

Acceptable

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

PRINTED: 10/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/18/2014
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
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F 000	INITIAL COMMENTS An Abbreviated Survey, Investigating complaints KY00022061 and KY00022111, was initiated on 08/19/14 and concluded on 08/22/14. KY00022061 was unsubstantiated with no deficiencies cited. KY 00022111 was substantiated with a related deficiency cited. Immediate Jeopardy (IJ) and Substandard Quality of Care was determined to exist on 08/08/14 through 08/11/14 at CFR 483.25 Quality of Care, F-323, at a Scope and Severity of a "J". The facility assessed Resident #1 to have wandering and exit seeking behaviors. On 08/08/14 at approximately 5:45 PM, Resident #1 pushed open the fire exit door on the Magnolia Unit setting off the alarm and went through the door onto the small concrete porch area. Staff responded to the alarm and Resident #1 was returned to the Magnolia Unit day area and placed on fifteen (15) minute checks. However, staff was not aware they needed to have Security Staff come and re-set the fire exit door and ensure the alarms were functioning appropriately. Between 7:45 PM and 8:00 PM on 08/08/14, Resident #1 eloped from the facility without staff's knowledge through the unsecured fire exit door on the Magnolia Unit. Resident #1 was found by the Social Services Director (SSD) at approximately 8:15 PM lying on the sidewalk approximately seven (7) feet from a busy city road, with skin tears to the left forearm and right knee. It was determined the facility had completed all corrective action prior to the State Survey Agency initiating the investigation on 08/19/14, thus resulting in the determination of Past Immediate	F 000	The following constitutes Lexington Country Place's plan of correction for the deficiencies cited and will serve as the facility's credible allegation that substantial compliance will be achieved by 10/15/2014. The submission of this plan of correction is not an admission on the part of the facility necessarily agrees with the accuracy of the surveyor's findings. Rather, it is being submitted as required by law.		

RECEIVED
OCT 27 2014
BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 10-27-14

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

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F 000	Continued From page 1 Jeopardy. However, after Supervisory review the Abbreviated Survey was re-opened on 9/11/14 and concluded with a new exit date of 09/18/14. Ongoing Immediate Jeopardy was identified on 09/12/14 and was determined to exist on 08/08/14, in the areas of CFR 483.20 Resident Assessment, F-280 Care Plan Revision F-282 Care Plan Implementation and 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. The facility was notified of the ongoing Immediate Jeopardy on 09/12/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 09/16/14 with the facility alleging removal of the Immediate Jeopardy on 09/16/14. The Immediate Jeopardy was verified to be removed on 09/16/14 with remaining non-compliance in the areas of 42 CFR 483.20 Resident Assessment, F-280 and F-282 and 42 CFR 483.25 Quality of Care (F-323) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes. In addition, deficient practice was identified during the Abbreviated Survey at 42 CFR 483.75 Laboratory Services, F-502.	F 000	F280 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was placed on one on one (1:1) supervision by the Director of Nursing (DON) on 09/12/2014. Care plan was reviewed by the Interdisciplinary Team, consisting of the DON, Unit Coordinator, Social Services & MDS Nurse & revised at this time to reflect new interventions to the identified problem, goals & interventions for direct care staff to implement when resident exhibits increased wandering/exit seeking behavior. How will the facility identify other residents having the potential to be affected by the same deficient practice?		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	The nursing staff will complete the Wandering/Elopement Risk Review Tool on the date of admission, quarterly and as needed.		

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F 280	Continued From page 2 Incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents' Comprehensive Care Plans were reviewed and revised to implement interventions to provide adequate supervision for one (1) of ten (10) sampled residents (Resident #1) who was assessed at risk for wandering and/or exit seeking behaviors. The facility assessed Resident #1 to have wandering and exit seeking behaviors. On 08/08/14, Resident #1 was agitated and exhibited increased wandering and exit seeking behavior. At approximately 5:45 PM, Resident #1 pushed open the fire exit door on the Magnolia Unit	F 280	On 09/05/14 there were a total of thirteen (13) residents identified with increased wandering risk behaviors based on the Wandering/Elopement Review Form. The IDT reviewed the list on 09/15/2014 to re-evaluate current interventions, problems and goals related to wandering and behavior episodes. These care plans were updated with changes to the identified problem, goals and interventions for direct care staff to implement when residents exhibit increased wandering behaviors.		

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F 280	Continued From page 3 setting off the alarm and went through the door onto the small concrete porch area. Staff responded to the alarm and Resident #1 was returned to the Magnolia Unit day area and placed on fifteen (15) minute checks. However, staff was not aware they needed to have Security Staff come and re-set the fire exit door and ensure the alarms were functioning appropriately. Between 7:45 PM and 8:00 PM on 08/08/14, Resident #1 eloped from the facility without staff's knowledge through the unsecured fire exit door on the Magnolia Unit. Resident #1 was found by the Social Services Director (SSD) at approximately 8:15 PM lying on the sidewalk approximately seven (7) feet from a busy city road, with skin tears to the left forearm and right knee In addition, interviews revealed Resident #1 had increased behaviors of wandering, exit seeking, and agitation on the days the resident's daughter did not visit. However, the facility failed to revise the resident's care plan to address these behaviors to ensure the resident remained safe. (Refer to F-323) The facility's failure to have an effective system in place to ensure residents' Comprehensive Care Plans were reviewed and revised to implement interventions to provide adequate supervision was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/12/14 and was determined to exist on 08/08/14. An acceptable credible Allegation of Compliance (AOC) was received on 09/16/14 which alleged removal of the Immediate Jeopardy on 09/16/14. The Immediate Jeopardy was verified to be	F 280	Ongoing monitoring including a daily Quality Assurance Performance Improvement Review (QAPI) which is a review of Nurse's Notes, Care Plans and any new Physician's Orders for any resident identified with increase wandering or elopement behaviors, including Resident #1. This audit will be conducted daily including weekends on an audit tool by the DON, UC and/or House Supervisors to identify any new elopement attempts and to monitor that staff was documenting Care Plan interventions for increased behaviors of anxiety or agitation and for the effectiveness of these interventions. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Re-education was/will be conducted for licensed nursing staff on 10/9/14 - 10/13/14 by the DON, MDS Nurse, & Staff Development Coordinator on the facility's policy titled "Process for Plan of Care Development and		

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F 280	<p>Continued From page 4</p> <p>removed on 09/16/14 with remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment (F-280) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure residents' Comprehensive Care Plans are reviewed and revised to implement interventions to provide adequate supervision of residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Safety Program: Wandering and Elopement", revised 10/31/07, revealed Policy's purpose for provision of a system to identify residents at risk for "unsafe wandering and elopement". The Policy stated if a resident was determined to be at risk for wandering potentially leading to elopement, an individualized care plan was to be immediately implemented and reviewed with staff to ensure the resident's safety. Per the Policy the care plan was to include interventions to minimize the potential for resident elopement, and the frequency and responsibility for monitoring the resident's location in the facility would be identified in the care plan. Further review of the Policy revealed if a resident was missing the care plan was to be updated.</p> <p>Review of the facility's policy titled, "Process for Plan of Care Development and Communication" dated 07/01/10, revealed the facility should follow a care planning process to ensure timely development and updating of residents' care plans. The Policy revealed the Registered Nurse (RN) was responsible to review all aspects of residents' care plans. Per the Policy, the care</p>	F 280	<p>Communication". This re-education included a review of the need for the licensed nurse to update the resident's care plan as resident needs change. Licensed nurses were also re-educated at this time that in the event any resident begins to experience increased wandering/exit seeking behaviors, the DON and/or Administrator are to be notified. Guidance on implementing the resident's individualized care planned interventions will be provided as indicated. The Care Plan will be reviewed and updated as indicated at that time by the licensed nurse, under the direction of the DON, to ensure a continued safe environment & adequate supervision.</p> <p>A copy of this policy has been placed in the new hire training packets. Newly hired licensed nurses will continue to receive this information & education during the orientation process.</p>		

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F 280	<p>Continued From page 5</p> <p>plan was to be viewed as a "work in progress" and changes made to it as residents' needs changed. Per the Policy, the direct care nurse was to update residents' care plans as resident's needs changed, with a note made in the Interdisciplinary Notes of the resident's medical record.</p> <p>Record review revealed the facility admitted Resident #1's on 01/26/12, with diagnoses which included Anxiety, Dementia and Alzheimer's Disease. Review of the 06/24/14 Annual Minimum Data Set (MDS) Assessment, revealed the facility assessed Resident #1 to be severely cognitively impaired. Review of the Wandering/Elopement Risk Review Tool, dated 06/24/14 revealed the facility assessed Resident #1 as at risk for elopement. Review of Resident #1's Comprehensive Care Plan (CCP), dated 05/11/12, revealed Resident #1 was care planned for the risk for wandering/exit seeking behavior, mainly at night with interventions which included offering snacks of choice and trying to redirect to other activities, offering to call the resident's family when behaviors escalated, offering reassurance his/her family would come to visit, soothing the resident by talking to him/her about his/her "kids" and observing the resident for exit seeking behaviors.</p> <p>Review of the facility's "Self-Reported Incident Form, 5 Day Follow Up/Final Report" form, dated 08/13/14, revealed on 08/08/14 an attempt to elope from the facility was made by Resident #1 through the Magnolia Unit fire exit door. Review revealed Resident #1 successfully opened the door and stepped outside the door onto the small porch area. Per the Form, Resident #1 was hard to re-direct, was taken for a walk outside around</p>	F 280	<p>Re-education was conducted by the DON on 9/12/14 & 10/9/14 – 10/13/14 for direct care nursing staff that includes RNs, LPNs & SRNAs. This re-education included instructions that in the event a door alarm is triggered, a staff member is to be stationed at the doorway until Security is notified & the alarm is returned to normal operation & a sign remains on each exit door stating "If alarms sound you must call security to reset."</p> <p>A bulleted point sheet containing this education has been developed by the DON & placed in the new hire packets for ongoing training for all newly hired employees.</p>		

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F 280	<p>Continued From page 6</p> <p>the facility and returned to the Magnolia Unit where he/she was given a snack. The Form revealed Resident #1 continued to be "agitated" and wandered to another unit and brought back to the Magnolia Unit where he/she resided. Per the Form, at approximately 8:00 PM, Resident #1 was missing and RN #1 searched the Magnolia Unit and other units, but was unable to locate the resident. According to the Form, at approximately 8:15 PM, Resident #1 was observed lying on the sidewalk outside the facility with skin tears to his/her left forearm and right knee.</p> <p>Interview with Resident #1's daughter and Power of Attorney (POA) on 09/12/14 at 10:28 AM and on 09/17/14 at 6:35 PM, revealed she did not visit the resident on Tuesdays and Fridays and on those days Resident #1 didn't do "very well at all" and tried to go home "constantly". Per interview, she was notified, on 08/08/14, Resident #1 successfully eloped from the facility without staff knowledge, and was found outside on the sidewalk. She stated this was one (1) of the days she didn't visit Resident #1. Per interview, sometimes on the days she didn't visit, staff would call her and let the resident talk to her which calmed the resident down. However, she did not receive a call on 08/08/14 prior to the elopement. Resident #1's daughter/POA was concerned with Resident #1's successful elopement on 08/08/14, and wondered what would have happened had the resident made in onto the busy road near where he/she was found.</p> <p>Interview, on 09/11/14 at 11:09 AM and on 09/12/14 at 7:17 PM, with RN #1 revealed Resident #1's behaviors were worse on days</p>	F 280	<p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>The Unit Coordinators will complete a daily review Monday – Friday of the Nurse's Note documentation, Physician Orders and current Care Plan for resident's identified at risk for wandering and/or exit seeking behaviors, based on the facility's Wandering/Elopement Risk Review Tool. The Nurses Notes will be compared to the new Physician Orders and current Plan of Care to ensure that the care plan has been revised by the licensed nurse as indicated related to wandering or exit seeking behaviors to provide adequate supervision. Medical Records will copy the orders from the Friday, Saturday and Sunday on Monday morning for review by the UCs/DON. Medical Records will copy the previous days Physicians Orders Monday-Friday.</p>		

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F 280	<p>Continued From page 7</p> <p>his/her daughter did not visit, and on Friday 08/08/14, a day the resident's daughter didn't visit, Resident #1 was distressed, very anxious, and more agitated. Per Interview, on the days Resident #1's daughter did not visit it was "usually harder" to care for Resident #1.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #4 on 09/11/14 at 5:45 PM, revealed on days his/her daughter did not visit the resident was "worse", wandering "a lot" more, "hard to keep an eye on" and trying to get out the doors.</p> <p>Interview, on 09/11/14 at 11:40 AM, with Licensed Practical Nurse (LPN) #5 revealed she knew on the days Resident #1's daughter did not visit the resident's behaviors were worse, and he/she was "more anxious".</p> <p>Interview, on 09/11/14 at 11:45 AM, with LPN #3 revealed on Tuesdays and Fridays when the resident's daughter didn't visit his/her behaviors were "worse", usually more confused and wandered more, and staff had to keep a closer eye on the resident.</p> <p>Interview, on 09/11/14 at 4:15 PM, with LPN #6 revealed she was very familiar with Resident #1 and knew when his/her daughter didn't visit the resident experienced increased wandering, agitation and would be searching for "people" like his/her "kids".</p> <p>Interview, on 09/11/14 at 8:45 PM, with RN #4/House Supervisor revealed she knew on Tuesdays and Fridays when Resident #1's daughter did not visit he/she became "really agitated", and roamed about much "worse" on those days. She stated on those days Resident</p>	F 280	<p>The House Supervisor will compare the Nurses Notes, Physician Orders and current Care Plan on the weekends to ensure Licensed Nurses have updated the care plan as indicated. The House Supervisor utilizes the Daily QAPI Chart Review Tool (Attachment 1) to review orders written on Saturday and Sunday. The orders are not copied at this time but House Supervisor goes to each unit reviewing them. The DON, Unit Coordinator, MDS Nurse, and/or House Supervisor will use these copies to conduct a daily audit review Monday – Friday to ensure that the care plan has been updated as indicated to reflect these new physician's orders for residents, including those identified with increased wandering/exit seeking behaviors, to identify that these residents have had care plan revisions made, if indicated, to provide adequate supervision to address increased need for supervision. Any discrepancies or identified concerns will be addressed at that time & documented on the Qi audit tool (Attachment 1) and addressed on Qi audit tool (Attachment 2).</p>		

