

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

PRINTED: 05/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2013
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>An abbreviated survey was conducted on 04/22/13 through 04/25/13 to determine the facility's compliance with Federal requirements. KY #20064 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 04/24/13, and determined to exist on 04/13/13 at 42 CFR 483.20 Resident Assessment F282, 42 CFR 483.25 Quality of Care F323 and 42 CFR 483.75 Administration F490 at a scope and severity of a "J". Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 04/24/13.</p> <p>Resident #1 was re-admitted to the facility on 09/24/12 with diagnoses to include Dementia with Behavior, Alzheimer's Disease, and Anxiety State. The facility assessed Resident #1 at risk for elopement and implemented a plan of care for elopement initiating the wander guard/care alert device. Resident #1 attempted to exit the building on 02/10/13, 03/09/13 and 03/27/13 by holding the door lever handle down for fifteen (15) seconds so the door lock would release. On 03/28/13, the facility determined Resident #1 needed a more secure environment due to the resident's increased incidents of exit seeking behavior and made a referral to a facility that had a locked unit. The resident was placed on fifteen (15) minute checks after the episode on 03/27/13; however, there was no documented evidence the fifteen (15) minutes checks were completed on a regular basis. Record review and staff interviews revealed the fifteen (15) minute checks were discontinued sometime between 03/27/13 and</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rebecca G. Colm* TITLE: *NHA* (X6) DATE: *5/29/13*

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

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F 000	<p>Continued From page 1</p> <p>04/13/13; however, no new interventions related to supervision were implemented for Resident #1. On 04/13/13, Resident #1 exited the building at approximately 3:05 PM. Interviews revealed the door alarm sounded and a Certified Nurse Aide (CNA) responded; however, the CNA went out the door and observed only one side of the building. The CNA re-entered the building and made other staff aware Resident #1 was missing and the staff searched the inside of the building before notifying the Charge Nurse Resident #1 was missing. When the staff was unable to find the resident in the building, staff exited the building and began to search the facility's perimeter. Resident #1 was found by staff at approximately 3:16 PM approximately one-tenth (0.1) of a mile from the facility. The resident had walked across a two-lane highway and was walking in the grass along another two lane highway with high traffic. The speed limit of both highways was 35 miles per hour. Interviews revealed staff had to obtain a wheelchair to bring the resident back to the building because the resident was tired and weak. The resident was assessed with no injuries. The resident was transferred to another facility on 04/18/13.</p> <p>An acceptable Allegation of Compliance (AoC) was received on 04/25/13 and the State Survey Agency validated that the Immediate Jeopardy was removed on 04/24/13, as alleged. The scope and severity was lowered to a "D" at 42 CFR 483.20 Resident Assessment F282, 42 CFR 483.25 Quality of Care F323 and 42 CFR Administration F490 while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p>	F 000		
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F 282 SS=J	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of the facility's guidelines, it was determined the facility failed to have an effective system to ensure provision of care in accordance with each resident's written plan of care for one resident (Resident #1), in the selected sample of five (5) residents.</p> <p>Resident #1 was re-admitted to the facility on 09/24/12 with diagnoses to include Dementia with Behavior, Alzheimer's Disease, and Anxiety State. The facility assessed Resident #1 at risk for elopement and implemented a plan of care for elopement initiating the wander guard/care alert device on 04/24/12. Resident #1 attempted to exit the building on 02/10/13, 03/09/13 and 03/27/13. On 03/28/13, the facility determined Resident #1 needed a more secure environment due to the resident's increased exit seeking behaviors and referred the resident to a facility with a locked ward. The care plan was revised to include fifteen (15) minute checks after the episode on 03/27/13; however, there was no documented evidence the fifteen (15) minutes checks were completed. On 04/13/13, Resident #1 exited the building unwitnessed at</p>	F 282	<ol style="list-style-type: none"> No changes were made to Resident # 1's care plan nor were any interventions revised as Resident # 1 was discharged from the facility on 4-18-2013 which was prior to the survey. An audit of care plans for all current residents was conducted on May 1, 2013, to ensure that care plans are appropriate and individualized to meet the needs of each resident and that care planned interventions were in place. No additional assessments were completed during this care plan audit; however, those interventions that needed to be added or changed as a result of the Interdisciplinary review were reflected on the resident's plan of care. No changes resulted in treatment changes or changes to the plan of care that resulted in the need to hold a care plan meeting with the resident and or responsible person. Therefore, no care plan meetings were held. The facility ensured correction of the concerns by completion of the audit for which the Interdisciplinary Team was responsible for ensuring correction with visual validation of care plan interventions. This audit was completed by the Director of Nursing, the Assistant Director of Nursing, Social Services Director, MDS Coordinator, Activities Director and Dietary Services Manager. Any identified concerns were immediately corrected. 	
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F 282	<p>Continued From page 3</p> <p>approximately 3:05 PM. Unsampled Resident A heard the door alarm sounding and went to the Hall II exit door because there was no staff on the hall. Resident A punched in the code which stopped the alarm from sounding and exited the building but did not see Resident #1. Resident #1 was found by staff at approximately 3:16 PM approximately one-tenth (0.1) of a mile from the facility. The resident had walked across a two-lane highway and was walking in the grass along another two lane highway with high traffic. The speed limit of both highways was 35 miles per hour. Interviews revealed staff had to obtain a wheelchair to bring the resident back to the building because the resident was tired and weak. The resident was assessed with no injuries. Interviews with staff working on 04/13/13, revealed the resident was not on fifteen (15) minute checks prior to the resident exiting the building on 04/13/13. Resident #1 was transferred to another facility on 04/18/13.</p> <p>The facility's failure to have provide care in accordance with Resident #1's care plan related to increased supervision has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/24/13 and was determined to exist on 04/13/13. The facility was notified of the Immediate Jeopardy on 04/24/13. An acceptable Allegation of Compliance (AoC) was received on 04/25/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 04/24/13, as alleged. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p>	F 282	<ol style="list-style-type: none"> 3. All licensed nurses and all certified nursing assistants will be re-educated on following the care plan. If staff are unable to follow the care plan, they will immediately report to the Licensed Nurse who will then report to the Director of Nursing. Education will be completed by 5-9-2013 with no nursing staff working after 5-9-2013 without having received this re-education. This education was conducted by the Administrator, Director of Nursing or the Assistant Director of Nursing. 4. The Director of Nursing will be responsible for monitoring to ensure effectiveness of actions taken. This will occur by completing an audit of five (5) resident's records per week for twelve (12) weeks to ensure that care plan interventions are in place. The results of these audits will be reviewed with the Quality Assurance Committee on a weekly basis until substantial compliance is achieved and then on a monthly basis for at least three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly. 	
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F 282	<p>Continued From page 4</p> <p>The findings include:</p> <p>A review of the facility's Guidelines for Resident Comprehensive Care Plan, dated 09/08, revealed the resident's comprehensive care plan should be viewed as an interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility. The comprehensive care plan should always have realistic goals and interventions to address the residents' needs.</p> <p>A record review revealed Resident #1 was re-admitted to the facility on 09/24/12 with diagnoses to include Dementia with Behavior, Alzheimer's Disease, and Anxiety State.</p> <p>A review of the Admission Assessment, dated 09/24/12, revealed the facility assessed Resident #1 at risk for elopement because the resident was cognitively impaired and had a history of wandering or pacing while trying to open doors, windows and/or gates. The assessment stated an elopement care plan should be initiated and reflect interventions appropriate to the resident which may include the use of the wander guard anklet.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 10/11/12 revealed the facility assessed Resident #1's cognition as moderately impaired, required the extensive assistance of two staff for ambulation, and had behaviors of wandering.</p> <p>A review of the Elopement Plan of Care, Assessment, Prevention and Management, last reviewed and revised 12/10/12, revealed</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>interventions for staff to initiate the wander alert system, photograph resident and document description, allow for safe wandering, offer redirection, and offer snack when wanders.</p> <p>A review of a SBAR report (Physician/Nurse Practitioner/Physician Assistant Communication and Progress Note for New Symptoms, Signs and Other Changes in Condition), dated 02/10/13 at 10:45 AM, revealed Resident #1 attempted to exit the building at the back Hall II door.</p> <p>A review of the At Risk for Elopement Care Plan, dated 03/01/13, revealed interventions to monitor for behaviors of packing belongings, verbalization of leaving and attempts to leave facility, place wander guard on resident and check daily for placement, reassess for elopement risk as needed and with all OBRA assessments. A review of the annual MDS assessment, dated 03/11/13, revealed the facility assessed Resident #1 as severely cognitively impaired, requiring the assistance of one staff for ambulation and had behaviors of wandering four to six days but not every day.</p> <p>A review of the Nurse's Note, dated 03/09/13 at 8:00 PM, revealed Resident #1 was observed opening the back door of Hall II and stepping out through the doorway. The resident was easily redirected back into the facility and placed on 15 minute checks.</p> <p>A review of a Social Worker Note, dated 03/27/13, revealed Resident #1 went out the back door causing the door alarm to sound while in visual eye sight of a Nurse. The resident was escorted back in the building and placed on 15</p>	F 282			

