

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

PRINTED: 09/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2015
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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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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	INITIAL COMMENTS  An Abbreviated/Partial Extended Survey investigating complaint KY00023699 was initiated on 08/19/15 and concluded on 08/26/15. KY00023699 was substantiated with Immediate Jeopardy (IJ) identified on 08/20/15 with deficiencies cited at 42 CFR 483.20 Resident Assessment, F-282; and 42 CFR 483.25 Quality of Care, F-323 all at a Scope and Severity (S/S) of a "J." Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined to exist on 08/15/15 and the facility was notified of the Immediate Jeopardy on 08/20/15.  Interview and record review revealed the facility was aware Resident #1 had a history of wandering behaviors, and was care planned for the behaviors. The care plan included interventions for increased supervision if the resident attempted to leave the facility unsupervised and the resident also had a Secure Care Bracelet placed to his/her rolling walker. On 08/15/15, Resident #1 utilized his/her rolling walker to exit the front door of the facility without staff knowledge at approximately 3:18 PM. Even though the resident had a Secure Care Bracelet attached to his/her rolling walker, the alarm did not sound when the resident exited the facility. Resident #1 returned to the facility through the front door utilizing his/her rolling walker at approximately 3:25 PM, at which point the Secure Care Bracelet alarm did sound, alerting staff. State Registered Nursing Assistant (SRNA) #1 responded to the alarm, and found Resident #1 in the main lobby with the door closed, with no evidence Resident #1 had been outside. Although Resident #1 reported to SRNA #1	F 000	This plan of correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.	
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6 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charles Roberts</i>	TITLE Administrative	(X6) DATE 10/6/15
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 he/she had returned from outside, SRNA #1 did not alert nursing staff and Resident #1 was not placed on increased supervision as directed by the care plan. Later on 08/15/15, at approximately 6:01 PM, Resident #1 again exited the facility through the front door utilizing his/her rolling walker, and again the alarm did not sound. Off-duty staff found Resident #1 lying on the ground in the parking lot by the side of the building. Staff inside the facility were alerted to the resident's whereabouts by the off-duty staff at approximately 6:15 PM.  In addition, Resident #1's Secure Care Bracelet was improperly placed on the walker instead of on the resident's ankle, per the manufacturer's guidelines. Therefore, the alarm was not triggered when the resident exited the building twice on 08/15/15 without staff knowledge. Staff interviews revealed they were not aware the bracelets were not to be secured to walkers.  An acceptable credible Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 08/25/15 alleging the Immediate Jeopardy was removed on 08/20/15. On 08/26/15, the State Survey Agency verified the Immediate Jeopardy was removed on 08/20/15 as alleged with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F-282; and 42 CFR 483.25 Quality of Care, F-323 all at a Scope and Severity of a "D", while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.	F 000		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	It is the policy of Bourbon Heights, Inc. to ensure that the care be provided by qualified persons in accordance with each resident's written plan of care.  When notified of the situation that created an immediate jeopardy to exist at Bourbon Heights, Inc. on Saturday, August 15, 2015, immediate steps were taken. Immediate investigation correction, supervision were initiated to protect the resident involved and all other residents, as well as steps initiated to prevent future issues with accident hazards and supervision. Below is a comprehensive list of immediate, corrective actions that have been taken. Items were accomplished by August 19, 2015 and represent the Facility's continuing efforts toward improving quality of care and compliance.  <b>Cause of the Immediate Jeopardy was identified.</b>  -The Immediate Jeopardy finding related to a resident elopement from facility. On Saturday, August 15, 2015, Resident #1 exited the building to the front porch at 3:18 p.m. with no evidence of the alarm sounding, upon re-entry at	

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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 the facility's policy, and video surveillance footage it was determined the facility failed to have an effective system in place to ensure services were provided in accordance with the written plan of care for one (1) of three (3) sampled residents (Resident #1).

Interview and record review revealed Resident #1 had a history of wandering. Review of Resident #1's Comprehensive Care Plan revealed staff were to perform fifteen (15) minute checks or one (1) on one (1) supervision if Resident #1 attempted to leave the facility unattended.

On 08/15/15, Resident #1 utilized his/her rolling walker to exit the front door of the facility without staff knowledge at approximately 3:18 PM. Even though the resident had a Secure Care Bracelet attached to his/her rolling walker, the alarm did not sound when the resident exited the facility. Resident #1 returned to the facility through the front door utilizing his/her rolling walker at approximately 3:25 PM, at which point the Secure Care Bracelet alarm did sound, alerting staff. State Registered Nursing Assistant (SRNA) #1 responded to the alarm, and found Resident #1 in the main lobby with the door closed, with no evidence Resident #1 had been outside. Although Resident #1 reported to SRNA #1

F 282

3:23 pm the alarm sounded and staff responded and asked if resident had been outside. Upon noticing that the alarm may not have sounded, the nursing assistant failed to effectively communicate to the charge nurse on duty and thus, the care plan intervention of 15 minute monitoring was not initiated. This allowed the resident to again exit the building with the alarm not sounding at 6:01 pm, resulting in Resident #1 falling in the parking lot.

**The facility has identified all residents that may be at potential risk for harm.**

-To identify the residents who may have been at potential risk for harm Tamara McCarty, LPN, MDS Assistant assessed all 17 residents with secure care bracelets utilizing the Elopement Risk Assessment (Decision Tree) with no changes required on August 15, 2015.

-All 17 care plans were reviewed and updated if needed by Tamara McCarty, LPN, MDS Assistant on August 15, 2015. Resident #2 refused to place secure care bracelet on ankle on 8/15/15, in addition to secure care bracelet on walker, additional secure care bracelet was added to wheelchair. Care plan was updated via care plan status update by Tamara McCarty on 8/15/15. 15 minute monitoring was initiated and implemented due to continued refusal to place on ankle on the morning of August 16, 2015 by Melanie Crawford, RN with care plan update status completed on August 16, 2015.

-The facility assessed all residents for the risk of elopement on August 17, 2015. The assessments were completed by Tamara

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F 282. Continued From page 3  
he/she had returned from outside, SRNA #1 did not alert nursing staff and Resident #1 was not placed on increased supervision as directed by the care plan. Later on 08/15/15, at approximately 6:01 PM, Resident #1 again exited the facility through the front door utilizing his/her rolling walker, and again the alarm did not sound. Off-duty staff found Resident #1 lying on the ground in the parking lot by the side of the building. Staff inside the facility were alerted to the resident's whereabouts by the off-duty staff at approximately 6:15 PM.

The facility's failure to have an effective system in place to ensure the Comprehensive Care Plan was followed related to providing increased supervision for at-risk residents has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 08/20/15 and was determined to exist on 08/15/15.

An acceptable credible Allegation of Compliance (AOC) was received on 08/25/15 which alleged removal of the Immediate Jeopardy on 08/19/15. The Immediate Jeopardy was verified to be removed on 08/26/15 as alleged with the remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment (F-282) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure care plans are followed to implement interventions to provide adequate supervision.

The findings include:  
Review of the facility's policy titled "E.H.R. - Care

F 282. McCarty, LPN, MDS Assistant, Rebecca Highfield, LPN, MDS Assistant, and Ashley Kincade, LPN, Infection Control and Wound Care Nurse, with no residents identified at risk for elopement other than the 17 on secure care bracelets already.

**Steps taken to remove the Immediate Jeopardy**

- Resident #1 care plan was updated by Tamara McCarty, LPN, MDS Assistant on August 15, 2015.
- Care plans were reviewed on all 17 residents with secure care bracelets with changes made if needed on August 15, 2015 by Tamara McCarty, LPN, MDS Assistant.
- Assessed all residents for the risk of elopement utilizing the Elopement Risk Assessment (Decision Tree) on August 17, 2015 by Tamara McCarty, LPN, MDS Assistant, Rebecca Highfield, LPN, MDS Assistant, and Ashley Kincade, LPN, Infection Control and Wound Care Nurse.
- Care signs were checked to be in place on all 17 residents with secure care bracelets on August 17, 2015 by Janet Patton, Quality Assurance Assistant.
- In-service training was prepared for all employees on elopement, elopement policy, and behaviors, including implementing interventions on the care plan on August 15, 2015 by Charlotte Roberts, Administrator. 150 of 152 current employees were in-serviced starting on August 15, 2015 and was completed

