

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

PRINTED: 08/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/15/2012
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NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

An Abbreviated Survey investigating complaints KY#00018880 and KY#00018878 was initiated on 08/08/12 and concluded on 08/15/12. KY#00018878 was unsubstantiated with no deficiencies. KY#00018880 was substantiated with deficiencies cited. Immediate Jeopardy (IJ) was identified on 08/14/12 and determined to exist on 08/04/12 at 42 CFR 483.20 Resident Assessment, F-280, at a S/S of a "J" and 42 CFR 483.25 Quality of Care, F-323, at a S/S of a "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F-323). Resident #4 was assessed by the facility to be at risk for elopement and had a Wanderguard applied. On 08/04/12 Resident #4 exited the building without staff knowledge, was found outside at the rear of the building by staff, and was returned to the facility unharmed. It was determined the facility had completed all corrective actions, including adding new alarms to rear exit doors, updating the comprehensive care plan, verifying proper functioning of the Wanderguard alarm system, and completing staff education by 08/06/12, prior to initiating the investigation by the State Agency (SA). Therefore, the SA made a determination of Past Jeopardy with IJ removed on 08/06/12.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=J

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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the

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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comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure a Comprehensive Care Plan was revised with individualized interventions to reflect the facility assessed elopement risk for one (1) of six (6) sampled residents (Resident #4). Resident #4 was assessed by the facility to be at risk for elopement. Review of the Comprehensive Care Plan revealed no reference to Resident #4's history of exit seeking behaviors nor were interventions revised to address these behaviors. Resident #4 eloped from the facility without staff knowledge on 08/04/12. (Refer to F-323)

The failure of the facility to ensure the Plan of Care was revised to include adequate supervision for residents assessed to be at risk for elopement placed residents at risk for serious

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Past noncompliance: no plan of correction required.

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harm, injury, impairment or death. Immediate Jeopardy was identified on 08/14/12, determined to exist on 08/04/12, and continued until 08/06/12. The facility implemented corrective actions which were completed prior to the State Agency's (SA) investigation, thus resulting in Past Jeopardy.

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The findings include:

Review of the Elopement policy, dated 01/2008, revealed the licensed nurse was to identify and implement immediate interventions, based on each resident's assessed risk for elopement. Continued review revealed the interventions were to be documented on the Care Plan.

Interview with the Director of Nursing Services (DNS) and review of the facility's investigation of the incident, on 08/15/12 at 11:10 AM, revealed Certified Nursing Assistant (CNA) #8 observed Resident #4 outside through a window on the 400 Hall on 08/04/12. CNA #8 and CNA #4 went out and brought the resident back inside the facility. Continued interview revealed the facility initiated an investigation of the elopement and identified an alarm did sound on the 100 Hall. However, staff silenced the alarm and did not further investigate. The facility concluded Resident #4 most likely exited through the door at the end of the 100 Hall.

Review of the clinical record revealed Resident #4 was admitted by the facility on 02/20/12 with diagnoses which included Alzheimer's Disease, Behavioral Disturbances, and Depressive Disorder.

Review of the admission Elopement/Wander Risk

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Evaluation Form, dated 02/21/12, revealed the facility assessed Resident #4 to have short term memory deficit. Review of the nurse's comment section on the form revealed, Resident #4 stated, "I want to go find my husband".

Review of the Comprehensive Care Plan, initiated on 02/21/12, revealed Resident #4 was at risk for wandering from a secure location related to Dementia and confusion. Continued review revealed the resident wandered into other resident areas and took their personal items. Documented interventions included the following: allow the resident to wander freely in a secure environment and apply an electronic safety device.

Further review of the Care Plan revealed additional problems and interventions were added on 02/22/12. The resident was noted to have the potential for social isolation due to confusion, agitation and wandering. Interventions included the following: provide structure at group activities; provide verbal cueing to engage in activities; and, provide an escort as appropriate. In addition, the Care Plan included a problem related to inappropriate behaviors, including wandering throughout the facility, wandering into other resident areas, taking other resident's belongings, confusion, and agitation.

