

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/24/2012
NAME OF PROVIDER OR SUPPLIER  GREENWOOD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	

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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 08/13/12 Changes made to F282 to further clarify the deficient practice as it relates to the care plan.</p> <p>An abbreviated survey (KY #18757) was conducted on 07/18/12 through 07/20/12. Immediate Jeopardy was identified on 07/19/12 at 42 CFR 483.20 Resident Assessment and 42 CFR 483.25 Quality of Care and determined to exist on 07/13/12. A partial extended survey was conducted on 07/23/12 through 07/24/12. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 07/19/12. KY #18757 was substantiated with deficiencies cited.</p> <p>Based on observation, interview, record review, and review of the facility's Wandering Risk Potential Protocol, it was determined the facility failed to ensure adequate supervision to prevent accidents was provided for one resident (#1) in the selected sample of six (6) residents. The facility failed to follow their Wandering Risk Potential Protocol. The facility had assessed and identified twenty-five (25) residents requiring supervision due to wandering and/or exit-seeking behaviors. The facility failed to ensure that all staff was trained and knowledgeable regarding the facility's wanderguard system, which doors were equipped with the wanderguard system and knowledgeable of all the residents who the facility identified at risk for wandering/elopement. The facility failed to ensure that all staff was knowledgeable of an elopement that occurred on 07/13/12 and that door #3 malfunctioned in order to ensure appropriate supervision of all</p>	F 000	<p>Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonathan M. Garce TITLE: Admin (X6) DATE: 8/10/12

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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PRINTED: 08/13/2012  
FORM APPROVED  
OMB NO. 0938-0391

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F 000	Continued From page 1 twenty-five (25) residents the facility had identified at risk for wandering/elopement. The facility assessed Resident #1, on 07/11/12, as high risk for wandering/elopement and nursing staff was aware of the resident's poor safety awareness and care planned on 07/12/12 to follow the wander protocol. However, on 07/13/12, Resident #1 exited the facility without staff knowledge. A visitor in the front parking lot witnessed the elopement and reported to the facility staff. The resident was found approximately 90 feet from a major highway. The facility failed to ensure the wanderguard board was updated to reflect Resident #1 as a wanderer from admission through 07/14/12, the day after the elopement. Furthermore, the facility failed to ensure door #3, which malfunctioned on 07/13/12 allowing Resident #1 to exit the building without supervision, was monitored to prevent all identified wandering residents from exiting the building unsupervised as this door did not have the wanderguard system applied. Additionally, four staff was unaware Resident #1 had eloped and did not know to increase supervision of door #3 and seven staff was not knowledgeable that there were exit doors not equipped with the wanderguard system. The facility's failure to ensure adequate supervision of residents identified as having wandering and/or exit-seeking behaviors has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/19/12 and determined to exist on 07/13/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. An acceptable AoC was received on 07/23/12. Immediate Jeopardy was removed, effective 07/21/12, as alleged in the AoC with the scope and severity	F 000	Tag 282  Resident #1 is no longer a resident in this facility. The resident was discharged on 7/19/12.  On 7/19/2012 a new At Risk Wandering Assessment was completed by Administrative Nursing Staff, including MDS Nurses, Unit Coordinators, QI Nurse, Treatment Nurse, Staff Facilltator and Director of Nursing on current residents to identify if any residents were exhibiting a new or increased behavior risk of wandering or elopement. Care plans & care guides were reviewed on 7/19/2012 by the MDS nurses of all residents who had been identified with risk of wandering based on the facility's at risk wandering assessment. Careplans/care guides were updated as needed to reflect Individualized interventions to plan for the resident's safety and well being within the facility and to prevent the resident's unsupervised exit. Verbal consent was obtained by Social Services on 8/14/12 for all current residents with a code alert bracelet from the Responsible Party to agree with posting of resident's picture on the wander board. Copies of this consent were placed on the medical record. The wander board was reviewed again on 8/15/12 by Activity director to ensure pictures were in place of all residents the facility had identified with increased risk of wandering based on the At Risk Wandering Assessment who wear a code alert bracelet.	

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F 000	Continued From page 2	F 000	A new consent form was developed by the Administrator to obtain consent from resident's responsible party for posting pictures on the wander board. The Admissions Coordinator & Social Services was educated on the use of this form on 8/14/12 by the Administrator. These forms will be completed on Admission/Readmission by the Admissions Coordinator & filed in the medical record to allow posting of resident pictures on the wander board. All residents including new admissions will continue to have services arranged & provided by qualified persons in accordance with their written plan of care, including following the facility's Wandering Risk Potential Protocol. Residents will continue to be assessed for risk of wandering/elopement upon admission, readmission, quarterly, annually & any significant change in condition. Care plans & Care guides will continue to be updated on admission, readmission, quarterly, annually & significant change in condition according to the RAI process. Consent for photo will continue to be obtained during the admission's process by the Admission's Coordinator with a copy placed in the resident's medical record. All residents identified with wandering behavior, who require a code alert bracelet will continue to have their picture added to our wandering boards located near each nurses' station, as appropriate. The admitting nurse will print photos from our documentation system on new admissions. Appropriate information will be added to the care plan/care guide also at that time by the admitting nurse.	
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  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 review of the Wandering Risk Potential Protocol, the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for one resident (#1) in the selected sample of six (6) residents. The facility failed to follow their Wandering Risk Potential Protocol. The facility had assessed and identified twenty-five (25) residents requiring supervision due to wandering and/or exit-seeking behaviors. The facility assessed Resident #1, on 07/11/12, as high risk for wandering/elopement. The facility developed and implemented a care plan on 07/12/12 detailing an intervention to follow the wander risk potential protocol. On 07/13/12, Resident #1 exited the facility without staff knowledge. A visitor in the front parking lot witnessed the elopement and reported to the facility staff. The resident was found approximately 90 feet from a major highway. The facility failed to ensure the admission Resident Care Guide (Care Guide used by the Certified Nurse Aides, CNA) reflected the resident's risk for wandering/elopement and failed to detail	F 282		

