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

Second SOD

PRINTED: 09/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185433		C 08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-CITIES NURSING & REHABILITATION CENTER	19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823

(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 000	INITIAL COMMENTS --Amended-- An abbreviated standard survey (KY18858) was initiated on 08/02/12. Immediate Jeopardy was identified on 08/03/12 and was determined to exist on 07/30/12. The facility was notified of the Immediate Jeopardy on 08/03/12. A partial extended survey was conducted on 08/06-07/12. On 07/30/12, Resident #1, who was assessed to be at risk for wandering/elopement, left the facility without staff knowledge. After receiving an outside call, the facility staff discovered the resident approximately one-fourth mile from the facility walking beside a busy two-lane highway. Deficiencies were cited at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F323). An acceptable Allegation of Compliance was received on 08/06/12 and alleged removal of the Immediate Jeopardy on 08/05/12. The State Agency determined the Immediate Jeopardy was removed on 08/05/12 prior to exit, which lowered the scope/severity to "D" at 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	Tri-Cities Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Tri-Cities Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Tri-Cities Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-13-12

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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SEP 14 2012
Division of Health Care
Southern Enforcement Branch

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F 282	Continued From page 1 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's comprehensive care plan policy and facility investigation it was determined the facility failed to have an effective system to ensure services were provided by qualified persons in accordance with each resident's plan of care for one of five sampled residents (Resident #1). Resident #1 was assessed by the facility to be at risk for wandering and elopement. The resident's plan of care directed facility staff to know the resident's location in the facility and complete/document 15-minute checks of the resident's location. On 07/30/12, Resident #1 left the facility grounds without the staff's knowledge and was discovered at approximately 4:20 PM, about one-fourth mile from the facility walking beside a busy highway. A review of the "Every 15 Minute Checks" monitoring tool revealed the facility had last documented a check of Resident #1's location at 3:00 PM on 07/30/12. Immediate Jeopardy was determined to exist on 07/30/12. An acceptable Allegation of Compliance was received on 08/06/12, which alleged removal of Immediate Jeopardy on 08/05/12. The State Agency determined the Immediate Jeopardy was removed on 08/05/12, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic	F 282	**ID Prefix Tag F 282** The facility will continue to provide or arrange for services to be provided by qualified persons in accordance with each resident's written plan of care. On 7-30-12 resident #1 was found outside the facility walking beside the highway. Within ten minutes of receiving the alerting phone call, the nurses had reached the resident, found him unharmed and returned to the building with the resident. Once back inside the facility, the charge nurse assessed resident #1 to be uninjured. The responsible party was notified and the attending physician was notified. On 7-30-12, resident #1 was fitted with a new transmitter, moved to a new room in the inner hall and placed 1:1 supervision immediately following the incident. On 8-13-12, 1:1 supervision was changed to Q 15 minute checks and continues. The DON and MDS nurses reassessed all the residents in the facility for wandering, implemented alarms, added	

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F 282	Continued From page 2 changes and quality assurance activities. The findings include: A review of the facility's policy titled "Resident Care Plan," with a revision date of 09/19/11, revealed it was the policy of the facility to provide an interdisciplinary written care plan based on the physician's orders and the assessment of the resident's needs. According to the policy, the resident care plan would be an ongoing process and would include current problems and/or needs identified from a complete assessment including the Minimum Data Set (MDS) assessment and Care Areas Assessment (CAA) relevant to the resident's response to aging, illness, and his/her general health status. The policy stated the care plan may consist of but is not limited to a permanent problem list, nursing summary, resident care guide, and physician's orders. A review of the facility's investigation dated 08/03/12, revealed on 07/30/12, at approximately 4:20 PM, the Administrator received an outside call from a dispatcher at the Police Department. The police dispatcher stated they had received a report of a person wearing burgundy pants and a plaid shirt walking away from the facility which the caller suspected could be one of the facility residents. It was noted the Administrator had remembered Resident #1 wearing burgundy pants and a plaid shirt earlier in the day. The Administrator immediately notified the Director of Nursing (DON) and they went out the front of the building. The Administrator observed a person walking down the road and this person was identified in the investigation as Resident #1. The investigation stated it took approximately 10	F 282	every 15 minute checks if indicated and updated care plans as directed by the wandering assessments on 7-31-12 and 8-1-12. Wandering boards - which show pictures of residents at risk for wandering out of the facility - were reviewed and updated as indicated by the MDS nurses on 8-4-2012. An updated list of wandering residents was posted at the nursing stations. A six month look-back chart review was conducted on all residents for any behaviors not previously identified, attempts/verbalizing to leave facility, increased agitation, care plans/guides, progress notes and wandering risk assessments. An 100% audit was completed on all residents Assistive Devices and Side Rail Assessments and care plans/resident care guides for completeness and being implemented.	

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F 282	Continued From page 3 minutes to get the resident back into the facility. The facility moved the resident to room 202-A and placed the resident on 1:1 observation. A review of the medical record for Resident #1 revealed the resident was admitted by the facility on 05/20/10, with diagnoses that included Dementia, Anxiety, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Cardiomyopathy. A review of the most recent MDS assessment dated 06/20/12, revealed Resident #1 was assessed by the facility to have moderately impaired cognition and to be independent with ambulation. The medical record for Resident #1 also revealed a wandering assessment completed for Resident #1 by the facility, dated 06/21/12, which indicated a score of 9 for the resident. According to the wandering assessment, any score greater than 5 meant the resident was at risk for wandering and elopement. A review of the Comprehensive Care Plan for Resident #1, revised on 06/28/12, revealed Resident #1 was assessed by the facility to be at risk for wandering and also at risk for unsupervised exits from the facility. The interventions on the Care Plan for Resident #1 were for the resident to be in the At Risk Wandering Ways Program, in which staff was expected to check daily to ensure the resident had an alarm bracelet on, and to ensure the alarm bracelet had been functioning properly. According to the care plan, staff was to ensure the resident's picture was on the wandering resident board. A review of the Resident Care Guide for Resident #1, which was undated, revealed the resident was at risk for wandering, was to have an alarm bracelet, and staff was to	F 282	This review was completed on 8-4-12 by the MDS nurses and the DON. An in-service for the nursing staff was initiated on 8-3-2012 by the Administrator, Director of Nursing and Staff Facilitator to ensure that resident care plans and care guides are being followed and communication (regarding change in behaviors including wandering, going to doors, trying to get out or making statement that they are going to leave) is made to the administrative team immediately and verbally. Also included in the in-service was completion of documentation including Q 15 minute checks and notification immediately to the on-call nurse, administrator and/or DON if any of the above mentioned should occur. All facility staff will receive this in-service prior to their next scheduled shift. This education will be provided for all newly hired staff upon orientation. To ensure safety of all residents who may experience increased agitation or a change in condition that may warrant	

