

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

PRINTED: 10/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/29/2014
NAME OF PROVIDER OR SUPPLIER CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031		
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F 000	<p>INITIAL COMMENTS</p> <p>**Amended**</p> <p>An Abbreviated Survey investigating Complaint #KY22252 was initiated on 09/22/14 and concluded on 09/29/14. Complaint #KY22252 was substantiated with deficiencies cited at a Scope and Severity of a "J".</p> <p>Resident #1 was assessed by the facility and care planned for elopement risks with interventions which included to have a wander guard bracelet in place and check every shift for placement. On 09/17/14, Resident #1 was sent to the hospital due to chest pain and returned to the facility at 5:20 PM. Upon readmission, the resident was assisted back into the facility by wheelchair, then immediately taken to the dining room to eat his/her meal. The facility failed to reassess Resident #1 on readmission and his/her wander guard was not replaced as ordered by the Physician. At approximately 6:45 PM, Resident #1 was found outside, at the back of the facility leaning on the back wall of the building by a staff member taking a break. Resident #1 was last seen in the dinning room by the Director of Nursing at approximately 6:20 PM.</p> <p>Immediate Jeopardy (IJ) was identified in the areas of CFR 483.20 Resident Assessment at F282 and CFR 483.25 Quality of Care at F323 at a Scope and Severity of a "J". Substandard Quality of Care was identified at CFR 483.25 at F323. Immediate Jeopardy was identified on 09/24/14 and was determined to exist on 09/17/14. The facility was notified of the Immediate Jeopardy on 09/24/14. An acceptable Allegation of Compliance (AoC)</p>	F 000			

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

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

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F 000	Continued From page 1 was received on 09/26/14, which alleged removal of the Immediate Jeopardy on 09/20/14, prior to the initiation of the Abbreviated Survey. The State Survey Agency determined the deficient practice was corrected related to lack of supervision on 09/20/14 as alleged in the AOC; therefore, it was determined to be Past Immediate Jeopardy.	F 000		
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 policy and procedure, it was determined the facility failed to provide services by qualified personnel according to the written care plan for one (1) of three (3) sampled residents (Resident #1) related to supervision. The facility assessed and care planned Resident #1 as having a history of exit seeking behavior. Interventions included a wander guard and to check placement of the wander guard every shift. On 09/17/14, Resident #1 was sent to the hospital due to chest pain and the wander guard was removed from the resident. Resident #1 returned to the facility at approximately 5:20 PM, and staff failed to implement the care plan and reapply the wander guard. At approximately 6:45 PM, Resident #1 was found outside, at the rear of the facility leaning on the back wall of the	F 282	Past noncompliance: no plan of correction required.	

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F 282	<p>Continued From page 2</p> <p>building, by a staff member taking a break. The resident was last seen in the dining room by the Director of Nursing (DON) at approximately 6:20 PM.</p> <p>The facility's failure to provide care in accordance with the care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/24/14 and determined to exist on 09/17/14. The facility was notified of the Immediate Jeopardy (IJ) on 09/24/14.</p> <p>The findings include:</p> <p>Review of the facility's policy titled: "Residents Plan of Care", last revised 07/12, revealed a Comprehensive Care Plan will be developed using an interdisciplinary team approach. The care plan will address the resident's strengths and preferences with measurable outcomes and timetables to meet the resident's needs.</p> <p>Record review revealed the facility admitted Resident #1 on 09/28/10 with diagnoses which included Alzheimer's Disease, Generalized Anxiety, Hypertension, and Chest Pain. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 07/31/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview Mental Status (BIMS) score of one (1), which indicated the resident was not interviewable.</p> <p>Review of Resident #1's Elopement Assessment, dated 07/21/14, revealed the resident was at risk for elopement, as evidenced by exit seeking behaviors, wanders aimlessly, confused, and moves without purpose. The resident had also</p>	F 282			

