F 323			

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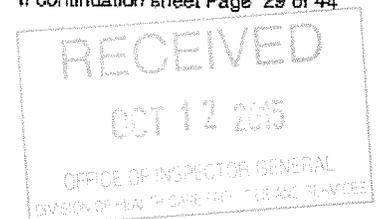
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F 323	<p>Continued From page 27</p> <p>room among his/her other belongings. The Blue Unit Manager placed a new code alert bracelet on the resident's ankle.</p> <p>Review of the Physician's Telephone Orders for Resident #7, dated 08/19/15, revealed the facility received an order to place a code alert to the resident's ankle. The order included instruction for staff to check the placement of the code alert bracelet every hour.</p> <p>However, review of the Medication Administration Record (MAR), dated 08/17/15 through 08/31/15, revealed the facility did not begin checking the resident to ensure the code alert bracelet was in place until 08/20/15 at 7:00 AM.</p> <p>Further review of the resident's clinical record revealed a Nursing Note, dated 08/20/15 at 4:11 PM, stating a CNA found a piece of the code alert on the resident's floor. The code alert was still in place at that time.</p> <p>Review of the Nursing Notes, 08/19/15 at 10:30 PM, revealed the Blue House Unit Supervisor discovered Resident #7 in his/her room without wearing the code alert bracelet. He asked the nurse who stated he/she had cut off the code alert bracelet with a pair of toenail clippers. The Blue House Unit Supervisor placed a new code alert on the resident's left ankle.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 08/27/15 at 3:00 PM, revealed the LPN discovered Resident #7 was not wearing the second code alert bracelet at 10:00 PM on 08/19/15. The LPN reported she had checked on the resident at approximately 9:30 PM and the resident was wearing the code alert bracelet on</p>	F 323			



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F 323	<p>Continued From page 28</p> <p>his/her ankle. LPN #1 stated the CNA informed her Resident #7 was not wearing the code alert bracelet at approximately 10:00 PM. LPN #1 asked Resident #7 what he/she had in their pocket and the resident pulled out two (2) pair of nail clippers. Nursing staff found the second code alert bracelet in the resident's room and it appeared someone had cut the bracelet in a "V" shape. The LPN placed a new code alert bracelet on the resident's ankle.</p> <p>Review of the Physician's Telephone Orders for Resident #7, dated 08/20/15, revealed the physician ordered nursing staff to place a code alert device on the resident's wheel chair.</p> <p>Further review of the facility's Combined Incident Report/Final Report, dated 08/20/15, revealed the facility called the resident's Power of Attorney (POA) who informed the facility the resident might have a pocket knife. Employees searched and found a pocket knife and the intact code alert bracelet in the resident's room. The POA also informed the facility the resident had been looking for his/her truck, which the family sold years ago. Nursing placed Resident #7 on increased supervision for nursing to check the code alert every hour. Later in the evening, nursing staff found two (2) nail clippers in the resident's room. Review of the document further revealed that on 08/20/15 the facility discovered Resident #7 had a history of elopement from home. On 08/20/15, the Director of Admissions spoke with the resident's POA. The POA informed the facility he/she had a history of elopement from the resident's personal home. The document stated the facility did not know about the elopement history at the time of admission.</p>	F 323			



