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| F 000 | INITIAL COMMENTS<br><br>An Abbreviated/Partial Extended Survey was initiated on 09/15/15 and concluded on 09/24/15 to investigate complaints KY23822 and KY23823. The Division of Health Care unsubstantiated KY23823; however, KY23822 was substantiated with Immediate Jeopardy (IJ) identified on 09/17/15. The Immediate Jeopardy was determined to exist on 09/08/15 at 42 CFR 483.25 Quality of Care (F323) at a scope and severity of a "J" and CFR 483.20 Resident Assessment (F280) at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 09/17/15.<br><br>Interview and record review revealed the facility failed to have an effective system to ensure adequate supervision of residents with known behaviors of wandering. Resident #1 was assessed by the facility to be an elopement risk and had a code alert/wander guard bracelet applied. On 09/08/15 between the hours of 6:00 PM and 6:45 PM, Resident #1 exited the facility without staff knowledge. The resident successfully ambulated from the facility and was located approximately ½ mile away. After being seen by a facility staff member while driving her vehicle, the staff member assisted Resident #1 into the vehicle and returned to the facility. The resident was assessed with a skin tear on the right lower leg above the knee and an abrasion on the left forearm. The facility failed to increase supervision of Resident #1 after the elopement. On the same date, 09/08/15 at approximately 7:00 PM, Resident #1 exited the facility a second time without staff knowledge. The facility was notified the resident had exited the building when | F 000 | | |

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.

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| F 000 | Continued From page 1<br>a person in the community alerted the facility the resident was outside on the sidewalk. The recorded weather for that day, 09/08/15, was verified to be ninety (90) degrees Fahrenheit (F) and sunny. Resident #1 wore a short sleeve tee shirt, long pants and tennis shoes.<br><br>The facility provided an acceptable Allegation of Compliance (AOC) on 09/23/15 which alleged removal of the Immediate Jeopardy on 09/12/15. The State Survey Agency verified Immediate Jeopardy was removed on 09/12/15 prior to the initiation of the abbreviated survey; therefore, the Immediate Jeopardy was determined to be Past Immediate Jeopardy. | F 000 | | |
| F 280<br>SS=J | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | | |

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| F 280 | Continued From page 2 | F 280 | | |
| | This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review and review of the facility's policy and investigation, it was determined the facility failed to have an effective system in place to ensure the comprehensive care plan interventions were revised for one (1) of nine (9) sampled residents (Resident #1). The facility failed to revise the care plan for Resident #1 to ensure the staff was clearly directed on how to provide additional supervision for safety needs after the resident eloped from the facility without staff knowledge. (Refer to F323)<br><br>On 09/08/15 between the hours of 6:00 PM and 6:45 PM, Resident #1 left the facility's premises without staff knowledge. The resident was found at approximately 6:30 PM, off the facility grounds, standing approximately two (2) feet from a busy two (2) lane road. The resident was located by a passing employee and assisted into their vehicle and returned to the facility. The recorded weather for that day, 09/08/15, was verified as ninety (90) degrees Fahrenheit (F), sunny and Resident #1 wore a short sleeve tee shirt, long pants and tennis shoes. Resident #1 was assessed by the facility upon return with a skin tear on the right lower leg above the knee and an abrasion on the left forearm. However, the facility failed to increase supervision of the resident and the resident eloped from the facility again without staff knowledge.<br><br>The facility's failure to ensure interventions were in place for increased supervision for a resident who eloped from the facility has caused or is | | Past noncompliance: no plan of correction required. | |

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| F 280 | Continued From page 3 likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/17/15 and was determined to exist on 09/08/15.<br><br>The facility provided an acceptable Allegation of Compliance on 09/23/15 which alleged removal of Immediate Jeopardy on 09/12/15. The State Survey Agency validated Immediate Jeopardy was removed on 09/12/15 as alleged, prior to the State Survey Agency's entrance on 09/15/15; therefore, the Immediate Jeopardy was determined to be Past Immediate Jeopardy.<br><br>The findings include:<br><br>The facility did not provide a policy regarding care plans.<br><br>Review of the facility's policy regarding Elopement, with an effective date 01/01/09, revealed through assessment, residents identified at risk for elopement would have a plan developed to eliminate or reduce the risk of elopement. The plan may include, but was not limited to visual checks, one (1) to one (1) supervision, bed alarm, motion detectors at doorway, activity programs, and code alert/wander guard bracelets or wandering monitoring system.<br><br>Review of the facility's investigation, dated 09/14/15, revealed on 09/08/15 Resident #1 successfully exited the building twice without staff knowledge. The investigation continued to state a nurse who had come to work that day at 6:33 PM, made her way to the nurses' station and stated she had a gut feeling about a resident being outside. Upon this statement the Nurse Manager | F 280 | | |

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| F 280 | Continued From page 4 quickly made her way to the resident's room where she discovered the resident was not there, a code yellow was called and staff immediately checked the interior and exterior of the building. The investigation stated a Nurse Manager found the resident within one-half (1/2) mile away and returned the resident safely to the facility. The investigation then stated within five (5) to ten (10) minutes of staff finishing cleaning up the resident, a neighbor reported the resident was seen outside the facility resulting in the resident exiting the facility a second time without staff knowledge. Review of the investigation revealed the facility had not determined how the resident had exited the building without staff knowledge.<br><br>Review of the clinical record for Resident #1 revealed the facility initially admitted the resident on 04/14/15, with diagnoses of Bi-Polar Disease, Altered Mental Status, and Dementia without Behavioral Disturbances. The record stated the resident wandered throughout the facility freely. The facility conducted an elopement risk evaluation upon admission, 04/14/15, with findings of wandering behaviors. The resident's picture was placed in the code alert/wander guard binder as well as the front of the Medication Administration Record (MAR) and a code alert/wander guard bracelet was placed on the resident.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/15/15, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of a possible fifteen (15) meaning the resident was interviewable. The facility assessed the resident as independent (needing no staff assistance) with bed mobility, | F 280 | | |

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| F 280 | Continued From page 5 transfers, and ambulation.<br><br>Review of the Comprehensive Care Plan, dated 07/14/15, for Resident #1 revealed all staff was to redirect the resident to go to the courtyard or take the resident for a walk around the facility if Resident #1 attempted to leave the facility. Other interventions included: a code alert/wander guard in place at all times; check placement of the code alert/wander guard every shift; and check the code alert/wander guard to make sure it was operational weekly. The care plan was not updated after the first (1st) elopement that occurred on 09/08/15. The care plan was updated after Resident #1's second elopement on 09/08/15 with an intervention for one (1) to one (1) monitoring.<br><br>Interview, on 09/17/15 at 8:30 AM, with Registered Nurse (RN) #1 revealed she instructed Certified Nursing Assistants (CNAs) to keep a close eye on Resident #1. RN #1 stated she should have revised the care plan and placed Resident #1 on one (1) to one (1) supervision at the time of the first elopement, but did not until the resident eloped the second time on 09/08/15. RN #1 stated CNAs were not specifically assigned to residents, but were assigned to wings during that shift only. Per interview, CNA assignments were not consistent and the CNAs worked on different units.<br><br>Interview, on 09/16/15 at 3:00 PM, with CNA #2 revealed she was instructed on 09/08/15 after Resident #1 eloped the first time by RN #1 to keep a close eye on the resident; however, was not instructed to provide one (1) to one (1) supervision for the resident and this was not placed on the care plan she carried with her. The | F 280 | | |