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F 282	<p>Continued From page 4</p> <p>Plans", dated December 2014, revealed the plan of care was used to inform staff of the needs of residents and included interventions for problems identified. Further review revealed care plans were communication tools to ensure continuity of care.</p> <p>Record review revealed the facility admitted Resident #1 on 12/08/10 with multiple diagnoses which included Dementia. Continued review of the admission documentation revealed the facility obtained a consent authorizing the use of the Secure Care Bracelet, signed by Resident #1's son on 12/06/10.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/08/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate impairment. Further review of the MDS Assessment revealed the facility assessed Resident #1 to ambulate independently with the assist of a walker.</p> <p>Review of Resident #1's Comprehensive Care Plan (CCP), dated 04/21/15, revealed Resident #1 was care planned for being at risk for elopement due to the diagnosis of Dementia. Further review of the CCP revealed interventions including the following: placement of a monitoring device on the resident which would sound an alarm when the resident left the building to alert staff of Resident #1's wandering behavior; staff were to report any threats of leaving the facility to the charge nurse; and the resident would be placed on fifteen (15) minute monitoring or one-on-one (1:1) supervision when attempting to leave the facility unattended.</p>	F 282	<p>by August 19, 2015. This was completed by Charlotte Roberts, Administrator, Teresa Earlywine, LPN, Quality Assurance Director, Janet Patton, Quality Assurance Assistant, Ashley Kincade, LPN, Infection Control and Wound Care Nurse, Willas Gray, LPN, Assistant Director of Nursing, Barbara Traylor, Housekeeping Supervisor, and Kim Mullins, Dining Services Supervisor. Remaining employees are PRN or as needed and are not currently scheduled, training will be required prior to returning to work. Bourbon Heights uses no agency staff.</p> <p>-In-service training was prepared by Charlotte Roberts, Administrator on the reporting of inconsistent testing or non-functioning alarms immediately to the charge nurse, Administrator or Director of Nursing on August 17, 2015. Training was conducted by Charlotte Roberts, Administrator, Janet Patton, Quality Assurance Assistant, Teresa Earlywine, Quality Assurance Assistant, Ashley Kincade, LPN, Infection Control and Wound Care Nurse, Willas Gray, LPN, Assistant Director of Nursing, Tamara McCarty, LPN, MDS Assistant, Barbara Traylor, Housekeeping Supervisor and Kim Mullins, Dining Services Supervisor.</p> <p>-Secure care checks were completed every shift for proper placement and functioning for 72 hours by nursing staff on duty. Beginning on August 15, 2015 and ending on August 18, 2015.</p> <p>-Head counts were completed every shift for 72 hours by nursing staff on duty beginning on</p>	

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F 282	Continued From page 5  Review of facility video surveillance footage for 08/15/15 revealed Resident #1 exited the facility with his/her rolling walker at 3:18 PM, at which time no staff were observed responding alarm (the video footage did not have sound recording capability). When Resident #1 returned to the facility at 3:25 PM, SRNA #1 was observed rushing up the hall to the lobby, where Resident #1 was ambulating at the time with no evidence of having been outside. Continued video footage review revealed at 6:01 PM Resident #1 exited the facility a second time with her rolling walker, with no staff response observed at that time.  Interview with State Registered Nurse Aide (SRNA) #1 on 08/19/15 at 10:47 AM revealed Resident #1 had been confused the morning of 08/15/15, and had been talking about seeing his/her mother in the hallway. SRNA #1 stated she questioned Kentucky Medication Aide (KMA) #1 about the resident's confusion and was told Resident #1 was recovering from a urinary tract infection which might explain the confusion. Continued interview revealed SRNA #1 responded to Resident #1's Secure Care alarm on 08/15/15 at approximately 3:25 PM and the resident reported having been outside. However, as SRNA #1 did not see the door open and the alarm had not sounded earlier when the resident reportedly went out the door, she thought Resident #1 was confused, and did not believe Resident #1 had really left or attempted to leave the facility at that time. SRNA #1 stated she told KMA #1 the resident reported having been outside. SRNA further revealed she should have informed the nurse of the alarm sounding, and the resident's comments about being outside. SRNA #1 stated, although she was uncertain	F 282	August 15, 2015 and ending on August 18, 2015.  -Daily walk throughs were completed by Charlotte Roberts, Administrator to ensure staff understanding of elopement, elopement policy, behaviors, and implementing interventions on the care plan starting on August 17, 2015 and continued through August 20, 2015. Daily observations were also completed to ensure interventions from the care plans were in place starting on August 17, 2015 and continuing through August 20, 2015.  <b>The facility has implemented systemic changes to ensure the jeopardy will not reoccur.</b>  -As of August 19, 2015, the facility has in-serviced 150 of 152 current employees on elopement, elopement policy, and behaviors, including implementing interventions on the care plan. This in-service was prepared by Charlotte Roberts, Administrator and began on August 15, 2015 and ending on August 19, 2015 by Charlotte Roberts, Administrator, Janet Patton, Quality Assurance Assistant, Teresa Earlywine, LPN, Quality Assurance Director, Willas Gray, LPN, Assistant Director of Nursing, Tamara McCarty, LPN, MDS Assistant, Ashley Kincade, LPN, Infection Control and Wound Care Nurse, Kim Mullins, Dining Services Director, and Barbara Traylor, Housekeeping Director. The remaining employees are PRN or as needed and are not currently scheduled. Training will be required prior to these employees returning to work.  Bourbon Heights uses no agency staff.		

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F 282 Continued From page 6  
what Resident #1's comprehensive care plan said, she felt Resident #1 warranted more attention, and attempted to keep a closer eye on Resident #1. Per interview, she encouraged the resident to eat dinner in the dining room so she could keep an eye on him/her, although Resident #1 refused, stating he/she was waiting on his/her sisters.

Interview with KMA #1 on 08/19/15 at 11:17 AM revealed SRNA #1 had approached her in the afternoon of 08/15/15 and she understood SRNA #1 to state Resident #1 had been at the door, but did not recall being told Resident #1 stated she had been outside. KMA #1 stated she reported to the nurse Resident #1 had been seen at the door. Continued interview revealed Resident #1 did have an elopement care plan, and had she understood the resident reported having been outside, she would have passed that information to the nurse and the resident might have been placed on fifteen (15) minute checks or one-on-one supervision.

Interview with Registered Nurse (RN) #1 on 08/19/15 at 2:24 PM revealed she did not witness any abnormal behavior from Resident #1 on 08/15/15. She stated Resident #1 liked to go to the door and look out, and when KMA #1 reported to her Resident #1 had been to the door that afternoon she did not consider it out of the ordinary, and did not think it was exit-seeking behavior. Continued interview revealed if it was exit-seeking behavior, she would have implemented Resident #1's CCP for fifteen (15) minute checks or one-on-one supervision.

Interview with SRNA #4 on 08/20/15 at 11:04 AM revealed she had not heard of Resident #1

F 282 -As of August 19, 2015, the facility has in-serviced 150 of 152 current employees on reporting immediately any inconsistent alarms or non-functioning alarms to the charge nurse, Administrator or Director of Nursing. This in-service was prepared by Charlotte Roberts, Administrator and given by Charlotte Roberts, Administrator, Janet Patton, Quality Assurance Assistant, Teresa Earlywine, LPN, Quality Assurance Director, Willas Gray, LPN, Assistant Director of Nursing, Ashley Kincade, LPN, Infection Control and Wound Care Nurse, Tamara McCarty, LPN, MDS Assistant, Kim Mullins, Dining Services Director and Barbara Traylor, Housekeeping Supervisor. The remaining employees are PRN or as needed and are not currently scheduled. Training will be required prior to returning to work. Bourbon Heights uses no agency staff.

-Both in-services will be added to the new employee orientation effective with the next new employee orientation, none are scheduled at the present time.

-The individual secure care bracelets will continue to be checked for proper placement on the resident ankle per manufacturer's recommendation on every shift by the nursing assistants. This will be documented in the Smart Charting section of the electronic health record.

-The individual secure care bracelets will continue to be checked for proper functioning weekly by the KMAs. This will be completed by the KMA taking each resident with a secure care bracelet through an area with a secure care

