

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185301	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/21/2014
NAME OF PROVIDER OR SUPPLIER REGIS WOODS			STREET ADDRESS, CITY, STATE, ZIP CODE 4604 LOWE RD LOUISVILLE, KY 40220		
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY21467 was initiated on 03/20/14 and concluded on 03/21/14. The Division of Health Care substantiated the allegation with Immediate Jeopardy determined to exist on 03/17/14. Immediate Jeopardy was identified at 42 CFR 483.20 Resident Assessment (F282 at S/S of "J"), 42 CFR 483.25 Quality of Care (F323 at S/S of "J"), and 42 CFR 483.75 Administration (F490 at S/S of "J"). Substandard Quality of Care was identified in 42 CFR 483.25 Quality of Care, F323.</p> <p>Resident #1 was admitted to the facility on 03/05/13 and assessed as an elopement risk due to the resident's history of wandering tendencies and current behaviors of wandering. The facility initiated the Comprehensive Care Plan to address the resident's risk for elopement with the goal the resident would not elope from the facility. On 03/17/14, at approximately 7:00 PM, Resident #1 exited the facility without staff knowledge. The resident was found off the facility's grounds, walking down a sidewalk beside a busy street. The resident was returned to the facility at 7:20 PM without harm. The investigation revealed a visitor had put in the code to open the front entrance door allowing Resident #1 to exit the facility. In addition, the visitor deactivated the alarms that were sounding due to the resident's WanderGuard device. The facility was aware visitors had the code to the exit doors and did not provide any monitoring or oversight.</p> <p>The facility's failure to provide adequate supervision of a resident of known elopement risks placed residents at risk for elopement in a</p>	F 000			

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

TITLE

(X6) DATE

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

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

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FORM APPROVED
OMB NO. 0938-0391

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F 000	Continued From page 1 situation that was likely to cause serious injury, harm, impairment or death.	F 000			
F 282 SS=J	<p>Immediate Jeopardy was identified on 03/21/14, determined to exist on 03/17/14 through 03/18/14. The facility completed corrective actions prior to the State Survey Agency's investigation initiated on 03/20/14; therefore the Jeopardy was determined to be Past Jeopardy.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure care plan interventions were implemented for one (1) of five (5) sampled residents (Resident #1). The facility assessed Resident #1 to be at risk for elopement and developed a Comprehensive Care Plan for that potential risk. Resident #1's care plan included interventions to prevent the resident from wandering from a secure environment. Those interventions included: placement of a WanderGuard bracelet, assessment for potential triggers for wandering, and documentation of any unsafe wandering.</p> <p>On 03/17/14, at approximately 7:00 PM, Resident #1 left the facility's premises without staff knowledge. The resident was found at</p>	F 282	Past noncompliance: no plan of correction required.		

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F 282	<p>Continued From page 2</p> <p>approximately 7:20 PM, off facility grounds, on a sidewalk beside a busy two (2) lane street. The resident was returned to the facility unharmed. Review of the facility's investigation revealed a visitor had put in the code to the exit door and allowed the resident to leave the facility. Staff interviews revealed the resident had exhibited potential triggers for elopement (wearing of jacket, wandering off unit, and going to the front entrance); however, the facility had failed to assess those triggers as indicated in the care plan. Refer to F-323.</p> <p>The facility's failure to implement the Comprehensive Care Plan interventions to ensure the resident's safety was likely to cause risk for serious injury, harm, impairment or death. Immediate Jeopardy was identified on 03/21/14 and was determined to exist on 03/17/14. The facility had completed corrective actions prior to the initiation of the State Survey Agency's investigation on 03/20/14; therefore, the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>The facility did not provide a policy for care plans.</p> <p>Review of the elopement policy, revision date of 10/01/10, revealed residents identified at risk for elopement would have an interdisciplinary elopement prevention care plan developed. The care plan would include individual risk factors and patterns.</p> <p>Record review revealed the facility admitted Resident #1 on 12/02/13, with diagnoses of Encephalopathy and Dementia. The record</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>revealed the resident had a history of wandering from home. The facility conducted an elopement risk evaluation upon admission, on 12/02/13, with findings of exit seeking/wandering behaviors. The resident's picture was placed in the Elopement Risk Binder and a WanderGuard bracelet was placed on the resident.</p> <p>Review of the initial Minimum Data Set (MDS) assessment, dated 12/09/13, revealed the facility assessed the resident to have a cognition loss with a Brief Interview for Mental Status (BIMS) score of seven (7) out of possible fifteen (15). The facility assessed the resident to be independent (needing no staff assistance) with bed mobility, transfers, and ambulation. A care plan was developed on 12/02/13 addressing the elopement risk with interventions directing staff to assess for potential triggers for wandering; document any unsafe wandering; and placement of a WanderGuard device. The stated goal was for the resident not to wander from a secure location unattended.</p> <p>Review of the facility's investigation revealed Resident #1 successfully exited the building without staff knowledge on 03/17/14.</p> <p>Interview with the Director of Nursing (DON), on 03/20/14 at 2:40 PM, revealed Resident #1 had been transferred from the locked unit to the NF-2 Unit on 12/09/13. She stated the resident had a weight loss with decreased appetite. An appetite stimulant was ordered and the resident improved. With that improvement, the resident started coming out of his/her room more. The resident would put on his/her coat and walk around the unit. The resident started going off the unit and was frequently seen in the hallway leading to the front entrance (Entrance B). When staff would</p>	F 282		