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| F 280 | Continued From page 6 CNA stated she assumed it was okay for the resident to continue to freely ambulate throughout the facility. CNA #2 further stated she carried a nurse aide care plan with her throughout her shift that listed all the residents in the entire facility. CNA #2 continued to state the nurse aide care plans were updated weekly, but if there was a significant change then an updated care plan would be provided from the nurse in charge that day.<br><br>Interview with the Director of Nursing (DON), on 09/17/15 at 10:00 AM, revealed Resident #1 was not placed on frequent visual checks or any type of monitoring after his/her first (1st) elopement on 09/08/15.<br><br>Further interview with the DON, on 09/23/15 at 1:48 PM, revealed the care plan was the tool used to inform staff of the resident's needed care and services. She stated nurses were responsible for updating and revising the care plan as needed.<br><br>The facility provided an acceptable Allegation of Compliance (AOC), on 09/23/15, that alleged removal of the Immediate Jeopardy on 09/12/15. Review of the AOC revealed the facility implemented the following:<br><br>1. An immediate investigation included checking monitored exterior doors for proper function. This action was completed on 09/08/15 by the Administrator, DON, the Nursing Floor Supervisor and the Maintenance Supervisor. All doors were functioning correctly.<br><br>2. The Corporate Regional Plant Operations Director came to the facility on 09/09/15 and | F 280 | | |

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| F 280 | Continued From page 7<br>tested all the door alarm systems and all systems were found to be functioning correctly.<br><br>3. Placement, expiration and function of code alert/wander guard devices was checked by the DON and the Nursing Floor Supervisor on 09/08/15 and found all devices were functioning properly.<br><br>4. Interviews with all the nursing staff on duty 09/08/15 during Resident #1's elopements were completed by the Administrator. Interviews revealed there was no exit seeking behaviors noted that day for Resident #1 prior to facility exit. It was also stated by all staff members present that there was no sounding of the alarm system.<br><br>5. A Special Quality Assurance (QA) meeting was held on 09/11/15 with the Administrator, DON, Medical Director, and the Corporate Consultants. The Policy and Procedure for elopement was reviewed to ensure the process remained effective. The agenda for this QA meeting was to update the Medical Director of the current actions taken to ensure continuous safety of the residents and the ongoing efforts by the facility to ensure the elopement process remained effective.<br><br>6. All sixty one (61) elopement risk screens were reviewed to ensure accuracy by the Administrator, DON, and the Nursing Floor Supervisor on 09/08/15 and again on 09/09/15 by the Corporate Consultants. No new residents were found to be at risk for elopement. Audits of elopement risk screen and interventions would be done no less than weekly for four (4) weeks and monthly as part of the QA process.<br><br>7. All sixteen (16) residents identified as at risk | F 280 | | |

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| F 280 | Continued From page 8 for elopement, their comprehensive care plan and nurse aide care plans were reviewed by the DON and the MDS Director on 09/10/15. Review showed care plans and nurse aide care plans were appropriate and interventions were present. An audit of residents' care plans and nurse aide care plans would be done no less than weekly for four (4) weeks and monthly as part of the QA process.<br><br>8. On 09/10/15 the Treatment Administration Records (TAR) were audited going back 30 days by the Nursing Floor Supervisor and the DON to ensure all placement checks were done and completed timely. No issues were found. A weekly audit of TARs would be done for four (4) weeks to ensure continuous timeliness and accuracy of placement checks as part of the QA process.<br><br>9. Education of eighty-seven (87) staff members, including therapy staff was conducted 09/11/15 by the Staff Development, Housekeeping Supervisor, Therapy Program Director, and the Dietary Supervisor on the elopement policy and procedure, responsibilities when a Code Yellow is called, indicators of exit seeking behaviors, interventions for exit seeking behaviors, appropriate usage of doors, hiding the door code, and responsible actions to take when exiting the building. This education was added to the facility orientation and CNA classes.<br><br>10. On 09/10/15, the Maintenance Director changed the exterior monitored door codes to ensure the code was unknown by all residents. The process for resetting the code was implemented. The process included resetting the exterior monitored door codes on the first of every | F 280 | | |

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| F 280 | Continued From page 9 month. An exception would be given if the first day of the month fell on a weekend, only during this exception would the code be changed on the following Monday. Beginning 09/11/15, a daily check of exterior monitored doors would be performed by the Maintenance Director or the Administrator to ensure proper function. Education of the code change process was given to all staff on this date.<br><br>11. On 09/09/15 an audit of the maintenance log was performed by the Corporate Consultants to ensure doors had been checked weekly. The audit revealed the maintenance log was up to date and the checks had been done timely.<br><br>12. An audit of the code alert/wander guard list of expiration dates was completed to ensure timeliness. An audit of the list of the sixteen (16) at risk residents, revealed the list was up to date and in front of each Medication Administration Record (MAR) and a copy was at the receptionist's desk. These audits were performed by the Corporate Consultant on 09/09/15. These lists would be audited no less than weekly for four (4) weeks and monthly as part of the QA process.<br><br>13. All residents' window sash vent stops were checked 09/10/15 by the Administrator and the Maintenance Director and were found in place and functioning properly with securing devices in place.<br><br>14. On 09/11/15 a review of all 24 hour report forms and all incident reports from the last 30 days were reviewed by the Corporate Consultant to identify any residents who had any indicators for exit seeking behaviors. None were found on any of the reports. The Social Services Director | F 280 | | |

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| F 280 | Continued From page 10 | F 280 | | |

was educated by the Corporate Consultant on continuing to monitor behavioral reports every morning to identify possible exiting behaviors and implementing interventions upon the presence of indicators of exiting behaviors.

15. On 09/11/15 an elopement drill/mock elopement was performed by the Administrator to test the second shift's accuracy of possible elopement response. The response was timely and proper elopement procedures were followed. Mock/drill elopements would be performed no less than monthly for three (3) months on each shift and then return to no less than quarterly drills to assure elopement response accuracy.

Through observation, interview and record review the State Survey Agency validated the AOC on 09/24/15 as follows:

1. Review of the immediate investigation of checking monitored/exterior doors conducted on 09/08/15 revealed the first door checked/tested was the front entrance door at 6:50 PM.

Observation, on 09/15/15 between 2:27 PM and 2:40 PM, of all the monitored/exterior doors in the facility, revealed all doors were functioning correctly.