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F 282	<p>Continued From page 3</p> <p>interventions staff was to ensure was in place related to his/her wandering. The facility failed to ensure the staff had gained consent to ensure the wander board (part of the Wandering Risk Potential Protocol) was updated to reflect Resident #1 as a wanderer from admission through 07/14/12, the day after the elopement. Furthermore, the facility failed to ensure door #3, which malfunctioned on 07/13/12 allowing Resident #1 to exit the building without supervision, was monitored to prevent all identified wandering residents from exiting the building unsupervised as this door did not have the wanderguard system applied. Additionally, after the elopement of 07/13/12, four staff (CNA #1, #2, Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #1) revealed they were unfamiliar with Resident #1, four staff (Certified Medication Aide (CMA) #1, CNA #1, #2, LPN #1) was unaware Resident #1 had eloped and did not know to increase supervision of door #3 and seven staff (RN #2, #3, #4, LPN #2, #3, #4, CMA #1, CNA #1) was not knowledgeable that there were exit doors not equipped with the wanderguard system in order to ensure adequate supervision of residents identified as wandering/elopement risk.</p> <p>The facility's failure to ensure the care plan interventions related to Resident #1's high risk for wandering/elopement prevented staff from being knowledgeable of all residents at risk for wandering/elopement in order to ensure adequate supervision was provided. These failures have caused or are likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/19/12 and determined to exist on 07/13/12 and</p>	F 282	<p>Staff re-education for all Licensed nursing staff was initiated on 7/19/12 &amp; continued until all Licensed Staff were re-educated, by the Staff Facilitator on the Wandering Risk Potential</p> <p>Protocol including completion wandering risk assessments, placing pictures of residents who are identified as having increased potential for wandering on the wandering board, application of code alert bracelets, steps to take for a new wandering behavior being identified or an increased wandering behavior which can include placing the resident on 1:1 supervision, &amp; following the resident's other identified individualized interventions for safety per the care plan/care guide, notification of the On Call Nurse, DON &amp;/or Administrator for further instructions after ensuring the resident's safety &amp; updating the care guide with any new interventions as necessary. Staff re-education was also initiated for all facility staff by the Staff Facilitator on 7/19/12 &amp; continued until all facility staff were re-educated on identifying residents with increased wandering behaviors &amp; notification of their supervisor, location of the wander boards to be used to identify residents who have previously been identified with increased risk of wandering, operation of the exit doors alarm system, what steps to take in the event the exit door does not operate properly which include immediate notification of Maintenance Department &amp; constant supervision of the door until deemed safe by Maintenance Director, definition of 1:1 monitoring interventions &amp; the importance of</p>	

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F 282	Continued From page 4 Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined removed effective 07/21/12, lowering the scope and severity to a "D." (Refer to F323)  The findings include:  A review of the facility's Wandering Risk Potential Protocol, revised 10/19/11, revealed "The purpose of the protocol is to implement guidelines to identify a resident's risk for inappropriate wandering within or outside the facility, and to ensure a resident's safety in regards to the identified behavior. To identify this behavior and to ensure a resident's safety, utilization of the Wandering Risk Potential Protocol should occur as indicated. These guidelines apply to all residents within this facility, including those residents who may reside on secured or Alzheimer's units." The Protocol detailed, "Purpose: to prevent the resident's unsupervised exit [and] to plan the resident's safety and well-being within the facility." The protocol detailed the procedure that "an initial care plan for the resident at risk for wandering should be placed on the resident's medical record in the Nurses Notes section. The care plan should include measurable goals and interventions to ensure resident's safety. (This shall be removed when the comprehensive resident care plan is developed.)" and "The [nurse aide] Resident Care Guide should be completed upon admission with interventions related to the resident's risk for wandering addressed." It further detailed, "The facility may implement a wandering board of identified potential wanderers per assessment. Resident pictures may be placed upon this board	F 282	following each resident's individualized care planned interventions per the care plan/care guide for safety. This education will be provided by the Staff Facilitator to all newly hired staff during the orientation process.  A weekly QI audit will be conducted by the QI nurse utilizing a QI tool to ensure that all residents identified at risk for wandering per the facility's At Risk Wandering Assessment have interventions care planned and in place, including consent for photo & picture in place, as indicated, on the wander board, to plan for the resident's safety & well being in the facility & to prevent the resident's unsupervised exit. This weekly QI audit will also include ensuring that all exit doors have been checked daily by maintenance and nightly by nursing staff per the facility's protocol. Immediate action will be taken by the QI nurse upon the identification of any potential concern to ensure appropriate interventions are implemented & in place for the resident's safety & well being in the facility & to prevent the resident's unsupervised exit from the facility.  The results of these audits will be reviewed with the DON & Administrator weekly in the QI Committee meeting that is composed of the QI Nurse, DON, Administrator, Staff Facilitator, Unit Coordinators, MDS Nurse, Safety Nurse, Social Worker, & Treatment Nurse with further corrective action taken as needed. Results and trends of audits will be reviewed in the monthly Executive QI meeting consisting of the	