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F 282	Continued From page 4 monitor the resident's location in the facility. A review of the monitoring tool which was used by the nurses to document the location checks of residents who were at risk for wandering titled "Every 15 Minute Checks," revealed the staff had completed the 15-minute checks for Resident #1 on 07/30/12, through 3:00 PM. However, there were no documented 15-minute checks of Resident #1 after 3:00 PM. An interview conducted with State Registered Nursing Assistant (SRNA) #3 on 08/02/12, at 2:05 PM, revealed the SRNA was responsible for the care of Resident #1 on 07/30/12. The SRNA revealed she was required to check the care guide for each resident she was assigned at the beginning of every shift to ensure she was aware of the individual resident care she was responsible to provide. The SRNA stated Resident #1 wandered throughout the facility and was required to wear a Wanderguard alarm bracelet. The SRNA stated she was required to check the location of the resident every 15 minutes. The SRNA stated the last time she saw the resident prior to his/her eloping from the facility was at approximately 3:00 PM at the South Unit nurses' station. An interview conducted with Licensed Practical Nurse (LPN) #4 on 08/02/12, at 2:45 PM, revealed the LPN was responsible for administering the medications for Resident #1 on 07/30/12. The LPN stated she had completed and documented the 15-minute checks on Resident #1 on 07/30/12, until 3:00 PM. After 3:00 PM, the LPN stated the Charge Nurse (CN) was responsible for both the checks and the documentation. The LPN stated all nursing staff	F 282	an elopement potential, staff must follow the wandering risk potential protocol immediately. The guidelines will assist in implementing a plan for resident safety, what to do if a resident refuses to wear an alarm, what to do when assessing an admission/readmission for wandering, what to do if staff does not feel a door is functioning properly, and the importance of not giving out door codes. An in-service for the nursing staff was initiated on 8-4-12 by the Administrator, Director of Nursing and Staff Facilitator. All facility staff will receive this in-service prior to their next scheduled shift. This education will be provided for all newly hired staff upon orientation. A daily chart audit will be completed Monday through Friday by the DON, ADON, QI nurse, MDS nurses, Staff Facilitator, Treatment Nurse and Social Worker to read the residents nurses progress notes to identify any residents who may begin exhibiting increased wandering behaviors for whom additional interventions may be necessary.	

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F 282	Continued From page 5 was required to check the resident care guide at the beginning of every shift to obtain the information regarding the care needs of a resident. An interview conducted with LPN #1 on 08/02/12, at 2:55 PM, revealed she was the Charge Nurse for the South Unit on 07/30/12, and was responsible for ensuring the 15-minute checks were completed on Resident #1. The LPN stated she was in the DON's office when the Administrator notified them of a possible missing resident. The LPN stated the last time she had observed Resident #1 on 07/30/12, prior to the elopement, was at 3:45 PM, when the resident was in the smoking room. The LPN stated she had forgotten to complete the 15-minute checks after 3:45 PM, and had forgotten to complete the documentation of the 3:00 PM to 3:45 PM "Every 15 Minute Checks." The LPN stated all nursing staff was required to check the care guide at the beginning of every shift to obtain the information regarding the care needs of a resident. The LPN said Resident #1's care guide included an intervention to monitor the resident's whereabouts. According to the LPN, Resident #1 required every 15 minute checks because he/she was assessed to be at risk for wandering. The LPN stated she just forgot to document the resident's location. An interview conducted with the DON on 08/06/12, at 3:50 PM, revealed the resident care guides included resident care information and staff was required to check the care guides at the beginning of every shift. The DON stated it was the CN's responsibility to ensure the resident care guides/plan of care was implemented which	F 282	The daily audits will also review Q15 min check sheets on applicable residents and check for 1) general room appearance and condition of resident (including facial hair, nails, odors and catheters etc.,). 2) All nursing notes (health status, behaviors, communication board) and residents who are on Q15min checks to make sure sheets are filled out. Also to check that care plans/resident care guides are up to date , accurate and being followed. 3.) All Assistive Devices/Side Rail Assessments are up to date and correct. 4.) All QI/Incidents have been investigated and interventions in place to prevent re-occurences. This will be reviewed weekly with the QI Committee. Residents with alarm bracelets are tested for effectiveness daily with manufacture's provided testing device. Corrective actions will be initiated when identified by these team members up to and including 1:1 supervision and updating the care plan/care guide as needed.	

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F 282	Continued From page 6 included the 15-minute checks and documentation on Resident #1's location. The DON stated she made rounds frequently throughout the day to ensure residents were being provided the care they require. The DON stated she conducted random spot checks for documentation. However, she had not identified any problems related to location checks not being completed for wandering residents. --A review of the Allegation of Compliance revealed the following: On 07/30/12, once Resident #1 had returned back to the facility, a complete head to toe assessment was conducted by the Charge Nurse and the resident was found to be uninjured. On 07/30/12, an investigation was initiated by the Administrator and the DON regarding the elopement of Resident #1. The investigation was completed on 08/03/12. On 07/30/12, Resident #1 was fitted with a new Wanderguard alarm bracelet, and then moved to a new resident room in the inner hallway. On 07/31/12 and 08/01/12, the MDS Nurses reassessed all residents in the facility for wandering, implemented alarms as indicated, added every 15 minute checks if indicated, and updated care plans as directed by the wandering assessments. Beginning on 08/03/12, nursing staff was in-serviced by the Administrator, DON, and Staff Facilitator (SF) on ensuring resident care plans and care guides were followed and	F 282	A weekly audit will be condlucted by the QI nurse utilizing a QI tool to ensure all residents identified at risk for wandering per the facility's At Risk Wandering Assessment have interventions care planned and in place to plan for the resident's safety and well being in the facility and to prevent the resident's unsupervised exit. Immediate action will be taken by the Director of Nursing and/or Administrator upon the identification of any potential concern to ensure appropriate interventions are implemented and in place for the resident's safety and well being in the facility and to prevent the resident's unsupervised exit from facility. The results of these audits will be reviewed by the DON and Administrator weekly in the QI Committee Meeting that is composed of the DON, Administrator, ADON, Staff Facilitator, MDS Nurses, Social Worker and Treatment Nurse with further corrective actions taken as needed.	8-17-12

