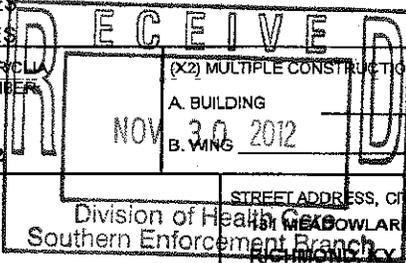


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/02/2012
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NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 51 MEADOWLARK DRIVE RICHMOND, KY 40475
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY19245, KY19280) was initiated on 10/30/12 and completed on 11/02/12. Both complaints were substantiated with deficiencies cited.</p> <p>Deficient practice was identified at "D" level at CFR 483.25 Quality of Care (F314) related to KY19245. Deficiencies were cited at "J" level at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323), with Substandard Quality of Care at 42 CFR 483.25 Quality of Care related to KY19280.</p> <p>The facility failed to have an effective system to ensure adequate supervision and monitoring was provided to prevent accidents for one of seven sampled residents (Resident #1). Resident #1 was assessed by the facility to be at risk for elopement. On 10/27/12, the resident eloped from the facility without staff knowledge and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at approximately 8:30 PM, and found six-tenths of a mile from the facility at approximately 9:30 PM (one hour later), by a community member. Resident #1 was assisted back to the facility and assessed to have sustained no injuries.</p> <p>The Immediate Jeopardy was identified on 10/31/12, was determined to exist on 10/27/12, and continued through 10/29/12. The facility completed corrective actions prior to the State Survey Agency's investigation on 10/30/12; therefore, the Jeopardy was determined to be Past Jeopardy.</p>	F 000		
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Royce Barber</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/30/12</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.

Received Time Nov. 30. 2012 10:13AM No. 3097

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F 282 SS=J	Continued From page 1 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to have an effective system to ensure services were provided in accordance with each written comprehensive plan of care for one of seven sampled residents (Resident #1). The facility identified Resident #1 to be at risk for elopement and developed a care plan with interventions which included allowing the resident safe wandering, and notification of the nurse and family if the resident displayed behaviors. However, the facility failed to ensure the interventions were implemented as detailed in the resident's plan of care. Direct care staff interviews revealed on 10/27/12 Resident #1 exhibited increased behaviors of agitation and wandering, wandered to a different unit, and voiced wanting to leave the facility. However, staff failed to report the resident's change in behavior to the nurse and failed to increase supervision for Resident #1. On 10/27/12, Resident #1 exited the building without staff knowledge, and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at approximately 8:30 PM, and returned to the facility at approximately	F 282	Past noncompliance: no plan of correction required.		

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F 282	<p>Continued From page 2</p> <p>9:30 PM (one hour later), Resident #1 was escorted back inside the building and assessed to have sustained no injuries.</p> <p>The facility's failure to have an effective system in place to ensure services were provided in accordance with each individual's written plan of care was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 10/27/12, and continued until 10/29/12. The facility completed corrective actions prior to the State Survey Agency's investigation on 10/30/12; therefore, the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>A review of the facility's Accidents and Supervision to Prevent Accidents, Elopement Risk Evaluation (both revised on 04/28/11) revealed the facility would identify residents at risk for elopement and implement measures to reduce the likelihood of the resident successfully eloping from the facility.</p> <p>A review of the facility's Care Plan Policy Statement (undated) and Elopement Prevention policy/procedure (undated) revealed resident risk factors associated with identified problems would be included on the resident's plan of care, which would be updated with any change in condition.</p> <p>A review of the facility's investigation revealed Resident #1 successfully eloped from the facility on 10/27/12, without staff knowledge, and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at approximately 8:30 PM, and was found</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>approximately 0.6 tenths of a mile from the facility by a member of the community at approximately 9:30 PM. The facility's investigation concluded that although Resident #1 utilized a wander guard bracelet, the resident most likely exited the facility via the front entrance after the wander guard system to the door was disabled, or behind a visitor, exiting the facility through one of three facility doors not equipped with the wander guard system.</p> <p>An interview conducted on 10/31/12 at 10:50 AM with Certified Nursing Assistant (CNA) #1 caring for Resident #1 on 10/27/12, revealed Resident #1 had displayed an increase in wandering behavior prior to leaving the facility without staff knowledge on 10/27/12. CNA #1 stated she had walked the resident around inside the facility in an attempt to tire the resident, and therefore decrease his/her wandering behaviors prior to the resident eloping. CNA #1 described Resident #1 as being "more anxious," and stated the resident was attempting to walk without assistance, and verbalizing a desire to leave the facility. However, CNA #1 stated she did not notify the nurse of Resident #1's increased behaviors or voicing desires to leave the facility, and no increased supervision was provided for Resident #1.</p> <p>Additional interviews conducted with staff caring for Resident #1 on 10/27/12, prior to the resident eloping from the facility, revealed the staff members were aware of a change in the residents behavior, but failed to notify the nurse of the changes in the resident's condition as required by Resident #1's plan of care. Interviews conducted on 10/31/12 at 2:30 PM with CNA #2, at 1:45 PM with CNA #3, and at 1:20 PM</p>	F 282			

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F 282	<p>Continued From page 4</p> <p>with CNA #4, revealed each of the staff members had observed Resident #1 to be more active on 10/27/12. CNA #3 stated Resident #1 was attempting to walk unassisted, displaying anxious behavior and appeared "to be on a mission." CNA #4 reported redirecting Resident #1 back to his/her unit after discovering the resident ambulating unassisted on a different unit. CNA #4 stated while assisting the resident to his room, the resident asked her to "let (him/her) out the door." Although the staff members all stated walking independently and voicing a desire to leave the facility was a change in condition for Resident #1, the staff did not report the change in behavior to the nurse, and no additional interventions were implemented in an effort to ensure Resident #1 remained safe in the facility.</p> <p>An interview was conducted on 10/31/12 at 12:55 PM with Registered Nurse (RN) #1 who was responsible for Resident #1's care on 10/27/12, prior to the resident eloping from the facility. RN #1 stated she had observed Resident #1 to be agitated on 10/27/12, but stated she had received no reports from staff that the resident was walking unassisted or voicing a desire to leave the facility.</p> <p>An interview conducted on 11/01/12 at 4:00 PM with the Director of Nursing (DON) revealed Resident #1 displaying agitation, walking unassisted, and voicing a desire to leave the facility would all be behaviors that required notifying the nurse so interventions could be determined and implemented to keep Resident #1 safe.</p> <p>Review of Resident #1's admission nursing</p>	F 282		

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F 282	<p>Continued From page 5</p> <p>assessment conducted on 07/26/12, revealed the facility assessed Resident #1 to be cognitively impaired, and able to move about the facility independently in a wheelchair, and therefore determined Resident #1 to be at risk for elopement.</p> <p>Resident #1's Minimum Data Set (MDS) Admission Assessment dated 08/08/12, revealed the facility assessed Resident #1 to be severely cognitively impaired, and to display verbal and physical behavioral symptoms.</p> <p>A review of Resident #1's Comprehensive Care Plan dated 07/27/12 and revised on 08/22/12, revealed Resident #1 would be provided opportunity for safe wandering, and redirection as needed to prevent elopement. Additionally, staff were to notify the nurse and Resident #1's family when behaviors were displayed so appropriate interventions could be determined and implemented.</p> <p>Observations of Resident #1 on 10/30/12 at 1:00 PM, revealed the resident to be awake and alert, and able to answer questions; however, Resident #1's answers to questions were not appropriate, and the resident displayed obvious cognitive impairment.</p> <p>*The facility implemented the following actions to correct the deficiency:</p> <p>The Director of Nursing was notified on 10/27/12 at 9:15 PM that Resident #1 was missing from the facility. A headcount was immediately performed, and all other residents were accounted for inside the facility.</p>	F 282			