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F 282	<p>Continued From page 7</p> <p>setting off the alarm prior to 08/15/15, although the resident did like to sit in the lobby and speak with other residents. She explained when a resident sets off an alarm, especially if it is unusual for the resident to do so, staff should keep a closer watch on the resident and inform the nurse. Continued interview revealed at times, the nurses put residents on fifteen (15) minute checks if a resident attempted to leave the facility.</p> <p>Interview with SRNA #6 on 08/20/15 at 11:30 AM revealed it was unusual for Resident #1 to go to the door and set off the Secure Care alarm; however, she reported the resident had been more confused in the past week and had been setting off the alarm. SRNA #6 stated the nurse aide care plan gave direction for the SRNAs to watch Resident #1 more closely if he/she set off an alarm by attempting to exit the building. SRNA #4 further stated she was responsible for ensuring the nurse was made aware of a resident's attempt to leave, or if the resident talked about leaving.</p> <p>Further interview with RN #1 on 08/20/15 at 1:15 PM revealed, even though the Secure Care alarm sounded at 3:25 PM, she wouldn't have necessarily done anything different if a nurse aide had informed her Resident #1 reported having been outside. She stated Resident #1 was confused, and unless she had evidence the resident had gone out of the building, or attempted to go out, she would not have implemented the care plan for increased supervision.</p> <p>Interview with the Director of Nursing (DON) on 08/20/15 at 11:43 AM revealed her expectation was for the SRNAs to inform their charge nurse</p>	F 282	<p>system in place (i.e. door or hallway) to ensure the alarm sounds. This will be documented in both the electronic health record and in the resident chart under the Secure Care sheet.</p> <p>-Maintenance will continue to perform weekly checks on the system to ensure proper functioning prior to the weekend. This will be documented on a log maintained in the maintenance office.</p> <p>-The Quality Assurance Committee will complete weekly walk-throughs to ask employees questions regarding elopement, behaviors, and reporting inconsistent or non-functioning alarms, and regarding implementing interventions on the care plan.</p> <p>-The Quality Assurance Committee will continue to complete weekly walk-throughs to randomly check care plans and make observations to ensure care plans interventions are in place. The quality assurance director will randomly choose 4 residents for the committee to audit. This will become a regular part of the QA Committee walk through.</p> <p>-Quality Assurance Chart Audits will continue to be performed on a quarterly basis to follow the MDS Care plan schedule to review care plans and ensure interventions are in place. These audits follow the care plan schedule, thus ensuring all charts are reviewed at least quarterly by the Quality Assurance Director or Quality Assurance Assistant. These audits are a regular function of the quality assurance office and will continue to be monitored indefinitely to ensure compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 282	Continued From page 8 whenever a resident triggered an exit alarm. She explained although going to the door in and of itself may not be exit-seeking, as residents like to look outside, going outside or saying they were returning from outside should have been considered exit-seeking for Resident #1 as it was unusual behavior. The DON stated she expected nursing to follow the CCP, and acknowledged they did not do so for Resident #1 on 08/15/15.  Interview with the Administrator on 08/19/15 at 12:19 PM revealed her expectation on 08/15/15 would have been for SRNA #1 to report to the charge nurse, RN #1, if Resident #1 set off the alarm and mentioned having been outside. She stated she would then expect RN #1 to follow the interventions outlined in the care plan and alert Administration of Resident #1 being placed on fifteen (15) minute checks or 1:1 supervision. The Administrator acknowledged staff failed to follow Resident #1's CCP when he/she exhibited exit seeking behavior.  The facility provided an acceptable, credible Allegation of Compliance (AOC) on 08/25/15, which alleged removal of the Immediate Jeopardy (IJ) effective 08/19/15. Review of the AOC revealed the facility implemented the following:  1. Resident #1 was sent to the hospital on the evening of 08/15/15 for evaluation in the Emergency Room (ER) and was discharged back to the facility the same night. Upon return to the facility, RN #1 performed a head to toe skin assessment.  2. Upon return from the hospital ER, Resident #1 was placed on fifteen (15) minute monitoring while asleep and one (1) on one (1) supervision	F 282	-The QA Committee consists of the Quality Assurance Director, Quality Assurance Assistant, Administrator, Business Office Manager, Maintenance Director, Housekeeping Director, Dining Services Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, MDS Assistants, Infection Control Nurse, Activity Director, and Social Services Director.  -By re-educating staff, adding the information to the new employee orientation, conducting regular walk-throughs to ensure staff understanding, conducting regular walk-throughs to randomly check care plans and observations to ensure interventions are in place and continuing to do ongoing chart audits for care plan updates and interventions are in place, systems are now in place to ensure care is provided by qualified persons in accordance with each resident's written plan of care.  <b>The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained.</b>  -To assure that each resident care is provided by qualified persons in accordance with each resident's written plan of care monitoring through Quality Assurance Committee weekly walk-throughs will continue on a weekly basis to ensure care plans are updated and interventions are in place. All findings from the weekly walk-throughs will be reported on after completed to allow for follow up education to be completed throughout the building. In addition, the medical director is at the facility		

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F 282 Continued From page 9  
while awake as directed by the Administrator upon Resident #1's return on 08/15/15.

3. The Secure Care system was checked by the Maintenance Director on 08/15/15 to identify the root cause of the accident.

4. Resident #1's Secure Care Bracelet was removed from his/her rolling walker, and a new Secure Care Bracelet was placed on his/her left ankle by KMA #1.

5. Two other residents with Secure Care Bracelet's on their walkers, Resident #2 and Resident #4, had Secure Care Bracelets removed from their walkers, with Resident #4's Secure Care Bracelet placed on his/her ankle the evening of 08/15/15. Resident #2 initially refused placement on his/her ankle, and was placed on fifteen (15) minute checks on the evening of 08/15/15. Resident #2 was determined by staff to no longer be an elopement risk on 08/20/15 with his/her Secure Care Bracelet's removed at that time and fifteen (15) minute checks discontinued at that time.

6. A video surveillance investigation was initiated on 08/15/15 by the Administrator to identify the source of Resident #1's exit from the facility. Further video investigation was conducted by the Administrator on 08/17/15.

7. An investigation of the events involving Resident #1 was initiated on 08/15/15 by the Social Services Director (SSD) and concluded on 08/18/15.

8. All Secure Care Bracelets in use were checked for functioning and placement by the unit

F 282 frequently through the week and is apprised of any areas of concern and input sought to monitor the ongoing concerns of the facility. The medical director's cell phone number is located on all units for easy access for consultation. Any areas of concern regarding the interventions being implemented will be reported to the Administrator immediately.

**The Facility has included dates of corrective action.**

The facility is confident that the situation creating immediate jeopardy was corrected by Wednesday, August 19, 2015. In addition, in order to prevent any future issues regarding accident and supervision, the quality assurance committee has been and will continue to conduct weekly walk-throughs to ensure interventions are in place as written in the plan of care and the monitoring of such has identified no other issues in the past month. Wandering behaviors have been correctly identified and proper interventions and care plans have been put into place by staff on duty which indicates understanding of policies and procedures in place to ensure care plan interventions are completed by qualified staff.

Compliance Date:

September 20, 2015

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F 282	Continued From page 10 charge nurse on duty on 08/15/15 and each shift for seventy-two (72) hours. This was in conjunction with a head count conducted every shift by the unit charge nurse on duty, also initiated on 08/15/15 and concluded on 08/18/15.  9. All residents were re-assessed utilizing the Elopement Risk Assessment (Decision Tree) on 08/17/15 by facility nursing staff with care plans updated as required.  10. All care signs for elopement were checked to be in place for seventeen (17) residents with Secure Care Bracelets on 08/17/15 by the Quality Assurance (QA) Assistant. Care signs were symbols placed above a resident's bed to alert staff providing care the resident was an elopement risk. Additionally, all Elopement Risk Boards were updated, with additional boards added to the Adult Day Care office and the Therapy Office.  11. The Secure Care Policy was updated to remove language pertaining to the allowance of the Secure Care Bracelet being placed on assistive devices on 08/19/15 by the DON.  12. Beginning on 08/17/15 and concluding 08/19/15, 150 of 152 current facility staff were in-serviced on elopement, behaviors, the facility's elopement policy and implementing care plan interventions. The remaining two (2) employees were to be educated prior to being scheduled for work.  13. Beginning on 08/17/15 and concluding 08/19/15, 150 of 152 current facility staff were in-serviced on reporting any inconsistencies in the Secure Care Bracelet alarm system or any	F 282			

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F 282	<p>Continued From page 11</p> <p>failures immediately to the charge nurse. Only two (2) staff remaining to be educated prior to being assigned any work.</p> <p>14. Daily rounds were made by the Administrator beginning on 08/17/15 and concluding on 08/20/15 to ensure staff understood the education they had received on elopement, behaviors, reporting, and implementing care plan interventions.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <p>1. Review of nursing notes for Resident #1 dated 08/15/15 revealed Resident #1 was sent to the hospital on the evening of 08/15/15. Review of ER nursing notes dated 08/15/15 revealed the hospital discharge impression was a contusion to the left elbow, a contusion to the left hip, and a concussion without loss of consciousness. Continued review of facility nursing notes dated 08/15/15 revealed upon return to the facility, RN #1 performed a head to toe skin assessment, revealing no additional areas of concern.</p> <p>Interview with the Medical Director (MD on 08/25/15 at 1:20 PM revealed he had been contacted on 08/15/15 when Resident #1 eloped, and the facility had reviewed it's Allegation of Compliance with him. The MD revealed he felt the underlying issue to be antibiotic medication Resident #1 was taking to combat a UTI. The MD stated it was an unfortunate situation which he hoped never happens again, but had supported the facility's efforts to correct it's problems.</p> <p>2. Review of 15 Minute Monitoring Form</p>	F 282		
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F 282	Continued From page 12  documentation for Resident #1 revealed he/she was placed on fifteen (15) minute monitoring on 08/15/15 at 9:00 PM and was documented as ongoing at the time of the Extended Survey on 08/26/15. Staff was observed with Resident #1 in Resident #1's room on 08/19/15 at 8:15 AM; in Resident #1's room on 08/20/15 at 11:35 AM; and on 08/26/15 at 11:10 AM. Interview with SRNA #7 on 08/26/15 at 10:03 AM revealed she was responsible for scheduling the increased supervision for Resident #1. Interview with monitoring staff on 08/26/15, SRNA #8 at 10:12 AM, and SRNA #9 at 10:24 AM, all confirmed they had sat with Resident #1 on more than one occasion on twelve (12) hour shifts since the 08/15/15 elopement. These statements were corroborated by staff initials on the 15 Minute Monitoring Forms.  3. The Secure Care system was checked by the Maintenance Director on 08/15/15 to identify the root cause of the accident. Interview with the Maintenance Director on 08/19/15 at 12:08 PM revealed he was called in the night of 08/15/15 after Resident #1 had eloped, and he tested the Secure Care alarm system at that time. The Maintenance Director revealed, in testing the system, he determined the Secure Care system was inconsistent in alerting staff when placed on resident walkers due to the height of the bracelet. Follow up interview with the Maintenance Director on 08/26/15 at 11:13 AM confirmed there was a height cutoff on the alarm system that wasn't 100% effective in alarming when placed on resident walkers. The Maintenance Director went on to reveal, now that all residents with Secure Care Bracelets have them on their ankles, the alarms have been working consistently without exception. The Maintenance Director revealed, in	F 282			