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F 323	<p>Continued From page 29</p> <p>Further interview with the Blue House Unit Manager, on 08/27/15 at 9:50 AM, revealed she talked with the resident's POA who stated the resident might have a pocket knife. Further search of the resident's belongings revealed a pocket knife and two (2) pair of nail clippers. The facility discussed Resident #7's exit seeking behaviors and elopement in morning meeting on 08/20/15. At this time, nursing staff initiated one (1) hour visual checks of the resident to ensure the resident's safety and placement of the code alert bracelet. Nursing staff also updated the resident's care plan and CNA care sheet on 08/20/15.</p> <p>Review of the Interim Care Plan for Resident #7, dated 08/18/15, revealed on 08/20/15 the facility updated the resident's care plan to include elopement interventions. Interventions in the care plan included staff to check placement of the code alert per physician's orders, staff to check the function of the code alert per physician's orders, monitor resident's whereabouts, redirect the resident as needed, and provide activities for diversion.</p> <p>Interview with the Administrator, on 08/27/15 at 4:07 PM, revealed Admissions addressed elopement risks with the family; however, they were not required to ask the family if the resident had a history of elopement. It was part of the Elopement Risk Screen for nursing to ask the resident's family if the resident had a history of elopement.</p> <p>Interview with the Admissions Director, on 08/27/15 at 1:35 PM, revealed she did not specifically ask Resident #7 or the resident's POA if the resident had a history of elopement at the</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>time of admission. She stated the facility had liaisons who conducted a pre-admission assessment with residents who moved to the facility directly from the hospital. However, the facility did not utilize a pre-admission assessment for residents moving from their homes. The Admissions Director stated she conducted the admission with Resident #7 with the resident's POA present on the evening of 08/17/15. The Admissions Director explained to the POA that the facility had limitations concerning elopements in that the facility did not have a locked memory care unit. The Admissions Director further stated she did not ask the POA if the resident had a history of elopement from any other facilities or from home. She stated the POA did not disclose any information regarding whether or not the resident had a history of elopement, leaving the home, or wandering.</p> <p>Interview with Resident #7's Power Of Attorney (POA), on 08/25/15 at 1:45 PM, revealed the facility did not ask the POA about elopement concerns, precautions, or interventions prior to the resident eloping from the facility. The POA stated the facility admitted Resident #7 from home for short-term rehab following surgery to his/her carotid artery. The POA further stated the resident had Dementia that included short-term memory loss and did not remember eloping from the facility on 08/19/15. The resident presented well in the moment, but may not remember what was going on earlier in the day. The POA stated the resident was often confused. The POA visited with the resident on 08/19/15 during the day and the facility did not discuss elopement concerns with the POA at the time of the visit. The facility called the POA after the resident eloped from the facility on the afternoon of</p>	F 323			

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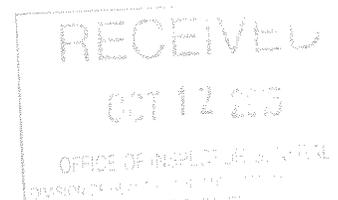
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F 323	<p>Continued From page 31 08/19/15.</p> <p>Observation and interview with Resident #7, on 08/25/15 at 1:45 PM, revealed the resident was able to answer yes/no questions by nodding or shaking his/her head. Resident #7 had no memory of having eloped from the facility on 08/19/15.</p> <p>The facility took the following actions to remove the Immediate Jeopardy:</p> <p>1. The Elopement Policy was reviewed by the Administrator, Director of Nursing (DON), Unit Managers, Corporate staff and Medical Director on 08/28/15. The Elopement Policy required: residents to be screened upon admission/readmission, between day three (3) and seven (7), between day thirty (30) and forty-five (45), quarterly and with any significant change. Residents identified at risk for elopement would have a care plan developed to eliminate or reduce the risk of elopement. The facility would maintain a list of all residents identified at risk for elopement at the reception area and in each Medication Administration Record (MAR). If a Code Alert bracelet was utilized, placement was checked every shift and function was checked no less than weekly. All monitored doors would be checked not less than weekly for function.</p> <p>2. All current ninety-four (94) residents' Elopement Risk Screens were reviewed to ensure accurate and timely assessments and the care plans and nurse aide care plans for the twelve (12) residents identified at risk for elopement were reviewed to ensure all appropriate interventions were in place, on</p>	F 323			