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F 282	<p>Continued From page 4</p> <p>ask the resident what he/she was doing, the resident would reply waiting for his/her sister to visit and take him/her out. She indicated she had seen the resident standing at this exit door many times prior to the elopement, but the resident was easily re-directed from the exit.</p> <p>Interview with the MDS Coordinator, on 03/20/14 at 5:35 PM, revealed the elopement care plans were generated from a computer program. The MDS Coordinator could not verbalize the exact triggers for Resident #1 related to elopement. However, she did state the potential triggers could be the wearing of a leather jacket and wandering off a unit. Further interview revealed she was unaware of these changes. She stated she developed the Comprehensive Care Plan and if any changes occurred, the Unit Managers would be responsible to include those changes. She indicated the entire facility would be a safe environment for residents who wandered because all exit doors required a code and had a WanderGuard alarm system.</p> <p>Interview with Registered Nurse (RN) #1, on 03/20/14 at 6:00 PM, revealed she was the nurse assigned to Resident #1 when the resident eloped from the facility on 03/17/14. She stated around 6:45 PM, she saw the resident walk off the NF-2 Unit (where the resident resided) toward NF-1. She stated the resident had a leather jacket on and often walked to the NF-1 Unit during the evening. She continued to state the resident would go to the main exit (entrance B) and look out the doors. She indicated this was the norm for this resident. She stated when the resident did not come back after two-three minutes as usual, she decided to walk to the NF-1 Unit to find the resident. However, another resident stopped her</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>and requested assistance. After caring for the other resident, she walked to the NF-1 Unit and asked the staff if they had seen the resident. The staff had not. She then went back to the resident's room to look for him/her. She stated she had passed the front entrance exit doors on her way to and from the NF-1 Unit. RN #1 stated she had looked out the window of the exit doors; however, she did not step outside the facility to look for the resident. She walked back to the resident's room and discovered the resident had not returned. She then initiated the elopement policy and began a search for the resident. She said the staff conducted a room to room search with a head count of all residents. Resident #1 was not found in the building. The search extended outside of the facility. After searching the front parking lot, staff looked off facility grounds and found the resident walking down a sidewalk greater than 300 feet from the front entrance.</p> <p>Interview, on 03/21/14 at 11:05 AM, with the Assistant Director of Nursing #1 (the nurse who found Resident #1 the day of elopement) revealed Resident #1 often put on a jacket and walked around the facility. When asked, the resident would say he/she was waiting for a family member. Although the resident often walked between the NF-2 and NF-1 units with his/her jacket on, the nurse stated the resident had not attempted to leave before.</p> <p>Interview with the NF-2 Unit Manager, on 03/21/14 at 1:50 PM, revealed she was familiar with Resident #1's care. She indicated the resident had improved since moving onto this unit. She revealed the resident used to stay in his/her room at first, but recently started coming</p>	F 282		

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F 282	<p>Continued From page 6</p> <p>out. She stated the resident loved to wear the black leather jacket and wore it often so this did not trigger anything with the staff when they saw the resident wearing it.</p> <p>Interview with CNA # 1, on 03/21/14 at 2:15 PM, revealed she was familiar with Resident #1's care. She stated when Resident #1 was transferred to NF-2 Unit, the resident stayed in the room a lot. Recently, she had observed the resident with a jacket on ambulating on the unit. She did not notice if the resident ambulated off the unit. She indicated this was new for this resident.</p> <p>Although multiple staff identified potential triggers for Resident #1 (wearing of jacket, wandering off unit, and going to front entrance), the facility failed to assess those triggers according to the Comprehensive Care Plan. Review of Residents #2, #3, #4 and #5's Care Plan revealed the same computer generated care plan with the same goals and interventions as those documented for Resident #1.</p> <p>The State Survey Agency validated the corrective actions on 03/21/14 prior to exit as follows:</p> <ol style="list-style-type: none"> 1. Review of the facility's action plan, dated 03/18/14, revealed after the resident was returned, RN #1 assessed Resident #1 on 03/17/14 and he/she was found to be without injury and was placed on one to one (1:1) supervision until moved to the locked unit at 11:00 PM. The resident's family came in and sat with the resident until the move. 2. Review of the maintenance log revealed the door alarms were checked daily prior to the 	F 282			