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F 282	Continued From page 13 addition to the staff testing that has been occurring since the elopement, in which staff escort residents with Secure Care Bracelets to a nearby receiver to ensure the receiver was triggered, maintenance routinely tests all of the exits on Friday to ensure they are functioning properly.  4. Interview with RN #1 on 08/20/15 at 1:15 PM confirmed Resident #1's Secure Care Bracelet was removed from his/her rolling walker, and a new Secure Care Bracelet was placed on his/her left ankle by KMA #1. Resident #1's Secure Care Bracelet was observed on his/her ankle by the State Survey Agency on 08/20/15 at 11:35 AM.  5. Two other residents with Secure Care Bracelet's on their walkers, Resident #2 and Resident #4, had Secure Care Bracelets removed from their walkers, with Resident #4's Secure Care Bracelet placed on his/her ankle the evening of 08/15/15. Resident #2 initially refused placement on his/her ankle, and was placed on fifteen (15) minute checks on the evening of 08/15/15. Fifteen (15) minute check sheets for Resident #2 were reviewed, and were current up to 08/20/15, when he/she was determined by facility staff to no longer be an elopement risk. Observation of both residents on 08/20/15 confirmed Secure Care Bracelets were no longer placed on walkers, with Resident #4 wearing his/her bracelet on his/her ankle.  6. Interview with the Administrator on 08/19/15 at 12:19 PM revealed a video surveillance investigation was initiated on 08/15/15 by the Administrator to identify the source of Resident #1's exit from the facility. Further video investigation was conducted by the Administrator	F 282			

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F 282 Continued From page 14  
on 08/17/15 and it was determined at that time Resident #1 had exited the facility earlier in the day on 08/15/15 and returned prior to the elopement at 6:01 PM. This video footage was reviewed by the State Survey Agency, with times identified in the facility investigation for Resident #1's exit(s) and return in the afternoon of 08/15/15 verified by the date/time stamp on the recording.

7. Interview with the Social Services Director (SSD) on 08/19/15 at 3:48 PM revealed she was called in the evening of 08/15/15 and began an initial investigation at that time. Continued interview revealed she completed her final investigation on 08/18/15. Review of the final investigation dated 08/18/15 revealed the SSD investigation further revealed Resident #1 had been to the nurses station and stated to RN #1 several times he/she was waiting on his/her daughter to come take her to pick beans. Interview with the SSD on 08/19/15 at 3:48 PM verified results of her investigation, and also verified she was involved in the planning process to address concerns and ensure the safety of residents.

8. Interview with RN #1 on 08/19/15 at 2:24 PM revealed, after Resident #1 eloped, she checked all Secure Care Bracelet's on Unit 1 for placement and functioning. This check, as well as checks completed by nursing staff on Unit 2 and Unit 3, were reviewed by the State Survey Agency on 08/25/15. Interview with the Assistant Director of Nursing (ADON) on 08/19/15 at 4:00 PM revealed these checks were completed again seventy-two (72) hours later on 08/18/15. This was also verified through documentation review by the State Survey Agency on 08/25/15.

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F 282 Continued From page 15  
Interview with SRNA #8 on 08/26/15 at 10:12 AM verified nurse aides had been checking placement and functioning of Secure Care Bracelets every shift from 08/15/15 through 08/18/15. Review of Unit Shift Reports for each unit revealed Secure Care Bracelets were checked for functioning and placement each shift as well as a head count conducted on each unit, with no concerns identified.

F 282

9. Review of the Elopement Risk Assessment (Decision Tree) revealed all residents were re-assessed on 08/17/15 by facility nursing staff with care plans updated as required. No additional residents were identified as at risk for elopement, requiring no care plan updates at that time. All Elopement Risk Assessment (Decision Tree)s completed on 08/17/15 were reviewed with LPN #2 on 08/26/15 at 9:35 AM by the state Survey Agency.

10. All care signs for elopement were checked on 08/17/15 by the Quality Assurance (QA) Assistant. Per interview with the QA Assistant on 08/26/15 at 10:48 AM, "Elopement Care Signs" consisted of a running man stick figure at the head of each bed of residents identified as elopement risks. Additionally, all Elopement Risk Boards were updated, with additional boards added to the Adult Day Care office and the Therapy Office. The QA Assistant revealed some updated resident photos were taken. A facility tour with the QA Assistant on 08/26/15 confirmed current boards were in place on each unit nursing station and break room, as well as the front office, the maintenance office, the employee lounge, the Adult Day Care office, and the Therapy Office.

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F 282	<p>Continued From page 16</p> <p>11. Review by the State Survey Agency on 08/25/15 of the Secure Care Transmitter User Guide, updated 02/25/15, and the facility's Policy Guidelines for the Secure Care System, updated 08/2015, revealed the facility policy no longer contained information contradictory to the User Guide. Interview on 08/25/15 at 10:37 AM with the Administrator revealed she had changed the policy, with the change consisting of the removal of information permitting staff to place a transmitter on a resident's walker or wheelchair.</p> <p>12. Review of sign-in sheets for in-services revealed 150 of 152 current facility staff were in-serviced on elopement and behaviors from 08/15/15 through 08/19/15. Interview with the Administrator on 08/25/15 at 11:51 AM revealed the remaining two (2) employees were to be educated prior to being scheduled for work. Interview on 08/19/15 at 2:24 PM with RN #1, the charge nurse of Unit 1 from which Resident #1 eloped on 08/15/15, revealed she in-serviced all staff working at that time on the elopement policy, staff responsibilities, the use of the Secure Care Bracelets, and resident behaviors.</p> <p>Interview with SRNA #1 on 08/19/15 at 2:38 PM revealed she was in-serviced following the elopement on 08/15/15. SRNA #1 stated the in-service covered staff responsibilities during an elopement, as well as recognizing and documenting resident behaviors. SRNA #1 stated the importance of alerting the charge nurse of behaviors was stressed.</p> <p>Interview with SRNA #4 on 08/20/15 at 11:04 AM revealed she attended two in-services when she came in to work on 08/17/17, one of which was on elopement and resident behaviors. SRNA #4</p>	F 282
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F 282	Continued From page 17 was able to discuss resident behaviors and staff interventions in detail, and also noted the importance of alerting the charge nurse whenever a resident has behavioral issues or is exit seeking.  Interview with SRNA #5 on 08/20/15 at 11:20 AM revealed she had attended in-services on elopement and resident behaviors. SRNA #5 stressed the importance of alerting nursing staff whenever a resident triggers a door alarm.  Interview with LPN #4 on 08/20/15 at 2:02 PM revealed she had been in-serviced regarding the elopement policy and resident behaviors. LPN #4 discussed the importance of trying to determine resident needs and ensure their needs are met, ensuring their Secure Care Bracelet was functioning, and possibly increasing resident supervision if setting off exit alarms.  Interview with SRNA #9 on 08/26/15 at 10:24 AM revealed she had been in-serviced on elopement and resident behaviors. SRNA #9 revealed the in-service covered how to respond if an elopement occurs, recognizing, documenting, and redirecting resident behaviors when possible, and the importance of keeping the charge nurse aware of the situation.  Comparison of in-service signatures with employee listing confirmed 150 of 152 employees had been in-services as of State Survey Agency review on 08/26/15.  13. Review of in-service signatures and comparison with a comprehensive employee listing revealed 150 of 152 current facility staff were in-serviced on reporting any inconsistencies	F 282		

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F 282 Continued From page 18

in the Secure Care Bracelet alarm system or any failures immediately to the charge nurse. The in-service was initiated on 08/15/15 and continued through 08/19/15. Interview with the Administrator on 08/25/15 at 11:51 AM revealed the two (2) staff remaining were to be educated prior to being assigned any work.

Interview with SRNA #1 on 08/19/15 at 2:38 PM revealed she had been in-service on what to do if the Secure Care Bracelet system doesn't work, which was to redirect and supervise the resident involved and to alert the charge nurse immediately.

Interview with Cook #1 on 08/19/15 at 3:12 PM confirmed she had been in-serviced on the importance of redirecting residents and reporting to her supervisor any time she witnessed a resident Secure Care Bracelet not functioning.

Interview with SRNA #6 on 08/20/15 at 11:30 AM revealed she had attended an in-service, and stressed the importance of informing the charge nurse any time a resident Secure Care Bracelet did not function.

Interview with KMA #2 on 08/26/15 at 11:29 AM revealed she had been in-serviced on the importance of redirecting residents and informing the charge nurse if a resident's Secure Care Bracelet does not alarm.

Comparison of in-service signatures with employee listing confirmed 150 of 152 employees had been in-services as of State Survey Agency review on 08/26/15.

F 282

14. Interview with the Administrator on 08/25/15

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F 282 Continued From page 19  
at 10:37 AM revealed daily rounds were made by the Administrator beginning on 08/17/15 and concluding on 08/20/15 to ensure staff understood the education they had received on elopement, behaviors, reporting, and implementing care plan interventions. Review of the daily rounds sheets revealed rounds were recorded on "Weekly Walk Thru" sheets, with multiple staff interviewed regarding the elopement policy and the use of and what to do if Secure Care Bracelets were determined to not be functioning. Several staff had been interviewed each day, per review of the documentation, with staff consistently providing appropriate responses.

Interview with KMA #2 on 08/25/15 at 11:29 AM revealed she had observed the QA Assistant on Unit 2 questioning staff about elopement procedure and Secure Care Bracelets, although she had not been questioned following the in-services.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  
SS=J

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, and review of the facility's policies, video surveillance footage,

F 282

F323

It is the policy of Bourbon Heights, Inc. to ensure the resident environment remains as free of accident hazards as is possible and for each resident to receive adequate supervision and assistance devices to prevent accidents.