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F 282	<p>Continued From page 6 minute checks.</p> <p>Further review of the At Risk for Elopement Care Plan, dated 03/01/13, revealed an intervention was added on 03/27/13 for increased observation; however review of the record revealed there was no evidence Supervision Flow Sheets were completed while the resident was on increased observation and no evidence the 15 minute checks were discontinued.</p> <p>A review of a Referral and Pre-Admission Screening form, dated 03/28/13, revealed the facility was trying to find placement at a facility with a locked ward due to Resident #1's wandering behavior and attempts of elopement.</p> <p>Interview with the Social Worker, on 04/22/13 at 1:55 PM, revealed the facility determined on 03/28/13, Resident #1 needed a more secure environment due to the resident's increased incidents of exit seeking behaviors so the Social Worker talked to the resident's guardian and made a referral to a facility that had a locked unit. She stated the locked unit facility agreed to take the resident on 04/13/13, however, the facility called and stated due to some issues at their building they would not be able to admit the resident until 04/18/13.</p> <p>A review of a SABR report, dated 04/13/13 at 3:15 PM, revealed Resident #1 eloped from the facility unwitnessed. A Code Wanda was called and the resident was located at 3:20 PM outside of the facility and was assessed with no injuries identified. The resident arrived at the facility at 3:30 PM and was placed on 1:1. The Assistant Director of Nursing (ADON) and Administrator</p>	F 282			

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F 282	<p>Continued From page 7 were notified.</p> <p>Interview with CNA #4, on 04/24/13 at 2:10 PM, revealed Resident #1 was wearing a pair of jeans, a blue short sleeve shirt and white sneakers. A review of a web site for the weather history of the area of the nursing facility revealed on 04/13/13 at 2:55 PM it was 61.2 degrees Fahrenheit with variable wind at 3.5 miles per hour and no precipitation.</p> <p>Interview with unsampled Resident A, on 04/23/13 at 8:30 AM, revealed Resident A was in his/her room at the back of Hall II when Resident A heard the Hall II back door alarm sounding. Resident A stated he/she went to the back door and punched in the code which stopped the alarm from sounding. Resident A exited the building and walked across the back of the building past the back of Hall I and looked in the parking lot along the side of the building and did not see anyone. Resident A stated he/she came back to the back of Hall II and sat outside in the wheelchair. The resident revealed a staff member came out of Hall II exit door and asked if he/she had seen Resident #1. Resident A stated he/she told the staff that if Resident #1 was outside, Resident #1 must have went up the hill and around the other side of the building where there was no parking lot. Resident A revealed when the Administrator interviewed him/her about the incident, he/she told the Administrator there was no staff on the hall when the Hall II alarm sounded and that was why he/she went to the door, punched in the code and went outside to see if Resident #1 was outside.</p> <p>Interview with CNA #1 and CNA #4, on 04/22/13</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>at 2:15 PM and 2:38 PM respectively, revealed Resident #1 was wandering up and down the hallway on 04/13/13 and CNA #1 walked the resident up to the lobby and sat the resident on the couch. CNA #1 and CNA #4 revealed they heard the Back Hall II door alarm sounding while they were in a resident's room providing care. CNA #4 and CNA #1 searched the resident rooms and bathrooms on Hall II and Hall I, then told LPN #2 that Resident #1 was missing. CNA #1 and CNA #4 revealed Resident #1 was found walking down the side of the road in front of a store. CNA #1 and CNA #4 said the resident was missing approximately 10-15 minutes. CNA #1 and CNA #4 revealed they were not told that Resident #1 was on 15 minute checks in report and they do not look at the care plan daily. The CNAs stated the Nurses made them aware if a resident was on increased supervision and this was not reported in change of shift report.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/22/13 at 1:10 PM, revealed she was at the medication cart on Hall I when CNA #1 and CNA #4 entered the back door of Hall I. The LPN stated CNA #4 stated she thought the LPN needed to call a Code Wanda because they could not find Resident #1. A Code Wanda was called. LPN #2 revealed when a Code Wanda was called staff are supposed to complete a head count and if they determine a resident is missing they immediately began a search of the inside and perimeter of the building. The LPN stated staff immediately conducted a head count and began searching for the resident inside and outside of the building. She stated staff found the resident walking down the side of the highway in front of a store "three (3) minutes or so later". LPN #2</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>revealed she was not aware Resident #1 was supposed to be on 15 minute checks prior to the elopement and she was not told this in shift report. She stated she did not review the care plan everyday.</p> <p>Interview with LPN #1, on 04/22/13 at 1:35 PM, revealed she was in another resident's room on Hall II when two Nurses and a CNA asked her if she had seen Resident #1. She stated Resident #1 was found down the road, in front of a store standing in the grass at the side of the road holding the hand of another staff. LPN #1 stated Resident #1 was exhausted but was not injured. The LPN stated staff brought a wheelchair from the facility and assisted the resident back to the facility. The resident was placed on 1:1 supervision. LPN #1 revealed she was not informed Resident #1 was supposed to be on 15 minute checks during shift report that day. The LPN stated staff report to the next shift during shift report any residents on increased supervision. She stated she did not look at the care plan everyday.</p> <p>Interview with CNA #5 and CNA #6, on 04/22/13 at 2:50 PM and 3:00 PM respectively, revealed they were talking to each other on Hall I on 04/13/13 when CNA #1 and CNA #4 entered the back door of Hall I. The CNAs stated CNA #1 and CNA #4 had told them the back door alarm of Hall II had sounded, and they were unable to find Resident #1. CNA #4 and #6 revealed they had not heard the door alarm sound. The Nurse called a Code Wanda and staff began searching for the resident. The resident was found out in front of a store. CNA #5 and CNA #6 stated they were not told in shift report that Resident #1 was</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>on 15 minute checks and they did not look at the care plan everyday.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 and LPN #4 , on 04/22/13 at 1:35 PM and 04/23/13 at 9:40 AM, revealed they recalled Resident #1 being on 15 minute observations but did not remember how often or how long the resident was on the increased supervision. LPN #1 and LPN #4 stated the staff was made aware when a resident was on increased supervision during change of shift report. The LPNs revealed they did not look at a resident's care plan everyday.</p> <p>Interview with the Director of Nursing (DON), on 04/23/13 at 11:20 AM, revealed it was the Nurse's judgement whether to place a resident on increased supervision or not. The staff use the Supervision Flow Sheets to document the monitoring of the resident on increased supervision. The nurse should update the care plan when a resident is placed on increased supervision. The DON stated Licensed staff and CNAs were made aware a resident was on increased supervision through shift report. The DON stated the Resident #1 should have remained on increased supervision (15 minute checks) from the time the resident was placed on 15 minute checks after the 03/27/13 incident until the time of the elopement on 04/13/13. The DON revealed he was unable to find the Supervision Flow Sheets or any other evidence that verified Resident #1 was on 15 minute checks after the 03/27/13 incident of exit seeking behavior.</p> <p>Interview with the Administrator, on 04/23/13 at 12:10 PM, revealed Resident #1 was placed on</p>	F 282		