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F 282	<p>Continued From page 7</p> <p>elopement. The door alarms were checked on the day of the elopement (03/17/14) and was found to be working properly. The code to the exit doors was changed on 03/17/14. Staff was instructed and letters were sent to families regarding not giving the code to anyone except staff. Completion date of 03/18/14.</p> <p>3. Review of an invoice, dated 03/18/14, from the facility's contracted door, locks and alarm service provider, revealed all door alarms and closures were checked by the company on 03/18/14 with no problems found.</p> <p>4. Review of the training sign in sheets and agendas, revealed staff was trained on the facility's policy for Elopement. Training consisted of elopement education, elopement assessment, and not giving out the code to the doors to any visitors. Interview with the DON, on 03/20/14 at 3:04 PM, revealed re-training on elopements began immediately after the elopement occurred. Review of the staff attendance roster for the staff training revealed all regular facility staff had been trained prior to returning to work. Employees on leave or vacation were provided training material via certified mail and instructed to read prior to returning to work. Interview with RN #1, on 03/20/14 at 6:00 PM, revealed she had been re-trained on the Elopement Policy after Resident #1 was returned to the facility. Interview with the Assistant Director of Nursing for the NF-1, NF-2, and Transitional Care Unit (TCU) revealed they returned to the facility the night of the elopement and were re-educated on the elopement policy and then they assisted with the retraining of direct care staff.</p> <p>5. Interview with the Administrator, on 03/20/14</p>	F 282		

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F 282	<p>Continued From page 8</p> <p>at 3:04 PM, revealed a Performance Improvement (PI) meeting with the Medical Director was held on 03/18/14. The purpose of the PI meeting was to review the elopement and action plans to ensure the facility's response and interventions were complete. Interview with the Medical Director, on 03/21/14 at 11:20 AM, validated he was informed of the elopement on 03/17/14 and came to the facility on 03/18/14 to discuss details of action plans. He stated he was in agreement of the facility's actions.</p> <p>6. The facility created, on 03/18/14, an Elopement Risk Information Sheet to be provided to residents/families upon admission that explained the facility's process of not sharing the door codes with anyone.</p> <p>7. Observation of the Administrator, on 03/20/14 at 6:30 PM, revealed he was putting in the keypad code for visitors to leave the building. In addition, staff was observed redirecting residents identified as at risk for elopement from exit doors</p> <p>8. Review of the clinical records for Residents #1, 2, 3, 4, and 5, identified as at risk for elopement, revealed these residents were reassessed by the Director of Nurses and Assistant Director of Nurses on 03/17/14 and the care plans were reviewed for appropriateness by the Director of Nurses and Assistant Director of Nurses, on 03/18/14.</p>	F 282		
F 323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives</p>	F 323		

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F 323	Continued From page 9 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's elopement policy, it was determined the facility failed to have an effective system to ensure adequate supervision of residents with known behaviors of wandering for one (1) of five (5) sampled residents (Resident #1). The facility admitted Resident #1 on 12/02/13 and assessed the resident to have elopement tendencies due to the resident's history. The facility initiated a Comprehensive Care Plan to address the resident's risk for elopement with a goal the resident would not wander from a secure environment and the resident would be observed for potential triggers to wandering. A WanderGuard device was applied to the resident's ankle. On 03/17/14, at approximately 7:00 PM, Resident #1 exited the facility without staff knowledge. The resident was found off the facility's grounds, walking down a sidewalk that was close to a very busy street. The resident was returned to the facility at 7:20 PM. The facility's failure to provide adequate supervision of residents with known wandering risk placed those residents in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care was determined to exist on 03/17/14 with corrective actions completed on	F 323	Past noncompliance: no plan of correction required.		