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F 282	Continued From page 5 upon permission of the resident or resident's representative. These should be located for staff awareness but not violate residents' rights to privacy..." The protocol also detailed, "implement preventative interventions up to or including the application of an alarm bracelet, monitoring the care plan, etc."  An interview with LPN #8, on 08/06/12 at 4:30 PM, revealed staff has access to the Care Plan, via the computer, once created.  A record review revealed the facility admitted Resident #1 on 07/11/12 with diagnoses to include Alzheimer's disease, Delirium, Depressive Disorder, Anxiety, Difficulty Walking, and Lack of Coordination. A review of the nursing admission assessment, dated 07/11/12, revealed the facility assessed the resident upon admission to be confused and disoriented to person, place, and time. A review of the "At Risk Wandering Assessment," completed 07/11/12, revealed the facility determined Resident #1 was at risk for wandering scoring a 14 (score above 5 is at risk). The assessment revealed the resident required a wanderguard alarm bracelet, wheelchair alarm, and bed alarm due to wandering and walking by himself/herself; however, review of the "Community A Resident Care Guide" (Care Guide used by the nursing aides), dated 07/11/12, revealed the guide did not reference that Resident #1 was at risk for wandering and did not detail any interventions specific to the resident's wandering risk to include the wanderguard alarm or the wheelchair and bed alarms applied as specified in the Wandering Assessment completed on 07/11/12. Therefore, there was no evidence that the facility followed their Wandering	F 282	Adminlstrator, DON, QI Nurse, Safety Nurse, Medical Director, Social Services, Unit Coordinators, Activity Director, plus any other person deemed appropriate by the Administrator present.  Completion Date: 8/19/12	8/19/12

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F 282	<p>Continued From page 6</p> <p>Risk Potential Protocol specific to having a Resident Care Guide completed upon admission with interventions related to the resident's risk for wandering addressed.</p> <p>Review of the care plan, created on 07/12/12, revealed the facility detailed Resident #1 as Wandering and/or at risk for unsupervised exits from the facility related to: exit seeking behaviors, wandering and Alzheimer's Dementia. The Goal developed, "whereabouts will be known to staff as demonstrated by no events of leaving facility unsupervised and 1:1 (one to one) monitoring through next review. Interventions were detailed as, created on 07/12/12, "at risk wandering protocol, check daily to ensure resident has an alarm bracelet on and that it is functioning properly (left ankle), document episodes of wandering per facility protocol, ensure resident's picture and name are on wandering resident board (as consent allows), ensure that alarmed exits are functional."</p> <p>Interview, on 07/19/12 at 3:00 PM, with the visitor, who witnessed Resident #1's elopement from the facility, described that she was sitting in her car between 8:30 PM and 9:00 PM and observed the resident exit out of a secondary exit door (door #3) that was located in the front of the building next to the facility's kitchen. She stated Resident #1 exited the building and walked to the visitor's car and tried to get in her car. The resident then attempted to get in the car next to the visitor's car. At that point, the visitor stated that she got out of her car and walked to the side of the building, entered the facility through the kitchen door where she informed the Dietary staff that was in the kitchen that Resident #1 was out in the</p>	F 282		

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F 282	<p>Continued From page 7</p> <p>parking lot; however, during this time the resident was unsupervised wandering in the front parking lot. Upon the visitor's return to the parking lot she stated the resident was trying to get in the facility's van. Interview with Dietary Aide #2, on 07/19/12 at 2:15 PM, revealed a visitor came up to her in the kitchen and told her that Resident #1 was in the parking lot and verified it was Resident #1 at the end of the parking lot attempting to enter the facility van. Interviews with Dietary Aide #2, #3, and #4, on 07/19/12 at 2:15 PM, 2:30 PM, and 2:45 PM, respectively, revealed they were in the kitchen when the visitor told them that a resident was outside in the parking lot; however, did not hear an alarm sound from door #3 (beside the kitchen).</p> <p>The facility completed an "At Risk Wandering Assessment", on 07/13/12 at 11:22 PM, which detailed the facility assessed Resident #1 as having increased to a score of 19 for wandering risk; however, there was no documented evidence of action or intervention implemented on the assessment for the risk increase after having successfully eloped unsupervised in order to "prevent the resident's unsupervised exit", per the care plan and the Wandering Risk Potential Protocol.</p> <p>The Protocol detailed, "Purpose: to prevent the resident's unsupervised exit [and] to plan the resident's safety and well-being within the facility," which was detailed in the facility's care plan; however, interview with the Maintenance Director, on 07/20/12 at 8:15 AM, revealed he addressed the malfunction of door #3 at approximately 9:10 PM on 07/13/12. He indicated there was a possibility the door could malfunction again. He</p>	F 282		