Interview with the Maintenance Director, on 09/15/15 at 2:40 PM, revealed all monitored/exterior doors were immediately tested by himself and the Administrator after the elopement occurred on 09/08/15 and all doors were functioning correctly.

Interview with the Administrator, DON and RN #1, on 09/23/15 at 1:30 PM, revealed they

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| F 280 | Continued From page 11 immediately began checking all the monitored/exterior doors throughout the facility and all the doors were functioning correctly.<br><br>2. Review of a written statement from the Corporate Regional Plant Operations Director (RPOD) revealed he completed a test on all the monitored/exterior doors and all doors were operating 100% with no issues.<br><br>Interview with the RPOD, on 09/23/15 at 3:30 PM, revealed on 09/09/15 he completed a test on all entry and exit doors, the overhead code alert paging system, and staff panels at both nurses' station. He stated he adjusted the volume on the overhead code alert/wander guard paging system, on all entry and exit doors and the staff panels at both nurses' stations. He further stated the paging system, including all pagers, was working and receiving pages and it appeared to him that the whole system itself had been and was currently operating with no issues.<br><br>3. Interview with the DON and RN #1, on 09/23/15 at 1:32 PM, revealed they both completed placement, expiration and function of the code alert/wander guard checks throughout the entire facility and all the devices were functioning properly.<br><br>Observation, on 09/16/15 at 1:38 PM, of Resident #1's and Resident #13's code alert/wander guard device being tested by the DON and Maintenance Director revealed the devices were functioning property.<br><br>4. Review of six (6) written statements by nursing staff on duty 09/08/15 during the time Resident #1 eloped revealed Resident #1 had no exit | F 280 | | |

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| F 280 | Continued From page 12 seeking behaviors noted that day and no staff heard the sounding of the code alarm system both times Resident #1 eloped.<br><br>Interviews, on 09/16/15 at 8:30 AM with LPN #2; at 10:05 AM with CMT #1; at 10:30 AM with LPN #5; and, at 3:00 PM with CNA #2; and continued interviews, on 09/17/15 at 8:00 AM with LPN #4 and at 8:30 AM with RN #1, revealed they all were working on 09/08/15 during the time Resident #1 eloped from the facility. All staff members stated Resident #1 had no exit seeking behaviors before eloping the first time on 09/08/15. All staff members stated they did not hear the code alert alarm system sound either time Resident #1 eloped on 09/08/15.<br><br>5. Review of the QA meeting minutes and sign-in sheet revealed the meeting was held on 09/11/15 with the Administrator, DON, Medical Director and Corporate Consultants. The meeting minutes consisted of the elopement policy and procedure being reviewed.<br><br>Interview, on 09/23/15 at 2:53 PM, with the Clinical Corporate Consultant and at 3:51 PM with a Corporate Consultant, revealed both attended the QA meeting on 09/11/15. Both Consultants stated the meeting was held due to the elopement on 09/08/15 with Resident #1. The Consultants stated the purpose of the meeting was to address issues found or observed, analyze and identify opportunities for quality improvement and to communicate best practices and lessons learned. The Consultants further stated the elopement policy and procedure was also reviewed.<br><br>Interview, on 09/23/15 at 3:00 PM, with the | F 280 | | |

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| F 280 | Continued From page 13<br>Medical Director revealed he attended the QA meeting by phone on 09/11/15. The Medical Director stated the purpose of the meeting was to discuss the elopement regarding Resident #1. The Medical Director stated he discussed with the QA Committee during the meeting the elopement policy and procedures, assessing residents for being at risk for elopement, interventions, goals and monitoring at risk residents. The Medical Director further stated he made a recommendation to discuss and review all elopement risk residents at all future QA meetings monthly to ensure the interventions remained effective.<br><br>Interview, on 09/23/15 at 1:38 PM, with the Administrator and DON, revealed they both attended the QA meeting held on 09/11/15. Both stated the group reviewed the elopement policy and procedures.<br><br>6. Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13's elopement risk screens revealed they were all completed timely and accurate.<br><br>Interview, on 09/23/15 at 1:48 PM, with the Administrator, DON and RN #1, revealed they reviewed sixty-one (61) elopement risks screens on 09/08/15 and found the assessments were completed timely and were accurate. The DON further stated audits of the elopement risk screens and interventions would be completed weekly for four (4) weeks then monthly as part of their QA process.<br><br>Interview, on 09/23/15 at 2:53 PM, with the Clinical Corporate Consultant, revealed she reviewed all sixty-one (61) elopement risk | F 280 | | |

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| F 280 | Continued From page 14 screens on 09/09/15 and she found the assessments were completed timely and were accurate.<br><br>7. Review of Resident #1, #3, #4, #10, #11, #12, and #13's care plan and nurse aide care plan, revealed they all had an elopement care plan and nurse aide care plan that included interventions.<br><br>Interview, on 09/22/15 at 1:55 PM, with the MDS Director, revealed she reviewed all sixteen (16) elopement risk resident care plans and aide care plans to monitor if appropriate and if interventions were present. The MDS Director stated no issues were found.<br><br>Interview, on 09/23/15 at 1:52 PM, with the DON revealed she reviewed all sixteen (16) elopement risk assessments and found that each care plan and nurse aide care plan was appropriate and interventions were present. The DON further stated audits of the care plans and nurse aide care plans would be completed weekly for four (4) weeks then monthly as part of their QA process.<br><br>8. Review of Resident #1, #3, #4, #10, #11, #12, and #13's Treatment Administration Record (TAR), revealed the placement checks were noted and completed timely.<br><br>Interview with the DON, on 09/23/15 at 1:52 PM, revealed she audited the TARs going back 30 days and found no issues with the placement checks being completed and all were timely. The DON further stated the TAR audits would be completed weekly for four (4) weeks to ensure timeliness and accuracy as part of their QA process. | F 280 | | |

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| F 280 | Continued From page 15<br>9. Review of the in-service training agenda and sign-in sheets revealed eighty-seven (87) staff members were trained on 09/11/15 that covered the elopement policy and procedures, responsibilities when a Code Yellow was called, indicators of exit seeking behaviors, interventions for exit seeking behaviors, appropriate usage of doors, hiding the door code, and responsible actions to take when exiting the building.<br><br>Interview, on 09/23/15 at 2:00 PM with CNA #1; at 2:05 PM with CNA #3; at 2:10 PM with Housekeeper #1; at 2:15 PM with Dietary Assistant; at 2:20 PM with LPN #6; at 2:25 PM with Dietary Aide; at 2:35 PM with Dishwasher; at 2:40 PM with CMT #2; at 2:45 PM with CNA #4; at 2:50 PM with CNA #5; at 2:55 PM with Certified Occupational Therapy Assistant (COTA); at 3:00 PM with Medical Records; at 3:05 PM with Housekeeper #2; at 3:10 PM with Housekeeper #3; at 3:15 PM with CNA #6; at 3:20 PM with Office Manager; and at 3:25 PM with the Bookkeeper; revealed all had been trained on 09/11/15 by their direct supervisor on the elopement policy and procedures, responsibilities when a Code Yellow was called, exit seeking residents, exit behaviors and usage of door codes.<br><br>Observation, on 09/22/15, 09/23/15, and 09/24/15 of staff keying in the code to enter and exit the facility revealed staff was looking around for residents and visitors before using the code at the door and staff hid the code so it could not be seen by any other person.<br><br>10. Review of the daily checks of exterior monitored doors revealed these doors had been checked each day beginning 09/09/15 and all | F 280 | | |