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F 282	<p>Continued From page 3</p> <p>verbally expressed the desire to go home and was staying near the exit doors.</p> <p>Review of the Comprehensive Plan of Care, dated 07/13/12, for "Resident has a history of exit seeking behavior. (He/she) has removed (his/her) wander guard bracelet in the past and exited the building", revealed interventions which included, resident wears a wander guard on his/her ankle to alert staff of attempts to exit the building unassisted; monitor placement and snap on a wander guard bracelet for secure closure every shift; resident needs his/her walker for transfer and ambulation; a second security alarm is attached to the resident's walker; and, check placement every shift.</p> <p>Review of a Nursing Note, dated 09/14/14 at 1:35 PM, revealed the resident was assessed and transferred to the hospital with complaints of chest pain by ambulance. Further review revealed, on 09/17/14 at 5:20 PM, the resident was transferred back to the facility via family car; he/she propelled himself/herself in a wheelchair, and was assisted to the dining room. There was no documented evidence the wander guard was placed on the resident when he/she returned to the facility.</p> <p>Review of a Nursing Note, dated 09/17/14 at 6:47 PM, revealed Resident #1 was noted standing at the edge of the building walking with an unsteady gait with his/her hand on the building for balance. The resident was assisted approximately fifteen (15) yards when he/she became weak and staff called for assistance of a wheelchair. The resident was propelled to his/her room and a head to toe assessment was completed which revealed an abraded area to the left knee,</p>	F 282			

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F 282	<p>Continued From page 4</p> <p>petechiae and bruising was noted to the right knee with ecchymotic areas to the right elbow and top of the left hand. A wander guard bracelet was placed and verified to be properly functioning.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/23/14 at 2:50 PM, revealed at the beginning of her shift Resident #1 was out to the emergency room and they had advised in report that the wander guard sensor was removed from the resident. She stated, the resident's family brought him/her back to the facility around 5:20 PM and asked for a wheelchair to assist the resident back into the building. She stated Resident #1 had tried to exit the South exit doors after finishing the meal and the door alarm alerted staff and they were able to redirect him/her back to the hallway. She stated the resident was propelling through the hallways in the wheelchair.</p> <p>Interview with LPN #2, on 09/24/14 at 9:30 AM, revealed the resident returned to the facility around 5:20 PM on 09/17/14, and she was his/her Charge Nurse that night. She stated the resident's family members had requested a wheelchair to help transfer the resident back into the facility. She stated it was meal time and the resident's tray was served, so she rolled him/her up to the table to eat and left him/her in the wheelchair. She stated she forgot to put the wander guard bracelet back on him/her per the resident's care plan. LPN #2 stated she did not know why she left the resident in the wheelchair.</p> <p>Interview with LPN #3, on 09/23/14 at 3:20 PM, revealed when Resident #1 was readmitted to the facility she would have completed a head to toe</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>assessment, checked for new orders, reviewed the previous orders and plans to make sure everything that was in place prior to the transfer was still in place.</p> <p>Interview with the DON, on 09/22/14 at 4:45 PM, revealed the resident was assessed and sent to the hospital emergency room for evaluation of chest pain on 09/17/14 at 1:45 PM, and his/her wander guard bracelet was removed at that time because the bracelet was removed from the resident if a hospital admission was expected. She revealed that during the shift change report at 2:30 PM, report was given to the Charge Nurse that the resident's bracelet had been removed and would need to be replaced if he/she returned to the facility. She stated it was the Charge Nurse's responsibility to assess the resident on readmission to the facility and put the wander guard bracelet back on the resident. The DON revealed Resident #1 had an elopement care plan, and he/she would try to leave the facility three (3) to four (4) times a day. Further interview revealed that was why the resident needed to wear the bracelet, and why the facility placed the wander guard censor on his/her walker. However, the resident was not using the walker at the time because he/she had been placed in a wheelchair. The DON stated she would have expected LPN #2 to reapply the wander guard bracelet as soon as the resident returned to the facility.</p> <p>Interview with the Administrator, on 09/24/14 at 10:45 AM, revealed he walked around the building the night Resident #1 was found outside and he estimated the distance the resident was able to travel was approximately one hundred and fifty (150) feet before he/she was found. He</p>	F 282			

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F 282	<p>Continued From page 6</p> <p>stated they had a system in place and report was given at shift change to remind the staff to replace the wander guard when the resident returned to the facility. He stated everyone knew the resident was at risk for elopement and the staff member failed to put the wander guard back on the resident upon readmission to the facility.</p> <p>Interview with the resident's Medical Provider, on 09/23/14 at 10:15 AM, revealed he was not totally surprised when he was notified about the elopement. He stated the resident tried to "get out" all the time, and it was always a possibility. He stated he expected it not to happen again and was glad he/she was found and he/she did not make it next to the highway.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. On 09/17/14, Resident #1 was returned to his/her room by LPN #2, and a head to toe assessment was completed. Documentation revealed abraded areas to the right elbow, and left knee and top of the right hand. Resident #1's physician was notified of the elopement and injuries with new orders noted by LPN #2. LPN #2 replaced Resident #1's wander guard bracelet on his/her ankle and checked it to ensure it was functioning correctly on 09/17/14. 2. Resident #1's Physician came to the facility to see the resident on 09/18/14. 3. The DON and Administrator started the investigation process upon entering the facility on 09/17/14. Event statements were collected from all staff members on 09/17/14 and 09/18/14 by the Administrator and the DON. A time line was 	F 282			