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F 282	Continued From page 7 communication was made to the Administrative Team immediately if any resident exhibited any changes in behavior, wandering, going to the exit doors, trying to exit the facility, or making statements that they were going to leave the facility. The in-service also included that nurses were required to ensure checks and documentation were completed for all residents who required every 15 minute checks. On 08/04/12, nursing staff was in-serviced on the facility's "Wandering Risk Potential Protocol," by the Administrator, DON, and SF. Staff was educated regarding what steps to take to implement a plan for resident safety. On 08/04/12, "wandering boards" showing pictures of residents assessed by the facility to be at risk for wandering and elopement, were reviewed and updated as needed by the MDS Nurses. An updated list of wandering residents was posted at each nursing station. On 08/04/12, all residents' charts were reviewed by the MDS nurses and the DON for the past six months. The review ensured all behaviors were identified, and any attempts or verbalization of wanting to leave the facility or increased agitation were addressed. The review included reviewing resident progress notes, wandering risk assessments, care plans, and care guides. A weekly audit tool will be utilized by the Quality Assurance (QA) Nurse to ensure all residents who have been identified by the facility to be at risk for wandering have care plan interventions in place to plan for the resident's safety and well-being in the facility and to prevent an unsupervised exit. The results of the audit will be	F 282		

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F 282	Continued From page 8 reviewed weekly in the Quality Assurance meeting. On 08/05/12, a new audit tool was instituted which will be completed by the DON, ADON, QA Nurse, MDS Nurses, SF, Treatment Nurses, and the Social Worker (SW). The audits will be completed Monday through Friday and will include a review of the residents' progress notes, and will ensure all 15-minute checks and alarm bracelet check sheets are filled out completely. The audit will also include updating the residents' care plans and care guides as needed. Information documented on Saturday and Sunday will be audited on Monday. The results of the audit will be reviewed weekly in the Quality Assurance meeting. –The surveyor validated the corrective actions taken by the facility as follows: A review of the progress notes for Resident #1 revealed on 07/30/12, at 6:31 PM, LPN #1 documented she completed a head to assessment of Resident #1 and no injuries were identified. An interview conducted with LPN #1 on 08/06/12, at 10:20 AM, revealed she completed the head to toe assessment on Resident #1 after the resident had eloped on 07/30/12. The LPN revealed she assessed the resident to have no injuries. A review of the facility's investigation regarding the elopement of Resident #1 on 07/30/12, completed by the Administrator and the DON, revealed it was completed on 08/03/12.	F 282		

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F 282	Continued From page 9 A review of the audit tool to monitor the Wanderguard alarm bracelets revealed Resident #1's Wanderguard bracelet was changed to a new bracelet on 07/30/12. The documentation revealed the bracelet was now located on the resident's left lower extremity with an expiration date of June 2015. Observation of Resident #1 on 08/07/12, at 9:30 AM, revealed the resident was wearing a Wanderguard alarm bracelet on his/her left lower extremity with an expiration date of June 2015. A review of nurse's notes for Resident #1 datad 07/30/12, revealed the resident was moved from resident room 122, which was near an exit door, to resident room 202-A in the Railroad Crossing Unit which located the resident's room away from any outside doors. Observation of Resident #1 on 08/07/12, at 9:30 AM, revealed the resident was residing in resident room 202-A and LPN #6 was observed providing 1:1 observation at the time. An interview conducted on 08/06/12, at 4:20 PM, with SRNA #6, on 08/06/12, at 4:30 PM, with SRNA #7, on 08/06/12, at 4:45 PM, with SRNA #4, and on 08/06/12, at 4:50 PM, with SRNA #8 revealed Resident #1 was currently being provided with 1:1 supervision, which meant a staff member had to be within eyesight of the resident at all times. A review of a wandering assessment for Resident #1 revealed it was completed on 07/30/12, after the resident had left the facility unnoticed and unsupervised. A review of wandering	F 282		

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F 282	Continued From page 10 assessments completed for all residents in the facility revealed the residents were assessed for wandering behaviors. The assessments were completed on 07/31/12 and 08/01/12. Two residents (unsampled Residents G and H) triggered as an elopement risk and were placed on the Wandering Ways program, and their care plans were updated, pictures were added to the wander boards, names were added to the wander lists at each nursing station, and an alarm bracelet was placed on Resident H. Resident G refused to wear the alarm bracelet and the resident was placed on every 15 minute checks due to the refusal. A review of Resident G's and Resident H's care plans revealed the care plans were updated with interventions to prevent elopement. An interview conducted with the MDS Coordinator on 08/07/12, at 10:55 AM, revealed she had assisted in assessing all the residents in the facility on 07/31/12 and 08/01/12, for wandering behaviors. The MDS Coordinator stated residents' care plans were also updated and interventions were instituted for residents related to wandering, if needed. A review of the in-service rosters revealed on 08/03/12, the Administrator, DON, and SF initiated an in-service for all facility nursing staff regarding resident care plans and care guides being followed, and communication regarding resident behaviors, wandering, going to doors, trying to get out, or statements that they are going to leave being made to the administrative team immediately and verbally. The in-service also included completing documentation, including visualization of the resident, 15-minute checks,	F 282		

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and immediately notifying the on-call nurse, Administrator, and/or the DON if any of the above behaviors occurred. The education will be ongoing until all facility nursing staff has attended and will be in-serviced by their next scheduled shift.

A review of in-service rosters revealed on 08/04/12, an in-service was initiated by the Administrator, DON, and SF related to staff being required to follow the wandering risk protocol immediately with any resident that experiences increased agitation, or a change in the resident's condition that may warrant an elopement potential. The in-service reviewed the guidelines contained in the protocol, implementing a plan, what to do if a resident refuses to wear an alarm such as adding every 15 minute checks, what to do when assessing for wandering, what to do if the staff feels a door is not working properly, and the importance of not giving out the door codes. The in-service will be ongoing until all staff has attended. All staff is required to receive the in-service prior to their next scheduled shift. The in-service will be provided to all newly hired employees.

An interview conducted on 08/06/12, at 4:20 PM, with SRNA #6, on 08/06/12, at 4:30 PM, with SRNA #7, on 08/06/12, at 4:45 PM, with SRNA #4, and on 08/06/12, at 4:50 PM, with SRNA #8 revealed the staff attended in-services regarding the door alarms, not to give codes to anyone, what to do with a wandering resident, and reporting immediately to the Charge Nurse and to the Administrator. The staff revealed they were required to stay by any door they felt wasn't working properly, until Maintenance arrived to

