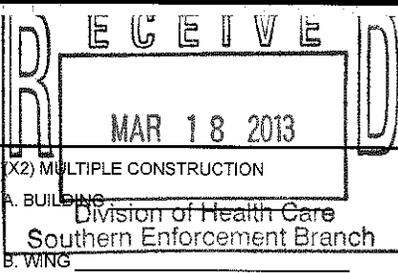


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185230	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED C 02/22/2013
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 945 WEST RUSSELL STREET ELKHORN CITY, KY 41522
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F 000	INITIAL COMMENTS	F 000	This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of this plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Furthermore, we request this Plan of Correction serve as our credible allegation of compliance.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policies and incident report, it was determined the facility failed to ensure one of three sampled residents (Resident #1) received adequate supervision. The facility identified by "Risk of Elopement/Wandering Review" assessment that Resident #1 wandered and was at risk for elopement (exiting/leaving facility without staff knowledge). The facility revised the Plan of Care for Resident #1 on 11/15/12 that addressed the resident's wandering behaviors and directed staff to redirect the resident from "inappropriate" areas. In addition, review of the undated "Care Directive," utilized by the facility's nurse aides to provide resident care revealed staff was to "redirect resident to secure area if by themselves in an unsupervised area." However, on 02/11/13, at approximately 8:00 PM,	F 323	Corrective actions accomplished for the resident found to have been affected: 1. Visual assessment was performed at 8 p.m. on 3/11/13 by LPN #1, noting the resident was adequately dressed for the moderate weather, with fleese pants, long sleeved sweatshirt, socks and shoes. 2. Physical assessment was performed by LPN #2, revealing no physical injury.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Judith Branham* TITLE: *Executive Director* (X6) DATE: *03/18/2013*

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 323	<p>Continued From page 1</p> <p>facility staff observed Resident #1 sitting in the front lobby, unsupervised, and failed to redirect the resident as indicated in the resident's Plan of Care and the Care Directives, and Resident #1 exited/eloped from the facility without staff knowledge. The resident ambulated along the facility sidewalk and knocked on exit door 4 of the facility and staff assisted the resident back into the facility. Resident #1 was outside of the facility approximately three to five minutes before re-entering the facility with no injuries identified.</p> <p>The findings include:</p> <p>Review of the facility's undated "Elopement Policy" revealed residents have the right to live in a safe and secure environment and the facility had the responsibility to ensure effective policies and procedures were developed and implemented to reduce the risk of elopement by residents. The review revealed each resident was assessed at time of admission, and as needed, for the potential of elopement based on the resident's prior history of wandering or elopement, and if the resident's history and/or assessments indicated the resident had impaired decision-making ability with the ability to be mobile. The policy indicated a specific plan and interventions would be developed and implemented for those residents at risk for wandering or elopement. The facility utilized an identification bracelet on the resident's wrist or ankle to identify each resident. The review also revealed residents and family members were informed/educated on the facility's elopement policy upon admission. According to the policy, when staff could not account for the whereabouts of a resident, staff was to notify the administrator,</p>	F 323	<ol style="list-style-type: none"> 3. Physician and responsible party were notified within 10 minutes. 4. The Director of Nurses (DON) was notified, as well as the Executive Director, and Maintenance Director within 10 minutes. 5. The residents care plan was updated by LPN #2, to include exit seeking behavior and approaches for redirecting the resident. 6. 15 minute minute checks were initiated by LPN #2 on 2/11/13. 7. Pursuant to monitoring, Resident #1 continued to exhibit exit seeking behavior. Due to the planned renovations, the family transferred Resident #1 to a facility with a locked unit on 03/07/13. <p>How the facility will identify other residents having the potential to be affected:</p> <ol style="list-style-type: none"> 1. Bed check was completed at time of occurrence to account for all residents. 2. 15 minute checks were initiated for all "at risk" residents. 3. At 9 p.m. Maintenance Director, Danny Dixon, came to the facility and checked the alarm system and it was found to be functioning properly. 4. Assessments and care plans of all at risk residents were 	

