

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

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

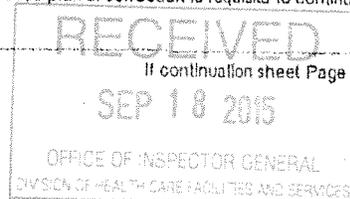
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/24/2015
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000	F-000 DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS ALLEGATION OF COMPLIANCE DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE ALLEGED DEFICIENCIES OR THE SCOPE AND SEVERITY. THE FACILITY IS COMPLETING THE POC BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY DISAGREES WITH AND DISPUTES THE DEFICIENCIES AS ALLEGED AND THE SCOPE AND SEVERITY AT WHICH THEY ARE CITED. FURTHER, THE FACILITY DISPUTES AND DISAGREES WITH THE ACCURACY OF STATEMENTS AND OTHER INFORMATION RELIED UPON IN SUPPORT OF THE ALLEGED DEFICIENCIES. THIS INCLUDES, BUT IS NOT LIMITED TO, THE ALLEGED CONTENT/SUMMARY OF INTERVIEWS, THE CHRONOLOGICAL/TIMING SEQUENCE OF EVENTS, CONTACT WITH HEALTH CARE PROFESSIONALS, AND THE DESCRIPTION OF THE CARE AND SUPERVISION PROVIDED TO THE RESIDENT AT ISSUE. THE FACILITY RESERVES ITS RIGHT TO CONTINUE DISPUTING, APPEALING AND CONTESTING THESE DEFICIENCIES AND ANY ACTION RELATED TO OR ARISING THEREFROM IN ANY OTHER FORUM AS NEEDED.		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review, Emergency Department records, and review of the facility's guidelines, it was determined the facility failed to ensure nursing staff developed a plan of care for	F 279			

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

TITLE

(X6) DATE

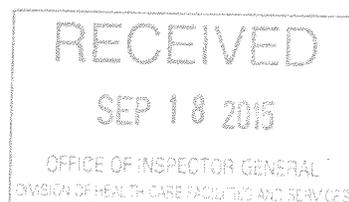
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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



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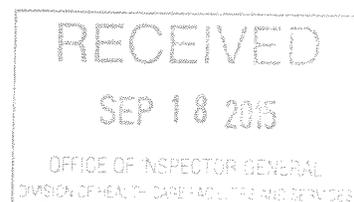
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F 279	<p>Continued From page 1</p> <p>one (1) of three (3) sampled residents (Resident #1) to address the resident's level of supervision.</p> <p>On 08/17/16 at 1:30 PM, Resident #1 exited the elevator on the first floor in his/her wheelchair and went out the front entrance to the patio area at 7:07 PM. There was no staff member on the front patio. The resident stayed on the patio until 7:18 PM when he/she opened the patio gate and wheeled himself/herself out of the patio area, without staff knowledge. Resident #1 was found at the bottom of a hill after falling out of the wheelchair near the nursing facility. The Emergency Medical Services (EMS) was called by a bystander. Staff was not aware the resident had left the facility until the resident was found inside the ambulance. The resident was transferred to the hospital.</p> <p>Resident #1 sustained a closed non-displaced fracture of the distal right radius (wrist fracture).</p> <p>The findings include:</p> <p>Review of the facility's Interdisciplinary Team Care Plan Guidelines, dated February 2014, revealed the facility developed and maintained a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain. The resident's care plan would be developed within seven (7) days of the completion of the resident's Comprehensive Minimum Data Set (MDS) Assessment, Quarterly, and as needed.</p> <p>Review of Resident #1's clinical record revealed the facility admitted Resident #1 on 10/21/09 with diagnoses which included Vascular Dementia, Cerebral Artery Occlusion, Unspecified, with</p>	F 279	<p>F-279</p> <p>1. On 8/18/15 Resident #1 was re-admitted to the facility and a thorough assessment was performed by the Unit Manager. No issues noted other than the injuries sustained from most recent fall. On 8/18/15 an elopement/wandering assessment was performed as part of the readmission process by the Unit Manager, and Resident #1 met the criteria for a Roam alert. On 8/18/15 the Roam alert was placed on Resident #1's right ankle. On 8/18/15 the Social Services Director ("SSD") placed calls to family and guardian for assistance in assessing if there were any unmet needs regarding family as resident pointed to family on her personal communications board. On 8/18/15 the volunteer Ombudsmen made aware and visited Resident. On 8/18/15, the Resident's Activities Care Plan was reviewed by the Activities Assistant Director, and Comprehensive Care Plan reviewed and updated by the Unit Manager.</p> <p>2. All residents have the potential to be affected. On 8/26/15-8/28/15 an audit was conducted by the Unit Managers to ensure Comprehensive Care Plans, CNA Care Plans and flow sheets were consistent for all residents.</p>		