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F 282	<p>Continued From page 11</p> <p>15 minute checks on 03/27/13 and the 15 minute checks were never discontinued .</p> <p>Interviews with members of the IDT (MDS Nurse, Life Enrichment Director, Dietary Service Manager, Director of Rehabilitation and Social Services Director) on 03/24/13 at 2:45 PM, 2:55 PM, 3:00 PM and 3:05 PM respectively, revealed they could not recall if Resident #1 was taken off increased observation or not.</p> <p>Observation of the area between the facility and the front of the store where Resident #1 was found revealed the area was approximately 0.1 mile from the facility. The resident had to cross a two lane highway with a speed limit of 35 miles per hour (mph) and was found walking down the side of another high traffic two lane highway with a speed limit of 35 mph.</p> <p>A review of the Supervision Flow Sheets, dated 04/13/13-04/18/13 revealed Resident #1 remained on 1:1 until he/she was transferred to a facility with a locked ward on 04/18/13.</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>*All current residents of the facility were reviewed by the IDT on 04/23/13, the IDT consisting of the DON, ADON, Minimum Data Set (MDS) Nurse, Social Services Director, Life Enrichment Director, Dietary Service Manager and Director of Rehabilitation. The IDT reviewed all residents to determine if the current level of supervision was adequate to meet the needs of the resident based on medical condition, behaviors, falls, elopement</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>risk, safety awareness and cognition status. If increased supervision was warranted it was reflected on the resident's care plan. No residents were felt to have a need for increased supervision not already reflected on the care plan.</p> <p>* The IDT to include the Administrator was reeducated by the Regional Nurse Consultant related to the process of IDT review prior to decreasing supervision for the resident, as well as things to consider prior to decreasing the supervision to include but not limit to current behaviors, medications, patterns or trends, medical needs and activity needs. This education was provided on 04/23/13. Any supervision changes will be noted on the resident's plan of care. The DON will be responsible for ensuring this is completed. the Supervision Flow Sheet will be utilized to document increased supervision. This form will be reviewed by the DON and then given to Medical Records for storage. This education was provided on 04/23/13.</p> <p>*All licensed Nurses were re-educated on the following: licensed staff may increase supervision using their nursing judgement and should notify the DON when they have increased supervision. Licensed staff may recommend decreasing supervision to the DON for IDT review prior to changes being made.</p> <p>*The facility also provided re-education to all nursing staff that increased supervision will be noted on the staff assignment sheets. The Administrator is responsible to ensure this is completed. This education began 04/23/13 with no staff working after 04/23/13 without having received this education. The education was</p>	F 282			

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F 282	<p>Continued From page 13 provided by the DON and ADON.</p> <p>*An ad hoc Quality Assurance Committee was convened on 04/23/14 to review the survey concerns related to supervision and the documentation of decreased supervision. In attendance was the Administrator, DON, ADON, Social Service Director, MDS Nurse, Activity Director and Dietary Services Manager. The Medical Director attended by conference. The above was reviewed with no further recommendations noted.</p> <p>*The facility will convene a Quality Assurance Committee weekly until substantial compliance to review all changes in supervision as well as any elopement attempts to assure that the interventions are carried out as care planned and that any decreases in supervision are reviewed by the IDT.</p> <p>The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>A record review of sampled resident revealed the residents were reviewed on 04/23/13 by the IDT team to determine if the current level of supervision was adequate and the care plan and assignment sheet showed the increased level of supervision. Interviews with the IDT team (Administrator, DON, ADON, Activity Director, Director of Rehabilitation, MDS Nurse, Social Service and Dietary Manager) on 04/24/13 at 3:05 PM, 3:40 PM, 3:45 PM, 3:50 PM, 4:00 PM, 4:05 PM, 4:10 PM, and 4:20 PM respectively, revealed they reviewed all residents' behaviors, falls, medical condition, elopement risk cognition and safety awareness to determine if they had the</p>	F 282			

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F 282	Continued From page 14 appropriate level of supervision and the care plans and assignment sheets reflected the appropriate level of increased supervision, if needed. In addition, the IDT team was re-educated on the process of reviewing to see if a resident was appropriate for decreased supervision by the Regional Nurse Consultant. Further interview with the DON revealed he was responsible for ensuring the increased level of supervision was noted on the resident's care plan and reviewing the increased supervision flow sheets to ensure staff were completing them. The DON revealed he was also responsible for ensuring the flow sheet were taken to Medical Records so the sheets could be place the the resident's overflow record. Further interviews with the Administrator, DON, Activity Director, Social Service Director and Activity Director and Dietary Service Manager revealed an Ad Hoc meeting was conducted on 04/23/13 with the Medical Director on conference call related to the concerns about supervision. No further recommendations were identified. Further interview revealed the Quality Assurance Committee would meet weekly to review all changes in supervision and if any elopement attempts were made by any residents. The IDT revealed their job during these meetings would be to ensure interventions were carried out and all increased supervision was reviewed by the IDT. The team revealed they would also be reviewing to ensure incidents of increased supervision was placed on the resident's care plan, on the assignment sheet and Supervision Flow Sheet were initiated. The Administrator revealed she received the same education and would be responsible to ensure the facility staff were following the facility's policy and procedures	F 282			

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F 282	Continued From page 15 related to supervision. In addition, she stated she would be responsible for ensuring the daily Assignment Sheets included any residents on increased supervision and she would be supervising the weekly Quality Assurance Meetings to ensure the plan developed and initiated to correct the deficient practice is effective. Interviews with Registered Nurse (RN) #1 and LPN #6, on 04/24/13 at 4:50 PM and 4:55 PM respectively, revealed they were re-educated by the DON related to the fact they could place a resident on increased supervision if warranted but they must notify the DON. In addition, they can recommend a decrease in supervision but IDT makes the final decision that the decreased supervision is warranted. Interviews with RN #1, LPN #6, CNA #2, CNA #7 and CNA #8 on 04/24/13 at 4:35 PM, 4:40 PM, 4:42 PM, 4:48 PM, 4:50 PM, revealed they received education from the DON and ADON related to all increased supervision will be placed on the assignment sheet.	F 282	Compliance Date: <u>5-28-2013</u>		
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.	F 323	F323 1. Resident # 1 was placed on one to one supervision on 4-13-2013 until discharge from the facility on 4-18-2013. 2. An audit of all current residents was conducted on April 23, 2013 by the Interdisciplinary Team (IDT) to ensure that the level of supervision is appropriate to the needs of the resident based on medical condition, behaviors, falls, elopement risk, safety awareness and cognitive status and to assure this identified supervision was in place for each resident. Any changes to supervision needs identified during this audit would be identified on the care plan. No residents were felt to have a need for increased supervision. The Interdisciplinary Team consisted of the Director of Nursing, Assistant Director of Nursing, MDS Nurse, Social Services Director, Life Enrichment Director, Dietary Services Manager and the Director of Rehabilitation. An environmental audit was conducted by the Administrator, Maintenance Director and Housekeeping Supervisor on 5-24-2013 to identify any concerns with environmental safety issues, any concerns were immediately corrected. 3. All licensed staff were re-educated on the following: <ul style="list-style-type: none">Licensed staff may increase supervision as per their licensed scope of practice based upon the clinical assessment of the nurse at the time. This increase in		

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F 323	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review and facility policy and procedure review, it was determined the facility failed to have an effective system to ensure supervision to prevent accidents was provided for one resident (Resident #1), in the selected sample of five. (Refer to F282)</p> <p>Resident #1 was re-admitted to the facility on 09/24/12 with diagnoses to include Dementia with Behavior, Alzheimer's Disease, and Anxiety State. The facility assessed Resident #1 at risk for elopement and implemented a plan of care for elopement initiating the wander guard/care alert device. Resident #1 attempted to exit the building on 02/10/13, 03/09/13 and 03/27/13 by holding the door lever handle down for fifteen (15) seconds so the door lock would release. On 03/28/13, the facility determined Resident #1 needed a more secure environment due to the resident's increased incidents of trying to leave the facility and made a referral to a facility that had a locked unit. The resident was placed on fifteen (15) minute checks after the episode on 03/27/13; however, there was no documented evidence the fifteen (15) minutes checks were completed on a regular basis. Record review and staff interviews revealed the fifteen (15) minute checks were discontinued sometime between 03/27/13 and 04/13/13, however, no new interventions related to supervision were implemented for Resident #1. On 04/13/13, Resident #1 exited the building at approximately 3:05 PM. Unsampled Resident #A stated he/she heard the Hall II exit door alarm sounding and went to the door because there was not staff on the hall. Resident A punched in the code which</p>	F 323	<p>supervision may include but is not limited to specific timed checks, fifteen (15) minute checks, thirty (30) minute checks hourly checks or up to and including one to one supervision. The nurse will notify the Director of Nursing when they have increased supervision. Examples of reasons to increase supervision were given to include elopement attempts, increase elopement risk, increased risk of falls, at risk behaviors or suicidal ideations, not to supersede the nurses judgment.</p> <ul style="list-style-type: none"> Licensed staff may recommend decreasing supervision to the Director of Nursing for IDT review prior to changes being made. Licensed staff can not implement decreasing supervision prior to the review of the Director of Nursing and the IDT. The above education to the Licensed Staff was completed by the Director of Nursing or the Assistant Director of Nursing and completed by 4-23-2013 with no licensed staff working past 4-23-2013 without having received this education. Any new licensed staff will be educated during their general orientation prior to assigned work duties. <p>The facility will list all residents who require increased supervision on the staff assignment sheets as well as the resident care plan to enhance</p>	