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F 323	<p>Continued From page 2</p> <p>responsible party, physician, and all department heads and initiate a search of the building and grounds. An Incident Report was to be completed and administrative staff was to investigate and determine whether the elopement occurred as a result of neglect.</p> <p>Review of the facility's Admission Packet given to the resident and family member upon the resident's admission to the facility revealed the packet contained a copy of the facility's Elopement Policy and the resident/family member was required to sign acknowledgment of the policy. The Admission Packet also contained an informational sheet entitled "Mountain View General Information" and criterion 5 on the sheet, "Elopement Policy," revealed, "Visitors must be aware that there are residents residing in the facility that may be cognitively impaired," and visitors were requested to "Please do not allow residents to follow you out any of the doors, alert the nurse."</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 05/29/09, to the "secure unit" and the resident's diagnoses included Anxiety, Psychosis, Depression, Dementia with behavioral disturbances, Alzheimer's disease, and Esophageal Reflux.</p> <p>Review of an annual Minimum Data Set (MDS) assessment dated 04/01/12, and the quarterly MDS dated 12/02/12, revealed Resident #1's cognition was severely impaired and the resident exhibited wandering behaviors.</p> <p>Review of assessments completed on 09/05/12, 12/05/12, and 02/11/13, entitled "Risk of</p>	F 323	<p>reviewed on 2/12/13 to assure they were complete and accurate.</p> <p>5. Residents are assessed for wandering/elopement behaviors upon admission, quarterly, annually, and when a resident exhibits a significant change. If behaviors are identified a photograph and face sheet is placed in the elopement book. Elopement books will be updated and maintained by the Social Services Director or Assistant and maintained at each nursing station and at reception desk. These books were reviewed by Social Services Director &/or Assistant to assure accurate and current information on an on-going basis.</p> <p>6. Staff receives in-service education during orientation regarding dementia care to include wandering/exit seeking behaviors, as well as the procedure for resetting door alarms that include opening the door and visually inspecting the area outside, closing the door, and resetting the alarm. In-service was conducted with staff following this incident to assure complete understanding. These in-services were provided by Becky Mullins, ADON, on 2/12/13, 2/13/13, and 2/19/13</p>		

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F 323	<p>Continued From page 3</p> <p>Elopement/Wandering Review," revealed Resident #1 was cognitively impaired and had poor decision-making skills. The assessments revealed the resident had diagnoses of Dementia, Alzheimer's, Anxiety, and Depression, ambulated independently, and had communication problems. The assessments also revealed Resident #1 had no history of elopement while at home or while at the facility and had not expressed a desire to go home. Although the assessments revealed the resident wandered aimlessly and the behavior was not new, the resident's family had voiced concerns related to Resident #1's wandering tendencies.</p> <p>Review of Resident #1's Care Area Triggers (CAT) worksheet dated 04/01/12, revealed the resident had communication problems due to difficulty with hearing and wore a hearing aid; and had a diagnosis of Dementia which caused communication problems due to the resident rambling often and answering questions incoherently. The CAT worksheet revealed the resident also had behavioral problems due to diagnoses of Alzheimer's disease and wandered frequently requiring frequent redirection from staff.</p> <p>Review of Resident #1's undated Care Directives utilized by the State Registered Nursing Assistants (SRNAs) revealed staff was to assess the resident for signs of increased agitation and wandering in and out of other resident rooms and to report these behaviors to the nurse. The Care Directives also instructed the aides to "redirect the resident to a secure area if the resident was in an unsupervised area."</p>	F 323	<p>to assure all employees participated.</p> <p>Measures that will be put into place or systemic changes made to assure the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. The door access code was changed and all staff received a new access code label for their badge to assure legibility on 3/12/13. New labels will be maintained by Human Resources Staff, Director of Nursing or Assistant Director of Nurses and made available to staff upon request when their current label becomes illegible. 2. Temporary signs were applied to the front entrance (inside & out), indicating that the front door cannot be used except Monday-Friday during business hours 8 a.m.-5 p.m. The side ambulance entrance will be utilized at all other times on 2/12/13. Permanent signs were received and applied on 3/14/13. 3. The Executive Director and Social Services Director held a family meeting on February 21, 2013 to discuss the change in access to the facility and to discuss the importance of resident safety and security, i.e. alert staff if residents are present when leaving and a duty to 		