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F 323	<p>Continued From page 32</p> <p>08/27/15 by the Staff Development Nurse, the Minimum Data Set (MDS) nurse, the Assistant Director of Nursing (ADON) and Unit Mangers. All were determined to be correct with exception of one care plan. It was determined all newly admitted residents would have an Elopement Risk Screen completed by the admitting nurse and the Elopement Risk Screen would be reviewed by the Director of Nursing, Unit Manager or House Supervisor to ensure accurate screening to begin 08/27/15 and continue for three (3) months. In addition, the Unit Managers and Assistant Managers verified the list of residents identified at risk for elopement was on each MAR and at the reception area on 08/27/15. On 08/28/15, the MARs and Treatment Administration Records (TARs) were checked by the DON retroactively to 08/01/15 for the twelve (12) residents identified as at risk for elopement to ensure all placement and function checks were completed.</p> <p>3. The Administrator completed a review of all exterior door function checks on 08/27/15 for the past sixty (60) days to ensure the policy was followed.</p> <p>4. On 08/28/15 a Quality Assurance (QA) meeting was held with the Medical Director, Corporate Consultant, Vice President of Operations, Administrator, DON and Unit Managers to review the Immediate Jeopardy (IJ) notification and the process and interventions to remove the IJ, review of facility policy and actions currently underway in regards education and audits. All in attendance at the meeting voiced understanding and agreement with the plan with no additional recommendations made. It was determined at the meeting all audits would be</p>	F 323		



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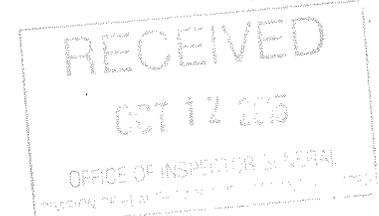
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F 323	<p>Continued From page 33</p> <p>reported to a QA subcommittee that would meet no less than monthly for six (6) months and then no less than quarterly to ensure sustained compliance.</p> <p>5. Re-education on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behavior and interventions to address exit seeking behavior was initiated on 08/27/15 and concluded on 08/28/15 for staff. No staff would be allowed to work until re-educated. The re-education included a pre and post test and was completed by the Administrator, DON, and Administrative Nurses to include MDS, Staff Development, House Supervisor, Unit Managers and Assistant Unit Managers. The facility did not utilize agency staff but did utilize contract therapy staff. All regular contract therapy staff had been trained on 08/28/15 and no as needed (prn) contract staff would be allowed to work until re-educated.</p> <p>6. On 08/28/15 education on the Elopement Policy, Elopement Risk Screen, Behavioral Indicators for Exit Seeking Behavior and Interventions to address exit seeking behaviors was added to the new hire orientation by the Staff Development Coordinator and that education would be repeated no less than annually by administrative nurses including Staff Development, the Administrator, DON, ADON and Unit Managers.</p> <p>7. Audits on Elopement Risk Screens, MAR, TAR, Care Plans and Nurse Aide Care Plans were to be done daily for seven (7) days, then weekly for three (3) weeks, then monthly for twelve (12) months to ensure accuracy and timeliness of the screens and placement and function checks with</p>	F 323			

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F 323	<p>Continued From page 34</p> <p>audits initiated on 08/28/15. Audits of all exterior door checks initiated on 08/28/15 are to be done weekly for three (3) months then monthly for twelve (12) months. Audit of review of new Elopement Risk Screens to be done weekly for three (3) months and was initiated on 08/28/15. Audits of education for newly hired employees to be completed weekly for twelve (12) months were initiated on 08/28/15. Audit of list at reception area and on MAR of all residents at risk for elopement to be completed weekly for three (3) weeks and then monthly for twelve (12) months were initiated on 08/28/15.</p> <p>The State Survey Agency validated the implementation of the acceptable AOC as follows:</p> <ol style="list-style-type: none"> <li>1. Review of the facility Elopement Policy on 09/10/15 revealed it contained all points as alleged. Interview with the Administrator, on 09/10/15 at 8:58 AM, the Director of Nursing (DON), on 09/10/15 at 9:25 AM, the Unit Manager, on 09/10/15 at 9:40 AM, the Blue Unit Manager, on 09/10/15 at 10:04 AM, the Vice President of Operations, on 09/10/15 at 10:25 AM via telephone, the Corporate Consultant, on 09/10/15 at 10:35 AM and the Medical Director, on 09/10/15 at 8:45 AM revealed they had reviewed the facility's Elopement Policy as alleged on 08/28/15.</li> <li>2. Review of the clinical records for sampled Residents' #20, #21, #22 and #23, who were assessed as elopement risks, revealed all had accurate, timely Elopement Risk Screens and appropriate interventions in place on their care plans and nurse aide care plans. Review of the MARs and TARs for Residents #20, #21, #22 and</li> </ol>	F 323			