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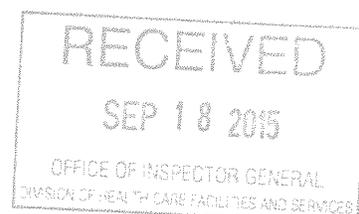
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F 279	<p>Continued From page 2</p> <p>Cerebral Infarction, Unspecified Hemiplegia Dominant Side, and Aphasia.</p> <p>Review of the Annual Minimum Data Set assessment, dated 06/12/15, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) with a score of 99, which indicated the resident was unable to complete the interview. Review of the Safety Schedule, dated 08/16/15 through 08/22/15, revealed the staff was to check the resident every hour.</p> <p>Review of the Emergency Department Resuscitation Notes, dated 08/17/15, revealed Resident #1 was found at the bottom of a hill after falling out of a wheelchair near a nursing facility. The Emergency Medical Services (EMS) was called by a bystander. The resident sustained a closed non-displaced fracture of the distal right radius.</p> <p>Review of the facility's video surveillance, on 08/20/15 at 1:30 PM, revealed Resident #1 exited the elevator on the first floor in his/her wheel chair and went out the front entrance to the patio area at 7:07 PM on 08/17/15. There was no staff member on the front patio. The resident stayed on the patio until 7:18 PM when he/she opened the patio gate and wheeled himself/herself out of the patio area.</p> <p>Review of Resident #1's Safety Schedule flow sheet revealed, on 08/17/15 at 6:00 PM, the safety check was completed as evidenced by a check mark and staff initials. The 7:00 PM and 8:00 PM safety checks were not documented as completed.</p>	F 279	<p>3. On 9/16/15-9/17/15 Clinical Director of Nursing, Assistant Director of Nursing ("ADON"), Administrative Director of Nursing educated the Interdisciplinary Care Team (Unit Managers, RAI Coordinators, ORT nurse, Treatment nurse, Dietary Assistant, PT Director, and Activities Assistant) that if changes are made to Comprehensive Care Plan, CNA Care Plans, and flow sheets must reflect those changes.</p> <p>4. Beginning 8/26/15, the Compliance Auditor, QA Coordinator, and/or Clinical Director of Nursing will perform random audits weekly x4 weeks, monthly x1 quarter and quarterly for the remainder of the year. The Compliance Auditor or QA Coordinator will audit to ensure Comprehensive Care Plans, CNA Care Plans and flow sheets are consistent. Results of audits will be brought to QA Committee for quarterly review. Based on the results of the audits, members of the QA Committee will decide on the need and timeliness of continued audits.</p>	9/18/15	



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F 279	<p>Continued From page 3</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 06/16/15, revealed prior to 08/18/15, the resident had interventions in place to have direct supervision by staff while smoking and this was accomplished by a staff person stationed on the 3rd floor patio during smoking. However, there was no supervision scheduled on the patio on the first floor as this was not a smoking area and there were no other smoking areas. Further review of the care plan revealed there was no care plan in place for supervision for the resident on an hourly basis as indicated on the Safety Check form.</p> <p>Interview with the Activity Assistant, on 08/20/15 at 9:35 AM, revealed the resident was allowed to come and go during smoking times on the third floor patio as long as staff was present.</p> <p>Review of Resident #1's Certified Nursing Assistant (CNA) Care Plan revealed there were no interventions related to supervision. The safety schedule checks were not part of the CNA care plan; however, under the daily routine it was noted for the 3-11 shift, that the resident was to go to bed after the last smoke session.</p> <p>Interview with CNA #3, on 08/20/15 at 2:00 PM, revealed every resident in the facility had a flow sheet in their room where they documented their repositioning and safety checks.</p> <p>Interview with CNA #1, on 08/20/15 at 2:25 PM, revealed there was a flow sheet on the resident's door for the week that had hourly checks. She stated the check mark on the flow sheet meant the resident was seen at that time. CNA #1 stated she was never told she had to visualize or call staff in the smoking area to check on the</p>	F 279		