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| F 280 | Continued From page 16<br>doors were functioning properly.<br><br>Interview with the Maintenance Director, on 09/15/15 at 2:40 PM, revealed he began checking all exterior monitored doors daily on 09/09/15. He stated he changed the door codes on 09/08/15 after the second elopement with Resident #1. The Maintenance Director also stated he would change the door codes monthly, on the first day of the month. He further stated if the first day of the month fell on a weekend then he would change the code the following Monday.<br><br>11. Interview with the RPOD, on 09/23/15 at 3:30 PM, revealed on 09/09/15 he completed an audit on all maintenance logs to ensure doors had been checked weekly. RPOD stated the audit showed maintenance logs were up to date and checks were completed timely.<br><br>12. Interview with the Clinical Corporate Consultant on 09/23/15 at 2:53 PM, revealed on 09/09/15 she conducted an audit on the code alert/wander guard list of the sixteen (16) residents at risk and audited their devices. The Consultant stated the devices' expiration dates were all timely and no issues were noted. The Consultant also stated code alert/wander guard list for at risk residents were all up to date in front of each Medication Administration Record (MAR) and at the receptionist's desk. The Consultant further stated the lists would be audited weekly for four (4) weeks and then monthly as part of their QA process.<br><br>Observation, on 09/15/15 at 4:00 PM, of Residents #1, #3, and #4, and on 09/22/15 at 4:45 PM, of Residents #10, #11, #12, and #13's MAR revealed the list was up to date. | F 280 | | |

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| F 280 | Continued From page 17<br><br>Observation, on 09/15/15 at 2:40 PM, of the at risk list at the receptionist's desk revealed it was also up to date.<br><br>13. Interview, on 09/15/15 at 2:40 PM, with the Maintenance Director, revealed the Administrator and himself checked all window sash vent stops throughout the entire facility and found all sashes in place and functioning with securing devices in place.<br><br>Interview, on 09/17/15 at 10:30 AM, with the Administrator revealed the Maintenance Director and himself checked all the window sash vent stops including Resident #1's windows and all sashes were in place and functioning with securing devices in place.<br><br>Observation, on 09/15/15 at 2:32 PM, of Resident #1's window revealed the securing device was in place.<br><br>14. Interview with Corporate Consultant on 09/23/15 at 3:51 PM, revealed she conducted audits on all twenty-four (24) hour report forms from the last thirty (30) days and all incident reports from the last thirty (30) days to identify if any residents had any indicators for exit seeking behaviors. The Consultant stated none were found during this audit on any of the reports. The Consultant further stated she educated the Social Services Director on continuing to monitor behavioral reports every morning to identify possible exiting behaviors and implementing interventions.<br><br>Interview with the Social Services Director (SSD) on 09/24/15 at 9:40 AM, revealed she was | F 280 | | |

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| F 280 | Continued From page 18 educated on 09/11/15 by the Corporate Consultant on continuing to monitor behavioral reports every morning to identify possible exiting behaviors and implementing interventions if any of these behaviors were found. SSD stated this was a verbal training and she was not given any type of documents and she did not sign a sign-in sheet. SSD further stated she was the only Social Services staff for the facility.<br><br>15. Interview with the Administrator, on 09/23/15 at 1:38 PM, revealed he conducted an elopement drill/mock elopement on 09/11/15 to test the timeliness of the staff on second shift and to see if the staff followed the proper elopement procedures. The Administrator stated all staff followed the proper elopement procedures and he would continue to perform mock/drills elopements monthly for three (3) months on each shift and then return to conducting the drills quarterly thereafter. Administrator further stated all audits would be reviewed during the monthly QA meetings and all discrepancies would be addressed. | F 280 | | |
| F 323<br>SS=J | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by: | F 323 | | |

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| F 323 | Continued From page 19<br>Based on interview, record review and review of the facility's policy and investigation, it was determined the facility failed to have an effective system to ensure adequate supervision of residents with known behaviors of wandering for one (1) of nine (9) sampled residents (Resident #1).<br><br>The facility assessed Resident #1, on 04/14/15, as an elopement risk and applied a Code Alert/Wander Guard bracelet. On 09/08/15, between the hours of 6:00 PM and 6:45 PM, Resident #1 left the facility's premises without staff knowledge. The resident was found at approximately 6:30 PM, approximately ½ mile away from the facility, standing approximately two (2) feet from a busy two (2) lane road. The resident was assisted into a staff member's vehicle then returned to the facility and was assessed with a skin tear on the right lower leg above the knee and an abrasion on the left forearm. The weather for that day, 09/08/15, was verified sunny, ninety (90) degrees Fahrenheit (F), and Resident #1 wore a short sleeve tee shirt, long pants and tennis shoes.<br><br>The facility's failure to provide adequate supervision of residents with known wandering risk has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified on 09/17/15 and was determined to exist on 09/08/15.<br><br>The facility provided an acceptable Allegation of Compliance on 09/23/15 which alleged removal of Immediate Jeopardy on 09/12/15. The State Survey Agency validated Immediate Jeopardy was removed on 09/12/15 as alleged, prior to the | F 323 | Past noncompliance: no plan of correction required. | |

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| F 323 | Continued From page 20<br>State Survey Agency's entrance on 09/15/15; therefore, the Immediate Jeopardy was determined to be Past Immediate Jeopardy.<br><br>The findings include:<br><br>Review of the facility's policy regarding Elopement, with an effective date 01/01/09, revealed the facility would assess all residents for elopement risk upon admission/readmission, between day three (3) and seven (7), between day thirty (30) and forty five (45), quarterly and with any significant change in Activity of Daily Living (ADL) function or cognitive function. Further review of the policy revealed a specific system had been developed to notify staff that an external door had been opened in an area accessible to residents; door alarms would be tested weekly; and, all bracelets or monitoring devices would be checked for placement every shift and recorded in the Medication Administration Record (MAR). Residents identified at risk for elopement would have a plan developed to eliminate or reduce the risk of elopement. The plan may include, but not limited to visual checks, one (1) to one (1) supervision, bed alarm, motion detectors at doorway, activity programs, and code alert bracelet or wandering monitoring system.<br><br>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 04/14/15, with diagnoses of Bi-Polar Disease, Altered Mental Status, and Dementia without Behavioral Disturbances. The record revealed the resident wandered throughout the facility freely. The facility conducted an elopement risk evaluation upon admission, 04/14/15, with findings of wandering behaviors. The resident's | F 323 | | |