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F 282	<p>Continued From page 6</p> <p>The Regional Nurse Consultant was notified at approximately 9:30 PM that Resident #1 had eloped from the facility.</p> <p>Upon return to the facility on 10/27/12, it was determined Resident #1 was wearing a wander guard bracelet which was determined to be functioning appropriately.</p> <p>Resident #1 was returned inside the facility and assessed to have sustained no injuries.</p> <p>RN #1 completed the post elopement form for Resident #1, and immediately placed the resident on 1:1 supervision.</p> <p>All wander guard bracelets utilized by residents were checked for function, placement and expiration date on 10/27/12 by RN #1 and Unit Manager #2.</p> <p>The Administrator verified Wander Risk Books were in place at the Nurses Stations, Administrator's Office and the Front Desk, and assessed all doors to be functioning appropriately on 10/27/12.</p> <p>The Regional Nurse Consultant, Director of Nursing and Unit Managers questioned all staff in the facility on 10/27/12 regarding facility residents to ensure all risk factors for elopement including changes in behavior had been identified and addressed.</p> <p>All staff were re-educated beginning on 10/27/12, and will continue until all staff have completed the training. Staff who has not had the</p>	F 282			

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F 282	<p>Continued From page 7</p> <p>training/competency exam will not be permitted to work in the facility. The training included the following:</p> <p>*Elopement- anyone leaving a safe place to an unsafe place without supervision.</p> <p>*On admission to the facility and with any change of condition, a nurse must complete an elopement assessment.</p> <p>*If the door alarm sounds, staff should immediately respond to appropriate door, bring the resident back in facility, and notify the nurse of the attempt to leave. If staff does not see the resident at the door, they need to check the immediate area. If staff still does not see the resident, report to the charge nurse.</p> <p>*If a head count confirms that a resident has left the building, staff is to check outside of the building on the premises. The Charge nurse will make sure the DON and the Administrator are aware of the situation. If the resident is not located on the premises, the DON, Administrator, and local law enforcement will be notified. Staff, along with help from the police, will search in any neighboring areas.</p> <p>*If an elopement occurs, make sure the nurse in charge of that resident does a skin assessment, pain assessment, interview, and a follow-up with DON for any further instructions.</p> <p>*Licensed Nurses will complete the Accident and Incident report and record the information on the 24-hour Report.</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>*A Missing resident action plan- Post Elopement Form will be completed(The form includes what the resident is wearing, what time the resident was found, where the resident was found, the temperature outside, etc.)</p> <p>*If the door alarms are not working properly, the DON, Administrator, and Maintenance Director are to be notified immediately. Perform a head count at this time and initiate one on one supervision with all residents with a wander guard. If necessary, staff may have to have two or three residents each and keep them together due to staffing, especially on night shift.</p> <p>*All residents that go outside the facility with anybody except staff (even to sit on the front porch or the gazebo) have to sign out.</p> <p>On 10/27/12, CNA's began hourly monitoring of residents who were at risk for wandering to ensure they were in the facility. Unit Managers were to ensure this monitoring was completed. If a CNA was unable to complete the hourly monitoring, it would be reported to the Charge Nurse for re-assignment. The Unit Manager would be responsible to verify that the hourly checks were completed.</p> <p>Beginning 10/27/12 facility doors not equipped with a wander guard system were being continually monitored by facility staff to ensure the doors were being utilized during emergencies only. The monitoring will continue until all facility doors are installed with a wander guard system, and they are verified to function appropriately.</p> <p>The Regional Nurse Consultant, Administrator,</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>Director of Nursing, Unit Managers and Social Services Director conducted a Quality Assurance meeting on 10/28/12 which included a review of the Head Count Policy, Elopement Prevention Policy, Missing Resident Action Plan, Post Elopement Form and the Activities and Care Plan policies/procedures.</p> <p>Resident #1's physician was notified of the elopement and the resident's assessment finding on 10/27/12. No new orders pertaining to Resident #1 were received.</p> <p>The facility's Medical Director was notified of Resident #1's elopement on 10/28/2012.</p> <p>The Interdisciplinary Team consisting of the Unit Manager, Director of Nursing, Regional Nurse Consultant, and the Social Services Director conducted a meeting on 10/28/12 to review/revise all elopement, behavioral, and activity care plans and all elopement assessments were reviewed.</p> <p>All doors in the facility will be checked every shift for proper functioning by the Maintenance Director, Department Manager, or designee to ensure function is ongoing.</p> <p>On 10/28/12, The Regional Nurse Consultant, Director of Nursing, Unit Manager, and Social Services Director verified all residents at risk for wandering had a wander guard bracelet in place, and their picture/identifying information was contained in the wander risk books.</p> <p>On 10/29/12, an elopement drill was completed by the facility, with no concerns identified. Elopement drills will be conducted at least three</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>times weekly on random shifts for 12 weeks. The elopement drills consist of initiating a wander guard alarm and ensuring that staff follows the required steps for locating a missing resident.</p> <p>The Treatment Administration Records (TAR) for all residents identified to utilize a wander guard bracelet were reviewed by the Regional Nurse Consultant, Director of Nursing and Unit Manager on 10/28/12 to ensure the TAR had the wander guard bracelet listed and that placement, functioning and expiration date was checked and documented every shift.</p> <p>The Director of Nursing and Social Service Department checked the CNA Care Guide and AccuNurse system on 10/29/12, to ensure they correctly identified any resident assessed to be at risk for elopement.</p> <p>On 10/29/12, staff was given a written list of all residents considered to be at risk for elopement, which was derived from the wander risk books. Department Managers will copy this list daily and Licensed Nurses on each unit are to ensure staff has a copy. The wander risk list will be reviewed and revised daily to ensure changes are documented on the list and staff is made aware of any changes.</p> <p>On 10/28/12 the Director of Nursing, Regional Nurse Consultant, Social Services Director, and the Unit Manager had completed re-evaluating all residents at risk for elopement. All elopement, activity, and behavioral care plans were updated with any changes and/or new interventions documented.</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>The "button" located adjacent to the front door which disabled the wander guard alarm to the front door was secured shut and made inaccessible to staff, visitors and residents by the Administrator on 10/27/12.</p> <p>A meeting will be conducted at least weekly by the Director of Nursing, Administrator, Unit Manager, Social Services Director, Maintenance Supervisor, and the Regional Director of Operations or the Regional Nurse Consultant to review the elopement policies/procedures, ensure all required monitoring has been completed correctly, review all residents at risk for elopements (by review of the medical record, twenty-four hour report, and staff interviews) to ensure any changes that are needed are implemented. The meeting will also ensure all newly admitted residents have been assessed for elopement risks and verify facility doors are functioning correctly.</p> <p>All newly hired employees will be educated regarding the facility's elopement policies/procedures by the Education Director.</p> <p>The Regional Nurse Consultant will audit all newly hired employee files weekly for eight weeks, beginning the week of 10/28/12.</p> <p>Beginning 10/28/12, the Regional Nurse Consultant will monitor weekly to ensure elopement procedures are followed and care plans are initiated and updated with changes to ensure any behaviors or newly identified risks have been addressed and appropriate interventions initiated.</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>Beginning 10/28/12, the Director of Nursing, Assistant Director of Nursing, or the Unit Manager will monitor each resident's Treatment Administration Record who utilizes a wander guard bracelet daily to ensure the staff has checked the wander guard bracelet for placement function and expiration date.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Interview with the DON on 11/02/12 at 10:45 AM confirmed she was notified of Resident #1's elopement on 10/27/12. Interview with RN #1 on 10/31/12, at 12:55 PM, and facility documentation revealed she had completed a head count for the entire facility and identified no concerns.</p> <p>Interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM confirmed she had been notified of Resident #1's elopement on 10/27/12.</p> <p>A review of facility documentation and interview with the RN #1 on 10/31/12 at 12:55 PM confirmed the wander guard Resident #1 was wearing at the time of the elopement was functioning appropriately and sounded when the resident re-entered the facility.</p> <p>A review of a post elopement form dated 10/27/12, and interview with RN #1 on 10/31/12 at 12:55 PM revealed the facility had assessed the resident and found no injuries.</p> <p>Documentation and interview with RN #1 on 10/31/12 at 12:55 PM revealed the resident was placed on 1:1 monitoring upon return to the facility. Facility documentation and observations</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>on 10/30/12-11/02/12 confirmed Resident #1 remained on 1:1 supervision</p> <p>Review of facility documentation and interview with RN #1 on 10/31/12 at 12:55 PM and Unit Manager #1 on 11/02/12 at 10:40 AM revealed all wander guards utilized by residents were checked for placement, function, and expiration date on 10/27/12. Observations conducted on 10/30/12 from 3:14 PM until 3:42 PM with Unit Manager #2 revealed all wander guard bracelets utilized by residents assessed to be at risk for elopement were in place and functioning appropriately.</p> <p>Interview with the Administrator on 11/02/12 at 9:30 AM revealed he had confirmed all the Wander Risk Books were in their designated places on 10/27/12. Observations on 10/30/12 at 3:45 PM revealed Wander Risk Books were located at the Front Desk, Administrators Office, and at each Nurses Station.</p> <p>A review of facility signed statements by staff working on 10/27/12, and interviews on 10/31/12 at 2:30 PM with CNA #2, at 1:45 PM with CNA #3, and at 1:20 PM with CNA #4 revealed they were questioned and provided answers regarding resident behaviors and if they believed anyone in the facility was at risk for elopement.</p> <p>Interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM, and the Education Director on 11/02/12 at 5:00 PM, and review of Elopement Education Sign in sheets confirmed on 10/27/12, the Regional Nurse Consultant initiated education with facility staff, to include all departments, on the elopement/missing resident protocols. Education is on-going by the Education Director.</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>The Education Director confirmed staff would not be permitted to work without having attended the in-service. Interviews conducted on 10/30/12, at 3:42 PM with Unit Manager #1, 11/01/12 at 10:40 AM with Unit Manager #2, 10/31/12 at 12:55 PM with RN #1, 11/02/12 at 11:40 AM with LPN #1, 11/02/12 at 11:30 AM with the Maintenance Director, 10/31/12 at 10:50 AM with CNA #1, 10/31/12 at 11:00 AM with LPN #2, 10/31/12 at 2:45 PM with RN #2, 10/31/12 at 10:35 AM with CNA #5, 10/31/12 at 1:20 PM with CNA #4, 10/31/12 at 2:30 PM with CNA #2, and 10/31/12 at 1:45 PM with CNA #3, revealed all the staff had attended the in-service, and was knowledgeable regarding the facility's elopement policies and procedures.</p> <p>A review of facility documentation and interviews on 10/31/12 at 11:00 AM with LPN #2, 10:50 AM with CNA #1 and at 10:35 AM with CNA #5, revealed the CNA's were checking all residents in the facility hourly to ensure they were in the building and/or accounted for. The staff were knowledgeable regarding notification of the nurse if they were unable to complete the hourly checks. Interviews on 11/2/12 at 11:00 AM with Unit Manager #2 and at 10:40 AM with Unit Manager #1 revealed they were responsible to ensure the hourly resident checks were conducted.</p> <p>Review of facility documentation, interview with the Administrator and Maintenance Director on 10/30/12 at 4:40 PM, and observations on 10/30/12 from 4:30 PM until 4:38 PM revealed doors not equipped with a wander guard system were being continually monitored by staff to ensure the doors were being utilized only as</p>	F 282			