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F 282	Continued From page 12 correct the problem. The staff revealed wander boards were available in each charting room, by the time clock, and in the QA office. The staff also revealed they were required to check the resident care guides at the beginning of their shifts. An interview conducted on 08/06/12, at 4:20 PM, with SRNA #6, on 08/06/12, at 4:30 PM, with SRNA #7, on 08/06/12, at 4:45 PM, with SRNA #4, on 08/06/12, at 4:50 PM, with SRNA #8, on 08/07/12, at 10:30 AM, with LPN #6, and on 08/06/12, at 10:20 AM, with LPN #1 revealed staff was required to check the resident care guides at the beginning of every shift, and administrative staff was to be notified of any change in behaviors. Staff further stated all 15-minute check observations were required to be completed and documented. An interview conducted on 08/06/12, at 4:20 PM, with SRNA #6, on 08/06/12, at 4:30 PM, with SRNA #7, on 08/06/12, at 4:45 PM, with SRNA #4, on 08/06/12, at 4:50 PM, with SRNA #8, on 08/07/12, at 10:05 AM, on 08/06/12, at 10:05 AM, with LPN #6, and on 08/06/12, at 10:20 AM, with LPN #1 revealed staff was to notify administrative staff if a resident exhibits any change in behaviors. The staff revealed they also discussed the wandering risk protocol at the in-service. An observation on 08/07/12, at 8:05 AM, revealed on 08/04/12, wander boards located in the North and South charting rooms, by the time clock, and in the Quality Assurance office had been updated by the MDS staff. The boards were reviewed which revealed two new resident pictures had	F 282		

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been placed on the boards. A review of the list for wandering residents revealed an updated list had been placed at both nursing stations.

An interview conducted on 08/06/12, at 4:20 PM, with SRNA #6, on 08/06/12, at 4:30 PM, with SRNA #7, on 08/06/12, at 4:45 PM, with SRNA #4, and on 08/06/12, at 4:50 PM, with SRNA #8 revealed the staff was able to verify where wandering boards were posted. The staff stated they were located in each charting room, by the time clock, and in the QA office. The staff members were also able to identify where the wandering lists were located at the nurses' stations.

A review of the audit sheets completed by the DON and MDS Nurses on 08/04/12, revealed a six-month chart review was completed on all residents for any behaviors that had not previously been identified for attempts/verbalizing wanting to leave the facility, and increased agitation.

An interview conducted with the DON on 08/07/12, at 11:30 AM, revealed she assisted with the audit of resident charts with a six-month look-back period. The DON stated they had audited progress notes, care plans, care guides, and wandering assessments for any behaviors that could lead to wandering or elopement, with the care plans and care guides being updated if needed.

A review of the daily audit tool which was completed by the DON, Assistant Director of Nursing (ADON), Quality Assurance (QA) nurse, MDS Nurse, SF, Treatment Nurse, and Social

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F 282	Continued From page 14 Worker (SW) revealed all resident medical records were audited daily by reviewing the resident progress notes to identify any residents who have begun exhibiting increased wandering behaviors for whom additional interventions may be necessary. The audit also included reviewing all 15-minute check sheets, testing of resident alarm bracelets, and updating the care plans as needed. The audits listed any corrective actions needed. The audits will be continued by the facility on an ongoing basis. An interview conducted with the DON on 08/07/12, at 11:30 AM, revealed she assisted with audits of the residents' medical records daily to ensure any resident who began exhibiting behaviors that could lead to wandering or elopement had interventions in place to prevent them from leaving the facility unsupervised. The DON stated they also checked the 15-minute check sheets, as well as the testing of the alarm bracelet sheets. The DON stated she made rounds throughout the day at different times and observed to ensure the care was being provided as required by the residents. Review of the auditing tool, which will be completed weekly by the Quality Assurance (QA) Nurse, revealed the tool included an audit of resident chart reviews to ensure all residents who have been identified as being at risk for wandering have interventions on the care plan in place to address the wandering and to prevent the unsupervised exit of a resident. The QA Nurse would immediately report any potential concerns to the Administrator and the DON. The results of the audits will be reviewed by the Administrator and the DON at the weekly QA	F 282		

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F 282	Continued From page 15 Committee meeting that is composed of the Administrator, DON, ADON, SF, MDS Nurse, SW, and Treatment Nurse. An interview conducted with the QA Nurse on 08/07/12, at 11:40 AM, revealed the QA Nurse would report any potential concerns she identified during the audits to the DON or the Administrator. The QA Nurse stated she was required to report her findings at the weekly QA meeting.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility investigation, and policy review, it was determined the facility failed to have an effective system to ensure one of five sampled residents (Resident #1) received adequate supervision to prevent accidents. The facility failed to ensure that key codes used to access exit doors were secured and that staff completed location checks per the plan of care for Resident #1. On 07/30/12, Resident #1, who the facility assessed as having Dementia and being a risk for wandering/elopement, left the facility grounds without the staff's knowledge and	F 323	***ID Prefix Tag F 323*** The facility will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervison and assistance devices to prevent accidents. On 7-30-2012, resident #1 was fitted with a new transmitter, moved to a new room in the inner hall and placed on 1:1 supervision immediately following the incident. On 8-13-12, 1:1 supervision was changed to Q 15 minute checks and continues. After being alerted that a resident was out of the building on 7-3-2012, the administrator directed two personnel to begin a head count of all residents and	

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F 323	Continued From page 16 was discovered at approximately 4:20 p.m., about one-fourth mile from the facility walking beside a busy highway. A review of the "Every 15 Minute Checks" monitoring tool revealed the facility staff had last documented a check of Resident #1's location at 3:00 PM on 07/30/12. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 07/30/12. An acceptable Allegation of Compliance was received on 08/06/12, which alleged removal of Immediate Jeopardy on 08/05/12. The State Agency determined the Immediate Jeopardy was removed on 08/05/12, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities. The findings include: A review of the facility's policy titled "Wandering Risk Potential Protocol," with a revision date of 10/19/11, revealed the facility would implement guidelines to identify a resident's risk for inappropriate wandering within or outside of the facility, and to ensure a resident's safety in regards to the identified behavior. The policy stated a "Risk Wandering Assessment" would be completed upon admission, re-entry to the facility, and quarterly. The policy directed if the resident's score on the assessment was greater than 5, then the facility would develop a care plan for the resident's risk for wandering, with interventions to ensure the resident's safety being addressed. The policy also stated that a "wandering board" of identified potential wanderers could be implemented whereby pictures of potential wanderers would be placed and located for staff	F 323	to specifically look for resident #1. The head count found all other residents to be accounted for and safely in the facility. On 7-30-2012, the administrator immediately began a check of the Secure Care doors and found them to be working properly. They were checked with the tester provided by the manufacturer and also a spare alarm. On 7-30-2012, the maintenance supervisor was notified by the administrator to come in and do 2nd checks on the doors. The exit door was monitored by the nursing staff until the maintenance supervisor arrived. He arrived at about 5:20 p.m. and did checks on the doors and also reprogrammed the security codes. On 7-31-2012, as an additional safety precaution, the administrator requested a service call from the Secure Care vendor to do a preventative maintenance check on all Secure Care doors to ensure they were working properly. Upgraded 1000DE panels were also ordered.	