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| F 323 | Continued From page 21 picture was placed in the Code Alert Binder and a Code Alert Bracelet was placed on the resident.<br><br>Review of the Elopement Risk Assessment, dated for 04/14/15, revealed a code alert/wander guard bracelet was placed on Resident #1's left ankle. The assessment revealed the resident was physically able to leave the facility on his/her own; the resident exhibited periods of confusion; the resident had a history of leaving the facility or home (actual or reported); and the resident exhibited periods of pacing, agitation or wandering. The resident was further assessed on 04/21/15, 07/07/15, and 09/09/15 with the same risk factors.<br><br>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/15/15, revealed the facility assessed the resident as cognitively intact with a Brief Interview for Mental Status (BIMS) score of fourteen (14) out of a possible fifteen (15) meaning the resident was interviewable. The facility assessed the resident as independent (needing no staff assistance) with bed mobility, transfers, and ambulation.<br><br>Review of the Comprehensive Care Plan, dated 07/14/15, revealed all staff was to redirect Resident #1 to go to the courtyard or take Resident #1 for a walk around the facility if Resident #1 attempted to leave the facility. Other interventions included: wander guard in place at all times; check placement of wander guard every shift; and check wander guard to make sure it was operational weekly.<br><br>Review of the facility's investigation, dated 09/14/15, revealed Resident #1 successfully exited the building without staff knowledge twice | F 323 | | |

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| F 323 | Continued From page 22 on 09/08/15. The investigation continued to state a nurse who arrived to work that day at 6:33 PM, made her way to the nurses' station and stated, she had a gut feeling about a resident being outside. Upon this statement the Nurse Manager quickly made her way to Resident #1's room where she discovered the resident was not in the room and a code yellow was called and staff immediately checked the interior and exterior of the building. The investigation stated a Nurse Manager found the resident within a half (1/2) mile away and returned the resident safely to the facility. The investigation then stated within five (5) to ten (10) minutes of the staff finishing cleaning up the resident, a neighbor reported to the facility a resident was outside, resulting in the resident exiting the facility a second time without staff knowledge. Review of the facility's investigation revealed the facility had not made a determination on how the resident had exited the facility without staff knowledge.<br><br>Observation on 09/15/15 at 3:15 PM of the location where Resident #1 was found, revealed the resident was off the facility grounds. The location required the resident to walk throughout a neighborhood and down the sidewalk of a busy two lane street. The location was ½ mile away from the front entrance and was not visible from any part of the facility.<br><br>Interview with Licensed Practical Nurse (LPN) #4, on 09/17/15 at 8:00 AM, revealed she did not see Resident #1 leave the facility on 09/08/15 nor did she hear the facility's alarm system sound when the resident eloped on 09/08/15. She stated she saw Resident #1 at approximately 5:30 PM on 09/08/15 standing in the front lobby/dining area looking out the glass door. She stated she then | F 323 | | |

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| F 323 | Continued From page 23 re-directed Resident #1 away from the front door due the resident's code alert/wander guard bracelet sounding the alarm. She stated Resident #1 turned and walked toward the west hallway and she did not see Resident #1 for the remainder of her shift. She stated at approximately 6:30 PM, LPN #1 walked up to the nurses' station and stated she thought she saw Resident #1 outside the facility. LPN #4 stated she immediately walked to Resident #1's room and found the resident not there. LPN #4 called a code yellow and all staff immediately began counting residents and searching inside and outside the building for Resident #1. LPN #4 stated at approximately 6:45 PM, the MDS Director called the facility and stated she found Resident #1. LPN #4 further stated Resident #1 never voiced to her that he/she wanted to leave the facility and LPN #4 stated she never saw Resident #1 trying to exit the facility without staff.<br><br>Interview with LPN #1, on 09/17/15 at 9:45 AM, revealed she thought she saw Resident #1 outside the facility on 09/08/15. LPN #1 stated on 09/08/15 at approximately 6:20 PM she pulled into the facility's employee parking lot and parked her vehicle. She stated she had food with her and she began eating her food and looking at her cell phone. LPN #1 stated she happened to glance over to the front of the building and she saw the back of a man who she thought resembled Resident #1 standing near the front of the building near the visitor's parking lot. LPN #1 stated she finished eating her meal and went into the facility to start her shift. LPN #1 stated after entering the facility she clocked in and walked straight to the nurses' station where she told the staff sitting there that she thought she had seen Resident #1 outside the facility. LPN #1 stated the | F 323 | | |

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STREET ADDRESS, CITY, STATE, ZIP CODE
**708 BARTLEY AVENUE**
**BARDSTOWN, KY 40004**

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| F 323 | Continued From page 24<br>staff immediately went to Resident #1's room and discovered he was missing and a code yellow was called and all the staff began head counts of the residents and searched for Resident #1. LPN #1 then stated the second time Resident #1 eloped on 09/08/15; she did not hear the code alert/wander guard system sound. LPN #1 further stated she never heard Resident #1 state he wanted to leave the facility and she never saw Resident #1 trying to exit the facility.<br><br>Interview with Registered Nurse (RN) #1, on 09/17/15 at 8:30 AM, revealed she had last seen Resident #1 at approximately 6:15 PM on 09/08/15 walking down the east hallway. RN #1 stated at approximately 6:25 PM on 09/08/15, LPN #1 came to the nurses' station and reported she thought she saw Resident #1 outside the facility. RN #1 stated she immediately walked to Resident #1's room with LPN #4 and they both discovered he/she was not in the room. RN #1 stated she immediately called a code yellow and began looking for the resident inside the building while the other staff member went outside the building to search for the resident. RN #1 stated the MDS Director called the facility at approximately 6:45 PM and stated she had found Resident #1. RN #1 further stated at approximately 7:00 PM on 09/08/15, Resident #1 was found outside the facility on the front sidewalk by a neighbor a second time. She stated the neighbor came to the front door of the facility and alerted staff that a resident was outside, standing on the sidewalk. RN #1 stated this was the second time on 09/08/15 that Resident #1 had exited the facility without staff knowledge. RN #1 also stated she did not hear the code alert sound either time Resident #1 eloped on 09/08/15. Further interview with RN #1 revealed | F 323 | | |

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| F 323 | Continued From page 25<br>Resident #1 never stated to her that he/she wanted to go home or leave the facility and RN #1 had never seen Resident #1 trying to exit the facility.<br><br>Interview with the Minimum Data Set (MDS) Director, on 09/15/15 at 3:15 PM, revealed she found Resident #1 off the facility grounds on 09/08/15 without staff present. She stated on 09/08/15 at approximately 6:30 PM she was driving when she received a text from the Administrator stating code yellow for Resident #1. She stated she continued driving when she saw Resident #1 walking away from the facility. She stated she immediately pulled over and assisted Resident #1 into her vehicle then drove the resident back to the facility. She stated the resident had dirt on his/her hands. She stated she asked the resident if he/she was okay and he/she stated, "Yes". The MDS Director stated when escorting Resident #1 back into the facility after this elopement his/her code alert/wander guard bracelet sounded the system. The MDS Director also stated Resident #1 wore a short sleeve shirt, long pants and tennis shoes. The MDS Director further stated she had never seen Resident #1 trying to push open doors to exit the facility in the past and Resident #1 never stated to her that he/she wanted to leave the facility.<br><br>Interview with Certified Medication Technician (CMT) #1, on 09/16/15 at 10:05 AM, revealed on 09/08/15 she observed Resident #1 during the first (1st) shift, seven (7) AM - seven (7) PM and Resident #1 was freely ambulating throughout the facility. CMT #1 revealed Resident #1 never stated to her that he/she wanted to leave the facility or go home, and Resident #1 was never observed by her displaying any exit seeking | F 323 | | |