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F 323	<p>Continued From page 17</p> <p>stopped the alarm and then exited the building but did not see Resident #1 outside. Interviews revealed the door alarm sounded and a Certified Nurse Aide (CNA) responded; however, the CNA went out the door and observed only one side of the building. The CNA re-entered the building and made other staff aware Resident #1 was missing and the staff searched the inside of the building before notifying the Charge Nurse Resident #1 was missing. When the staff was unable to find the resident in the building, staff exited the building and began to search the facility's perimeter. Resident #1 was found by staff at approximately 3:16 PM approximately one-tenth (0.1) of a mile from the facility. The resident had walked across a two-lane highway and was walking in the grass along another two lane highway with high traffic. The speed limit of both highways was 35 miles per hour. Interviews revealed staff had to obtain a wheelchair to bring the resident back to the building because the resident was tired and weak. The resident was assessed with no injuries. Resident #1 was transferred to another facility on 04/18/13.</p> <p>The facility's failure to have an effective system in place to provide supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/24/13 and was determined to exist on 04/13/13. The facility was notified of the Immediate Jeopardy on 04/24/13. An acceptable Allegation of Compliance (AoC) was received on 04/25/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 04/24/13, as alleged. The scope and severity was lowered to a "D" while the facility develops and implements the</p>	F 323	<p>communication of supervision needs. The facility provided education to all nursing staff that increased supervision needs will be noted on the staff assignment sheets as well as the resident's care plan. This education was provided by the Administrator, Director of Nursing or Assistant Director of Nursing with no nursing staff working past 4-23-2013 without having received this education. Any new nursing staff will be educated during general orientation prior to the start of assigned work duties.</p> <p>The IDT team was also re-educated by the Regional Nurse Consultant on 4-23-2013 related to the IDT review process prior to decreasing supervision for the resident, as well as items to consider prior to decreasing supervision to include but not limited to current behaviors, medications, patterns or trends, medical needs and activity needs.</p> <p>Review for the reduction of supervision will be documented on the Supervision worksheet and will be submitted to the Quality Assurance Committee weekly.</p> <p>All nursing staff were re-educated on following the care plan. If staff are unable to follow the care plan, they will report to the Licensed Nurse who will then report to the Director of Nursing. This education was completed on May 9, 2013, with no</p>		

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F 323	<p>Continued From page 18</p> <p>Plan of Correction (PoC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>A review of the facility's Missing Resident/Elopement policy and procedure, no date, revealed when staff identify a resident is missing staff should obtain assistance from other staff members in the immediate vicinity, instruct another staff member to make the Charge Nurse aware and conduct a thorough search of the building and premises.</p> <p>A review of the facility's Resident Elopement Policy, no date, revealed all residents should be assessed quarterly by the Social Services Director for potential for elopement. This should be completed using the AHT elopement risk assessment. A resident who is assessed as a potential risk will be assessed for the need of wander guard placement. Any residents with elopement attempts should be reassessed immediately for the need of further intervention to prevent elopement.</p> <p>A record review revealed Resident #1 was re-admitted to the facility on 09/24/12 with diagnoses to include Dementia with Behavior, Alzheimer's Disease, and Anxiety State. A review of the Admission Assessment, dated 09/24/13, revealed the facility assessed Resident #1 at risk for elopement because the resident was cognitively impaired and had a history of wandering or pacing while trying to open doors, windows and/or gates. The assessment stated an elopement care plan should be initiated and</p>	F 323	<p>staff working past May 9, 2013 without this education. This re-education was conducted by the Director of Nursing, Assistant Director of Nursing and Administrator. Any new nursing staff will be educated during general orientation prior to start of assigned work duties.</p> <p>All Facility staff has been trained on the elopement procedure to include the process to check doors and search surrounding areas when alarms sound on April 23, 2013, with no staff working past April 23, 2013 without this education. All three (3) shifts and the weekend shift have been trained and are knowledgeable on the facility's elopement plan on April 23, 2013, with no staff working past April 23, 2013 without this education. This re-education was completed by the Administrator, Director of Nursing and Assistant Director of Nursing. Any new staff will be educated during general orientation prior to start of assigned work duties</p> <p>The Administrator completed education with the Maintenance Supervisor and Housekeeping Supervisor on how to conduct environmental safety rounds with examples to include those noted in F323 Guidelines to Surveyors, this was completed on 5-23-2013.</p> <p>4. An ad hoc Quality Assurance Committee was convened on 4-23-2013 to review the survey concerns</p>		

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F 323	<p>Continued From page 19</p> <p>reflect interventions appropriate to the resident which may include the use of the wander guard anklet.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 10/11/12 revealed the facility assessed Resident #1's cognition as moderately impaired, required the extensive assistance of two staff for ambulation, and had behaviors of wandering.</p> <p>A review of the Elopement Plan of Care, Assessment, Prevention and Management, last reviewed and revised 12/10/12, revealed interventions for staff to initiate the wander alert system, photograph resident and document description, allow for safe wandering, offer redirection, and offer snack when wanders.</p> <p>Observation of the Elopement Book at the nursing station revealed there was a page with a picture of Resident #1 and identifying descriptive information of the resident.</p> <p>A review of the February, March and April 2013 Treatment Records, revealed Resident #1's wander guard was in place and functioning.</p> <p>A review of a SBAR report (Physician/Nurse Practitioner/Physician Assistant Communication and Progress Note for New Symptoms, Signs and Other Changes in Condition), dated 02/10/13 at 10:45 AM, revealed Resident #1 attempted to exit the building at the back Hall II door. The resident was placed on fifteen (15) minute checks. A review of Morning Meeting Minutes revealed the 15 minute checks were discontinued on 02/21/13, however, a review of the resident's record</p>	F 323	<p>related to supervision and documentation of decreased supervision as well as the facility plan of correction. In attendance were the Administrator, Director of Nursing, Assistant Director of Nursing, Social Service Director, MDS Nurse, Activity Director and Dietary Services Manager. The Medical Director attended by conference. No further recommendations were noted.</p> <p>The Director of Nursing or Assistant Director of Nursing is responsible for monitoring to ensure the effectiveness of actions taken. The Director of Nursing or Assistant Director of Nursing will review supervision flow sheets(documentation for the actual timed checks of the resident by the staff) for accuracy and completion to include staff documentation of the care planed increased supervision five (5) times per week until substantial compliance is achieved and then weekly for twelve (12) weeks. In addition the Director of Nursing or Assistant Director of Nursing will make observations of residents assigned increased supervision five (5) times per week for twelve weeks to assure increased supervision is occurring per the resident's plan of care.</p> <p>The Administrator is responsible for effectiveness of training and implementation of identification of supervision on the staffing assignment sheets and will review daily staffing</p>		