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F 282	<p>Continued From page 15 emergency exits.</p> <p>Review of facility documentation, and interviews on 10/30/12 at 1:30 PM with the Regional Nurse Consultant and Administrator, 11/02/12 at 10:45 AM with the DON, 11/02/12 at 10:40 AM with Unit Manager #2, and 11/02/12 at 4:50 PM with the Social Services Director, revealed a Quality Assurance meeting was conducted on 10/28/12 which included a review of the facility's head count policy, elopement prevention policy, missing resident action plan, post elopement form, and the Care Plan policy.</p> <p>Review of the Post Elopement form for Resident #1 dated 10/27/12, and interview on 11/02/12 at 10:40 AM with Unit Manager #2 revealed Resident #1's physician was notified of the elopement on 10/27/12, but gave no new orders pertaining to Resident #1.</p> <p>Review of facility documentation and interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM revealed the Medical Director was notified of the incident on 10/28/12.</p> <p>Interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM, and review of facility documentation confirmed the facility had performed the following actions: On 10/28/12, the DON, Regional Nurse Consultant, and Social Services Director reviewed all wander/elopement assessments for all residents previously identified at risk for elopement for accuracy. The assessments were deemed accurate. Additionally, on 10/28/12, all residents behavioral and activity care plans were reviewed for accuracy and all the assessments were deemed</p>	F 282			

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F 282	<p>Continued From page 16 accurate.</p> <p>Review of facility documentation and interview with the Maintenance Director on 10/31/12 at 11:30 AM, revealed all doors in the facility were checked every shift to ensure proper functioning.</p> <p>Review of facility documentation and interview on 10/30/12 at 1:30 PM, 11/02/12 at 10:45 AM with the Director of Nursing, 11/02/12 at 10:40 AM with Unit Manager #2, and on 11/02/12 at 4:50 PM with the Social Services Director revealed on 10/28/12 all residents at risk for wandering were determined to have a wander guard bracelet in place, and their picture/identifying information was contained in the wander risk books. All resident Treatment Administration Records were audited to ensure each record had the wander guard bracelet listed, and staff was ensuring it was in place, functioning, and within the expiration date every shift.</p> <p>A review of an elopement drill dated 10/29/12 and interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM, Unit Manager #1 on 11/02/12 at 11:00 AM, and Unit Manager #2 on 11/02/12 at 10:40 AM revealed the elopement drill had been conducted. A review of a tentative facility calendar revealed elopement drills were scheduled every three weeks on random shifts.</p> <p>A review of Resident #1's CNA Care Guide on 10/30/12 revealed the resident was identified to be at risk for elopement. Interviews with the DON on 11/02/12 at 10:45 AM revealed the AccuNurse system and CNA care guides had been updated on 10/29/12 to ensure all information was correct. No problems were identified, and all residents</p>	F 282			

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F 282	<p>Continued From page 17</p> <p>were correctly identified to be at risk for elopement.</p> <p>Observation and interview on 11/02/12 at 11:40 AM with LPN #2 revealed the staff had a written list containing the names of all residents at risk for elopement. Interviews on 11/02/12 at 11:00 AM with Unit Manager #1, and at 10:40 AM with Unit Manager #2, revealed they were responsible to ensure staff has a written copy of the list provided to them daily, and to review and revise the list daily to ensure change is documented on the list and staff made aware.</p> <p>Observation on 10/30/12 at 4:42 PM revealed the "button" to disengage the wander guard system to the front door had been secured and was inaccessible to any staff, resident, or visitor. Additionally, the wander guard system was confirmed to be functioning appropriately at the front door.</p> <p>Review of facility documentation and interview with the DON 11/02/12 at 11:05 AM, revealed the facility is reviewing elopement policies/procedures and the corrective action implemented as a result of Resident #1 eloping on 10/27/12, daily in the facility stand down meetings.</p> <p>Interview on 11/02/12 at 5:00 PM with the Education Director and review of employee files hired on 10/31/12, revealed education regarding elopement policies/procedures had been completed.</p> <p>Review of facility documentation dated 10/28/12 and 10/31/12, and interviews with the Regional Nurse Consultant on 10/30/12 at 1:30 PM</p>	F 282			