Review of the Elopement/Wander Risk Evaluation Form, dated 02/26/12, revealed the facility assessed Resident #4 as having short-term memory deficit and in the nurse's comments section it stated the resident continued to state he/she wanted to go home and the resident propelled self to doors. However, review of the

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Care Plan revealed no documented evidence the facility revised the Care Plan to include interventions to address Resident #4 propelling self to the doors.

Review of the Admission Minimum Data Set (MDS) Assessment, dated 03/02/12, revealed the facility assessed Resident #4 as severely cognitively impaired but did not exhibit wandering behavior in the seven (7) day look-back period.

Further review of the quarterly Elopement/Wander Risk Evaluation Form, dated 05/31/12, revealed Resident #4 had short-term memory deficit and was noted to be independently mobile with wheelchair. The resident was assessed by the facility as being an elopement risk related to "always wanting to go home" and behaviors of gravitating to doors. Review of the Care Plan revealed no documented evidence the plan was revised to include interventions to redirect Resident #4 from the exit doors and no evidence of increased supervision interventions.

Continued review of the Quarterly MDS Assessment, dated 06/29/12, revealed the facility assessed Resident #4 as severely cognitively impaired and exhibited wandering behavior daily during the seven (7) day look-back period.

Review of the quarterly Elopement/Wander Risk Evaluation Form, dated 06/29/12, revealed Resident #4 was assessed for a short-term memory deficit and repetitive wandering. In addition, the resident was assessed to be independently mobile with a wheelchair. Review of the nurse's comment on the assessment form,

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related to the resident's elopement potential, revealed the resident repeatedly stated "I want to go home" and propelled self to doors.

On 07/03/12, after the quarterly Elopement/Wander Risk Evaluation Form, dated 06/29/12, the Comprehensive Care Plan was revised; however, the only added intervention was to place information and a photograph in the elopement book. Continued review revealed the care plan problem was not individualized related to exit-seeking behaviors exhibited by the resident, as documented on the Elopement/Wander Risk Evaluation Form and interventions did not include specific actions to take if the resident attempted to exit the building without supervision.

Interview with the Director of Nursing Services (DNS), on 08/15/12 at 5:10 PM, revealed the MDS nurse was responsible for updating/revising the Care Plan after each assessment. She stated the staff nurses could update the Care Plan at any time the resident's condition changed, either by writing updates directly on the Care Plan, or updating the Care Plan in the computer.

The facility presented documentation of implementing the following actions to correct the deficiency:

- The facility assessed Resident #4 for injuries, notified the resident's Physician and responsible party, and placed Resident #4 on 1:1 supervision on 08/04/12. The facility immediately initiated an investigation.

- All doors in the center were checked for proper

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functioning by the Assistant DNS on 08/04/12 at 3:50 and all doors were checked again by the Maintenance Director at 5:30 PM.

-An Elopement Risk Review was completed on all residents identified as at-risk for elopement on 08/04/12 by the DNS and LPN #2. All residents in the facility were reassessed by 08/06/12.

-A review was completed of the elopement binders throughout the facility to ensure accuracy on 08/04/12 by the DNS and ADNS.

-Care plans and elopement assessments of all elopement risk residents were reviewed and updated as indicated on 08/04/12 by the DNS and ADNS.

-Elopement packs, which were already in place prior to the elopement, were verified to be in place with all articles present on 08/04/12 by the Social Worker and ADNS. These packs contain items such as a flash light, walkie-talkie, bottled water and other supplies that may be necessary in the event of an elopement.

-CNA care cards for all elopement risk residents were reviewed and updated as indicated by the DNS on 08/04/12.

-Placement and function of Wanderguard devices were verified on all identified elopement risk residents by the ADNS on 08/04/12.

-Interviews of all on-duty staff were initiated and completed on 08/04/12 by the ADNS and Administrator regarding any information about the elopement.