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F 279	<p>Continued From page 4</p> <p>residents who were allowed to leave the unit by themselves. She stated Resident #1 was able to go smoke by himself/herself and go to other parts of the facility unescorted.</p> <p>Interview with the Unit Manager (UM), on 08/24/15 at 2:00 PM, revealed she reviewed the CNA care plans quarterly and it was her understanding that hourly safety checks were on the CNA care plans. However, the UM could not provide any evidence the CNA care plans were reviewed.</p> <p>Interview with the Staff Development Coordinator, on 08/24/15 at 2:15 PM, revealed the Safety Schedule Flow Sheets were reviewed during new hire orientation. She stated all residents get an hourly safety check. Further interview revealed staff was to go and visualize the residents if they were off the unit for such things as smoking, activities, or therapy. She stated if they could not visualize the resident, staff was to call the responsible staff member, such as the activity staff, smoking staff, or therapist, to check on the resident. The Staff Development Coordinator stated safety checks should be on the residents' care plans.</p> <p>Interview the Clinical Director of Nursing, on 08/21/15 at 2:50 PM, revealed CNAs were trained to either find the resident or call the designated areas off the unit to complete safety checks on the residents. Further interview with the Clinical Director of Nursing on 08/24/15 at 2:45 PM, revealed the resident safety schedule was not on the Comprehensive Care Plan or the CNA Care Plan because the Safety Schedule Flow Sheet hung under the CNA care plan in the resident's room.</p>	F 279			

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F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of video surveillance, and review of the Emergency Department records, it was determined the facility failed to ensure residents received adequate supervision to prevent accidents for one (1) of three (3) sampled residents (Resident #1).</p> <p>On 08/17/15, facility staff was unaware Resident #1 had exited the facility grounds while out on the patio on the first floor. The assigned staff checked the resident at 6:00 PM; however, staff failed to check the resident at 7:00 PM. Staff did not miss the resident until 8:00 PM. The resident was found approximately 200 feet from the facility. A bystander found the resident and called an ambulance. The resident was transported to the hospital. Resident #1 had sustained a fractured wrist when he/she fell out of the wheelchair.</p> <p>The findings include:</p> <p>Review of Resident #1's clinical record revealed the facility admitted the resident on 10/21/09 with diagnoses which included Vascular Dementia,</p>	F 323	<p>F-323</p> <ol style="list-style-type: none"> The Resident involved in this allegation was immediately reassessed by staff nurse upon her re-admission from the hospital on 8/18/15. A Roam alert bracelet was applied on 8/18/15 upon return from the hospital. Resident's care plan was updated on 8/18/15 by Unit Manager. The Resident indicated via personal communication board that she was attempting to see family. This Resident is Guardianship with no family involvement. On 8/17/15, at approximately 8:33 p.m. the House Supervisor instructed the staff to conduct a facility sweep to validate that all residents were accounted for; all residents were present. On 8/18/15, the Compliance Auditor checked all residents with Roam alerts to ensure that Roam alerts were in place. On 8/19/15, a staff member was assigned to stay on the ground outside patio at all times when the doors to the facility are unlocked to observe residents on the patio. This will continue until the gates on the patio are secured with a Mag Lock System. 	

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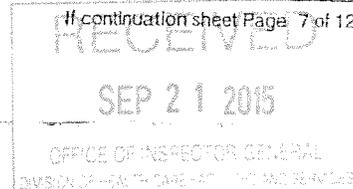
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F 323	<p>Continued From page 6</p> <p>Cerebral Artery Occlusion, Unspecified, with Cerebral Infarction, Unspecified Hemiplegia Dominant Side, and Aphasia.</p> <p>Observation of Resident #1, on 08/20/15 at 9:25 AM, revealed the resident was in his/her room laying in bed. The resident had a plaster splint on his/her right forearm and hand with limited movement of the arm. There was a room alert bracelet to the resident's right ankle. The resident had a communication board laying on the over the bed table beside his/her bed. Resident #1 was only able to say "yeah" to questions.</p> <p>Review of the Emergency Department Resuscitation Record, dated 08/17/15, revealed Resident #1, after leaving a nearby nursing facility, was found at the bottom of a hill after falling out of a wheelchair. The Emergency Medical Services (EMS) was called by a bystander. The resident sustained a closed non-displaced fracture of the distal right radius.</p> <p>Review of the facility's video surveillance, on 08/20/15 at 1:30 PM, revealed on 08/17/15, Resident #1 exited the elevator on the first floor in his/her wheel chair and went out the front entrance to the patio area at 7:07 PM. The resident was propelling himself/herself using his/her left leg. The only other person on the patio was a resident sitting in a chair next to the entrance door. Resident #1 stayed on the patio until 7:18 PM when he/she opened the patio gate and wheeled himself/herself out of the patio area, without staff knowledge. The video did not show any area of the facility grounds beyond the patio gate.</p>	F 323	<p>4. Human Resources Director has ensured that a staff member has been assigned to monitor the front patio daily beginning 8/19/15. Human Resources staff, Receptionist, Security Guard or House Supervisor will monitor the assigned staff member at the patio utilizing an hourly flow sheet which will be reviewed by Directors of Nursing and/or Administrator to ensure compliance.</p>	8/20/15	

