

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

PRINTED: 03/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/25/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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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 000}	<p>INITIAL COMMENTS</p> <p>An onsite re-visit survey was conducted on 03/25/15 and found the facility in compliance on 03/20/15 as alleged in their PoC.</p>	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	

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F 000	INITIAL COMMENTS An Abbreviated/partial extended survey was initiated on 02/02/15 and concluded on 02/13/15 investigating KY22770, KY22771, KY22772, KY22773, and KY22774. The Division of Health Care substantiated KY22770 with Immediate Jeopardy identified on 02/06/15. The Immediate Jeopardy was determined to exist on 01/21/15 with deficiencies cited at 42 CFR 483.20 Resident Assessment (F282) at a Scope and Severity of a "J" and 42 CFR 483.25 Quality of Care (F323) at a Scope and Severity of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care.	F 000		
	On 01/21/15 at 11:42 PM, Resident #1 exited his/her unit without an alarm sounding and exited the building through the unlocked doors to the front lobby without staff knowledge. At 12:30 AM, the resident attempted to re-enter the front lobby doors after recognizing it was too cold outside and he/she would need a jacket. However, these doors locked from the outside and re-entrance was prohibited. The resident walked around the building to the Ambulance Entrance near the One South Unit entrance and rang the door bell. The staff answered the door bell to find the resident outside wearing street clothing; shoes, socks, blue jeans and a pull over shirt. Staff noted the resident appeared cold upon entering the building, with recorded weather conditions on 01/21/15 of cloudy skies and forty-two (42) degrees Fahrenheit at midnight with a westerly wind at 8.1 miles per hour. Upon returning Resident #1 to the unit, the resident's alarm did not sound. After the staff checked the alarm it was determined the battery was dead and the alarm was non-functioning.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____
[Signature] X NHA X 3/16/15

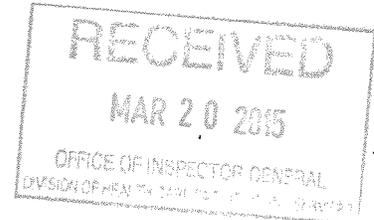
any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 30 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	Continued From page 1	F 000		
	The facility provided a credible Allegation of Compliance (AOC) on 02/11/15 alleging removal of Immediate Jeopardy on 02/07/15. However, the State Survey Agency verified Immediate Jeopardy was not removed until 02/13/15 due to re-education of staff. Record review and interview revealed forty-two (42) percent of staff was education via the telephone prior to 02/07/15. The Scope and Severity was lowered to a "D" in 42 CFR 483.20 Resident Assessment (F282) and 42 CFR 483.25 Quality of Care (F323) while the facility implements and monitors the Plan of Correction and for the effectiveness of systemic changes and quality assurance activities.			
F 157 SS=D	The Division of Health Care unsubstantiated the allegation for KY22771 with no deficiencies cited. KY22772 was unsubstantiated with a related deficiency cited. KY22773 was unsubstantiated with no deficiencies cited. KY22774 was substantiated with deficiencies cited. Additional deficiencies were cited at 42 CFR 483.10 Resident Rights (F157); 42 CFR 483.25 Quality of Care (F325); and, 42 CFR 483.75 Administration (F514) all at a Scope and Severity of a "D". 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a	F 157	F 157 1. Resident #5 is no longer a resident at this facility. Resident #5 discharged from this facility on 01/16/15.	01/16/15

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F 157	Continued From page 2 deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	2. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Restorative Nurse, Staff Development Coordinator, Director of Nursing from a sister facility, and	03/19/15
	The facility must also promptly notify the resident and, if known, the resident's legal representative or Interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.		MDS nurses are completing an audit to review changes of condition and new orders pertaining to Registered Dietitian recommendations to ensure families have been notified of any changes of condition. This Will be completed on 3/19/15, The Director of Nursing, Assistant	
	The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify one (1) of fourteen (14) sampled residents, Resident #5's legal representative as it related to Resident #5 sustaining a weight loss prior to a hospital transfer. The findings include: The facility did not provide a policy regarding notification of family for changes in condition. Review of the facility's investigation initiated after		Director of Nursing, Unit Manager, Restorative Nurse, Staff Development Coordinator, or MDS nurses will notify families of any change of condition identified that did not have previous notification.	

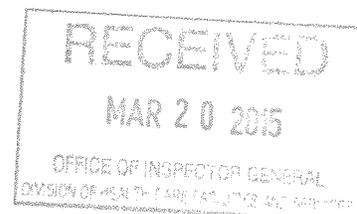
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ELEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 157	Continued From page 3 a family concern for Resident #5, revealed on 01/16/15, the family learned at the hospital that Resident #5 had sustained a weight loss and was concerned that they were not notified prior to Resident #5 being transferred from the facility.	F 157	The Signature Care Consultants, Director of Nursing, Assistant Director of Nursing, Unit Manager, Restorative Nurse, Staff Development Coordinator, Directors of Nursing and administrative nurses from sister facilities, and MDS nurses reviewed charts on 01/24/15 for any change of conditions including skin assessments, weight loss, the last 30 days to ensure families were notified.	
	Review of Resident #5's Nursing Notes, dated 01/16/15 at 10:23 PM, revealed Resident #5 was observed to have shortness of breath and was sent the hospital via Emergency Medical Services (EMS) on 01/16/15 at 9:40 PM. Interview with Licensed Practical Nurse (LPN) #1, on 02/04/15 at 11:15 AM, revealed she had noticed some weight loss the day the resident was sent out, but thought Resident #5 was on some form of a supplement. LPN #1 stated the family came to see the resident weekly; however, she had not discussed the resident's weight loss with the family. Review of Resident #5's closed record, revealed the facility admitted the resident on 07/16/13, with diagnoses of Depressive Disorder, Dementia, Paralysis, Muscle Weakness, Acute Pain, Cerebral Vascular Accident and Senile Dementia. Review of Resident #5's Weight Log, revealed the facility documented a weight of 156.6 pounds on 09/26/14 to 142.4 pounds on 01/07/15, a 14.2 pound weight loss (4.1%) in 104 days (3 and 1/2 months). Review of the Dieticians Notes, dated 01/05/15, revealed Resident #5 had sustained a 4.1% weight loss. The Dietician then documented recommendations for TwoCal supplement 60 milliliters (ml) two (2) times a day and a Thyroid Stimulating Hormone (TSH) blood level to ensure the level was not contributing to Resident #5's		3. The Staff Development Coordinator will reeducate licensed nurses regarding the change of condition policy. The Staff Development Coordinator will reeducate licensed nurses on notifying the MD and family on any changes of condition including weight loss or Dietitian recommendations. This education will be completed on 3/19/15.	03/19/15



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F 157	Continued From page 4 weight loss. Interview with the Assistant Director of Nursing (ADON) #1, on 02/10/15 at 3:04 PM, revealed when the Dietician made a recommendation she would call the doctor to obtain orders. All orders were then talked about in the morning clinical meeting; however, she had not spoken with the doctor regarding Resident #5 or to the family. Interview with an Interim ADON, on 02/10/15 at 3:29 PM, revealed she received the Dietician's recommendations and did not remember receiving a recommendation for Resident #5. The Interim ADON stated she would discuss the recommendations with the Doctor, obtain the orders and report the orders in the morning meeting. She would then call the family to inform them of the new orders or any changes. The family would not be informed if they did not identify a concern, although the family of Resident #5 should have been informed if there was a change in the resident's status.	F 157	4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Customer Experience Director, Restorative Nurse, Staff Development Coordinator, MDS Nurses, or Medical Records Clerk will audit all change of conditions five days a week beginning 02/02/15 for 6 months. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit ten charts monthly times six months to ensure compliance. The results of these audits will be reviewed at the Quality Assurance Meeting for further review and recommendations. 5. Completion Date 3/20/15	02/02/15
F 282 SS-J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Interview with the Director of Nursing (DON), on 02/10/15 at 4:52 PM, revealed once the orders were obtained the family would be notified of the new orders or any changes that would have occurred. The DON would then go over the new orders in the morning clinical meeting. The DON stated she did not remember receiving a recommendation for Resident #5 from the Dietician and if she had received the recommendation the family would have been notified.	F 282	1. Resident #1 on 1/21/2015 was noted by staff to be outside at the Ambulance entrance due to resident attempting to re-enter the facility by ringing the doorbell. Resident #1 was assessed by the Charge Nurse on 1/21/2015 at approximately 12:45am. No injury was noted and vital signs were stable. Responsible party	02/07/15

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F 282	Continued From page 5 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to have an effective system to ensure the implementation of the care plan for ongoing supervision for one (1) of fourteen (14) sampled residents, Resident #1. The facility assessed Resident #1 at risk for elopement with a care plan for staff to monitor the whereabouts of the resident on an ongoing basis. However, the facility staff failed to monitor the whereabouts of the resident and was not aware the resident had left the unit and facility until the resident rang the facility's door bell. On 01/21/15 at 11:42 PM, Resident #1 exited his/her unit without an alarm sounding and exited the building through the unlocked doors to the front lobby without staff knowledge. At 12:30 AM, the resident attempted to re-enter the front lobby doors after recognizing it was too cold outside and he/she would need a jacket. However, these doors locked from the outside and re-entrance was prohibited. The resident walked around the building to the Ambulance Entrance near the One South Unit entrance and rang the door bell. The staff answered the door bell to find the resident outside wearing street clothing; shoes, socks, blue jeans and a pull over shirt. Staff noted the resident appeared cold upon entering the building, with recorded weather conditions on 01/21/15 of cloudy skies and forty-two (42)	F 282	and physician were notified of incident by the Charge Nurse on 01/21/15. Care plan was updated by the Director of Nursing on 01/21/15 to reflect this recent incident. Resident was placed on q 15 min checks which were completed by the resident's Charge Nurses upon returning to facility. Residents wander guard was removed by staff nurse, RN, and checked in which battery was low. A new wander guard was immediately placed by staff nurse, RN. A head count of the entire facility was conducted on 1/21/2015 by the charge nurses with Administrator and DON oversight to ensure all residents were accounted for and were safe. Our census was 127 and all 127 residents were accounted for and were safe. On 1/21/2015 all exits were checked initially by the charge nurses on duty. The wander guard doors were manned and continuously monitored by facility staff until 01/22/15. The Plant Operations Director was notified and immediately came to the facility and checked all exits. One door on the 2 nd floor 2 North was adjusted by Plant Operations Director as there was a slight gap in closing; all other exit doors were found to be functioning properly. This resident resides on the first floor so this could not have been a door she used to exit the facility.	

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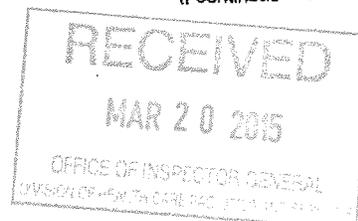
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F 282	Continued From page 6 degrees Fahrenheit at midnight with a westerly wind at 8.1 miles per hour. In addition, upon returning to the unit the resident's alarm did not sound. After the staff checked the alarm it was determined the battery was dead and the alarm was non-functioning. The facility's failure to ensure residents' plans of care were implemented placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 02/06/15 and was found to exist on 01/21/15. The facility was notified on 02/06/15.	F 282	Upon investigation by the charge nurses on 01/21/15, it was determined that Residents #1's wander guard tag had a low battery. Further investigation on 01/21/15 by the Administrator, Director of Nursing, and Plant Operations Director confirmed that the wander guard tag had a low battery. On 1/21/15 all resident wander guards were checked for placement and functioning by the Charge Nurses on duty followed by Plant Operations Director and all were properly functioning. On 2/04/15, Plant Operations Director and Regional Plant Operations Director utilized an outside vendor to adjust the front interior lobby doors. A keypad lock was activated and these doors will lock automatically at 9 p.m. daily and will unlock at 8 a.m. daily. The doors were wired so that anyone attempting to exit without the staff code during the hours of 9 p.m. and 8 a.m. will set off an alarm which will be audible at the nurses' stations. The monitoring panel at each nurse's station will also visibly show that the front door is being opened without the staff code between the hours of 9 p.m. and 8 a.m. The delayed egress system is in place on these doors. A receptionist will be at the front desk from 8 a.m. to 9 p.m. seven days a week.	
	The facility provided a credible Allegation of Compliance (AOC) on 02/11/15 alleging removal of Immediate Jeopardy on 02/07/15. However, the State Survey Agency verified Immediate Jeopardy was not removed until 02/13/15 due to re-education of staff. Record review and interview revealed forty-two (42) percent of staff was education via the telephone prior to 02/07/15. The scope and severity was lowered to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of the implemented action plans to achieve and maintain compliance with the plan of correction. The findings include: Review of the facility's policy regarding Care Plan-Comprehensive, revised October 2010, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. When possible, Interventions would address the underlying			