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F 323	<p>Continued From page 10</p> <p>03/18/14, prior to the State Survey Agency's investigation; therefore, the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Elopement of Patient, revision date of 10/01/10, revealed all residents would be assessed for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Those determined to be at risk for elopement would receive appropriate interventions to reduce risk and minimize injury. The policy detailed elopement occurred when a patient left the premises without authorization or necessary supervision. For those residents identified at risk, an interdisciplinary elopement prevention care plan would be developed with individual risk factors and patterns identified and addressed in the care plan. All staff would be trained on the facility's door security system and required to respond to a sounding alarm.</p> <p>Record review revealed the facility admitted Resident #1 on 12/02/13, with diagnoses which included Encephalopathy and Dementia. The facility placed the resident on the locked Dementia Unit. Review of the hospital History and Physical completed on 11/21/13, revealed the resident was found on the street in front of a house the resident thought was his/her sister's house. The resident had sustained a minor injury to the head and had altered mental status. Emergency Medical Services (EMS) was called and the resident was taken to the hospital with an altered mental status change. Review of the hospital record revealed the resident had driven about eighty (80) miles from his/her home in a car</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>taken from a local dealership. The record stated the resident lived with a brother and the brother told the hospital Social Worker the resident had a similar episode in May 2013 where he/she got out of the house and got lost. The brother stated the resident was progressively becoming more forgetful. Documentation from the hospital's discharge planning section revealed a diagnosis of Vascular Dementia with history of wandering off. The hospital's Social Worker documented that the resident had exhausted the family, who lived locally, related to the resident's wandering off from the home.</p> <p>Continued review of the clinical record revealed the facility conducted an elopement risk evaluation upon admission, on 12/02/13, with findings of exit seeking/wandering behaviors. The resident's picture was placed in the Elopement Risk Binder and a WanderGuard bracelet was placed on the resident. Review of the initial Minimum Data Set (MDS) assessment, dated 12/09/13, revealed the facility assessed the resident to have a cognition loss with a Brief Interview for Mental Status (BIMS) score of seven (7) out of possible fifteen (15). The facility assessed the resident to be independent (needing no staff assistance) with bed mobility, transfers, and ambulation. A Care Plan was developed on 12/02/13 addressing the elopement risk with interventions directing staff to assess for potential triggers for wandering, document any unsafe wandering, and placement of a WanderGuard device. The stated goal was for the resident not to wander from a secure location unattended. Review of the behavioral monitoring sheet revealed two (2) specific behaviors were to be monitored for Resident #1, wandering and exit seeking. The record revealed the resident was</p>	F 323		

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F 323	<p>Continued From page 12 transferred from the locked unit to the general population on 12/09/13.</p> <p>Review of the facility's investigation, dated 03/17/14, revealed Resident #1 successfully exited the building without staff knowledge on 03/17/14.</p> <p>Observation of Resident #1, on 03/20/14 at 12:56 PM, revealed the resident dressed in clean street clothing sitting in a recliner in his/her room. Observation revealed a WanderGuard bracelet on the resident's right ankle.</p> <p>Interview with the resident, on 03/21/14 at 12:58 PM, revealed he/she did recall some of the events of the elopement. The resident stated he/she was going to a nearby store to buy potato chips. The resident stated he/she didn't tell anyone he/she was leaving. "I thought I could go and come back without anyone knowing I had left." He/she could not recall which door he/she went out. The resident revealed he/she was on a sidewalk when the "bird dogs" of the facility came and got him/her. The resident stated a uniform Deputy Sheriff opened the door for him/her to leave because the resident didn't know the code. The resident stated the Sheriff put in the code and he/she walked out the door. When asked about the WanderGuard device on the resident's right ankle, the resident replied they put that device on because it is a requirement in this facility.</p> <p>Interview with the Director of Nursing (DON), on 03/20/14 at 2:40 PM, revealed Resident #1 had been transferred from the locked unit per family request on 12/09/13. She stated the resident had a weight loss with decreased appetite while</p>	F 323		

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F 323	<p>Continued From page 13</p> <p>he/she was in the locked unit and appeared to be depressed. An appetite stimulant was ordered and the resident improved. With that improvement, the resident started coming out of his/her room more. The resident would put on his/her coat and walk around the unit. The resident started going off the unit and was frequently seen in the hallway leading to the front entrance (Entrance B). When staff would ask the resident what he/she was doing, the resident would reply waiting for his/her sister to visit and take him/her out. She indicated she had seen the resident standing at this exit door many times prior to the elopement, but the resident was easily re-directed from the exit.</p> <p>Interview with the Administrator and DON, on 03/20/14 at 3:04 PM, revealed they were notified of the elopement on 03/17/14 and began an investigation and corrective actions immediately. The staff reported the resident told them a police officer had let him/her out. They thought of Family Member #1 who visited often. They spoke with the Family Member and he/she told the Administrator they had opened the door for a gentlemen thought to be a visitor. The Administrator stated when Family Member #1 described the details of the incident, he conducted the same scenario and found that if you put the code into the keypad twice it will override the WanderGuard alarm system. Especially if you entered the code quickly. That was how the family member described to administration how he/she had silenced the alarm.</p> <p>The Administrator stated all staff who was working at the time of the elopement were interviewed and no staff heard the alarm sound.</p>	F 323		