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F 282	<p>Continued From page 7</p> <p>completed beginning with the resident being sent out to the hospital, and ending with him/her being brought back to his/her room after the occurrence on 09/17/14 by the DON.</p> <p>4. All fourteen (14) residents with wander guards were assessed for placement and proper functioning. All were found to be in place and functioning correctly on 09/17/14. All forty-three (43) residents were viewed to verify they were in the facility by the DON and LPN #2 on 09/17/14.</p> <p>5. The housekeeping supervisor returned to the facility on 09/17/14 to complete an audit of all twelve (12) doors to ensure they were functioning properly. All twelve doors were functioning properly.</p> <p>6. Charts for all fourteen (14) residents with wander guards were audited for care plans, Certified Nurse Aide (CNA) Care Plans, Elopement Assessments, and Treatment Administration Records (TARs) for proper documentation. Wander guard interventions were noted on all fourteen care plans, and elopement assessments had been completed correctly for all fourteen residents. Documentation on the TARs noted placement of wander guards had been checked every shift for all fourteen residents was completed. Documentation on the TAR noting all fourteen wander guards were checked daily for proper functioning was completed for all fourteen residents. Audits were completed by the DON and LPN #3 on 09/18/14.</p> <p>7. The Safety Committee met and discussed the incident and recommended adding a secure door lock system, and began quarterly drills for missing residents on 09/18/14. A Secure Care</p>	F 282		
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F 282	<p>Continued From page 8</p> <p>Advantage 1000 DE lock was placed at the front lobby door allowing no one to exit the facility without a code on 09/19/14.</p> <p>8. The Employee (LPN #2) involved was suspended for seven (7) days for non-placement of the wander guard and not completing an immediate assessment upon return to the facility by DON and Administrator on 09/19/14.</p> <p>9. A facility policy, along with a check list for the nurses to complete, was implemented for any resident who returns from the hospital in less than twenty four (24) hours. Notation of head to toe assessments, vital signs, cognitive status, mood and behavior, pain, safety devices, wander guards, updating of care plans as needed, any medication changes phoned to pharmacy, and Nurses' Notes documentation are to be completed by the Charge Nurse. Check off sheets are to be placed in the DON's mail box after completion, and was completed on 09/18/14 by the DON.</p> <p>10. Oral and written in-service reviewing: wander guard system, missing residents, Explorer Club was provided by the DON and the Administrator on 09/18/14 and 09/19/14 to all facility employees.</p> <p>Training was provided to all licensed nursing staff regarding the new policy and procedure of residents returning to the facility after less than twenty four (24) hour discharge by the DON on 09/19/14.</p> <p>Training of the use of wander guards and Explorer Club will be given upon hiring of all new employees prior to providing care, and the new</p>	F 282			