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F 323	<p>Continued From page 6</p> <p>Cerebral Artery Occlusion, Unspecified, with Cerebral Infarction, Unspecified Hemiplegia Dominant Side, and Aphasia.</p> <p>Observation of Resident #1, on 08/20/15 at 9:25 AM, revealed the resident was in his/her room laying in bed. The resident had a plaster splint on his/her right forearm and hand with limited movement of the arm. There was a roam alert bracelet to the resident's right ankle. The resident had a communication board laying on the over the bed table beside his/her bed. Resident #1 was only able to say "yeah" to questions.</p> <p>Review of the Emergency Department Resuscitation Record, dated 08/17/15, revealed Resident #1, after leaving a nearby nursing facility, was found at the bottom of a hill after falling out of a wheelchair. The Emergency Medical Services (EMS) was called by a bystander. The resident sustained a closed non-displaced fracture of the distal right radius.</p> <p>Review of the facility's video surveillance, on 08/20/15 at 1:30 PM, revealed on 08/17/15, Resident #1 exited the elevator on the first floor in his/her wheel chair and went out the front entrance to the patio area at 7:07 PM. The resident was propelling himself/herself using his/her left leg. The only other person on the patio was a resident sitting in a chair next to the entrance door. Resident #1 stayed on the patio until 7:18 PM when he/she opened the patio gate and wheeled himself/herself out of the patio area, without staff knowledge. The video did not show any area of the facility grounds beyond the patio gate.</p>	F 323	4. Human Resources Director has ensured that a staff member has been assigned to monitor the front patio daily beginning 8/19/15. Human Resources staff, Receptionist, Security Guard or House Supervisor will monitor the assigned staff member at the patio utilizing an hourly flow sheet which will be reviewed by Directors of Nursing and/or Administrator to ensure compliance. Results of the audits will be brought to the QA Committee for quarterly review by the Human Resources Director or his/her Designee. Based on the results of the audits, members of the QA Committee will decide on the need and timeliness of continued audits	8/25/15	



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F 323	<p>Continued From page 7</p> <p>Review of Resident #1's Safety Schedule Flow Sheet revealed, on 08/17/15 at 6:00 PM, the safety check was completed as evidenced by a check mark and staff initials. The 7:00 PM and 8:00 PM safety checks were not documented as completed.</p> <p>Interview with the Activities Assistant, on 08/20/15 at 8:30 AM, revealed the smoking patio, which was located on the third floor, was opened for smoking every day from 8:00 AM-9:30 AM; 12:00-2:00 PM; and, 6:00-7:30 PM. She stated there was always a staff member with the residents while they smoked. The Activities Assistant stated the residents did not have to stay during the entire smoke break. Further interview revealed staff assisted the residents, who needed help back to their units; and, the residents who did not need assistance left the smoke area on their own.</p> <p>Interview with the Rehabilitation Technician, on 08/20/15 at 10:09 AM, revealed she had monitored the smokers on the smoking patio on 08/17/15 during the 6:00-7:30 PM smoke break. She stated Resident #1 left the smoking patio at 7:00 PM on his/her own. Further interview revealed Resident #1's normal routine was to go back to his/her unit (fifth floor) after he/she finished smoking. She stated the resident was allowed to go to the front patio, as he/she usually went back to his/her unit.</p> <p>Interview with the Clinical Support Person, on 08/20/15 at 11:40 AM, revealed she had worked on the sixth floor on 08/17/15 when two (2) Certified Nursing Assistants (CNA) came to the floor and reported Resident #1 was missing. She stated she went outside and looked around the</p>	F 323			