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F 323	<p>Continued From page 20</p> <p>revealed there was no documented evidence the 15 minute checks were conducted or discontinued.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 04/22/13 at 1:35 PM, revealed she was on Hall II on 02/10/13 and heard the back door alarm sounding. LPN #1 stated she went to the back door and saw Resident #1 had the lever handle of the door pressed down and then walked out the door. The LPN revealed she was able to go out the door and assist the resident back into the building. LPN #1 stated she placed the resident on 15 minute checks but she did not know how long the resident stayed on the 15 minute checks. LPN #1 stated Nurses could place the residents on increased supervision (15 minute, 30 minute, one hour, or other), but it was up to the Interdisciplinary Team (IDT) to discontinue the increased supervision. The nurse stated she recalled Resident #1 being on 15 minute observations but did not remember how often or how long the resident was on the increased supervision. LPN #1 stated the staff was made aware when a resident was on increased supervision during change of shift report.</p> <p>A review of the At Risk for Elopement Care Plan, dated 03/01/13, revealed interventions to monitor for behaviors of packing belongings, verbalization of leaving and attempts to leave facility, place wander guard on resident and check daily for placement, reassess for elopement risk as needed and with all OBRA assessments. A review of the annual MDS assessment, dated 03/11/13, revealed the facility assessed Resident #1 as severely cognitively impaired, requiring the assistance of one staff for ambulation and had</p>	F 323	<p>assignment sheets to assure that supervision needs are identified on the assignment sheets. This will occur daily until substantial compliance is achieved and then weekly for twelve (12) weeks.</p> <p>Elopement drills are conducted on each shift weekly for four (4) weeks by the Administrator, Director of Nursing or Assistant Director of Nursing. This will be followed by weekly for eight (8) weeks. The Administrator is responsible to assure these drills occur and are effective.</p> <p>Supervision revision worksheets are reviewed by the Quality Assurance Committee weekly until substantial compliance is achieved and then monthly thereafter. Supervision revision worksheets are a form documenting the Interdisciplinary Teams review of the resident whose supervision requirements are being lowered, as well as the resident's condition that required increased supervision and the interventions that were implemented to justify a reduction of supervision. The form is completed by the Interdisciplinary Team. The Administrator is responsible to assure that this occurs. The Administrator, Maintenance Director and Housekeeping Supervisor will complete weekly safety rounds using a safety round check sheet to identify and environmental hazards, results of these audits will be reviewed with the safety committee and QA on a monthly basis ongoing.</p>		

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F 323	<p>Continued From page 21</p> <p>behaviors of wandering four to six days but not every day.</p> <p>A review of the Nurse's Note, dated 03/09/13 at 8:00 PM, revealed Resident #1 was observed opening the back door of Hall II and stepping out through the doorway. The resident was easily redirected back into the facility and placed on 15 minute checks. A review of the Morning Meeting Minutes revealed the 15 minute checks were discontinued on 03/12/13; however a review of the resident's record revealed there was no evidence the 15 minute checks were conducted after 03/10/13 or discontinued.</p> <p>An interview with LPN #4, on 04/23/13 at 9:40 AM, revealed she was passing medications on 03/09/13 when she heard the alarm on the back door to Hall II sounding. She stated she locked the medication cart and went to the back door and when she arrived, Resident #1 was walking through the door to the outside. The LPN revealed she grabbed the back of the resident's shirt and was able to assist the resident back into the building. She stated she placed the resident on 15 minute checks but was not aware of how long the resident stayed on the 15 minute checks. LPN #4 stated Nurses could place the residents on increased supervision, but it was up to the IDT to discontinue the increased supervision. She stated the residents usually stay on 15 minute checks for approximately 72 hours. LPN #4 revealed the nurse made staff aware of when a resident was on increased supervision during the change of shift report.</p> <p>A review of a Social Worker Note, dated 03/27/13, revealed Resident #1 went out the back</p>	F 323	<p>If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will meet weekly until substantial compliance is achieved and then monthly thereafter. The Quality Assurance Committee will consist of at a minimum the Administrator, Director of Nursing, Assistant Director of Nursing and the Social Service Director with the Medical Director attending at least monthly and as needed.</p>		

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F 323	<p>Continued From page 22</p> <p>door causing the door alarm to sound while in visual eye sight of a Nurse. The resident was escorted back in the building and placed on 15 minute checks. Further review of the At Risk for Elopement Care Plan, dated 03/01/13, revealed an intervention was added on 03/27/13 for increased observation; however review of the record revealed there was no evidence any increased observation was conducted and/or discontinued.</p> <p>A review of a Referral and Pre-Admission Screening form, dated 03/28/13, revealed the facility was trying to find placement at a facility with a locked ward due to Resident #1's wandering behavior and attempts of elopement.</p> <p>Interview with the Social Worker, on 04/22/13 at 1:55 PM, revealed she and three other staff exited the morning meeting and exited out the back door of Hall II on 03/27/13. She stated they walked to the pavilion at the back of Hall I, and the Hall I door alarm was sounding. The Social Worker revealed she saw Resident #1 coming out the back door of Hall I with a Nurse several steps behind him/her. She stated the Nurse redirected the resident back into the building and placed the resident on 15 minute checks. She stated she thought the resident remained on 15 minutes checks for approximately 12 hours but was not sure. Further interview revealed the facility determined on 03/28/13, Resident #1 needed a more secure environment due to the resident's increased incidents of exit seeking behaviors so the Social Worker talked to the resident's guardian and made a referral to a facility that had a locked unit. She stated the locked unit facility agreed to take the resident on</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>04/13/13, however, the facility called and stated due to some issues at their building they would not be able to admit the resident until 04/18/13. The Social Worker stated Resident #1 had been on increased supervision in the past but she did not remember when or for how long.</p> <p>A review of a SABR report, dated 04/13/13 at 3:15 PM, revealed Resident #1 eloped from the facility unwitnessed. A Code Wanda was called and the resident was located at 3:20 PM outside of the facility and was assessed with no injuries identified. The resident arrived at the facility at 3:30 PM and was placed on 1:1. The Assistant Director of Nursing (ADON) and Administrator were notified.</p> <p>Interview with CNA #4, on 04/24/13 at 2:10 PM, revealed Resident #1 was wearing a pair of jeans, a blue short sleeve shirt and white sneakers on 04/13/13 when the resident was found. A review of a website for the weather history of the area of the nursing facility revealed on 04/13/13 at 2:55 PM it was 61.2 degrees Fahrenheit with variable wind at 3.5 miles per hour and no precipitation.</p> <p>Interview with unsampled Resident A, on 04/23/13 at 8:30 AM, revealed the Resident A was in his/her room at the back of Hall II when he/she heard the Hall II back door alarm sounding. Resident A went to the back door and punched in the code which stopped the alarm from sounding. Resident A exited the building and walked across the back of the building past the back of Hall I and looked in the parking lot along the side of the building and did not see anyone. Resident A stated he/she came back to</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>the back of Hall II and sat outside in the wheelchair. The resident revealed a staff member came out of Hall II exit door and asked if he/she had seen Resident #1. Resident A stated he/she told the staff that if Resident #1 was outside, Resident #1 must have went up the hill and around the other side of the building where there was no parking lot. Resident A stated he/she told the Administrator that he/she went to the door to look for Resident #1 when the door alarm sounded because there was no staff on the hall.</p> <p>Interview with CNA #1 and CNA #4, on 04/22/13 at 2:15 PM and 2:38 PM respectively, revealed Resident #1 was wandering up and down the hallway on 04/13/13 and CNA #1 walked the resident up to the lobby and sat the resident on the couch. CNA #1 stated she then went to another resident's room to toilet him/her. CNA #1 revealed CNA #4 entered the room to provide care to the roommate when they heard the Hall II back door alarm sounding. CNA #4 stated she went to the back door of Hall II but the alarm was no longer sounding. CNA #4 stated she saw unsampled Resident A sitting outside the door so she opened the door and asked Resident A if he/she had seen anyone come outside of the building and Resident A said no. CNA #4 stated she walked across the back of the building and up the side parking lot to the side door of Hall I and did not see anyone. CNA #4 stated she did not go out to the road or look up the road and did not go up the hill at the back of the building so she could observe the other side of the building. CNA #4 stated she reentered the building through the Hall I side door. CNA #4 told CNA #1 she had not seen Resident #1 outside. CNA #1 and</p>	F 323			