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F 282	<p>Continued From page 9</p> <p>process regarding the return of residents from hospital in less than twenty four (24) hours will be placed in the orientation process for any new licensed staff hired, revised 09/19/14 by the DON.</p> <p>11. The monitoring of the wander guard system and their functioning properly will be performed by the DON/Assistant Director of Nursing (ADON) weekly times four (4) weeks then monthly times twelve (12) months. The monitoring to ensure compliance with policy and procedure regarding residents who return to facility in less than twenty four (24) hours will be performed by the DON/ADON/Supervisor weekly times four (4) weeks then monthly times twelve (12) months. Monitoring to ensure check off sheets are completed upon return from the hospital will be monitored daily by the DON/ADON or by the Charge Nurse if the DON/ADON is not available. The monitoring of implementing the care plans will be performed weekly times four (4) weeks then monthly times twelve (12) months by the DON and the ADON.</p> <p>12. The monitoring of the doors and their functioning properly will be performed by housekeeping supervisor and or assistant weekly times four (4) weeks then monthly times twelve (12) months.</p> <p>Actions taken related to issues based on findings from the monitoring: Human errors will be handled through disciplinary actions by Department Heads/Administrator. Process errors will be reviewed immediately through the Quality Assurance (QA) process for causative factors and corrections by the QA Committee.</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>All audits/monitoring will be reviewed by the QA Committee quarterly for ongoing compliance and improvement. QA committee consisting of but not limited to the DON, Administrator, Medical Director, Social Services, and Maintenance.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <ol style="list-style-type: none"> 1. Review of Resident #1's chart, on 09/29/14 at 12:00 PM, revealed Resident #1 was taken to his/her room and a head to toe skin assessment was completed and injuries documented, vital signs were assessed and the resident was placed on fifteen (15) minute security checks after replacing the wander guard and checking for proper function. The Administrator, DON, Physician, and Family members were all notified as documented in the Nurse's Notes. 2. Review of Resident #1's medical record revealed a progress note, dated 09/18/14 by Resident #1's Medical Doctor, indicating he was aware of the elopement and no serious injuries were noted. 3. Interview with the DON, on 09/29/14 at 12:00 PM, revealed she started the investigation on 09/17/14 interviewing employees that were still in the facility, and completed her interviews on 09/18/14. She stated she was able to put together a time line of the incident after she completed her interviews. She stated the time line was completed beginning with the resident being sent to the emergency room, ending with him/her being found outside, and then brought back to his/her room after the elopement. Review of employee interviews and documentation of the time line was completed on 09/19/14 with no 	F 282			

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F 282	<p>Continued From page 11 concerns.</p> <p>4. Documentation completed, on 09/17/14 by the DON and LPN #2, revealed all fourteen (14) residents identified as at risk for elopement were identified and their wander guards were checked to ensure they were working properly, all were found to be working properly. A head count of all forty three (43) residents in the building was completed by the DON on 09/17/14 with no concerns found.</p> <p>5. Record review and interview with the House Keeping Supervisor, on 09/29/14 at 2:00 PM, revealed she came back to the facility and checked all twelve (12) door alarms on 09/17/14 and found no problems with the doors. Review of the door alarm test log, dated 09/17/14, revealed all twelve (12) door alarms were checked on 09/17/14 and all were working correctly with no concerns.</p> <p>6. Record review revealed no concerns with Documentation, Care Plan Assessments, and Medication Administration records related to the fourteen (14) residents identified at risk for elopement. Record review completed on 09/29/14, revealed all fourteen charts were reviewed with no concerns noted.</p> <p>7. Interview with the Administrator, on 09/29/14 at 12:55 PM, revealed the Safety Committee met on 08/18/14, the sign in sheet was reviewed, which covered the discussion of elopements. He stated they decided to install a better locking system to the front lobby door, and planned to start quarterly drills for missing residents. He also stated they plan to rotate them to different shifts each quarter, and all staff members present</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>during the drill would be required to participate. Record review revealed the first drill was completed on 09/25/14 on first shift. He stated the next Safety Meeting was scheduled for 10/16/14 to discuss the results of the drill and schedule the second drill. The new door locks were installed on 09/19/14; the locks require an code to exit the facility. The wander guard alarm was still connected to the lobby door. Observation, on 09/29/14, revealed the new door alarm panel was in place on the front lobby door, and working properly. Observations were made of residents and visitors using the door code to exit as indicated with no concerns. An invoice, dated 09/19/14, was reviewed to verify the placement of the two Secure Care Doors as indicated on 09/29/14.</p> <p>8. Review of an Employee Counseling Statement, dated 09/19/14, revealed LPN #2 was counseled related to failure to perform an admission assessment and to reapply the wander guard to Resident #1 upon readmission to the facility as per his/her plan of care. LPN #2 was suspended for seven (7) working days, to return to work on 10/01/14. Interview with the DON, on 09/29/14, verified the suspension.</p> <p>9. Interview with the DON, on 09/29/14 at 1:30 PM, revealed a new process was put in place for all residents returning from the hospital with less than a twenty-four (24) hour stay on 09/18/14. She stated that all licensed staff was inserviced on the new policy on 09/18/14. Review of sign in sheets, and interview with licensed staff revealed the inservice was completed. The new policy and the check sheet that has been put in place for less than twenty-four (24) hour re-admissions was reviewed with no concerns. The DON stated</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>the new policy and check sheet for less than twenty four hour re-admissions to the facility has been added to the new orientation packet, as well as education and training on the use of wander guards, and the Explorer Club will be given upon hiring of all employees prior to providing care.</p> <p>10. Interview with the ADON, on 09/29/14 at 12:27 PM, revealed they had an inservice on 09/18/14 to discuss the new policy and check sheet related to less than twenty-four (24) hour readmission to the facility with all licensed staff, and again on 09/19/14 with all staff members to discuss the process to search for a missing resident. They also reviewed the wander guard system and discussed the new door code to exit the lobby door.</p> <p>Interview with Registered Nurse (RN) #1, on 09/29/14 at 12:45 PM, revealed she was aware of the new check sheet and policy change put in place for readmission to the facility if the resident was out less than twenty-four (24) hours. She stated she attended the inservices on 09/18/14 and again on 09/19/14. RN #1 stated, she also participated in the missing resident drill completed last week.</p> <p>Interview with the ADON, on 09/29/14 at 12:27 PM, revealed she will be assisting the DON in performing the audits to make sure the wander guards were checked each shift and the door alarms were functioning properly. They would also be auditing resident care plans to make sure everything was in place. She also stated the new policy and procedure was added to the new employee orientation process.</p> <p>Interview with Housekeeping Aide #1, on</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>09/29/14 at 1:32 PM, revealed she was inserviced on the two (2) new door codes installed. She was also given the code to use to exit the facility. Housekeeping Aide #1 stated the inservice discussed wander guards, missing residents, and the Explorer Club.</p> <p>Interview with LPN #3, on 09/29/14 at 1:30 PM, revealed she had been inserviced on the new policy for assessment, and use of the check sheet if a resident was readmitted to facility after less than 24 hour discharge. She stated she was inserviced on the wander guard system, missing residents, and the Explorer Club drills.</p> <p>All inservice sign in sheets were reviewed and discussed with the DON, on 09/29/14 at 1:30 PM, with no concerns. The new policy and the check sheet that has been put in place for the less than twenty-four (24) hour readmission was reviewed with no concerns. The DON stated that the new policy and check sheet for less than twenty four hour re-admission to the facility had been added to the new orientation packet as well as education and training on the use of wander guards and, the Explorer Club was given upon hiring of all employees prior to providing care.</p> <p>11. Interview with the DON, on 09/29/14 at 1:30 PM, revealed the monitoring of the wander guards and their functioning properly will be performed by the DON or ADON weekly times four (4) weeks then monthly time twelve (12) months. She stated the monitoring to ensure compliance with Policy and Procedure regarding residents who return to facility in less than twenty-four (24) hours, and monitoring the implementation of care plans would be performed by the DON and the ADON during the week and</p>	F 282			