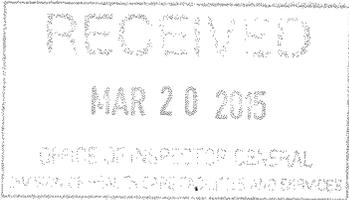
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F 282	Continued From page 6 degrees Fahrenheit at midnight with a westerly wind at 8.1 miles per hour. In addition, upon returning to the unit the resident's alarm did not sound. After the staff checked the alarm it was determined the battery was dead and the alarm was non-functioning.	F 282	The Staff Development Coordinator reeducated Nursing Assistants on how to follow the plan of care and where the care plans are located for non-licensed staff. This education was completed on 3/19/15.	
	The facility's failure to ensure residents' plans of care were implemented placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 02/06/15 and was found to exist on 01/21/15. The facility was notified on 02/06/15.		The Staff Development Coordinator reeducated licensed staff on how to initiate a care plan upon admission and with any change of condition and implementing care plans with measurable and realistic goals. This education will be completed on 03/19/15.	
	The facility provided a credible Allegation of Compliance (AOC) on 02/11/15 alleging removal of Immediate Jeopardy on 02/07/15. However, the State Survey Agency verified Immediate Jeopardy was not removed until 02/13/15 due to re-education of staff. Record review and interview revealed forty-two (42) percent of staff was education via the telephone prior to 02/07/15. The scope and severity was lowered to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of the implemented action plans to achieve and maintain compliance with the plan of correction. The findings include: Review of the facility's policy regarding Care Plan-Comprehensive, revised October 2010, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was developed for each resident. When possible, interventions would address the underlying		4. Charts for residents with a change of condition, new orders, new admits, discharges, or transfers to the hospital are reviewed at the daily clinical meeting five days a week by the clinical team which consists of Director of Nursing, Assistant Directors of Nursing, Medical Records Clerk, Dietary Services Manager, Restorative Nurse Coordinator, Quality of Life Director, Administrator, Chaplain, Staff Development Coordinator, Social Services Director, Social Services Assistant, or Customer Experience Director.	02/17/15.



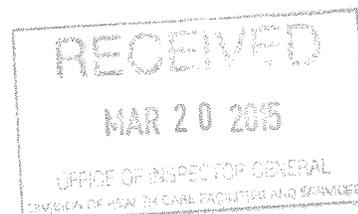
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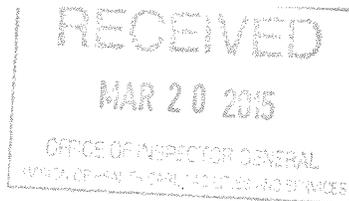
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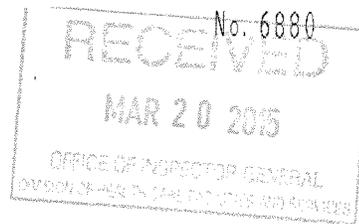
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 sources of the problem areas, rather than addressing only symptom or triggers. However, the policy did not address implementation of the care plan.	F 282	.These staff will review care plans to ensure they are updated appropriately. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations.	
	Review of Resident #1's record revealed the facility assessed Resident #1 on admission, on 07/17/14, as an elopement risk. The Elopement Risk Evaluation stated if there was a yes answer to questions four (4), five (5) or six (6), the Resident would be automatically at risk for elopement. The facility identified Resident #1 with a yes answer to cognitively impaired; independently ambulates; has poor decision making skills; had demonstrated exit-seeking behaviors; and, the resident had the ability to exit the facility.		5. Completion Date 03/14/15	
	Review of Resident #1's Elopement Care Plan, dated 08/14/14, revealed Resident #1 was at risk for elopement due to Dementia and walking around the units. The goal was for Resident #1 not to elope from the facility and staff would monitor the whereabouts of the resident on an ongoing basis. Post survey interview with Certified Nursing Assistant (CNA) #19, on 02/27/15 at 5:00 PM, revealed she was familiar with Resident #1 and if she needed to know how to provide care for Resident #1, she would look at the care plan book or the resident's closet which had a copy of the care plan. CNA #19 stated the care plan binder obtained the comprehensive nursing and CNA care plans. CNA #19 stated as far as she was aware Resident #1 was care planned for an Accutech Tag and for wandering. CNA #19 stated she monitored the residents every two (2) hours and was not aware Resident #1 was to have			



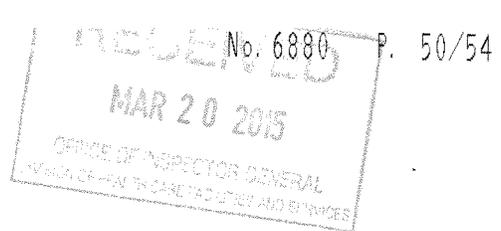


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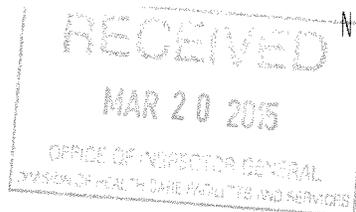
1. Resident #1 on 1/21/2015 was noted by staff to be outside at the Ambulance entrance due to resident attempting to re-enter the facility by ringing the doorbell.
2. Resident #1 was assessed by the Charge Nurse on 1/21/2015 at approximately 12:45am. No injury was noted and vital signs were stable. Responsible party and physician were notified of incident by the Charge Nurse on 01/21/15. Care plan was updated by the Director of Nursing on 01/21/15 to reflect this recent incident.
3. Resident was placed on q 15 min checks which were completed by the resident's Charge Nurses upon returning to facility. Residents wander guard was removed by staff nurse, RN, and checked in which battery was low. A new wander guard was immediately placed by staff nurse, RN.
4. A head count of the entire facility was conducted on 1/21/2015 by the charge nurses with Administrator and DON oversight to ensure all residents were accounted for and were safe. Our census was 127 and all 127 residents were accounted for and were safe.
5. On 1/21/2015 all exits were checked initially by the charge nurses on duty. The wander guard doors were manned and continuously monitored by facility staff until 01/22/15. The Plant Operations Director was notified and immediately came to the facility and checked all exits. One door on the 2nd floor 2 North was adjusted by Plant Operations Director as there was a slight gap in closing; all other exit doors were found to be functioning properly. This resident resides on the first floor so this could not have been a door she used to exit the facility.
6. Upon investigation by the charge nurses on 01/21/15, it was determined that Residents #1's wander guard tag had a low battery. Further investigation on 01/21/15 by the Administrator, Director of Nursing, and Plant Operations Director confirmed that the wander guard tag had a low battery.
7. On 1/21/15 all resident wander guards were checked for placement and functioning by the Charge Nurses on duty followed by Plant Operations Director and all were properly functioning.
8. On 2/04/15, Plant Operations Director and Regional Plant Operations Director utilized an outside vendor to adjust the front interior lobby doors. A keypad lock was activated and these doors will lock automatically at 9 p.m. daily and will unlock at 8 a.m. daily. The doors were wired so that anyone attempting to exit without the staff code during the hours of 9 p.m. and 8 a.m. will set off an alarm which will be audible at the nurses' stations. The monitoring panel at each nurse's station will also visibly show that the front door is being opened without the staff code between the hours of 9 p.m. and 8 a.m. The delayed egress system is in place on these doors. A receptionist will be at the front desk from 8 a.m. to 9 p.m. seven days a week.
9. On 2/03/15, staff were placed at the front receptionist desk for 24/7 monitoring. This monitoring will end on 2/06/15 after all staff education is completed.
10. Beginning 01/21/15, nursing and social services staff followed up with the resident daily for 72 hours to identify and address any psychosocial needs this resident might have. No issues were identified.
11. The entire facility consisting of 127 residents were reassessed for risk of elopement on 1/21/2015 by Assistant Director of Nursing, Director of Nursing, Social Services Assistant, or Social



- Services Director. No new residents were identified as elopement risk.
12. Care plans and nursing assistant care record were updated for 16 residents identified as being at risk for elopement on 1/21/2015 by Director of Nursing, Signature Care Consultant, Assistant Director of Nursing, or Unit Manager.
 13. The five binders which identify residents who are at risk for elopement were reviewed by the Administrator and Director of Nursing to ensure that they were updated and in place at each nurse's station and at the receptionist's desk on 1/21/2015, all were correct.
 14. The Administrator and Director of Nursing were reeducated via phone by the Signature Care Consultant, Regional Vice President, and Chief Nurse Executive on 01/21/15 on the elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments. There were no revisions to our elopement and missing person policy and procedure. This education was completed prior to education being initiated with staff on 1/21/15.
 15. 113 staff was trained on 01/21/15. 34 staff was trained on 01/22/15. 17 staff was trained on 01/23/15. 9 staff was trained on 01/24/15. 3 staff was trained on 01/25/15. 1 staff was trained on 01/28/15. 1 staff was trained on 01/30/15. 2 staff was trained on 01/31/15. 1 staff was trained on 02/01/15. This training was on the above mentioned in above #14.
 16. Education on elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments was initiated to staff on duty on 1/21/15 will continue prior to staff working by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Chaplain, Customer Experience Director, Dietary Services Manager, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager. The Administrator and Director of Nursing trained these educators on the material to cover for the education. This education was completed for nursing, administrative, housekeeping, laundry, therapy, dietary, plant operations for 181 staff. Post tests were completed by 02/02/15.
 17. Education and return demonstration on use of Accutech transmitter (device to check function) to ensure staff competency of wander guard function and battery checks was initiated on 01/21/15 by the Plant Operations Director or Plant Operations Assistant for licensed nurses. A post test was given to staff that received the education in which a passing score of 100% must be obtained. If staff did not receive a score of 100% on test the staff member will be re-educated on the spot and a new post-test will be given. 42 licensed nurses were educated.
 18. Staff that were not working on 1/21/2015 will be educated on the elopement policy and procedure, missing resident, care plan and Accutech by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Dietary Services Manager, Chaplain, Customer Experience Director, Admissions Director, Plant



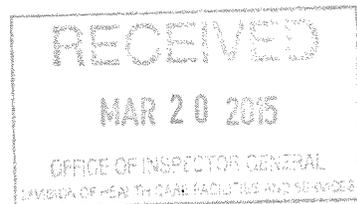
- Operations Director, Plant Operations Assistant, or Business Office Manager prior to taking their assignment upon return to work. A post test will be given in which a passing score of 100% must be obtained. If 100% not obtained the staff member will be re-educated and a post test will be reissued.
19. Staff who are PRN, on FLMA or on leave will be issued a certified letter by Administrator with return receipt on 1/26/2015 alerting them that they must receive an education on elopement policy, missing resident, care plans and Accutech (device to check wander guard function) before being allowed to work. There were 33 PRN staff and 3 FMLA on 1/21/15. The facility does not utilize agency staff.
 20. Staff will be educated on the new front door procedure by the Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Administrative Assistant, Admissions Director, Business Office Manager, Human Resources Director, Dietary Manager, Quality of Life Assistant, Chaplain, or Assistant Director of Nursing. 200 staff was educated and this was completed on 02/06/15.
 21. Assistant Directors of Nursing, and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 02/06/15 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments.
 22. Elopement and missing person policy and procedure were reviewed on 1/21/15 and no revisions were made to the policies. A new procedure was implemented on dating wander guard tags when received in the facility and placed on residents. The Plant Operations Director is opening and dating new wander guard tag when they arrive at the facility. Manufacturers recommendations state that the wander guard tag will last at least 12 months or longer. Wander guard tags will be replaced at 11 months. The Plant Operations Director and Director of Nursing are each keeping a roster of dates that wander guards are placed on residents with their activation date and when they need to be replaced. The Plant Operations Director or Director of Nursing will notify nursing staff when to replace a tag at the 11 month mark. Anytime a wander guard tag is replaced, the tag is to be labeled "BAD" and given to the Plant Operations Staff and logged in their maintenance log in the maintenance binder at each nurses station. See attached procedure
 23. A QA meeting was held in the afternoon on 1/21/2015 and attended by ADMIN, DON, two Regional Nurse Consultants, and Medical Director in regards to root cause of event, education, Interventions and plans to prevent reoccurrence. The elopement policy and procedure was reviewed and no revisions were made.
 24. A QA Meeting was held on 02/04/15 with the Medical Director to review procedure changes related to front door monitoring (See attached).
 25. A QA meeting was held on 02/06/15 with the Medical Director to review elopement plan. No further issues were identified.
 26. Director of Nursing or Regional Nurse Consultant reviewed 113 incident and accident reports for the last 3 months on 1/21/2015 for any other concerns of elopement or wandering. None were identified.
 27. Beginning 01/24/15 and going through 01/30/15, daily audits will be completed each shift for wander guard functioning on all identified residents, return demonstration by four licensed staff on wander guard functioning, and 12 staff members each shift will be given the post test for elopement by