F 323

When notified of the situation that created an immediate jeopardy to exist at Bourbon Heights, Inc. on Saturday, August 15, 2015, immediate steps were taken. Immediate investigation, correction, supervision were initiated to protect the resident involved and all other residents, as well as steps initiated to prevent future issues with accident hazards and supervision. Below is a comprehensive list of immediate, corrective actions that have been taken. Items were accomplished by August 19, 2015 and represent the Facility's continuing efforts toward improving quality of care and compliance.

**Cause of the Immediate Jeopardy was identified.**

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F 323	<p>Continued From page 20</p> <p>and manufacturer's guidelines, it was determined the facility failed to have an effective system in place to ensure a safe environment and adequate supervision for residents who had been assessed to be at risk for elopement, and who exhibited exit-seeking behavior, for one (1) of three (3) sampled residents (Resident #1).</p> <p>On 08/15/15, Resident #1 utilized his/her rolling walker to exit the front door of the facility without staff knowledge at approximately 3:18 PM. Even though the resident had a Secure Care Bracelet attached to his/her rolling walker, the alarm did not sound when the resident exited the facility. Resident #1 returned to the facility through the front door utilizing his/her rolling walker at approximately 3:25 PM, at which point the Secure Care Bracelet alarm did sound, alerting staff. State Registered Nursing Assistant (SRNA) #1 responded to the alarm, and found Resident #1 in the main lobby with the door closed, with no evidence Resident #1 had been outside. Although Resident #1 reported to SRNA #1 he/she had returned from outside, SRNA #1 did not alert nursing staff and Resident #1 was not placed on increased supervision as directed by the care plan. Later on 08/15/15, at approximately 6:01 PM, Resident #1 again exited the facility through the front door utilizing his/her rolling walker, and again the alarm did not sound. Off-duty staff found Resident #1 lying on the ground in the parking lot by the side of the building. Staff inside the facility were alerted to the resident's whereabouts by the off-duty staff at approximately 6:15 PM.</p> <p>In addition, Resident #1's Secure Care Bracelet was improperly placed on the walker instead of on the resident's ankle, per the manufacturer's</p>	F 323	<p>-The Immediate Jeopardy finding related to a resident elopement from the facility. On Saturday, August 15, 2015. Resident #1 left her room and exited through the front doors of the facility to the front porch at approximately 6:01 p.m. and was found by an off-duty employee at approximately 6:15 pm in the parking lot where resident #1 had fallen. After investigation it was determined that her secure care alarm did not sound due to the positioning of the alarm on the walker and that the resident had exited the building earlier in the day at 3:18 pm without on duty staff being aware until her return into the building at 3:23 pm.</p> <p><b>The facility has identified all residents that may be at potential risk for harm.</b></p> <p>-To identify the residents who may have been at potential risk for harm, all resident alarms were checked to ensure they were in place and functioning. This was completed immediately following the incident on August 15, 2015 by nursing staff on duty at the time.</p> <p>-Two other residents with secure care bracelets secured to an assistive device were asked to place the bracelet on their ankle, with one complying. Bracelet placed on ankle of complying resident by Teasha Hatfield, KMA on August 15, 2015.</p> <p>-Resident #2 refused to allow staff to remove the secure care bracelet from his walker and place on his ankle on 8/15/15, an additional alarm was added to the resident #2 wheelchair and placed on 15 minute monitoring. Resident #2 was placed on a secure care system due to</p>	

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<p>F 323</p> <p>Continued From page 21</p> <p>guidelines. Therefore, the alarm was not triggered when the resident exited the building twice on 08/15/15 without staff knowledge. Staff interviews revealed they were not aware the bracelets were not to be secured to walkers.</p> <p>The facility's failure to have an effective system in place to ensure the proper utilization and functioning of the Secure Care system, and the failure to provide increased supervision to Resident #1 when exit-seeking behavior was exhibited, has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 08/20/15 and was determined to exist on 08/15/15.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 08/25/15 which alleged removal of the Immediate Jeopardy on 08/20/15. The Immediate Jeopardy was verified to be removed on 08/20/15 as alleged with remaining non-compliance in the area of 42 CFR 483.25 Quality of Care (F-323) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure care plans are followed to implement interventions to provide adequate supervision.</p> <p>The findings include:</p> <p>Review of the facility's "Policy Guidelines for the Secure Care System," revised 09/2014, revealed the Secure Care Bracelet could be placed on a walker or wheelchair if a resident refused to have it placed on his/her ankle.</p> <p>Review of the Secure Care Transmitter User</p>	<p>F 323</p> <p>threats to go home upon his admission, however since his wife's admission, resident #2 is much more satisfied with his stay. Resident #2 was reassessed and discussed in the QA Committee, which consists of Charlotte Roberts, Administrator, Deanna Eads, Director of Nursing, Teresa Earlywine, Quality Assurance Director, Kim Mullins, Dining Services Director, Janet Caswell, MDS Coordinator, Sharon Patterson, Social Services Director, Barbara Traylor, Housekeeping Supervisor, Jerri Villaflor, Therapy Coordinator, Tracy Mattox, Business Office Manager, Nancy Underwood, Activity Assistant. It was decided that Resident #2 was no longer an elopement risk and his bracelet and monitoring was removed on Thursday, August 20, 2015.</p> <p>-All 17 residents with secure care bracelets were re-assessed by Tamara McCarty, LPN, MDS Assistant with the Elopement Risk Assessment (Decision Tree) on August 15, 2015.</p> <p>-All 17 residents with secure care bracelets care plans were checked and updated if needed by Tamara McCarty, LPN, MDS Assistant on August 15, 2015.</p> <p>-The facility also assessed all residents for the risk of elopement on Monday, August 17, 2015. The assessment of all residents for risk of elopement was completed by Tamara McCarty, LPN, MDS Assistant, Ashley Kincade, LPN, Infection Control and Wound Care Nurse, Rebecca Highfield, LPN MDS Assistant, which identified no other residents at risk for elopement other than the 17 already identified on the Secure Care Bracelet list.</p>
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Guide, dated 02/25/15, revealed to ensure proper functioning, the Secure Care transmitter was to be placed on a resident's ankle, unless a resident was confined to a wheelchair with both legs elevated, in which case it could be applied to a rod above the wheel of the wheelchair.

Interview with the Director of Nursing (DON) on 08/20/15 at 11:43 AM revealed prior to Resident #1's exiting the building twice on 08/15/15 without the alarm sounding, it was her understanding the Secure Care Bracelet could be placed on an assistive device such as a walker or wheelchair. She stated she was not aware of the manufacturers guidelines for the proper placement of the Secure Care Bracelets until the facility requested and received a copy of the guidelines from their supplier on 08/20/15. The DON further stated, following the incident, Resident #1's and one other resident's Secure Care Bracelets were removed from their walkers and placed on their ankles. A third resident (Resident #2) who refused to have his/her Secure Care Bracelet placed on his/her ankle was immediately placed on fifteen (15) minute checks, with the Secure Care Bracelet being ultimately removed from the resident on 08/20/15 as his/her circumstances had changed and he/she was no longer determined to be an elopement risk.

Record review revealed the facility admitted Resident #1 on 12/08/10, with multiple diagnoses which included Dementia. Continued review of the admission documentation revealed the facility obtained written consent authorizing the use of the Secure Care Bracelet, signed by Resident #1's son on 12/06/10.

Review of the Quarterly Minimum Data Set

F 323

**Steps taken to remove the Immediate Jeopardy**

-Resident #1 was sent to the hospital via ambulance to seek treatment and be evaluated by Melanie Crawford, RN on August 15, 2015.

-Upon return to the building from the ER, Resident #1 secure care bracelet was moved and placed on left ankle by Teasha Hatfield, KMA on August 15, 2015.

-Resident #1 was placed on 15 minute monitoring while asleep and 1 on 1 supervision while awake as directed by Charlotte Roberts, Administrator on August 15, 2015.

-Staffing was secured to facilitate the monitoring by Elaine Christopher, SRNA, Scheduling Coordinator

-A video surveillance investigation was initiated on August 15, 2015 by Charlotte Roberts, Administrator to identify the source of exit.

-An investigation was conducted by Sharon Patterson, Social Services Director on August 15, 2015, including staff interviews.

-Further video investigation was completed on August 17, 2015 to determine information about earlier incident during the day by Charlotte Roberts, Administrator.

-All residents with secure care bracelets were checked for functioning and placement and continued to be checked every shift for 72 hours by each unit charge nurse on duty. This was initiated on August 15, 2015 and ended on August 18, 2015.

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(MDS) Assessment, dated 07/08/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Further review of the MDS Assessment revealed the facility assessed Resident #1 to ambulate independently with the assist of a walker.

Review of Resident #1's Comprehensive Care Plan (CCP), dated 04/21/15, revealed Resident #1 was care planned for being at risk for elopement due to the diagnosis of Dementia. Review of the care plan revealed interventions included the following: placement of a monitoring device on the resident which would sound an alarm when the resident left the building to alert staff to Resident #1's wandering behavior; staff were to report any threats of leaving the facility to the charge nurse; and the resident would be placed on fifteen (15) minute monitoring or one-on-one (1:1) supervision when attempting to leave the facility unattended.

The facility had a video security system which recorded video but not audio. Review of the facility's video surveillance footage for 08/15/15 revealed Resident #1 first exited the building at 3:18 PM through the front door, at which time the alarm did not function as there was no staff response observed. Further review of the video revealed when the resident re-entered the facility at 3:25 PM, also through the front door, SRNA #1 rushed to the door, clearly responding to an alarm. Resident #1 was observed to be back in the lobby with the doors closed in the time it took SRNA #1 to respond. Resident #1 again exited the facility at 6:01 PM through the front doors, again with no alarm sounding and no staff

F 323 -A head count was completed every shift by nursing staff for 72 hours by each unit charge nurse. This was initiated on August 15, 2015 and ended on August 18, 2015.