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F 282	Continued From page 18 revealed the Regional Nurse Consultant had monitored to ensure elopement procedures had been followed and care plans were initiated and updated with changes to ensure any behaviors or newly identified risks had been addressed and appropriate interventions initiated. A review of facility documentation and interviews on 10/30/12 at 1:30 PM with the Regional Nurse Consultant, and on 11/02/12 at 10:45 AM with the DON, and at 11:15 AM with the Assistant DON, revealed Treatment Administration Records had been reviewed daily to ensure they contained documentation that the residents wander guard bracelet was in place, functioning and within the expiration date.	F 282			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policies/procedures, it was determined the facility failed to ensure one of three sampled residents (Resident #5) received necessary treatment/services to promote healing or to prevent the development of new pressure	F 314	F314 1. Resident #5 physician and family were notified by the Director of Nursing (DON) of all wounds, treatments and assessment on 11/2/2012.No new orders noted. The Medical Director was notified of all findings on 11/3/2012 by the D.O.N. and the result of a 100% skin audit completed on all residents in the center on 11/2/2012.No new orders noted. 2. A 100% skin audit was completed on every resident in the center on 11/2/2012 by the DON/Unit Manager (UM)/Regional Nurse Consultant (RNC) and ADON (Assistant Director of Nursing) to identify any resident with changes /impairment in skin, to identify if any skin change was previously documented and that all wounds are staged correctly and if there was a treatment in place.		

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F 314	<p>Continued From page 19</p> <p>ulcers. Resident #5 was readmitted to the facility on 09/07/12 with a Stage IV pressure ulcer of the sacrum, a Stage II pressure sore of the left foot, and was assessed upon readmission to be at risk for the development of pressure ulcers. Review of physician orders dated 09/07/12, revealed staff were to provide treatment to the pressure area on the resident's sacrum. However, there was no evidence the physician had prescribed a treatment for the pressure sore on the resident's left foot or that facility obtained an order from the physician for treatment of the ulcer upon readmission. In addition, staff interview confirmed a skin assessment was conducted for Resident #5 on 10/12/12 and a newly developed pressure ulcer was present on the resident's left lower leg. However, facility staff failed to appropriately assess the ulcer and failed to obtain a treatment order for the newly developed ulcer until 10/14/12 (2 days later).</p> <p>The findings include:</p> <p>Review of the facility policy "Prevention of Pressure Ulcers" (no date) revealed risk factors for pressure ulcer development would be assessed and interventions would be implemented to prevent the development of pressure ulcers. The policy identified risk factors as moisture, friction/shearing, clinical conditions, decreased mobility, impaired blood flow, and resident non-compliance.</p> <p>Review of the medical record revealed the facility readmitted Resident #5 on 09/07/12 after an extended acute care hospital stay with diagnoses to include Multiple Sclerosis, Debility, Stage IV pressure ulcer to the sacrum, Stage II pressure</p>	F 314	<p>Any issue identified was immediately corrected and both physician and family were notified. ADON reviewed all Treatment Administration Record (TAR) on 11/2/2012 and compared them to current physicians orders to identify if every skin change/impairment had the correct order, that all skin change had an order on the TAR, that all residents had an order on the TAR for a weekly skin assessment and that every treatment was being performed per the physicians orders. Any issue identified was immediately corrected and both physician and family were notified. DON reviewed every admission/re admission within past 30 days(10/1/2012 through 11/2/2012) to identify any admission or re admission that did not have a timely skin assessment, that the physicians orders were transcribed per the physicians order and any area of skin impairment/change noted on any admission/re admission had an order to address. This was completed on 11/6/2012. Any issue identified was immediately corrected and both the physician and family were notified.</p> <p>3.RNC re educated DON and ADON on 11/2/2012 regarding procedure for skin assessments on admission; weekly skin assessments, correct wound staging, physician and family notification of skin impairment, turning and repositioning, identification of patients with increased risk for skin impairment and skin impairment prevention protocol. Education Training Director re educated licensed nurses on 11/9/2012 regarding admission skin assessment, the skin protocol, , weekly skin assessments, correct wound staging, following</p>	
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F 314	<p>Continued From page 20</p> <p>ulcer to the left heel, history of bilateral lower extremity deep venous thrombosis(DVT), and Depression. Review of the admission physician orders dated 09/07/12, revealed the physician requested staff to provide treatment to the resident's sacrum. Although Resident #5's admission physician orders dated 09/07/12, revealed facility staff was to provide treatment for the sacral ulcer, there was no evidence the physician had ordered a treatment for the left foot ulcer.</p> <p>Interview with Licensed Practical Nurse (LPN #2) conducted on 11/01/12, at 2:15 PM, revealed she had worked the 7:00 AM to 7:00 PM shift when Resident #5 was readmitted to the facility on 09/07/12. LPN #2 stated the resident was transferred back to the facility from the hospital near the end of the 7:00 AM to 7:00 PM shift. LPN #2 stated she received the resident's readmission physician's orders and faxed the orders to the pharmacy. The LPN stated she did not complete a skin assessment for Resident #5 when the resident was readmitted since the on-coming shift was responsible to complete the skin assessment and notify the physician for additional orders, if indicated.</p> <p>Interview conducted Registered Nurse (RN #1) on 11/01/12, at 3:25 PM, revealed she was the 7:00 PM to 7:00 AM shift nurse on 09/07/12. RN #1 stated she did not conduct a skin assessment for Resident #5 and did not identify the Stage II left heel ulcer because she believed the 7:00 AM to 7:00 PM nurse had completed the admission and skin assessment.</p> <p>Interview conducted with the Unit Manager (UM)</p>	F 314	<p>physician orders and ensuring all orders are transcribed per the physicians orders and notifying DON of questions related to skin impairment.</p> <p>RNC to randomly complete at least 5 skin assessments monthly x 3 months beginning 11/2012.</p> <p>UM/ADON/DON to complete 10 random, look back skin assessments after the nurse completes weekly x 6 weeks beginning week of 11/9/2012. Then 5 weekly x 4 weeks. Any issue identified will require immediate written re education of the nurse who had completed the skin assessment prior.</p> <p>Re education of licensed nurses with skin assessment monitoring and validation of staging during skin assessment to be done monthly by the UM and ADON beginning 11//2012 x 3 months.</p> <p>Any new hire will have education by the Education and training Director regarding skin protocol, turning and repositioning, transcribing orders to the TAR, re admission and admission skin assessments and comparing to written orders as well as physician and family notification, recognizing risk for skin impairment and staging of wounds. This will be ongoing.</p> <p>All new admissions and re admissions will have a look back skin assessment completed by the DON/UM and/or the ADON within 72 hours to validate any skin impairment, ensure correct staging, ensure that all orders transcribed correctly and that skin assessment was completed on admit/re admit. This will be completed x 3 months beginning week of 11/9/2012.</p>	
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F 314	<p>Continued From page 21</p> <p>on 11/01/12, at 3:30 PM, revealed she reviewed Resident #5's admission records on 09/10/12. The UM stated she conducted a head to toe skin assessment on 09/10/12 and assessed the Stage II ulcer present upon readmission of the resident's left heel. The UM stated she contacted the physician and obtained orders to apply Skin prep to both heels. The UM stated she failed to write the physician's order and failed to transcribe the treatment order to the Treatment Administration Record (TAR). The UM stated although the treatment had not been documented on the TAR, skin prep had been applied to the resident's heels twice a day.</p> <p>Interview conducted with the Resident #5's physician on 11/10/12, at 5:50 PM, revealed the physician stated he had been called regarding the Stage II ulcer to the left heel; however, the physician stated he could not recall the specific date. The physician stated the skin prep was an appropriate treatment for the skin breakdown to the resident's heel and felt he had been notified timely regarding the resident's condition.</p> <p>Further review of the physician orders revealed a telephone order was written on 09/21/12 (14 days after the admission physician orders) to apply skin prep twice a day to the resident's bilateral feet.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment (reference date 09/12/12) conducted upon readmission revealed the facility assessed Resident #5 required extensive assistance of two staff persons for bed mobility and activities of daily living, was totally incontinent of bowel and bladder, and had sustained an</p>	F 314	<p>DON to randomly assess two known stageable wounds weekly to ensure that staging is correct beginning week of 11/9/2012 x 4 weeks. DON/UM/ADON/ETD and /or RNC to complete random turning and repositioning audits of at least 20 patients a week beginning week of 11/5/2012 x 8 weeks.</p> <p>4. Quality Assurance Team to meet weekly x 8 weeks beginning week of 11/5/2012 then at least monthly to review audit finding, revise plan and make any needed recommendations. This will be ongoing until concern is corrected.</p> <p>5. Date of Compliance 11/11/2012</p>		