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F 323	Continued From page 17 awareness but not in view of visitors in the facility. A review of the facility's investigation and interview with the Administrator and Director of Nursing (DON) on 08/02/12, at 10:30 AM, revealed on 07/30/12, at approximately 4:20 PM, the Administrator received an outside call from Dispatch at City Hall that they thought one of the facility's residents was walking away from the facility and that the person was wearing burgundy pants and a plaid shirt. The Administrator stated he remembered Resident #1 having on burgundy pants and a plaid shirt earlier in the day. He notified the Director of Nursing (DON) and they went out the front of the building. The Administrator stated he observed a person across the road approximately one-fourth mile from the facility. The DON stated she and Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #1, and LPN #6 went to the person while the Administrator went back to direct the staff to begin a head count of all residents and to specifically look for Resident #1. The DON stated the person beside the roadway was Resident #1 and he/she was agitated. The DON stated it took approximately 10 minutes to get the resident back into the facility. Further interview with the Administrator on 08/02/12, at 10:30 AM, revealed once the resident was back in the facility staff conducted a head to toe assessment which revealed the resident had not sustained an injury, and both the family and the resident's physician were notified. The Administrator stated he immediately checked if the resident was wearing a Wanderguard bracelet and stated it was on the resident. According to the Administrator, he then checked	F 323	On 8-3-2012 to ensure safety to all residents, manual audible alarms were activated on all exit doors in addition to the Secure Care alarms. These alarms can only be controlled with a key located at the nursing stations. The alarms are located at the very top of the door frame and work on a push-pin type device. When the door is opened the pin comes out and the alarm sounds. The alarm cannot be reset until the door is closed (closing the push-pin) and the alarm is reset to the on position with key. An in-service was initiated on 8-3-2012 by the administrator and maintenance supervisor on the use of the manual alarms as a secondary measure until the Secure Care alarms are upgraded. A 100% audit/chart review for a six month period was done on all residents in facility to look for any behaviors not previously identified, attempts/verbalizations to leave facility, increased agitation, care plans/resident care guides , progress notes, Wandering Risk Assessments, Assistive Device and Side Rail Assessments and all were	

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F 323	Continued From page 18 the alarms on the exit doors and found them to be in working order. Resident #1's Wanderguard bracelet was checked and found to be in working order. The Maintenance Supervisor (MS) was notified by the Administrator to return to the facility and perform a second check on the exit doors. The Administrator revealed after the second check was completed, which showed the doors were working properly, the MS changed the keypad code on all exit doors. The Administrator stated when a resident wearing a Wanderguard bracelet approaches the door, the door will automatically lock; however, when the code is pushed on the keypad, it automatically releases the door lock and the door alarm will not sound. The Administrator stated a new transmitter was placed on Resident #1 as a precautionary measure. The Administrator stated Resident #1's room was located near the exit door. Both the DON and the Administrator revealed they decided to move the resident to the Railroad Crossing Unit which would be farther from the exit door. The facility moved the resident to room 202-A and placed the resident on 1:1 observation. The Administrator stated he asked the resident how he/she had gotten out of the facility and the resident had taken him to the keypad and started punching numbers and stated, "It did not work this time." The Administrator and the DON both stated the door code was only to given to employees and they were unaware of any resident or visitor ever having the door code. The Administrator stated the facility had not routinely changed the door code. However, the MS had changed the code to all the exit doors on 07/30/12, after Resident #1 eloped from the facility.	F 323	reviewed and updated as needed by the DON and MDS nurses on 8-4-2012. An in-service was initiated on 8-3-2012 by the administrator and maintenance supervisor on the use of the manual alarms as a secondary measure until the Secure Care alarms are upgraded. All facility staff received this in-service prior to their next scheduled shift. The in-service included documentation of secondary alarms to show they were in the on position was completed with Q15 minute check sheets by the nurse, med aide, or nurse aide who were trained with this in-service. The check sheets were changed to Q 1 hour checks on 8-13-2012. The in-service provided a printed picture showing alarm in "on" position. If the manual alarm is activated, staff must respond immediately to assure that a resident is safe and also to reset manual alarm. During business hours 8:30 a.m.-4:30 p.m. M/F, the manual alarm on the double lobby doors is inactivated in lieu of front office staff - who are familiar with wandering residents via the wandering board - being physically present at this location (The secure care	

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F 323	Continued From page 19 A review of the medical record for Resident #1 revealed the resident was admitted by the facility on 05/20/10, with diagnoses that included Dementia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Anxiety, and Cardiomyopathy. A review of Resident #1's most recent quarterly Minimum Data Set (MDS) assessment dated 06/20/12, revealed the facility assessed the resident as moderately cognitively impaired and to be independent with ambulation. The medical record also revealed an "At Risk Wandering Assessment," dated 06/21/12, which revealed the resident was assessed to have dementia and moderate cognitive loss, poor decisions, and also required supervision. The facility assessed the resident to have a score of 9. According to the assessment, any resident scoring greater than 5 on the assessment was at risk for wandering. The assessment stated the resident was on the At Risk Wandering Ways Program, with a Wanderguard (alarm bracelet) to be used. A review of the Comprehensive Care Plan for Resident #1 with a revision date of 06/28/12, revealed the resident was assessed to be at risk for wandering and at risk for unsupervised exits from the facility. The interventions listed on the Care Plan were for the resident to be in the At Risk Wandering Ways Program, to check daily to ensure the resident has an alarm bracelet on and that it is functioning properly, and to ensure the resident's picture was on the wandering resident board. A review of the Resident Care Guide for Resident #1, which was undated, revealed the resident was at risk for wandering, was to have an alarm bracelet, and staff was to monitor for the resident's location in the facility.	F 323	alarm on the main entrance door in the lobby is still activated). On 8-6-2012, the Secure Care vendor provided preventative maintenance service to all Secure Care doors and found them to be functioning properly. The vendor installed updated 1000DE exit panels on 8-6-2012 that will not allow the door to open when a code is entered if a wander guard transmitter is present. As an additional safety measure, on 8-17-2012, a motion sensing alert was installed in the front lobby to alert staff of anyone entering the area. All exit doors in the facility will be monitored daily utilizing a QI tool by the maintenance supervisor to ensure they are functioning appropriately. Immediate action will be taken by the maintenance supervisor upon identification of any potential concern with the functioning of the door alarms. Upon identification, the Maintenance Department will notify the	