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F 280	Continued From page 8 #1 needed "increased supervision". However, record review revealed no documented evidence Resident #1's care plan interventions were revised to address the resident's increased behaviors of exit seeking on days the resident's daughter did not visit. Interview, on 09/12/14 at 5:17 PM and 5:37 PM, with MDS #1 and MDS #2 revealed MDS #1 was responsible for Resident #1 MDS Assessments and care plans. MDS #2 stated the MDS nurses were "constantly updating" residents' care plans, and the nurses and Unit Coordinators could also update the care plans. MDS #1 stated she was aware Resident #1 had behaviors of exit seeking, wandering, getting confused, "calling" out for family, and stated staff had reported Resident #1 was "worse" on days his/her daughter didn't visit with increased wandering and agitation, but she had not witnessed these behaviors. According to MDS #1, she had heard staff say "that for quite awhile", however, without witnessing this herself she would not know if the resident required increased supervision on those days. MDS #1 stated she guessed increased supervision on the days Resident #1's daughter didn't visit might have been an appropriate intervention; however, the care plan was not revised to include increased supervision. MDS #2 and MDS #1 stated also, if a resident had experienced an elopement attempt previously the care plan should have been revised to include more frequent monitoring than every fifteen (15) minute checks, such as one on one (1:1) supervision. The MDS Nurses stated Resident #1's care plan should have been updated and revised on 08/08/14 for increased supervision after the first elopement attempt, and to address the increased	F 280	Copies of these completed audit tools will be forwarded to the DON weekly & a summary of findings will be discussed in a weekly QI Committee meeting, consisting of but not limited to, the Administrator, DON, Social Worker, MDS Nurse & Unit Coordinators with additional corrective action taken as indicated. These audit tools & any accompanying corrective actions will be reviewed in the monthly interdisciplinary QAPI meeting, which includes, but is not limited to, the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, & Wound Nurse, to ensure effectiveness of the system & further corrective action will be taken as indicated. The facility will compare residents' care plans to observations made on a daily basis by clinical staff (Licensed Nursing) and to include but not limited to SRNA, Social Services, Activities, Therapy, and Admissions on the room rounds		

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F 280	<p>Continued From page 9</p> <p>behaviors on days his/her daughter didn't visit.</p> <p>Interview, on 09/11/14 at 10:10 AM and on 09/12/14 at 7:42 PM, with the Director of Nursing (DON) revealed on 08/08/14 after Resident #1's elopement his/her care plan would not have been revised if staff felt it met the resident's needs, but stated in looking back it should have been revised with increased supervision after the first elopement attempt. She stated she was not aware of Resident #1's increase behaviors when his/her daughter did not visit; however, indicated the resident's care plan should have been updated to include this information, and if necessary for increased supervision of Resident #1 on those days.</p> <p>Interview, on 09/11/14 at 10:10 AM and on 09/12/14 at 8:42 PM, with the Administrator revealed prior to 09/11/14, he had not been aware on days Resident #1's daughter did not visit the resident had increased behaviors, and indicated the care plan could have been revised for increased supervision on those days. The Administrator reported staff should revise residents' care plans anytime it was necessary.</p> <p>The facility provided an acceptable, credible Allegation of Compliance (AOC) on 09/16/14, which alleged removal of the Immediate Jeopardy (IJ), effective 09/16/14. Review of the AOC revealed the facility implemented the following:</p> <ol style="list-style-type: none"> 1. Resident #1 was placed on one on one (1:1) supervision by the Director of Nursing (DON) at 11:00 PM on 09/12/14. Ongoing 1:1 assignment would be determined by the licensed nurse and identified on the daily staffing sheet. A sign in log was to be used to record the time each assigned 	F 280	<p>conducted Monday-Friday and with the "Stop and Watch" documents that can be found at each Nurses Station.</p> <p>Completion Date: October 22, 2014</p>		

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F 280	<p>Continued From page 10</p> <p>staff member assumed responsibility for the resident for tracking purposes.</p> <p>2. The Wandering Risk Care Plan problem was updated on 09/12/14 at 11:00 PM by the DON for Resident #1 to include increased 1:1 supervision. Resident #1's daughter was notified on 09/12/14 at 11:05 PM by the licensed nurse that the resident's care plan had been updated with this information. The Advanced Practice Registered Nurse (APRN) was made aware on 09/13/14 by the licensed nurse of the need to change the resident's care plan.</p> <p>3. Resident #1 would remain on 1:1 supervision until Registered Nurses (RN's), Licensed Practical Nurses (LPN's) and State Registered Nurse Aides (SRNA's) had been re-educated by the DON and Staff Development Coordinator on consistently implementing the care planned interventions to decrease risk of further elopement events. Any RN, LPN, or SRNA not receiving this education by 09/15/14 would receive the education prior to working their next scheduled shift.</p> <p>4. The Care Plan for Resident #1 was reviewed on 09/15/14 by the Interdisciplinary Team which included the DON, Minimum Data Set (MDS) Nurse, Social Worker, Unit Coordinator, and Therapy to re-evaluate current interventions related to wandering and behavior episodes. Resident #1 received showers on Tuesdays and Fridays and this intervention was updated to reflect additional showers as needed since showers had been effective in the past to help calm behaviors.</p> <p>5. A total of thirteen (13) additional residents</p>	F 280		

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F 280	<p>Continued From page 11</p> <p>Identified with increased wandering risk behaviors based on their most recent Wandering/Elopement Review Form, were reviewed on 09/15/14 by the Interdisciplinary Team (IDT) that included the DON, MDS Nurse, Social Worker (SW), Unit Coordinator (UC), and Therapy to re-evaluate current interventions, problems and goals related to wandering and behavior episodes. These care plans were updated with any changes to the identified problem, goals and interventions for direct care staff to implement when residents exhibit increased wandering behavior.</p> <p>6. Staff education was initiated by the DON on 09/12/14 at 11:00 PM for direct care nursing staff, which included RN's, LPN's, and State Registered Nurse Aides (SRNA's), in reference to; Resident #1 must remain in visual contact of the assigned staff member at all times. This education also included instructions that in the event of any resident's attempt to exit the facility they must immediately notify the DON or Administrator and interventions must be initiated per the resident's individualized plan of care to decrease risk of another elopement attempt. This re-education also included information that in the event a door alarm was triggered, a staff member was to be stationed at the doorway until security was notified and the alarm returned to normal operation. A sign had been placed on each exit door stating "if an alarm sounds you must call security to reset". Staff members verbalized understanding of these instructions at the time of the education. Out of seventy-nine (79) full time employees, sixty-five (65) would receive the above education by 09/15/14. Out of eight (8) part time employees, four (4) would receive the education by 09/15/14. Out of thirty-nine (39) as needed (pm) employees,</p>	F 280		

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F 280	Continued From page 12 twenty (20) would receive the above education by 09/15/14. This training would continue to be provided by the DON, House Supervisor, UC's, and Staff Development Coordinator for RN's, LPN's, and SRNA's prior to their next scheduled shift until all have been educated on this information. A bulleted point sheet containing this education was developed by the DON and placed in the new hire packets for ongoing training for all newly hired employees. Lexington Country Place did not utilize agency staff. 7. Ongoing monitoring included a daily Quality Assurance Performance Improvement (QAPI) review of Nurse's Notes, Care Plans, and any new Physician's orders for any resident identified with increased wandering or elopement behaviors, including Resident #1. This audit would be conducted and documented daily, including weekends, on an audit tool by the DON, UC, and/or House Supervisor to identify any new elopement attempts and to monitor that staff was documenting care planned interventions for increased behaviors of anxiety or agitation and for the effectiveness of these interventions. Any issues identified in these audits would be addressed as indicated, based on the direction of the DON. 8. The evening and night shift security staff was educated on parameters for testing the secondary red box alarms ("Stop" back up alarm) located on the fire safety doors on 09/12/14 and 09/13/14 by the Administrator. These instructions included to allow the red box's audible alarms to sound for a minimum of fifteen (15) seconds when being tested to ensure they maintain a sustained volume level within normal range. Instructions also included, in the event of a low or weak	F 280			

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F 280	Continued From page 13 sounding alarm, a staff member was to be stationed at the doorway until the Administrator was notified and the battery was replaced and the alarm was returned to normal operation. These tests would be documented on the Door Inspection of three (3) times a day by Security and Maintenance Staff. A sign was placed on each exit door stating "if alarm sounds you must call security to reset". Staff members verbalized understanding of these instructions at the time of the educations. 9. Other security and maintenance staff would be educated on the minimum fifteen (15) second testing parameter procedure prior to working their next scheduled shift by the Administrator or Director of Security and Transportation. Seven (7) of twelve (12) Maintenance and Security employees would have received this education by end of day on 09/15/14 and there was five (5) additional Security and Maintenance employees who would receive this education prior to working their next scheduled shift. Education on this door testing parameter procedures would be included as part of the new hire orientation provided to new Security and Maintenance Staff which was conducted by the Director of Security and Transportation and the procedure would be reviewed annually ongoing with Security and Maintenance staff by the Director of Security and Transportation and Director of Plant Operations under the direction of the Administrator. 10. Door alarms, including the delayed egress on the fire safety door and the secondary red box alarms located on the fire safety doors would continue to be checked by Security and Maintenance Staff a minimum of three (3) times each day, including on weekends. Testing would	F 280			

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F 280	<p>Continued From page 14</p> <p>be conducted on each shift by sounding the alarm for a duration of at least fifteen (15) seconds. In the event the alarm does not sound at at sustained volume level within range, a staff member would be posted at the door and the problem would be immediately reported to the Administrator. A staff member would remain at the door until Maintenance and the Administrator were notified and the battery was replaced and the alarm was returned to normal operation. Batteries in the secondary red box alarms would be changed a minimum of monthly. This battery change would be documented in the facility's TELS system. The Administrator would verify this on at least a monthly basis.</p> <p>11. Elopement /Missing Resident Drills would be conducted daily on alternating shifts, including weekends, for a minimum of two (2) weeks by the Staff Development Coordinator and Administrator. An Elopement/Missing Person Drill Evaluation Form would be completed with each drill.</p> <p>12. Ongoing monitoring would also include completion of Elopement/Missing Resident Drills at a minimum of four (4) times a year. One (1) drill would be held on each shift and on a weekend day. An Elopement/Missing Person Drill Evaluation Form would be completed for each drill held. The facility would develop an action plan for staff education and correction of issues if encountered during the drills. Monitoring would also include a daily QAPI review of the Door Inspection Logs by the Administrator and/or Director of Security and Transportation. The Administrator would initial these logs to indicate review. Any issues identified would be addressed as indicated by the Administrator and documented on the QAPI tool.</p>	F 280		

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F 280	Continued From page 15 The State Agency validated the implementation of the facility's AOC as follows: 1. Review of the One on One Staff Observation Log, revealed Resident #1 was placed on 1:1 observation on 09/12/14 at 11:00 PM. Continued review of the One on One Staff Observation Log revealed Resident #1 was still on 1:1 observation as of 09/18/14 at the time of the survey. Per the Observation Log the date and time was recorded for each staff member who was resuming responsibility for the resident. Review of the daily staffing sheets from 09/12/14 through 09/18/14 revealed the person responsible for the 1:1 observation of Resident #1 was identified. 2. Review of Resident #1's Wandering Risk Care Plan revealed an update on 09/12/14 with an intervention for 1:1 observation. Review of the Nurse's Note dated 09/12/14 at 11:05 PM, revealed Resident #1's daughter was informed of the resident being on 1:1 care and was agreeable. Review of the Nurse's Note dated 09/13/14 at 1:14 PM, revealed the APRN was notified of the resident being placed on 1:1 observation continuously. 3. Interview on 09/18/14 at 2:30 PM with SRNA #9 and at 2:45 PM with LPN #1 who worked the Magnolia Unit where Resident #1 resided, verified Resident #1 was still on 1:1 observation. Interview with the DON on 09/18/14 at 6:00 PM revealed staff was not allowed to work until they received inservices including implementing care plan interventions to decrease risk of further elopement events and Resident #1 would remain on 1:1 until all staff had been educated.	F 280			

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F 280	<p>Continued From page 16</p> <p>4. Review of Resident #1's Care Plan revealed it was revised on 09/15/14 to include an intervention for showers Tuesdays, Fridays and as needed.</p> <p>Interview, on 09/18/14 at 7:20 PM, with the DON revealed the Interdisciplinary Team (IDT) met and reviewed Resident #1's care plan to re-evaluate current interventions related to wandering.</p> <p>5. Review of the Care Plans for the thirteen (13) residents who were identified with increased wandering behaviors based on their most recent Wandering/Elopement Review Form, revealed the care plans were reviewed and revised on 09/15/14 by the IDT. Changes were made to the care plans with additional interventions for direct care staff to implement when the resident exhibited increased wandering behaviors. Also, some of the Care Plans problems and goals were updated related to the resident's wandering behaviors.</p> <p>6. Review of the inservice information and Attendance Record revealed inservices began on 09/12/14 and continued each day and were still taking place for nursing staff including RN's, LPN's and SRNA's related to the following; 1) Resident #1 to remain in visual contact at all times and a sign in sheet must be completed by each staff member who was assigned to the resident for one on one observation, 2) in the event of any resident's attempt to exit the facility the DON or Administrator must be notified immediately and interventions must be initiated per the resident's individualized plan of care to decrease the risk of another elopement attempt, 3) if there was a weak or low sounding battery or if a door was opened for any reason, a staff</p>	F 280		

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F 280	<p>Continued From page 17</p> <p>member must be stationed at the doorway until the alarm was returned to normal.</p> <p>Observation of the facility exit doors on 09/18/14 from 5:00 PM until 5:30 PM revealed signs on the doors or beside the doors which stated "if an alarm sounds you must call security to reset". As of 09/18/14 all employees but three (3) full time employees, two (2) part time, and thirteen (13) employees had not received the education. Further review revealed a total of seventy-four (74) full time, six (6) part time, and twenty-seven (27) prn staff had received the inservice education. Interview with the DON on 09/18/14 at 7:20 PM, revealed the inservice education started on 09/12/14, and is ongoing. She stated at change of shift, administrative staff stand by the time clock, and anyone who has not received the inservice was not allowed to work until they had been educated. Further interview revealed the Staff Development Coordinator, and House Supervisors assisted with the education.</p> <p>Interview on 09/18/14 at 11:58 AM with the Staff Development nurse revealed a bullet point sheet containing the inservice education was placed in the new hire packet for all newly hired employees. She confirmed the facility did not utilize agency staff.</p> <p>Interview on 09/18/14 with SRNA #9 at 2:30 PM, with LPN #1 at 2:45 PM, LPN #8 at 3:23 PM, with SRNA #16 at 4:00 PM, with SRNA #17 at 4:17 PM, revealed they had been inserviced and trained ensuring Resident #1 remained in visual contact, they must immediately notify the DON or Administrator of any other residents' attempt to exit and that interventions must be initiated, to ensure someone was stationed at any fire exit</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>door alarm which had been triggered until Security returned the door alarm to normal operation.</p> <p>7. Review of the Daily QAPI Chart Review Tool, revealed daily audits starting 09/13/14 through 09/18/14 of Physician's Orders, Nurse's Notes, Care Plans, Concerns and Resolution for a sample identified as having wandering behaviors.</p> <p>Interview with the DON on 09/18/14 at 7:20 PM, revealed administrative nursing staff was checking new Physician's Orders and Nurse's Notes for any behavior concerns and to see if the care plan needed revised and updated related to behaviors and interventions. She stated she reviewed all the audits and was checking for any escalating behaviors she was unaware of, so she could address the behaviors. She further stated the audits would continue until it was decided in the QAPI meeting that the audits could stop</p> <p>8. Review of the Staff Inservice Summary and Attendance Record revealed the Administrator educated Maintenance and Security staff on 09/12/14 through 09/16/14 related to the following; allow audible door alarms (red boxes) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door checks daily every shift, the Door Alarm Inspection Form must have the timing of these tests documented (document the seconds the door alarm sounds), any problems noted during the door inspections must be reported immediately to the Administrator and Maintenance, and in the event of a weak or low sounding alarm a staff member was to be stationed at the doorway until the Administrator was notified and the battery was replaced and the alarm was returned to normal</p>	F 280		