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F 323	<p>Continued From page 14</p> <p>He said Registered Nurse (RN) #1 was working on the NF-2 Unit and saw the resident walk onto the other unit. She was going to check on the resident, but was stopped by another resident. After caring for that resident, RN #1 went to the other unit and discovered Resident #1 was not on the NF-1 unit. A search was conducted of the building with a head count of all residents completed. Resident #1 was not found. The Administrator revealed previously an elopement drill had been conducted on 03/14/14, and stated the staff followed policy and procedures during this elopement drill. The DON stated when the resident was returned to the facility, a complete physical exam was performed and found the resident had not sustained any injuries. She stated the resident was placed on 1:1 supervision until the resident was moved to the locked unit at 11:00 PM. The resident's family was called and came to sit with the resident. The physician was notified including the Medical Director. She indicated training of staff began that night and was completed on 03/18/14. The Administrator revealed the door code was changed that night and only staff was allowed to have the code. Letters were sent to the families notifying them of the changes. The Administrator stated all exit door alarms were checked to ensure they were working properly and he stated they were. The Administrator and DON concluded the resident eloped from the front entrance when Family Member #1 opened the door for the resident. The WanderGuard alarm was deactivated and only sounded for just a short time; therefore, the staff probably did not hear the alarm.</p> <p>Additional interview with the Administrator, on 03/20/14 at 5:10 PM, revealed he was aware visitors knew the code to the exit doors. He said</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>codes were changed monthly, but families usually learned the changed code. He stated he did not know how the visitor knew the code, probably staff gave the code to the visitor when asked. He stated Family Member #1 knew the code and used it to open the front exit door the night Resident #1 eloped from the building. Prior to the elopement, he had witnessed visitors using the code to open the door without staff assistance. He revealed there was no policy against giving visitors the door code. In addition, EMS and transport services would ask for the code and it was given to them by staff. The Administrator stated the code was changed the night of the elopement and no visitors could have the code now. He said staff had been trained on the new rule.</p> <p>Interview with Registered Nurse (RN) #1, on 03/20/14 at 6:00 PM, revealed she was the nurse assigned to Resident #1 when the resident eloped from the facility on 03/17/14. She stated around 6:45 PM, she saw the resident walk off NF-2 unit (where the resident resided) toward NF-1. She stated the resident had a leather jacket on and often walked to the NF-1 unit during the evening. She continued to state the resident would go to the main exit (entrance B) and look out the doors. She indicated this was the norm for this resident. She stated when the resident did not come back after two-three minutes as usual, she decided to walk to NF-1 unit to find the resident. She walked to NF-1 unit (around a corner and down a long hallway) and asked the staff of that unit if they had seen the resident. The staff of NF-1 told the nurse they had not seen Resident #1. She then went back to the resident's room to look for him/her. She stated she had passed the front entrance on her way to and from</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>NF-1 unit and she had looked out the windows, but did not see the resident. However, she revealed she had not stepped outside the facility to look for the resident. She recalled seeing Family Member #1 getting into a car in the parking lot. She walked back to the resident's room and discovered the resident had not returned. She then initiated the elopement policy by calling Resident #1's name three times over the intercom requesting the resident to return to his/her room. The resident did not return. The staff then initiated a search for the resident. She said the staff conducted a room to room search with a head count of all the residents. Resident #1 was not found in the building. The search extended to outside the facility. After searching the front parking lot, staff looked off facility grounds and found the resident walking down a sidewalk. She revealed Resident #1 wore a WanderGuard bracelet that should have alarmed whenever the resident left the building. However, she stated she heard no alarms sounding. The nurse stated when the resident was walked back into the facility, through the front entrance door, the resident's WanderGuard bracelet did activate the door alarms.</p> <p>Continued interview with RN #1 revealed the resident told staff that a person in a police uniform had let him/her out of the facility. She recalled Family Member #1 (who was a Police Officer) had left the building at the same time Resident #1 must have left the facility. Family Member #1 was called and validated the resident's story. The family member told the nurse he/she had put in the code for the exit door and allowed Resident #1 to leave. The family member told the nurse when he/she had walked up to the front entrance to exit the building, the</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>resident was putting in numbers in the keypad but the door would not open. The family member thought the resident was a visitor and had just forgot the code, so she put in the code for the resident. When asked how Family Member #1 knew the code, she replied, all families know the door code and they come and go freely. She didn't know if there was a rule against giving out the code.</p> <p>Interview with Family Member #1, on 03/20/14 at 6:30 PM, revealed he/she visited their family often. The day of the elopement, he/she had visited, was tired and worried and when he approached the front entrance exit door, he saw a man/woman pushing the keypad buttons to the exit door. He thought the man/woman had just forgotten the code numbers, so he put in the right code numbers. The door would still not open. The family member said it never crossed his mind the man/woman was a resident. He further stated he thought the man/woman had "just put in the numbers wrong". The man/woman "was dressed in a jacket and looked like any other visitor." Family Member #1 continued to say he put in the door code again and noticed a flashing light. He just thought the man/woman had put in too many numbers that caused the door not to open. When the resident stepped back behind the family member, he was able to put in the correct code and the door opened. He let the resident go through the door first. He did recall hearing a whistling sound and the door code panel on the outside of the door was flashing. He thought it was because they had punched in so many numbers and held the door opened too long. The Family Member stated he did not want to disturb the staff so he immediately started punching the code number into the keypad and the whistling</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>sound and flashing light stopped. "I did not know I had deactivated the alarm system." The resident and I walked out the door into the parking lot. The resident thanked me for my assistance and told me to have a good night. I got into my car and left. When asked how he knew the code to the exit door, he replied staff had given it to him a long time ago. However, the family member stated they do not know the code today and staff would have to assist him from the building.