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F 282	<p>Continued From page 8</p> <p>revealed the door was checked periodically over the weekend, on 07/14/12 and 07/15/12; however, validated the door was not constantly monitored prior to an outside vendor replacing the panel to door #3 on 07/16/12. He further revealed door #3 was not equipped with the wanderguard system. There were only 2 out of 13 exit doors that were equipped with the wanderguard system. He revealed he did not in-service staff on 07/13/12 to ensure the door was monitored over the weekend, as he only checked the equipment at that time. Interviews with RN #1, Certified Medication Aide (CMA) #1, CNA #1, LPN #1, and CNA #2, on 07/19/12 at 4:00 PM, 4:05 PM, 4:20 PM, 4:25 PM, and on 07/20/12 at 11:05 AM, respectively, revealed they were not aware Resident #1 eloped from the building on 07/13/12 and were not informed to increase supervision of the exit doors. Interviews with CMA #1, LPN #2, LPN #3, RN #2, LPN #4, RN #3, and RN #4, on 07/19/12 at 4:05 PM, 4:45 PM, 5:50 PM, and on 07/20/12 at 9:30 AM, 10:00 AM, 10:30 AM, and 10:50 AM, respectively, revealed they were unaware that all exit doors were not equipped with the wanderguard system. Therefore, the facility did not ensure the care plan was followed per the Wandering Risk Potential Protocol as multiple staff was unaware Resident #1 had eloped, had not been made aware of the door malfunction and had not been instructed to monitor the doors to prevent further unsupervised exits, per Resident #1's care plan and as specified by the protocol. This also put twenty-four additional residents, who the facility identified at risk for wandering, at risk for eloping from the facility unsupervised.</p> <p>Record review revealed, the day after Resident</p>	F 282		
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F 282	<p>Continued From page 9</p> <p>#1 successfully eloped from the facility unsupervised, the facility completed an assessment of all residents, dated 07/14/12, to include Resident #1. Review of this assessment revealed the facility's action taken was to continue the application of the wanderguard and added "one to one staff at this time". The facility's documentation revealed they had not put Resident #1's picture on the wander board until 07/14/12, the day after the resident's unsupervised exit. The facility's Wandering Risk Potential Protocol states the facility would implement a wandering board of identified potential wanderers per the assessment. Resident pictures would be placed upon the board and located for staff awareness upon permission from the resident or responsible party; however, further review of Resident #1's medical record revealed no documented evidence that nursing staff had attempted to get consent from the responsible party to post Resident #1's picture on the wander board, per the care plan and per the policy. Interviews with RN #1, CNA #1, LPN #1, CNA #2 on 07/19/12 at 4:00 PM, 4:20 PM, 4:25 PM and on 07/20/12 at 11:05 AM, respectively, revealed they were not familiar with Resident #1. An interview with the DON, on 07/20/12 at 12:25 PM and 07/24/12 at 3:30 PM, revealed the staff should be more familiar with residents on different units.</p> <p>Thus, the facility failed to follow Resident #1's care plan, created 07/12/12, by not intervening with the " At Risk Wandering Protocol ", ensuring the admission Resident care guide identified Resident #1 as at risk for wandering with interventions detailed, gaining consent from the responsible party to ensure the wander board</p>	F 282		

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F 282	<p>Continued From page 10</p> <p>had Resident #1's picture so that staff would be aware of Resident #1's risk potential, and monitoring of door #3 after the malfunction which allowed Resident #1 to successfully elope unsupervised.</p> <p>The state agency verified the following action taken by the facility to remove the Immediate Jeopardy as of 07/21/12:</p> <ol style="list-style-type: none"> <li>1. A review of the facility's documentation revealed all residents in the facility were re-assessed by RN #7, on 07/14/12, for any indication of new or increased behavior of wandering. No new residents were identified at that time with new or increased behaviors. The documentation indicated Resident #1 did not have a picture on the Wander Board, per the policy; however, there was no concern with the Wander Board during the abbreviated survey.</li> <li>2. On 07/16/12, the exit panel on door #3 was replaced by an outside vendor.</li> <li>3. On 07/19/12, a new At Risk Wandering Assessment was completed by Administrative Staff, including Minimum Data Set (MDS) Nurses, Unit Coordinators, Quality Improvement (QI) Nurse, Treatment Nurse, Staff Facilitator, and DON, on all residents to identify if any other residents were exhibiting an increased risk of wandering/elopement. The care plans/care guides were updated to reflect individualized interventions to plan for the resident's safety and well-being within the facility and prevent the resident's unsupervised exit.</li> <li>4. Review of the in-service documentation</li> </ol>	F 282		

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F 282	<p>Continued From page 11</p> <p>verified all staff was trained on 07/19/12 by the Staff Facilitator on alerting the nurse if they identify wandering or exit seeking behaviors in any resident so further assessment can be completed. All staff members were trained on the location of the Wandering Boards, how the exit doors operate and which doors have the wanderguard system, and what steps to take in the event the doors did not operate properly which would include assigning a staff member to monitor the door and to immediately alert the Maintenance Department. Newly hired employees would receive the training during orientation and prior to the next scheduled shift (if currently on vacation). Interviews with RN #7, CNA #9, LPN #8, CNA #8, Housekeeping, Dietary Aide #3, and the Maintenance Director on 07/23/12 at 1:55 PM, 2:20 PM, 2:15 PM, 2:40 PM, 2:50 PM, 3:00 PM, and on 07/24/12 at 4:00 PM, respectively, revealed all these staff attended the training and validated an understanding of the Wander Boards, exit doors, wander guard system, what to do if a door malfunctions, and reporting exit seeking behaviors.</p> <p>5. Review of the in-service documentation verified all licensed staff were trained, on 07/19/12, by the Staff Facilitator with pictures of residents who have wander guard bracelets in place that allowed staff to be aware of residents who have increased wandering behaviors, steps to take in the event of a new wandering behavior being identified or an increase in wandering behavior which can include immediately placing the resident on one to one supervision and notification of the On-Call Nurse, DON, and/or Administrator for further instructions. Interviews with RN #7, RN #6, LPN #7, RN #3, LPN #9, LPN</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>#8 and DON on 07/23/12 at 1:55 PM, 2:00 PM, 2:15 PM, 2:30 PM, 2:45 PM, 2:50 PM and 3:30 PM, respectively, revealed they attended the training and validated their understanding of the information.</p> <p>6. Interview with the Maintenance Director, on 07/24/12 at 4:00 PM, revealed all exit doors to include door #3 were monitored daily utilizing a Quality Improvement (QI) tool to ensure appropriate function. The Administrator would be immediately notified of any concerns with the door functioning and action would be taken to resolve the issue. Documentation was verified of daily monitoring since 07/13/12.</p> <p>7. Daily chart audits would be completed Monday through Friday by the Administrative Staff, including the Treatment Nurse, QI Nurse, Safety Nurse, MDS Nurses, Unit Coordinators, Staff Facilitator, and Social Workers, to read the nurse progress notes to identify any residents who may begin exhibiting increased wandering behaviors for who additional interventions may be necessary. On Monday morning the charts would be audited for progress notes over the weekend to ensure compliance. Documentation was verified of the daily chart audits starting on 07/20/12.</p> <p>8. The QI nurse would conduct a weekly QI audit utilizing a QI tool to ensure that all residents identified at risk for wandering, per the facility's At Risk Wandering Assessment have interventions in place to plan for the resident's safety and well-being in the facility and prevent the resident's unsupervised exit. Any concerns would be addressed with the DON and/or Administrator.</p>	F 282			