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F 280	<p>Continued From page 19</p> <p>operation. Observation of the facility exit doors revealed a sign on the door or beside the door which stated, "if alarm sounds you must call security to reset".</p> <p>Interview, on 09/18/14 with Security Guard #3 at 6:00 PM revealed he was educated on the minimum fifteen (15) second testing parameter procedure to ensure the alarm maintained a sustained volume within normal range, and in the event of a low or weak sounding alarm a staff member was to be stationed at the doorway until the Administrator was notified and the battery replaced.</p> <p>9. Interview with the Administrator on 09/18/14 at 8:00 PM revealed Security and Maintenance staff had been educated related to allowing audible door alarms (red boxes) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door checks daily every shift. He stated if the alarm did not work or had a low volume, security or maintenance was to notify him and someone was to guard the door until the alarm was fixed. He further stated maintenance was checking the door alarms on the day shift and security was checking the alarms on 2nd and 3rd shifts. Continued interview revealed maintenance and security was documenting checking the door alarms on separate door inspection logs, and he verified this was being done by checking the logs daily. He stated there was one (1) more security employee to educate because he was on vacation; however, the rest of the maintenance and security staff had been educated by him or the Director of Security. Further interview revealed this training would be provided as part of the new hire orientation provided to new hires for maintenance and</p>	F 280		

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F 280	<p>Continued From page 20</p> <p>security and would also be reviewed at least annually ongoing with maintenance and security staff.</p> <p>Interview with the Maintenance Director on 09/18/14 at 5:30 PM, revealed he was educated on the testing of the door alarms by the Administrator. He stated maintenance staff checked the doors each day on day shift. Continued interview revealed they were to allow the audible door alarms (red box) to sound for at least fifteen (15) seconds when being tested. He stated if the door alarms did not work, they were to have staff guard the door until the alarm was fixed. He further stated if there was a concern with the door alarms they were to notify the Administrator.</p> <p>Interview with Security Guard #3 on 09/18/14 at 6:00 PM, revealed he had received education on 09/13/14 related to allowing the audible door alarms (red box) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door on evening and night shift. Continued interview revealed if the alarm did not work or had a low volume, the Administrator was to be notified, and a staff member was to guard the door until it was fixed. He stated security checked the door alarms on evening and night shift.</p> <p>10. Review of the Door Inspections Log revealed the door alarms including the delayed egress on the fire safety door and the secondary red box alarms were being checked three (3) times a day 09/12/14 through 09/18/14. Review of the Red Box Emergency Door Battery Change Log, revealed the batteries were changed on 08/09/14 for the secondary red box alarms.</p>	F 280	
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F 280	Continued From page 21 Continued interview with the Administrator on 09/18/14 at 8:00 PM, revealed the batteries on the secondary Red Box alarms would be changed monthly and documented on the battery change log. 11. Review of the Elopement/Missing Resident Drill Evaluation Forms revealed drills were performed on 08/13/14, 08/19/14, 08/20/14 for all three (3) shifts and weekend personnel, and on 09/15/14 at 6:45 PM, 09/17/14 at 6:36 AM. Interview on 09/18/14 at 11:56 AM with the Staff Development Nurse revealed since the Immediate Jeopardy was called, they were doing elopement drills more frequently and at different times of the day. She stated she had done one (1) of the drills and was told on 09/15/14 they would be doing the drills daily. Interview on 09/16/14 at 7:20 PM, with the DON, and the Consultant DON, revealed they had been participating in the elopement drills which were being done daily, on different shifts and on weekends as well which were being done by the Staff Development Coordinator and the Administrator. Interview on 09/18/14 with SRNA #9 at 2:30 PM, with LPN #1 at 2:45 PM, with Laundry Worker #1 at 3:10 PM, with Housekeeper #1 at 3:20 PM, LPN #8 at 3:23 PM, with SRNA #16 at 4:00 PM, with SRNA #17 at 4:17 PM, revealed they had been inserviced and trained on elopement and elopement drills had been taking place since 09/12/14. 12. Interview with the Administrator on 09/18/14	F 280			

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F 280	Continued From page 22 at 8:00 PM, revealed education started on 09/12/14 and was ongoing related to elopement drills, elopement policy, and door alarms. He stated the elopement drills were to be performed every day for two (2) weeks, then depending on if there was opportunity for improvement they may be done monthly. He stated after a drill and Evaluation was completed and the results were summarized. He stated if there was a problem identified with the drills, an action plan would be developed and staff would be re-educated. He further stated there would be a daily QAPI review of the Door Inspection Logs and he would initial the logs to indicate they were reviewed. The Administrator further stated if a concern was identified with the door alarms, re-education would be done and the problem would be addressed. Continued interview revealed through the QAPI process, they would identify weak areas and issues identified would be addressed and documented on the QAPI tool.	F 280			
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 facility's policies, it was determined the facility failed to have an effective system in place to ensure residents' Comprehensive Care Plans were implemented to ensure monitoring, safety and supervision for one (1) of ten (10) sampled	F 282	F 282 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 was placed on one on one (1:1) supervision by the Director of Nursing (DON) on 09/12/2014. Care plan was reviewed by the Interdisciplinary Team, consisting of the DON, Unit Coordinator, MDS Nurse & Social Services & revised at this time to reflect new interventions to the identified problem, goals & interventions for direct care staff to implement when resident exhibits increased wandering/exit seeking behavior.		

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F 282	<p>Continued From page 23</p> <p>residents (Resident #1) who was assessed at risk for wandering and/or exit seeking behaviors.</p> <p>On 08/08/14, Resident #1 was agitated and exhibited increased wandering and exit seeking behavior. At approximately 5:45 PM, Resident #1 pushed open the fire exit door on the Magnolia Unit setting off the alarm and went through the door onto the small concrete porch area. Staff responded to the alarm and Resident #1 was returned to the Magnolia Unit day area and placed on fifteen (15) minute checks. However, staff was not aware they needed to have Security Staff come and re-set the fire exit door and ensure the alarms were functioning appropriately. Between 7:45 PM and 8:00 PM on 08/08/14, Resident #1 eloped from the facility without staff's knowledge through the unsecured fire exit door on the Magnolia Unit. Resident #1 was found by the Social Services Director (SSD) at approximately 8:15 PM lying on the sidewalk approximately seven (7) feet from a busy city road, with skin tears to the left forearm and right knee. Interviews with staff revealed the resident exhibited agitation, was hard to redirect, and had increased exhibit seeking behavior on days the daughter did not visit. Review the care plan revealed interventions to call the daughter to calm the resident. However, staff failed to implement this intervention on 08/08/14. (Refer to F-323)</p> <p>The facility's failure to have an effective system in place to ensure residents' Comprehensive Care Plans were implemented to ensure monitoring, safety and supervision for residents assessed as at risk for wandering and/or exit seeking behaviors was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/12/14</p>	F 282	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>The nursing staff will complete the Wandering/Elopement Risk Review Tool on admission, quarterly and as needed.</p> <p>On 09/05/14 there were a total of thirteen (13) residents identified with increased wandering risk behaviors based on the Wandering/Elopement Review Form. The IDT reviewed the list on 09/15/2014 to re-evaluate current interventions, problems and goals related to wandering and behavior episodes. These care plans were updated with changes to the identified problem, goals and interventions for direct care staff to implement when residents exhibit increased wandering behaviors.</p>	

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F 282	<p>Continued From page 24 and was determined to exist on 08/08/14.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 09/16/14 which alleged removal of the Immediate Jeopardy on 09/16/14. The Immediate Jeopardy was verified to be removed on 09/16/14 with remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment (F-282) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure to ensure residents' Comprehensive Care Plans were implemented to ensure monitoring, safety and supervision for residents assessed as at risk for wandering and/or exit seeking behaviors.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Resident Safety Program: Wandering and Elopement", revised 10/31/07, revealed if a resident was determined to be at risk for wandering and/or elopement, the facility would develop an individualized care plan which should be reviewed with staff and immediately implemented for ensuring safety of the resident.</p> <p>Review of the facility's policy titled, "Process for Plan of Care Development and Communication" dated 07/01/10, revealed the purpose of the Policy was to ensure effective delivery of comprehensive, coordinated quality care in an organized manner designated to meet the ongoing individualized needs of residents. The Policy revealed the Registered Nurse (RN) was responsible to review all aspects of residents' care plans, and direct care staff should be</p>	F 282	<p>Ongoing monitoring including a daily Quality Assurance Performance Improvement Review (QAPI) which is a review of Nurse's Notes, Care Plans and any new Physician's Orders for any resident identified with increase wandering or elopement behaviors, including Resident #1. This audit will be conducted daily including weekends on an audit tool by the DON, UC and/or House Supervisors to identify any new elopement attempts and to monitor that staff was documenting Care Plan Interventions for increased behaviors of anxiety or agitated and for the effectiveness of these interventions.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Licensed nurses were/will be re-educated on 10/9/14 – 10/13/14 by the DON, MDS Nurse & Staff Development Coordinator on ensuring resident's individualized care planned interventions are implemented by direct care staff to ensure monitoring, safety & supervision of residents,</p>	

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F 282	Continued From page 25 "directly" involved in the care planning process as they spent the most time with residents. Review of the facility's "Self-Reported Incident Form, 5 Day Follow Up/Final Report" form, dated 08/13/14, revealed Resident #1 attempted to exit the facility on 08/08/14 at about 6:15 PM through the Magnolia Unit fire exit door. The Form noted Resident #1 was hard to re-direct, so State Registered Nursing Assistant (SRNA) #5 took the resident for a walk, and every fifteen (15) minute checks were implemented when the resident returned to the Magnolia Unit. Per the Form, Resident #1 remained "agitated", wandered to another unit and had to be brought back to the Magnolia Unit. Continued review of the Form revealed Resident #1 was missing again from the Magnolia Unit at about 8:00 PM, and Registered Nurse (RN) #1 searched the unit and other units. The Form noted Resident #1 was found outside the facility at approximately 8:15 PM, by the Social Service Director (SSD), and the resident had sustained skin tears. Review of Resident #1's record revealed the facility admitted Resident #1 on 01/26/12, with diagnoses which included Alzheimer's Disease, Dementia and Anxiety. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/24/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of four (4) which indicated the resident was severely cognitively impaired. Review of the Wandering/Elopement Risk Review Tool, revealed Resident #1 was assessed to be at risk for elopement on 06/24/14. Review of Resident #1's Comprehensive Care Plan (CCP), dated 05/11/12, revealed Resident #1 was care planned to be at risk for wandering/exit seeking	F 282	including residents who are assessed at increased risk for wandering and/or exit seeking behaviors. A bulleted point sheet containing this education was developed by the DON & placed in the new hire training packets for ongoing training for newly hired nursing staff. Re-education was/will be conducted by the DON on 9/12/14 & 10/9/14 - 10/13/14 for direct care nursing staff, that includes RNs, LPNs & SRNAs that included instructions in the event a door alarm is triggered, a staff member is to be stationed at the doorway until Security is notified & the alarm is returned to normal operation & a sign remains on each exit door stating "if alarms sound you must call security to reset." A bulleted point sheet containing this education has been developed by the DON & placed in the new hire packets for ongoing training for all newly hired RNs, LPNs, & SRNAs.		

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F 282	<p>Continued From page 26</p> <p>behavior, mainly at night with interventions in place which included calling family if behaviors escalated, soothing the resident by talking to him/her about his/her children, observing Resident #1 for exit seeking behaviors, trying to redirect to other activities and offering snack of his/her choice.</p> <p>Interview, on 09/12/14 at 10:28 AM and on 09/17/14 at 6:35 PM, with Resident #1's daughter/Power of Attorney (POA) revealed on Tuesdays and Fridays when she didn't visit the resident, he/she did not do "very well at all", and staff had a "hard time" with him/her on days she didn't visit. Per interview, on those days Resident #1 "constantly" tried to go home, and on 08/08/14 she was notified the resident had eloped from the facility without staff's knowledge. Continued interview revealed 08/08/14 was a Friday, and "of course was one (1) of the nights" she didn't visit Resident #1; however, if they had called her as they sometimes did and let her talk to the resident in might have calmed him/her down and prevented the elopement. Resident #1's daughter/POA was concerned after learning of the successful elopement, and wondered "what would have happened if" he/she "had gotten onto" the busy road near where he/she was found on 08/08/14.</p> <p>Interview, on 09/11/14 at 2:55 PM, with SRNA #5 revealed he walked Resident #1 around the facility outside after his/her first elopement attempt on 08/08/14. SRNA #5 stated after the walk he took Resident #1 back to the Magnolia Unit, had him/her sit in the day area and gave the resident a snack. SRNA #5 revealed he was not aware of Resident #1's care plan interventions and had not attempted to call the resident's</p>	F 282	<p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>The Unit Coordinators will complete a daily review Monday – Friday of the Nurse's Note documentation, Physician Orders and current Care Plan for resident's identified at risk for wandering and/or exit seeking behaviors, based on the facility's Wandering/Elopement Risk Review Tool. The Nurses Notes will be compared to the new Physician Orders and current Plan of Care, to ensure that the resident's individualized care planned interventions has been implemented by direct care staff. Any discrepancies or identified potential concerns will be documented on a QI audit tool (Attachment 1) & addressed as indicated.</p> <p>Medical Records will copy the orders from the Friday, Saturday and Sunday on Monday morning for review by the UCs/DON/MDS Nurses. Medical Records will copy the previous days Physicians Orders Monday-Friday.</p>	

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F 282	Continued From page 27 family. Interview on 09/11/14 at 3:34 PM with SRNA #10, who worked on Resident #1's hall on 08/08/14, and at 5:45 PM with SRNA #4, who was assigned to Resident #1's care on 08/08/14, revealed they were not aware of Resident #1's care plan interventions or if the interventions had been followed on 08/08/14 after the resident's first elopement attempt around dinner time as they were busy providing care for other residents. Interview with RN #1 on 08/21/14 at 5:15 PM, on 09/11/14 at 11:09 AM and on 09/12/14 at 7:17 PM, revealed Resident #1's behaviors were usually increased on days his/her daughter didn't visit, which was on Tuesdays and Fridays. She stated on 08/08/14, Resident #1 had been very anxious, distressed and more agitated that night which was a Friday and the daughter was not there visiting. RN #1 reported on 08/08/14, Resident #1 attempted to elope from the facility and was placed on every fifteen (15) minute checks, but continued to be agitated and eloped from the facility later on that evening at approximately 8:15 PM. Per interview, after Resident #1's first elopement attempt, she had not implemented other interventions, such as calling the resident's daughter and letting the resident talk to her, talking to the resident about his/her children, or trying to redirect him/her to other activities. Continued interview revealed she should have followed Resident #1's care plan interventions, such as calling the daughter which might have helped decrease his/her exit seeking behaviors on 08/08/14. RN #1 stated Resident #1 might not have successfully eloped from the facility on 08/08/14, if she had ensured the care plan interventions were carried out.	F 262	The House Supervisor will compare the Nurses Notes, Physician Orders and current Care Plan on the weekends to ensure that the resident's individualized care planned interventions has been implemented by direct care staff. The House Supervisor utilizes the Daily QAPI Chart Review Tool (Attachment 1) to review orders written on Saturday and Sunday. The orders are not copied at this time but House Supervisor goes to each unit reviewing them. The DON, Unit Coordinator, MDS Nurse, and/or House Supervisor will use these copies to conduct a daily audit review Monday – Friday to ensure that the care plan interventions reflect these new physician's orders for residents, including those identified with increased wandering/exit seeking behaviors. This process is to identify that these residents have had care plan revisions made, if indicated and that current interventions are appropriate to provide adequate supervision to address increased need for supervision.		