- the Administrator, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. A score of 100% was required, if less than 100% employee were reinserviced and then given the post- test again until 100% compliance was obtained. Beginning 01/31/15, these audits were completed three times a week through 02/28/15 and then weekly times 24 weeks.
28. The Administrator or DON are reviewing the Post Tests given daily for any noted concerns. Any concerns will be addressed immediately.
 29. Daily for two weeks beginning 01/21/15, the Plant Operations Director and the Plant Operations Assistant will check the exit doors in the facility for correct functioning and place on their log. It will continue to be checked seven days a week by Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Restorative Coordinator, Customer Experience Director, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant.
 30. Daily for two weeks beginning 01/21/15, the Plant Operations Director or Plant Operations Assistant Department checked the functioning of Wander guards on all identified residents.
 31. Charts for residents with a change of condition, new orders, new admits, discharges, or transfers to the hospital are reviewed at the daily clinical meeting five days a week by the clinical team which consists of Director of Nursing, Assistant Directors of Nursing, Medical Records Clerk, Dietary Services Manager, Restorative Nurse Coordinator, Quality of Life Director, Administrator, Chaplain, Staff Development Coordinator, Social Services Director, Social Services Assistant, or Customer Experience Director. These staff will review care plans to ensure they are updated appropriately.
 32. Regional Care Consultant Staff are providing oversight to the audits four times a week beginning 01/21/15 and continuing through 02/13/15.
 33. The elopement policy and procedure, missing resident, care plans and Accutech system were in serviced in orientation for all new hires beginning 01/23/15 in which a post test will be given and a score of 100% must be obtained. Staff Development Coordinator is responsible for orientation.
 34. The elopement binders are being brought to the weekly at risk meeting, checked and updated as needed by the Social Services Director or Social Services Assistant. The At Risk Team will review the binders during the meeting. The At Risk team consists of Director of Nursing, Assistant Directors of Nursing, Social Services Director, Social Services Assistant, Dietary Manager, Restorative Coordinator, or Quality of Life Director.
 35. The QAPI Committee will review the results of elopement prevention plan post test and audits upon completion of the seven days to determine if there are any trends or concerns. The QAPI committee will then continue post test and audits three days week for one week, then weekly for two weeks at which time based upon the findings will

determine the continued frequency of
the above audits.

Completion Date: 3/20/15



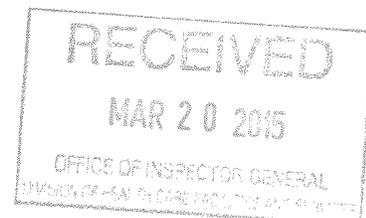
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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F 282	Continued From page 7 sources of the problem areas, rather than addressing only symptom or triggers. However, the policy did not address implementation of the care plan.	F 282	On 2/03/15, staff were placed at the front receptionist desk for 24/7 monitoring. This monitoring will end on 2/06/15 after all staff education is completed.	
	Review of Resident #1's record revealed the facility assessed Resident #1 on admission, on 07/17/14, as an elopement risk. The Elopement Risk Evaluation stated if there was a yes answer to questions four (4), five (5) or six (6), the Resident would be automatically at risk for elopement. The facility identified Resident #1 with a yes answer to cognitively impaired; independently ambulates; has poor decision making skills; had demonstrated exit-seeking behaviors; and, the resident had the ability to exit the facility.		Beginning 01/21/15, nursing and social services staff followed up with the resident daily for 72 hours to identify and address any psychosocial needs this resident might have. No issues were identified.	
	Review of Resident #1's Elopement Care Plan, dated 08/14/14, revealed Resident #1 was at risk for elopement due to Dementia and walking around the units. The goal was for Resident #1 not to elope from the facility and staff would monitor the whereabouts of the resident on an ongoing basis.		The entire facility consisting of 127 residents were reassessed for risk of elopement on 1/21/2015 by Assistant Director of Nursing, Director of Nursing, Social Services Assistant, or Social Services Director. No new residents were identified as elopement risk.	
	Post survey interview with Certified Nursing Assistant (CNA) #19, on 02/27/15 at 5:00 PM, revealed she was familiar with Resident #1 and if she needed to know how to provide care for Resident #1, she would look at the care plan book or the resident's closet which had a copy of the care plan. CNA #19 stated the care plan binder obtained the comprehensive nursing and CNA care plans. CNA #19 stated as far as she was aware Resident #1 was care planned for an Accutech Tag and for wandering. CNA #19 stated she monitored the residents every two (2) hours and was not aware Resident #1 was to have		Care plans and nursing assistant care record were updated for 16 residents identified as being at risk for elopement on 1/21/2015 by Director of Nursing, Signature Care Consultant, Assistant Director of Nursing, or Unit Manager. The five binders which identify residents who are at risk for elopement were reviewed by the Administrator and Director of Nursing to ensure that they were updated and in place at each nurse's station and at the receptionist's desk on 1/21/2015, all were correct. The Administrator and Director of Nursing were reeducated via phone by the Signature Care Consultant, Regional	



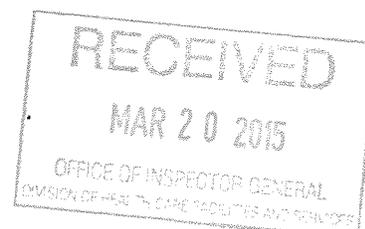
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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F 282	Continued From page 8 ongoing supervision. CNA #19 stated there were times when the nurses and aids were in rooms at the same time. CNA #19 stated ongoing meant to monitor the resident every fifteen (15) minutes or continuously until the nurse told her differently. CNA #19 stated she would think the nurses would inform her if a resident was to receive ongoing supervision. Post survey interview with CNA #4, on 02/27/15 at 10:47 PM, revealed she did not remember Resident #1's care plan stating the resident had ongoing supervision. CNA #4 stated ongoing supervision meant every fifteen (15) minutes checks. CNA #4 stated the night of the incident, no staff member was assigned to monitor the halls, especially when the nurse and aids were in the room providing care. CNA #4 stated if Resident #1 was to have ongoing supervision she would have informed the nurse to monitor when she had to provide resident care. CNA #4 stated if the care plan stated to monitor more frequently then the care plan should have been followed. Post survey interview with CNA #9, on 02/27/15 at 10:37 PM, revealed she was familiar with Resident #1 and if she needed to know how to provide care for Resident #1 she would look at the Care Plan Book. CNA #9 stated she had not seen on the care plan that Resident #9 was to be monitored on an ongoing basis. On going meant all night supervision. CNA #9 stated if she wanted to provide care for other residents she would have to inform someone to monitor Resident #1 while she was busy. She stated there were times when the aides and nurses were in rooms together and there was no one to monitor the halls. CNA #9 stated if Resident #1 was not being monitored then the care plan was not followed.	F 282	Vice President, and Chief Nurse Executive on 01/21/15 on the elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments. There were no revisions to our elopement and missing person policy and procedure. This education was completed prior to education being initiated with staff on 1/21/15. 113 staff was trained on 01/21/15. 34 staff was trained on 01/22/15. 17 staff was trained on 01/23/15. 9 staff was trained on 01/24/15. 3 staff was trained on 01/25/15. 1 staff was trained on 01/28/15. 1 staff was trained on 01/30/15. 2 staff was trained on 01/31/15. 1 staff was trained on 02/01/15. This training was on the above mentioned in above #14. Education on elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments was initiated to staff on duty on 1/21/15 will continue prior to staff	



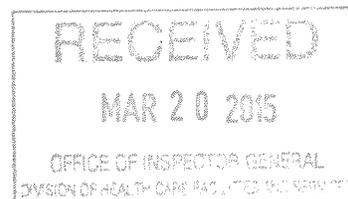
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES A. PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 282	Continued From page 9 She stated if the resident was monitored he/she may not have exited the building. Post survey interview with CNA #20, on 02/27/15 at 10:10 PM, revealed she was familiar with Resident #1 and was aware Resident #1 was an elopement risk and had an Accutech Tag. CNA #20 stated to supervise a resident on an ongoing basis, meant to check on the resident every fifteen (15) minutes. CNA #20 stated she would document the fifteen (15) minute checks if told to do so. CNA #20 stated she had not seen any documents that stated Resident #1 was to be ongoing supervision. CNA #20 stated if the resident was on ongoing monitoring she would expect the nurse to monitor when she was completing her rounds because it was a team effort. CNA #20 stated if she and the nurses were in rooms providing care at the same time, she was not sure how the residents were to be monitored. CNA #20 stated she had never observed Resident #1 trying to leave the unit. Review of the fifteen (15) minute checks, revealed no record of documented checks before 01/21/15. Post survey interview with Licensed Practical Nurse (LPN) #5, on 02/27/15 at 11:00 PM, revealed she monitored behaviors by looking at the behavior book and then documenting in the nurses notes. LPN #5 stated ongoing supervision meant for the resident to be monitored every (15) minutes and the aid would document the monitoring. LPN #5 stated if an aide was completing incontinent care she would expect the aides to inform her so that she could complete the fifteen (15) minute checks. If she had to provide care she would let an aide know to	F 282	working by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Chaplain, Customer Experience Director, Dietary Services Manager, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager. The Administrator and Director of Nursing trained these educators on the material to cover for the education. This education was completed for nursing, administrative, housekeeping, laundry, therapy, dietary, plant operations for 181 staff. Post tests were completed by 02/02/15. Education and return demonstration on use of Accutech transmitter (device to check function) to ensure staff competency of wander guard function and battery checks was initiated on 01/21/15 by the Plant Operations Director or Plant Operations Assistant for licensed nurses. A post test was given to staff that received the education in which a passing score of 100% must be obtained. If staff did not receive a score of 100% on test the staff member will be re-educated on the spot and a new post-test will be given. 42 licensed nurses were educated. Staff that were not working on 1/21/2015 will be educated on the	



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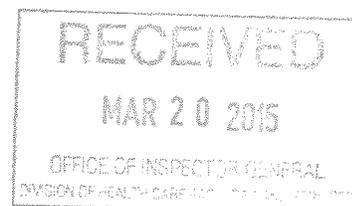
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 282	Continued From page 10 monitor the halls; however, she worked a different unit on the night the resident left the unit. She stated in situations where the nurse and aids were providing care at the same time, then there would be no one to monitor the halls. LPN #5 stated if Resident #1 was care planned to be supervised on an ongoing basis then the care plan should have been followed. Record review of the nurses notes, on 01/20/15, revealed no behaviors of wandering was documented. Interview with Registered (RN) #1, on 02/06/15 at 1:08 PM, revealed she was ultimately responsible to ensure all residents were safe on the unit. She stated there was enough staff to monitor the doors to the unit and that the staff was doing what they needed to do. RN #1 stated there was a possibility that all three staff members, who worked on the unit, could be in rooms assisting other residents without monitoring the halls. RN #1 gave no definition of what ongoing observation on the care plan meant. Interview with the Minimum Data Set (MDS) Coordinator #1, on 02/06/15 at 1:39 PM, revealed the care plan for Resident #1 was not being followed because to monitor the resident ongoing meant to monitor Resident #1 for exit seeking behaviors at all times. The MDS Coordinator #1 stated if they could not visibly see the residents at all times, the Accutech Tab was a second back up to the supervision. The MDS Coordinator stated Resident #1 was known to have intermittent confusion; however, had no changes in his/her status and the care plan was appropriate for this resident.	F 282	elopement policy and procedure, missing resident, care plan and Accutech by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Dietary Services Manager, Chaplain, Customer Experience Director, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager prior to taking their assignment upon return to work. A post test will be given in which a passing score of 100% must be obtained. If 100% not obtained the staff member will be re-educated and a post test will be reissued. Staff who are PRN, on FLMA or on leave will be issued a certified letter by Administrator with return receipt on 1/26/2015 alerting them that they must receive an education on elopement policy, missing resident, care plans and Accutech (device to check wander guard function) before being allowed to work. There were 33 PRN staff and 3 FMLA on 1/21/15. The facility does not utilize agency staff. Staff will be educated on the new front door procedure by the Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Administrative Assistant, Admissions Director, Business Office Manager,	

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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