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F 323	<p>Continued From page 35</p> <p>#23 revealed they had all placement and function checks completed for their Code Alert Bracelets documented back to 08/01/15.</p> <p>Interview with the Staff Development Nurse, on 09/10/15 at 9:45 AM, the Green Unit Nurse Manager, on 09/10/15 at 9:40 AM, and the Blue Unit Nurse Manager, on 09/10/15 at 10:04 AM, revealed they were all involved in an audit of the ninety-four (94) residents' (census as of 08/27/15) Elopement Risk Screens on 08/27/15 to ensure accurate and timely assessments.</p> <p>In addition, the Staff Development nurse, the Green Unit Nurse Manager, the Blue Unit Nurse Manager, the Green Unit Assistant Manager, on 09/10/15 at 9:10 AM and the Blue Unit Assistant Manager, on 09/10/15 at 9:58 AM, all revealed they participated in reviewing the care plans and the nurse aide care plans to ensure appropriate interventions were in place on 08/27/15 for risk of elopement.</p> <p>Further interview with the Green Unit Nurse Manager, the Blue Unit Nurse Manager, the Green Unit Assistant Manager, on 09/10/15 at 9:10 AM and the Blue Unit Assistant Manager, on 09/10/15 at 9:58 AM, all revealed they verified the list of residents identified at risk for elopement was on each MAR and at the reception area on 08/27/15.</p> <p>Interview with the DON, on 09/10/15 at 9:25 AM, the Green Unit Nurse Manager, on 09/10/15 at 9:40 AM, the Blue Unit Nurse Manager, on 09/10/15 at 10:04 AM, and an RN Supervisor, on 09/10/15 at 12:30 PM, revealed they understood they were to review the Elopement Risk Screen completed for all newly admitted residents. No</p>	F 323			