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F 323	<p>Continued From page 4</p> <p>Further review of Resident #1's medical record revealed the resident was transferred from the "secure unit" to a regular unit on 11/15/12, at which time the facility revised the care plan that addressed the resident's wandering behavior which included interventions for staff to implement. A review of the care plan revealed staff identified the resident to have behaviors of wandering and staff was to redirect the resident from "inappropriate" areas; however, the care plan failed to define what the "inappropriate" areas were.</p> <p>Review of the facility's internal investigation initiated on Monday, 02/11/13, revealed Licensed Practical Nurse (LPN) #1 reported that at approximately 8:00 PM on 02/11/13, the LPN observed Resident #1 sitting in the front lobby watching television. The investigation revealed less than five minutes later LPN #1 heard a knock at side door 4, looked out, and observed Resident #1 at the door. The resident was dressed in fleece pants, long sleeved sweatshirt, socks, and shoes. The investigation revealed a head to toe assessment was conducted with no injuries noted. LPN #1 notified the resident's physician, responsible party, and the Director of Nursing (DON). The DON notified the Administrator and the Maintenance Director. The Maintenance Director came to the facility and the alarm system was checked and found to be functioning properly. The investigation revealed on 02/12/13, the Administrator notified the appropriate state agencies of the incident.</p> <p>While investigating Resident #1's elopement, the facility learned during interviews that on 02/11/13, State Registered Nursing Assistant (SRNA) #1</p>	F 323	<p>protect our loved ones. Please note the facility does require residents family, responsible party, and or POA to read and sign an elopement policy upon admission. This practice will continue.</p> <p>4. An additional alarm was installed on 2/13/13 to produce a much louder sound with a different tone that alarms when any door is opened without a code. During the hours from 5 p.m.-8 a.m. and week-ends, all doors will be alarmed with or without a code, except for door 4 (emergency entrance) and door 7 (employee entrance). A log will be kept at each nurses station for the Charge Nurse to make an entry should an employee enter the facility through any other door. Employees who are on the log will be provided in-service education regarding the system.</p> <p>5. On 2/13/13 A "Yellow Dot" system was implemented to identify that the resident is "at risk" for elopement. A yellow dot was placed on the resident's identification bracelet, the medical record, and on the door to their room.</p>		

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F 323	<p>Continued From page 5</p> <p>was on the nursing unit and a family member requested assistance from SRNA #1 to exit the facility through the front lobby; however, before SRNA #1 could obtain the door alarm code the door alarm sounded. Documentation in the facility's report revealed SRNA #1 immediately responded to the door alarm, opened the door in the front lobby, looked out, and then closed the door and reset the alarm.</p> <p>Interview conducted on 02/19/13, at 5:10 PM with LPN #1 revealed on 02/11/13, at approximately 8:00 PM, the LPN left the unit to obtain supplies prior to medication pass and observed Resident #1 sitting in a chair in the front lobby watching television. Although the LPN stated there were no other staff members or residents in the lobby with Resident #1, she felt the resident was fine and did not redirect the resident from the area. The LPN stated she gathered the needed supplies, and when she went back to the unit to start the medication pass at 8:00 PM she heard a knock at side door 4. According to the LPN, Resident #1 had knocked on the door and she opened the door and assisted the resident back into the facility. The interview revealed it had been less than five minutes since the LPN observed Resident #1 in the front lobby. The LPN stated she assisted Resident #1 to the resident's appropriate unit and informed the resident's nurse (LPN #2) that the resident had been outside the facility. LPN #1 stated a head count was initiated after the incident. The interview revealed Resident #1 had not exhibited exit-seeking behaviors previously or on 02/11/13.</p> <p>Interview with SRNA #1 conducted on 02/20/13, at 10:10 AM and 11:15 AM, revealed while she</p>	F 323	<p>6. On 2/12/13, 2/13/13 & 2/19/13 Staff received in-service education regarding all the above noted changes i.e. Change in front entrance door times for public access; elopement policy, and the "Yellow Dot" system implementation and which doors they could exit and enter.</p> <p>How the facility plans to monitor its performance to ensure solutions are sustained:</p> <ol style="list-style-type: none"> 1. The equipment used to assure resident safety though an alarm system is tested monthly by the Maintenance Director Danny Dixon. 2. Staff education will occur upon hire, annually and as needed, by SDC (Rebecca Mullins, RN) based on Performance Improvement Monitoring. 3. Documentation will be maintained related to testing and employee education, including the results of the log used for recording discrepancies. This will be audited by the ED (Judith Branhan), DON (Aimee Mullins), or SDC (Rebecca Mullins) weekly for 3 months, then monthly for 3 months. 4. On 3/15/13 all the above actions were discussed and monitoring 	