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F 282	Continued From page 28 Interview, on 09/11/14 at 10:10 AM and on 09/12/14 at 7:42 PM, with the Director of Nursing (DON) revealed on 08/08/14 after Resident #1's first elopement attempt his/her care plan interventions should have been implemented to try to decrease the exit seeking behaviors. The DON revealed if staff was aware of Resident #1's increased behaviors when his/her daughter did not visit implementing the intervention to call family might have helped decrease his/her behaviors. Interview, on 09/11/14 at 10:10 AM and on 09/12/14 at 8:42 PM, with the Administrator revealed the expectation was staff should always follow residents' care plans. He stated if staff was aware Resident #1 had increased behaviors when his/her daughter didn't visit, calling the daughter and letting the resident talk to her, after the first elopement attempt, might have helped to calm him/her. The facility provided an acceptable, credible Allegation of Compliance (AOC) on 09/16/14, which alleged removal of the Immediate Jeopardy (IJ), effective 09/16/14. Review of the AOC revealed the facility implemented the following: 1. Resident #1 was placed on one on one (1:1) supervision by the Director of Nursing (DON) at 11:00 PM on 09/12/14. Ongoing 1:1 assignment would be determined by the licensed nurse and identified on the daily staffing sheet. A sign in log was to be used to record the time each assigned staff member assumed responsibility for the resident for tracking purposes. 2. The Wandering Risk Care Plan problem was	F 282	Any discrepancies or identified concerns will be addressed at that time & documented on the QI audit tool (Attachment 1) and addressed on QI audit tool (Attachment 2). Copies of these completed audit tools will be forwarded to the DON weekly & a summary of findings will be discussed in a weekly QI Committee meeting, consisting of but not limited to, the Administrator, DON, Social Worker, MDS Nurse & Unit Coordinators with additional corrective action taken as indicated. These audit tools & any accompanying corrective actions will be reviewed in the monthly interdisciplinary QAPI meeting, which includes, but is not limited to, the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, & Wound Nurse, to ensure effectiveness of the system & further corrective action will be taken as indicated.		

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F 282	Continued From page 29 updated on 09/12/14 at 11:00 PM by the DON for Resident #1 to include increased 1:1 supervision. Resident #1's daughter was notified on 09/12/14 at 11:05 PM by the licensed nurse that the resident's care plan had been updated with this information. The Advanced Practice Registered Nurse (APRN) was made aware on 09/13/14 by the licensed nurse of the need to change the resident's care plan 3. Resident #1 would remain on 1:1 supervision until Registered Nurses (RN's), Licensed Practical Nurses (LPN's) and State Registered Nurse Aides (SRNA's) had been re-educated by the DON and Staff Development Coordinator on consistently implementing the care planned interventions to decrease risk of further elopement events. Any RN, LPN, or SRNA not receiving this education by 09/15/14 would receive the education prior to working their next scheduled shift. 4. The Care Plan for Resident #1 was reviewed on 09/15/14 by the Interdisciplinary Team which included the DON, Minimum Data Set (MDS) Nurse, Social Worker, Unit Coordinator, and Therapy to re-evaluate current interventions related to wandering and behavior episodes. Resident #1 received showers on Tuesdays and Fridays and this intervention was updated to reflect additional showers as needed since showers had been effective in the past to help calm behaviors. 5. A total of thirteen (13) additional residents identified with increased wandering risk behaviors based on their most recent Wandering/Elopement Review Form, were reviewed on 09/15/14 by the Interdisciplinary Team (IDT) that included the	F 282	The facility will compare residents' care plans to observations made on a daily basis by staff to include but not limited to the room rounds conducted Monday-Friday and with the "Stop and Watch" documents that all departments have access to seven days a week. The Nurses Notes will be compared to the new Physician Orders and current Plan of Care to ensure that the care plan has been revised to contain goals and interventions that are specific to the resident to ensure adequate interventions are in place. Copies of these completed audit tools will be forwarded to the DON weekly & a summary of findings will be discussed in a weekly QI Committee meeting, consisting of but not limited to, the Administrator, DON, Social Worker, MDS Nurse & Unit Coordinators with additional corrective action taken as indicated.		

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F 282	Continued From page 41 every day for two (2) weeks, then depending on if there was opportunity for improvement they may be done monthly. He stated after a drill and Evaluation was completed and the results were summarized. He stated if there was a problem identified with the drills, an action plan would be developed and staff would be re-educated. He further stated there would be a daily QAPI review of the Door Inspection Logs and he would initial the logs to indicate they were reviewed. The Administrator further stated if a concern was identified with the door alarms, re-education would be done and the problem would be addressed. Continued interview revealed through the QAPI process, they would identify weak areas and issues identified would be addressed and documented on the QAPI tool.		F 282 These audit tools & any accompanying corrective actions will be reviewed in the monthly interdisciplinary QAPI meeting, which includes, but is not limited to, the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, & Wound Nurse, to ensure effectiveness of the system & further corrective action will be taken as indicated.		
F 323 SS=J	483 25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Incident Reports, Investigations and policies, it was determined the facility failed to have an effective system in place to ensure a safe environment and adequate supervision for residents who had been assessed at risk for wandering and/or exit seeking		F 323 Completion Date: October 22, 2014		

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F 282	Continued From page 30 DON, MDS Nurse, Social Worker (SW), Unit Coordinator (UC), and Therapy to re-evaluate current interventions, problems and goals related to wandering and behavior episodes. These care plans were updated with any changes to the identified problem, goals and interventions for direct care staff to implement when residents exhibit increased wandering behavior. 6. Staff education was initiated by the DON on 09/12/14 at 11:00 PM for direct care nursing staff, which included RN's, LPN's, and State Registered Nurse Aides (SRNA's), in reference to: Resident #1 must remain in visual contact of the assigned staff member at all times. This education also included instructions that in the event of any resident's attempt to exit the facility they must immediately notify the DON or Administrator and interventions must be initiated per the resident's individualized plan of care to decrease risk of another elopement attempt. This re-education also included information that in the event a door alarm was triggered, a staff member was to be stationed at the doorway until security was notified and the alarm returned to normal operation. A sign had been placed on each exit door stating "if an alarm sounds you must call security to reset". Staff members verbalized understanding of these instructions at the time of the education. Out of seventy-nine (79) full time employees, sixty-five (65) would receive the above education by 09/15/14. Out of eight (8) part time employees, four (4) would receive the education by 09/15/14. Out of thirty-nine (39) as needed (pm) employees, twenty (20) would receive the above education by 09/15/14. This training would continue to be provided by the DON, House Supervisor, UC's, and Staff Development Coordinator for RN's,	F 282			

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F 282	Continued From page 31 LPN's, and SRNA's prior to their next scheduled shift until all have been educated on this information. A bulleted point sheet containing this education was developed by the DON and placed in the new hire packets for ongoing training for all newly hired employees. Lexington Country Place did not utilize agency staff. 7. Ongoing monitoring included a daily Quality Assurance Performance Improvement (QAPI) review of Nurse's Notes, Care Plans, and any new Physician's orders for any resident identified with increased wandering or elopement behaviors, including Resident #1. This audit would be conducted and documented daily, including weekends, on an audit tool by the DON, UC, and/or House Supervisor to identify any new elopement attempts and to monitor that staff was documenting care planned interventions for increased behaviors of anxiety or agitation and for the effectiveness of these interventions. Any issues identified in these audits would be addressed as indicated, based on the direction of the DON. 8. The evening and night shift security staff was educated on parameters for testing the secondary red box alarms ("Stop" back up alarm) located on the fire safety doors on 09/12/14 and 09/13/14 by the Administrator. These instructions included to allow the red box's audible alarms to sound for a minimum of fifteen (15) seconds when being tested to ensure they maintain a sustained volume level within normal range. Instructions also included, in the event of a low or weak sounding alarm, a staff member was to be stationed at the doorway until the Administrator was notified and the battery was replaced and the alarm was returned to normal operation. These	F 282			

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F 282	Continued From page 32 tests would be documented on the Door Inspection of three (3) times a day by Security and Maintenance Staff. A sign was placed on each exit door stating "if alarm sounds you must call security to reset". Staff members verbalized understanding of these instructions at the time of the educations. 9. Other security and maintenance staff would be educated on the minimum fifteen (15) second testing parameter procedure prior to working their next scheduled shift by the Administrator or Director of Security and Transportation. Seven (7) of twelve (12) Maintenance and Security employees would have received this education by end of day on 09/15/14 and there was five (5) additional Security and Maintenance employees who would receive this education prior to working their next scheduled shift. Education on this door testing parameter procedures would be included as part of the new hire orientation provided to new Security and Maintenance Staff which was conducted by the Director of Security and Transportation and the procedure would be reviewed annually ongoing with Security and Maintenance staff by the Director of Security and Transportation and Director of Plant Operations under the direction of the Administrator. 10. Door alarms, including the delayed egress on the fire safety door and the secondary red box alarms located on the fire safety doors would continue to be checked by Security and Maintenance Staff a minimum of three (3) times each day, including on weekends. Testing would be conducted on each shift by sounding the alarm for a duration of at least fifteen (15) seconds. In the event the alarm does not sound at a sustained volume level within range, a staff	F 282			

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F 282	<p>Continued From page 33</p> <p>member would be posted at the door and the problem would be immediately reported to the Administrator. A staff member would remain at the door until Maintenance and the Administrator were notified and the battery was replaced and the alarm was returned to normal operation. Batteries in the secondary red box alarms would be changed a minimum of monthly. This battery change would be documented in the facility's TELS system. The Administrator would verify this on at least a monthly basis.</p> <p>11. Elopement /Missing Resident Drills would be conducted daily on alternating shifts, including weekends, for a minimum of two (2) weeks by the Staff Development Coordinator and Administrator. An Elopement/Missing Person Drill Evaluation Form would be completed with each drill.</p> <p>12. Ongoing monitoring would also include completion of Elopement/Missing Resident Drills at a minimum of four (4) times a year. One (1) drill would be held on each shift and on a weekend day. An Elopement/Missing Person Drill Evaluation Form would be completed for each drill held. The facility would develop an action plan for staff education and correction of issues if encountered during the drills. Monitoring would also include a daily QAPI review of the Door Inspection Logs by the Administrator and/or Director of Security and Transportation. The Administrator would initial these logs to indicate review. Any issues identified would be addressed as indicated by the Administrator and documented on the QAPI tool.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p>	F 282			

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F 282	<p>Continued From page 34</p> <ol style="list-style-type: none"> Review of the One on One Staff Observation Log, revealed Resident #1 was placed on 1:1 observation on 09/12/14 at 11:00 PM. Continued review of the One on One Staff Observation Log revealed Resident #1 was still on 1:1 observation as of 09/18/14 at the time of the survey. Per the Observation Log the date and time was recorded for each staff member who was resuming responsibility for the resident. Review of the daily staffing sheets from 09/12/14 through 09/18/14 revealed the person responsible for the 1:1 observation of Resident #1 was identified. Review of Resident #1's Wandering Risk Care Plan revealed an update on 09/12/14 with an intervention for 1:1 observation. Review of the Nurse's Note dated 09/12/14 at 11:05 PM, revealed Resident #1's daughter was informed of the resident being on 1:1 care and was agreeable. Review of the Nurse's Note dated 09/13/14 at 1:14 PM, revealed the APRN was notified of the resident being placed on 1:1 observation continuously. Interview on 09/18/14 at 2:30 PM with SRNA #9 and at 2:45 PM with LPN #1 who worked the Magnolia Unit where Resident #1 resided, verified Resident #1 was still on 1:1 observation. Interview with the DON on 09/18/14 at 6:00 PM revealed staff was not allowed to work until they received inservices including implementing care plan interventions to decrease risk of further elopement events and Resident #1 would remain on 1:1 until all staff had been educated. Review of Resident #1's Care Plan revealed it was revised on 09/15/14 to include an intervention for showers Tuesdays, Fridays and as needed. 	F 282	

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F 282 Continued From page 35

F 282

Interview, on 09/18/14 at 7:20 PM, with the DON revealed the Interdisciplinary Team (IDT) met and reviewed Resident #1's care plan to re-evaluate current interventions related to wandering.

5. Review of the Care Plans for the thirteen (13) residents who were identified with increased wandering behaviors based on their most recent Wandering/Elopement Review Form, revealed the care plans were reviewed and revised on 09/15/14 by the IDT. Changes were made to the care plans with additional interventions for direct care staff to implement when the resident exhibited increased wandering behaviors. Also, some of the Care Plans problems and goals were updated related to the resident's wandering behaviors.

6. Review of the inservice information and Attendance Record revealed inservices began on 09/12/14 and continued each day and were still taking place for nursing staff including RN's, LPN's and SRNA's related to the following; 1) Resident #1 to remain in visual contact at all times and a sign in sheet must be completed by each staff member who was assigned to the resident for one on one observation, 2) in the event of any resident's attempt to exit the facility the DON or Administrator must be notified immediately and interventions must be initiated per the resident's individualized plan of care to decrease the risk of another elopement attempt, 3) if there was a weak or low sounding battery or if a door was opened for any reason, a staff member must be stationed at the doorway until the alarm was returned to normal.