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F 323	Continued From page 20 A review of the monitoring tool which was used by the nurses to document the location checks revealed staff had completed the 15-minute checks for Resident #1 on 07/30/12, through 3:00 PM; however, there was no documentation the 15-minute checks were completed after 3:00 PM. An interview conducted with State Registered Nursing Assistant (SRNA) #3 on 08/02/12, at 2:05 PM, revealed SRNA #3 and SRNA #4 were both responsible for the care of Resident #1 on 07/30/12. The SRNA stated she was required to check the care guide for each resident she was assigned to at the beginning of every shift to locate the care needs required for each resident. The SRNA stated Resident #1 wore a Wanderguard alarm bracelet due to wandering behaviors. The SRNA stated staff was required to do every 15 minute checks to ensure the location of the resident. The SRNA stated she did not document the 15-minute checks, the nurse did the documentation. The SRNA stated the last time she saw the resident prior to his/her eloping from the facility was at approximately 3:00 PM, at the South Unit nurses' station. The SRNA stated she observed visitors using the keypad to unlock the door. The SRNA stated she had only known the codes to the doors being changed three to four times in five years. The SRNA stated she could not recall ever being told who could have the code to the exit doors. An interview conducted with SRNA #4 on 08/03/12, at 12:10 PM, revealed both SRNA #3 and SRNA #4 were responsible for providing care for Resident #1 on 07/30/12, at the time the resident eloped from the facility. The SRNA	F 323	Administrator of any potential concern with the door alarms and the action taken to resolve the issue. These results will be monitored by the administrator weekly. A daily chart audit will be completed Mon thru Fri by the DON, ADON, QI nurse, MDS nurses, Staff Facilitator, Treatment nurse and Social Worker to read the residents notes to identify any resident who may begin exhibiting increased wandering behaviors for whon additional interventions may be necessary. The daily audits will also review Q15min check sheets on applicable residents and check for completeness of documentation. The audit will include: 1) Reviewing the rooms for general appearance and conditon of resident (including facial hair, nails, odors and catheters etc., 2) All Nursing Notes (health status, behaviors etc., and communication board, if they are on Q15min checks make sure that sheets are filled out and care plan/resident care guides are up to date.	

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F 323	Continued From page 21 stated Resident #1 was required to have a Wanderguard bracelet and also to have every 15 minute checks which were to be documented by the nurse. The SRNA stated she had not seen the resident for approximately 30 to 40 minutes prior to the nurse informing her a resident had eloped, and staff then began doing a head count of all residents living on the South Unit. The SRNA stated she felt the resident had followed someone out of the facility exit. The SRNA stated if a resident was wearing a Wanderguard bracelet when they approached the door it would lock and would not unlock until the correct code was entered on the keypad. The SRNA stated she had observed visitors using the keypad to unlock the door. The SRNA stated she had never known the codes to the exit doors to be changed until after Resident #1 had gotten out of the facility. The SRNA stated she could not recall ever being told who could have the code to the exit doors. An interview conducted with LPN #4 on 08/02/12, at 2:45 PM, revealed the LPN was responsible for medications for Resident #1 on 07/30/12. The LPN stated she completed and documented the 15-minute checks on Resident #1 on 07/30/12, until 3:00 PM. After 3:00 PM, the LPN said it was the Charge Nurse's responsibility to complete and document the 15-minute checks on Resident #1. The LPN stated only staff was to have door codes and she had never observed visitors using the door codes. An interview conducted with LPN #1 on 08/02/12, at 2:55 PM, revealed she was the Charge Nurse for the South Unit on 07/30/12, and was responsible for ensuring the 15-minute checks were completed on Resident #1. The LPN stated	F 323	3) All Assistive Devices and Side Rail Asssessments are up to date and accurate and on care plan/care guide as indicated. 4) All QI/Incidents have been investigated and interventions are in place to prevent re-occurences or harm to residents. The results of these audits will be reviewed by the Administrator, DON weekly in the QI Committee Mtg. that is composed of the DON, Administrator, Staff Facilitor, MDS Nurses, Social Worker, QI Coordinator, Treatment Nurse for trending and development of further action plans and or interventions and staff training.	8-17-12

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F 323	Continued From page 22 she was in the DON's office when the Administrator notified them of a possible missing resident. The LPN stated Resident #1 was agitated when they got to him/her. The LPN revealed the resident was wearing a Wanderguard bracelet. When the resident was returned to the facility, the LPN completed a head to toe assessment, with no injuries to the resident observed. The LPN stated she asked the resident where he/she was going and the resident answered, "I am going home." The LPN stated the only way the resident could have gotten out the door was to have keyed in the right code on the keypad at the exit door, or followed someone out after they had keyed in the code. The LPN stated the last time she had observed Resident #1 on 07/30/12, prior to the elopement, was at 3:45 PM, when the resident was in the smoking room. The LPN stated had forgotten to complete the 15-minute checks after 3:45 PM, and had forgotten to complete the documentation of the 3:00 PM to 3:45 PM "Every 15 Minute Checks." The LPN stated the care guide was where the information was found regarding the care needs that each resident required, and staff was required to check the care guides for every resident they were assigned at the beginning of every shift. The LPN stated Resident #1 was care planned to require every 15 minute checks due to being assessed as at risk for wandering. The LPN stated only staff was to have door codes and she had never observed a visitor using the door codes. A group interview with five residents, who had been assessed by the facility to be interviewable, on 08/02/12, at 11:10 AM, revealed they had never observed a resident going outside the exit	F 323		

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F 323	Continued From page 23 doors except with staff or family. Resident A stated he/she was aware of the previous door code prior to the facility changing the code on 07/30/12. The resident stated he/she had overheard the code from the staff talking. Resident B stated his/her family was aware of the code to the exit doors. The resident stated his/her family did not have to bother the staff when leaving. Resident B stated he/she had also gotten the code from overhearing the staff, and then had given it to family members. An interview conducted with the Maintenance Supervisor (MS) on 08/02/12, at 5:00 PM, revealed he had not routinely changed the door codes. The MS stated that when he changed the door codes on 07/30/12, it was the first time he had changed the codes in the past year. The MS stated when a resident wearing a Wanderguard bracelet approached the door, the door locked and would only open if the code was entered on the keypad. The MS stated the only way Resident #1 could have gotten out of the facility was if he/she had followed someone out the door or if the resident keyed in the code to the door. An interview conducted with the Staff Facilitator (SF) on 08/03/12, at 3:25 PM, revealed she was responsible for conducting staff training in-services and for orientation of all new staff. The SF stated staff was told during initial orientation how to use the door codes and that the codes were not to be given to anyone. The SF stated staff was also told to be discreet when using the code. The SF stated she provided an in-service to staff every other week and she mentioned the door codes and importance of not giving the codes to anyone other than the facility	F 323		