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

ELEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748	
(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 282	Continued From page 11 Interview with the Director of Nursing (DON), on 02/06/15 at 2:36 PM, revealed she was not expecting the Accutech Tab alarming system to replace the supervision of the staff and expected the staff to check on the residents. The DON did not provide a definition to what ongoing supervision as documented on the care plan meant, except that Resident #1 was checked at 11:30 PM on 01/20/15 and that staff had completed their rounds every two hours. The DON stated the staff did not document the whereabouts of residents on an ongoing basis. The DON stated Resident #1 did not require more supervision, than any of the other identified elopement residents, just because she was at risk. The DON stated at times the nursing staff would be in resident rooms and could not supervise each resident unless that resident was made one (1) to one (1). However, this was not on the care plan. Interview with the Administrator, on 02/13/15 at 2:28 PM, revealed there were no supervision concerns identified. The Administrator stated she felt like the facility was staffed appropriately. The Administrator stated she did not identify the staff on unit as a concern, but that the concern was the alarm not sounding on the unit. The Administrator stated ongoing supervision meant, for example, that staff would be aware of the resident's whereabouts as they did rounds and came out of resident rooms. The Administrator stated the only way to provide continuous supervision was to provide one (1) to one (1) coverage. Review of the acceptable Allegation of Compliance (AOC), dated 02/11/15, revealed the	F 282	Human Resources Director, Dietary Manager, Quality of Life Assistant, Chaplain, or Assistant Director of Nursing. 200 staff was educated and this was completed on 02/06/15. Assistant Directors of Nursing, and MDS Coordinators were reeducated by the Administrator and Director of Nursing on 02/06/15 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Elopement and missing person policy and procedure were reviewed on 1/21/15 and no revisions were made to the policies. A new procedure was implemented on dating wanderguard tags when received in the facility and placed on residents. The Plant Operations Director is opening and dating new wanderguard tag when they arrive at the facility. Manufacturers recommendations state that the wanderguard tag will last at least 12 months or longer. Wanderguard tags will be replaced at 11 months. The Plant Operations Director and Director of Nursing are each keeping a roster of dates that wanderguards are placed on residents with their activation date and when they need to be replaced. The Plant Operations Director or Director of Nursing will notify nursing staff when to replace a tag at the 11 month mark.	



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F 282	Continued From page 12 facility took the following immediate actions: 1. Resident #1 was assessed by the Charge Nurse on 01/21/15 at approximately 12:45 AM. The Responsible Party and Physician were notified of the incident by the Charge Nurse on 01/21/15. The care plan was updated by the Director of Nursing on 01/21/15 to reflect the recent incident. 2. Resident #1 was placed on 15 minute checks which were completed by the resident's Charge Nurse upon returning to the facility. The RN removed the Accutech tag, checked it, and determined the battery was low. A new Accutech tag was immediately placed by the RN.	F 282	Anytime a wander guard tag is replaced, the tag is to be labeled "BAD" and given to the Plant Operations Staff and logged in their maintenance log in the maintenance binder at each nurses station. See attached procedure A QA meeting was held in the afternoon on 1/21/2015 and attended by ADMIN, DON, two Regional Nurse Consultants, and Medical Director in regards to root cause of event, education, interventions and plans to prevent reoccurrence. The elopement policy and procedure was reviewed and no revisions were made. A QA Meeting was held on 02/04/15 with the Medical Director to review procedure changes related to front door monitoring (See attached). A QA meeting was held on 02/06/15 with the Medical Director to review elopement plan. No further issues were identified. Director of Nursing or Regional Nurse Consultant reviewed 113 incident and accident reports for the last 3 months on 1/21/2015 for any other concerns of elopement or wandering. None were identified. Beginning 01/24/15 and going through 01/30/15, dally audits will be completed each shift for wanderguard functioning on all identified residents, return demonstration by four licensed staff on wanderguard functioning, and	
	3. A head count of the entire facility was conducted on 01/21/15 by the charge nurses with the Administrator and DON oversight to ensure all residents were accounted for and were safe. 4. On 01/21/15 all exits were checked initially by the charge nurses on duty. The Accutech doors were manned and continuously monitored by facility staff until 01/22/15. The Plant Operations Director was notified and immediately came to check all exit doors. One door on the 2nd floor Two North was adjusted by the Plant Operations Director as there was a slight gap in closing: all other exit doors were found to be functioning properly. 5. On 01/21/15, the Administrator, Director of Nursing and Plant Operations Director confirmed the Accutech tag had a low battery. 6. On 01/21/15 all resident Accutech tags were checked for placement and function by the			

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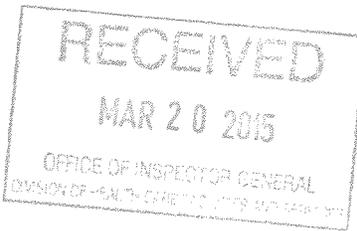
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 282	Continued From page 13 Charge Nurses on duty and the Plant Operations Director. 7. On 02/04/15, the Plant Operations Director and Regional Plant Operations Director utilized an outside vendor to adjust the front interior lobby doors. A keypad lock was activated and the doors would lock automatically at 9:00 PM daily and would unlock at 8:00 AM daily. The doors were wired so that anyone attempting to exit without the door code during the hours of 9:00 PM and 8:00 AM would set off an alarm which would be audible at the nurses stations. The monitoring panel at each nurses station would also visibly show that the front door was being opened without the door code between the hours of 9:00 PM and 8:00 AM. The Delayed egress system was in place on these doors. A Receptionist would be at the front desk from 8:00 AM to 9:00 PM seven days a week. 8. On 02/03/15, staff were placed at the front receptionist desk for 24/7 monitoring. This monitoring would end on 02/06/15 after all staff education was completed. 9. Beginning 01/21/15 the nursing and Social Services staff would follow up with the resident daily for seventy-two hours to identify and address any psychosocial needs Resident #1 may have. 10. On 01/21/15, all 127 residents were reassessed for risk of elopement by the Assistant Director of Nursing (ADON), Director of Nursing (DON) and Social Services Assistant. 11. Care plans and nursing assistant care records were updated for sixteen (16) residents who were	F 282	12 staff members each shift will be given the post test for elopement by the Administrator, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. A score of 100% was required, if less than 100% employee were reinserviced and then given the post- test again until 100% compliance was obtained. Beginning 01/31/15, these audits were completed three times a week through 02/28/15 and then weekly times 24 weeks. The Administrator or DON are reviewing the Post Tests given daily for any noted concerns. Any concerns will be addressed immediately. Daily for two weeks beginning 01/21/15, the Plant Operations Director and the Plant Operations Assistant will check the exit doors in the facility for correct functioning and place on their log. It will continue to be checked seven days a week by Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Restorative Coordinator, Customer Experience Director, Business Office Assistant, Human Resources Director, Dietary Services	



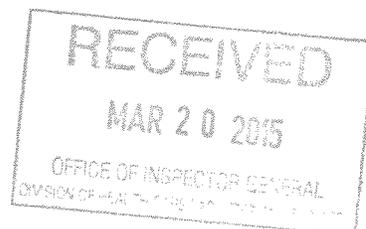
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F 282	Continued From page 14 identified as being at risk for elopement on 01/21/15 by the DON, Facility Consultant, and the ADON.	F 282	Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant.	
	12. On 01/21/15, the five (5) binders which identified eighteen (18) residents who were at risk for elopement were reviewed by the Administrator and DON to ensure they were updated and in place at each nurses station and at the receptionist desk.		Daily for two weeks beginning 01/21/15, the Plant Operations Director or Plant Operations Assistant Department checked the functioning of Wander guards on all identified residents.	
	13. On 01/21/15 The Administrator and DON were reeducated via phone by the Facility Consultant, Regional Vice President and Chief Nurse Executive on the elopement policy, missing resident policy, including how to respond to door alarms, complete a head count, checking the wander-guard function of the doors, Accutech tags and implementation of care plans related to triggered areas including elopement risk assessments. There were no revisions to the elopement and missing person policy and procedure. This education was completed prior to the education being initiated with staff on 01/21/15.		Charts for residents with a change of condition, new orders, new admits, discharges, or transfers to the hospital are reviewed at the daily clinical meeting five days a week by the clinical team which consists of Director of Nursing, Assistant Directors of Nursing, Medical Records Clerk, Dietary Services Manager, Restorative Nurse Coordinator, Quality of Life Director, Administrator, Chaplain, Staff Development Coordinator, Social Services Director, Social Services Assistant, or Customer Experience Director. These staff will review care plans to ensure they are updated appropriately.	
	14. Education regarding the elopement policy, missing resident policy including how to respond to door alarms, completing head counts, checking the wander-guard function of the doors, Accutech tags and implementation of care plans related to triggered areas including elopement risk assessments were provided by the Administrator and the DON on 01/21/15 to all the Administrative staff who were to provide education. Education was completed for nursing, housekeeping, laundry, therapy, dietary and plant operations that included 183 staff. Post tests were completed by 02/02/15.		Regional Care Consultant Staff are providing oversight to the audits four times a week beginning 01/21/15 and continuing through 02/13/15. The elopement policy and procedure,	



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F 282	Continued From page 15 15. Education and return demonstrations on use of Accutech Transmitter (device to check function) to ensure staff competency of the wander-guard function and battery checks were initiated on 01/21/15 by the Plant Operations Director or Plant Operations Assistant for licensed nurses. A post test was given to staff that received the education in which a passing score of 100 % had to be obtained. If a score of 100 % on the test was not obtained the staff member would be re-educated on the spot and a new post-test would be given. Forty-two (42) licensed nurses were educated. 16. Staff that were not working on 01/21/15, would be educated prior to taking their assignment upon return to work. A post test would be given in which a passing score of 100 % had to be obtained. If 100 % was not obtained the staff member would be re-educated and a post test would be reissued. 17. Staff who were PRN (as needed staff) or Family Leave Medical Act (FMLA) or on leave would be issued a certified letter by the Administrator with a return receipt on 01/26/15 alerting them that they must receive an education on the elopement policy, missing resident, care plans and Accutech before being allowed to work. There were 33 PRN and 3 FMLA on 01/21/15. The facility does not utilize Agency Staff. 18. On 02/06/15 the ADON and Minimum Data Set (MDS) Coordinator were re-educated by the Administrator and DON on completion of care plans upon admission, quarterly and with changes of condition, including care plans to reflect the nursing assessment.	F 282	missing resident, care plans and Accutech system were in serviced in orientation for all new hires beginning 01/23/15 in which a post test will be given and a score of 100% must be obtained. Staff Development Coordinator is responsible for orientation. The elopement binders are being brought to the weekly at risk meeting, checked and updated as needed by the Social Services Director or Social Services Assistant. The At Risk Team will review the binders during the meeting. The At Risk team consists of Director of Nursing, Assistant Directors of Nursing, Social Services Director, Social Services Assistant, Dietary Manager, Restorative Coordinator, or Quality of Life Director. The QAPI Committee will review the results of elopement prevention plan post test and audits upon completion of the seven days to determine if there are any trends or concerns. The QAPI committee will then continue post test and audits three days week for one week, then weekly for two weeks at which time based upon the findings will determine the continued frequency of the above audits.		