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F 323	<p>Continued From page 25</p> <p>CNA #4 checked the residents' rooms and bathrooms and asked staff if they had seen Resident #1 as they went up Hall II. The CNAs stated they exited the back door of Hall II and re-entered the building through the back door of Hall I. CNA #1 and CNA #4 said they checked the rooms and bathrooms on Hall I. CNA #1 stated LPN #2 was at the medication cart and the CNA told her Resident #1 was missing. CNA #1 went back outside and Resident A was still sitting at the back of Hall II. Resident #A told the CNA if Resident #1 came out there, Resident #1 must have walked up the hill and went around the other way. CNA #1 revealed she and some other staff walked up the hill and around the other side of the building which leads to the side road. CNA #1 stated they saw Resident #1 down the road in front of a store on the side of the highway in the grass with CNA #3 holding his/her hand. Meanwhile, CNA #4 had walked back out the side door of Hall I and walked from the side door to the front door of the building. CNA #4 revealed she entered the front door and CNA #3 immediately stuck her head in the front door and stated the resident was down the street. CNA #4 stated the resident was down the road in front of the store in the grassy area by the road. CNA #1 and CNA #4 said the resident was missing approximately 10-15 minutes. CNA #1 and CNA #4 revealed they were not told that Resident #1 was on 15 minute checks. The CNAs stated the Nurses made them aware if a resident was on increased supervision and this was not reported in change of shift report.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 04/22/13 at 1:10 PM, revealed she was at the medication cart on Hall I when CNA #1 and CNA</p>	F 323		

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F 323	<p>Continued From page 26</p> <p>#4 entered the back door of Hall I. The LPN stated CNA #4 stated she thought the LPN needed to call a Code Wanda because they could not find Resident #1. She stated she attempted to call the code from the phone at the back of Hall I, but the phone would not work, so she walked to the Nurse's desk at the front of the hall and the weekend Supervisor called the Code Wanda. She revealed the Nurse called a Code Wanda when a door alarm sounds and staff cannot identify the cause or staff suspect a resident is missing. When the code is called staff are to complete a head count and if they determine a resident is missing they immediately began a search of the inside and perimeter of the building. The LPN stated the staff immediately conducted a head count and began searching for the resident inside and outside of the building. She stated staff found the resident walking down the side of the highway in front of a store "three (3) minutes or so later". LPN #2 revealed she was not aware Resident #1 was supposed to be on 15 minute checks prior to the elopement.</p> <p>Interview with LPN #1, on 04/22/13 at 1:35 PM, revealed she was in another resident's room on Hall II when two Nurses and a CNA asked her if she had seen Resident #1. The LPN stated she and CNA #1 walked out the back Hall II door and spoke to unsampled Resident A who was sitting outside the door. She stated Resident A stated if Resident #1 had come outside, the resident must have went up the hill and around the other side of the building. The LPN revealed her and the other staff went up the hill at the back of the building which goes around and comes out on a side road. She revealed they saw Resident #1 in front of a store standing in the grass at the side of the</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>road holding the hand of another staff. They ran to the staff and resident to assist. LPN #1 stated Resident #1 was exhausted but was not injured. The LPN stated staff brought a wheelchair from the facility and assisted the resident back to the facility. The resident was placed on 1:1 supervision. LPN #1 revealed she was not informed Resident #1 was supposed to be on 15 minute checks during shift report that day. The LPN stated staff report to the next shift during shift report any residents on increased supervision.</p> <p>Interview with CNA #5 and CNA #6, on 04/22/13 at 2:50 PM and 3:00 PM respectively, revealed they were talking to each other on Hall I on 04/13/13 when CNA #1 and CNA #4 entered the back door of Hall I. The CNAs stated CNA #1 and CNA #4 had told them the back door alarm of Hall II had sounded, and they were unable to find Resident #1. CNA #4 and #6 revealed they had not heard the door alarm sound. The Nurse called a Code Wanda and staff began searching for the resident. The resident was found out in front of a store. CNA #5 and CNA #6 stated they were not told in shift report that Resident #1 was on 15 minute checks.</p> <p>Interview with the Assistant Director of Nursing (ADON) 04/23/13 at 11:10 AM, revealed it was the Nurse's judgement to place a resident on increased supervision. The ADON stated staff used the Supervision Flow Sheets to document a resident was on the increased supervision. The ADON revealed she was not aware of Resident #1 being on increased supervision at the time of the elopement.</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>Interview with the Director of Nursing (DON), on 04/23/13 at 11:20 AM, revealed it was the Nurse's judgement whether to place a resident on increased supervision or not. The staff use the Supervision Flow Sheets to document the monitoring of the resident on increased supervision. The nurse should update the care plan when a resident is placed on increased supervision. The DON stated Licensed staff and CNAs were made aware a resident was on increased supervision through shift report. The Interdisciplinary Team conducts a morning meeting every day and discusses any residents on increased supervision and decides if the resident needs to continue on increased supervision or not. The DON revealed when a resident attempts to exit the facility the Interdisciplinary Team tries to determine the the cause of the resident attempting to leave. The DON stated if the IDT team determined the resident should be discontinued from increased supervision, the IDT team should update the care plan and make the Nurse on duty aware. The DON stated the Resident #1 should have remained on increased supervision (15 minute checks) from the time the resident was placed on 15 minute checks after the 03/27/13 incident until the time of the elopement on 04/13/13. The DON revealed he was unable to find the Supervision Flow Sheets or any other evidence that verified Resident #1 was monitored while on 15 minute checks after the 02/10/13, 03/09/13, and 03/27/13 incidents of exit seeking behavior.</p> <p>Interview with the Administrator, on 04/23/13 at 12:10 PM, revealed Resident #1 was placed on 15 minute checks on 03/27/13 and the 15 minute checks were never discontinued .</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>Interviews with members of the IDT (MDS Nurse, Life Enrichment Director, Dietary Service Manager, Director of Rehabilitation and Social Services Director) on 03/24/13 at 2:45 PM, 2:55 PM, 3:00 PM and 3:05 PM respectively, revealed they could not recall if Resident #1 was taken off increased observation or not.</p> <p>Observation of the area between the facility and the front of the store where Resident #1 was found revealed the area was approximately 0.1 mile from the facility. The resident had to cross a two lane highway with a speed limit of 35 miles per hour (mph) and was found walking down the side of another high traffic two lane highway with a speed limit of 35 mph.</p> <p>A review of the Supervision Flow Sheets, dated 04/13/13-04/18/13 revealed Resident #1 remained on 1:1 until he/she was transferred to a facility with a locked ward on 04/18/13.</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>*All current residents of the facility were reviewed by the IDT on 04/23/13, the IDT consisting of the DON, ADON, Minimum Data Set (MDS) Nurse, Social Services Director, Life Enrichment Director, Dietary Service Manager and Director of Rehabilitation. The IDT reviewed all residents to determine if the current level of supervision was adequate to meet the needs of the resident based on medical condition, behaviors, falls, elopement risk, safety awareness and cognition status. If increased supervision was warranted it was</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>reflected on the resident's care plan. No residents were felt to have a need for increased supervision not already reflected on the care plan.</p> <p>* The IDT to include the Administrator was reeducated by the Regional Nurse Consultant related to the process of IDT review prior to decreasing supervision for the resident, as well as things to consider prior to decreasing the supervision to include but not limit to current behaviors, medications, patterns or trends, medical needs and activity needs. This education was provided on 04/23/13. Any supervision changes will be noted on the resident's plan of care. The DON will be responsible for ensuring this is completed. the Supervision Flow Sheet will be utilized to document increased supervision. This form will be reviewed by the DON and then given to Medical Records for storage. This education was provided on 04/23/13.</p> <p>*All licensed Nurses were re-educated on the following: licensed staff may increase supervision using their nursing judgement and should notify the DON when they have increased supervision. Licensed staff may recommend decreasing supervision to the DON for IDT review prior to changes being made.</p> <p>*The facility also provided re-education to all nursing staff that increased supervision will be noted on the staff assignment sheets. The Administrator is responsible to ensure this is completed. This education began 04/23/13 with no staff working after 04/23/13 without having received this education. The education was provided by the DON and ADON.</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>*An ad hoc Quality Assurance Committee was convened on 04/23/14 to review the survey concerns related to supervision and the documentation of decreased supervision. In attendance was the Administrator, DON, ADON, Social Service Director, MDS Nurse, Activity Director and Dietary Services Manager. The Medical Director attended by conference. The above was reviewed with no further recommendations noted.</p> <p>*The facility will convene a Quality Assurance Committee weekly until substantial compliance to review all changes in supervision as well as any elopement attempts to assure that the interventions are carried out as care planned and that any decreases in supervision are reviewed by the IDT.</p> <p>The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>A record review of sampled resident revealed the residents were reviewed on 04/23/13 by the IDT team to determine if the current level of supervision was adequate and the care plan and assignment sheet showed the increased level of supervision. Interviews with the IDT team (Administrator, DON, ADON, Activity Director, Director of Rehabilitation, MDS Nurse, Social Service and Dietary Manager) on 04/24/13 at 3:05 PM, 3:40 PM, 3:45 PM, 3:50 PM, 4:00 PM, 4:05 PM, 4:10 PM, and 4:20 PM respectively, revealed they reviewed all residents' behaviors, falls, medical condition, elopement risk cognition and safety awareness to determine if they had the appropriate level of supervision and the care plans and assignment sheets reflected the</p>	F 323			