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F 323	Continued From page 24 staff. The SF stated Resident #1's picture was on the wander board, which contained the pictures of residents who were assessed by the facility to be wanderers. The SF stated the wander boards were hung by the time clock, in both charting rooms in the nursing stations, and in the Quality Assurance office. The SF stated she instructed all new employees on the residents on the wander board, location of the board, and the importance of all staff monitoring the residents who were placed on the board for possible elopement. --A review of the Allegation of Compliance (AOC) revealed the following: On 07/30/12, once Resident #1 returned back to the facility, a complete head to toe assessment was conducted by the Charge Nurse and the resident was found to be uninjured. On 07/30/12, an investigation was begun on Resident #1 regarding the resident's elopement. The investigation was completed on 08/03/12. On 07/30/12, Resident #1 was fitted with a new Wanderguard alarm bracelet and moved to a new resident room in the inner hallway. On 07/31/12 and 08/01/12, the MDS Nurses reassessed all residents for wandering, implemented alarms, added every 15 minute checks, and updated care plans as indicated by the wandering assessments. Beginning on 08/03/12, staff was in-serviced by the Administrator and the Maintenance Supervisor (MS) on the manual audible alarm use	F 323		

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F 323	Continued From page 25 and 15-minute alarm check sheets that were to be completed by the nurse. The in-service included where the alarms were located, how to reset the alarm, and that facility staff must respond immediately if the alarm sounded. Beginning on 08/03/12, nursing staff was in-serviced by the Administrator, DON, and Staff Facilitator (SF) on ensuring resident care plans and care guides were followed. The in-service also directed staff to communicate with the Administrative Team immediately if a resident exhibits a change in behavior, wandering, going to the exit doors, trying to exit the facility, or making statements that they were going to leave the facility. The in-service directed nurses to ensure visual checks and documentation were completed every 15 minutes on all residents whose care plan/guide required the 15-minute checks. On 08/03/12, the Administrator conducted an in-service with all facility staff related to the manual alarms being activated on all exit doors, how to use the alarm, how to turn the alarm on, how to reset the alarm, where the keys are located, and that extra keys would be kept by the MS and the Administrator. The in-service included instruction to nurses, medication aides and SRNAs on documenting that the manual alarms were checked every 15 minutes to ensure they were in the 'on' position. The AOC also revealed during business hours, 8:30 AM-4:30 PM, Monday through Friday, the manual alarm on the front door (main entrance) would be deactivated in lieu of the Admissions Coordinator (AC) being physically present at the door. The secure care alarm on the main entrance would	F 323		

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F 323	Continued From page 26 still be activated. On 08/04/12, nursing staff was in-serviced on the facility's "Wandering Risk Potential Protocol" by the Administrator, DON, and SF. Staff was educated regarding what steps to take in order to implement a plan for resident safety. On 08/04/12, education was begun for all facility staff on the steps to take if an exit door was not functioning properly, and the importance of not giving out the door codes. On 08/04/12, wandering boards showing pictures of residents assessed by the facility to be at risk for wandering and elopement were reviewed and updated as needed by the MDS Nurses. An updated list of wandering residents was posted at each nursing station. On 08/04/12, all residents' charts were reviewed by the MDS nurses and the DON for the past six months. The review ensured all behaviors were identified, and any attempts or verbalization of wanting to leave the facility or increased agitation addressed. The review included reviewing resident progress notes, wandering risk assessments, care plans, and care guides. A weekly audit tool was developed by the Quality Assurance (QA) Nurse to ensure all residents identified as at risk for wandering have care plan interventions implemented to ensure the resident's safety and to prevent an unsupervised exit. The results of the audit will be reviewed weekly in the Quality Assurance meeting. On 07/30/12, an audit tool was instituted by the facility to be completed by the Maintenance	F 323		

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F 323	Continued From page 27 Supervisor (MS) daily to ensure doors and alarms were functioning properly. Any potential concerns will have immediate corrective action taken by the MS to correct the issue. The problem and the action taken to resolve the issue will be brought to the attention of the Administrator immediately. The results of the audit will be reviewed weekly in the Quality Assurance meeting. On 08/05/12, a new audit tool was instituted which will be completed by the DON, ADON, QA Nurse, MDS Nurses, SF, Treatment Nurses, and the Social Worker (SW). The audits will be completed Monday through Friday and will include a review of the residents' progress notes, and ensure all 15-minute check and alarm bracelet check sheets are filled out completely. The audit will also include updating the residents' care plans and care guides as needed. Information documented on Saturday and Sunday will be audited on Monday. The results of the audit will be reviewed weekly in the Quality Assurance meeting. –The surveyor validated the corrective actions taken by the facility as follows: A review of the progress notes for Resident #1 revealed on 07/30/12, at 6:31 PM, LPN #1 documented she had completed a head to assessment of Resident #1 and no injuries were identified. An interview conducted with LPN #1 on 08/06/12, at 10:20 AM, revealed she had completed the head to toe assessment on Resident #1 after the resident had eloped on 07/30/12. The LPN revealed she had assessed the resident to have	F 323		

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F 323	Continued From page 28 no injuries. A review of the facility's investigation regarding the elopement of Resident #1 on 07/30/12, completed by the Administrator and the DON revealed it had been completed on 08/03/12. A review of the audit tool for the secure care doors revealed the reviews had begun on 07/30/12, and were completed by the MS, and were ongoing and also revealed the codes were changed on 07/30/12. The audit sheets revealed the Administrator had tested the doors with alarm bracelets on 07/30/12 and 07/31/12. An invoice was reviewed to replace the secure care door panels, dated 08/03/12. An interview conducted with the Administrator on 08/07/12, at 11:45 AM, revealed the new door panels were an upgrade and the door will automatically lock when a resident gets near the door with a Wanderguard bracelet and will not unlock even if the code was keyed in. A review of the audit tool to monitor the Wanderguard alarm bracelets revealed Resident #1's Wanderguard bracelet was changed to a new bracelet on 07/30/12. The documentation revealed the bracelet was now located on the resident's left lower extremity with an expiration date of June 2015. Observation of Resident #1 on 08/07/12, at 9:30 AM, revealed the resident was wearing a Wanderguard alarm bracelet on his/her left lower extremity with an expiration date of June 2015. A review of nurse's notes for Resident #1 dated 07/30/12, revealed the resident was moved from	F 323		