- All 17 residents with secure care bracelets were re-assessed utilizing the Elopement Risk Assessment (Decision Tree) by Tamara McCarty, LPN, MDS Assistant, with no changes needed on August 15, 2015.

-All 17 residents with secure care bracelets care plans were reviewed with updates made if needed by Tamara McCarty, LPN, MDS Assistant on August 15, 2015.

-All residents were re-assessed utilizing the Elopement Risk Assessment (Decision Tree) on August 17, 2015 by Tamara McCarty, LPN, MDS Assistant, Rebecca Highfield, LPN, MDS Assistant, and Ashley Kincade, LPN, Infection Control and Wound Care Nurse, which identified no other residents at risk for elopement other than the 17 residents already with secure care bracelets.

-All care signs for elopement were checked on August 17, 2015 by Janet Patton, Quality Assurance Assistant to ensure placed properly.

-Secure care policy was updated to remove language pertaining to the allowance of the bracelet being placed on assistive devices on August 19, 2015 by Deanna Eads, RN, Director of Nursing.

-150 of 152 current staff was educated on elopement and behaviors starting on August 15, 2015 and was completed on August 19, 2015

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response was observed on the video.

Interview with SRNA #1 on 08/19/15 at 10:47 AM and again at 2:38 PM revealed she responded to the Secure Care alarm at 3:25 PM, and found Resident #1 in the lobby at that time. SRNA #1 stated she asked Resident #1 if she had been on the porch, to which Resident #1 responded "yes". SRNA #1 further stated she walked with Resident #1 back to the unit, and told Kentucky Medication Aide (KMA) #1 the resident reported having been outside. SRNA #1 revealed she did not see Registered Nurse (RN) #1 when she took Resident #1 back to the unit, or she would have reported what the resident had said to the nurse. SRNA #1 went on to reveal she thought Resident #1 was confused and had not really been outside, as she was unaware Resident #1 had exited the facility at 3:18 PM as no alarm had sounded.

Interview with KMA #1 on 08/19/15 at 11:17 AM revealed she heard SRNA #1 tell her on the afternoon of 08/15/15 Resident #1 had been to the door; she stated she didn't understand Resident #1 had stated he/she was coming in from outside. KMA #1 further stated she informed RN #1 that Resident #1 had been to the door and set off the Secure Care alarm.

Interview with RN #1 on 08/19/15 at 2:24 PM revealed she had been working on 08/15/15, and had heard from KMA #1 Resident #1 had gone to the door to look out and set off the alarm. She stated she was not told Resident #1 had stated he/she had been outside. RN #1 revealed when Resident #1 exited the building at 6:01 PM, no alarm sounded to alert staff of the resident's exit. Continued interview revealed RN #1 was made aware of the elopement when the unit received a

through in-service as directed by Charlotte Roberts, Administrator. Remaining employees to be educated are PRN or as needed and are not currently scheduled, these employees will be required to complete the training prior to being scheduled. Bourbon Heights utilizes no agency staff.

-150 of 152 current staff was educated on reporting any inconsistent testing or non-functioning alarms immediately to the Charge Nurse, Administrator, or Director of Nursing for investigation. This education was completed by Charlotte Roberts, Administrator and Janet Patton, Quality Assurance Assistant and through in-servicing starting on August 17, 2015 and was completed on August 19, 2015. Remaining employees to be educated are PRN or as needed and are not currently scheduled, these employees will be required to complete the training prior to being scheduled. Bourbon Heights utilizes no agency staff.

-The secure care system was checked by Anthony Collier, Maintenance Supervisor on August 15, 2015 to identify the root cause of the incident.

-Risk for elopement boards were added in the Adult Day Care office and the Therapy office on August 19, 2015, this is in addition to the front office, maintenance, each unit in the nurses station and breakroom and in the employee lounge in the basement.

-Daily rounds were made by Charlotte Roberts, Administrator starting on Monday, August 15, 2015 through Thursday, August 20, 2015 to

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call at 6:15 PM from off-duty staff who reported Resident #1 was outside in the parking lot. Further interview revealed RN #1 went outside in response to the call and found Resident #1 lying on his/her left side in the parking lot, and assessed the resident to have a skin tear to his/her left elbow. RN #1 stated she asked Resident #1 what she was doing outside, to which Resident #1 responded "I don't know." RN #1 called Resident #1's doctor and received an order to send Resident #1 to the Emergency Room. RN #1 notified Emergency Medical Services (EMS) who arrived transported Resident #1 to the hospital at approximately 6:43 PM.

Interview with Cook #1 on 08/19/15 at 3:12 PM revealed she was driving past the facility on 08/15/15 after 6:00 PM when she noticed someone on the ground in the side parking lot. Cook #1 stated she found Resident #1 lying on his/her left side across a speed bump with his/her walker lying on the ground nearby. Cook #1 further stated Resident #1 appeared to have some blood on the left elbow. Cook #1 called inside to Unit #1 where Resident #1 resided, and informed KMA #1 of the resident's location.

Interview with the Maintenance Director revealed he was called in to the facility on the evening of 08/15/15 following the elopement. The Maintenance Director revealed he tested all of the facility exits, and also tested Resident #1's walker at the exits. He stated he discovered Resident #1's alarm did not sound every time when he took the walker, with the Secure Care Bracelet attached to it, through the exit door. He further stated he was previously aware of the problem. He explained due to the height of the Secure Care Bracelet on the walker, it did not

F 323 ensure staff understanding of education on elopement, behaviors, reporting, and implementing care plan interventions.

**The facility has implemented systemic changes to ensure the jeopardy will not reoccur.**

-As of August 19, 2015, the facility has educated 150 of 152 staff on elopement and behaviors, which reviewed the policies and what to monitor for and implement if exhibiting various behaviors. This education was completed through in-servicing completed by Charlotte Roberts, Administrator, Willas Gray, LPN, Assistant Director of Nursing, Teresa Earlywine, LPN, Quality Assurance Director, Janet Patton, Quality Assurance Assistant, Tamara McCarty, LPN, MDS Assistant, Ashley Kincade, LPN, Infection Control and Wound Care Nurse, Barbara Traylor, Housekeeping Supervisor and Kim Mullins, Dining Services Supervisor.

-As of August 19, 2015, the facility has educated 150 of 152 staff on reporting any inconsistency or non-functioning alarm, immediately to the charge nurse, Administrator, Director of Nursing. This education was completed through in-servicing by Charlotte Roberts, Administrator, Janet Patton, Quality Assurance Assistant, Willas Gray, LPN, Assistant Director of Nursing, Ashley Kincade, LPN Infection Control and Wound Care Nurse, Teresa Earlywine, Quality Assurance Director, Tamara McCarty, LPN, MDS Assistant, Barbara Traylor, Housekeeping Supervisor and Kim Mullins, Dining Services Supervisor.

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consistently trigger the alarm at the exit door. The Maintenance Director reported he did not know the precise height at which the transmitter bracelet should be placed for consistent detection by the system, but determined it was a concern if the bracelet was not placed on the ankle as recommended by the manufacturer.

Interview with the Administrator on 08/19/15 at 12:19 PM revealed she was called to the facility the evening of 08/15/15 after Resident #1 had eloped. She revealed, in her review of the video footage, it was clear the alarm did not trigger when Resident #1 exited the facility at 3:18 PM or 6:01 PM. She stated after testing Resident #1's walker at the front exit, it was determined it did not consistently trigger the alarm. Continued interview revealed although there was a problem with the placement of the Secure Care Bracelet which led to a failure to alert staff of the resident exiting the building, the facility also identified staff failed to implement the Care Plan for increased supervision after Resident #1 first exited the building at 3:18 PM.

Interview with the DON on 08/20/15 at 11:43 AM revealed her expectation was for the Secure Care system to alert staff by alarming whenever a resident was in close proximity to a receiver or attempted to exit the facility. She acknowledged this could only be assured by proper placement of the bracelet on the resident's ankle. She further acknowledge, based on Resident #1's exit-seeking behavior on 08/15/15, staff should have implemented the Care Plan related to increased supervision.

An attempt was made to interview Resident #1 on 08/20/15 at 11:35 AM, at which time the resident

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-Both the in-services will be added to the new employee orientation effective with the next new employee orientation, none are scheduled at the present time.

-The individual secure care bracelets will continue to be checked for proper placement on the resident's ankle per manufacturer's guidelines every shift by the nursing assistants. This information will be scheduled and documented in the Smart Charting section of the electronic health record for each resident.

-The individual secure care bracelets will continue to be checked for proper functioning weekly on Wednesdays by the KMA's on each unit. This will be completed by the KMA taking each resident with a secure care bracelet through an area with an alarm system in place (i.e. door or hallway) to ensure the alarm sounds. This will be recorded in both the electronic health record and on the resident's chart on the Secure Care Sheet.

-Maintenance will continue to perform weekly checks on the system in ensure proper functioning prior to the weekend. These checks will be logged on a Secure Care weekly check sheet maintained in the maintenance office.