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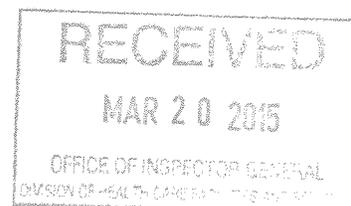
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F 282	Continued From page 17 reviewed 113 incident and accident reports for the last three (3) months on 01/21/15 for any other concerns of elopement or wandering. None were identified.	F 282	4. Charts for residents with a change of condition, new orders, new admits, discharges or transfers to the hospital are reviewed at the daily clinical meeting five days a week by the clinical team which consists of the Director of Nursing, Assistant Directors of Nursing, Medical Records Clerk, Dietary Services Manager, Restorative Nurse Coordinator, Quality of Life Director, Administrator, Chaplain, Staff Development Coordinator, Social Services Director, Social Services Assistant, or Customer Experience Director. These staff will review care plans to ensure they are update appropriately. The results of these audits will be forwarded to the Quality Assurance Committee for further review and recommendations. Completion Date: 3/20/15	3/19/15
	24. Beginning 01/24/15 and going through 01/30/15, daily audits would be completed each shift for Accutech tag function on all identified residents, return demonstration by four (4) licensed staff on wander-guard functioning and twelve (12) staff members each shift would be given the post test for elopement by the Administrative staff. A score of 100 % would be required.			
	25. Daily for two (2) weeks beginning 01/21/15, the Plant Operations Director and the Plant Operations Assistant would check the exit doors in the facility for correct function and place on their log.			
	26. Daily for two (2) weeks beginning 01/21/15, the Plant Operations Director or Plant Operations Assistant would check the function of the Accutech tags on all identified residents.			
	27. Charts for residents with a change of condition, new orders, new admissions, discharges, or transfers to the hospital were reviewed at the daily clinical meeting five (5) days a week by the clinical team.			
	28. The Regional Care Consultant Staff were providing oversight to the audits four (4) times a week beginning 01/21/15 and continued through 02/13/15.			
	29. The elopement policy and procedure, missing resident, care plans and Accutech system would			



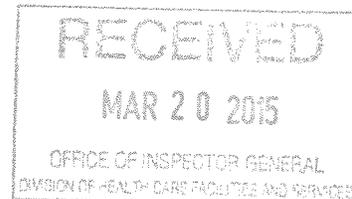
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F 282	Continued From page 18 be in-serviced in orientation for all new hires beginning 01/23/15 in which a post test would be given and a score of 100 % must be obtained. The Staff Development Coordinator would be responsible for the orientation.	F 282		
	The State Survey Agency validated the AOC on 02/13/15 through observation, interview and record review prior to exit as follows: 1. Interview with the Charge Nurse (RN #1), on 02/06/15 at 1:08 PM, revealed she notified the family and physician of Resident #1 the morning of the incident. Record review of the Incident Report dated 01/21/15 at 1:00 AM, revealed the Physician was called at 01/21/15 at 3:00 AM and the Family was called on 01/21/15 at 1:20 AM. 2. Review of the fifteen (15) minutes checks revealed Resident #1 was monitored every fifteen (15) minutes starting at 1:15 AM on 01/21/15 through 01/27/15. Interview with RN #1, on 02/02/15 at 10:35 PM, revealed Resident #1 was monitored every fifteen (15) minutes once the resident was back in the building. 3. Interview with Licensed Practical Nurse (LPN) #5, on 02/02/15 at 10:00 PM, revealed on the night of 01/21/15 she had completed a head count of all residents on her unit. Interview with RN #1, on 02/02/15 at 10:35 PM, revealed a head count of all residents occurred through out the building. Interview with the Director of Nursing (DON), on 02/05/15 at 9:40 AM, revealed she instructed the staff to ensure all residents were accounted for the day of 01/21/15 at about 1:00 AM. Interview with the Administrator, on 02/05/15 at 10:10 AM, revealed she instructed the staff to complete a head count when she received a			



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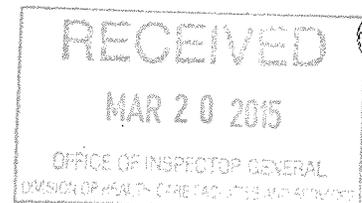
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F 282	Continued From page 19 phone call from RN #1 on 01/21/15. 4. Interview with LPN #3, on 02/02/15 at 10:12 PM, revealed she helped with the check of the doors and found that the Two North needed to be manned by staff and all other doors were monitored every fifteen (15) minutes. Interview with RN #1 on 02/02/15 at 10:35 PM, revealed she helped with checking that all doors were secure. RN #1 stated the doors were checked every fifteen (15) minutes and later on that day someone manned all of the doors. Interview with the Plant Operations Director, on 02/03/15 at 4:40 PM, revealed the morning of the incident he received a call and made sure there were staff monitoring the doors until he was sure that the doors were working appropriately. The door on Two North had to be readjusted. The doors were found to be functioning appropriately. 5. Interview with the Plant Operations Director, on 02/03/15 at 4:40 PM, interview with the DON, on 02/05/15 at 9:40 AM and interview with the Administrator, on 02/05/15 at 10:10 AM, revealed when they had observed Resident #1's Accutech tag it was found to have a low battery. 6. The State Agency validated through interview with RN #1 on 02/06/15 at 1:08 PM and interview with the Plant Operations Director, on 02/05/15 at 2:22 PM, revealed all resident wander-guards were checked. 7. Review a list of items completed to fix the front door from the Regional Plant Operations Director, on 02/04/15, revealed he came to meet with a technician to have him add an additional alarm at the nurses station that would sound when the front corridor door was opened without a code, it	F 282		

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F 282	Continued From page 20 would remain in alarm mode until an employee reset the keypad. The System was installed with a timer to automatically lock the door from 9:00 PM until 8:00 AM and the timer was programmable. Interview with the Plant Operations Director, on 02/06/15 at 2:19 PM, revealed on 02/04/15 the front lobby corridor would be locked down after 9:00 PM and the staff would have to utilize a key pad to get out. The delayed egress system was in place on these doors. A Receptionist would be at the front desk Interview with the Administrator, on 02/04/15 at 3:36 PM, revealed she adjusted the monitoring of the front door to the hours of 8:00 AM to 9:00 PM Monday through Sunday which was seven (7) days a week. Observation on 02/05/15 at 8:30 AM, revealed a key pad outside of the front corridor and a sign which stated If in an emergency situation hit the red button to the right to exit. 8. Interview with the Receptionist, on 02/12/15 at 3:47 PM, revealed she could remember staff having to man the front lobby 24/7 to ensure residents were safe. Receptionist #1 stated she would stay until 10:00 PM and would be relieved by another staff member. She stated now the doors were locked automatically after a certain time. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed on 02/03/15 through 02/06/15, she placed someone at the receptionist desk 24/7. The front interior lobby door was adjusted with a keypad to lock automatically after 9:00 PM. 9. Review of Resident #1's nurses notes revealed, the staff documented behaviors for Resident #1 on an ongoing basis, shift to shift. Review of Resident #1's fifteen (15) minute	F 282			



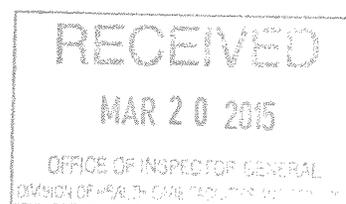
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F 282	Continued From page 21 checks revealed he/she was checked from 1:00 AM on 01/21/15 through 01/27/15 at 10:00 PM. Interview with Social Services on 02/12/15 at 2:33 PM, revealed she attended morning clinical meetings and went over behaviors and wondering concerns of the staff. She also reviewed change of condition to monitor the residents of any changes. Social Services reviewed the Nurses Notes, Incident Reports, twenty-four (24) hour report, admissions, and discharges for any changes.	F 282		
	10. Record review of Residents' #1, #3, #8, #10, #11, #12, #13 and #14 Elopement Risk Assessments revealed all the assessments were re-evaluated on 01/21/15. Interview with the Interim ADON, on 02/12/15 at 1:13 PM, Interview with the DON, on 02/12/15 at 4:12 PM and interview with Social Services, on 02/12/15 at 2:33 PM, revealed they reassessed all residents for the risk of elopement on 01/21/15.			
	11. Record review of Residents' #1, #3, #8, #10, #11, #12, #13 and #14 were all identified to have elopement concerns and all care plans were validated to be up-to-date as of 01/21/15. Interview with the ADON #2 on 02/12/15 at 1:45 PM, interview with DON, on 02/12/15 at 4:12 PM and the Facility Consultant, on 02/12/15 at 3:00 PM, revealed the Care plans and the nursing assistant care records were updated for residents who were identified to be an elopement risk.			
	12. Observations revealed five (5) binders containing eighteen (18) residents were present on each unit and at the receptionist desk on 02/05/15 at 9:00 AM. Interview with the DON, on 02/12/15 at 4:12 PM, revealed she took the elopement binders to the daily clinical meetings to			



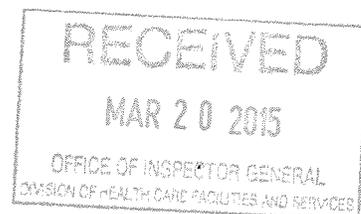
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 282	Continued From page 22 make sure the binders were up-to-date. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed there were five (5) elopement binders and they were being reviewed daily in the clinical morning meeting.	F 282		
	13. Interview with the Facility Consultant, on 02/12/15 at 3:00 PM, revealed she provided education to the Administrator and the DON via phone on the morning of 01/21/15 and then came in around 7:00 AM on 01/21/15. The Facility Consultant stated she educated the Administrator and DON, on the elopement policy, validated that they followed the policy and checked all doors. She also ensured the bracelets were checked along with their batteries. She educated the Administrator and DON on the missing resident policy. Interview with Chief Nurse Executive, on 02/13/15 at 12:42 PM, revealed she had educated the DON and Administrator on 01/21/15. She educated them on the elopement policy, missing person policy and checking the Accutech tags, how to complete a head count, update care plans and resident assessments. Interview with the DON, on 02/12/15 at 4:12 PM and the Administrator on 02/12/15 at 5:01 PM, revealed they were educated by the Facility Consultant, Regional Vice President and the Chief Executive on 01/21/15.			
	14. Interview with the Plant Operations Director, on 02/12/15 at 3:05 PM, revealed he received training from the DON and Administrator on the elopement policy and missing resident policy. He was also educated on the door alarms, completing a head count, checking Accutech tags and implementing a care plan. The Plant Operations Director stated he had to complete a post test. Interview with Receptionist #1, on			



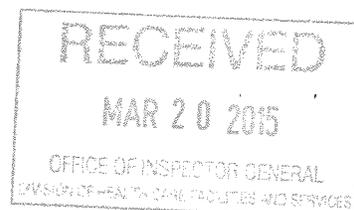
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F 282	Continued From page 23 02/12/15 at 3:47 PM, revealed she received training on elopement and when to call a code green by the Administrator.	F 282		
	Record review of the training record for the elopement and missing resident policy, revealed there were 161 staff who were trained in person and twenty-two (22) persons who were called by phone. Record review of the training on the front doors, revealed 112 staff members were trained in person and seventy-one (71) staff members were trained by phone.			
	Interview with Certified Nursing Assistant (CNA) #17, on 02/13/15 at 4:02 PM, revealed she originally was educated by phone in regards to the front door on 02/06/15. CNA #17 stated she was educated in person on 02/12/15 to obtain education on the doors. CNA #17 stated she was taught that the doors would lock down after 9:00 PM at night and that staff would have to utilize a code to get out. If the alarm was to go off at the front door the alarm would alert at the nurses station.			
	Interview with a Physical Therapist Assistant (PTA), on 02/13/15 at 4:05 PM, revealed she was educated on the front doors and the elopement policy by phone. The PTA stated she was asked to come in on 02/13/15 to receive education in person. She stated she had received training by the Dietary Manager and the Chaplain. The PTA stated the Dietary Manager educated her on the elopement policy and how they must assess why the door was alarming. He stated if they did not find a resident to complete a head count, call a code green and grab the elopement binder to see who was missing. The PTA stated she was educated by the Chaplain in regards to the front			



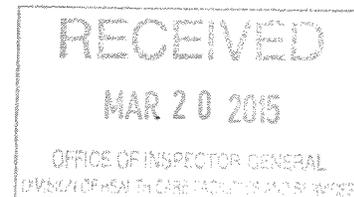
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F 282	Continued From page 24 door locking after 9:00 PM. Interview with the Supply Clerk, on 02/13/15 at 4:10 PM, revealed she received a phone call about education on both the elopement policy and the front door policy. The Supply Clerk stated she obtained education by the Dietary Manager on 02/13/15. The Supply Clerk stated they went over code green and procedures to ensure resident safety. The Supply Clerk was also educated on how the front doors would lock down after 9:00 PM, the door would alarm if a code was not utilized which would alarm at the nurses station. Interview with the DON, on 02/13/15 at 4:30 PM, revealed there were 183 staff members in total. Five (5) of which would have to have a certified letter sent to them because they were either out of the state or on Family Medical Leave Act (FMLA). Interview with the Administrator, on 02/13/15 at 2:28 PM, revealed she and the Administrative staff had educated staff members via phone on the elopement policy and the front door training. The Administrator stated she was not aware she could not provide education by phone. Those staff members who were educated by phone had "by phone" written next to their name. The Administrator stated she had all of the staff members to come in and receive education, as well as meet with staff at their homes and other places to ensure they were educated in person and would obtain their signature. Record review of the signatures, revealed all but five (5) staff members were not educated and would be upon starting their shift.	F 282		