Observation of the facility exit doors on 09/18/14

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F 282	<p>Continued From page 36</p> <p>from 5:00 PM until 5:30 PM revealed signs on the doors or beside the doors which stated "if an alarm sounds you must call security to reset". As of 09/18/14 all employees but three (3) full time employees, two (2) part time, and (thirteen (13) employees had not received the education. Further review revealed a total of seventy-four (74) full time, six (6) part time, and twenty-seven (27) prn staff had received the inservice education. Interview with the DON on 09/18/14 at 7:20 PM, revealed the inservice education started on 09/12/14, and is ongoing. She stated at change of shift, administrative staff stand by the time clock, and anyone who has not received the inservice was not allowed to work until they had been educated. Further interview revealed the Staff Development Coordinator, and House Supervisors assisted with the education.</p> <p>Interview on 09/18/14 at 11:56 AM with the Staff Development nurse revealed a bullet point sheet containing the inservice education was placed in the new hire packet for all newly hired employees. She confirmed the facility did not utilize agency staff.</p> <p>Interview on 09/18/14 with SRNA #9 at 2:30 PM, with LPN #1 at 2:45 PM, LPN #8 at 3:23 PM, with SRNA #16 at 4:00 PM, with SRNA #17 at 4:17 PM, revealed they had been inserviced and trained ensuring Resident #1 remained in visual contact, they must immediately notify the DON or Administrator of any other residents' attempt to exit and that interventions must be initiated, to ensure someone was stationed at any fire exit door alarm which had been triggered until Security returned the door alarm to normal operation.</p>	F 282		

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F 282	<p>Continued From page 37</p> <p>7. Review of the Daily QAPI Chart Review Tool, revealed daily audits starting 09/13/14 through 09/18/14 of Physician's Orders, Nurse's Notes, Care Plans, Concerns and Resolution for a sample identified as having wandering behaviors.</p> <p>Interview with the DON on 09/18/14 at 7:20 PM, revealed administrative nursing staff was checking new Physician's Orders and Nurse's Notes for any behavior concerns and to see if the care plan needed revised and updated related to behaviors and interventions. She stated she reviewed all the audits and was checking for any escalating behaviors she was unaware of, so she could address the behaviors. She further stated the audits would continue until it was decided in the QAPI meeting that the audits could stop.</p> <p>8. Review of the Staff Inservice Summary and Attendance Record revealed the Administrator educated Maintenance and Security staff on 09/12/14 through 09/16/14 related to the following; allow audible door alarms (red boxes) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door checks daily every shift, the Door Alarm Inspection Form must have the timing of these tests documented (document the seconds the door alarm sounds), any problems noted during the door inspections must be reported immediately to the Administrator and Maintenance, and in the event of a weak or low sounding alarm a staff member was to be stationed at the doorway until the Administrator was notified and the battery was replaced and the alarm was returned to normal operation. Observation of the facility exit doors revealed a sign on the door or beside the door which stated, "if alarm sounds you must call security to reset".</p>	F 282		

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F 282	Continued From page 38 Interview, on 09/18/14 with Security Guard #3 at 6:00 PM revealed he was educated on the minimum fifteen (15) second testing parameter procedure to ensure the alarm maintained a sustained volume within normal range, and in the event of a low or weak sounding alarm a staff member was to be stationed at the doorway until the Administrator was notified and the battery replaced. 9. Interview with the Administrator on 09/18/14 at 8:00 PM revealed Security and Maintenance staff had been educated related to allowing audible door alarms (red boxes) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door checks daily every shift. He stated if the alarm did not work or had a low volume, security or maintenance was to notify him and someone was to guard the door until the alarm was fixed. He further stated maintenance was checking the door alarms on the day shift and security was checking the alarms on 2nd and 3rd shifts. Continued interview revealed maintenance and security was documenting checking the door alarms on separate door inspection logs, and he verified this was being done by checking the logs daily. He stated there was one (1) more security employee to educate because he was on vacation; however, the rest of the maintenance and security staff had been educated by him or the Director of Security. Further interview revealed this training would be provided as part of the new hire orientation provided to new hires for maintenance and security and would also be reviewed at least annually ongoing with maintenance and security staff.	F 282			

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F 282	<p>Continued From page 39</p> <p>Interview with the Maintenance Director on 09/18/14 at 5:30 PM, revealed he was educated on the testing of the door alarms by the Administrator. He stated maintenance staff checked the doors each day on day shift. Continued interview revealed they were to allow the audible door alarms (red box) to sound for at least fifteen (15) seconds when being tested. He stated if the door alarms did not work, they were to have staff guard the door until the alarm was fixed. He further stated if there was a concern with the door alarms they were to notify the Administrator.</p> <p>Interview with Security Guard #3 on 09/18/14 at 6:00 PM, revealed he had received education on 09/13/14 related to allowing the audible door alarms (red box) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door on evening and night shift. Continued interview revealed if the alarm did not work or had a low volume, the Administrator was to be notified, and a staff member was to guard the door until it was fixed. He stated security checked the door alarms on evening and night shift.</p> <p>10. Review of the Door Inspections Log revealed the door alarms including the delayed egress on the fire safety door and the secondary red box alarms were being checked three (3) times a day 09/12/14 through 09/18/14. Review of the Red Box Emergency Door Battery Change Log, revealed the batteries were changed on 08/09/14 for the secondary red box alarms.</p> <p>Continued interview with the Administrator on 09/18/14 at 8:00 PM, revealed the batteries on the secondary Red Box alarms would be changed</p>	F 282			

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F 282	<p>Continued From page 40 monthly and documented on the battery change log.</p> <p>11. Review of the Elopement/Missing Resident Drill Evaluation Forms revealed drills were performed on 08/13/14, 08/19/14, 08/20/14 for all three (3) shifts and weekend personnel, and on 09/15/14 at 6:45 PM, 09/17/14 at 6:36 AM.</p> <p>Interview on 09/18/14 at 11:58 AM with the Staff Development Nurse revealed since the Immediate Jeopardy was called, they were doing elopement drills more frequently and at different times of the day. She stated she had done one (1) of the drills and was told on 09/15/14 they would be doing the drills daily.</p> <p>Interview on 09/18/14 at 7:20 PM, with the DON, and the Consultant DON, revealed they had been participating in the elopement drills which were being done daily, on different shifts and on weekends as well which were being done by the Staff Development Coordinator and the Administrator.</p> <p>Interview on 09/18/14 with SRNA #9 at 2:30 PM, with LPN #1 at 2:45 PM, with Laundry Worker #1 at 3:10 PM, with Housekeeper #1 at 3:20 PM, LPN #8 at 3:23 PM, with SRNA #16 at 4:00 PM, with SRNA #17 at 4:17 PM, revealed they had been inserviced and trained on elopement and elopement drills had been taking place since 09/12/14.</p> <p>12. Interview with the Administrator on 09/18/14 at 8:00 PM, revealed education started on 09/12/14 and was ongoing related to elopement drills, elopement policy, and door alarms. He stated the elopement drills were to be performed</p>	F 282		

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F 323 Continued From page 42 behaviors for one (1) of ten (10) sampled residents (Resident #1).

On 08/08/14, Resident #1 was agitated and exhibited increased wandering and exit seeking behavior. At approximately 5:45 PM, Resident #1 pushed open the fire exit door on the Magnolia Unit setting off the alarm and went through the door onto the small concrete porch area. Staff responded to the alarm and Resident #1 was returned to the Magnolia Unit day area and placed on fifteen (15) minute checks. However, staff was not aware they needed to have Security Staff come and re-set the fire exit door and ensure the alarms were functioning appropriately. Between 7:45 PM and 8:00 PM on 08/08/14, Resident #1 eloped from the facility without staff's knowledge through the unsecured fire exit door on the Magnolia Unit. Resident #1 was found by the Social Services Director (SSD) at approximately 8:15 PM lying on the sidewalk approximately seven (7) feet from a busy city road, with skin tears to the left forearm and right knee.

The facility's failures to have an effective system in place to ensure a safe environment and adequate supervision was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/12/14 and was determined to exist on 08/08/14.

An acceptable credible Allegation of Compliance (AOC) was received on 09/16/14 which alleged removal of the Immediate Jeopardy on 09/16/14. The Immediate Jeopardy was verified to be removed on 09/16/14 with remaining non-compliance in the area of 42 CFR 483.25 Quality of Care (F-323) at a Scope and Severity

F 323 F323

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Resident #1 was placed on one on one (1:1) supervision by the Director of Nursing (DON) on 09/12/2014. Care plan was reviewed by the Interdisciplinary Team, consisting of the DON, Unit Coordinator, Social Services & MDS Nurse & revised at this time to reflect new interventions to the identified problem, goals & interventions for direct care staff to implement when resident exhibits increased wandering/exit seeking behavior to ensure a safe environment & adequate supervision.

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F 323	Continued From page 43 of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure a safe environment and adequate supervision of residents. The findings include: Review of the facility's policy titled, "Resident Safety Program: Wandering and Elopement", revised 10/31/07, revealed the facility would provide a "proactive" program of supervision and interventions to minimize the risk for elopement, and provide a program for staff education in effective wandering/elopement management through "in-services and drills". The Policy revealed the person who identified a resident was missing was to immediately notify the Administrator and/or Director of Nursing (DON) or designee who would immediately mobilize staff to initiate a search. Review of the facility's, "Missing Person/Elopement Tips" form, undated, revealed staff were to initiate an overhead page of "Dr. Hunt" with the resident's name and room number of the missing resident to notify other staff. Review of the facility's policy titled, "Resident Safety Program: Wandering & Elopement: Resident Security Systems and Devices", revised 10/31/07, revealed the purpose of the Policy was to provide a security system to enhance the safety of the residents in the facility, and to ensure the resident signaling device and door alarm equipment was tested, used and maintained properly to reduce the risk associated with wandering. Record review revealed the facility admitted				
F 323	How will the facility identify other residents having the potential to be affected by the same deficient practice? The nursing staff will complete the Wandering/Elopement Risk Review Tool on the date of admission, quarterly and as needed. On 09/05/14 there were a total of thirteen (13) residents identified with increased wandering risk behaviors based on the Wandering/Elopement Review Form. The IDT reviewed the list on 09/15/2014 to re-evaluate current interventions, problems and goals related to wandering and behavior episodes. These care plans were updated with changes to the identified problem, goals and interventions for direct care staff to implement when residents exhibit increased wandering behaviors.				

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F 323	<p>Continued From page 44</p> <p>Resident #1 on 01/26/12, with diagnoses which included Dementia, Alzheimer's Disease, Anxiety, and New Onset Seizure Activity diagnosed on 03/24/14. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/24/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15), indicating severe cognitive impairment. Further review of the MDS Assessment revealed the facility assessed Resident #1 to require supervision and one (1) person assist with a walker for ambulation. Further record review revealed the facility assessed Resident #1 as an elopement risk on the facility's Wandering/Elopement Risk Review Tool, when he/she was re-admitted in March 2014, again on 04/21/14 and also on 06/24/14.</p> <p>Review of Resident #1's Comprehensive Care Plan (CCP), dated 05/11/12, revealed Resident #1 was care planned for at risk for wandering/exit seeking behavior, mainly at night, related to his/her diagnosis of Dementia. Review of the care plan revealed interventions which included observing Resident #1 for exit seeking behaviors, calling family if behaviors escalated, soothing the resident by talking to him/her about his/her children, offering snacks and trying to redirect to other activities.</p> <p>Review of the facility's "Self-Reported Incident Form, 5 Day Follow Up/Final Report" form, dated 08/13/14, revealed Resident #1 was observed "around 6:15 PM" attempting to exit the building at the fire exit door on the Magnolia Unit (where he/she resided). Review of the Form revealed Resident #1 was "able to open the fire exit door by pressing the bar and activating the delayed egress" (magnetic locking device system which</p>	F 323	<p>Ongoing monitoring including a daily Quality Assurance Performance Improvement Review (QAPI) which is a review of Nurse's Notes, Care Plans and any new Physician's Orders for any resident identified with increase wandering or elopement behaviors, including Resident #1. This audit will be conducted daily including weekends on an audit tool by the DON, UC and/or House Supervisors to identify any new elopement attempts and to monitor that staff was documenting Care Plan Interventions for increased behaviors of anxiety or agitated and for the effectiveness of these interventions.</p>	

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F 323	Continued From page 45 prevented doors from being opened for protection of residents inside and outside to prevent entrance through the door). The Form noted the alarm was sounding and staff heard the alarm and responded attempting to re-direct Resident #1. According to the Form, Resident #1 was "difficult" to re-direct, so State Registered Nursing Assistant (SRNA) #5 took the resident for a walk, brought him/her back into the building where every fifteen (15) minute checks were implemented. The Form revealed Resident #1 "continued to be agitated", wandered to another unit and was brought back to the Magnolia Unit. Continued review of the Form revealed Registered Nurse (RN) #1 administered Ativan (anti-anxiety medication) PRN (as needed) to Resident #1, and the resident became "sleepy" while sitting in the "day area" of the Magnolia Unit after the Ativan was given. Review revealed RN #1 observed Resident #1 "at a table in the day area" of the Magnolia Unit at 7:55 PM, left to "go give another resident medication", and when she returned "around 8:00 PM" the resident was no longer in the "day area". The Form noted RN #1 searched the unit and other units, returned to the Magnolia Unit "around 8:15 PM", where a Security Guard informed her she had found the fire exit door "unlocked and not alarmed while doing her nightly rounds". Review of the Form revealed the Security Guard informed RN #1 she had "just" re-set the fire exit door and locked it. Further review of the Form revealed "it was around 8:15 PM" when the Social Services Director (SSD) "spotted" Resident #1 on the "sidewalk outside the door of" the Magnolia Unit. The Form noted Resident #1 had "tripped and sustained minor skin tears", was assessed and took "back into the facility" where he/she received first aid.	F 323	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Door alarms, including the delayed egress on the fire safety door & the secondary red box alarms located on the fire safety doors will continue to be checked by Security & Maintenance Staff a minimum of three times each day, including on weekends. Testing will be conducted on each shift by sounding the alarm for duration of at least 15 seconds. These tests will be documented on the Door Inspection Log. Any problems identified with the		

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F 323	Continued From page 46 Record review revealed a Nurse's Note dated 08/08/14 at 10.00 PM, which stated Resident #1 got outside the facility by himself/herself and had an unwitnessed fall on the sidewalk. Continued review of the Note revealed Resident #1 sustained one (1) skin tear to the left forearm (LFA) and two (2) skin tears to the right knee. Review of the Note revealed Resident #1 was returned to his/her room and assessment and first aid was administered by a nurse. Further review of the Nurse's Note revealed Resident #1's family and Physician were notified. Observation of the area Resident #1 was found, on 09/11/14 at 4:27 PM, with LPN #8, and on 09/12/14 at 4:10 PM, with the SSD, revealed it was approximately six and a half feet to seven feet from the busy city road. Observation, on 09/12/14 at 3:45 PM, of the Maintenance Director measuring the distance from the Magnolia Unit's fire exit door to where Resident #1 was found revealed it was one hundred and sixty-six (166) feet. Continued observation of the Maintenance Director revealed he measured the distance from where the SSD reported finding Resident #1 as seven (7) feet from the busy city road. Interview, on 09/11/14 at 3:34 PM, SRNA #10 revealed she was working on the Magnolia Unit on 08/08/14 when Resident #1 eloped from the facility. According to SRNA #10, that night Resident #1 was really confused, "frustrated", going in and out of other residents' rooms and being redirected and stating he/she "wanted to go home". Per interview, Resident #1 was "convinced" he/she was a "little girl" and kept wanting to go out the fire exit door "to go home to" his/her "parents". She stated when Resident	F 323	door alarm test will be immediately reported to the Administrator & documented on the testing log. In the event of an identified problem with the door or alarm a staff member will be stationed at the doorway until the Administrator is notified & the door alarm is returned to normal operation. Batteries in the secondary red box alarms will be changed a minimum of monthly on going & documented in the facility's TELS system. A sign remains on each exit door stating "If alarm sounds you must call security to reset" to alert staff of the need to notify Security staff to re-set the alarm.		

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F 323 Continued From page 47

#1 opened the fire exit door on 08/08/14, she was the first to respond as she saw the resident pushing on the door and opening it. SRNA #10 stated the alarms sounded when Resident #1 pushed on the fire exit door and the resident stepped outside the fire exit door onto the small porch area. SRNA #10 had to step in front of the resident to prevent him/her from going onto the long ramp leading to the sidewalk. Continued interview revealed she and RN #1 tried quite awhile to redirect Resident #1 back into the building; however, he/she would not go. She reported SRNA #5 came and volunteered to take Resident #1 ahead down the ramp and around the facility for a walk. SRNA #10 stated it took approximately twenty-five (25) minutes to get Resident #1 back inside the facility. Per interview, SRNA #5 brought Resident #1 back to the Magnolia Unit and sat him/her in a chair in the day area where the nurse kept an eye on the resident. She stated she was not "entirely sure" the first elopement attempt staff had performed every fifteen (15) minute checks. The SRNA stated she had gone to a resident's room to give a bed bath, and when she was finished RN #1 had asked her if she had seen Resident #1. She stated she told RN #1 "no", and right after that she found out Resident #1 was found outside and she had seen RN #1 "jump over the fence" to get to where the resident was found outside. SRNA #10 stated even though she did hear alarms when Resident #1 first attempted to elope, she had not heard any alarms when the resident successfully eloped through the fire exit door the second time.