</p> <p>A demonstration of how Family Member #1 had opened the door the day of the elopement was conducted on 03/21/14 at 6:50 PM, using a WanderGuard device. When facility staff attempted to exit through the front entrance with the WanderGuard device, the door would lock and flash a yellow light on the keypad box. The Family Member demonstrated how he/she had put in the code to set off the alarm. Whenever the staff stepped back out of range of the door alarm system, the exit door opened when the correct code was put in. When the staff member went through the door holding the WanderGuard device, it activated the WanderGuard alarm and the whistling sound began. The WanderGuard was given to the surveyor and when they stepped away from the exit door as the staff member put in the code twice like the family member did the night of the elopement. The alarm was deactivated and did not sound anymore. The family member stated this was how they had entered the code that night. He told the surveyor they were just trying to stop the noise because he didn't want to make staff come to the door for assistance. The family member thought the alarm went off because he/she had put in too many numbers, never thinking the resident was wearing a device that would trigger an alarm. The family</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>member stated the alarm did not sound very long and he/she doubted if the staff could have heard the alarm.</p> <p>Interview, on 03/21/14 at 11:05 AM, with the Assistant Director of Nursing #1 (the nurse who found Resident #1 off facility's property) revealed RN #1 came to TCU unit and asked if anyone had seen Resident #1. Nobody had seen the resident so everyone started looking for the resident. She stated they conducted a complete head count of each resident and searched the building. The resident was not found. She went outside to search. She went out the front exit (the same exit door the resident had eloped from) to the front parking lot and did not see the resident. She walked around the building and spotted a person with a jacket on walking down the street. She stated she got into her car and drove down the street toward the person wearing the jacket. She recognized it was Resident #1 walking on the sidewalk. She turned her car around and drove back to the resident. She told Resident #1 to get in her car and she would give the resident a ride. The resident got into her car and was returned to the facility without any problems. She revealed the resident was returned through the same door that the resident had eloped through. She indicated when the resident walked through the door, the WanderGuard device activated the alarm. She stated Resident #1 often put on the leather jacket and walked around the facility. When asked, the resident would say he/she was waiting for a family member. She revealed the resident often walked between NF-2 and NF-1 units with his/her jacket on.</p> <p>Interview with NF-2 Unit Manager, on 03/21/14 at 1:50 PM, revealed she was familiar with Resident</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>#1's care. She indicated the resident had improved since moving onto this unit. She revealed the resident used to stay in his/her room at first, but recently started coming out. She stated the resident loved a black leather jacket and wore it often so that did not trigger anything when staff saw the resident wearing it. She validated what RN#1 had said about visitors having the code to the exit doors. She acknowledged she had seen visitors putting the code into the keypad box without staff's assistance prior to the elopement, but now staff had to assist visitors out of the facility.</p> <p>Interview with CNA #1, on 03/21/14 at 2:15 PM, revealed she was familiar with Resident #1's care. She stated when Resident #1 was transferred to NF-2 Unit, the resident stayed in the room a lot. Recently, she had observed the resident wearing a jacket and walking on the unit. She did not notice if the resident walked off the unit.</p> <p>Observation of the location where Resident #1 was found, on 03/20/14 at 2:20 PM, revealed the resident was off the facility grounds. The location required the resident to walk around the building and down the sidewalk of a busy street. The location was greater than 300 feet from the front entrance and was not visible from any part of the facility.</p> <p>The State Survey Agency validated the facility's corrective actions on 03/21/14 prior to exit as follows:</p> <p>1. Review of the facility's action plan, dated 03/18/14, revealed after the resident was returned, RN #1 assessed Resident #1 on</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>03/17/14 and he/she was found to be without injury and was placed on one to one (1:1) supervision until moved to the locked unit at 11:00 PM. The resident's family came in and sat with the resident until the move.</p> <p>2. Review of the maintenance log revealed the door alarms were checked daily prior to the elopement. The door alarms were checked on the day of the elopement (03/17/14) and was found to be working properly. The code to the exit doors was changed on 03/17/14. Staff was instructed and letters were sent to families regarding not giving the code to anyone except staff. Completion date of 03/18/14.</p> <p>3. Review of an invoice, dated 03/18/14, from the facility's contracted door, locks and alarm service provider, revealed all door alarms and closures were checked by the company on 03/18/14 with no problems found.</p> <p>4. Review of the training sign in sheets and agendas, revealed staff was trained on the facility's policy for Elopement. Training consisted of elopement education, elopement assessment, and not giving out the code to the doors to any visitors. Interview with the DON, on 03/20/14 at 3:04 PM, revealed re-training on elopements began immediately after the elopement occurred. Review of the staff attendance roster for the staff training revealed all regular facility staff had been trained prior to returning to work. Employees on leave or vacation were provided training material via certified mail and instructed to read prior to returning to work. Interview with RN #1, on 03/20/14 at 6:00 PM, revealed she had been re-trained on the Elopement Policy after Resident #1 was returned to the facility. Interview with the</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>Assistant Director of Nursing for the NF-1, NF-2, and Transitional Care Unit (TCU) revealed they returned to the facility the night of the elopement and were re-educated on the elopement policy and then they assisted with the retraining of direct care staff.</p> <p>5. Interview with the Administrator, on 03/20/14 at 3:04 PM, revealed a Performance Improvement (PI) meeting with the Medical Director was held on 03/18/14. The purpose of the PI meeting was to review the elopement and action plans to ensure the facility's response and interventions were complete. Interview with the Medical Director, on 03/21/14 at 11:20 AM, validated he was informed of the elopement on 03/17/14 and came to the facility on 03/18/14 to discuss details of action plans. He stated he was in agreement of the facility's actions.</p> <p>6. The facility created, on 03/18/14, an Elopement Risk Information Sheet to be provided to residents/families upon admission that explained the facility's process of not sharing the door codes with anyone.</p> <p>7. Observation of the Administrator, on 03/20/14 at 6:30 PM, revealed he was putting in the keypad code for visitors to leave the building. In addition, staff was observed redirecting residents identified as at risk for elopement from exit doors</p> <p>8. Review of the clinical records for Residents #1, 2, 3, 4, and 5, identified as at risk for elopement, revealed these residents were reassessed by the Director of Nurses and Assistant Director of Nurses on 03/17/14 and the care plans were reviewed for appropriateness by the Director of Nurses and Assistant Director of</p>	F 323		