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ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">185057</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">C 02/13/2015</p>
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F 282	Continued From page 25 Review of the post test revealed they were completed by staff on 02/02/15.	F 282		
	15. Review of the signatures of nurses who had obtained the training for how to complete an Accutech Tag function and battery check revealed return demonstrations were performed. Interviews with three (3) Registered Nurses and five (5) Licensed Practical Nurses revealed they had to complete a check off for how to utilize the Accutech tag to check for the function of the battery with the Plant Operations Director. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM, revealed the nurses had to complete demonstrations on the Accutech Tag devices. He made the nursing staff show him how to activate and deactivate the Accutech Tag and to identify if a tag was good or bad and if the tag was identified as low battery to have the staff document bad on the back of the Tag. Interview with the Plant Operations Assistant, on 02/12/15 at 3:05 PM, revealed he was educated by the Plant Operations Director on how to use the Stad-N device with the Accutech Tag with return demonstration. He then educated the nurses on how to utilize the machines as well.			
	16. Interview with the DON, on 02/12/15 at 4:12 PM, revealed she and the Administrator trained the staff and the staff members were given a post test which had to be passed with 100%, or re-education would be provided. The DON stated she had one (1) staff member who had to take the test again with re-education. The DON stated the post tests were completed by 02/06/15. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed she and the DON ensured staff received Post tests to the education that was covered for the when the door alarm sounds and			

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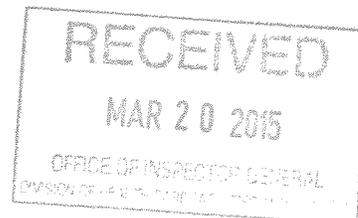
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F 282	Continued From page 26 how to respond. What the code for a missing person was and where were the elopement books were located. Review of the Post tests revealed 183 staff members completed post exams of the total 188 staff.	F 282		
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	17. Interview with the Receptionist, on 02/12/15 at 3:47 PM, revealed she mailed out thirty-six (36) certified letters to the staff whom could not come into the facility for training through the Administrators directive. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed she sent out Certified letters to the staff on FMLA and who were PRN. She made sure she received responses to ensure the staff had received the letters.			
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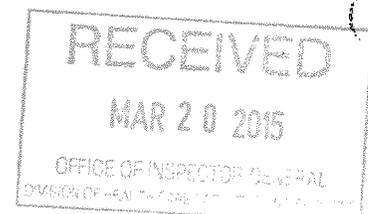
	18. Interview with the Interim ADON, on 02/12/15 at 1:13 PM, revealed she was educated by the DON on the care plans and making sure the Doctor's orders, risk for elopement and behaviors matched the care plan. The DON also taught them to ensure the assessments were completed upon admission, quarterly and annually. Interview with the MDS Coordinator #2, on 02/12/15 at 3:30 PM, revealed she had received training by the DON in regards to the care plans, elopement and the assessments to ensure they were completed. The MDS Coordinator #2 stated during the morning clinical meetings staff would ensure that assessments were completed timely. Record review of the signatures for training revealed the Interim ADON and the MDS Coordinator #2 was in attendance for the care plan training that was provided on 01/27/15. Interview with the DON, on 02/12/15 at 4:12 PM, revealed she educated the ADONs and the MDS Coordinators about the care plans and ensuring the care plans matched the orders and assessments. The DON stated			
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F 282	Continued From page 27 now the elopement binders had to come to the clinical meetings to ensure the care plans were up-to-date and all assessments were completed timely.	F 282		
	<p>19. Observation of Residents #12, #13 and #14 on 02/13/15 at 4:30 PM, revealed their Accutech tags had dates of when the Accutech tag was activated. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM, revealed he had ordered a new batch of Accutech Tags and removed all of the old Accutech Tags from the residents who were identified to be an elopement risk. The Plant Operations Director stated he then dated the new Accutech tags and placed new ones on all of the residents identified to be an elopement. He stated he has a binder in which now he and the DON keeps track of the Accutech Tags and would be removing them at the eleven (11) month mark to ensure the Accutech tags function at their highest potential. Record review and observation of the Accutech Binder, revealed the binder was in place to keep track of the Accutech Tags. Both the Plant Operations Director and the DON had their own binder. Interview with the DON, on on 02/12/15 at 4:12 PM, revealed when new Accutech tags were received, the Plant Operations Director would date all of the tags and then have them logged into a binder so that they could monitor how old the Accutech tags were. The Nursing staff was not responsible to monitor the dates. The DON stated the Maintenance Director would write "BAD" on any Accutech Tags that were running on low battery or not functioning properly. The DON stated there was a binder in which she and the Plant Operations Director kept up with daily.</p> <p>20. Review of the sign in sheet for the Quality</p>			



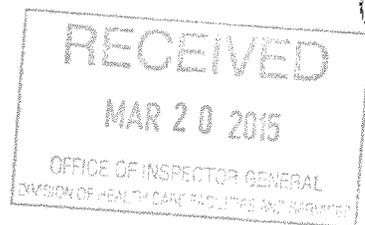
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F 282	Continued From page 28 Assurance Meetings, revealed the DON, Administrator, Medical Director and the Regional Nurse Consultants attended QA on 01/21/15. Interview with the DON, on 02/12/15 at 4:12 PM, the Administrator on 02/12/15 at 5:01 PM, the	F 282		
	Medical Director, on 02/05/15 at 5:47 PM and the Regional Nurse Consultant, on 02/12/15 at 3:00 PM, revealed all had attended the QA meeting on 01/21/15. The meeting consisted of root cause analysis, education, interventions, plans to prevent elopement and the policies. They also reviewed the audits to ensure there were no trends.			
	21. Review of the sign in sheet for the QA meeting, held on 02/04/15, revealed the Medical Director attended a QA meeting. Interview with the Medical Director, on 02/05/15 at 5:47 PM, revealed he reviewed the procedures related to the change of the front door monitoring.			
	22. Review of the sign in sheet for the QA meeting on 02/06/15, revealed the Medical Director was in attendance. Interview with the Medical Director, on 02/05/15 at 5:47 PM, revealed he reviewed the elopement plan and was in agreement with the plan.			
	23. Interview with the DON, on 02/12/15 at 4:12 PM and the Regional Nurse Consultant, on 02/12/15 at 3:00 PM, revealed they had reviewed 113 incident and accident reports with no concerns with elopement noted.			
	24. Interview with the Plant Operations Director, on 02/12/15 at 3:05 PM, revealed he assessed the nursing staff on the Accutech Tag daily by doing return demonstrations. Interview with Social Services, on 02/12/15 at 2:33 PM, revealed there			



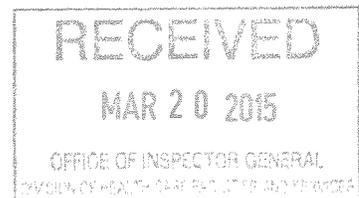
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F 282	Continued From page 29 were random exams completed on staff daily to ensure competency of the elopement process. Interview with the Administrator, on 02/12/15 at 5:01 PM, revealed the staff completed random exams on staff daily to ensure competency. Record review of the post exams, located in a binder, revealed all 183 staff members were given an exam with a pass rate of 100 %.	F 282		
	25. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM and the Plant Operations Assistant, on 02/12/15 at 3:05 PM, revealed they checked the door function daily and kept a log. Reviews of the Weekly Door Check Log, revealed the doors were checked daily for functioning.			
	26. Interview with the Plant Operations Director, on 02/13/15 at 1:36 PM and the Plant Operations Assistant, on 02/12/15 at 3:05 PM, revealed they checked the functioning of the Accutech tags daily of residents who were identified to be an elopement risk.			
	27. Interview with the MDS Coordinator #2, on 02/12/15 at 3:30 PM, interview with Social Services on 02/12/15 at 2:33 PM, interview with the Interim ADON, on 02/12/15 at 1:13 PM and the DON, on 02/12/15 at 4:12 PM, revealed they all attended morning meetings and reviewed change of condition, new orders, new admissions, discharges and or transfers 5 days a week.			
	28. Interview with the Regional Care Consultant, on 02/12/15 at 3:00 PM, revealed she provided oversight to the audits of post test, door checks and Accutech tag checks, she had not identified any concerns patterns or concerns with the audits. Review of the Accutech tag checks by			



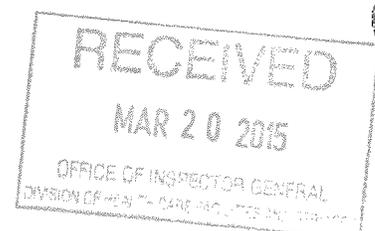
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F 282	Continued From page 30 nursing on 01/21/15 revealed they were completed. Review of the door checks by maintenance revealed they were completed daily.	F 282	1. Resident #1 on 1/21/2015 was noted by staff to be outside at the Ambulance entrance due to resident attempting to re-enter the facility by ringing the doorbell. Resident #1 was assessed by the Charge Nurse on 1/21/2015 at approximately 12:45am. No injury was noted and vital signs were stable. Responsible party and physician were notified of incident by the Charge Nurse on 01/21/15. Care plan was updated by the Director of Nursing on 01/21/15 to reflect this recent incident.	02/16/15
F 323 SS-J	29. Interview with RN #2, on 02/05/15 11:33 AM, revealed she had worked at the facility for three (3) weeks and had obtained training on the Accutech Tag and the elopement procedures during orientation. She was familiar with the fact she had to assess the resident upon admission for elopement. She stated she was checking the Accutech Tags on every shift she worked. She stated if a battery was low she would obtain a new Accutech Tag and apply to the resident. She stated she was given a post test in which she passed. Interview with the Staff Development Coordinator, on 02/06/15 at 3:32 PM, revealed she educated the new hires on the policies, Accutech Tag, and how to activate and deactivate to assess for battery life. A test was given and the staff had to pass with a 100%. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, it was determined the facility failed to have an effective system in place to ensure the	F 323	Resident was placed on q 15 min checks which were completed by the resident's Charge Nurses upon returning to facility. Residents wander guard was removed by staff nurse, RN, and checked in which battery was low. A new wander guard was immediately placed by staff nurse, RN. A head count of the entire facility was conducted on 1/21/2015 by the charge nurses with Administrator and DON oversight to ensure all residents were accounted for and were safe. Our census was 127 and all 127 residents were accounted for and were safe. On 1/21/2015 all exits were checked initially by the charge nurses on duty. The wander guard doors were manned and continuously monitored by facility staff until 01/22/15. The Plant	



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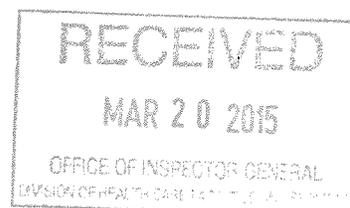
NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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F 323	Continued From page 31 facility staff provided adequate supervision for one (1) of fourteen (14) sampled residents (Resident #1). The facility assessed Resident #1 to be at risk for elopement and the resident's care plan stated staff would monitor the whereabouts of the resident on an ongoing basis. The facility utilized an alarm (Accutech) system and an Accutech Tag was applied to Resident #1. Interview and record review revealed the facility failed to have a system in place to monitor the battery life of the Accutech Tags to determine when the Tags should be replaced. In addition, the resident unit doors were alarmed with the Accutech system; however, the front corridor and lobby double doors to the building were not alarmed. The facility failed to have a system in place to secure the front corridor and lobby double doors to the building on weekday nights between the hours of 9:00 PM and 8:00 AM, and on the weekends between 7:00 PM and 10:00 AM. (Refer to F282) On 01/21/15 at 11:42 PM, Resident #1 exited his/her unit without an alarm sounding and exited the building through the unlocked doors to the front lobby without staff knowledge. At 12:30 AM, the resident attempted to re-enter the front lobby doors after recognizing it was too cold outside and he/she would need a jacket. However, these doors locked from the outside and re-entrance was prohibited. The resident walked around the building to the Ambulance Entrance near the One South Unit entrance and rang the door bell. The staff answered the door bell to find the resident outside wearing street clothing; shoes, socks, blue jeans and a pull over shirt. Staff noted the resident appeared cold upon entering the building, with recorded weather conditions on 01/21/15 of cloudy skies and forty-two (42)	F 323	Operations Director was notified and immediately came to the facility and checked all exits. One door on the 2 nd floor 2 North was adjusted by Plant Operations Director as there was a slight gap in closing; all other exit doors were found to be functioning properly. This resident resides on the first floor so this could not have been a door she used to exit the facility. Upon investigation by the charge nurses on 01/21/15, it was determined that Residents #1's wander guard tag had a low battery. Further investigation on 01/21/15 by the Administrator, Director of Nursing, and Plant Operations Director confirmed that the wander guard tag had a low battery. On 1/21/15 all resident wander guards were checked for placement and functioning by the Charge Nurses on duty followed by Plant Operations Director and all were properly functioning. On 2/04/15, Plant Operations Director and Regional Plant Operations Director utilized an outside vendor to adjust the front interior lobby doors. A keypad lock was activated and these doors will lock automatically at 9 p.m. daily and will unlock at 8 a.m. daily. The doors were wired so that anyone attempting to exit without the staff code during the hours of 9 p.m. and 8 a.m. will set off an	