-The Quality Assurance Department will monitor for the documentation from the Nursing Assistants and KMA to ensure secure care bracelets are checked for placement and function per the policy. The Maintenance Director will monitor the log for the documentation of the weekly functioning tests

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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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F 323 Continued From page 27

was sitting in his/her room in a recliner. Resident #1 was hard of hearing, and was very difficult to engage in conversation. The resident did not appear to recall exiting the facility on 08/15/15, although agreed to being able to move about the facility pretty well using the walker. Resident #1 had a Secure Care Bracelet on his/her left ankle during the interview.

Observation on 08/19/15 of the area where Resident #1 was found on 08/15/15 revealed it was approximately one hundred and twenty-eight (128) feet from the entrance to the facility, on a speed bump in the parking lot by the side of the facility.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 08/25/15, which alleged removal of the Immediate Jeopardy (IJ) effective 08/20/15. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was sent to the hospital on the evening of 08/15/15 for evaluation in the Emergency Room (ER) and was discharged back to the facility the same night. Upon return to the facility, RN #1 performed a head to toe skin assessment.
2. Upon return from the hospital ER, Resident #1 was placed on fifteen (15) minute monitoring while asleep and one (1) on one (1) supervision while awake as directed by the Administrator upon Resident #1's return on 08/15/15.
3. The Secure Care system was checked by the Maintenance Director on 08/15/15 to identify the root cause of the accident.

F 323 of the secure care system by the maintenance staff.

- The QA committee will complete weekly walk thrus to ask employees questions regarding elopement, behaviors, and reporting inconsistent or non-functioning alarms and implementing interventions from the care plan. The committee will ask 5-7 employees to ensure understanding of the policies.
- The QA Committee that completes walk-throughs consists of the Quality Assurance Director, Quality Assurance Assistant, Activity Director, Social Services Director, Director of Nursing, Assistant Director of Nursing, Administrator, Business Office Manager, Maintenance Director, Dining Services Director, Housekeeping Director, Infection Control Nurse, MDS Coordinator, MDS Assistants.

By re-educating all staff, adding the information into the new employee orientation and conducting regular walk throughs to ensure staff understanding, systems are now in place to ensure the resident environment is as free from accident hazards as is possible and that adequate supervision is in place.

**The facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained.**

- To assure that the resident environment is as free from accident hazards as is possible and that adequate supervision is in place, the facility

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F 323 Continued From page 28

4. Resident #1's Secure Care Bracelet was removed from his/her rolling walker, and a new Secure Care Bracelet was placed on his/her left ankle by KMA #1.

5. Two other residents with Secure Care Bracelet's on their walkers, Resident #2 and Resident #4, had Secure Care Bracelets removed from their walkers, with Resident #4's Secure Care Bracelet placed on his/her ankle the evening of 08/15/15. Resident #2 initially refused placement on his/her ankle, and was placed on fifteen (15) minute checks on the evening of 08/15/15. Resident #2 was determined by staff to no longer be an elopement risk on 08/20/15 with his/her Secure Care Bracelet's removed at that time and fifteen (15) minute checks discontinued at that time.

6. A video surveillance investigation was initiated on 08/15/15 by the Administrator to identify the source of Resident #1's exit from the facility. Further video investigation was conducted by the Administrator on 08/17/15.

7. An investigation of the events involving Resident #1 was initiated on 08/15/15 by the Social Services Director (SSD) and concluded on 08/18/15.

8. All Secure Care Bracelets in use were checked for functioning and placement by the unit charge nurse on duty on 08/15/15 and each shift for seventy-two (72) hours. This was in conjunction with a head count conducted every shift by the unit charge nurse on duty, also initiated on 08/15/15 and concluded on 08/18/15.

9. All residents were re-assessed utilizing the

F 323 will monitor through Quality Assurance Committee weekly walk-throughs on an ongoing basis to identify areas of potential hazards and inadequate supervision, including asking employees questions regarding elopement, behaviors, implementing interventions from the care plan and reporting inconsistent or non-functioning alarms. The medical director will have an on-going role in the monitoring of these solutions as both the medical director and as the personal physician for Resident #1. The QA committee will review through daily reports and investigation from each unit to track and trend any potential accident hazards that may be identified and report such findings to the daily QA committee and the Quarterly QA Committee, including the medical director. Any areas of potential harm or inadequate supervision will be reported to the Administrator for immediate attention.

-The facility has in place a policy and procedure on checking the secure care system for placement on the resident's ankle, functioning of the bracelet on the resident, and functioning of the alarm system at the doors and notification board as well. Employees will monitor for the proper placement of the secure care bracelets on the resident's ankle at each shift and will check the functioning of each resident's bracelet once weekly. Maintenance will check the functioning of the door alarms and the notification panel weekly as well to ensure proper functioning. This system helps to ensure that the Secure Care Bracelet system is functioning properly and maintains the monitoring of all residents at risk for elopement.

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F 323 Continued From page 29  
Elopement Risk Assessment (Decision Tree) on 08/17/15 by facility nursing staff with care plans updated as required.

10. All care signs for elopement were checked to be in place for seventeen (17) residents with Secure Care Bracelets on 08/17/15 by the Quality Assurance (QA) Assistant. Care signs were symbols placed above a resident's bed to alert staff providing care the resident was an elopement risk. Additionally, all Elopement Risk Boards were updated, with additional boards added to the Adult Day Care office and the Therapy Office.

11. The Secure Care Policy was updated to remove language pertaining to the allowance of the Secure Care Bracelet being placed on assistive devices on 08/19/15 by the DON.

12. Beginning on 08/17/15 and concluding 08/19/15, 150 of 152 current facility staff were in-serviced on elopement, behaviors, the facility's elopement policy and implementing care plan interventions. The remaining two (2) employees were to be educated prior to being scheduled for work.

13. Beginning on 08/17/15 and concluding 08/19/15, 150 of 152 current facility staff were in-serviced on reporting any inconsistencies in the Secure Care Bracelet alarm system or any failures immediately to the charge nurse. Only two (2) staff remaining to be educated prior to being assigned any work.

14. Daily rounds were made by the Administrator beginning on 08/17/15 and concluding on 08/20/15 to ensure staff understood the education

F 323 **The Facility has included dates of corrective action.**

The facility is confident that the situation creating immediate jeopardy was corrected by Wednesday, August 19, 2015. In addition, in order to prevent any future issues regarding accident and supervision, the quality assurance committee has been and will continue to conduct weekly walk-throughs to ensure staff understanding on elopement, behaviors, reporting inconsistent or non-functioning alarms and the monitoring of such with no further incidents found in the past month. Wandering behaviors have been correctly identified and proper measures have been put into place by staff on duty which indicates understanding of policies and procedures in place to ensure resident safety.

Compliance Date:

September 20, 2015

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F 323	<p>Continued From page 30</p> <p>they had received on elopement, behaviors, reporting, and implementing care plan interventions.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> <li>1. Review of nursing notes for Resident #1 dated 08/15/15 revealed Resident #1 was sent to the hospital on the evening of 08/15/15. Review of ER nursing notes dated 08/15/15 revealed the hospital discharge impression was a contusion to the left elbow, a contusion to the left hip, and a concussion without loss of consciousness. Continued review of facility nursing notes dated 08/15/15 revealed upon return to the facility, RN #1 performed a head to toe skin assessment, revealing no additional areas of concern.</li> <li>Interview with the Medical Director (MD on 08/25/15 at 1:20 PM revealed he had been contacted on 08/15/15 when Resident #1 eloped, and the facility had reviewed it's Allegation of Compliance with him. The MD revealed he felt the underlying issue to be antibiotic medication Resident #1 was taking to combat a UTI. The MD stated it was an unfortunate situation which he hoped never happens again, but had supported the facility's efforts to correct it's problems.</li> <li>2. Review of 15 Minute Monitoring Form documentation for Resident #1 revealed he/she was placed on fifteen (15) minute monitoring on 08/15/15 at 9:00 PM and was documented as ongoing at the time of the Extended Survey on 08/26/15. Staff was observed with Resident #1 in Resident #1's room on 08/19/15 at 8:15 AM; in Resident #1's room on 08/20/15 at 11:35 AM; and</li> </ol>	F 323	<p>Bourbon Heights, Inc. is an excellent nursing facility with a committed staff and dedicated board of directors. The facility remains committed to providing a delivery of high quality health care and will continue to make whatever changes and improvement necessary to satisfy that objective. Please do not consider the filing of this Plan of Correction to be an admission of the finding of deficient practice.</p>	
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F 323 Continued From page 31  
on 08/26/15 at 11:10 AM. Interview with SRNA #7 on 08/26/15 at 10:03 AM revealed she was responsible for scheduling the increased supervision for Resident #1. Interview with monitoring staff on 08/26/15, SRNA #8 at 10:12 AM, and SRNA #9 at 10:24 AM, all confirmed they had sat with Resident #1 on more than one occasion on twelve (12) hour shifts since the 08/15/15 elopement. These statements were corroborated by staff initials on the 15 Minute Monitoring Forms.

F 323

3. The Secure Care system was checked by the Maintenance Director on 08/15/15 to identify the root cause of the accident. Interview with the Maintenance Director on 08/19/15 at 12:08 PM revealed he was called in the night of 08/15/15 after Resident #1 had eloped, and he tested the Secure Care alarm system at that time. The Maintenance Director revealed, in testing the system, he determined the Secure Care system was inconsistent in alerting staff when placed on resident walkers due to the height of the bracelet. Follow up interview with the Maintenance Director on 08/26/15 at 11:13 AM confirmed there was a height cutoff on the alarm system that wasn't 100% effective in alarming when placed on resident walkers. The Maintenance Director went on to reveal, now that all residents with Secure Care Bracelets have them on their ankles, the alarms have been working consistently without exception. The Maintenance Director revealed, in addition to the staff testing that has been occurring since the elopement, in which staff escort residents with Secure Care Bracelets to a nearby receiver to ensure the receiver was triggered, maintenance routinely tests all of the exits on Friday to ensure they are functioning properly.