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F 323	Continued From page 32 appropriate level of increased supervision, if needed. In addition, the IDT team was re-educated on the process of reviewing to see if a resident was appropriate for decreased supervision by the Regional Nurse Consultant. Further interview with the DON revealed he was responsible for ensuring the increased level of supervision was noted on the resident's care plan and reviewing the increased supervision flow sheets to ensure staff were completing them. The DON revealed he was also responsible for ensuring the flow sheet were taken to Medical Records so the sheets could be place the the resident's overflow record. Further interviews with the Administrator, DON, Activity Director, Social Service Director and Activity Director and Dietary Service Manager revealed an Ad Hoc meeting was conducted on 04/23/13 with the Medical Director on conference call related to the concerns about supervision. No further recommendations were identified. Further interview revealed the Quality Assurance Committee would meet weekly to review all changes in supervision and if any elopement attempts were made by any residents. The IDT revealed their job during these meetings would be to ensure interventions were carried out and all increased supervision was reviewed by the IDT. The team revealed they would also be reviewing to ensure incidents of increased supervision was placed on the resident's care plan, on the assignment sheet and Supervision Flow Sheet were initiated. The Administrator revealed she received the same education and would be responsible to ensure the facility staff were following the facility's policy and procedures related to supervision. In addition, she stated she would be responsible for ensuring the daily	F 323			

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F 323	Continued From page 33 Assignment Sheets included any residents on increased supervision and she would be supervising the weekly Quality Assurance Meetings to ensure the plan developed and initiated to correct the deficient practice is effective. Interviews with Registered Nurse (RN) #1 and LPN #6, on 04/24/13 at 4:50 PM and 4:55 PM respectively, revealed they were re-educated by the DON related to the fact they could place a resident on increased supervision if warranted but they must notify the DON. In addition, they can recommend a decrease in supervision but IDT makes the final decision that the decreased supervision is warranted.	F 323	Compliance Date: <u>5-28-2013</u>		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy	F 490	F490 1. Resident # 1 was placed on one to one supervision on 4-13-2013 and was discharged from the facility on 4-18-2013. 2. A review by the Regional Director of Operations on May 8, 2013, noted that the Administrator was assuring the policies and procedures were implemented and that the residents were provided with the appropriate identified level of supervision. The review included a review of the facility's plan of correction as well as audits, the Quality Assurance process, staff assignments including those residents on increased supervision. Documentation related to supervision and observation of the Administrator's overall oversight of the facility		

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F 490	<p>Continued From page 34</p> <p>and procedure review, and the Administrator's job description it was determined the facility failed to be administered in a manner which enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident (#1), in the selected sample of five residents. The Administrator failed to ensure policies and procedures were implemented to provide adequate supervision for Resident #1. (Refer to F282 and F323).</p> <p>Resident #1 was re-admitted to the facility on 09/24/12 with diagnoses to include Dementia with Behavior, Alzheimer Disease, and Anxiety State. The facility assessed Resident #1 at risk for elopement and implemented a plan of care for elopement initiating the wander guard/care alert device. Resident #1 attempted to exit the building on 02/10/13, 03/09/13 and 03/27/13 by holding the door lever handle down for fifteen (15) seconds so the door lock would release. On 03/28/13, the facility determined Resident #1 needed a more secure environment due to the resident's increased incidents of trying to leave the facility and made a referral to a facility that had a locked unit. The resident was placed on fifteen (15) minute checks after the episode on 03/27/13; however, there was no documented evidence the fifteen (15) minutes checks were completed on a regular basis. Staff interviews revealed the fifteen (15) minute checks were either discontinued sometime between 03/27/13 and 04/13/13 or should have continued and were not being completed. On 04/13/13, Resident #1 exited the building at approximately 3:05 PM. Interviews revealed the door alarm sounded and a Certified Nurse Aide (CNA) responded;</p>	F 490	<p>functions, supervision and process implementation including review of facilities effectiveness and efficiency.</p> <p>3. The Administrator was re-educated by the Regional Director of Operations on May 2, 2013, related to adherence to State and Federal Regulations, investigative processes related to abuse, neglect, elopement attempts, overall oversight of systems and implementation, and supervision and accountability of Department Heads.</p> <p>4. The Regional Director of Operations is responsible for monitoring to ensure the effectiveness of the actions taken and will review the facility plan of correction and the results of all investigations of Abuse and Neglect as well as the facility's Quality Assurance program monthly for three (3) months to assure the facility is adhering to policy and procedures and being administered in a manner which enables it to use it's resources effectively and efficiently to attain or maintain the highest residents practicable physical, mental and psychosocial well-being. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) and quarterly for three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of</p>		

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F 490	<p>Continued From page 35</p> <p>however, the CNA went out the door and observed only one side of the building. The CNA re-entered the building and made other staff aware Resident #1 was missing and the staff searched the inside of the building before notifying the Charge Nurse Resident #1 was missing. When the staff was unable to find the resident in the building, staff exited the building and began to search the facility's perimeter. Resident #1 was found by staff at approximately 3:16 PM approximately one-tenth (0.1) of a mile from the facility. The resident had walked across a two-lane highway and was walking in the grass along another two lane highway with high traffic. The speed limit of both highways was 35 miles per hour. Interviews revealed staff had to obtain a wheelchair to bring the resident back to the building because the resident was tired and weak. The resident was assessed with no injuries.</p> <p>The facility's failure to administer the facility effectively and efficiently to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 04/24/13 and was determined to exist on 04/13/13. The facility was notified of the Immediate Jeopardy on 04/24/13. An acceptable Allegation of Compliance (AoC) was received on 04/25/13 and the State Survey Agency validated the Immediate Jeopardy was removed on 04/24/13, as alleged. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC) and the facility's Quality Assurance monitors the effectiveness of the systemic</p>	F 490	<p>at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p>		

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F 490	<p>Continued From page 36 changes.</p> <p>The findings include:</p> <p>A review of the Administrator's job description, no date, revealed the purpose of the Administrator was to direct the day to day functions of the facility in accordance with current federal, state, and local standard, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided residents at all times. Essential Functions of the position were to ensure excellent care for residents was maintained by overseeing and monitoring patient care services delivered and to direct committees and meetings per company policies.</p> <p>A review of the facility's Missing Resident/Elopement policy and procedure, no date, revealed when staff identify a resident is missing staff should obtain assistance from other staff members in the immediate vicinity, instruct another staff member to make the Charge Nurse aware and conduct a thorough search of the building and premises.</p> <p>A review of the facility's Guidelines for Resident Comprehensive Care Plan, dated 09/08, revealed the resident's comprehensive care plan should be viewed as an Interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility. The comprehensive care plan should always have realistic goals and interventions to address the residents' needs.</p> <p>The facility assessed Resident #1 at risk for elopement and implemented a plan of care for</p>	F 490		
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F 490	<p>Continued From page 37</p> <p>elopement initiating the wander guard/care alert device. Resident #1 attempted to exit the building on 02/10/13, 03/09/13 and 03/27/13, and on 03/28/13, the facility determined Resident #1 needed a more secure environment and made a referral to a facility that had a locked unit. The resident was placed on fifteen (15) minute checks after the episode on 03/27/13; however, there was no documented evidence the fifteen (15) minutes checks were completed on a regular basis. Staff interviews revealed the fifteen (15) minute checks were either discontinued sometime between 03/27/13 and 04/13/13 or should have continued and were not being done. Review of the At Risk for Elopement Care Plan, dated 03/01/13, revealed an intervention was added on 03/27/13 for increased observation; however review of the record revealed there was no evidence Supervision Flow Sheets were completed while the resident was on increased observation and no evidence the 15 minute checks were discontinued.</p> <p>On 04/13/13, Resident #1 exited the building at approximately 3:05 PM. Interviews revealed the door alarm sounded and a CNA responded; however, the CNA went out the door and observed only one side of the building. Staff searched the inside of the building before notifying the Charge Nurse Resident #1 was missing. Resident #1 was found by staff at approximately 3:16 PM approximately one-tenth (0.1) of a mile from the facility.</p> <p>Interview with the Administrator, on 04/23/13 at 12:10 PM, revealed Resident #1 was assessed and care planned as an elopement risk. Resident #1 was placed on increased supervision (15</p>	F 490			