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-Re-education on elopement and door response procedures was initiated and completed for all staff by the Administrator, DNS, and ADNS by 08/06/12. No staff were permitted to work until they had received the re-education.

-The Administrator, the DNS and the Medical Director held a Quality Assurance meeting via telephone to review the incident, initial investigation findings, and new interventions were put into place on 08/04/12.

-Audits were initiated on 08/04/12. Process Improvement (PI) audits were being conducted five (5) times per week for four (4) weeks, three (3) times per week for four (4) weeks, and weekly for four (4) weeks. The PI audits include monitoring of staff response time to triggered door alarms, and initiation of the mandatory head count when there was no identifiable cause for the alarm.

-On 08/06/12 the facility contacted a door alarm company to maintain the door alarms system for the facility. The company checked all doors and found them to be functioning properly.

The survey team validated the corrective actions as follows:

During a facility tour with the Maintenance Supervisor, on 08/08/12 at 9:45 AM, observation revealed all exit doors had functioning alarms. Interview revealed he checked all door alarms for proper function on 08/04/12 at 5:30 PM.

Interview with the DNS, on 08/14/12 at 1:00 PM,

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revealed there were ten (10) exit doors in the facility. She stated new and louder alarms were installed on the four (4) rear exit doors. She explained the rear exit doors were not on the Wanderguard alarm system. She stated, to prevent residents exiting when someone entered the building, the rear doors could not be opened from the outside. She demonstrated how these doors alarmed anytime they were opened, even if the access code was used. Continued interview revealed the six (6) remaining doors in the facility were on the Wanderguard system and alarmed anytime a resident was within the detection area of 2-3 feet from the door. In addition, the Wanderguard doors could not be opened from the inside or outside if the alarm is triggered, until manual reset of the alarm has occurred and the resident is directed out of the detection range. Observation at the time of the interview revealed the Wanderguard alarms did function as described.

Review of the work order, dated 08/06/12 at 6:55 PM, revealed a door alarm company was contracted to maintain the door alarms system for the facility. The company checked all doors and found them to be functioning properly. Review of receipts dated 08/06/12 revealed funds were dispersed to local retailers for new door alarms.

Continued interview with the DNS, on 08/14/12 at 1:00 PM, revealed all previously identified at-risk residents were reassessed for elopement risk on 08/04/12. She stated all residents in the facility were reassessed by 08/06/12. Record reviews of the six (6) sampled residents and sixteen (16) elopement-risk residents confirmed reassessments were completed as stated. On

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further interview, the DNS stated Resident #4 was monitored one on one after the incident, until the new alarms were installed and all staff were educated on the alarm response procedure.

Interview with Certified Nursing Assistant (CNA) #6, on 08/14/12 at 2:15 PM, revealed he had been assigned to one to one supervision during his shifts between 08/04/12 and 08/06/12. He stated he walked with Resident #4 several times each shift and the resident made no attempt to get out of the facility.

Interview with CNA #5, on 08/14/12 at 2:30 PM, revealed he had been assigned one to one monitoring of Resident #4. He stated he read to the resident and walked with him/her to keep him/her occupied. Continued interview revealed the resident voiced a desire to go home, but made no attempt to do so.

Review of the Elopement Book revealed sixteen (16) residents in the facility, including Resident #4, were assessed to be at risk for elopement. Continued review revealed a photograph and physical description with contact information for the Responsible Party was present for each of the sixteen (16) residents.

Review of care plans for the sixteen (16) at-risk residents revealed they were reviewed and updated by 08/06/12. Review of Resident #4's care plan revealed it was updated on 08/04/12 to include the following new interventions: refer to activity interventions; encourage activity box with increased attempts of elopement; and take on a walk with increased attempts of elopement. Review of the care plan related to activities

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revealed new interventions as follows: activity box to be kept at station; and 1 on 1 activities up to five (5) times per week.

Observation, on 08/15/12 at 10:30 AM, revealed elopement packs containing supplies, including a flashlight, blanket, walkie-talkie, bottled water, disposable gloves and simple dressing supplies were located at each nursing station.