Interview, on 09/11/14 at 2:55 PM, with SRNA #5 revealed he had not provided care for Resident #1 before; however, he did work on the Magnolia

F 323 The evening & night shift security staff and maintenance staff were re-educated on the parameters for testing the secondary red box alarms located on the fire safety doors by the Administrator, Director of Security & Transportation and Maintenance Director (Director of Plant Operations) on 9/12/14-09/21/14 & 10/9/14 - 10/13/14. These instructions included to allow the red box's audible alarms to sound for a minimum of 15 seconds when being tested to ensure that they maintain a sustained volume level within normal range. In the event of a weak or low sounding alarm, a staff member is to be stationed at the doorway until the Administrator is notified, the battery is replaced & the alarm is returned to normal operation. Batteries in the secondary red box alarms are to be changed a minimum of monthly on going & documented in the facility's TELS system. A sign is to remain on each exit door stating "If

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F 323 Continued From page 48

Unit where Resident #1 resided, and everyone on the unit knew to watch out for as Resident #1 "walked around all the time". SRNA #5 stated Resident #1 had increased restlessness and wandering on 08/08/14, and "after supper" went to the fire exit door on the Magnolia Unit, pushed on it and it opened. He stated he could not remember hearing "any kind of alarm at all"; however, observed RN #1 and SRNA #10 attempting to get Resident #1, who appeared frustrated, back inside the fire exit door. The SRNA stated he offered to walk the resident around outside and RN #1 agreed. According to SRNA #5, he walked Resident #1 around the outside of the facility and returned him/her to the Magnolia Unit day area and he/she was given a snack. SRNA #5 stated when Resident #1 eloped from the building "the second time" he was giving a resident a shower and did not remember hearing any kind of alarm. Additional interview, on 09/12/14 at 10:20 AM, with SRNA #5 revealed he did not know when the every fifteen (15) minute checks were started, and had not performed them or documented them anywhere.

Interview with RN #1 on 08/21/14 at 5:15 PM, on 09/11/14 at 11:09 AM, and on 09/12/14 at 7:17 PM, revealed she usually worked on Resident #1's hall on the Magnolia Unit, and was assigned as the resident's nurse on 08/08/14. She stated Resident #1 had been very anxious, distressed and more agitated that evening, which was a Friday and his/her daughter was not there to visit on Tuesdays and Fridays. RN #1 reported on the evening of 08/08/14 it was "really busy", and right after supper, Resident #1 attempted to go outside by pressing the fire exit door bar which caused the door alarm to go off briefly; however, the

F 323 alarm sounds you must call security to reset."

The Director of Security & Maintenance will provide this education on the door testing parameter procedure as part of the new hire orientation provided to new Security & Maintenance Staff ongoing.

Licensed Nursing Staff have been/will be re-educated on 9/12/14 & 10/9/14 - 10/13/14 by the DON that in the event a resident begins to experience increased wandering/ exit seeking behaviors, the DON and/or Administrator are to be notified & that interventions must be initiated per the resident's individualized care plan to promote safety & decrease risk of accident. The Care Plan will continue to be reviewed and updated as indicated at that time by the licensed nurse, under the direction of the DON.

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F 323 Continued From page 49
 "Stop" back up alarm only sounded faintly. RN #1 stated SRNA #5 then took Resident #1 outside for a walk to help calm the resident down, walked him/her around to the front door of the facility and back to the Magnolia Unit day area. Per interview, she stated Resident #1 got up from where SRNA #5 had sat him/her in the day area, and had experienced increased wandering and was still agitated, so she gave him/her a PRN dose of Ativan (medication used for Anxiety) at 7:15 PM. She stated her supervisor, RN #4 placed Resident #1 on every fifteen (15) minute checks sometime after the resident was returned to the unit which had been documented on a monitoring form. RN #1 stated she guessed the responsibility for doing the every fifteen (15) checks had fallen mainly on her because the SRNAs were busy providing care for residents. The RN stated she was unable to recall exactly what time the every fifteen (15) minute checks were started, and reported the monitoring form of 08/08/14, which had been completed by staff, was now missing and could not be located. She stated in hindsight Resident #1 should have been put on one on one (1:1) supervision since she had experienced the elopement attempt earlier. The RN stated she checked on Resident #1 at approximately 7:45 PM, and the resident was "less anxious" and becoming sleepy while sitting in the dayroom on the Magnolia Court unit. Continued interview with RN #1 revealed she left Resident #1 sitting in the day area of the Magnolia Unit at approximately 7:55 PM to 8:00 PM to go give another resident's medication and when she returned to the day area approximately five (5) minutes later, Resident #1 was no longer sitting there. However, review of RN #1 time clock punches revealed she clocked out for her lunch break at 7:35 PM and clocked back in at

F 323 Re-education was/will be also conducted on 9/12/14, 09/15, 09-16 & 10/9/14 - 10/13/14 by the DON for direct care nursing staff that included RNs, LPNs, & SRNAs that included instructions that in the event a door alarm is triggered, a staff member is to be stationed at the doorway until Security is notified & the alarm is returned to normal operation & a sign remains on each exit door stating "if alarms sound you must call security to reset." Re-education also included the facility's process for residents at risk of wandering or elopement to ensure the deficient practice does not recur.

A bulleted point sheet containing this education has been developed by the DON & placed in the new hire training packets for ongoing training for all newly hired employees.

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F 323	<p>Continued From page 50</p> <p>8:05 PM. Further interview with RN #1 revealed she immediately checked Resident #1's room, and searched other areas of the facility in attempt to locate him/her; however, did not call the "Dr. Hunt" overhead page as per the facility policy. The RN stated she should have performed the "Dr. Hunt" overhead page as per facility policy when she didn't find Resident #1 in his/her room. However, she reported searching for Resident #1 for approximately fifteen (15) minutes, but was unsuccessful in locating the resident. Per interview, after returning to the Magnolia Unit interview revealed Security Guard #1 notified her the fire exit door was not secure on Magnolia Court and the alarms weren't working. RN #1 stated right after seeing Security Guard #1, RN #4/House Supervisor told her Resident #1 had been found on the sidewalk outside, and the resident "had gotten pretty far the down the sidewalk near the driveway". She stated she went to where Resident #1 was outside and Licensed Practical Nurse (LPN) #8 was with the resident who had skin tears to his/her left forearm and right knee.</p> <p>Interview, on 09/11/14 at 4:15 PM, with LPN #6 revealed was sitting at the nurse's station on 08/08/14 when she received a phone call from the SSD telling her Resident #1 was lying on the sidewalk outside the facility, and the SSD thought the resident was hurt. LPN #6 stated when she got to Resident #1 the resident was sitting up with his/her legs straight out in front of him/her on the grass by the sidewalk near the busy city road. Continued interview revealed she had assessed Resident #1 and found the resident to have "wounds" on his/her left forearm and right knee, which she administered first aid to and measured once the resident was returned to his/her room in</p>	F 323	<p>The Activity Department, Housekeeping, Rehabilitation, Dietary, Social Services, Security and Maintenance were all educated by the Administrator, DON and/ or department heads on 09/12-09/15 and 09/20-09/21/2014 regarding identifying potential risks or hazards in the resident's environment & on ensuring that individualized care planned interventions promote safety for residents are in place. The education also included the process for fire safety exit doors if the alarm is triggered.</p> <p>The Business Office staff, Housekeeping, Dietary, Rehabilitation Department, Maintenance, Security and Nursing were all re-educated on 10/10-10/14 by the Administrator, DON and/or department heads regarding identifying potential risk or hazards in the resident's environment & on ensuring that individualized care planned interventions to promote safety for residents are in place.</p>		

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F 323	<p>Continued From page 51</p> <p>the facility. LPN #6 stated the SSD pushed on the Magnolia Unit fire exit door that night after Resident #1 was returned to his/her room, and the "Stop" back up alarm only made a "little noise" and then quit which it was not supposed to do. Per interview, the "Stop" back up alarm was supposed to be very loud and stay on until the fire exit door was re-set by Security. She stated she knew the fire exit doors needed to be re-set, but didn't think the staff on the Magnolia Unit were aware of that information. LPN #6 stated the facility's process for locating missing residents was to search for "no more than five (5) minutes", then if the resident was not found, call the "Dr. Hunt" overhead page and each unit's staff searched the areas they were assigned to search. She stated, however, no "Dr. Hunt" overhead page was made the night of 08/08/14 when Resident #1 eloped from the facility.</p> <p>Interview, on 08/22/14 at 11:00 AM, on 09/12/14 at 4:15 PM and 6:20 PM, with the SSD revealed she was already clocked out from work on 08/08/14, and leaving the driveway of the facility at about 8:15 PM, when she observed a "bystander" bent over someone on the sidewalk and realized it was Resident #1, who was lying on his/her left side on the sidewalk near the busy road. She stated the "bystander" informed her she had witnessed Resident #1 fall onto the sidewalk when she was driving by the facility on the busy road, and had pulled her car over to check on the resident. Per interview, Resident #1's walker was standing up near the resident. Continued interview revealed the SSD called the facility and reached LPN #6 whom she informed of Resident #1 lying on the sidewalk outside the facility, and LPN #6 immediately came to assess the resident. The SSD stated she called the</p>	F 323	<p>Elopement/Missing Resident Drills were conducted daily on alternating shifts, including weekends, for 2 weeks (09/15-09/28/14) by the Staff Development Coordinator & Administrator. An Elopement/Missing Person Drill Evaluation Form was completed with each drill.</p> <p>Ongoing monitoring includes completion of Elopement/Missing Resident Drills weekly for one month beginning 09/29/2014 and then</p> <p>monthly for four months beginning 10/29/2014-02/29/2014. One drill will be held on each shift and on a weekend day. An Elopement/Missing Person Drill Evaluation Form will be completed for each drill held.</p> <p>If during the Elopement/Missing Resident Drills a problem is identified, the facility will develop an action plan for staff education and correction of issues. However, the staff involved will be re-educated to the proper procedures by the Administrator, DON or Staff Development Coordinator.</p>	

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NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504
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F 323 Continued From page 52
Administrator too, while outside with Resident #1, and then went into the building, and proceeded to the Magnolia Unit fire exit door. Further interview revealed RN #1 should have called a "Dr. Hunt" overhead page within minutes of discovering Resident #1 missing as per facility policy, however, had not done so.

Interview, on 09/11/14 at 8:45 PM, with RN #4/House Supervisor revealed on 08/08/14, she was aware the resident had "tried to get out" of the facility "about 6:00 PM". Per interview, every fifteen (15) minute checks were initiated "right after" that incident, and she had assisted with the checks which were documented on a monitoring "sheet" which had now "disappeared". She stated after the first incident Resident #1 had remained "agitated", and the resident "probably" needed to be on one on one (1:1) supervision, but there had not been enough staff that night to have someone sit one on one (1:1) with Resident #1. RN #4/House Supervisor stated so she thought at the time the every fifteen (15) minute checks were appropriate; however, did not call the DON and was later told had she called the DON one on one (1:1) supervision could have been arranged. Continued interview revealed about 8:15 PM to 8:20 PM, RN #1 came to her and asked if she had seen Resident #1. RN #4/House Supervisor revealed RN #1 told her she had "just seen" Resident #1, but now couldn't find him/her and would continue searching for the resident. RN #4/House Supervisor stated the facility's process was for a "Dr. Hunt" overhead page to be made within five (5) minutes of discovering a resident missing; however, RN #1 had not done this. Further interview revealed "nobody was aware" that night Security was supposed to be called to re-set fire exit doors and

F 323 Monitoring will also include a daily QAPI review of the Door Inspection Logs by Administrator and/or Director of Security and Transportation. The Administrator will initial these logs to indicate review. Any issues identified will be addressed as indicated by the Administrator and documented on the QAPI tool.

How will the facility monitor its performance to ensure solutions are sustained?

Copies of the Door Inspection Logs (Attachment 3) will be forwarded to the Administrator daily, Monday – Friday. Inspection Logs completed on the weekend will be forwarded on Monday. A summary of findings will be compiled by the Administrator & discussed in a weekly QI Committee meeting, consisting of but not limited to, the Administrator, DON, Social Worker, MDS Nurse, Maintenance & Unit Coordinators with additional corrective action taken as indicated.

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F 323	Continued From page 53 alarms; however, she stated she was told by the DON later that night Security had to re-set it. Interview with RN #1 on 08/21/14 at 5:15 PM, on 09/11/14 at 11:09 AM, and on 09/12/14 at 7:17 PM, revealed she thought once the fire exit door was closed, the alarm "re-enabled itself", and she was not aware she needed a Security Guard to come and re-set the door. Further interview with RN #1 revealed she later learned the "Stop" back up alarm on the fire exit door should have sounded loudly until the fire exit door had been re-set. Interview, on 09/11/14 at 2:55 PM with SRNA #5, on 09/11/14 at 5:45 PM with SRNA #4, and on 09/11/14 at 3:34 PM with SRNA #10, revealed they did not realize the fire exit door and alarms needed to be re-set. Interview, on 09/11/14 at 2.25 PM and on 09/12/14 at 11:26 AM with Security Guard #1, revealed on 08/08/14 about 8:15 PM, during her rounds of the facility she checked the Magnolia Unit fire exit door and found it "not locked" as it "opened right up" when she pushed on it. She stated the "Stop" back up alarm did not sound. Security Guard #1 stated she locked the fire exit door. According to Security Guard #1, she had not realized the "Stop" back up alarm was not working as she thought the fire exit door and the back up alarm had not been re-set. She stated to re-set the "Stop" back up alarm she had to insert a key to re-set the alarm and thought that's all that was wrong until the Administrator called her later that evening. Security Guard #1 stated the Administrator asked her to check the fire exit doors and alarms every hour because he thought the batteries were not good in the "Stop" back up	F 323	A Physical Plant & Environmental Cleanliness QI audit tool (Attachment 4) maybe completed by the following departments but not limited to Social Services, Nursing, Activities, Human Resources, Dietary, Housekeeping, Maintenance, MDS and Admissions a minimum of 15 rounds per week in assigned areas of the facility on various days & times, including weekends for a minimum of 6 weeks to identify potential hazards or risks to residents. The Physical Plant & Environmental Cleanliness QI audit tool started 10/15/2014 and will end 11/23/2014. Any concerns will be addressed as indicated. Copies of these QI audit tools will be given to the appropriate department manager as issues are identified so that corrective action may be taken as indicated.		