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F 323	<p>Continued From page 36 residents had been newly admitted.</p> <p>3. Review of exterior door function checks revealed they had been completed for sixty (60) days prior to 8/27/15 per the facility policy. Interview with Maintenance Staff #1 and Maintenance Staff #2, on 09/10/15 at 10:15 AM, revealed they had been completing the door function checks per the facility policy for the sixty (60) days prior to 08/27/15 and were continuing to do so. They indicated they had and would continue to provide computer generated print-outs of the door checks to the Administrator. Interview with the Administrator, on 09/10/15 at 9:10 AM, revealed she did receive and was continuing to receive the door function checks from the Maintenance personnel and she was conducting an audit of those function checks as evidenced by her signature and date reviewed on the computer print-outs for the door checks. Observation of the exterior doors on the Blue Unit, the 600 hallway, the Blue Unit dining room, the main dining room, the back door by the kitchen, the Green Unit dining room, the 300 hallway and the 200 hallway, on 09/10/15 from 8:25 AM - 9:15 AM, revealed all alarms operational per policy.</p> <p>4. Review of the Quality Assurance (QA) Meeting signature sheet revealed a meeting was held on 08/28/15 to review the Immediate Jeopardy (IJ) Notification, the process to remove the IJ, review of the facility Elopement Policy and actions to be taken in regard education and audits.</p> <p>Telephone interview with the Vice President of Operations, on 09/10/15 at 10:25 AM, and the Corporate Consultant, on 09/10/15 at 10:35 AM revealed they had been present in the QA</p>	F 323		
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F 323	<p>Continued From page 37</p> <p>Meeting held on 08/27/15 at the facility and it was decided all audits would be reported to a QA subcommittee which would meet no less than monthly for six (6) months and then no less than quarterly to ensure sustained compliance.</p> <p>Interview with the Administrator, on 09/10/15 at 8:58 AM, revealed she had been present in the QA Meeting held on 09/10/15 to discuss the U. Interview with the Director of Nursing (DON), on 09/10/15 at 9:25 AM, revealed she had been present in the QA Meeting held on 09/10/15 to discuss the IJ and interview with the Blue and Green Unit Managers, on 09/10/15 at 9:40 AM and 10:04 AM, revealed they had also been present in that QA Meeting. Interview with the Medical Director, on 09/10/15 at 8:45 AM, revealed he had been present at the QA Meeting to review the IJ Notification, the process to remove the I.); review of the facility Elopement Policy and actions to be taken in regard education and audits.</p> <p>5. Telephone interview with the Vice President of Operations, on 09/10/15 at 10:25 AM, and the Corporate Consultant, on 09/10/15 at 10:35 AM revealed they held a meeting on 08/27/15 to re-educate the administrative staff of the facility on the Elopement Policy, the Elopement Risk Screen, behavioral indicators for exit seeking behavior and interventions to address exit seeking behaviors.</p> <p>Interview with the Administrator, on 09/10/15 at 8:58 AM, the DON, on 09/10/15 at 9:25 AM, the Green Unit Manager, on 09/10/15 a 9:40 AM, the Blue Unit Manager, on 09/10/15 at 10:04 AM, the Staff Development Nurse, on 09/10/15 at 9:45 AM, the Blue Unit Assistant Nurse Manager, on</p>	F 323			

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

PRINTED: 10/07/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185169	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/10/2015
NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
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F 323	<p>Continued From page 38</p> <p>09/10/15 at 9:58 AM, the Green Unit Assistant Nurse Manager, on 09/10/15 at 9:10 AM, and the RN Supervisor, on 09/10/15 at 12:30 PM, revealed they had received re-education on the Elopement Policy, the Elopement Risk Screen, behavioral indicators for exit seeking behaviors and interventions to address exit seeking behaviors by the Vice President of Operations and the Corporate Consultant on 08/27/15 and prior to the administrative staff giving any re-training to the other facility staff. They all indicated they participated in re-training the other facility staff ending on 08/28/15 and indicated no staff would be allowed to work until they had received the re-training.</p> <p>6. Interview with the Staff Development Nurse, on 09/10/15 at 9:45 AM, revealed she had done most of the staff re-training beginning on 08/27/15 and ending on 08/28/15 and she had added training on the Elopement Policy, the Elopement Risk Screen, behavioral indicators for exit seeking behavior and interventions to address exit seeking behaviors to the new hire orientation and that training would be repeated for facility staff no less than annually by administrative nurses.</p> <p>Review of the new hire orientation documents revealed the training had been added to the content by the Staff Development Nurse as alleged.</p> <p>7. Audits on Elopement Risk Screens, MARs, TARs, Care Plans and Nurse Aide Care Plans, exterior door checks, education of newly hired employees, and the audit of the list of residents at risk of elopement kept at the reception area and on the MARs for those residents completed by</p>	F 323			