Review of the CNA care cards for each resident at risk for elopement revealed all were updated to reflect elopement precautions.

Review of the Process Improvement audit tool revealed all Wanderguard devices were checked by the Assistant DNS on 08/04/12 at 3:50 PM. Observation by the surveyor, on 08/10/12 at 12:35 PM, revealed all Wanderguard devices were functioning properly.

Review of the facility investigation revealed all staff on duty, on 08/04/12 at 3:30 PM, were interviewed and submitted signed statements regarding any encounters with Resident #4 on that day.

Review of in-service records revealed education was provided to all staff on the following topics: the elopement policy; the different types of doors and alarms throughout the facility; immediate response to all alarms and if the alarm was an exit door alarm, staff should perform a mandatory head count if the cause of the door alarm could not be determined; and doors on the Wanderguard system could be opened if held for fifteen (15) seconds, with or without a Wanderguard device. Review of sign-in sheets

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revealed all staff were educated by 08/06/12.

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Interview with Registered Nurse (RN) #1, on 08/10/12 at 2:55 PM, revealed she received education related to elopement and door alarm procedures following the incident on 08/04/12. She explained the elopement packs kept at the nursing stations, the mandatory head count required for door alarms of unidentified cause, and Wanderguard checks for proper placement and function were to be completed every shift.

Interview with RN #4, on 08/14/12 at 2:00 PM, revealed she received mandatory training related to facility's elopement policies and procedures as well as door alarm procedures after Resident #4 eloped. She reported education included the elopement packs and the elopement books, located at each nursing station and at the front office.

Interview with Housekeeping Staff #5, on 08/14/12 at 2:00 PM, revealed she was knowledgeable about redirection of a resident attempting to exit the facility and her role if an actual elopement occurred. She further stated she was educated on the door alarm procedures and the Elopement Policy.

On 08/14/12 at 2:35 PM, observation of the nursing shift report revealed the day nurse reported on each resident and identified all who had Wanderguard devices, and stated all had been checked and were functioning properly.

Interview with the Administrative Assistant, on 08/15/12 at 4:10 PM, revealed she had attended the mandatory in-service related to elopement

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and the procedures for door alarms on 08/04/12. She confirmed the presence of the Elopement book located in the front office by the main entrance.

Interview with CNA #7, on 08/15/12 at 4:13 PM, revealed she attended the in-services related to elopement and door alarm procedures. She reported staff received training on all doors, new alarms and different-sounding alarms. She stated a door-to-door demonstration of doors and alarms was part of the in-service. Continued interview revealed she was knowledgeable about the elopement packs, the mandatory head count process, and her role if a resident was determined to be missing.

Interview with the Unit Manager for the 300 and 400 Halls, on 08/15/12 at 4:17 PM, revealed she had attended mandatory in-services on topics including Wanderguard checks, the Elopement Policy, door alarm procedures, elopement packs and the elopement books.

Interview with CNA #2, on 08/15/12 at 4:22 PM, revealed she attended mandatory in-services regarding the exit doors and alarms, Wanderguard checks, redirection of residents, how to respond to an actual elopement, and when and how to do a head count.

Interview with the DNS and the Administrator, on 08/15/12 at 2:25 PM, revealed Process Improvement (PI) audits were being conducted five (5) times per week for four (4) weeks, three (3) times per week for four (4) weeks, and weekly for four (4) weeks. The PI audits include monitoring of staff response time to triggered

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door alarms, and initiation of the mandatory head count when there was no identifiable cause for the alarm. The DNS stated audits will continue after three (3) months if determined to be necessary. Continued interview revealed audit results will be reported to monthly PI team meetings, the first to be held 08/22/12.

F 280

Based on the review of the facility's investigation, the corrective action provided by the facility and verification through observation, interview and record review it was determined the Immediate Jeopardy was removed on 08/06/12, prior to initiating the survey.