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| F 323 | Continued From page 26<br>behaviors. She stated she last saw Resident #1 on 09/08/15 at approximately 5:45 PM in the back hallway and she did not hear the code alert/wander guard system sound when Resident #1 eloped.<br><br>Interview with LPN #5, on 09/16/15 at 10:30 AM, revealed she saw Resident #1 on 09/08/15 before he eloped from the facility. LPN #5 stated on 09/08/15 at approximately 6:00 PM she entered Resident #1's room to give him/her a dinner tray. LPN #5 stated at that time Resident #1 was lying flat on his/her back on his/her bed. LPN #5 stated when she arrived in the room with the tray Resident #1 immediately sat up and began eating. LPN #5 stated she did not see Resident #1 again before he eloped. LPN #5 stated she did not hear the code alert/wander guard system sound either time when Resident #1 eloped on 09/08/15. LPN #5 further stated she had never seen Resident #1 exit seeking or trying to leave the facility at any time and Resident #1 never expressed to her that he/she wanted to leave the facility.<br><br>Interview with Certified Nursing Assistance (CNA) #2, on 09/16/15 at 3:00 PM, revealed she worked second (2nd) shift, 2:00 PM - 10:00 PM on 09/08/15. CNA #2 stated she saw Resident #1 walking freely throughout the facility on 09/08/15 and could not recall the time, but knew it was before Resident #1 eloped the first (1st) time. CNA #2 stated she did not see Resident #1 exit seeking at any point while she was working on 09/08/15 and the resident did not voice any concerns about leaving the facility or going home. CNA #2 further stated she did not hear the code alert/wander guard system sound when Resident #1 exited the facility twice on 09/08/15. | F 323 | | |

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| F 323 | Continued From page 27<br><br>Interview with the Director of Nursing (DON), on 09/17/15 at 10:00 AM, revealed she was made aware Resident #1 had eloped the first time on 09/08/15 at approximately 6:40 PM by receiving a phone call from RN #1. The DON stated she was not on facility grounds when the first elopement occurred with Resident #1. The DON stated she arrived shortly after receiving the first phone call, but did not remember the time of arrival. She stated upon arrival to the facility she immediately began corrective action as well as an investigation that consisted of getting a head count of all the residents in the facility and checking the code alert/wander guard bracelets of the "at risk" residents.<br><br>Interview with the Administrator, on 09/17/15 at 10:30 AM, revealed he was made aware Resident #1 had eloped from the facility on 09/08/15 at approximately 6:30 PM by receiving a phone call from LPN #1. The Administrator stated he was out of the building and off facility grounds when the first elopement occurred with Resident #1. He stated he arrived at the facility at approximately 6:45 PM and began an investigation and corrective actions immediately that consisted of checking all monitored exterior doors for proper function. Per interview, the facility had not identified how Resident #1 exited the facility.<br><br>Continued interview with the DON, on 09/17/15 at 10:00 AM, revealed the facility did not have a standard of practice to monitor the residents. The DON stated the facility did not have a policy on supervision of residents and frequent visual checks were only initiated with a Physician's order. The DON stated Resident #1 was not | F 323 | | |

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| F 323 | Continued From page 28 placed on frequent visual checks or any type of monitoring after his/her first (1st) elopement on 09/08/15.<br><br>The facility provided an acceptable Allegation of Compliance (AOC), on 09/23/15, that alleged removal of the Immediate Jeopardy on 09/12/15. Review of the AOC revealed the facility implemented the following:<br><br>1. An immediate investigation included checking monitored exterior doors for proper function. This action was completed on 09/08/15 by the Administrator, DON, the Nursing Floor Supervisor and the Maintenance Supervisor. All doors were functioning correctly.<br><br>2. The Corporate Regional Plant Operations Director came to the facility on 09/09/15 and tested all the door alarm systems and all systems were found to be functioning correctly.<br><br>3. Placement, expiration and function of code alert/wander guard devices was checked by the DON and the Nursing Floor Supervisor on 09/08/15 and found all devices were functioning properly.<br><br>4. Interviews with all the nursing staff on duty 09/08/15 during Resident #1's elopements were completed by the Administrator. Interviews revealed there was no exit seeking behaviors noted that day for Resident #1 prior to facility exit. It was also stated by all staff members present that there was no sounding of the alarm system.<br><br>5. A Special Quality Assurance (QA) meeting was held on 09/11/15 with the Administrator, DON, Medical Director, and the Corporate Consultants. | F 323 | | |

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| F 323 | Continued From page 29<br>The Policy and Procedure for elopement was reviewed to ensure the process remained effective. The agenda for this QA meeting was to update the Medical Director of the current actions taken to ensure continuous safety of the residents and the ongoing efforts by the facility to ensure the elopement process remained effective.<br><br>6. All sixty one (61) elopement risk screens were reviewed to ensure accuracy by the Administrator, DON, and the Nursing Floor Supervisor on 09/08/15 and again on 09/09/15 by the Corporate Consultants. No new residents were found to be at risk for elopement. Audits of elopement risk screen and interventions would be done no less than weekly for four (4) weeks and monthly as part of the QA process.<br><br>7. All sixteen (16) residents identified as at risk for elopement, their comprehensive care plan and nurse aide care plans were reviewed by the DON and the MDS Director on 09/10/15. Review showed care plans and nurse aide care plans were appropriate and interventions were present. An audit of residents' care plans and nurse aide care plans would be done no less than weekly for four (4) weeks and monthly as part of the QA process.<br><br>8. On 09/10/15 the Treatment Administration Records (TAR) were audited going back 30 days by the Nursing Floor Supervisor and the DON to ensure all placement checks were done and completed timely. No issues were found. A weekly audit of TARs would be done for four (4) weeks to ensure continuous timeliness and accuracy of placement checks as part of the QA process. | F 323 | | |