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F 282	Continued From page 13 The results of these audits would be reviewed by the DON and Administrator in the weekly QI Committee meeting. An interview with the QI nurse, on 07/24/12 at 4:05 PM, revealed the first care plan/At Risk Wander Assessment review was completed on 07/19/12 and reviewed on 07/20/12. Documentation was verified of the review on 07/20/12. The first weekly QI meeting would be 07/27/12.	F 282		
F 323 SS=J	Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 07/21/12, with the scope and severity lowered to a "D." 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Wandering Risk Potential Protocol, it was determined the facility failed to ensure adequate supervision to prevent accidents was provided for one resident (#1) in the selected sample of six (6) residents. The facility failed to follow their Wandering Risk Potential Protocol. The facility had assessed and identified twenty-five (25) residents requiring	F 323	Tag 323-  Resident #1 is no longer a resident in this facility. The resident was discharged on 7/19/12.  On 7/19/2012 a new At Risk Wandering Assessment was completed by Administrative Nursing Staff, including MDS Nurses, Unit Coordinators, QI Nurse, Treatment Nurse, Staff Facilitator and Director of Nursing on all current residents to identify if any other residents were exhibiting an increased risk of wandering or elopement behavior. Care plans & care guides were reviewed on 7/19/2012 by the MDS nurses of all residents who had been identified with risk of wandering based on the facility's At Risk Wandering assessment. Careplans/care guides were updated as needed to reflect individualized interventions to plan for the resident's safety and well being within the facility and to prevent the resident's unsupervised exit. Verbal consent was obtained by Social Services on 8/14/12 for all current residents with a code alert bracelet from the Responsible Party to agree with posting of resident's picture on the wander board. Copies of this consent were placed on the medical record. The Wander board was reviewed again on 8/15/12 by Activity director to ensure pictures were in place of all residents the facility had identified with increased risk of	

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F 323	Continued From page 14 supervision due to wandering and/or exit-seeking behaviors. The facility failed to ensure that all staff was trained and knowledgeable regarding the facility's wanderguard system, which doors were equipped with the wanderguard system and knowledgeable of all the residents who the facility identified at risk for wandering/elopement. The facility failed to ensure that all staff was knowledgeable of an elopement that occurred on 07/13/12 and that door #3 malfunctioned in order to ensure appropriate supervision of all twenty-five (25) residents the facility had identified at risk for wandering/elopement. The facility assessed resident #1, on 07/11/12, as high risk for wandering/elopement and nursing staff was aware of the resident's poor safety awareness and care planned on 07/12/12 to follow the wander protocol. However on 07/13/12, Resident #1 exited the facility without staff knowledge. A visitor in the front parking lot witnessed the elopement and reported to the facility staff. The resident was found approximately 90 feet from a major highway. The facility failed to ensure the wanderguard board was updated to reflect Resident #1 as a wanderer from admission through 07/14/12, the day after the elopement. Furthermore, the facility failed to ensure door #3, which malfunctioned on 07/13/12 allowing Resident #1 to exit the building without supervision, was monitored to prevent all identified wandering residents from exiting the building unsupervised as this door did not have the wanderguard system applied. Additionally, four staff was unaware Resident #1 had eloped and did not know to increase supervision of door #3 and seven staff was not knowledgeable that there were exit doors not equipped with the wanderguard system.	F 323	wandering based on the At Risk Wandering assessment who wear a code alert bracelet.  All residents & new admissions will continue to receive services to maintain their environment as free of accident hazards as is possible & receive adequate supervision & assistive devices to prevent accidents, including following the facility's Wandering Risk Protocol. Residents will continue to be assessed for risk of wandering/elopement upon admission, readmission, quarterly, annually and with significant change in condition. A new consent form was developed by the Administrator to obtain consent from resident's responsible party for posting pictures on the wander board. The Admissions Coordinator & Social Services was educated on the use of this form on 8/14/12 by the Administrator. These forms will be completed on Admission/Readmission by the Admissions Coordinator & filed in the medical record to allow posting of resident pictures on the wander board. Residents with wandering risk behaviors who require a code alert bracelet will have their picture added to our wandering boards located near each nurses' station. The admitting nurse will print photos from our documentation system. Appropriate information will be also be added to the care plan/care guide at that time by the admitting nurse.	