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

F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of the facility's policy and investigation it was determined the facility failed to have an effective system to ensure adequate supervision for one (1) of six (6) sampled residents (Resident #4). On 08/04/12, Resident #4, who was assessed by the facility as being at risk for wandering and had exhibited exit seeking behaviors, exited the facility without staff

Past noncompliance: no plan of correction required.

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F 323 Continued From page 14
knowledge. Staff was not aware the resident had exited prior to him/her being observed through a window. Resident #4 was found by staff outside the facility at the rear of the building.

F 323

The failure of the facility to provide adequate supervision for residents assessed to be at risk for elopement placed residents at risk for serious harm, injury, impairment or death. Immediate Jeopardy and Substandard Quality of Care was identified on 08/14/12, determined to exist on 08/04/12, and continued until 08/06/12. The facility implemented corrective actions which were completed prior to the State Agency's (SA) investigation, thus resulting in Past Jeopardy.

The findings include:

Review of the facility's Elopement Policy, dated 01/2008, revealed it was the policy of the center to provide a safe environment and that residents who were at risk for elopement were identified. Continued review revealed the facility defined elopement to be "when a resident leaves the premises or a safe area without authority and/or any necessary supervision to do so". Residents assessed as being at risk for exit seeking behavior and elopement were to be identified on the Elopement Risk Identification Form, which was maintained in a binder readily accessible to staff. Continued review revealed the remainder of the policy referred to missing residents.

Interview with the Director of Nursing Services (DNS) and review of the facility's investigation of the incident, on 08/15/12 at 11:10 AM, revealed Certified Nursing Assistant (CNA) #8 observed Resident #4 outside through a window on the 400

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F 323	<p>Continued From page 15</p> <p>Hall on 08/04/12. CNA #8 and CNA #4 went out and brought the resident back inside the facility. Continued interview revealed the facility initiated an investigation of the elopement and identified an alarm did sound on the 100 Hall. However, staff silenced the alarm and did not further investigate. The facility concluded Resident #4 most likely exited through the door at the end of the 100 Hall.</p> <p>Interview with Dietary Staff #4, on 08/10/12 at 4:00 PM, revealed she observed Resident #4 attempting to exit a rear door on 08/04/12 at 3:23 PM. She stated this occurred when she was clocking out. (Review of the time card confirmed the time of 3:23 PM). Continued interview revealed she took the resident to the nurse's desk and informed the nurse of the resident's behavior.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 08/12/12 at 9:40 AM, revealed a dietary staff member had brought Resident #4 to the nurse's station on 08/04/12, and reported he/she was trying to get out the door. The LPN stated she administered the resident's scheduled Xanax, 0.25 milligram (mg), prescribed for agitation. Continued interview revealed after administering the medication the nurse directed the resident to his/her room.</p> <p>Interview with CNA #3, on 08/15/12 at 12:00 PM, revealed she began her duties on the unit at approximately 2:45 PM on 08/04/12. She stated she performed several tasks and then assisted another resident with a shower. She further stated she came out of the shower room in response to the door alarm at the end of the 100 Hall, which would have been around the time</p>	F 323		
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Resident #4 was observed outside the facility. Continued interview revealed she reset the alarm. She reported she did not see anyone near the door, inside or outside. She further stated she did not go outside to look, and did not report the alarm to any other staff.

Interview with CNA #8, on 08/15/12 at 12:00 PM, revealed she and CNA #4 found Resident #4 outside the exit door at the end of the 400 Hall at approximately 3:30 PM on 08/04/12. She stated the resident was brought back into the facility. Continued interview revealed she could not recall if the Wanderguard device worn by the resident alarmed when they returned to the building.

Interview with CNA #4, on 08/10/12 at 2:50 PM, revealed she was returning from break at approximately 3:30 PM on 08/04/12, when CNA #8 stopped her and asked for assistance in bringing Resident #4 back into the facility. She stated she and CNA #8 went out the front door and around to the back of the building. Continued interview revealed the resident was standing near the exit door at the end of the 400 Hall. She further stated they brought the resident back inside and the Wanderguard device worn by the resident alarmed on re-entering the facility.