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F 314	<p>Continued From page 22</p> <p>unplanned weight loss. In addition, the assessment revealed Resident #5 was identified to be at high risk for pressure ulcer development and was admitted to the facility with a Stage IV and an unstageable pressure ulcer. Resident #5 was also assessed to be alert and oriented with a Brief Interview for Mental Status (BIMS) score of 14.</p> <p>Review of the comprehensive care plan for Resident #5 dated 09/19/12, revealed the resident was assessed to have actual skin breakdown and had the potential for further alteration in skin integrity. Interventions included turn/reposition the resident every two hours, to keep skin clean, dry, and free from body waste, to apply a Stat III air mattress for pressure relief, and to provide nutritional supplements to promote wound healing.</p> <p>A review of the weekly skin assessments conducted on 09/10/12 through 10/24/12 by the facility revealed no evidence the left heel ulcer progressed in size, depth, or general condition of the wound. The skin assessment revealed the left heel ulcer was assessed as eschar; measuring 1.5 cm x 2.5 cm with no depth, odor or drainage. The most recent skin assessment conducted on 10/24/12 revealed the left heel ulcer was still described as eschar; measuring 1.0 cm x 1.5 cm with no depth, odor, or drainage.</p> <p>Further review of the weekly skin assessments conducted on 10/16/12 for Resident #5 revealed the facility identified two (2) additional eschar areas to the left outer foot and two (2) additional eschar areas to the right outer foot and heel area. Review of the physician orders revealed the</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>physician was contacted on 10/16/12 and treatment orders were obtained for these areas. In addition, resident #5 was referred to the local wound center for additional treatment and evaluation on 10/25/12.</p> <p>Further review of the medical record revealed a routine weekly skin assessment was also conducted on 10/12/12 and no new skin breakdown was documented. Review of the physician's orders revealed a telephone order was written on 10/14/12 (2 days later) to administer treatment to the left lower leg wound. The wound was identified as an open ulcer with sloughing present; measuring (2.3 cm x 3.7 cm x 0.2 cm) to the left lower outer leg.</p> <p>Interview conducted with LPN #3 on 11/01/12, at 4:30 PM, revealed she conducted the weekly skin assessment for Resident #5 on 10/12/12. LPN #3 stated she observed an area on the resident's left lower leg and described the area as a bruise or blister area. The LPN stated she had not been trained in staging wounds and could not clearly identify what the skin area was. LPN #3 stated she confirmed with the direct care staff the area had not previously been present on the resident's left lower leg. LPN #3 further stated she did not document the observations of the resident's left lower leg and did not consult with the resident's physician regarding a possible treatment order.</p> <p>Resident #5 was observed on 10/30/12, at 11:10 AM, to be lying on his/her back and at 12:50 PM was observed to be lying on the right side with a pillow placed behind the resident's back. A skin assessment conducted on 10/30/12, at 1:15 PM, (twenty-five minutes later) revealed the resident</p>	F 314			

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F 314	Continued From page 24 continued to be on his/her back. The skin assessment conducted with facility staff revealed a Stage IV sacral ulcer (approximately 4.0 cm x 6.8 cm x 3.4 cm), Stage II left heel ulcer (approximately 1.8 cm x 1.7 cm), unstageable area to the left lateral foot (approximately 1.5 cm x 2.5 cm), Stage III to the left lower lateral leg (approximately 4.8 cm x 2.4 cm x 0.5 cm), unstageable ulcer of the right heel (approximately 11.4 cm x 9.5 cm), and an unstageable ulcer to the right lateral foot (approximately 10 cm x 6.0 cm). Interview conducted with Resident #5's physician on 11/10/12, at 5:50 PM, revealed the resident was at high risk for pressure ulcer development due to history of tobacco use, DVT history, recent weight loss, edema of bilateral feet/legs, and debilitating state secondary to Multiple Sclerosis. The physician stated the wound could have developed and progressed in a short time due to these medical factors. The physician stated he felt he had been informed timely regarding the changes in the resident's skin condition. Interview with the Director of Nurses (DON) on 11/01/12, at 7:10 PM, revealed nurses were required to conduct a head to toe skin assessment upon readmission and weekly for all residents. The DON stated the physician should be consulted for treatment orders for all areas when the breakdown was originally identified. The DON confirmed all nurses had received training during orientation regarding pressure ulcer prevention, treatment, and staging of wounds.	F 314		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 25 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's investigation and policy and procedures it was determined the facility failed to have an effective system to ensure that each resident received adequate supervision and monitoring to prevent accidents for one of seven sampled residents (Resident #1). The facility assessed Resident #1 to be an elopement risk on 07/27/12, due to having cognitive impairment and being independently mobile utilizing a wheelchair, and a wander guard device was applied to the resident and to the resident's wheelchair. Direct care staff interviews revealed on 10/27/12, Resident #exhibited increased behaviors of agitation and wandering, wandered to a different unit, and voiced wanting to leave the facility. However, staff failed to report the resident's change in behavior to the Nurse or increase supervision for Resident #1. On 10/27/12, Resident #1 exited the facility without staff knowledge and was outside without supervision for an undetermined amount of time. Resident #1 was last seen in the facility at approximately 8:30 PM , and was returned to the facility at approximately 9:30 PM by a community member who had discovered	F 323	Past noncompliance: no plan of correction required.		

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F 323	<p>Continued From page 26</p> <p>Resident #1 approximately 0.6 tenths of a mile from the facility. Resident #1 was escorted back into the facility by staff, and assessed to have sustained no injuries.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who were at risk for elopement was likely to cause serious injury, harm, impairment, or death. The Immediate Jeopardy was determined to exist on 10/27/12, and continued until 10/29/12. The facility completed corrective actions prior to the State Survey Agency's investigation on 10/30/12; therefore, the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>A review of the facility's Elopement Management policy/procedure (undated) revealed the facility would provide an environment free of hazards over which the facility had control and provide supervision and assistive devices to prevent avoidable accidents. The policy stated the facility would utilize mechanisms (door alarms, wander guards, and the wander guard system) and procedures (nursing assessments and supervision) to mitigate the risk of a resident leaving a safe area without staff supervision.</p> <p>A review of the facility's investigation initiated 10/27/12, revealed on 10/27/12, at approximately 9:00 PM, staff discovered Resident #1's wheelchair outside the facility turned over near a large culvert, with the sensor pad in the wheelchair (utilized to alert staff when the resident stood up unassisted from the</p>	F 323			

