

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

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FORM APPROVED
OMB NO. 0938-0391

APR 28 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2011
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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F 000	INITIAL COMMENTS An abbreviated and partial extended complaint survey (KY #16144) was initiated on 03/21/11 and concluded on 03/25/11. Immediate Jeopardy was determined to exist on 03/19/11 at 42 CFR 483.25 (F323 S/S "J") resulting in substandard quality of care. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 03/22/11. The facility provided an acceptable credible Allegation of Compliance (AOC) on 03/24/11. The state agency verified Immediately Jeopardy was removed on 03/25/11, which lowered the scope and severity to a "D" at 42 CFR 483.25 Quality of Care, F323 while the facility's Quality Assurance monitors the effectiveness of the new wander guard alarm transmitters and door checks.	F 000	This plan of correction constitutes Mercy Sacred Heart Village's credible allegation of compliance for the cited deficiency. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulations, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an abbreviated and partial extended survey.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to provide adequate supervision to prevent accidents for one (Resident #1) of four sampled residents. The facility failed to follow the "Missing Resident/Elopement Policy". These failures resulted in Resident #1, who the facility	F 323	Corrective action for those residents found to have been affected by the deficient practice: 1. Resident #1 was returned to the facility and a head to toe assessment was completed. 2. Resident #1 was placed on Q 15 minute checks until a new Wanderguard transmitter bracelet was placed on March 21, 2011.	04/01/11

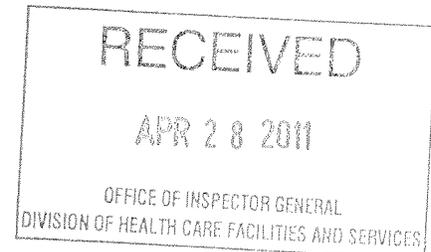
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jason Nichols / RT</i>	TITLE President Senior Health+Housing	(X6) DATE 4/28/2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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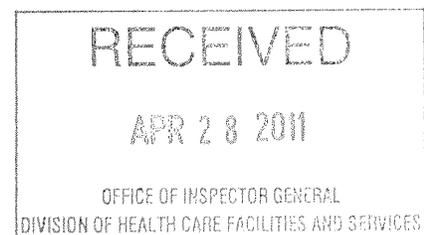
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F 323	<p>Continued From page 1</p> <p>assessed as at risk for elopement, exiting the facility without staff knowledge. The resident successfully ambulated, with a walker, down the facility's driveway and onto a busy street. The facility failure to provide adequate supervision and appropriate functional assistive devices placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident.</p> <p>The facility provided an acceptable credible allegation of compliance (AOC) on 03/24/11. Immediate Jeopardy was verified to be removed prior to exit on 03/25/11 with remaining non-compliance at 42 CFR 483.25 Quality of Care, scope and severity at a "D", while the facility's Quality Assurance continues to monitor the wander guard transmitters for proper function and completion of door checks for the at risk residents who utilize the wander guard bracelets.</p> <p>The findings include:</p> <p>Review of the "Missing Resident/Elopement" policy (revised February 2003) revealed the residents who are at risk for wander/elopement shall wear a security bracelet to alert staff when the resident attempts to leave the facility without staff assistance or knowledge. The charge nurse will check for appropriate bracelet placement no less than daily and document on the wander guard checklist. The security bracelet and alarm system will be checked on a routine basis to assure proper functioning.</p> <p>On 03/21/11 at 5:30pm, interview with the night shift supervisor revealed all staff nurses are suppose to check the wander guard bracelets every night to assure the transmitters are working</p>	F 323	<p>3. Once a new Wanderguard transmitter was available, documentation logs were put into place for testing of the Wanderguard transmitter.</p> <p>4. Resident #1's picture was placed in a Wander Risk Book located at each nurses' stations, therapy, social services and the receptionist desk.</p> <p>5. Resident #1's care plan was updated.</p> <p>6. Resident #1's orders were verified and the TAR was verified for monitoring that Wanderguard bracelet was in place.</p> <p>7. Resident #1 was reassessed for risk of elopement on March 20 and 23, 2011.</p>		