Further interview with Licensed Practical Nurse (LPN) #2, on 08/12/12 at 9:40 AM, revealed it was about ten (10) minutes after she had directed the resident back to his/her room when she was informed by another resident the resident had gotten outside. She reported Resident #4 was returned to his/her room and assessed for injury at approximately 3:30 PM to 3:35 PM. The LPN stated no injuries were noted.

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F 323

Clinical record review revealed Resident #4 was admitted by the facility on 02/20/12 with diagnoses which included Alzheimer's Disease, Dementia with Behavioral Disturbance, and Depressive Disorder.

Review of the quarterly Minimum Data Set (MDS) Assessment, dated 06/29/12, revealed the facility assessed Resident #4 as severely cognitively impaired. Continued review revealed the resident exhibited wandering behavior daily during the seven (7) day look-back period.

Review of the Comprehensive Care Plan, initiated on 02/21/12, revealed Resident #4 was at risk for wandering from a secure location related to Dementia and confusion. Continued review revealed the resident wandered into other resident areas and took their personal items. Documented interventions included the following: allow the resident to wander freely in a secure environment and apply an electronic safety device.

Further review of the Care Plan revealed additional problems and interventions were added on 02/22/12. The resident was noted to have the potential for social isolation due to confusion, agitation and wandering. Interventions included the following: provide structure at group activities; provide verbal cueing to engage in activities; and provide an escort as appropriate. In addition, the Care Plan included a problem related to inappropriate behaviors, including wandering throughout the facility, wandering into other resident areas, taking other resident's belongings, confusion, and agitation.

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Review of the quarterly Elopement/Wander Risk Evaluation Form, dated 06/29/12, revealed Resident #4 was assessed for a short term memory deficit and repetitive wandering. In addition, the resident was assessed to be independently mobile with a wheelchair. Review of the nurse's comment noted on the assessment, related to the resident's elopement potential, revealed the resident repeatedly stated "I want to go home" and propelled self to doors.

Review of the Elopement Risk Identification Form located in the Elopement Book revealed Resident #4 was identified as an elopement risk. Continued review revealed the resident was "always talking about 247 Lyons Drive".

However, review of the resident's plan of care revealed the care plan had not been revised to include interventions of increased supervision to address the resident's exit seeking behavior.

The facility presented documentation of implementing the following actions to correct the deficiency:

-The facility assessed Resident #4 for injuries, notified the resident's Physician and responsible party, and placed Resident #4 on 1:1 supervision on 08/04/12. The facility immediately initiated an investigation.

-All doors in the center were checked for proper functioning by the Assistant DNS on 08/04/12 at 3:50 and all doors were checked again by the Maintenance Director at 5:30 PM.

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- An Elopement Risk Review was completed on all residents identified as at-risk for elopement on 08/04/12 by the DNS and LPN #2. All residents in the facility were reassessed by 08/06/12.
- A review was completed of the elopement binders throughout the facility to ensure accuracy on 08/04/12 by the DNS and ADNS.
- Care plans and elopement assessments of all elopement risk residents were reviewed and updated as indicated on 08/04/12 by the DNS and ADNS.
- Elopement packs, which were already in place prior to the elopement, were verified to be in place with all articles present on 08/04/12 by the Social Worker and ADNS. These packs contain items such as a flash light, walkie-talkie, bottled water and other supplies that may be necessary in the event of an elopement.
- CNA care cards for all elopement risk residents were reviewed and updated as indicated by the DNS on 08/04/12.
- Placement and function of Wanderguard devices were verified on all identified elopement risk residents by the ADNS on 08/04/12.
- Interviews of all on-duty staff were initiated and completed on 08/04/12 by the ADNS and Administrator regarding any information about the elopement.
- Re-education on elopement and door response procedures was initiated and completed for all staff by the Administrator, DNS, and ADNS by

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08/06/12. No staff were permitted to work until they had received the re-education.