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F 323	Continued From page 27 wheelchair) audibly alarming. According to the investigation, Resident #1 was not in the vicinity of the wheelchair, but staff immediately recognized the wheelchair belonged to the resident, and initiated a search for Resident #1. According to the facility's investigation, the last time Resident #1 was seen inside the facility was at approximately 8:30 PM (30 minutes prior to staff recognizing the resident was missing). The facility investigation confirmed Resident #1 was wearing a wander guard bracelet which had been implemented on 07/27/12, once the resident had been determined to be at risk for elopement, and a wander guard bracelet was also secured to the resident's wheelchair, both of which were determined to be functioning appropriately, once the resident was returned to the facility. Interview on 10/31/12 at 10:50 AM with Certified Nursing Assistant (CNA) #1 assigned to care for Resident #1 on 10/27/12 during the evening shift, revealed she last saw Resident #1 in the facility at approximately 8:30 PM on 10/27/12, going up and down the hallways independently in a wheelchair. CNA #1 stated she exited the building for a break at approximately 9:00 PM and "kept hearing something." CNA #1 stated she eventually found the source of the noise when she discovered Resident #1's wheelchair turned over by a culvert, with the sensor seat alarm sounding, but Resident #1 was not in the vicinity of the wheelchair. CNA #1 stated she immediately returned to the facility and alerted staff that Resident #1 was missing. CNA #1 stated an extensive search was conducted for Resident #1, who was eventually returned to the facility at approximately 9:30 PM by a community member	F 323			

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F 323	<p>Continued From page 28</p> <p>who found Resident #1 in the vicinity of a convenient store (0.6 tenths of a mile from the facility). CNA #1 stated it was "cold and rainy outside." (A review of weather archives for the facility's area on Weather Underground revealed the temperature on 10/27/12 from 6:15 PM through 9:55 PM revealed the weather condition was overcast with the temperature remaining at 46.4 degrees Fahrenheit).</p> <p>CNA #1 stated Resident #1 had displayed an increase in wandering prior to the incident, stating she had walked the resident around inside the facility from 7:30 PM until 8:00 PM to try and "wear (him/her) out." CNA #1 stated Resident #1 was "more anxious and trying to walk by (him/herself), and "would say (he/she) was leaving." However, CNA #1 stated she did not notify the nurse of the increased behaviors displayed by Resident #1, and no additional supervision was provided for the resident.</p> <p>Interviews conducted on 10/31/12 at 2:30 PM with CNA #2, at 1:45 PM with CNA #3, and at 1:20 PM with CNA #4 revealed all the staff had observed Resident #1 to be more active on 10/27/12. CNA #3 stated Resident #1 was "going up and down the hallway, like (he/she) was on a mission." CNA #3 stated Resident #1 was "anxious" and "actually getting up walking (him/herself), I had never seen (him/her) like that." CNA #4 stated she had redirected Resident #1 to his/her room that evening prior to the incident after discovering the resident on a different unit. CNA #4 stated while assisting the resident to his room, he/she had asked me to "let him/her out the door." Although the staff members all indicated they had recognized that Resident #1 was acting different</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>and displaying increased behaviors, the staff failed to report the changes to the nurse or implement any increased supervision for Resident #1.</p> <p>An interview with Registered Nurse (RN) #1 on 10/31/12, at 12:55 PM revealed she had noticed on 10/27/12, that Resident #1 was "agitated", but stated staff had not report any increased behaviors to her, or notify her that the Resident #1 had voiced desire to leave the facility.</p> <p>The facility admitted Resident #1 on 07/26/12, with diagnoses including Left Hip Fracture and Dementia. A review of the admission nursing assessment for Resident #1 revealed the facility assessed Resident #1 to be cognitively impaired, and able to move about the facility independently in a wheelchair, and determined Resident #1 to be at risk for elopement.</p> <p>Review of Resident #1's Care Plan dated 07/27/12, revealed the facility initiated the interventions of Resident #1 wearing a wander guard bracelet; placing the resident's photograph and documented description in the "wander alert books" located at each nurses station, Administrators office, and at the front desk; allowing for safe wandering; and offering redirection and conversation as needed. Additionally, staff was to notify the nurse if Resident #1 displayed behaviors, and attempt to contact the resident's family for assistance.</p> <p>Review of Resident #1's nurses' notes revealed on 07/29/12, Resident #1 repeatedly voiced the desire to "go home". However, there was no documented evidence the facility increased</p>	F 323			

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F 323	<p>Continued From page 30 supervision for Resident #1.</p> <p>Review of Resident #1's Minimum Data Set (MDS) Admission Assessment dated 08/08/12, revealed the facility assessed Resident #1 to have severe cognitive impairment, display physical and verbal behavioral symptoms toward others, display behavioral symptoms not directed toward others, and reject care. Further review of Resident #1's Plan of Care revealed on 08/22/12, revisions were made to include interventions that staff would notify the nurse and Resident #1's family when behaviors were exhibited.</p> <p>Review of Resident #1's nurses' notes revealed on 08/20/12, Resident #1 refused to go to bed, and stated he/she "was going to (another state)". However, there was no documented evidence the facility increased supervision for Resident #1.</p> <p>Observation of Resident #1 on 10/30/12 at 10:20 AM revealed the resident to be up in a wheelchair in the room with staff present. Resident #1 was very friendly, smiling and talking, but with obvious confusion. When questioned regarding leaving the facility on 10/27/12, Resident #1 answered, but the answers were not appropriate. Resident #1 was able to move about in the wheelchair without difficulty. Wander guard bracelets were observed attached to the resident's right ankle and the resident's wheelchair.</p> <p>Further review of the facility's investigation revealed although the facility's investigation failed to definitively determine how Resident #1 was able to exit the facility without staff knowledge, the facility did identify two potential contributing factors. The investigation revealed that</p>	F 323			

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F 323	Continued From page 31 approximately three months earlier the facility had installed a "disarming button" which, when pushed, disabled the wander guard system to the front door. The facility installed the button to enable staff to assist residents with wander guards who smoked onto the front porch easier access in and out of the facility, without the wander guard alarm sounding. Once the "disarming button" was activated, the wander guard system would not sound even if a wander guard device passed through the door until the door shut, at which time the system was again "re-engaged." Additionally, the facility recognized that three doors utilized in the facility were not equipped with the wander guard system. The three doors were designated as "emergency exits," and each door was equipped with a magnetic lock, and an audible alarm sounded when the doors were opened. However, once a numeric code was entered into the corresponding key pad adjacent to each door, the door could be opened and exited without an alarm sounding. Although the numeric codes were to be known and utilized by staff only, the facility investigation determined the codes had become known to staff and visitors on occasions, who would utilize the doors as exits. Interview on 10/30/12 at 1:30 PM with the Administrator and Regional Nurse Consultant revealed the facility had failed to consider, when installing the device to disable the wander guard alarm at the front door, that the "button" would be accessible to residents and visitors as well as staff, and failed to consider the risk of a resident disarming the alarm and exiting the building. Additionally, the Administrator stated he had recognized in September of 2012, that for	F 323		

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F 323	<p>Continued From page 32</p> <p>increased resident safety, all the exit doors in the facility needed to be equipped with the wander guard alarm system. The Administrator stated at that time he did submit a request to the corporation for installation of the wander guard system to all facility doors, and was pending approval of the request at the time of Resident #1's elopement from the facility.</p> <p>*The facility implemented the following actions to correct the deficiency:</p> <p>The Director of Nursing was notified on 10/27/12 at 9:15 PM that Resident #1 was missing from the facility. A headcount was immediately performed, and all other residents were accounted for inside the facility.</p> <p>The Regional Nurse Consultant was notified at approximately 9:30 PM that Resident #1 had eloped from the facility.</p> <p>Upon return to the facility on 10/27/12, it was determined Resident #1 was wearing a wander guard bracelet which was determined to be functioning appropriately.</p> <p>Resident #1 was returned inside the facility and assessed to have sustained no injuries.</p> <p>RN #1 completed the post elopement form for Resident #1, and immediately placed the resident on 1:1 supervision.</p> <p>All wander guard bracelets utilized by residents were checked for function, placement and expiration date on 10/27/12 by RN #1 and Unit</p>	F 323			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185262	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/02/2012
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 131 MEADOWLARK DRIVE RICHMOND, KY 40475		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 33 Manager #2.</p> <p>The Administrator verified Wander Risk Books were in place at the Nurses Stations, Administrator's Office and the Front Desk, and assessed all doors to be functioning appropriately on 10/27/12.</p> <p>The Regional Nurse Consultant, Director of Nursing and Unit Managers questioned all staff in the facility on 10/27/12 regarding facility residents to ensure all risk factors for elopement including changes in behavior had been identified and addressed.</p> <p>All staff were re-educated beginning on 10/27/12, and will continue until all staff have completed the training. Staff who has not had the training/competency exam will not be permitted to work in the facility. The training included the following:</p> <p>*Elopement- anyone leaving a safe place to an unsafe place without supervision.</p> <p>*On admission to the facility and with any change of condition, a nurse must complete an elopement assessment.</p> <p>*If the door alarm sounds, staff should immediately respond to appropriate door, bring the resident back in facility, and notify the nurse of the attempt to leave. If staff does not see the resident at the door, they need to check the immediate area. If staff still does not see the resident, report to the charge nurse.</p> <p>*If a head count confirms that a resident has left</p>	F 323		