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F 323 F 490 SS=J	Continued From page 23 Nurses, on 03/18/14. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility's Administration failed to have an effective system to ensure resources, including care plans were used effectively and efficiently to attain and maintain the highest practical, physical, mental, and psychosocial well-being of one (1) resident (Resident #1) in a sample of five (5) residents. The Administration failed to ensure elopement and care plan policies and procedures were implemented by failing to reassess and evaluate Resident #1 for elopement/wandering when changes occurred. On 03/17/14, at approximately 7:00 PM, Resident #1 left the facility's premises without staff knowledge. The resident was found at approximately 7:20 PM, off facility grounds, on a sidewalk beside a busy two (2) lane street. The resident was returned to the facility unharmed. Review of the facility's investigation revealed a visitor had put in the code to the exit door and allowed the resident to leave the facility. The facility was aware that visitors had the code to the	F 323 F 490	Past noncompliance: no plan of correction required.	

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F 490	<p>Continued From page 24</p> <p>exit doors and failed to provide any education to the visitors or oversight to ensure residents at risk for elopement remained safe.</p> <p>Refer to F-282 and F-323</p> <p>The Administration's failure to ensure facility policies/procedures related to elopement and care plan implementation caused, or was likely to cause, serious injury, harm, impairment, or death to residents at the facility. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 03/17/14. The facility completed corrective actions prior to the initiation of the State Survey Agency's investigation on 03/20/14; therefore, the Jeopardy was determined to be Past Jeopardy.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Elopement of Patient, revision date of 10/01/10, revealed all residents would be assessed for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Those determined to be at risk for elopement would receive appropriate interventions to reduce risk and minimize injury. For those residents identified at risk, an interdisciplinary elopement prevention care plan would be developed with individual risk factors and patterns identified and addressed in the care plan.</p> <p>Interview and record review revealed the facility admitted Resident #1 on 12/02/13, with diagnosis of Dementia. Further review revealed upon</p>	F 490		