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F 490	<p>Continued From page 38</p> <p>minute checks) on 03/27/13 after attempting to exit the building. The Administrator revealed as far as she was aware the resident should have been on 15 minutes checks at the time of the resident's elopement on 04/13/13. She stated staff were supposed to fill out the Supervision Flow Sheet while the resident was on increased supervision and the Interdisciplinary Team (IDT) was who determined if the increased supervision could be discontinued. The Administrator revealed when she conducted her investigation into the incident staff had told her they were conducting fifteen (15) checks on Resident #1 prior to him/her exiting the building. The Administrator stated she had determined staff had responded appropriately to the door alarm and thought the supervision forms were completed.</p> <p>However, interviews with CNA #1 and CNA #4 revealed they were not told that Resident #1 was on 15 minute checks and they were not conducting 15 minute checks on Resident #1 on 04/13/13. The CNAs stated the Nurses made them aware if a resident was on increased supervision and this was not reported in change of shift report. Interviews with Licensed Practical Nurse (LPN) #1 and LPN #2 revealed the LPNs were not aware Resident #1 was supposed to be on 15 minute checks on 04/13/13, prior to the elopement.</p> <p>Interview with the Assistant Director of Nursing (ADON) 04/23/13 at 11:10 AM, revealed she was not aware of Resident #1 being on increased supervision at the time of the elopement. Interview with the Director of Nursing (DON), on 04/23/13 at 11:20 AM, revealed he was unable to</p>	F 490		

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F 490	<p>Continued From page 39</p> <p>find the Supervision Flow Sheets or any other evidence that verified Resident #1 was monitored while on 15 minute checks after the 03/27/13 incident of exit seeking behavior.</p> <p>** The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>*All current residents of the facility were reviewed by the IDT on 04/23/13, the IDT consisting of the DON, ADON, Minimum Data Set (MDS) Nurse, Social Services Director, Life Enrichment Director, Dietary Service Manager and Director of Rehabilitation. The IDT reviewed all residents to determine if the current level of supervision was adequate to meet the needs of the resident based on medical condition, behaviors, falls, elopement risk, safety awareness and cognition status. If increased supervision was warranted it was reflected on the resident's care plan. No residents were felt to have a need for increased supervision not already reflected on the care plan.</p> <p>* The IDT was reeducated by the Regional Nurse Consultant related to the process of IDT review prior to decreasing supervision for the resident, as well as things to consider prior to decreasing the supervision to include but not limit to current behaviors, medications, patterns or trends, medical needs and activity needs. This education was provided on 04/23/13. Any supervision changes will be noted on the resident's plan of care. The DON will be responsible for ensuring this is completed. the Supervision Flow Sheet will be utilized to document increased supervision. This form will be reviewed by the DON and then given to Medical Records for storage. This education was provided on 04/23/13.</p>	F 490		
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42286		
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F 490	<p>Continued From page 40</p> <p>*All licensed Nurses were re-educated on the following: licensed staff may increase supervision using their nursing judgement and should notify the DON when they have increased supervision. Licensed staff may recommend decreasing supervision to the DON for IDT review prior to changes being made.</p> <p>*The facility also provided re-education to all nursing staff that increased supervision will be noted on the staff assignment sheets. The Administrator is responsible to ensure this is completed. This education began 04/23/13 with no staff working after 04/23/13 without having received this education. The education was provided by the DON and ADON.</p> <p>*An ad hoc Quality Assurance Committee was convened on 04/23/14 to review the survey concerns related to supervision and the documentation of decreased supervision. In attendance was the Administrator, DON, ADON, Social Service Director, MDS Nurse, Activity Director and Dietary Services Manager. The Medical Director attended by conference. The above was reviewed with no further recommendations noted.</p> <p>*The facility will convene a Quality Assurance Committee weekly until substantial compliance to review all changes in supervision as well as any elopement attempts to assure that the interventions are carried out as care planned and that any decreases in supervision are reviewed by the IDT.</p> <p>The State Survey Agency validated the corrective</p>	F 490			

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

PRINTED: 05/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/25/2013
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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 490	Continued From page 41 action taken by the facility as follows: A record review of sampled resident revealed the residents were reviewed on 04/23/13 by the IDT team to determine if the current level of supervision was adequate and the care plan and assignment sheet showed the increased level of supervision. Interviews with the IDT team (Administrator, DON, ADON, Activity Director, Director of Rehabilitation, MDS Nurse, Social Service and Dietary Manager) on 04/24/13 at 3:05 PM, 3:40 PM, 3:45 PM, 3:50 PM, 4:00 PM, 4:05 PM, 4:10 PM, and 4:20 PM respectively, revealed they reviewed all residents' behaviors, falls, medical condition, elopement risk cognition and safety awareness to determine if they had the appropriate level of supervision and the care plans and assignment sheets reflected the appropriate level of increased supervision, if needed. In addition, the IDT team was re-educated on the process of reviewing to see if a resident was appropriate for decreased supervision by the Regional Nurse Consultant. Further interview with the DON revealed he was responsible for ensuring the increased level of supervision was noted on the resident's care plan and reviewing the increased supervision flow sheets to ensure staff were completing them. The DON revealed he was also responsible for ensuring the flow sheet were taken to Medical Records so the sheets could be placed in the resident's overflow record. Further interviews with the Administrator, DON, Activity Director, Social Service Director and Activity Director and Dietary Service Manager revealed an Ad Hoc meeting was conducted on 04/23/13 with the Medical Director on conference call related to the concerns about supervision. No further	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 490	<p>Continued From page 42</p> <p>recommendations were identified. Further interview revealed the Quality Assurance Committee would meet weekly to review all changes in supervision and if any elopement attempts were made by any residents. The IDT revealed their job during these meetings would be to ensure interventions were carried out and all increased supervision was reviewed by the IDT. The team revealed they would also be reviewing to ensure incidents of increased supervision was placed on the resident's care plan, on the assignment sheet and Supervision Flow Sheet were initiated. The Administrator revealed she received the same education and would be responsible to ensure the facility staff were following the facility's policy and procedures related to supervision. In addition, she stated she would be responsible for ensuring the daily Assignment Sheets included any residents on increased supervision and she would be supervising the weekly Quality Assurance Meetings to ensure the plan developed and initiated to correct the deficient practice is effective.</p> <p>Interviews with Registered Nurse (RN) #1 and LPN #6, on 04/24/13 at 4:50 PM and 4:55 PM respectively, revealed they were re-educated by the DON related to the fact they could place a resident on increased supervision if warranted but they must notify the DON. In addition, they can recommend a decrease in supervision but IDT makes the final decision that the decreased supervision is warranted.</p> <p>Interviews with RN #1, LPN #6, CNA #2, CNA #7 and CNA #8 on 04/24/13 at 4:35 PM, 4:40 PM, 4:42 PM, 4:48 PM, 4:50 PM, revealed they</p>	F 490			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
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F 490	Continued From page 43 received education from the DON and ADON related to all increased supervision will be placed on the assignment sheet.	F 490	Compliance Date: 5-28-2013 _____		