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F 323	Continued From page 54 alarm on the Magnolia Unit. Interview, on 08/21/14 at 1:00 PM, and on 09/12/14 at 9:53 AM, with Maintenance Worker #1 revealed fire exit doors were monitored weekly by maintenance before 08/08/14; however, the monitoring did not include checking the door alarm batteries. Maintenance Worker #1 revealed he was notified by the Administrator on 08/08/14 at "around 8:30 PM to 9.00 PM" the Magnolia Unit fire exit door "Stop" back up alarm was not working. He stated the Administrator had requested the "re-set code" for the Magnolia Unit fire exit door, and said it had been "activated"; however, he was not told how it was "activated" until the next morning on 08/09/14. Maintenance Worker #1 reported the facility's Executive Director told him there was a "problem" with the "Stop" back up alarm on the Magnolia Unit's fire exit door, and asked him that morning to check that alarm, which he did, and discovered when he "activated" the alarm it "went off", but was "weak" and "almost dead", "buzzed and cut off after five (5) to ten (10) seconds". He stated when the fire exit door was activated, the "Stop" back up alarm was also and the back up alarm was "supposed to keep going off" loudly until it the door and alarm were re-set. Continued interview revealed he reported this information to the Executive Director after checking the alarm, and was told to check the rest of the facility's fire exit doors and replace all the batteries in the "Stop" back up alarms which he did. He reported another "Stop" back up alarm on the fire exit door by the employee lounge was also weak and "almost dead". Maintenance Worker #1 stated prior to 08/08/14, the facility had no process in place to check the batteries on the "Stop" back up alarms on a regular basis, and had only changed the	F 323	Copies of these Physical Plant & Environmental Cleanliness QI audit tools will be forwarded to the Administrator when completed & a summary of findings discussed in a weekly QA Committee meeting consisting of the Administrator, DON, Housekeeping & Maintenance. Any corrective actions from the Door Inspection Logs (Attachment 3), Physical Plant & Environmental Cleanliness QI audit tool (Attachment 4) and the Elopement/Missing Resident Drills will be reviewed in the monthly interdisciplinary QAPI meeting, which includes, but is not limited to, the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, & Wound Nurse, to ensure effectiveness of the system & further corrective action will be taken as indicated. Completion Date: October 22, 2014		

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F 323	Continued From page 55 batteries if they were notified one (1) of those alarms quit working. However, review of the manufacturer's recommendation for the fire safety door lock, "Exit Stopper STI-6400", revealed all fire safety door lock units were to be tested periodically to verify the life of battery, and the manufacturer recommended changing the fire safety door back up battery twice a year. The Maintenance Worker indicated he was unaware of that information until after 08/08/14. Review of the facility's security systems and devices maintenance logs from 04/28/14 through 08/06/14, revealed a maintenance worker checked the functioning of the fire safety doors once a week; however, there was no documented evidence as part of the checks performed the maintenance worker was checking or changing the batteries in the door alarms. Interview with the Administrator and Executive Director on 08/21/14 at 12:00 PM, revealed the policy regarding the security checks of the facility's fire exit doors, was for the maintenance department to check the functioning of the door alarm once a week, and the Security Guard to check the functioning of the doors and alarms daily one (1) time on the second shift around 8:00 PM, and one (1) time on the third shift around midnight daily. However, they indicated the functioning of the door alarm batteries for the fire exit doors was not routinely checked prior to the elopement of Resident #1 on 08/08/14. The facility's Executive Director revealed all of the employees had received the information during their orientation regarding the need to contact security to re-set the door, but the staff had forgotten to contact Security to re-set the Magnolia Unit fire exit door on 08/08/14 after	F 323			

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F 323	Continued From page 56 Resident #1's first elopement attempt. According to the Executive Director, as a result of the fire exit door not being re-set the magnetic lock was not functioning, and the "Stop" back up alarm sounded only "very weakly" when Resident #1 walked out the door, unattended the second time on the evening of 08/08/14 around 8:00 PM. Further interview with the Administrator on 09/11/14 at 10:10 AM and on 09/12/14 at 8:42 PM, revealed staff had not known to have the fire exit door re-set by Security after the first attempt, and he had found out about the "Stop" back up alarm not working the "next day" when the investigation was being conducted. The Administrator the facility had no system or process in place prior to 08/08/14 to check the batteries in the "Stop" back up alarms on the fire exit doors, and no process for the "routine changing" of the batteries in the alarms. He stated Maintenance Worker #1 discovered on 08/09/14, two batteries in the "Stop" back up alarms on the facility's fire exit doors, batteries "were almost dead" and had to be replaced. Interview with the DON on 08/20/14 at 4:30 PM, on 09/11/14 at 10:10 AM and on 09/12/14 at 7:42 PM, revealed the Magnolia Unit had two (2) alarms on the door, one (1) of which was the "Stop" back up alarm. The DON indicated the "Stop" back up alarm was a battery alarm which alarmed when the door was opened, and the other was a sensor alarm for when the door was not locked with the magnetic lock. Per interview, on 08/08/14 staff had not realized after Resident #1 activated the door on his/her first attempt to elope, the fire exit door and "Stop" back up alarm needed to be re-set by Security staff. Further interview revealed she had seen the 08/08/14	F 323			

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F 323 Continued From page 57

fifteen (15) minute monitoring form on 08/11/14 during the morning meeting, as had the Administrator and SSD. However, she reported the monitoring form was misplaced on 08/11/14, and the facility had been unable to locate it. Continued interview revealed on 08/08/14 when Resident #1 successfully eloped from the facility without staff's knowledge, she was told by RN #1 she had last seen Resident #1 at approximately 7:55 PM; however, since then she had learned RN #1 had not clocked back in from her break yet at that time. The DON revealed if the resident wasn't located staff was to overhead page the "Dr. Hunt" code, and staff on each unit were to search their specified area. She stated RN #1 should have done this as per the facility policy, and in orientation staff was trained on doing the codes.

Interview with the Administrator on 09/11/14 at 10:10 AM and on 09/12/14 at 8:42 PM, revealed Resident #1 was placed on every fifteen (15) minute checks on 08/08/14. He stated he had seen the 08/08/14 fifteen (15) minute check sheet on 08/11/14 during the morning meeting; however, since then the sheet had been misplaced and could not be located. According to the Administrator, he thought the every fifteen (15) minute checks had been an appropriate intervention to monitor Resident #1. Per interview, he was not aware of Resident #1's first elopement attempt until the investigation into the successful elopement and subsequent fall.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 09/16/14, which alleged removal of the Immediate Jeopardy (IJ), effective 09/16/14. Review of the AOC revealed the facility implemented the following:

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F 323	Continued From page 58 1. Resident #1 was placed on one on one (1:1) supervision by the Director of Nursing (DON) at 11:00 PM on 09/12/14. Ongoing 1:1 assignment would be determined by the licensed nurse and identified on the daily staffing sheet. A sign in log was to be used to record the time each assigned staff member assumed responsibility for the resident for tracking purposes. 2. The Wandering Risk Care Plan problem was updated on 09/12/14 at 11:00 PM by the DON for Resident #1 to include increased 1:1 supervision. Resident #1's daughter was notified on 09/12/14 at 11 05 PM by the licensed nurse that the resident's care plan had been updated with this information. The Advanced Practice Registered Nurse (APRN) was made aware on 09/13/14 by the licensed nurse of the need to change the resident's care plan. 3. Resident #1 would remain on 1:1 supervision until Registered Nurses (RN's), Licensed Practical Nurses (LPN's) and State Registered Nurse Aides (SRNA's) had been re-educated by the DON and Staff Development Coordinator on consistently implementing the care planned interventions to decrease risk of further elopement events. Any RN, LPN, or SRNA not receiving this education by 09/15/14 would receive the education prior to working their next scheduled shift. 4. The Care Plan for Resident #1 was reviewed on 09/15/14 by the Interdisciplinary Team which included the DON, Minimum Data Set (MDS) Nurse, Social Worker, Unit Coordinator, and Therapy to re-evaluate current interventions related to wandering and behavior episodes.	F 323			

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F 323	<p>Continued From page 59</p> <p>Resident #1 received showers on Tuesdays and Fridays and this intervention was updated to reflect additional showers as needed since showers had been effective in the past to help calm behaviors.</p> <p>5. A total of thirteen (13) additional residents identified with increased wandering risk behaviors based on their most recent Wandering/Elopement Review Form, were reviewed on 09/15/14 by the Interdisciplinary Team (IDT) that included the DON, MDS Nurse, Social Worker (SW), Unit Coordinator (UC), and Therapy to re-evaluate current interventions, problems and goals related to wandering and behavior episodes. These care plans were updated with any changes to the identified problem, goals and interventions for direct care staff to implement when residents exhibit increased wandering behavior.</p> <p>6. Staff education was initiated by the DON on 09/12/14 at 11:00 PM for direct care nursing staff, which included RN's, LPN's, and State Registered Nurse Aides (SRNA's), in reference to; Resident #1 must remain in visual contact of the assigned staff member at all times. This education also included instructions that in the event of any resident's attempt to exit the facility they must immediately notify the DON or Administrator and interventions must be initiated per the resident's individualized plan of care to decrease risk of another elopement attempt. This re-education also included information that in the event a door alarm was triggered, a staff member was to be stationed at the doorway until security was notified and the alarm returned to normal operation. A sign had been placed on each exit door stating "if an alarm sounds you must call security to reset". Staff members</p>	F 323		

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F 323	Continued From page 60 <p>verbalized understanding of these instructions at the time of the education. Out of seventy-nine (79) full time employees, sixty-five (65) would receive the above education by 09/15/14. Out of eight (8) part time employees, four (4) would receive the education by 09/15/14. Out of thirty-nine (39) as needed (prn) employees, twenty (20) would receive the above education by 09/15/14. This training would continue to be provided by the DON, House Supervisor, UC's, and Staff Development Coordinator for RN's, LPN's, and SRNA's prior to their next scheduled shift until all have been educated on this information. A bulleted point sheet containing this education was developed by the DON and placed in the new hire packets for ongoing training for all newly hired employees. Lexington Country Place did not utilize agency staff.</p> <p>7. Ongoing monitoring included a daily Quality Assurance Performance Improvement (QAPI) review of Nurse's Notes, Care Plans, and any new Physician's orders for any resident identified with increased wandering or elopement behaviors, including Resident #1. This audit would be conducted and documented daily, including weekends, on an audit tool by the DON, UC, and/or House Supervisor to identify any new elopement attempts and to monitor that staff was documenting care planned interventions for increased behaviors of anxiety or agitation and for the effectiveness of these interventions. Any issues identified in these audits would be addressed as indicated, based on the direction of the DON.</p> <p>8. The evening and night shift security staff was educated on parameters for testing the secondary red box alarms ("Stop" back up alarm) located on</p>	F 323			

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F 323	Continued From page 61 the fire safety doors on 09/12/14 and 09/13/14 by the Administrator. These instructions included to allow the red box's audible alarms to sound for a minimum of fifteen (15) seconds when being tested to ensure they maintain a sustained volume level within normal range. Instructions also included, in the event of a low or weak sounding alarm, a staff member was to be stationed at the doorway until the Administrator was notified and the battery was replaced and the alarm was returned to normal operation. These tests would be documented on the Door Inspection of three (3) times a day by Security and Maintenance Staff. A sign was placed on each exit door stating "if alarm sounds you must call security to reset". Staff members verbalized understanding of these instructions at the time of the educations. 9. Other security and maintenance staff would be educated on the minimum fifteen (15) second testing parameter procedure prior to working their next scheduled shift by the Administrator or Director of Security and Transportation. Seven (7) of twelve (12) Maintenance and Security employees would have received this education by end of day on 09/15/14 and there was five (5) additional Security and Maintenance employees who would receive this education prior to working their next scheduled shift. Education on this door testing parameter procedures would be included as part of the new hire orientation provided to new Security and Maintenance Staff which was conducted by the Director of Security and Transportation and the procedure would be reviewed annually ongoing with Security and Maintenance staff by the Director of Security and Transportation and Director of Plant Operations under the direction of the Administrator.	F 323			

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F 323	Continued From page 62 10. Door alarms, including the delayed egress on the fire safety door and the secondary red box alarms located on the fire safety doors would continue to be checked by Security and Maintenance Staff a minimum of three (3) times each day, including on weekends. Testing would be conducted on each shift by sounding the alarm for a duration of at least fifteen (15) seconds. In the event the alarm does not sound at at sustained volume level within range, a staff member would be posted at the door and the problem would be immediately reported to the Administrator. A staff member would remain at the door until Maintenance and the Administrator were notified and the battery was replaced and the alarm was returned to normal operation. Batteries in the secondary red box alarms would be changed a minimum of monthly. This battery change would be documented in the facility's TELS system. The Administrator would verify this on at least a monthly basis. 11. Elopement /Missing Resident Drills would be conducted daily on alternating shifts, including weekends, for a minimum of two (2) weeks by the Staff Development Coordinator and Administrator. An Elopement/Missing Person Drill Evaluation Form would be completed with each drill. 12. Ongoing monitoring would also include completion of Elopement/Missing Resident Drills at a minimum of four (4) times a year. One (1) drill would be held on each shift and on a weekend day. An Elopement/Missing Person Drill Evaluation Form would be completed for each drill held. The facility would develop an action plan for staff education and correction of issues if encountered during the drills. Monitoring would	F 323			

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F 323	<p>Continued From page 63</p> <p>also include a daily QAPI review of the Door Inspection Logs by the Administrator and/or Director of Security and Transportation. The Administrator would initial these logs to indicate review. Any issues identified would be addressed as indicated by the Administrator and documented on the QAPI tool.</p> <p>The State Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> 1. Review of the One on One Staff Observation Log, revealed Resident #1 was placed on 1:1 observation on 09/12/14 at 11:00 PM. Continued review of the One on One Staff Observation Log revealed Resident #1 was still on 1:1 observation as of 09/18/14 at the time of the survey. Per the Observation Log the date and time was recorded for each staff member who was resuming responsibility for the resident. Review of the daily staffing sheets from 09/12/14 through 09/18/14 revealed the person responsible for the 1:1 observation of Resident #1 was identified. 2. Review of Resident #1's Wandering Risk Care Plan revealed an update on 09/12/14 with an Intervention for 1:1 observation. Review of the Nurse's Note dated 09/12/14 at 11:05 PM, revealed Resident #1's daughter was informed of the resident being on 1:1 care and was agreeable. Review of the Nurse's Note dated 09/13/14 at 1:14 PM, revealed the APRN was notified of the resident being placed on 1:1 observation continuously. 3. Interview on 09/18/14 at 2:30 PM with SRNA #9 and at 2:45 PM with LPN #1 who worked the Magnolia Unit where Resident #1 resided, verified Resident #1 was still on 1:1 observation. 	F 323		

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F 323	<p>Continued From page 64</p> <p>Interview with the DON on 09/18/14 at 6:00 PM revealed staff was not allowed to work until they received inservices including implementing care plan interventions to decrease risk of further elopement events and Resident #1 would remain on 1:1 until all staff had been educated.</p> <p>4. Review of Resident #1's Care Plan revealed it was revised on 09/15/14 to include an intervention for showers Tuesdays, Fridays and as needed.</p> <p>Interview, on 09/18/14 at 7:20 PM, with the DON revealed the Interdisciplinary Team (IDT) met and reviewed Resident #1's care plan to re-evaluate current interventions related to wandering.</p> <p>5. Review of the Care Plans for the thirteen (13) residents who were identified with increased wandering behaviors based on their most recent Wandering/Elopement Review Form, revealed the care plans were reviewed and revised on 09/15/14 by the IDT. Changes were made to the care plans with additional interventions for direct care staff to implement when the resident exhibited increased wandering behaviors. Also, some of the Care Plans problems and goals were updated related to the resident's wandering behaviors.</p> <p>6. Review of the Inservice information and Attendance Record revealed inservices began on 09/12/14 and continued each day and were still taking place for nursing staff including RN's, LPN's and SRNA's related to the following; 1) Resident #1 to remain in visual contact at all times and a sign in sheet must be completed by each staff member who was assigned to the resident for one on one observation, 2) in the</p>	F 323		

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F 323 Continued From page 65

event of any resident's attempt to exit the facility the DON or Administrator must be notified immediately and interventions must be initiated per the resident's individualized plan of care to decrease the risk of another elopement attempt, 3) If there was a weak or low sounding battery or if a door was opened for any reason, a staff member must be stationed at the doorway until the alarm was returned to normal.