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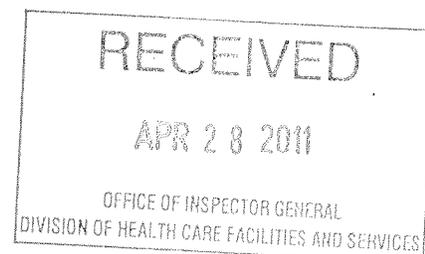
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F 323	<p>Continued From page 2</p> <p>properly. She indicated there was a signaling device log where the nurses would document if the transmitter was operable or not.</p> <p>On 03/21/11 at 3:40pm, interview with the Director of Nursing (DON) revealed nurses are to check for placement of the security bracelets every shift and the night shift nurses are responsible for checking the bracelets by using a tester to ensure proper bracelet functioning each night. She indicated the maintenance department was responsible for checking the alarm doors.</p> <p>Medical record review revealed the facility admitted Resident #1 on 01/07/10 with multiple diagnoses which included Alzheimer's disease. The facility assessed the resident as confused and unable to accurately recall events. The Elopement Risk Assessment form dated 04/05/10 revealed the facility assessed the resident at high risk for elopement related to the resident's impaired cognition, history of past attempts, and fixation on past life roles/routine. Review of the 05/21/10 annual minimum data set (MDS) assessment revealed the facility had assessed and determined the resident only required supervision with ambulation using a walker. The facility developed a care plan on 04/05/10 with the following interventions: 1. security bracelet on walker; 2. Establish daily routine; 3. If resident is heading towards exits, attempt to redirect, if unsuccessful, accompany resident for a walk until able to return to unit. 4. Notify the physician of any elopement behaviors and ability to be redirected; 5. Offer divisional activities, food, fluids, toileting. Interview with CNA #1, on 03/21/11 at 3:50 pm, revealed Resident #1 always ambulates with a walker and usually stays on the unit; however, receives no</p>	F 323	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <ol style="list-style-type: none"> 1. All residents in the facility were assessed using the "Elopement Risk Assessment" form for risk of elopement on March 23, 2011. 2. All residents wearing a Wanderguard transmitter had it checked and all were found to be working on March 19, 2011. 3. Documentation logs were put into place for testing of Wanderguard transmitters for each resident. 4. The care plans of those residents wearing a Wanderguard transmitter were updated. 5. Residents wearing a Wanderguard transmitter had orders verified and TARs verified for monitoring that Wanderguard bracelets were in place. 	



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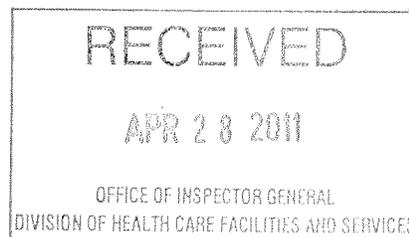
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F 323	<p>Continued From page 3 additional supervision than other residents.</p> <p>Review of a facility investigation, dated 03/22/11, revealed on 03/19/11 Resident #1 was found on the street in front of the assisted living apartments on the facility's campus. The resident was ambulating independently with a walker. At 2:45pm, a citizen came to the 500 unit nurses station and asked if any of the residents wore black because there was an elderly person found on the street. The staff found Resident #1 sitting on the porch of the assisted living apartments with another citizen. Upon return to the nursing facility, the resident's wander guard bracelet did not activate the wander guard alarm on the exit door as they entered the building.</p> <p>Interview with the facility's front lobby receptionist, on 03/24/11 at 2:45pm, (who resides in the assisted-living apartment on the facility's campus) revealed she looked out the window on 03/19/11 and witnessed an elderly person walking (with a walker) down the middle of the street. Although she was unaware it was Resident #1 at that time, she was afraid that person was going to get hit by a car. In fact, the receptionist revealed, a car came up behind the resident and had to swerve around the resident. She stated another car stopped in the middle of the road and assisted Resident #1 from the road onto the sidewalk. The citizen then was observed assisting the resident back onto the facility's property.</p> <p>On 03/21/11 at 3:40pm, interview with the DON and continued interview with CNA #1, the aide assigned to Resident #1, revealed Resident #1 had last been seen by staff in the chapel at approximately 2:30pm on 03/19/11. The DON and interview with LPN #2, on 03/22/11 at 2:35pm,</p>	F 323	<p>6. Residents who were at risk for elopement had pictures placed in the Wander Risk Book located at each nurses station, therapy, social services and the receptionist desk by March 23, 2011.</p> <p>7. All Wanderguard doors were checked and found to be working on March 21, 2011 and daily thereafter.</p> <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. Additional equipment for testing of the doors and bracelet transmitters was ordered on March 21, 2011. 2. Daily checking of Wanderguard doors by Maintenance was implemented on March 21, 2011. 	