-The Administrator, the DNS and the Medical Director held a Quality Assurance meeting via telephone to review the incident, initial investigation findings, and new interventions were put into place on 08/04/12.

-Audits were initiated on 08/04/12. Process Improvement (PI) audits were being conducted five (5) times per week for four (4) weeks, three (3) times per week for four (4) weeks, and weekly for four (4) weeks. The PI audits include monitoring of staff response time to triggered door alarms, and initiation of the mandatory head count when there was no identifiable cause for the alarm.

-On 08/06/12 the facility contacted a door alarm company to maintain the door alarms system for the facility. The company checked all doors and found them to be functioning properly.

The survey team validated the corrective actions as follows:

During a facility tour with the Maintenance Supervisor, on 08/08/12 at 9:45 AM, observation revealed all exit doors had functioning alarms. Interview revealed he checked all door alarms for proper function on 08/04/12 at 5:30 PM.

Interview with the DNS, on 08/14/12 at 1:00 PM, revealed there were ten (10) exit doors in the facility. She stated new and louder alarms were installed on the four (4) rear exit doors. She explained the rear exit doors were not on the

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Wanderguard alarm system. She stated, to prevent residents exiting when someone entered the building, the rear doors could not be opened from the outside. She demonstrated how these doors alarmed anytime they were opened, even if the access code was used. Continued interview revealed the six (6) remaining doors in the facility were on the Wanderguard system and alarmed anytime a resident was within the detection area of 2-3 feet from the door. In addition, the Wanderguard doors could not be opened from the inside or outside if the alarm is triggered, until manual reset of the alarm has occurred and the resident is directed out of the detection range. Observation at the time of the interview revealed the Wanderguard alarms did function as described.

Review of the work order, dated 08/06/12 at 6:55 PM, revealed a door alarm company was contracted to maintain the door alarms system for the facility. The company checked all doors and found them to be functioning properly. Review of receipts dated 08/06/12 revealed funds were dispersed to local retailers for new door alarms.

Continued interview with the DNS, on 08/14/12 at 1:00 PM, revealed all previously identified at-risk residents were reassessed for elopement risk on 08/04/12. She stated all residents in the facility were reassessed by 08/06/12. Record reviews of the six (6) sampled residents and sixteen (16) elopement-risk residents confirmed reassessments were completed as stated. On further interview, the DNS stated Resident #4 was monitored one on one after the incident, until the new alarms were installed and all staff were educated on the alarm response procedure.

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Interview with Certified Nursing Assistant (CNA) #6, on 08/14/12 at 2:15 PM, revealed he had been assigned to one to one supervision during his shifts between 08/04/12 and 08/06/12. He stated he walked with Resident #4 several times each shift and the resident made no attempt to get out of the facility.

Interview with CNA #5, on 08/14/12 at 2:30 PM, revealed he had been assigned one to one monitoring of Resident #4. He stated he read to the resident and walked with him/her to keep him/her occupied. Continued interview revealed the resident voiced a desire to go home, but made no attempt to do so.

Review of the Elopement Book revealed sixteen (16) residents in the facility, including Resident #4, were assessed to be at risk for elopement. Continued review revealed a photograph and physical description with contact information for the Responsible Party was present for each of the sixteen (16) residents.

Review of care plans for the sixteen (16) at-risk residents revealed they were reviewed and updated by 08/06/12. Review of Resident #4's care plan revealed it was updated on 08/04/12 to include the following new interventions: refer to activity interventions; encourage activity box with increased attempts of elopement; and take on a walk with increased attempts of elopement. Review of the care plan related to activities revealed new interventions as follows: activity box to be kept at station; and 1 on 1 activities up to five (5) times per week.

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 Observation, on 08/15/12 at 10:30 AM, revealed elopement packs containing supplies, including a flashlight, blanket, walkie-talkie, bottled water, disposable gloves and simple dressing supplies were located at each nursing station.