Observation of the facility exit doors on 09/18/14 from 5:00 PM until 5:30 PM revealed signs on the doors or beside the doors which stated "if an alarm sounds you must call security to reset". As of 09/18/14 all employees but three (3) full time employees, two (2) part time, and thirteen (13) employees had not received the education. Further review revealed a total of seventy-four (74) full time, six (6) part time, and twenty-seven (27) prn staff had received the inservice education. Interview with the DON on 09/18/14 at 7:20 PM, revealed the inservice education started on 09/12/14, and is ongoing. She stated at change of shift, administrative staff stand by the time clock, and anyone who has not received the inservice was not allowed to work until they had been educated. Further interview revealed the Staff Development Coordinator, and House Supervisors assisted with the education.

Interview on 09/18/14 at 11:56 AM with the Staff Development nurse revealed a bullet point sheet containing the inservice education was placed in the new hire packet for all newly hired employees. She confirmed the facility did not utilize agency staff.

Interview on 09/18/14 with SRNA #9 at 2:30 PM, with LPN #1 at 2:45 PM, LPN #8 at 3:23 PM, with

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F 323 Continued From page 66
SRNA #16 at 4:00 PM, with SRNA #17 at 4:17 PM, revealed they had been Inservice'd and trained ensuring Resident #1 remained in visual contact, they must immediately notify the DON or Administrator of any other residents' attempt to exit and that interventions must be initiated, to ensure someone was stationed at any fire exit door alarm which had been triggered until Security returned the door alarm to normal operation.

7. Review of the Daily QAPI Chart Review Tool, revealed daily audits starting 09/13/14 through 09/18/14 of Physician's Orders, Nurse's Notes, Care Plans, Concerns and Resolution for a sample identified as having wandering behaviors.

Interview with the DON on 09/18/14 at 7:20 PM, revealed administrative nursing staff was checking new Physician's Orders and Nurse's Notes for any behavior concerns and to see if the care plan needed revised and updated related to behaviors and interventions. She stated she reviewed all the audits and was checking for any escalating behaviors she was unaware of, so she could address the behaviors. She further stated the audits would continue until it was decided in the QAPI meeting that the audits could stop.

8. Review of the Staff Inservice Summary and Attendance Record revealed the Administrator educated Maintenance and Security staff on 09/12/14 through 09/16/14 related to the following; allow audible door alarms (red boxes) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door checks daily every shift, the Door Alarm Inspection Form must have the timing of these tests documented (document the seconds the door alarm sounds),

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F 323	Continued From page 67 any problems noted during the door inspections must be reported immediately to the Administrator and Maintenance, and in the event of a weak or low sounding alarm a staff member was to be stationed at the doorway until the Administrator was notified and the battery was replaced and the alarm was returned to normal operation. Observation of the facility exit doors revealed a sign on the door or beside the door which stated, "if alarm sounds you must call security to reset". Interview, on 09/18/14 with Security Guard #3 at 6:00 PM revealed he was educated on the minimum fifteen (15) second testing parameter procedure to ensure the alarm maintained a sustained volume within normal range, and in the event of a low or weak sounding alarm a staff member was to be stationed at the doorway until the Administrator was notified and the battery replaced. 9. Interview with the Administrator on 09/18/14 at 8:00 PM revealed Security and Maintenance staff had been educated related to allowing audible door alarms (red boxes) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door checks daily every shift. He stated if the alarm did not work or had a low volume, security or maintenance was to notify him and someone was to guard the door until the alarm was fixed. He further stated maintenance was checking the door alarms on the day shift and security was checking the alarms on 2nd and 3rd shifts. Continued interview revealed maintenance and security was documenting checking the door alarms on separate door inspection logs, and he verified this was being done by checking the logs daily. He stated there	F 323		

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F 323	Continued From page 68 was one (1) more security employee to educate because he was on vacation; however, the rest of the maintenance and security staff had been educated by him or the Director of Security. Further interview revealed this training would be provided as part of the new hire orientation provided to new hires for maintenance and security and would also be reviewed at least annually ongoing with maintenance and security staff. Interview with the Maintenance Director on 09/18/14 at 5:30 PM, revealed he was educated on the testing of the door alarms by the Administrator. He stated maintenance staff checked the doors each day on day shift. Continued interview revealed they were to allow the audible door alarms (red box) to sound for at least fifteen (15) seconds when being tested. He stated if the door alarms did not work, they were to have staff guard the door until the alarm was fixed. He further stated if there was a concern with the door alarms they were to notify the Administrator. Interview with Security Guard #3 on 09/18/14 at 6:00 PM, revealed he had received education on 09/13/14 related to allowing the audible door alarms (red box) to sound for a minimum of fifteen (15) seconds when being tested as part of routine door on evening and night shift. Continued interview revealed if the alarm did not work or had a low volume, the Administrator was to be notified, and a staff member was to guard the door until it was fixed. He stated security checked the door alarms on evening and night shift. 10. Review of the Door Inspections Log revealed	F 323			

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F 323	<p>Continued From page 69</p> <p>the door alarms including the delayed egress on the fire safety door and the secondary red box alarms were being checked three (3) times a day 09/12/14 through 09/18/14. Review of the Red Box Emergency Door Battery Change Log, revealed the batteries were changed on 08/09/14 for the secondary red box alarms.</p> <p>Continued interview with the Administrator on 09/18/14 at 8:00 PM, revealed the batteries on the secondary Red Box alarms would be changed monthly and documented on the battery change log.</p> <p>11. Review of the Elopement/Missing Resident Drill Evaluation Forms revealed drills were performed on 08/13/14, 08/19/14, 08/20/14 for all three (3) shifts and weekend personnel, and on 09/15/14 at 6:45 PM, 09/17/14 at 6:36 AM.</p> <p>Interview on 09/18/14 at 11:56 AM with the Staff Development Nurse revealed since the Immediate Jeopardy was called, they were doing elopement drills more frequently and at different times of the day. She stated she had done one (1) of the drills and was told on 09/15/14 they would be doing the drills daily.</p> <p>Interview on 09/18/14 at 7:20 PM, with the DON, and the Consultant DON, revealed they had been participating in the elopement drills which were being done daily, on different shifts and on weekends as well which were being done by the Staff Development Coordinator and the Administrator.</p> <p>Interview on 09/18/14 with SRNA #9 at 2:30 PM, with LPN #1 at 2:45 PM, with Laundry Worker #1 at 3:10 PM, with Housekeeper #1 at 3:20 PM,</p>	F 323			

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F 323	Continued From page 70 LPN #8 at 3:23 PM, with SRNA #16 at 4:00 PM, with SRNA #17 at 4:17 PM, revealed they had been inserviced and trained on elopement and elopement drills had been taking place since 09/12/14. 12. Interview with the Administrator on 09/18/14 at 8:00 PM, revealed education started on 09/12/14 and was ongoing related to elopement drills, elopement policy, and door alarms. He stated the elopement drills were to be performed every day for two (2) weeks, then depending on if there was opportunity for improvement they may be done monthly. He stated after a drill and Evaluation was completed and the results were summarized. He stated if there was a problem identified with the drills, an action plan would be developed and staff would be re-educated. He further stated there would be a daily QAPI review of the Door Inspection Logs and he would initial the logs to indicate they were reviewed. The Administrator further stated if a concern was identified with the door alarms, re-education would be done and the problem would be addressed. Continued interview revealed through the QAPI process, they would identify weak areas and issues identified would be addressed and documented on the QAPI tool.	F 323			
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 502	F502 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Lab results for Resident #8 were obtained on 7/25/14 & the results were reported to the Health Care Provider.		

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F 502	<p>Continued From page 71</p> <p>Based on interview, record review and review of the facility's documents, it was determined the facility failed to ensure laboratory (lab) tests were obtained as ordered for one (1) of ten (10) sampled residents (Resident #8). Facility staff failed to ensure the Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP) and Thyroid (TSH) lab tests ordered for Resident #8 on 07/14/14 were obtained in a timely manner.</p> <p>The findings include:</p> <p>Review of the facility document titled, "Lab Audit", undated, revealed the process for obtaining lab tests ordered by Physicians was for the nurse to take the order and fill out a lab slip in the lab book. Continued review revealed in the mornings the Unit Coordinator (UC) was to go over the Physician's Orders, checking for lab orders and were to make sure there was a lab slip completed and the lab was written in the lab book. The UC was also to check the lab book to follow up on any labs performed to make sure the labs were "charted".</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident, on 07/10/14, with diagnoses which included Muscle Weakness, Atrial Fibrillation (A-fib), Dehydration, Malnutrition, History of Breast and Colon Cancer and Debility. Review of the Advanced Practice Registered Nurse (APRN) Note, dated 07/14/14, revealed the resident had "cachexia" (general physical wasting and malnutrition usually associated with chronic disease). Review of the Nurse's Note dated 07/14/14 timed 6:45 PM, written by Registered Nurse (RN) #7 revealed orders were received for morning labs for CBS, CMP and TSH. Review of the Physician Orders</p>	F 502	<p>How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>A QI lab audit was completed on 09/19/14 using the facility Lab QI Audit Tool (Attachment 7) which verified Physician Orders in the last three months (July, August and September) were obtained and reported to the physician as ordered. This audit was completed by the Unit Coordinators. Any identified problems or concerns were reported to the Healthcare Provider & addressed as ordered. Residents will continue to have</p> <p>laboratory tests obtained in a timely manner as ordered.</p>		

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F 502	Continued From page 72 written by the APRN on 07/14/14 revealed an order for a CBC (blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia), CMP (blood test that measures your sugar level and electrolyte imbalances and fluid balance, kidney function, and liver function) and TSH (blood test is used to detect problems affecting the thyroid gland) labs to be obtained on the morning of 07/15/14 for a baseline. However, review of the lab reports revealed no documented evidence of the labs ordered on 07/14/14 having been obtained with results present in the medical record. Continued of the Physician's Orders revealed a "clarification" order dated 07/24/14 for a CBC, CMP and TSH to be obtained on the morning of 07/25/14 for a baseline. Interview with the RN #7 on 09/18/14 at 5:07 PM, revealed she was a PRN (as needed) nurse for the facility, and the facility's lab process was when a lab order was received, the nurse transcribing the orders filled out a lab requisition slip, put the lab slip in lab's "box" under the correct date and pass the lab order along in shift report. She stated the lab book helped the UC track labs to ensure they were completed. RN #7 revealed nurses entered the lab order in the lab book, then when the lab results were received the nurse receiving the results called the Physician or APRN and completed the rest of the information in the lab book. Per interview, if the Physician gave new orders when notified the nurse wrote the telephone order and faxed a copy to pharmacy. She stated she was not sure why she had not followed the facility's process for Resident #8's lab orders dated 07/14/14; however, stated she should have.	F 502	What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? A new Lab Absentee Audit Tool (Attachment 5) was implemented on 9/19/14 by the DON. This tool will clarify which Unit Coordinator is responsible for checking lab audits when a Unit Coordinator is absent. Prior to implementation, all Unit Coordinators were trained by the DON on the Lab Absentee Audit Tool on 9/19/14. Licensed Nurses were re-educated on 9/19/14 by the Unit Coordinators on the facility's lab process & obtaining lab results as ordered. All new Licensed Nurses will be educated on facility's lab process & obtaining lab results as ordered as part of new hire orientation. The lab process is posted on each unit and available to all nursing staff including PRN staff.		

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: 185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/18/2014
NAME OF PROVIDER OR SUPPLIER LEXINGTON COUNTRY PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 700 MASON HEADLEY ROAD LEXINGTON, KY 40504		
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F 502	<p>Continued From page 73</p> <p>Further review of Resident #8's medical record revealed a Nurse's Note dated 07/24/14 which noted the APRN had been in to visit the resident and had given a "clarification" order for a CMP, CBC and TSH to be obtained on 07/25/14 for a baseline.</p> <p>Interview with Licensed Practical Nurse (LPN) #9, on 09/18/14 at 11:48 AM, revealed the UC "told" her to get a clarification order for Resident #8's labs ordered on 07/14/14. She stated she didn't know for sure what happened to cause the labs not to be obtained as ordered on 07/15/14; however, RN #7 was a PRN nurse who didn't fill out the lab slip or put the labs ordered in the unit lab book. LPN #9 stated the UC "caught" the unattained labs when she was doing her chart audits. She stated the UC got copies of all Physician's Orders and audited residents' charts to ensure the orders were carried out and transcribed appropriately, and that's how she identified Resident #8's unattained labs.</p> <p>Interview with RN #8, on 09/18/14 at 11:35 AM, revealed the facility's process for labs was when a lab order was received a lab requisition slip was filled out and the lab order was noted in the unit lab book for tracking purposes. RN #8 stated the lab slip was placed in the lab's container under the date the lab was to be obtained. She stated after the lab was obtained and results received via the unit facsimile (fax) machine, the rest of the information in the lab book was completed and the Physician was notified of the results. She stated the UC was responsible for the lab book and ensuring nurses completed it.</p> <p>Interview with the APRN on 09/18/14 at 4:50 PM, revealed she had ordered the labs on 07/14/14 as</p>	F 502	<p>How will the facility monitor its performance to ensure solutions are sustained?</p> <p>The facility's Lab Audit Tool (Attachment 6) will be reviewed daily Monday – Friday by the Unit Coordinators & by the House Supervisor on weekends. Any discrepancy identified by comparing the Physician's Orders with the Lab Audit Tool will be addressed.</p> <p>In the absence of a Unit Coordinator Monday – Friday, the Lab Absentee Form is implemented. In the absence of a House Supervisor on the weekend, the DON/Unit Coordinator will complete the form.</p>		

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F 502	<p>Continued From page 74</p> <p>Resident #8 was a newly admitted resident and she wanted to have a "baseline" for future labs ordered. She stated the facility did not notify her when the labs were not obtained as ordered the morning of 07/15/14. However, she stated the Physician and APRNs ordered labs for the next day because they wanted the results the next day. Per interview, "fortunately" the facility had "stop gaps in place" and the labs were obtained after she gave a "clarification" order on 07/24/14.</p> <p>Interview with the Director of Nursing (DON), on 09/18/14 at 7:20 PM, revealed all Physician's Orders were reviewed in the daily morning meeting. The DON revealed the facility's process was when a lab order was received the nurse was to write the order on a lab requisition sheet, document the lab order in the unit lab book, put the lab requisition sheet in the lab's accordion type container under the correct date for the lab to be obtained. Per interview, the Medical Record person made copies of all the Physician's Orders for the previous day and the copies were taken to the morning meeting and discussed. She stated the UC went over the Physician's Orders prior to the morning meetings while they were on their units. The DON revealed the UC for Resident #8's unit had been on vacation on 07/14/14 when the lab order was written; however, the UCs were supposed to cover for each other when someone was on vacation. She stated "usually" something like this would be "caught" the next day by the UC. The DON stated she didn't know where the 07/14/14 lab orders Resident #8's had fallen threw the cracks, but should have been caught and completed as ordered.</p>	F 502	<p>As an additional new process a copy of the lab audit tool will be forwarded to the DON on a weekly basis & a summary of findings will be discussed in a weekly QI Committee meeting, consisting of but not limited to, the Administrator, DON, Social Worker, MDS Nurse & Unit Coordinators with additional corrective action taken as indicated.</p> <p>These audit tools & any accompanying corrective actions will be reviewed in the monthly interdisciplinary QAPI meeting, which includes, but is not limited to, the Administrator, DON, Medical Director, Consulting Pharmacist, Medical Records Consultant, RD, Social Services, Unit Coordinators, & Wound Nurse, to ensure effectiveness of the system & further corrective action will be taken as indicated.</p> <p>Completion Date: October 22, 2014</p>		