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F 323	<p>Continued From page 34</p> <p>the building, staff is to check outside of the building on the premises. The Charge nurse will make sure the DON and the Administrator are aware of the situation. If the resident is not located on the premises, the DON, Administrator, and local law enforcement will be notified. Staff, along with help from the police, will search in any neighboring areas.</p> <p>*If an elopement occurs, make sure the nurse in charge of that resident does a skin assessment, pain assessment, interview, and a follow-up with DON for any further instructions.</p> <p>*Licensed Nurses will complete the Accident and Incident report and record the information on the 24-hour Report.</p> <p>*A Missing resident action plan - Post Elopement Form will be completed(The form includes what the resident is wearing, what time the resident was found, where the resident was found, the temperature outside, etc.)</p> <p>*If the door alarms are not working properly, the DON, Administrator, and Maintenance Director are to be notified immediately. Perform a head count at this time and initiate one on one supervision with all residents with a wander guard. If necessary, staff may have to have two or three residents each and keep them together due to staffing, especially on night shift.</p> <p>*All residents that go outside the facility with anybody except staff (even to sit on the front porch or the gazebo) have to sign out.</p> <p>On 10/27/12, CNA's began hourly monitoring of</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>residents who were at risk for wandering to ensure they were in the facility. Unit Managers were to ensure this monitoring was completed. If a CNA was unable to complete the hourly monitoring, it would be reported to the Charge Nurse for re-assignment. The Unit Manager would be responsible to verify that the hourly checks were completed.</p> <p>Beginning 10/27/12 facility doors not equipped with a wander guard system were being continually monitored by facility staff to ensure the doors were being utilized during emergencies only. The monitoring will continue until all facility doors are installed with a wander guard system, and they are verified to function appropriately.</p> <p>The Regional Nurse Consultant, Administrator, Director of Nursing, Unit Managers and Social Services Director conducted a Quality Assurance meeting on 10/28/12 which included a review of the Head Count Policy, Elopement Prevention Policy, Missing Resident Action Plan, Post Elopement Form and the Activities and Care Plan policies/procedures.</p> <p>Resident #1's physician was notified of the elopement and the resident's assessment finding on 10/27/12. No new orders pertaining to Resident #1 were received.</p> <p>The facility's Medical Director was notified of Resident #1's elopement on 10/28/2012.</p> <p>The Interdisciplinary Team consisting of the Unit Manager, Director of Nursing, Regional Nurse Consultant, and the Social Services Director conducted a meeting on 10/28/12 to review/revise</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>all elopement, behavioral, and activity care plans and all elopement assessments were reviewed.</p> <p>All doors in the facility will be checked every shift for proper functioning by the Maintenance Director, Department Manager, or designee to ensure function is ongoing.</p> <p>On 10/28/12, The Regional Nurse Consultant, Director of Nursing, Unit Manager, and Social Services Director verified all residents at risk for wandering had a wander guard bracelet in place, and their picture/identifying information was contained in the wander risk books.</p> <p>On 10/29/12, an elopement drill was completed by the facility, with no concerns identified. Elopement drills will be conducted at least three times weekly on random shifts for 12 weeks. The elopement drills consist of initiating a wander guard alarm and ensuring that staff follows the required steps for locating a missing resident.</p> <p>The Treatment Administration Records (TAR) for all residents identified to utilize a wander guard bracelet were reviewed by the Regional Nurse Consultant, Director of Nursing and Unit Manager on 10/28/12 to ensure the TAR had the wander guard bracelet listed and that placement, functioning and expiration date was checked and documented every shift.</p> <p>The Director of Nursing and Social Service Department checked the CNA Care Guide and AccuNurse system on 10/29/12, to ensure they correctly identified any resident assessed to be at risk for elopement.</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>On 10/29/12, staff was given a written list of all residents considered to be at risk for elopement, which was derived from the wander risk books. Department Managers will copy this list daily and Licensed Nurses on each unit are to ensure staff has a copy. The wander risk list will be reviewed and revised daily to ensure changes are documented on the list and staff is made aware of any changes.</p> <p>On 10/28/12 the Director of Nursing, Regional Nurse Consultant, Social Services Director, and the Unit Manager had completed re-evaluating all residents at risk for elopement. All elopement, activity, and behavioral care plans were updated with any changes and/or new interventions documented.</p> <p>The "button" located adjacent to the front door which disabled the wander guard alarm to the front door was secured shut and made inaccessible to staff, visitors and residents by the Administrator on 10/27/12.</p> <p>A meeting will be conducted at least weekly by the Director of Nursing, Administrator, Unit Manager, Social Services Director, Maintenance Supervisor, and the Regional Director of Operations or the Regional Nurse Consultant to review the elopement policies/procedures, ensure all required monitoring has been completed correctly, review all residents at risk for elopements (by review of the medical record, twenty-four hour report, and staff interviews) to ensure any changes that are needed are implemented. The meeting will also ensure all newly admitted residents have been assessed for elopement risks and verify facility doors are</p>	F 323			

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F 323	<p>Continued From page 38 functioning correctly.</p> <p>All newly hired employees will be educated regarding the facility's elopement policies/procedures by the Education Director.</p> <p>The Regional Nurse Consultant will audit all newly hired employee files weekly for eight weeks, beginning the week of 10/28/12.</p> <p>Beginning 10/28/12, the Regional Nurse Consultant will monitor weekly to ensure elopement procedures are followed and care plans are initiated and updated with changes to ensure any behaviors or newly identified risks have been addressed and appropriate interventions initiated.</p> <p>Beginning 10/28/12, the Director of Nursing, Assistant Director of Nursing, or the Unit Manager will monitor each resident's Treatment Administration Record who utilizes a wander guard bracelet daily to ensure the staff has checked the wander guard bracelet for placement function and expiration date.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Interview with the DON on 11/02/12 at 10:45 AM confirmed she was notified of Resident #1's elopement on 10/27/12. Interview with RN #1 on 10/31/12, at 12:55 PM, and facility documentation revealed she had completed a head count for the entire facility and identified no concerns.</p> <p>Interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM confirmed she had been</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>notified of Resident #1's elopement on 10/27/12.</p> <p>A review of facility documentation and interview with the RN #1 on 10/31/12 at 12:55 PM confirmed the wander guard Resident #1 was wearing at the time of the elopement was functioning appropriately and sounded when the resident re-entered the facility.</p> <p>A review of a post elopement form dated 10/27/12, and interview with RN #1 on 10/31/12 at 12:55 PM revealed the facility had assessed the resident and found no injuries.</p> <p>Documentation and interview with RN #1 on 10/31/12 at 12:55 PM revealed the resident was placed on 1:1 monitoring upon return to the facility. Facility documentation and observations on 10/30/12-11/02/12 confirmed Resident #1 remained on 1:1 supervision</p> <p>Review of facility documentation and interview with RN #1 on 10/31/12 at 12:55 PM and Unit Manager #1 on 11/02/12 at 10:40 AM revealed all wander guards utilized by residents were checked for placement, function, and expiration date on 10/27/12. Observations conducted on 10/30/12 from 3:14 PM until 3:42 PM with Unit Manager #2 revealed all wander guard bracelets utilized by residents assessed to be at risk for elopement were in place and functioning appropriately.</p> <p>Interview with the Administrator on 11/02/12 at 9:30 AM revealed he had confirmed all the Wander Risk Books were in their designated places on 10/27/12. Observations on 10/30/12 at 3:45 PM revealed Wander Risk Books were located at the Front Desk, Administrators Office,</p>	F 323			