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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	
F 323	<p>Continued From page 8</p> <p>front parking area and saw an EMS vehicle parked on the street near the corner of the intersection. Clinical Support Staff stated the EMS personnel told her they had the resident in the vehicle. She stated EMS was able to identify the resident by the facility's arm band the resident was wearing. Further interview revealed the resident was not an elopement risk and was able to have access to the front patio.</p> <p>Interview with CNA #3, on 08/20/15 at 2:00 PM, revealed she worked on the fifth floor on 08/17/15 when Resident #1 could not be found. She stated she assisted in searching the floors for the resident along with going outside to search the facility grounds. She stated she was with the Clinical Support Person when they saw the EMS vehicle; they ran up to the EMS personnel who informed them they had the resident in the vehicle. CNA #3 further stated every resident in the facility had a flow sheet in their room where repositioning and safety checks were documented. However, there was no area to document the location or visual checks of the resident.</p> <p>Interview with CNA #1, on 08/20/15 at 2:25 PM, revealed she worked the fifth floor on 08/17/15 and was assigned to Resident #1. She stated at approximately 8:00 PM, the nurse went to see the resident and he/she was not in his/her room. She stated she went with CNA #3 to look for the resident. CNA #1 stated they looked on all the floors and then went outside to search the facility's grounds. She stated CNA #3 and the Clinical Support Staff informed her at approximately 8:20-8:30 PM, the resident was in the EMS vehicle. Further interview with CNA #1 revealed there was a flow sheet on the resident's</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>door for the week that had hourly checks. She stated the check mark on the flow sheet meant the resident was seen at that time. She stated she was never told she had to visualize or call staff in the smoking area to check on the residents who were allowed to leave the unit by themselves. Further interview revealed Resident #1 was able to go smoke by himself/herself and go to other parts of the facility unescorted.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 08/20/15 at 3:05 PM, revealed on 08/17/15, she went to look for Resident #1 between 8:00 and 8:15 PM and could not find the resident. She stated she had the CNAs on the floor begin to look for the resident. Further interview revealed she stated she notified the Nursing Supervisor and a code yellow (per the Wandering/Elopement Risk Policy a code yellow was to be initiated in the event of a noted wander/elopement resident) was called. LPN #2 stated she was notified at approximately 8:40 PM that the resident was found and on his/her way to the hospital. She further stated Resident #1's usual routine was to go to the smoking patio and return to the unit between 7:00-7:30 PM.</p> <p>Interview with the Nursing Supervisor, on 08/20/15 at 3:55 PM, revealed he was first alerted Resident #1 was missing at approximately 8:15 PM on 08/17/15. He stated he sent the CNAs to search the floors and he called a code yellow and staff went outside to search the facility grounds. The Nursing Supervisor stated the Clinical Support Staff reported to him that the resident was on his/her way to the hospital via EMS.</p> <p>Interview with the Staff Development Coordinator, on 08/24/15 at 2:15 PM, revealed the Safety</p>	F 323		

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F 323	<p>Continued From page 10</p> <p>Schedule flow sheets were reviewed during new hire orientation. She stated all residents received an hourly safety check. Further interview revealed staff was to go and visualize the residents if they were off the unit for such things as smoking, activities, or therapy. She stated if staff was not able to leave the unit to visualize the resident, they were to call the responsible staff member, such as the activity staff, smoking staff, or therapist, to check on the resident.</p> <p>Interview with the Clinical Director of Nursing (DON), on 08/21/15 at 2:50 PM, revealed the every one (1) hour checks are completed on all residents. The form is also for turning and repositioning. The CNAs go in and make sure the resident doesn't need anything, turns and repositions them, or either finds the resident or calls the smoke patio, therapy, dining room, lobby or beauty shop, where over the resident might be/suppose to be. An elopement risk was completed on Resident #26 in February and he/she did not meet the criteria for elopement.</p> <p>Post Survey Interview with the Clinical DON and Administrator, on 09/09/15 at 10:00 AM, revealed every one hour checks was a facility process; however, not a required process. The facility placed every resident on one hour checks whether they needed it or not, it was just an automatic action by the facility. For new residents the staff would search out the resident until a routine was established by the resident. Then staff would call to check on the residents. The staff did not check on Resident #26 at 7:00 PM because they knew the resident was on the smoking patio with staff. However, the resident changed the routine and went outside instead of back to the floor where he/she lived.</p>	F 323			

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