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DIVISION OF HEALTH CARE LICENSING AND SURVEILLANCE

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185169</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/10/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON MANOR HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 LYNN WAY LOUISVILLE, KY 40222</b>		
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F 323	Continued From page 39 09/10/15 were reviewed and were completed as alleged.  Interview with the DON, on 09/10/15 at 9:25 AM, the Green Unit Manager, on 09/10/15 at 9:40 AM, the Blue Unit Manager, on 09/10/15 at 10:04 AM, the Staff Development Nurse, on 09/10/15 at 9:45 AM, the Blue Unit Assistant Nurse Manager, on 09/10/15 at 9:58 AM, the Green Unit Assistant Nurse Manager, on 09/10/15 at 9:10 AM, revealed they were involved in doing audits of the list of residents at risk of elopement kept at the reception area and on the MARs and TARs and of their Elopement Risk Assessments, care plans and nurse aide care plans and submit those audits to the Administrator.  Interview with Maintenance #1 and Maintenance #2, on 09/10/15 at 10:15 AM, revealed they had been completing the door function checks per the facility policy and submit those checks to the Administrator as alleged.  Interview with the Administrator, on 09/10/15 at 8:58 AM, revealed she received all audits to date and reviewed them and will continue to do so to ensure sustained compliance.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	On 9/25/15 all open food items were checked to ensure that they had been removed from use if past the safe "use by" dates by the Administrator and on 9/28/15 by the Dining Service Director.	10/13/15	

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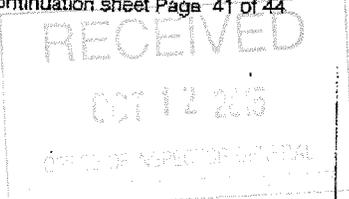
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NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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F 371	Continued From page 40  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure food was stored, prepared and served in a sanitary manner. The facility failed to ensure food items were removed from use that were beyond the safe "use by" dates. The steam table pans and lids had a brown burnt looking build-up around all the edges, clean dish racks were stored on the floor outside the dish room, and the edges of the large bins holding flour, sugar and powdered sugar as well as the edges of the lids were soiled with dried splashes and dried food particles. The shelves in the dry storage area were soiled with particles and spilled product and there were fourteen (14) plastic storage drawers with soiled tape labels and crumbs and particles inside the drawers and a sticky tan substance on the outside. The spice containers on a shelf were covered with a greasy gray film. The ice machine had a white substance all around the lid. A clean rack of bowls was contaminated. In addition, during the meal service on 08/26/15 at lunch, dishes were contaminated.  The findings include:  Requests for policies regarding the sanitation in the kitchen were requested and not received.  Review of the facility's cleaning schedule, not dated, revealed there was no schedule for	F 371	Open food items will be audited to ensure items are removed if past the safe "use by" date by the Director of Dining Services or Cook Supervisor on a daily basis for one week and then weekly for 3 months and then on a monthly basis. All dietary staff will be re-educated on discarding food items past the safe "use by" date by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services.  All findings will be reported no less than quarterly to the Quality Assurance Committee.  The steam table pans and lids were cleaned on 9/28/15 by the Administrator. On 9/30/15 all other cooking utensils were checked to ensure that they were without build-up by the Director of Dining Services. The Director of Dining Services or Cook Supervisor will perform an audit weekly for 4 weeks then monthly of the steam table pans and lids to ensure that they are cleaned thoroughly.  All dietary staff will be re-educated on proper cleaning of cooking utensils by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services.	
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F 371	Continued From page 41 deliming the ice machine, cleaning the shelves in the dry storage room, cleaning the large rolling bins and lids of sugar, flour, and powdered sugar, keeping the storage bins in the pantry clean, cleaning the steam table pans and lids, cleaning the microwave and discarding food past their safe date.  Observation, on 08/25/15 at 10:31 AM, during the initial tour of the kitchen revealed two (2) clear pitchers of yellow liquid in the reach-in refrigerator, one dated 08/18/15, and the other 07/31/15. It was also observed to contain an unknown green bottle with a closed lid containing a white substance without a label. The microwave had a light brown dry substance stuck to the inside door.	F 371	All findings will be reported no less than quarterly to the Quality Assurance Committee.  On 9/25/15 the Administrator performed an audit to ensure that clean dish racks were stored properly on wheeled carts. The Director of Dining Services or Cook Supervisor will audit the placement of clean dish racks on a daily basis for a week and then weekly for 3 months and then on a monthly basis. All dietary staff will be re-education on storage of clean dish racks by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services. All findings will be reported		
	Observation, on 08/26/2015 at 12:31 PM, revealed the microwave continued to have a light brown, dry substance stuck to the inside door.  Observation, on 08/27/2015 at 3:25 PM, revealed the microwave still had light brown dry particles stuck to the inside door. An open bag of yellow/white dry substance labeled cornmeal had no cover or wrapping. A clear bottle of dark brown liquid with a yellow cap had no date nor any label to identify what the bottle contained. Several pans under the prep table were stored right-side up with standing water inside. There were six (6) clean dish racks stored on the floor in the kitchen next to the dishroom. The floor was noted to be sticky throughout the kitchen. There was a cardboard box containing chemicals resting on the floor under the three (3) compartment sink.  Interview with the Dietary Manager, on 08/27/15		no less than quarterly to the Quality Assurance Committee.  On 9/28/15 the large storage bins were cleaned by the dietary assistant. All other large bins were checked on 9/28/15 by the Administrator to ensure they were clean. The Director of Dining Services or Cook Supervisor will audit the large storage bins daily for a week and then weekly for 3 months, then on a monthly basis to ensure that all bins are clean. All dietary staff will be re-educated on cleaning of the large storage bins by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services. All findings will be reported no less than quarterly to the Quality Assurance Committee.		