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F 323	<p>Continued From page 40 and at each Nurses Station.</p> <p>A review of facility signed statements by staff working on 10/27/12, and interviews on 10/31/12 at 2:30 PM with CNA #2, at 1:45 PM with CNA #3, and at 1:20 PM with CNA #4 revealed they were questioned and provided answers regarding resident behaviors and if they believed anyone in the facility was at risk for elopement.</p> <p>Interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM, and the Education Director on 11/02/12 at 5:00 PM, and review of Elopement Education Sign in sheets confirmed on 10/27/12, the Regional Nurse Consultant initiated education with facility staff, to include all departments, on the elopement/missing resident protocols. Education is on-going by the Education Director. The Education Director confirmed staff would not be permitted to work without having attended the in-service. Interviews conducted on 10/30/12, at 3:42 PM with Unit Manager #1, 11/01/12 at 10:40 AM with Unit Manager #2, 10/31/12 at 12:55 PM with RN #1, 11/02/12 at 11:40 AM with LPN #1, 11/02/12 at 11:30 AM with the Maintenance Director, 10/31/12 at 10:50 AM with CNA #1, 10/31/12 at 11:00 AM with LPN #2, 10/31/12 at 2:45 PM with RN #2, 10/31/12 at 10:35 AM with CNA #5, 10/31/12 at 1:20 PM with CNA #4, 10/31/12 at 2:30 PM with CNA #2, and 10/31/12 at 1:45 PM with CNA #3, revealed all the staff had attended the in-service, and was knowledgeable regarding the facility's elopement policies and procedures.</p> <p>A review of facility documentation and interviews on 10/31/12 at 11:00 AM with LPN #2, 10:50 AM with CNA #1 and at 10:35 AM with CNA #5,</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>revealed the CNA's were checking all residents in the facility hourly to ensure they were in the building and/or accounted for. The staff were knowledgeable regarding notification of the nurse if they were unable to complete the hourly checks. Interviews on 11/2/12 at 11:00 AM with Unit Manager #2 and at 10:40 AM with Unit Manager #1 revealed they were responsible to ensure the hourly resident checks were conducted.</p> <p>Review of facility documentation, interview with the Administrator and Maintenance Director on 10/30/12 at 4:40 PM, and observations on 10/30/12 from 4:30 PM until 4:38 PM revealed doors not equipped with a wander guard system were being continually monitored by staff to ensure the doors were being utilized only as emergency exits.</p> <p>Review of facility documentation, and interviews on 10/30/12 at 1:30 PM with the Regional Nurse Consultant and Administrator, 11/02/12 at 10:45 AM with the DON, 11/02/12 at 10:40 AM with Unit Manager #2, and 11/02/12 at 4:50 PM with the Social Services Director, revealed a Quality Assurance meeting was conducted on 10/28/12 which included a review of the facility's head count policy, elopement prevention policy, missing resident action plan, post elopement form, and the Care Plan policy.</p> <p>Review of the Post Elopement form for Resident #1 dated 10/27/12, and interview on 11/02/12 at 10:40 AM with Unit Manager #2 revealed Resident #1's physician was notified of the elopement on 10/27/12, but gave no new orders pertaining to Resident #1.</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>Review of facility documentation and interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM revealed the Medical Director was notified of the incident on 10/28/12.</p> <p>Interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM, and review of facility documentation confirmed the facility had performed the following actions: On 10/28/12, the DON, Regional Nurse Consultant, and Social Services Director reviewed all wander/elopement assessments for all residents previously identified at risk for elopement for accuracy. The assessments were deemed accurate. Additionally, on 10/28/12, all residents behavioral and activity care plans were reviewed for accuracy and all the assessments were deemed accurate.</p> <p>Review of facility documentation and interview with the Maintenance Director on 10/31/12 at 11:30 AM, revealed all doors in the facility were checked every shift to ensure proper functioning.</p> <p>Review of facility documentation and interview on 10/30/12 at 1:30 PM, 11/02/12 at 10:45 AM with the Director of Nursing, 11/02/12 at 10:40 AM with Unit Manager #2, and on 11/02/12 at 4:50 PM with the Social Services Director revealed on 10/28/12 all residents at risk for wandering were determined to have a wander guard bracelet in place, and their picture/identifying information was contained in the wander risk books. All resident Treatment Administration Records were audited to ensure each record had the wander guard bracelet listed, and staff was ensuring it was in place, functioning, and within the</p>	F 323			

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F 323	<p>Continued From page 43 expiration date every shift.</p> <p>A review of an elopement drill dated 10/29/12 and interview with the Regional Nurse Consultant on 10/30/12 at 1:30 PM, Unit Manager #1 on 11/02/12 at 11:00 AM, and Unit Manager #2 on 11/02/12 at 10:40 AM revealed the elopement drill had been conducted. A review of a tentative facility calendar revealed elopement drills were scheduled every three weeks on random shifts.</p> <p>A review of Resident #1's CNA Care Guide on 10/30/12 revealed the resident was identified to be at risk for elopement. Interviews with the DON on 11/02/12 at 10:45 AM revealed the AccuNurse system and CNA care guides had been updated on 10/29/12 to ensure all information was correct. No problems were identified, and all residents were correctly identified to be at risk for elopement.</p> <p>Observation and interview on 11/02/12 at 11:40 AM with LPN #2 revealed the staff had a written list containing the names of all residents at risk for elopement. Interviews on 11/02/12 at 11:00 AM with Unit Manager #1, and at 10:40 AM with Unit Manager #2, revealed they were responsible to ensure staff has a written copy of the list provided to them daily, and to review and revise the list daily to ensure change is documented on the list and staff made aware.</p> <p>Observation on 10/30/12 at 4:42 PM revealed the "button" to disengage the wander guard system to the front door had been secured and was inaccessible to any staff, resident, or visitor. Additionally, the wander guard system was confirmed to be functioning appropriately at the</p>	F 323			

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F 323	<p>Continued From page 44 front door.</p> <p>Review of facility documentation and interview with the DON 11/02/12 at 11:05 AM, revealed the facility is reviewing elopement policies/procedures and the corrective action implemented as a result of Resident #1 eloping on 10/27/12, daily in the facility stand down meetings.</p> <p>Interview on 11/02/12 at 5:00 PM with the Education Director and review of employee files hired on 10/31/12, revealed education regarding elopement policies/procedures had been completed.</p> <p>Review of facility documentation dated 10/28/12 and 10/31/12, and interviews with the Regional Nurse Consultant on 10/30/12 at 1:30 PM revealed the Regional Nurse Consultant had monitored to ensure elopement procedures had been followed and care plans were initiated and updated with changes to ensure any behaviors or newly identified risks had been addressed and appropriate interventions initiated.</p> <p>A review of facility documentation and interviews on 10/30/12 at 1:30 PM with the Regional Nurse Consultant, and on 11/02/12 at 10:45 AM with the DON, and at 11:15 AM with the Assistant DON, revealed Treatment Administration Records had been reviewed daily to ensure they contained documentation that the residents wander guard bracelet was in place, functioning and within the expiration date.</p>	F 323			