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F 282	<p>Continued From page 15</p> <p>the Charge Nurse will complete the audits on the weekends; and, will also be completed weekly times four (4) weeks then monthly times twelve (12) months. She stated the monitoring to ensure check off sheets were completed upon return from the hospital in less than twenty-four (24) hours would be monitored daily by the DON, ADON, or Charge Nurse, if the DON was not available.</p> <p>Interview with the House Keeping Supervisor, on 09/29/14 at 1:10 PM, revealed she does the door alarm checks every day using the test box. She stated should a door fail to alarm, she immediately notifies maintenance and a complete head count is done of all residents in the building. She also stated that anyone wearing a wander guard cannot get on the elevator. She stated she was called to return to the facility by the Administrator on the night of 09/17/14 to check all the door alarms to ensure they were all working properly and documented in the door alarm log. She stated the monitoring of the doors and their functioning properly would be performed by the Housekeeping Supervisor, and/or the Assistant, weekly times four (4) weeks then monthly times twelve (12) months. A tour was completed with the Housekeeping Supervisor and all twelve (12) doors were checked and working properly on 09/29/14.</p> <p>Interview with the Administrator and DON, on 09/29/14 at 1:30 PM, revealed all audits/monitoring will be reviewed by the QA Team quarterly for ongoing compliance and improvement. The Administrator stated, human errors will be handled through disciplinary actions by the Department Heads and Administration, and process errors will be reviewed immediately</p>	F 282			

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F 282	Continued From page 16 through the QA process for causative factors and corrections by the QA Committee.	F 282			
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 interview, record review, and review of the the facility policy and procedure, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1), received adequate supervision and assistive devices to prevent accidents. The facility failed to ensure Resident #1 who was identified at risk for elopement, and had a wander device implemented, was adequately monitored both physically and per the facility's electronic monitoring system. The facility failed to have an effective system to ensure each resident received the necessary supervision to prevent avoidable accidents. On 09/17/14 at approximately 6:45 PM, Resident #1 was found out back of the facility leaning on the back wall of the building by a staff member taking a break. He/she was last seen in the dining room by the Director of Nursing (DON) at approximately 6:20 PM. Resident #1 had been assessed and care planned by the facility as an	F 323	Past noncompliance: no plan of correction required.		