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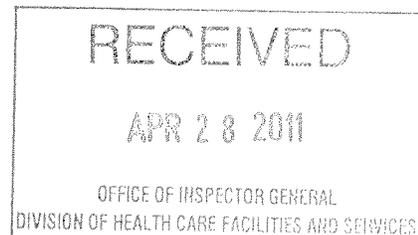
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F 323	<p>Continued From page 4</p> <p>revealed a visitor came to the facility asking if anyone in the nursing facility wore black and white, describing a person the citizen had found on the street. They stated the staff immediately knew it was Resident #1. The DON stated Resident #1 exited from the building through an exit door directly across from the chapel. She further revealed the exit door is equipped with an alarm that activates whenever a wander guard transmitter comes close to the exit door. She stated the resident's wander guard bracelet (transmitter) had been placed on the resident's walker and the resident was using the walker the day of the elopement. The DON, LPN #2, CNA #1 and interview with LPN #1, on 03/22/11 at 2:50 pm, revealed resident #1's wander guard bracelet did not activate the exit door alarm; therefore, the resident was able to leave the building without staff knowledge. LPN #1 revealed the facility conducted an assessment of Resident #1 upon the resident's return to the facility identifying no sustained injuries.</p> <p>Continued interview with the DON revealed there was no documented evidence the night shift nurses had checked Resident #1's wander guard transmitter prior to the elopement. The DON stated interview with the the night shift supervisor confirmed the checks were not completed. On 03/21/11 at 5:30pm, interview with the night shift supervisor revealed while all staff nurses are suppose to check to ensure the wander guard bracelets worked every night and document the completion on the signalling device log; however, the supervisor revealed she had not checked those logs to assure the checks were being completed by staff.</p> <p>On 03/22/11 at 5:45pm, observation of the</p>	F 323	<p>3. The "Wandering, Unsafe Resident"(Exhibit A), "Monitoring of Wander Prevention System" (Exhibit B), and "Resident Elopement" (Exhibit C) policies were reviewed and revised. Policies were approved at a CQI meeting held on March 24, 2011 with physician representation.</p> <p>4. An "Elopement Risk Assessment" (Exhibit D) will be completed on all new admissions and re-entries into the facility.</p> <p>5. All Wanderguard doors and transmitters in use will be checked daily and documented on the "Wander Transmitter Daily Testing Log" (Exhibit E) or "Wander System Door Testing Log" (Exhibit F) starting March 23, 2011. These logs will be monitored by the Director of Nursing, Nurse Manager, and shift supervisors daily for 30 days, weekly X4, then monthly for the remainder of the year. Findings will be reported at the monthly CQI Committee Meetings.</p>		



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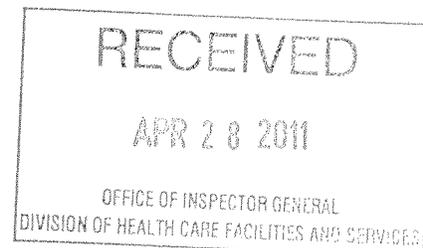
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F 323	<p>Continued From page 5</p> <p>signaling device testers (used to test the wander guard bracelets to ensure the devices are working properly) revealed one tester had expired on 12/04/10 and the other tester had written instructions of "this device tester requires periodic calibration for proper operation." Return tester on or before "06/14/10". Interview with the interim administrator on 03/21/11 at 5:30pm, revealed the facility had not calibrated the testers.</p> <p>Interview on 03/22/11 at 3:10pm, with the Maintenance Assistant, during the observations revealed they check the exit door alarms monthly. Review of the log detailing the wander guard door checks revealed the doors were checked on 03/14/11 and again on 03/21/11. However, the log did not detail which doors were checked.</p> <p>Furthermore, the facility was unable to provide evidence that they ensured staff was supervising Resident #1, monitoring the use of the assistive devices (i.e. wander guard and door alarms) in order to prevent elopement, as no staff was knowledgeable that the resident had eloped and there was no evidence staff redirected the resident from the exit door. Thus, resulting in Resident #1 successfully exiting the facility without staff knowledge and staff identifying the resident was missing.</p> <p>Review of the investigative report (dated 03/22/11) and interview with the DON, on 03/22/11 at approximately 5:30pm, revealed the facility took the following immediate action:</p> <ol style="list-style-type: none"> 1. The facility performed a physical assessment on Resident #1 and found no injuries. 2. Resident #1 was placed on Q 15 minute 	F 323	<ol style="list-style-type: none"> 6. All Wanderguard transmitters will be placed on resident's wrists as instructed per manufacturer's specifications. Transmitters will be place don a resident's ankle only when resident resists placement on wrist. 7. Wanderguard transmitters will not be placed on a resident's wheelchair or other metal devices per manufacturers specifications. 8. Staff of all departments were trained on the new policies and forms with completion of a post-test (Exhibit G) on March 22, 23, and 24, 2011. Training was completed by the Director of Nursing, Nurse Managers, and Executive Director. 		