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F 323	<p>Continued From page 6</p> <p>was conducting the first bed check rounds on 02/11/13, at approximately 8:00 PM a family member requested assistance with exiting the facility through the front lobby. The SRNA stated the code to the door had been rubbed off her name badge so she informed the family member she would have to obtain the code from the nurse. According to SRNA #1, she walked straight to the nurses' station to obtain the code to the door and heard the front lobby door alarm. SRNA #1 stated she immediately went to the front lobby door and there was no one in the front lobby at that time. According to SRNA #1, she opened the door, looked outside but did not see anyone, and closed the door and reset the alarm. The SRNA stated when she returned to the unit she initiated a head count of the residents but before she had completed the head count, the nurse came to the unit with Resident #1 and reported the resident had been outside the facility. The interview revealed SRNA #1 was not aware of any instances when Resident #1 had exhibited exit-seeking behavior since his/her admission to the facility or on 02/11/13, and was not aware Resident #1 had been sitting in the front lobby watching television prior to the front door alarm sounding.</p> <p>Interview with LPN #2 conducted on 02/19/13, at 9:10 PM, revealed on 02/11/13, at approximately 7:45 PM Resident #1 was at the nurses' station and the LPN gave juice to the resident to drink. LPN #2 stated approximately 10 minutes later, LPN #1 assisted Resident #1 to the unit and informed the LPN the resident had been outside the facility. According to LPN #2, she took the resident to the resident's room, conducted a head to toe assessment of the resident, and the</p>	F 323	<p>implemented. These actions will become part of the Performance Improvement Program with reporting at each PI meeting.</p> <p>Date of compliance 3/22/13</p>		

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F 323	<p>Continued From page 7</p> <p>resident appeared unharmed. The interview revealed Resident #1 had not exhibited exit-seeking behaviors since the resident's admission to the facility or on 02/11/13. The LPN stated she notified the Director of Nursing (DON) and the Maintenance Director of the incident involving Resident #1 and started a head count of all residents on the unit and 15-minute checks on the wanderers. LPN #1 stated all residents were accounted for.</p> <p>Interviews on 02/20/13 at 2:30 PM with SRNA #2; 2:40 PM with SRNA #3; 4:50 PM with LPN #3; 5:15 PM with LPN #4; 6:35 PM with SRNA #4; 6:45 PM with SRNA #5; 6:50 PM with SRNA #6; and 7:05 PM with SRNA #7 also revealed Resident #1 had never exhibited exit-seeking behaviors prior to 02/11/13.</p> <p>Interview with the Maintenance Director on 02/21/13, at 11:40 AM revealed all the doors had alarms and once a week all the exit doors were checked to ensure they were functioning and alarming properly. According to the Maintenance Director, he had not identified any alarms that were not functioning prior to, or at the time of, the incident on 02/11/13.</p> <p>Interviews with the Director of Nursing (DON) and the Assistant DON conducted on 02/19/13 at 4:00 PM, and on 02/20/13 at 10:50 AM, revealed the DON was made aware Resident #1 exited the facility without staff knowledge by LPN #1 at approximately 8:10 PM. According to the DON and Assistant DON, all residents were to be assessed for wandering/elopement behaviors upon admission, quarterly, annually, and when the resident exhibited a significant change. The</p>	F 323		
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F 323	<p>Continued From page 8</p> <p>DON stated nurses utilized an assessment sheet entitled "Risk of Elopement/Wandering Review" for each resident upon admission, and the nurse that completed the Minimum Data Set (MDS) assessment would also review the "Risk of Elopement/Wandering Review" assessment to ensure the information was accurate. According to the ADON, all nurses were educated on the assessment sheets during their orientation. The ADON revealed all staff received in-service education annually on the facility's "Elopement Policy," in which the staff receives a copy of the policy and forms pertinent to elopement. The DON stated any time a resident was identified to be a wanderer/elopement risk staff was to identify the problem and develop interventions on a Plan of Care. In addition, the DON stated residents identified to be a wanderer/elopement risk had a copy of their information sheet and a photograph in the "elopement" binder kept at each nursing station. According to the DON, the staff received in-service education during orientation on the facility procedure for resetting door alarms that included opening the door, visually inspecting the area outside, closing the door, and resetting the door alarm. Interviews revealed facility staff failed to implement Resident #1's Plan of Care when the resident was observed to be sitting in the front lobby of the facility, unsupervised by staff. The DON stated as a result of the facility's investigation it was determined Resident #1 had followed the family member out the door.</p> <p>Interview conducted on 02/22/13, at 9:05 AM with the Administrator, revealed she was made aware Resident #1 had exited the facility unsupervised on 02/11/13, at approximately 8:10 PM by the DON. The Administrator stated the facility's</p>	F 323			

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F 323	Continued From page 9 investigation revealed Resident #1 had followed the family member out the door and acknowledged SRNA #1 failed to thoroughly search outside before resetting the door alarm.	F 323		