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F 490	<p>Continued From page 25</p> <p>admission the resident was assessed as an elopement/wander risk. The resident was assessed to be cognitively impaired and review of the comprehensive care plan, dated 12/02/13, revealed interventions were put in place to keep the resident safe. These interventions included a WanderGuard bracelet, assessing for potential triggers to wandering, and documentation of any unsafe wandering. Review of the facility's investigation, dated 03/17/14, revealed on 03/17/14, Resident #1 left the facility's premises without staff knowledge. The investigation found a visitor had opened the code alarm door and allowed the resident to leave the facility. The resident was found off facility grounds, walking down a sidewalk beside a busy two (2) lane street.</p> <p>Interview with the Director of Nursing, on 03/20/14 at 2:40 PM, Assistant Director of Nursing #1, on 03/21/14 at 11:05 AM, RN #1, on 03/20/14 at 6:00 PM, NF-2 Unit Manager, on 03/21/13 at 1:50 PM, and Certified Nursing Assistant #1, on 03/21/14 at 2:15 PM, revealed the staff had knowledge of Resident #1's wandering triggers. The staff was aware of a change in the resident's pattern, but failed to follow the care plan intervention and the elopement policy to assess for those triggers. In addition, the staff was aware visitors had the code to the security door and observed visitors using the code frequently.</p> <p>Interview with the Administrator, on 03/20/14 at 5:10 PM, revealed he was aware visitors knew the code to the exit doors. He said codes were changed monthly, but families usually learned the changed code and used them without staff assistance. He stated he did not know how</p>	F 490			

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F 490	<p>Continued From page 26</p> <p>visitors knew the code, that probably staff gave the code to the visitors when asked. He stated Family Member #1 knew the code and used it to open the front exit door the night Resident #1 eloped from the building. Prior to the elopement, he had witnessed visitors using the code to open the door without staff assistance. He revealed there was no policy against giving visitors the door code.</p> <p>The State Survey Agency validated the facility's corrective actions on 03/21/14 prior to exit as follows:</p> <ol style="list-style-type: none"> 1. Review of the facility's action plan, dated 03/18/14, revealed after the resident was returned, RN #1 assessed Resident #1 on 03/17/14 and he/she was found to be without injury and was placed on one to one (1:1) supervision until moved to the locked unit at 11:00 PM. The resident's family came in and sat with the resident until the move. 2. Review of the maintenance log revealed the door alarms were checked daily prior to the elopement. The door alarms were checked on the day of the elopement (03/17/14) and was found to be working properly. The code to the exit doors was changed on 03/17/14. Staff was instructed and letters were sent to families regarding not giving the code to anyone except staff. Completion date of 03/18/14. 3. Review of an invoice, dated 03/18/14, from the facility's contracted door, locks and alarm service provider, revealed all door alarms and closures were checked by the company on 03/18/14 with no problems found. 	F 490		

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F 490	Continued From page 27 4. Review of the training sign in sheets and agendas, revealed staff was trained on the facility's policy for Elopement. Training consisted of elopement education, elopement assessment, and not giving out the code to the doors to any visitors. Interview with the DON, on 03/20/14 at 3:04 PM, revealed re-training on elopements began immediately after the elopement occurred. Review of the staff attendance roster for the staff training revealed all regular facility staff had been trained prior to returning to work. Employees on leave or vacation were provided training material via certified mail and instructed to read prior to returning to work. Interview with RN #1, on 03/20/14 at 6:00 PM, revealed she had been re-trained on the Elopement Policy after Resident #1 was returned to the facility. Interview with the Assistant Director of Nursing for the NF-1, NF-2, and Transitional Care Unit (TCU) revealed they returned to the facility the night of the elopement and were re-educated on the elopement policy and then they assisted with the retraining of direct care staff. 5. Interview with the Administrator, on 03/20/14 at 3:04 PM, revealed a Performance Improvement (PI) meeting with the Medical Director was held on 03/18/14. The purpose of the PI meeting was to review the elopement and action plans to ensure the facility's response and interventions were complete. Interview with the Medical Director, on 03/21/14 at 11:20 AM, validated he was informed of the elopement on 03/17/14 and came to the facility on 03/18/14 to discuss details of action plans. He stated he was in agreement of the facility's actions. 6. The facility created, on 03/18/14, an Elopement Risk Information Sheet to be provided	F 490		

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F 490	<p>Continued From page 28</p> <p>to residents/families upon admission that explained the facility's process of not sharing the door codes with anyone.</p> <p>7. Observation of the Administrator, on 03/20/14 at 6:30 PM, revealed he was putting in the keypad code for visitors to leave the building. In addition, staff was observed redirecting residents identified as at risk for elopement from exit doors</p> <p>8. Review of the clinical records for Residents #1, 2, 3, 4, and 5, identified as at risk for elopement, revealed these residents were reassessed by the Director of Nurses and Assistant Director of Nurses on 03/17/14 and the care plans were reviewed for appropriateness by the Director of Nurses and Assistant Director of Nurses, on 03/18/14.</p>	F 490		