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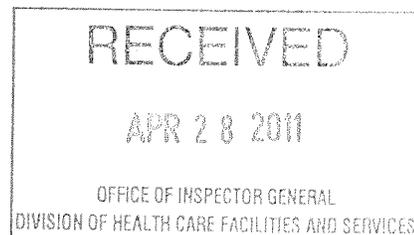
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F 323	<p>Continued From page 6</p> <p>checks. These checks were continued until 03/21/11 when a new wander guard transmitter was placed on Resident #1.</p> <p>3. Wander guard transmitters of other residents (2) identified at risk for elopement were checked for placement and verified the transmitter worked properly on 03/19/11.</p> <p>4. Pictures of the 3 residents identified at risk for elopement were placed at all nurses stations and the front desk. (Resident #1, #2 and #3).</p> <p>Additional measures were taken on 03/21-24, 2011:</p> <p>1. The facility verified orders for the wanderguard bracelet placement for Residents #1, #2 and #3. The facility verified the TAR (treatment administration record) listed wanderguard bracelet placement for monitoring.</p> <p>2. New transmitter testing logs were implemented to ensure wanderguard bracelet transmission testing.</p> <p>3. Additional testers were ordered on 03/21/11.</p> <p>4. Implementation of a new wander alarm door testing log was implemented. The maintenance department will test all alarming doors daily.</p> <p>5. An elopement risk assessment was implemented and completed on all residents on 03/23/11.</p> <p>6. New elopement policy and procedure developed on 03/22/11.</p>	F 323	<p>9. Explanation of the Wanderguard System and policies will continue to be part of orientation with all new employees to include reason for use of transmitters, doors that alarm, and resetting of alarms. Training with nursing employees will also include proper placement of the bracelets, daily checking of transmitter function and door function. Training with maintenance employees will also include daily checking of door function. Training will be completed by Maintenance Assistant and/or Staff Development Coordinator or Nurse Manager.</p>		



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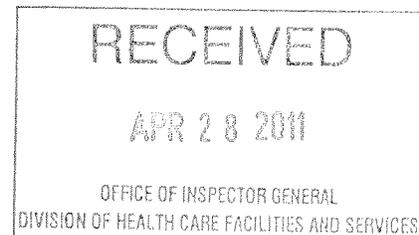
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F 323	<p>Continued From page 7</p> <p>7. Training of staff (all departments) on the new policies and forms with completion of a post test. (March 20-24, 2011)</p> <p>8. A QA monitoring tool was implemented on 03/22/11. Monitoring will be done daily for 30 days of the door checks and wander guard transmitters. A QA meeting was held with a physician representation on 03/24/11. The policies were approved and one revision made.</p> <p>9. Pictures of residents who have been identified as an elopement risk were placed in an elopement risk binder located on each nurses station (Unit 300, 400, 500, and 600) and the front desk.</p> <p>Observation of Resident #1 on 03/21/11 at 3:40pm revealed the resident sitting in a chair with a wander guard bracelet applied to the left lower extremity. Observations of Residents #2, #3, and #4 on 03/24/11 revealed the wander guard bracelets were applied to the residents' wheelchairs.</p> <p>Review of the clinical record of Residents #1, #2, and #3 during the survey revealed the residents had been assessed for risk for elopement and had wander guard bracelets. Resident #2 wanders off the unit but has not attempted to leave the facility. Resident #3 was found in the parking lot on 03/18/11. The resident left the designated smoking area and went out the front door to the parking lot. (This was prior to wander guard placement). In addition, when the facility conducted elopement risk assessments, Resident #4 was identified at risk for elopement. A wander guard bracelet was applied on 03/24/11, a care plan developed, and the resident's picture placed</p>	F 323	<p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <ol style="list-style-type: none"> 1. The Director of Nursing, Nurse Manager, and shift supervisors will monitor that Wanderguard door checks and transmitter checks are done daily for 30 days, weekly X4, then monthly for the remainder of the year. Beginning March 24, 2011. 2. All findings will be reviewed and analyzed at the monthly CQI Committee Meetings. 	