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NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222		
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F 371	<p>Continued From page 42</p> <p>at 3:43 PM, revealed the facility policy stated to allow dishes and utensils to air dry before use. He stated the dietary employees were trained on proper storage to prevent cross-contamination. He was unaware of what was contained in the green bottle found in the reach-in refrigerator, who the bottle belonged to, or when the bottle was placed in the refrigerator. He stated the microwave had been cleaned and the procedure and policy was for all containers used to store food in the refrigerator and/or dry storage area should have had a label containing a date. If they had been opened they should be wrapped or sealed. He stated the bottle of dark brown liquid appeared to be food coloring. He also stated there could be a potential harm to residents for using wet dishes because of the possibility of growing bacteria.</p> <p>Observation of the meal service, on 08/26/15 at 11:52 PM, revealed the server removed his gloves after rinsing the food thermometer in the sink. He regloved without washing his hands.</p> <p>Observation of the server, at 12:12 PM and 12:22 PM, revealed he left the serving line to open cans of soup and placed them in the microwave to warm. He removed his gloves and put on clean ones without washing his hands.</p> <p>Observation of the meal service, on 08/26/15 at 12:22 PM, revealed a stack of dish racks next to the steam table. The server emptied the top rack of dishes and set the rack on the floor. At 12:26 PM, the server was noted to pick up the dish rack on the floor and place it back on the stack of clean racks containing clean dishes.</p> <p>Interview with the Server, on 08/26/15 at 12:30 PM, revealed he had been trained to wash hands</p>	F 371	<p>On 9/25/15 the shelves in the dry storage and all of the plastic bins were cleaned and tape labels were removed by the Administrator. The Director of Dining Services or Cook Supervisor will audit the dry storage room shelving and plastic bins on a daily basis for a week and then weekly for 3 months, then on a monthly basis to ensure compliance. All dietary staff will be re-educated on cleaning of the dry storage room by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services. All findings will be reported no less than quarterly to the Quality Assurance Committee.</p> <p>On 9/25/15 the Administrator cleaned all spice containers and all other containers were checked to ensure that they were clean. The Director of Dining Services or Cook Supervisor will audit the spice containers on a daily basis for a week and then weekly for 3 months, then on a monthly basis to ensure compliance. All dietary staff will be re-educated on cleaning off containers before placing them back into storage by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services. All findings will be reported no less than quarterly to the Quality Assurance Committee.</p>		