Review of the CNA care cards for each resident at risk for elopement revealed all were updated to reflect elopement precautions.

Review of the Process Improvement audit tool revealed all Wanderguard devices were checked by the Assistant DNS on 08/04/12 at 3:50 PM. Observation by the surveyor, on 08/10/12 at 12:35 PM, revealed all Wanderguard devices were functioning properly.

Review of the facility investigation revealed all staff on duty, on 08/04/12 at 3:30 PM, were interviewed and submitted signed statements regarding any encounters with Resident #4 on that day.

Review of in-service records revealed education was provided to all staff on the following topics: the elopement policy; the different types of doors and alarms throughout the facility; immediate response to all alarms and if the alarm was an exit door alarm, staff should perform a mandatory head count if the cause of the door alarm could not be determined; and doors on the Wanderguard system could be opened if held for fifteen (15) seconds, with or without a Wanderguard device. Review of sign-in sheets revealed all staff were educated by 08/06/12.

Interview with Registered Nurse (RN) #1, on 08/10/12 at 2:55 PM, revealed she received

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185170	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/15/2012
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NAME OF PROVIDER OR SUPPLIER BRADFORD SQUARE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 US 127 SOUTH FRANKFORT, KY 40601
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education related to elopement and door alarm procedures following the incident on 08/04/12. She explained the elopement packs kept at the nursing stations, the mandatory head count required for door alarms of unidentified cause, and Wanderguard checks for proper placement and function were to be completed every shift.

Interview with RN #4, on 08/14/12 at 2:00 PM, revealed she received mandatory training related to facility's elopement policies and procedures as well as door alarm procedures after Resident #4 eloped. She reported education included the elopement packs and the elopement books, located at each nursing station and at the front office.

Interview with Housekeeping Staff #5, on 08/14/12 at 2:00 PM, revealed she was knowledgeable about redirection of a resident attempting to exit the facility and her role if an actual elopement occurred. She further stated she was educated on the door alarm procedures and the Elopement Policy.

On 08/14/12 at 2:35 PM, observation of the nursing shift report revealed the day nurse reported on each resident and identified all who had Wanderguard devices, and stated all had been checked and were functioning properly.

Interview with the Administrative Assistant, on 08/15/12 at 4:10 PM, revealed she had attended the mandatory in-service related to elopement and the procedures for door alarms on 08/04/12. She confirmed the presence of the Elopement book located in the front office by the main entrance.

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Interview with CNA #7, on 08/15/12 at 4:13 PM, revealed she attended the in-services related to elopement and door alarm procedures. She reported staff received training on all doors, new alarms and different-sounding alarms. She stated a door-to-door demonstration of doors and alarms was part of the in-service. Continued interview revealed she was knowledgeable about the elopement packs, the mandatory head count process, and her role if a resident was determined to be missing.

Interview with the Unit Manager for the 300 and 400 Halls, on 08/15/12 at 4:17 PM, revealed she had attended mandatory in-services on topics including Wanderguard checks, the Elopement Policy, door alarm procedures, elopement packs and the elopement books.

Interview with CNA #2, on 08/15/12 at 4:22 PM, revealed she attended mandatory in-services regarding the exit doors and alarms, Wanderguard checks, redirection of residents, how to respond to an actual elopement, and when and how to do a head count.

Interview with the DNS and the Administrator, on 08/15/12 at 2:25 PM, revealed Process Improvement (PI) audits were being conducted five (5) times per week for four (4) weeks, three (3) times per week for four (4) weeks, and weekly for four (4) weeks. The PI audits include monitoring of staff response time to triggered door alarms, and initiation of the mandatory head count when there was no identifiable cause for the alarm. The DNS stated audits will continue after three (3) months if determined to be

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 necessary. Continued interview revealed audit results will be reported to monthly PI team meetings, the first to be held 08/22/12.
 Based on the review of the facility's investigation, the corrective action provided by the facility and verification through observation, interview and record review it was determined the Immediate Jeopardy was removed on 08/06/12, prior to initiating the survey.

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