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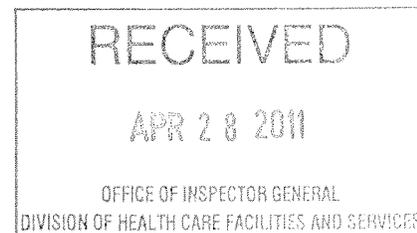
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F 323	<p>Continued From page 8 in the elopement risk binder.</p> <p>Interview with the Medical Director on 03/22/11 at approximately 5:30pm revealed the facility had notified him of the elopement. He had not been involved with drafting a new policy and had not contributed to the plan of correction. He stated he is very involved with QA; however, he had not been informed of a QA meeting so far.</p> <p>Interview with the Interim Administrator on 03/24/11 at 11:30am, revealed a QA meeting was held that morning with physician representation (the house Psychiatrist). Review of the signature sheet and interview with the physician on 03/24/11 at 11:45am, verified participation in the QA meeting with recommendations given.</p> <p>The following additional measures were validated as completed prior to the survey exit on 03/25/11:</p> <ul style="list-style-type: none"> * Facility reassessed all residents for elopement risk. Residents #1, #2, #3, and #4 were identified at risk for elopement with care plan revision verified. * Observations on 03/24/11 revealed the residents had a wander guard transmitter applied either on person or the wheelchair. * Review of the revised signaling device log: which detailed all transmitters were in working order. Interviews with staff validated they were performing those checks on 03/24/11. * Interview with the Medical Director, on 03/22/11 at 5:30pm, revealed the facility notified him of the findings. Review of the QA committee signature sheet on 03/24/11, validated completion of the 	F 323			



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/25/2011	
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
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F 323	<p>Continued From page 9 meeting and attendance by a house physician.</p> <p>* On 03/22/11 at 3:10pm, a check of all exit doors were completed with the facility's maintenance department. Observation revealed all alarming exit doors were functioning properly. Observation of staff response to the alarm activation revealed a respond time of less than 30 seconds.</p> <p>* Validated each nursing unit (Unit 300, 400, 500, and 600) and the front desk had the elopement risk binder with Residents #1, #2, #3, and #4 pictures in the binders.</p> <p>Interview with the Interim Administrator on 03/22/11 at approximately 5:45pm revealed the testers were removed from service on 03/20/11 and new testers were ordered. The residents were taken individually to the alarmed doors to test the wander guard bracelets.</p> <p>Validation of staff training March 21-24, 2011 via sign-in roster checked against staffing list. Validated all staff were trained through 03/24/11 except those on medical leave or vacation. Those staff will receive training, prior to being assigned to work with the residents.</p> <p>Interview with facility staff, on 03/24/11 on Unit 300 at 2:35pm, with CNA#3, CMT#1 and housekeeper #1; on Unit 400 with CNA #4, and #5, CMT#2; Unit 500 at 10:30am with CNA#6, housekeeper #2, and LPN#3; and Unit 600 at 1:40pm with CNA#7 and RN #1 revealed they had been in-serviced on the new elopement policy and procedure, proper functioning of the door alarm system and wander guard system. All staff was able to demonstrate the procedures.</p>	F 323		



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F 323	Continued From page 10 Immediate Jeopardy was verified to be removed prior to exit on 03/25/11 with remaining non-compliance at 42 CFR 483.25 Quality of Care, scope and severity at a "D", while the facility's Quality Assurance continues to monitor the wander guard transmitters for proper function and completion of door checks for the at risk residents who utilize the wander guard bracelets.	F 323		