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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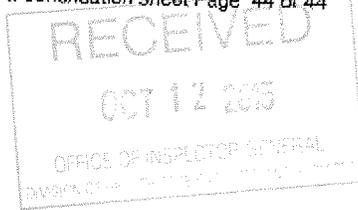
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NAME OF PROVIDER OR SUPPLIER  <b>JEFFERSON MANOR HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1801 LYNN WAY LOUISVILLE, KY 40222</b>
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F 371	<p>Continued From page 43</p> <p>when he changed gloves. He stated he forgot to wash his hands when he changed his gloves. He stated he did get clean dishes from a stack of dish racks; however, he did not realize he placed the emptied rack on the floor before replacing it back on top of the stack of clean dish racks. He stated when he placed the rack that was on the floor back on the racks of clean dishes that he did contaminate the clean dishes which could cause illness to the residents.</p> <p>Interview with the Dietary Manager, on 08/26/15 at 12:40 PM, revealed the emptied dish rack placed on the floor should not have been placed back on the racks of clean dishes. In addition, he stated staff was trained to wash their hands when they changed gloves. He stated staff was aware residents could become sick from bacteria if hands or equipment were soiled.</p>	F 371	<p>On 9/28/15 the Director of Maintenance and Maintenance Assistant de-limited and cleaned out the ice machine. This will be completed at least every 6 months by the maintenance department. The Director of Dining Services or Cook Supervisor will check the ice machine on a monthly basis for 12 months to ensure that there is no lime build-up. All findings will be reported no less than quarterly to the Quality Assurance Committee.</p> <p>The 2 clear pitchers in the reach-in were discarded on 8/25/15 by the Director of Dining Services. The green bottle was discarded on 8/25/15 by the Director of Dining Services.</p> <p>On 9/25/15 all open containers were checked to ensure that all items were properly labeled with the contents by the administrator. The Director of Dining Services or Cook Supervisor will audit open containers on a daily basis for a week and then weekly for 3 months, then on a monthly basis to ensure compliance. All dietary staff will be re-educated on properly labeling all opened items by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services. All findings will be reported no less than quarterly to the Quality Assurance Committee.</p>	
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The microwave was checked on 9/28/15, the substance was between the glass and the screen and unable to clean this area, the microwave was discarded and replaced with a new one. The Director of Dining Services or Cook Supervisor will check the microwave on a daily basis for a week, then weekly for 3 months, then on a monthly basis to ensure the microwave is clean. All dietary staff will be re-educated on cleaning the microwave at least daily by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services. All findings will be reported no less than quarterly to the Quality Assurance Committee.

On 9/25/15 an audit was performed by the Administrator and no open containers of cornmeal were found, all other open items were checked to ensure that they were covered. On 8/27/15 the bottle of brown liquid were discarded by the Directory of Dining Services. On 9/25/15 an audit was performed by the Administrator to ensure all open food items were properly stored and labeled with a date and the name of the product, that all pans were stored upside down and that all dish racks were stored on the wheeled cart. On 9/29/15 the chemicals were removed from the box and placed in a container off of the floor by the Director of Maintenance. On 9/28/15 the Director of Dining Services cleaned the kitchen floor.

Any newly hired dietary staff will receive this education during orientation by the Director of Dining Services.

The Director of Dining Services or Cook Supervisor will audit labeling of open food items, storage of pans, proper placement of dish racks and storage of chemicals on a daily basis for a week, then weekly for 3 months, then on a monthly basis to ensure compliance. All findings will be reported no less than quarterly to the Quality Assurance Committee.

All dietary staff will be re-educated on proper hand washing, including hand hygiene when removing gloves by the Director of Dining Services, Staff Development Coordinator or Administrator. Any newly hired dietary staff will receive this education during orientation by the Director of Dietary Services.

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NAME OF PROVIDER OR SUPPLIER  JEFFERSON MANOR HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 LYNN WAY LOUISVILLE, KY 40222
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1982</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (111).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II, 45 KW generator. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 08/25/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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