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| F 323 | Continued From page 30<br>9. Education of eighty-seven (87) staff members, including therapy staff was conducted 09/11/15 by the Staff Development, Housekeeping Supervisor, Therapy Program Director, and the Dietary Supervisor on the elopement policy and procedure, responsibilities when a Code Yellow is called, indicators of exit seeking behaviors, interventions for exit seeking behaviors, appropriate usage of doors, hiding the door code, and responsible actions to take when exiting the building. This education was added to the facility orientation and CNA classes.<br><br>10. On 09/10/15, the Maintenance Director changed the exterior monitored door codes to ensure the code was unknown by all residents. The process for resetting the code was implemented. The process included resetting the exterior monitored door codes on the first of every month. An exception would be given if the first day of the month fell on a weekend, only during this exception would the code be changed on the following Monday. Beginning 09/11/15, a daily check of exterior monitored doors would be performed by the Maintenance Director or the Administrator to ensure proper function. Education of the code change process was given to all staff on this date.<br><br>11. On 09/09/15 an audit of the maintenance log was performed by the Corporate Consultants to ensure doors had been checked weekly. The audit revealed the maintenance log was up to date and the checks had been done timely.<br><br>12. An audit of the code alert/wander guard list of expiration dates was completed to ensure timeliness. An audit of the list of the sixteen (16) at risk residents, revealed the list was up to date | F 323 | | |

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| F 323 | Continued From page 31 and in front of each Medication Administration Record (MAR) and a copy was at the receptionist's desk. These audits were performed by the Corporate Consultant on 09/09/15. These lists would be audited no less than weekly for four (4) weeks and monthly as part of the QA process.<br><br>13. All residents' window sash vent stops were checked 09/10/15 by the Administrator and the Maintenance Director and were found in place and functioning properly with securing devices in place.<br><br>14. On 09/11/15 a review of all 24 hour report forms and all incident reports from the last 30 days were reviewed by the Corporate Consultant to identify any residents who had any indicators for exit seeking behaviors. None were found on any of the reports. The Social Services Director was educated by the Corporate Consultant on continuing to monitor behavioral reports every morning to identify possible exiting behaviors and implementing interventions upon the presence of indicators of exiting behaviors.<br><br>15. On 09/11/15 an elopement drill/mock elopement was performed by the Administrator to test the second shift's accuracy of possible elopement response. The response was timely and proper elopement procedures were followed. Mock/drill elopements would be performed no less than monthly for three (3) months on each shift and then return to no less than quarterly drills to assure elopement response accuracy.<br><br>Through observation, interview and record review the State Survey Agency validated the AOC on 09/24/15 as follows: | F 323 | | |

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| F 323 | Continued From page 32<br>1. Review of the immediate investigation of checking monitored/exterior doors conducted on 09/08/15 revealed the first door checked/tested was the front entrance door at 6:50 PM.<br><br>Observation, on 09/15/15 between 2:27 PM and 2:40 PM, of all the monitored/exterior doors in the facility, revealed all doors were functioning correctly.<br><br>Interview with the Maintenance Director, on 09/15/15 at 2:40 PM, revealed all monitored/exterior doors were immediately tested by himself and the Administrator after the elopement occurred on 09/08/15 and all doors were functioning correctly.<br><br>Interview with the Administrator, DON and RN #1, on 09/23/15 at 1:30 PM, revealed they immediately began checking all the monitored/exterior doors throughout the facility and all the doors were functioning correctly.<br><br>2. Review of a written statement from the Corporate Regional Plant Operations Director (RPOD) revealed he completed a test on all the monitored/exterior doors and all doors were operating 100% with no issues.<br><br>Interview with the RPOD, on 09/23/15 at 3:30 PM, revealed on 09/09/15 he completed a test on all entry and exit doors, the overhead code alert paging system, and staff panels at both nurses' station. He stated he adjusted the volume on the overhead code alert/wander guard paging system, on all entry and exit doors and the staff panels at both nurses' stations. He further stated the paging system, including all pagers, was working and receiving pages and it appeared to | F 323 | | |

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| F 323 | Continued From page 33 | F 323 | | |

him that the whole system itself had been and was currently operating with no issues.

3. Interview with the DON and RN #1, on 09/23/15 at 1:32 PM, revealed they both completed placement, expiration and function of the code alert/wander guard checks throughout the entire facility and all the devices were functioning properly.

Observation, on 09/16/15 at 1:38 PM, of Resident #1's and Resident #13's code alert/wander guard device being tested by the DON and Maintenance Director revealed the devices were functioning property.

4. Review of six (6) written statements by nursing staff on duty 09/08/15 during the time Resident #1 eloped revealed Resident #1 had no exit seeking behaviors noted that day and no staff heard the sounding of the code alarm system both times Resident #1 eloped.

Interviews, on 09/16/15 at 8:30 AM with LPN #2; at 10:05 AM with CMT #1; at 10:30 AM with LPN #5; and, at 3:00 PM with CNA #2; and continued interviews, on 09/17/15 at 8:00 AM with LPN #4 and at 8:30 AM with RN #1, revealed they all were working on 09/08/15 during the time Resident #1 eloped from the facility. All staff members stated Resident #1 had no exit seeking behaviors before eloping the first time on 09/08/15. All staff members stated they did not hear the code alert alarm system sound either time Resident #1 eloped on 09/08/15.

5. Review of the QA meeting minutes and sign-in sheet revealed the meeting was held on 09/11/15 with the Administrator, DON, Medical Director and

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| F 323 | Continued From page 34 Corporate Consultants. The meeting minutes consisted of the elopement policy and procedure being reviewed.<br><br>Interview, on 09/23/15 at 2:53 PM, with the Clinical Corporate Consultant and at 3:51 PM with a Corporate Consultant, revealed both attended the QA meeting on 09/11/15. Both Consultants stated the meeting was held due to the elopement on 09/08/15 with Resident #1. The Consultants stated the purpose of the meeting was to address issues found or observed, analyze and identify opportunities for quality improvement and to communicate best practices and lessons learned. The Consultants further stated the elopement policy and procedure was also reviewed.<br><br>Interview, on 09/23/15 at 3:00 PM, with the Medical Director revealed he attended the QA meeting by phone on 09/11/15. The Medical Director stated the purpose of the meeting was to discuss the elopement regarding Resident #1. The Medical Director stated he discussed with the QA Committee during the meeting the elopement policy and procedures, assessing residents for being at risk for elopement, interventions, goals and monitoring at risk residents. The Medical Director further stated he made a recommendation to discuss and review all elopement risk residents at all future QA meetings monthly to ensure the interventions remained effective.<br><br>Interview, on 09/23/15 at 1:38 PM, with the Administrator and DON, revealed they both attended the QA meeting held on 09/11/15. Both stated the group reviewed the elopement policy and procedures. | F 323 | | |