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F 323	Continued From page 29 resident room 122, which had been near an exit door, to resident room 202-A in the Railroad Crossing Unit, which located the resident's room away from any outside doors. Observation of Resident #1 on 08/07/12, at 9:30 AM, revealed the resident was residing in resident room 202-A. LPN #6 was observed providing 1:1 supervision for the resident. A review of a wandering assessment for Resident #1, revealed it was completed on 07/30/12, after the resident left the facility unnoticed and unsupervised. A review of wandering assessments completed for all residents in the facility revealed the residents were assessed for wandering behaviors. The assessments were completed on 07/31/12 and 08/01/12. Two residents (unsampled Residents G and H) triggered as an elopement risk and were placed on the Wandering Ways program, and their care plans were updated, pictures added to the wander boards, names added to the wander lists at each nursing station, and an alarm bracelet was placed on one resident (Resident H); however, the other resident (Resident G) refused to wear the alarm bracelet and every 15 minute checks were added due to the refusal. Resident H was placed on every 15 minute checks because the resident had exhibited wandering behaviors. A review of both Resident G's and Resident H's care plans revealed the care plans were updated with interventions to prevent elopement. An interview conducted with the MDS Coordinator on 08/07/12, at 10:55 AM, revealed she assisted with the At Risk Wandering Assessments of the	F 323		

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F 323	Continued From page 30 facility residents on 07/31/12 and 08/01/12. The MDS Coordinator stated residents' care plans were updated if needed and interventions were instituted for residents related to wandering if needed. A review of the in-service rosters revealed on 08/03/12, the Administrator, DON, and SF initiated an in-service for all facility nursing staff which covered the following: staff following and implementing resident care plans and care guides, and communication to the administrative team immediately of resident behaviors and residents wandering, going to doors, trying to get out, or making statements they were going to leave. The in-service also included instructing staff to document 15-minute checks and immediately notify the on-call nurse, Administrator, and/or the DON if any of the above behaviors occur. The education will be ongoing until all facility nursing staff has attended and will be in-serviced by their next scheduled shift. A review of in-service rosters revealed on 08/04/12, an in-service was initiated by the Administrator, DON, and SF regarding staff which directed staff to follow the "Wandering Risk Protocol" immediately for any resident who experienced increased agitation or a change in condition that may warrant an elopement potential. The in-service reviewed the guidelines contained in the protocol, implementing a plan, direction for staff if a resident refuses to wear an alarm such as implementing every 15 minute checks, how to assess for wandering, staff actions if the staff feels a door is not working properly, and the importance of not giving out the door codes. The in-service will be ongoing until	F 323		

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F 323	Continued From page 31 all staff has attended. All staff is required to receive the in-service prior to their next scheduled shift. The in-service will be provided to all newly hired employees. A review of the audit sheets revealed manual alarms were checked every 15 minutes to ensure they were in the 'on' position. Observation on 08/06/12 and 08/07/12, revealed the Admissions Coordinator was physically present in the front lobby at the front door to the facility. An interview conducted with the Admissions Coordinator (AC) on 08/06/12, at 4:20 PM, revealed she was responsible for monitoring the main entrance to the facility from 8:30 AM until 4:30 PM. The AC stated she had been trained by the facility to check the wander board for pictures of wandering residents daily. The AC stated she is required to call for assistance if a wandering resident approaches the door. Observation on 08/07/12, at 8:05 AM, revealed on 08/04/12, wander boards located in the North and South charting rooms, by the time clock, and in the Quality Assurance office had been updated by the MDS staff. The boards were reviewed, which revealed two new resident pictures had been placed on the boards. A review of the list for wandering residents revealed an updated list had been placed at both nursing stations. An interview conducted on 08/06/12, at 4:20 PM, with SRNA #6, on 08/06/12, at 4:30 PM, with SRNA #7, on 08/06/12, at 4:45 PM, with SRNA #4, and on 08/06/12, at 4:50 PM, with SRNA #8	F 323		

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F 323	Continued From page 32 revealed the staff was able to verify where in the facility wandering boards were posted (in each charting room, by the time clock, and in the QA office) and were able to relay the location of the "Wandering Lists." The staff revealed they were required to check these every shift as well as the resident care guides. According to the above staff, they had attended in-services regarding the following: the door alarms, instructions on not to give the door codes to anyone, and immediately notifying the charge nurse and Administrator if a resident began exhibiting wandering behaviors. In addition, the staff stated if a door was not functioning properly a staff person was required to stay by the door until Maintenance arrived to correct the problem. A review of the audit sheets completed by the DON and MDS Nurses on 08/04/12, revealed a six-month chart review was completed on all residents for any behaviors that had not previously been identified. These behaviors included attempts to leave the facility or verbalizing wanting to leave the facility and increased agitation. The resident care plans, care guides, progress notes, and wandering risk assessments were also reviewed/audited. An interview with the DON on 08/07/12, at 11:30 AM, confirmed she had assisted with the above audits. A review of the Quality Assurance audit tool completed on the exit doors to ensure the doors were functioning properly was conducted. The audit tool was completed by the Maintenance Supervisor on a daily basis and he was to report any problems to the Administrator. An interview with the Maintenance Supervisor on 08/07/12, at	F 323		

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F 323	Continued From page 33 11:05 AM, confirmed he completed the door audits daily and reported any problems to the Administrator. A review of the daily audit tool used by the facility which was completed by the DON, Assistant Director of Nursing (ADON), Quality Assurance (QA) Nurse, MDS Nurse, SF, Treatment Nurse, and Social Worker (SW) revealed the resident charts are being audited daily. This audit includes a review of the resident progress notes to identify any resident displaying an increase in wandering behaviors for whom additional interventions may be necessary. The audit included reviewing the 15-minute check sheets, testing of resident alarm bracelets, and updating the care plans as needed. The audits also included if any corrective actions were needed. The audit will be continued by the facility ongoing. An interview with the DON on 08/07/12, at 11:30 AM, confirmed she was assisting with the daily chart audits. An interview conducted with the DON on 08/07/12, at 11:30 AM, revealed she was assisting to audit the charts daily to ensure any resident who began exhibiting behaviors that could lead to wandering or elopement had interventions in place to prevent them from leaving the facility unsupervised. The DON stated they also checked the 15-minute check sheets, as well as the testing of the alarm bracelet sheets. The DON stated she makes rounds throughout the day at different times and observes staff to ensure the care is being provided as required by the residents. Review of the auditing tool, which will be	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-CITIES NURSING & REHABILITATION CENTER	19101 US HIGHWAY 119 NORTH CUMBERLAND, KY 40823

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 34 completed weekly by the Quality Assurance (QA) Nurse, revealed the tool included an audit of resident chart reviews to ensure all residents who have been identified as being at risk for wandering have interventions on the care plan in place to address the wandering and to prevent the unsupervised exit of a resident. The QA Nurse would immediately report any potential concerns to the Administrator and the DON. The results of the audits will be reviewed by the Administrator and the DON at the weekly QA Committee meeting that is composed of the Administrator, DON, ADON, SF, MDS Nurse, SW, and Treatment Nurse. An interview conducted with the QA Nurse on 08/07/12, at 11:40 AM, revealed the QA Nurse would report any potential concerns she identified during the audits to the DON or the Administrator. The QA Nurse stated she was required to report her findings at the weekly QA meeting.	F 323		