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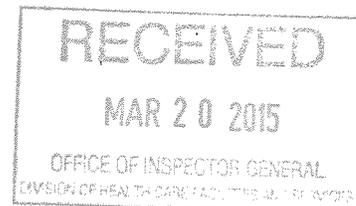
STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 323	Continued From page 32 degrees Fahrenheit at midnight with a westerly wind at 8.1 miles per hour. Upon returning Resident #1 to the unit, the resident's alarm did not sound. After the staff checked the alarm it was determined the battery was dead and the alarm was non-functioning. The facility's failure to provide adequate supervision placed residents at risk for elopement in a situation that has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 02/06/15 and was found to exist on 01/21/15. The facility was notified of the Immediate Jeopardy on 02/06/15.	F 323	alarm which will be audible at the nurses' stations. The monitoring panel at each nurse's station will also visibly show that the front door is being opened without the staff code between the hours of 9 p.m. and 8 a.m. The delayed egress system is in place on these doors. A receptionist will be at the front desk from 8 a.m. to 9 p.m. seven days a week. On 2/03/15, staff were placed at the front receptionist desk for 24/7 monitoring. This monitoring will end on 2/06/15 after all staff education is completed. Beginning 01/21/15, nursing and social services staff followed up with the resident daily for 72 hours to identify and address any psychosocial needs this resident might have. No issues were identified. The entire facility consisting of 127 residents were reassessed for risk of elopement on 1/21/2015 by Assistant Director of Nursing, Director of Nursing, Social Services Assistant, or Social Services Director. No new residents were identified as elopement risk. Care plans and nursing assistant care record were updated for 16 residents identified as being as risk for elopement on 1/21/2015 by Director of Nursing, Signature Care Consultant, Assistant Director of Nursing, or Unit Manager.		
	The facility provided a credible Allegation of Compliance (AOC) on 02/11/15 alleging removal of Immediate Jeopardy on 02/07/15. However, the State Survey Agency verified Immediate Jeopardy was not removed until 02/13/15 due to re-education of staff. Record review and interview revealed forty-two (42) percent of staff was educated via the telephone prior to 02/07/15. The scope and severity was lowered to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of the implemented action plans to achieve and maintain compliance with the plan of correction. The findings include: Review of the facility's policy regarding Elopement/Wandering Residents, effective December 2010, revealed it was the intent of the facility to determine which residents had significant wandering behavior and enhance staff awareness as well as educate them on how to deal with such residents. An				



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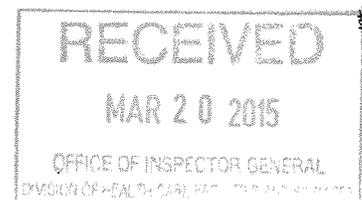
ELEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/13/2015
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F 323	Continued From page 33 elopement/wandering assessment would be completed upon admission located in the nursing admission information packet and quarterly thereafter.	F 323	The five binders which identify residents who are at risk for elopement were reviewed by the Administrator and Director of Nursing to ensure that they were updated and in place at each nurse's station and at the receptionist's desk on 1/21/2015, all were correct. The Administrator and Director of Nursing were reeducated via phone by the Signature Care Consultant, Regional Vice President, and Chief Nurse Executive on 01/21/15 on the elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments. There were no revisions to our elopement and missing person policy and procedure. This education was completed prior to education being initiated with staff on 1/21/15.		
	Review of the Stad-N Base Components LC 1200 Manual, (utilized as a guideline for monitoring the Accutech tag alarm system), not dated, revealed the Stad-N was used to check the function of an Accutech Tag (wander-guard). The Accutech Tags are operated by internal battery. Over the course of normal operation the Tags eventually lose battery power and the Tags would need to be replaced. The Tag batteries were not replaceable. The Stad-N was used to determine if a tag had sufficient battery power to respond to an activated signal. When the enter button is pressed on the tag a green LED lights. The wait LED will illuminate red for two (2) seconds. The tags graphic LED on the STAD-N will illuminate a pulsing yellow indicating the tag is active. The Tags had been engineered for greater than twelve (12) months of use. Once an Accutech Tag's battery was drained, the low battery LED will illuminate red and the tag would have to be replaced. Review of the clinical record for Resident #1, revealed Resident #1 was admitted on 07/17/14 with diagnoses of Senile Dementia and Depressive Disorder. On 07/17/14, the facility assessed the resident as being at high risk for elopement related to the resident being cognitively impaired; however, scored a 15 upon admission using the Brief Interview for Mental Status (BIMS); having the ability to ambulate independently; having poor decision making skills; demonstrating exit-seeking behaviors; and, for having the ability to exit the facility. An Accutech Tag was applied to the resident due to		113 staff was trained on 01/21/15. 34 staff was trained on 01/22/15. 17 staff was trained on 01/23/15. 9 staff was trained on 01/24/15. 3 staff was trained on 01/25/15. 1 staff was trained on 01/28/15. 1 staff was trained on 01/30/15. 2 staff was trained on 01/31/15. 1 staff was trained on 02/01/15. This training was on the above mentioned in above #14.		



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F 323	Continued From page 34 the resident's exit seeking behaviors and poor decision skills. Resident #1 was care planned for elopement risk due to his/her dementia and walking around the unit and the staff would monitor the resident's whereabouts on an ongoing basis. Further review of the clinical record revealed, on 01/09/15, the facility assessed the resident as a 12 on the BIMS. Review of the incident report, dated 01/21/15, revealed it was discovered a resident (Resident #1) had left the building, when the ambulance door bell rang and the resident was found outside at the door. The resident was last seen at the nurses station by a Certified Nursing Assistant (CNA). The resident had a Accutech Tag applied, but the device did not function properly and the resident was able to exit his/her unit without staff knowledge. The resident was able to exit the facility through the lobby door. The resident was brought back in to the facility and taken to their room where they were assessed and fitted for a new Accutech Tag. The resident denied any injury or pain. The resident was cold since he/she had gone out without a coat, but did have street clothes on (slacks and a pullover shirt) and shoes. Interview with Licensed Practical Nurse (LPN) #3, on 02/02/15 at 10:12 PM, revealed around 11:30 PM to 12:00 AM, on 01/21/15, when completing a narcotic count with LPN #5, the Ambulance Entrance doorbell rang (on the side of the building). LPN #3 stated she and LPN #5 were expecting Pharmacy Services to arrive at that hour, but when LPN #3 went to the Ambulance Entrance, she found Resident #1 standing outside of the door. Resident #1 had informed LPN #3 that he/she had left "home" to go to the	F 323	Education on elopement policy, missing resident policy including how to respond to door alarms, complete head counts, check wanderguard functioning of door and tags, and implement care plans related to triggered areas including elopement risk assessments was initiated to staff on duty on 1/21/15 will continue prior to staff working by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Chaplain, Customer Experience Director, Dietary Services Manager, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager. The Administrator and Director of Nursing trained these educators on the material to cover for the education. This education was completed for nursing, administrative, housekeeping, laundry, therapy, dietary, plant operations for 181 staff. Post tests were completed by 02/02/15. Education and return demonstration on use of Accutech transmitter (device to check function) to ensure staff competency of wander guard function and battery checks was initiated on 01/21/15 by the Plant Operations Director or Plant Operations Assistant for licensed nurses. A post test was be	



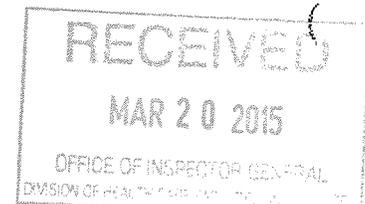
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F 323	Continued From page 35 local jamboree, but realized he/she had left their jacket. Resident #1 stated he/she had seen all of the lights on at the side of the building and rang the doorbell. LPN #3 stated when Resident #1 entered the building no alarms sounded. LPN #3 stated once a resident entered the building from the Ambulance Entrance the Accutech alarm should have alarmed. LPN #3 escorted Resident #1 to the One North Unit, where he/she lived and "delivered" Resident #1 to Registered Nurse (RN) #1. When entering the One North Unit the entrance equipped with the Accutech alarm did not sound when Resident #1 re-entered, but an alarm should have sounded.	F 323	given to staff that received the education in which a passing score of 100% must be obtained. If staff did not receive a score of 100% on test the staff member will be re-educated on the spot and a new post-test will be given. 42 licensed nurses were educated. Staff that were not working on 1/21/2015 will be educated on the elopement policy and procedure, missing resident, care plan and Accutech by Administrator, Director of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Social Services Assistant, Dietary Services Manager, Chaplain, Customer Experience Director, Admissions Director, Plant Operations Director, Plant Operations Assistant, or Business Office Manager prior to taking their assignment upon return to work. A post test will be given in which a passing score of 100% must be obtained. If 100% not obtained the staff member will be re-educated and a post test will be reissued. Staff who are PRN, on FLMA or on leave will be issued a certified letter by Administrator with return receipt on 1/26/2015 alerting them that they must receive an education on elopement policy, missing resident, care plans and Accutech (device to check wander guard function) before being allowed to	
	Interview with RN #1, on 02/02/15 at 9:40 PM and at 10:35 PM, revealed when coming out of a resident's room at approximately 12:30 AM on 01/21/15, she saw LPN #3 coming through the One North door with Resident #1. LPN #3 stated someone had rang the doorbell and she found it was Resident #1. RN #1 stated she did not hear any alarms sound when Resident #1 came through the One North door. Since the resident had an Accutech alarm to the left leg, the alarm system should have sounded and alerted staff. Per interview, she completed an assessment of the resident. Resident #1 was not dirty or wet, but appeared to be cold with no injury noted. RN #1 revealed the resident was very talkative and laughing, wearing street clothing; shoes, socks, blue jeans and a pull over shirt. Resident #1 also had his/her cane which he/she utilized.			
	Interview with Certified Nursing Assistant (CNA) #3, on 02/02/15 at 10:50 PM, revealed she came in for her shift at 10:00 PM on 01/20/15. CNA #3 stated the last time she saw Resident #1 was when she was completing her rounds, between			



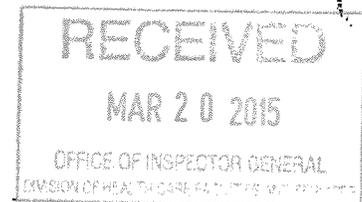
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F 323	Continued From page 36 . 11:00 PM to 11:30 PM. Resident #1 was sitting at the nurses' station in a chair. CNA #3 stated she did not observe Resident #1 wandering in the hall or any exit seeking behaviors.	F 323	work. There were 33 PRN staff and 3 FMLA on 1/21/15. The facility does not utilize agency staff. Staff will be educated on the new front door procedure by the Administrator, Director of Nursing, Staff Development	
	Interview with CNA #4, on 02/02/15 at 10:55 PM, revealed she came in for her shift at 10:00 PM. CNA #4 stated the last time she saw Resident #1, was at 11:30 PM sitting at the nurses' station. CNA #4 stated Resident #1 was wearing a pink top and cream colored pants with his/her shoes on. Interview on 02/13/15 at 2:28 PM, with the Interim Assistant Director of Nursing (ADON) who supervised the first floor units, revealed on		Coordinator, Quality of Life Director, Administrative Assistant, Admissions Director, Business Office Manager, Human Resources Director, Dietary Manager, Quality of Life Assistant, Chaplain, or Assistant Director of Nursing. 200 staff was educated and this was completed on 02/06/15. Assistant Directors of Nursing, and MDS	
	01/20/15 at 11:42 PM, she observed Resident #1 at her office door on the One (1) North Unit. The Interim ADON stated she asked Resident #1 if he/she was tired and Resident #1 responded "no". The Interim ADON stated she remembered as she was leaving the facility, Resident #1 was walking to a chair which was located at the nurses' station. Interview with Resident #1, on 02/03/15 at 12:20 PM, revealed he/she remembered leaving the building to obtain a coke for another resident. Resident #1 did not remember the time he/she left the building, or the time he/she came back to the building. Resident #1 stated he/she remembered it was cold outside and decided to come back home to get a jacket. Resident #1 stated he/she had never left the building before and would inform the staff if he/she wanted to leave the building. Continued interview with RN #1, on 02/02/15 at 10:35 PM, revealed Resident #1 did not inform		Coordinators were reeducated by the Administrator and Director of Nursing on 02/06/15 on completion of care plans on admission, quarterly, and with changes of condition, including that care plans should reflect nursing assessments. Elopement and missing person policy and procedure were reviewed on 1/21/15 and no revisions were made to the policies. A new procedure was implemented on dating wanderguard tags when received in the facility and placed on residents. The Plant Operations Director is opening and dating new wanderguard tag when they arrive at the facility. Manufacturers	