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F 323	<p>Continued From page 15</p> <p>The facility's failure to ensure adequate supervision of residents the facility identified as having wandering and/or exit-seeking behaviors has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/19/12 and determined to exist on 07/13/12 and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The Immediate Jeopardy was determined removed effective 07/21/12, lowering the scope and severity to a "D." (Refer to F282)</p> <p>The findings include:</p> <p>A review of the facility's Wandering Risk Potential Protocol, revised 10/19/11, revealed the purpose of the protocol was to implement guidelines to identify a resident's risk for inappropriate wandering within or outside the facility, and to ensure a resident's safety in regards to the identified behavior. The purpose of the protocol was to prevent the resident's unsupervised exit and to plan the resident's safety and well being within the facility. The procedure included that any change in behavior/wandering or a one time attempt to leave the facility unsupervised should trigger a new wander risk assessment for the resident. The facility would implement a wandering board of identified potential wanderers per the assessment. Resident pictures would be placed upon the board and located for staff awareness. Preventative interventions would be implemented.</p> <p>A record review revealed the facility admitted Resident #1 on 07/11/12 with diagnoses to</p>	F 323	<p>Staff re-education for all Licensed nursing staff was initiated on 7/19/12 &amp; continued until all Licensed Staff were re-educated, by the Staff Facilitator on supervision to prevent accidents including the Wandering Risk Potential Protocol, completion of wandering risk assessments, placing pictures of residents who are identified as having increased potential for wandering on the wandering board, application of code alert bracelets, steps to take for a new wandering behavior being identified or an increased wandering behavior which can include placing the resident on 1:1 supervision, &amp; following the resident's other identified individualized interventions for safety per the care plan, notification of the On Call Nurse, DON &amp;/or Administrator for further instructions after ensuring the resident's safety &amp; updating the care guide with any new interventions as necessary. Staff re-education was also initiated for all facility Staff by the Staff Facilitator on July 19, 2012 &amp; continued until all facility staff were re-educated on identifying residents with increased wandering behaviors &amp; notification of their supervisor, location of the wander boards to be used to identify residents who have previously been identified with increased risk of wandering, operation of the exit doors alarm system, what steps to take in the event the exit door does not operate properly which include immediate notification of Maintenance Department &amp; constant supervision of the door until deemed safe by Maintenance Director, definition of 1:1 monitoring interventions, importance of following each resident's</p>	

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F 323	<p>Continued From page 16</p> <p>include Alzheimer's Disease, Delirium, Depressive Disorder, Anxiety, Difficulty Walking, and Lack of Coordination. A review of the nursing admission assessment, dated 07/11/12, revealed the facility assessed the resident upon admission to be confused and disoriented to person, place, and time. A review of the "At Risk Wandering Assessment," completed 07/11/12, revealed the resident required a wanderguard alarm bracelet, wheelchair alarm, and bed alarm due to wandering and walking by himself/herself. A review of the Care Plan, created 07/12/12, revealed to follow the Wandering Risk Potential Protocol. An interview with LPN #8, on 08/06/12 at 4:30 PM, revealed staff have access to the Care Plan, via the computer, once created.</p> <p>A review of the nurse's notes revealed the following information:            07/12/12 at 10:52 AM-the facility moved Resident #1 in a room closer to the nurse's station due to the resident's behaviors and risk for falls.            07/12/12 at 2:48 PM-the resident was very confused and uncooperative, making multiple attempts to get up from the wheelchair with disregard to instruction and safety. The assessment revealed the resident was at high risk for falls and exhibited combative behavior toward the staff.            07/12/12 at 5:56 PM- the resident was extremely confused requiring one to one supervision for safety. 07/13/12 at 7:15 AM- staff responded to the resident's bed alarm and he/she was found beside the bed with toothpaste on his/her hands, legs, arms, and feet.            07/13/12 at 11:05 AM-the resident was unable to comprehend safety.            07/13/12 at 2:05 PM-the resident required one to</p>	F 323	<p>individualized care planned interventions per the care guide for safety. This education will be provided by the Staff Facilitator to all newly hired staff during the orientation process.</p> <p>Progress Notes for each resident are being reviewed daily, Monday - Friday by a member of the administrative staff which includes Unit Coordinators, Staff Facilitator, Treatment Nurse, QI Nurse, Safety Nurse, MDS Nurses, DON, &amp; Social Services. Progress Notes for Friday, Saturday &amp; Sunday are being reviewed on Monday. These reviews are to identify and discuss any increased wandering behaviors and to ensure interventions have been initiated to provide adequate supervision to prevent accidents. Any resident that is placed on increased supervision is reviewed by the Administrative staff, which includes Administrator Unit Coordinators, Staff Facilitator, Treatment Nurse, QI Nurse, Safety Nurse, MDS Nurses, DON &amp; Social Services each morning for need of maintaining the increased supervision or initiating other interventions for resident's safety.</p> <p>The results of these audits will be reviewed with the DON &amp; Administrator weekly in the QI Committee meeting that is composed of the DON, Administrator, Staff Facilitator, Unit Coordinators, MDS Nurse, Safety Nurse, Social Worker, &amp; Treatment Nurse with further corrective action taken as needed. Results and trends of audits will be reviewed in the monthly Executive QI meeting consisting of the</p>	