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F 323	Continued From page 32  4. Interview with RN #1 on 08/20/15 at 1:15 PM confirmed Resident #1's Secure Care Bracelet was removed from his/her rolling walker, and a new Secure Care Bracelet was placed on his/her left ankle by KMA #1. Resident #1's Secure Care Bracelet was observed on his/her ankle by the State Survey Agency on 08/20/15 at 11:35 AM.  5. Two other residents with Secure Care Bracelet's on their walkers, Resident #2 and Resident #4, had Secure Care Bracelets removed from their walkers, with Resident #4's Secure Care Bracelet placed on his/her ankle the evening of 08/15/15. Resident #2 initially refused placement on his/her ankle, and was placed on fifteen (15) minute checks on the evening of 08/15/15. Fifteen (15) minute check sheets for Resident #2 were reviewed, and were current up to 08/20/15, when he/she was determined by facility staff to no longer be an elopement risk. Observation of both residents on 08/20/15 confirmed Secure Care Bracelets were no longer placed on walkers, with Resident #4 wearing his/her bracelet on his/her ankle.  6. Interview with the Administrator on 08/19/15 at 12:19 PM revealed a video surveillance investigation was initiated on 08/15/15 by the Administrator to identify the source of Resident #1's exit from the facility. Further video investigation was conducted by the Administrator on 08/17/15 and it was determined at that time Resident #1 had exited the facility earlier in the day on 08/15/15 and returned prior to the elopement at 6:01 PM. This video footage was reviewed by the State Survey Agency, with times identified in the facility investigation for Resident #1's exit(s) and return in the afternoon of	F 323		
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F 323 Continued From page 33  
08/15/15 verified by the date/time stamp on the recording.

F 323

7. Interview with the Social Services Director (SSD) on 08/19/15 at 3:48 PM revealed she was called in the evening of 08/15/15 and began an initial investigation at that time. Continued interview revealed she completed her final investigation on 08/18/15. Review of the final investigation dated 08/18/15 revealed the SSD investigation further revealed Resident #1 had been to the nurses station and stated to RN #1 several times he/she was waiting on his/her daughter to come take her to pick beans. Interview with the SSD on 08/19/15 at 3:48 PM verified results of her investigation, and also verified she was involved in the planning process to address concerns and ensure the safety of residents.

8. Interview with RN #1 on 08/19/15 at 2:24 PM revealed, after Resident #1 eloped, she checked all Secure Care Bracelet's on Unit 1 for placement and functioning. This check, as well as checks completed by nursing staff on Unit 2 and Unit 3, were reviewed by the State Survey Agency on 08/25/15. Interview with the Assistant Director of Nursing (ADON) on 08/19/15 at 4:00 PM revealed these checks were completed again seventy-two (72) hours later on 08/18/15. This was also verified through documentation review by the State Survey Agency on 08/25/15. Interview with SRNA #8 on 08/26/15 at 10:12 AM verified nurse aides had been checking placement and functioning of Secure Care Bracelets every shift from 08/15/15 through 08/18/15. Review of Unit Shift Reports for each unit revealed Secure Care Bracelets were checked for functioning and placement each shift

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F 323 Continued From page 34  
as well as a head count conducted on each unit, with no concerns identified.

F 323:

9. Review of the Elopement Risk Assessment (Decision Tree) revealed all residents were re-assessed on 08/17/15 by facility nursing staff with care plans updated as required. No additional residents were identified as at risk for elopement, requiring no care plan updates at that time. All Elopement Risk Assessment (Decision Tree)s completed on 08/17/15 were reviewed with LPN #2 on 08/26/15 at 9:35 AM by the state Survey Agency.

10. All care signs for elopement were checked on 08/17/15 by the Quality Assurance (QA) Assistant. Per interview with the QA Assistant on 08/26/15 at 10:48 AM, "Elopement Care Signs" consisted of a running man stick figure at the head of each bed of residents identified as elopement risks. Additionally, all Elopement Risk Boards were updated, with additional boards added to the Adult Day Care office and the Therapy Office. The QA Assistant revealed some updated resident photos were taken. A facility tour with the QA Assistant on 08/26/15 confirmed current boards were in place on each unit nursing station and break room, as well as the front office, the maintenance office, the employee lounge, the Adult Day Care office, and the Therapy Office.

11. Review by the State Survey Agency on 08/25/15 of the Secure Care Transmitter User Guide, updated 02/25/15, and the facility's Policy Guidelines for the Secure Care System, updated 08/2015, revealed the facility policy no longer contained information contradictory to the User Guide. Interview on 08/25/15 at 10:37 AM with

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F 323 Continued From page 35  
the Administrator revealed she had changed the policy, with the change consisting of the removal of information permitting staff to place a transmitter on a resident's walker or wheelchair.

F 323

12. Review of sign-in sheets for in-services revealed 150 of 152 current facility staff were in-serviced on elopement and behaviors from 08/15/15 through 08/19/15. Interview with the Administrator on 08/25/15 at 11:51 AM revealed the remaining two (2) employees were to be educated prior to being scheduled for work. Interview on 08/19/15 at 2:24 PM with RN #1, the charge nurse of Unit 1 from which Resident #1 eloped on 08/15/15, revealed she in-serviced all staff working at that time on the elopement policy, staff responsibilities, the use of the Secure Care Bracelets, and resident behaviors.

Interview with SRNA #1 on 08/19/15 at 2:38 PM revealed she was in-serviced following the elopement on 08/15/15. SRNA #1 stated the in-service covered staff responsibilities during an elopement, as well as recognizing and documenting resident behaviors. SRNA #1 stated the importance of alerting the charge nurse of behaviors was stressed.

Interview with SRNA #4 on 08/20/15 at 11:04 AM revealed she attended two in-services when she came in to work on 08/17/15, one of which was on elopement and resident behaviors. SRNA #4 was able to discuss resident behaviors and staff interventions in detail, and also noted the importance of alerting the charge nurse whenever a resident has behavioral issues or is exit seeking.

Interview with SRNA #5 on 08/20/15 at 11:20 AM

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revealed she had attended in-services on elopement and resident behaviors. SRNA #5 stressed the importance of alerting nursing staff whenever a resident triggers a door alarm.

Interview with LPN #4 on 08/20/15 at 2:02 PM revealed she had been in-serviced regarding the elopement policy and resident behaviors. LPN #4 discussed the importance of trying to determine resident needs and ensure their needs are met, ensuring their Secure Care Bracelet was functioning, and possibly increasing resident supervision if setting off exit alarms.

Interview with SRNA #9 on 08/26/15 at 10:24 AM revealed she had been in-serviced on elopement and resident behaviors. SRNA #9 revealed the in-service covered how to respond if an elopement occurs, recognizing, documenting, and redirecting resident behaviors when possible, and the importance of keeping the charge nurse aware of the situation.

Comparison of in-service signatures with employee listing confirmed 150 of 152 employees had been in-services as of State Survey Agency review on 08/26/15.

13. Review of in-service signatures and comparison with a comprehensive employee listing revealed 150 of 152 current facility staff were in-serviced on reporting any inconsistencies in the Secure Care Bracelet alarm system or any failures immediately to the charge nurse. The in-service was initiated on 08/15/15 and continued through 08/19/15. Interview with the Administrator on 08/25/15 at 11:51 AM revealed the two (2) staff remaining were to be educated prior to being assigned any work.

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/26/2015
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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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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 323

Interview with SRNA #1 on 08/19/15 at 2:38 PM revealed she had been in-service on what to do if the Secure Care Bracelet system doesn't work, which was to redirect and supervise the resident involved and to alert the charge nurse immediately.

Interview with Cook #1 on 08/19/15 at 3:12 PM confirmed she had been in-serviced on the importance of redirecting residents and reporting to her supervisor any time she witnessed a resident Secure Care Bracelet not functioning.

Interview with SRNA #6 on 08/20/15 at 11:30 AM revealed she had attended an in-service, and stressed the importance of informing the charge nurse any time a resident Secure Care Bracelet did not function.

Interview with KMA #2 on 08/26/15 at 11:29 AM revealed she had been in-serviced on the importance of redirecting residents and informing the charge nurse if a resident's Secure Care Bracelet does not alarm.

Comparison of in-service signatures with employee listing confirmed 150 of 152 employees had been in-services as of State Survey Agency review on 08/26/15.

14. Interview with the Administrator on 08/25/15 at 10:37 AM revealed daily rounds were made by the Administrator beginning on 08/17/15 and concluding on 08/20/15 to ensure staff understood the education they had received on elopement, behaviors, reporting, and implementing care plan interventions. Review of the daily rounds sheets revealed rounds were

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 recorded on "Weekly Walk Thru" sheets, with multiple staff interviewed regarding the elopement policy and the use of and what to do if Secure Care Bracelets were determined to not be functioning. Several staff had been interviewed each day, per review of the documentation, with staff consistently providing appropriate responses.  
 Interview with KMA #2 on 08/25/15 at 11:29 AM revealed she had observed the QA Assistant on Unit 2 questioning staff about elopement procedure and Secure Care Bracelets, although she had not been questioned following the in-services.

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