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F 323	Continued From page 37 her of how he/she had left the building. RN #1 stated she then called the Administrator and notified the other nurses on the unit of the elopement.	F 323	recommendations state that the wanderguard tag will last at least 12 months or longer. Wanderguard tags will be replaced at 11 months. The Plant Operations Director and Director of Nursing are each keeping a roster of dates that wanderguards are placed on residents with their activation date and when they need to be replaced. The Plant Operations Director or Director of Nursing will notify nursing staff when to replace a tag at the 11 month mark. Anytime a wander guard tag is replaced, the tag is to be labeled "BAD" and given to the Plant Operations Staff and logged in their maintenance log in the maintenance binder at each nurses station. See attached procedure A QA meeting was held in the afternoon on 1/21/2015 and attended by ADMIN, DON, two Regional Nurse Consultants, and Medical Director in regards to root cause of event, education, interventions and plans to prevent reoccurrence. The elopement policy and procedure was reviewed and no revisions were made. A QA Meeting was held on 02/04/15 with the Medical Director to review procedure changes related to front door monitoring (See attached). A QA meeting was held on 02/06/15 with the Medical Director to review elopement plan. No further issues were identified.		
	Interview with the Director of Nursing (DON), on 02/05/15 at 9:40 AM, revealed on 01/21/15 at 1:00 AM, she had received a call from RN #1 informing her that Resident #1 had gotten out of the facility and came back and rang the doorbell through the Ambulance Entrance and she came to the facility immediately. The DON asked RN #1 if she had phoned the Administrator. RN #1 stated she was instructed by the Administrator to check all doors, complete a head count of all residents and assess Resident #1 for injuries.				
	Interview with the Administrator, on 02/05/15 at 10:10 AM, revealed she was called around 1:00 AM by RN #1, who informed her Resident #1 had left the facility and rang the doorbell at the Ambulance Entrance to get back in. The Administrator stated she asked RN #1 if the alarm had sounded when the resident had come on the unit and RN #1 stated "no". The Administrator stated she asked RN #1 if the Accutech Tag was not working and if not to replace the Tag. The Administrator informed RN #1 to ensure all residents were accounted for and to check all Accutech Tags and doors to ensure they were functioning. The Administrator stated she informed RN #1 to ensure 100% of the resident count, tags and doors were completed. Interview, on 02/05/15 at 1:19 PM, with ADON #1 who supervised the second floor units, revealed she was pulled to the One North Unit during second shift on 01/20/15 because of a call-in. ADON #1 stated she remembered assessing				

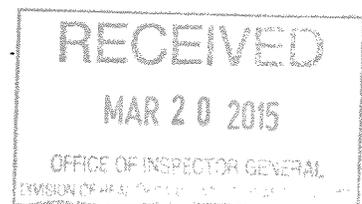
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F 323	Continued From page 38 Resident #1's Accutech Tag between the hours of 3:00 PM and 4:00 PM on 01/20/15 by checking the Accutech Tag with the Stad-N box (which was used to check the function of the Accutech Tag). ADON #1 stated she turned on the Stad-N device, placed the Stad-N next to the Accutech Tag, and then the Stad-N box flashed a yellow color to show the battery had sufficient power. Upon observation of Resident #1's Accutech Tag, ADON #1 recognized the red light blinking on the Accutech Tag to indicate the tag was on. ADON #1 stated she recognized Resident #1 was answering questions appropriately and did not appear to be wandering on the unit.	F 323	Director of Nursing or regional nurse Consultant reviewed 113 incident and accident reports for the last 3 months on 1/21/2015 for any other concerns of elopement or wandering. None were identified.	
	Further interview with RN #1, on 02/02/15 at 9:40 PM, revealed the Accutech Tag located around Resident #1's ankle was checked every shift; however, it had not been checked at the beginning of her shift, but was on her to-do list when she completed her treatments for the night. RN #1 stated it was normal for Resident #1 to sleep most of the day and meander about at night. However, as a nursing judgement the resident was not monitored due to not displaying exit seeking behavior.		Beginning 01/24/15 and going through 01/30/15, daily audits will be completed each shift for wanderguard functioning on all identified residents, return demonstration by four licensed staff on wanderguard functioning, and 12 staff members each shift will be given the post test for elopement by the Administrator, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. A score of 100% was required, if less than 100% employee were reinserviced and then given the post- test again until 100% compliance was obtained. Beginning 01/31/15, these audits were completed three times a week through 02/28/15 and then weekly times 24 weeks.	
	Further interview with RN #1, on 02/02/15 at 10:35 PM, revealed a head count of all residents in the building was completed, with no concerns. RN #1 then checked all of the doors to ensure they were working properly.		The Administrator or DON are reviewing the Post Tests given daily for any noted concerns. Any concerns will be addressed immediately. Daily for two weeks beginning	
	Interview with LPN #3, on 02/02/15 at 10:12 PM, revealed they had identified the Two North door did not close completely and a staff member was placed at the door until someone could fix the door.			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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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	Continued From page 39 Continued interview with the Director of Nursing (DON), on 02/05/15 at 9:40 AM, revealed the facility ensured a staff member was sitting at the Two North door because the door was not latching all the way. The other seven (7) doors on the units were monitored as well by the nursing staff every 15 minutes. There was also Accutech Tag checks on all the other residents who were identified as an elopement risk. The DON stated she looked at Resident #1's affected Accutech Tag after it was removed from the resident and it was not blinking to indicate that it was on. The DON stated she was expecting the staff to check the Accutech Tags every shift. She stated the staff was to place the Stad-N device next to the Accutech Tag to ensure the system was functioning properly. This was to be done every shift, by the nurse on duty, and documented on the treatment administration record. The battery of the tag was not dated and did not indicate how long the battery would last. The tag would only be changed when the Stad-N LED was red. However, per the Manual for the Accutech system, the red light would indicate the battery was drained. Continued interview with the DON, on 02/05/15 at 9:40 AM, revealed Resident #1 exited the facility through the front door of the building as this was the only way for the resident to leave undetected. There were locks on the front door that automatically lock from the outside preventing re-entry; however, exiting the building through those doors was still possible after 9:00 PM even though it was locked. These doors were not locked when the receptionist was on duty and were locked at 9:00 PM when she left the facility. The DON stated there was an Accutech system in place to protect residents from going outside	F 323	01/21/15, the Plant Operations Director and the Plant Operations Assistant will check the exit doors in the facility for correct functioning and place on their log. It will continue to be checked seven days a week by Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Restorative Coordinator, Customer Experience Director, Business Office Assistant, Human Resources Director, Dietary Services Manager, Quality of Life Director, Admissions Director, Chaplain, Environmental Services Director, Social Services Director, Business Office Manager, Plant Operations Director or Social Services Assistant. Daily for two weeks beginning 01/21/15, the Plant Operations Director or Plant Operations Assistant Department checked the functioning of Wander guards on all identified residents. Charts for residents with a change of condition, new orders, new admits, discharges, or transfers to the hospital are reviewed at the daily clinical meeting five days a week by the clinical team which consists of Director of Nursing, Assistant Directors of Nursing, Medical Records Clerk, Dietary Services Manager, Restorative Nurse Coordinator, Quality of Life Director,	

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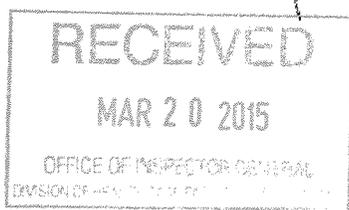
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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F 323	Continued From page 40 without staff knowledge. However, the Accutech system was only on the resident unit doors. Continued interview with the Administrator, on 02/05/15 at 10:10 AM, revealed she called the DON and Maintenance. The Administrator stated she became aware that the back door to Two (2) North was not closing appropriately and made sure there was staff present at that door to ensure resident safety. The Administrator stated she began to interview staff, nurses and CNAs, and Maintenance came in to check all of the doors and made the adjustment to the back door of the 2nd floor. The Administrator stated she had an Accutech system to protect the residents who were not cognitive enough to make a decision if it was safe to leave the building on their own. However, the facility did not have a system in place to monitor the life of the tag. Interview with the Plant Operations Director, on 02/03/15 at 4:31 PM, revealed he checked the function of all seven (7) doors that lead out of the building and the eight (8) doors to all four (4) units, which totaled fifteen (15) doors, daily. The Plant Operations Director stated the door exiting from the One (1) North Unit, where the resident resided, and the other resident units, had a Accutech alarm. Continued interview with the Plant Operations Director revealed the exit doors from the unit into the hallways would release after fifteen (15) seconds if held continuously. The Ambulance Entrance was a fire exit, but did not have a wander-guard system. Further interview with the Plant Operations Director, on 02/03/15 at 4:40 PM, revealed the night of the elopement, it was discovered Resident #1's Accutech Tag was functioning and	F 323	Administrator, Chaplain, Staff Development Coordinator, Social Services Director, Social Services Assistant, or Customer Experience Director. These staff will review care plans to ensure they are updated appropriately. Regional Care Consultant Staff are providing oversight to the audits four times a week beginning 01/21/15 and continuing through 02/13/15. The elopement policy and procedure, missing resident, care plans and Accutech system were in serviced in orientation for all new hires beginning 01/23/15 in which a post test will be given and a score of 100% must be obtained. Staff Development Coordinator is responsible for orientation. The elopement binders are being brought to the weekly at risk meeting, checked and updated as needed by the Social Services Director or Social Services Assistant. The At Risk Team will review the binders during the meeting. The At Risk team consists of Director of Nursing, Assistant Directors of Nursing, Social Services Director, Social Services Assistant, Dietary Manager, Restorative Coordinator, or Quality of Life Director. The QAPI Committee will review the results of elopement prevention plan	



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STATEMENT OF DEFICIENCIES (X1) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185057	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2015
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NAME OF PROVIDER OR SUPPLIER SUNRISE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 717 NORTH LINCOLN BLVD HODGENVILLE, KY 42748
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F 323	Continued From page 41 flashing red, but had a low battery. The Plant Operations Director stated the alarm should have sounded even if it was showing a low battery; however, it did not alarm. Per interview, there was a possibility that if the Accutech Tag had a low battery it could have become low between the hours when the Second shift nurse checked it and when Resident #1 eloped. The Plant Operations Director stated he was notified in the early morning of 01/21/15, but could not remember the time. He stated he made sure there was staff monitoring the doors until they were working properly.	F 323	post test and audits upon completion of the seven days to determine if there are any trends or concerns. The QAPI committee will then continue post test and audits three days week for one week, then weekly for two weeks at which time based upon the findings will determine the continued frequency of the above audits.	
	Continued Interview with the Plant Operations Director, on 02/03/15 at 4:31 PM, revealed he had not identified the front door as a possible way for a resident to elope, after the receptionist left for the evening, because there was a working Accutech alarm system in place on the unit doors. The Plant Operations Director stated if a resident was to get through the unit double doors, the resident could walk through the front lobby corridor which leads to the front lobby doors and exit the building without causing the alarm system to activate.		A. Resident #1 on 1/21/2015 was noted by staff to be outside at the Ambulance entrance due to resident attempting to re-enter the facility by ringing the doorbell. Resident #1 was assessed by the Charge Nurse on 1/21/2015 at approximately 12:45am. No injury was noted and vital signs were stable. Responsible party and physician were notified of incident by the Charge Nurse on 01/21/15. Care plan was updated by the Director of Nursing on 01/21/15 to reflect this recent incident. Resident was placed on q 15 min checks which were completed by the resident's Charge Nurses upon returning to facility. Residents wander guard was removed by staff nurse, RN, and checked in which battery was low. A new wander guard was immediately placed by staff nurse, RN. A head count of the entire facility was conducted on 1/21/2015 by the charge nurses with Administrator and DON oversight to ensure all residents were	02/07/15
	Additional interview with the DON, on 02/06/15 at 2:36 PM, revealed she did not expect the Accutech Tag alarming system to replace supervision by the staff and expected the staff to check on the residents. The DON stated she did not identify the front door to be a risk for residents assessed as a risk for elopement. The DON stated she did identify that Resident #1 went through the front door because his/her battery was low on his/her Accutech Tag. The DON stated she had not identified any hazards or any inadequate supervision from staff related to this			

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