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F 323	<p>Continued From page 17            one supervision for safety.            07/13/12 at 6:41 PM-the wheelchair alarm was removed due to the resident's ability to ambulate with a steady gait.</p> <p>An interview with Registered Nurse (RN) #2, on 07/20/12 at 9:30 AM, revealed she worked on night shift with Resident #1 and staff were providing constant supervision for the resident even though the resident was not "technically" on one to one supervision. She felt the resident needed one to one supervision because the resident was not able to understand the danger of going into certain areas of the facility. The resident wandered into other residents' rooms, was a fall risk, and was combative at times.</p> <p>An interview with RN #4, on 07/20/12 at 10:50 AM, revealed she did not feel Resident #1 was safe to walk by himself/herself. She revealed the resident voiced many times he/she did not like it at the facility and wanted to go home. She revealed the resident required one to one supervision, on 07/12/12 at 5:56 PM, and it was provided throughout her shift (7:00 AM-3:00 PM).</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 07/19/12 at 5:50 PM, revealed Resident #1 was very confused and required frequent redirection. She revealed she witnessed the resident attempt to exit the door on 200 hall "a couple of times" since the resident's admission; however, the alarm sounded and the resident was redirected.</p> <p>An interview with Certified Nurse Aide (CNA) #7, on 07/20/12 at 2:00 PM, revealed she worked with Resident #1 the night of 07/12/12. She</p>	F 323	<p>Administrator, DON, Qi Nurse, Safety Nurse, Medical Director, Social Services, Unit Coordinators, Activity Director, plus any other person deemed appropriate by the Administrator present.</p> <p>Completion Date: 8/19/12</p>	8/19/12

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F 323	<p>Continued From page 18</p> <p>revealed the resident made frequent statements of needing to go home to see his/her family.</p> <p>An interview with LPN #2, on 07/19/12 at 4:45 PM, revealed she removed the resident's chair alarm because the resident continually attempted to ambulate without assistance and the resident had a steady gait. She inquired about one to one supervision with the resident, but was told it was not possible (except in extreme cases). She indicated she felt the resident needed one to one supervision for safety.</p> <p>An interview with a visitor, on 07/19/12 at 3:00 PM, revealed that on 07/13/12 between 8:30 PM and 9:00 PM, she witnessed a resident exit the facility using door #3. The resident attempted to enter the visitor's vehicle and other vehicles in the front parking lot. The visitor then entered the facility and reported the incident to Dietary Staff.</p> <p>An interview with Dietary Aide #2, on 07/19/12 at 2:15 PM, revealed she was in the kitchen when the incident was reported by the visitor. She verified it was Resident #1 at the end of the parking lot attempting to enter the facility van.</p> <p>An observation of the facility's front parking lot, on 07/20/12 at 8:50 AM, revealed the facility van parking spot was approximately 60 feet from door #3. The parking spot was approximately 90 feet from a major highway.</p> <p>An interview with the Director of Nursing (DON), on 07/20/12 at 12:25 PM, revealed she was aware that the activity staff was providing one to one supervised activities for the resident during the day; however, she was not aware the resident</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>voiced wanting to leave the facility, wandered into other residents' rooms, or made attempts to exit the building prior to 07/13/12. She stated that if she had been made aware, she would have placed the resident on increased supervision. She revealed staff was expected to report these behaviors.</p> <p>Interviews with Dietary Aide #2, #3, and #4, on 07/19/12 at 2:15 PM, 2:30 PM, and 2:45 PM, respectively, revealed they were in the kitchen when the visitor made the report; however, did not hear an alarm sound from door #3 (beside the kitchen).</p> <p>An interview with the Maintenance Director, on 07/20/12 at 8:15 AM, revealed he was made aware of the malfunction with door #3 at approximately 9:00 PM on 07/13/12. He inspected the door at approximately 9:10 PM. The panel indicated the door was locked; however, the door opened freely and the audible alarm was not working. The keypad was reset and the door was functioning properly. He was not sure what happened, but indicated a "relay" in the panel could have been "stuck." He revealed the door was checked periodically over the weekend, on 07/14/12 and 07/15/12, until the panel was replaced on 07/16/12 by an outside vendor. He revealed he did not inservice staff on 07/13/12 to ensure the door was monitored over the weekend, as he only checked the equipment et that time. He indicated it was a possibility the door was not constantly monitored prior to replacing the panel on 07/16/12. He further revealed door #3 did not work with the wanderguard system. There were only 2 out of 13</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/24/2012
NAME OF PROVIDER OR SUPPLIER  GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	
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F 323	<p>Continued From page 20</p> <p>exit doors that were equipped with the wanderguard system. He revealed the wanderguard system was a more "sophisticated" panel that would alarm when a resident wearing a wanderguard bracelet became too close to the door; however, he detailed door #3 was not equipped with this system.</p> <p>Interviews with RN #1, Certified Medication Aide (CMA) #1, CNA #1, LPN #1, and CNA #2, on 07/19/12 at 4:00 PM, 4:05 PM, 4:20 PM, 4:25 PM, and on 07/20/12 at 11:05 AM, respectively, revealed they were not aware Resident #1 eloped from the building on 07/13/12 and were not informed to increase supervision of the exit doors. Interviews with CMA #1, LPN #2, LPN #3, RN #2, LPN #4, RN #3, and RN #4, on 07/19/12 at 4:05 PM, 4:45 PM, 5:50 PM, and on 07/20/12 at 9:30 AM, 10:00 AM, 10:30 AM, and 10:50 AM, respectively, revealed they were unaware that all exit doors were not equipped with the wanderguard system.</p> <p>A review of the Wander Board Information, updated 07/18/12, revealed there were 25 residents identified by the facility as a wander risk. A documented assessment of all residents, dated 07/14/12, was completed after the elopement by the facility. The facility's documentation revealed the facility did not have Resident #1's picture on the wandering board, per the policy until 07/14/12 the day after Resident #1's elopement. Interviews with RN #1, CNA #1, LPN #1, CNA #2 on 07/19/12 at 4:00 PM, 4:20 PM, 4:25 PM and on 07/20/12 at 11:05 AM, respectively, revealed they were not familiar with Resident #1. An interview with the DON, on 07/20/12 at 12:25 PM and 07/24/12 at 3:30 PM,</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>revealed the Activity Director was responsible for updating the pictures on the Wander Board. She admitted staff should be more familiar with residents on different units.</p> <p>An interview with the DON, on 07/20/12 at 12:25 PM, revealed one to one supervision was initiated for Resident #1 after the elopement on 07/13/12; however, she thought the door was fully repaired by Maintenance and did not initiate increased supervision of other residents.</p> <p>An interview with the Administrator, on 07/20/12 at 1:05 PM, revealed the door was repaired by Maintenance after the elopement on 07/13/12. It was monitored at least three times a day over the weekend and replaced on 07/16/12. He revealed it was his decision to replace the panel due to the possibility it would malfunction again; however, he did not feel it was necessary to constantly monitor the door over the weekend. He further revealed staff should have been aware of the wanderguard system as they were trained in orientation and annually.</p> <p>The state agency verified the following action taken by the facility to remove the Immediate Jeopardy as of 07/21/12:</p> <ol style="list-style-type: none"> <li>1. A review of the facility's documentation revealed all residents in the facility were re-assessed by RN #7, on 07/14/12, for any indication of new or increased behavior of wandering. No new residents were identified at that time with new or increased behaviors. The documentation indicated Resident #1 did not have a picture on the Wander Board, per the policy; however, there was no concern with the</li> </ol>	F 323		