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| F 323 | Continued From page 35<br><br>6. Review of Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13's elopement risk screens revealed they were all completed timely and accurate.<br><br>Interview, on 09/23/15 at 1:48 PM, with the Administrator, DON and RN #1, revealed they reviewed sixty-one (61) elopement risks screens on 09/08/15 and found the assessments were completed timely and were accurate. The DON further stated audits of the elopement risk screens and interventions would be completed weekly for four (4) weeks then monthly as part of their QA process.<br><br>Interview, on 09/23/15 at 2:53 PM, with the Clinical Corporate Consultant, revealed she reviewed all sixty-one (61) elopement risk screens on 09/09/15 and she found the assessments were completed timely and were accurate.<br><br>7. Review of Resident #1, #3, #4, #10, #11, #12, and #13's care plan and nurse aide care plan, revealed they all had an elopement care plan and nurse aide care plan that included interventions.<br><br>Interview, on 09/22/15 at 1:55 PM, with the MDS Director, revealed she reviewed all sixteen (16) elopement risk resident care plans and aide care plans to monitor if appropriate and if interventions were present. The MDS Director stated no issues were found.<br><br>Interview, on 09/23/15 at 1:52 PM, with the DON revealed she reviewed all sixteen (16) elopement risk assessments and found that each care plan and nurse aide care plan was appropriate and | F 323 | | |

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| COLONIAL HEALTH AND REHABILITATION CENTER | 708 BARTLEY AVENUE BARDSTOWN, KY 40004 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 323 | Continued From page 36 interventions were present. The DON further stated audits of the care plans and nurse aide care plans would be completed weekly for four (4) weeks then monthly as part of their QA process.<br><br>8. Review of Resident #1, #3, #4, #10, #11, #12, and #13's Treatment Administration Record (TAR), revealed the placement checks were noted and completed timely.<br><br>Interview with the DON, on 09/23/15 at 1:52 PM, revealed she audited the TARs going back 30 days and found no issues with the placement checks being completed and all were timely. The DON further stated the TAR audits would be completed weekly for four (4) weeks to ensure timeliness and accuracy as part of their QA process.<br><br>9. Review of the in-service training agenda and sign-in sheets revealed eighty-seven (87) staff members were trained on 09/11/15 that covered the elopement policy and procedures, responsibilities when a Code Yellow was called, indicators of exit seeking behaviors, interventions for exit seeking behaviors, appropriate usage of doors, hiding the door code, and responsible actions to take when exiting the building.<br><br>Interview, on 09/23/15 at 2:00 PM with CNA #1; at 2:05 PM with CNA #3; at 2:10 PM with Housekeeper #1; at 2:15 PM with Dietary Assistant; at 2:20 PM with LPN #6; at 2:25 PM with Dietary Aide; at 2:35 PM with Dishwasher; at 2:40 PM with CMT #2; at 2:45 PM with CNA #4; at 2:50 PM with CNA #5; at 2:55 PM with Certified Occupational Therapy Assistant (COTA); at 3:00 PM with Medical Records; at 3:05 PM with Housekeeper #2; at 3:10 PM with Housekeeper | F 323 | | |

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|---|---|---|---|
| | 185342 | | C 09/24/2015 |

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| F 323 | Continued From page 37<br>#3; at 3:15 PM with CNA #6; at 3:20 PM with Office Manager; and at 3:25 PM with the Bookkeeper; revealed all had been trained on 09/11/15 by their direct supervisor on the elopement policy and procedures, responsibilities when a Code Yellow was called, exit seeking residents, exit behaviors and usage of door codes.<br><br>Observation, on 09/22/15, 09/23/15, and 09/24/15 of staff keying in the code to enter and exit the facility revealed staff was looking around for residents and visitors before using the code at the door and staff hid the code so it could not be seen by any other person.<br><br>10. Review of the daily checks of exterior monitored doors revealed these doors had been checked each day beginning 09/09/15 and all doors were functioning properly.<br><br>Interview with the Maintenance Director, on 09/15/15 at 2:40 PM, revealed he began checking all exterior monitored doors daily on 09/09/15. He stated he changed the door codes on 09/08/15 after the second elopement with Resident #1. The Maintenance Director also stated he would change the door codes monthly, on the first day of the month. He further stated if the first day of the month fell on a weekend then he would change the code the following Monday.<br><br>11. Interview with the RPOD, on 09/23/15 at 3:30 PM, revealed on 09/09/15 he completed an audit on all maintenance logs to ensure doors had been checked weekly. RPOD stated the audit showed maintenance logs were up to date and checks were completed timely. | F 323 | | |

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| F 323 | Continued From page 38<br>12. Interview with the Clinical Corporate Consultant on 09/23/15 at 2:53 PM, revealed on 09/09/15 she conducted an audit on the code alert/wander guard list of the sixteen (16) residents at risk and audited their devices. The Consultant stated the devices' expiration dates were all timely and no issues were noted. The Consultant also stated code alert/wander guard list for at risk residents were all up to date in front of each Medication Administration Record (MAR) and at the receptionist's desk. The Consultant further stated the lists would be audited weekly for four (4) weeks and then monthly as part of their QA process.<br><br>Observation, on 09/15/15 at 4:00 PM, of Residents #1, #3, and #4, and on 09/22/15 at 4:45 PM, of Residents #10, #11, #12, and #13's MAR revealed the list was up to date.<br><br>Observation, on 09/15/15 at 2:40 PM, of the at risk list at the receptionist's desk revealed it was also up to date.<br><br>13. Interview, on 09/15/15 at 2:40 PM, with the Maintenance Director, revealed the Administrator and himself checked all window sash vent stops throughout the entire facility and found all sashes in place and functioning with securing devices in place.<br><br>Interview, on 09/17/15 at 10:30 AM, with the Administrator revealed the Maintenance Director and himself checked all the window sash vent stops including Resident #1's windows and all sashes were in place and functioning with securing devices in place.<br><br>Observation, on 09/15/15 at 2:32 PM, of Resident | F 323 | | |

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| F 323 | Continued From page 39<br>#1's window revealed the securing device was in place.<br><br>14. Interview with Corporate Consultant on 09/23/15 at 3:51 PM, revealed she conducted audits on all twenty-four (24) hour report forms from the last thirty (30) days and all incident reports from the last thirty (30) days to identify if any residents had any indicators for exit seeking behaviors. The Consultant stated none were found during this audit on any of the reports. The Consultant further stated she educated the Social Services Director on continuing to monitor behavioral reports every morning to identify possible exiting behaviors and implementing interventions.<br><br>Interview with the Social Services Director (SSD) on 09/24/15 at 9:40 AM, revealed she was educated on 09/11/15 by the Corporate Consultant on continuing to monitor behavioral reports every morning to identify possible exiting behaviors and implementing interventions if any of these behaviors were found. SSD stated this was a verbal training and she was not given any type of documents and she did not sign a sign-in sheet. SSD further stated she was the only Social Services staff for the facility.<br><br>15. Interview with the Administrator, on 09/23/15 at 1:38 PM, revealed he conducted an elopement drill/mock elopement on 09/11/15 to test the timeliness of the staff on second shift and to see if the staff followed the proper elopement procedures. The Administrator stated all staff followed the proper elopement procedures and he would continue to perform mock/drills elopements monthly for three (3) months on each shift and then return to conducting the drills quarterly | F 323 | | |

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| F 323 | Continued From page 40 thereafter. Administrator further stated all audits would be reviewed during the monthly QA meetings and all discrepancies would be addressed. | F 323 | | |