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F 323	Continued From page 22 Wander Board during the abbreviated survey.  2. On 07/16/12, the exit panel on door #3 was replaced by an outside vendor.  3. On 07/19/12, a new At Risk Wandering Assessment was completed by Administrative Staff, including Minimum Data Set (MDS) Nurses, Unit Coordinators, Quality Improvement (QI) Nurse, Treatment Nurse, Staff Facilitator, and DON, on all residents to identify if any other residents were exhibiting an increased risk of wandering/elopement. The care plans/care guides were updated to reflect individualized interventions to plan for the resident's safety and well being within the facility and prevent the resident's unsupervised exit.  4. Review of the inservice documentation verified all staff were trained on 07/19/12 by the Staff Facilitator on alerting the nurse if they identify wandering or exit seeking behaviors in any resident so further assessment can be completed. All staff members were trained on the location of the Wandering Boards, how the exit doors operate and which doors have the wanderguard system, and what steps to take in the event the doors did not operate properly which would include assigning a staff member to monitor the door and to immediately alert the Maintenance Department. Newly hired employees would receive the training during orientation and prior to the next scheduled shift (if currently on vacation). Interviews with RN #7, CNA #9, LPN #8, CNA #8, Housekeeping, Dietary Aide #3, and the Maintenance Director on 07/23/12 at 1:55 PM, 2:20 PM, 2:15 PM, 2:40 PM, 2:50 PM, 3:00 PM, and on 07/24/12 at 4:00 PM, respectively,	F 323			

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F 323	<p>Continued From page 23</p> <p>revealed all these staff attended the training and validated an understanding of the Wander Boards, exit doors, wander guard system, what to do if a door malfunctions, and reporting exit seeking behaviors.</p> <p>5. Review of the inservice documentation verified all licensed staff were trained, on 07/19/12, by the Staff Facilitator with pictures of residents who have wander guard bracelets in place that allowed staff to be aware of residents who have increased wandering behaviors, steps to take in the event of a new wandering behavior being identified or an increase in wandering behavior which can include immediately placing the resident on one to one supervision and notification of the On-Call Nurse, DON, and/or Administrator for further instructions. Interviews with RN #7, RN #6, LPN #7, RN #3, LPN #9, LPN #8 and DON on 07/23/12 at 1:55 PM, 2:00 PM, 2:15 PM, 2:30 PM, 2:45 PM, 2:50 PM and 3:30 PM, respectively, revealed they attended the training and validated their understanding of the information.</p> <p>6. Interview with the Maintenance Director, on 07/24/12 at 4:00 PM, revealed all exit doors to include door #3 were monitored daily utilizing a Quality Improvement (QI) tool to ensure appropriate function. The Administrator would be immediately notified of any concerns with the door functioning and action would be taken to resolve the issue. Documentation was verified of daily monitoring since 07/13/12.</p> <p>7. Daily chart audits would be completed Monday through Friday by the Administrative Staff, including the Treatment Nurse, QI Nurse,</p>	F 323		

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F 323	<p>Continued From page 24</p> <p>Safety Nurse, MDS Nurses, Unit Coordinators, Staff Facilitator, and Social Workers, to read the nurse progress notes to identify any residents who may begin exhibiting increased wandering behaviors for who additional interventions may be necessary. On Monday morning the charts would be audited for progress notes over the weekend to ensure compliance. Documentation was verified of the daily chart audits starting on 07/20/12.</p> <p>8. The QI nurse would conduct a weekly QI audit utilizing a QI tool to ensure that all residents identified at risk for wandering, per the facility's At Risk Wandering Assessment have interventions in place to plan for the resident's safety and well being in the facility and prevent the resident's unsupervised exit. Any concerns would be addressed with the DON and/or Administrator. The results of these audits would be reviewed by the DON and Administrator in the weekly QI Committee meeting. An interview with the QI nurse, on 07/24/12 at 4:05 PM, revealed the first care plan/At Risk Wander Assessment review was completed on 07/19/12 and reviewed on 07/20/12. Documentation was verified of the review on 07/20/12. The first weekly QI meeting would be 07/27/12.</p> <p>Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 07/21/12, with the scope and severity lowered to a "D."</p>	F 323		