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F 323	<p>Continued From page 17</p> <p>elopement risk and it was determined the resident required wander guard bracelet in place to assist with supervision. Resident #1 had been sent out earlier in the day to the hospital due to chest pain and returned to the facility at 5:20 PM with family members in a private car. Upon readmission to the facility the resident was assisted back into the facility by wheelchair, then immediately taken to the dining room to eat his/her meal. Resident #1 was never taken out of the wheelchair and was allowed to propel through out the facility in the wheelchair. Resident #1 was not accessed by the nursing staff on readmission and his/her wander guard was not replaced as ordered by the Physician.</p> <p>The facility's failure to provide supervision to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/24/14 and determined to exist on 09/17/14. The facility was notified of the Immediate Jeopardy (IJ) on 09/24/14.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Elopement Policy", last revised 12/2013, revealed it was the policy of the facility for all residents to be assessed upon admission for risk factors that may put them at risk for potential elopement. Procedures to include, completing a elopement assessment upon admission.</p> <p>Review of the facility's policy titled "Secure Care Transmitter", last revised 08/31/12, revealed it shall be the policy of the facility that all residents who have been assessed to have a wander guard shall be fitted with a secure care transmitter</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>bracelet. The secure care wandering system is installed at each exit door from the nursing facility to alert staff of resident attempting to exit a door. It is the responsibility of the licensed nurse to ensure that the transmitters are in place and secured, on assigned residents at the beginning of each shift. It is the responsibility of the Nurse Aide to report to the nurses any resident that has been assigned a transmitter and does not have one in place.</p> <p>Record review revealed the facility admitted Resident #1 on 09/28/10 with diagnoses which included Alzheimer's Disease, Generalized Anxiety, Hypertension, and Chest Pain.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 07/31/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview Mental Status (BIMS) score as one (1), indicating the resident was not interviewable. Review of Resident #1's Elopement Assessment, dated 07/21/14, revealed the resident to be at risk for elopement, as evidenced by exit seeking, wanders aimlessly, confused, and moves without purpose. The resident has verbally expressed the desire to go home and has stayed near exit doors.</p> <p>Review of the Comprehensive Plan of Care, "Resident has a history of exit seeking behavior. He/she has removed his wander guard bracelet in the past and exited the building", dated 07/13/12, revealed interventions which included the resident wears a wander guard on his/her ankle to alert staff of attempts to exit the building unassisted, monitor placement and snap on the wander guard bracelet for secure closure every shift, resident needs his/her walker for transfer and ambulation,</p>	F 323			

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F 323	<p>Continued From page 19</p> <p>a second security alarm is attached to the resident's walker and check placement every shift.</p> <p>Review of Physician's Orders, dated of 08/27/14, revealed a Physician's order for elopement precautions, monitor placement of the wander guard every shift, check the snap for secure closure, check the wander guard with a transmitter daily for proper functioning.</p> <p>Review of a Nursing Note, dated 09/14/14 at 1:35 PM, revealed the resident was assessed and transferred to the hospital with complaints of chest pain by ambulance. Further review revealed, on 09/17/14 at 5:20 PM, the resident was brought back to the facility via family car, propelling self in a wheelchair, and was assisted to the dining room. There was no documented evidence the resident was assessed and/or a wander guard was placed on the resident when readmitted to the facility.</p> <p>Review of a Nursing Note, dated 09/17/14 at 6:47 PM, revealed Resident #1 was noted standing at the edge of the building walking with an unsteady gait with his/her hand on the building for balance. The resident was assisted to return to the building but after ambulating approximately fifteen (15) feet the resident became weak and a wheelchair was brought to propel the resident into the building. A head to toe assessment was completed and it was identified the resident had an abraded area to the left knee, and petechiae and bruising noted to the right knee with ecchymotic areas to the right elbow and the top of his/her left hand. A wander guard bracelet was applied.</p>	F 323			

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F 323	<p>Continued From page 20</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 09/23/14 at 2:15 PM, revealed she was assigned to take care of Resident #1 on 09/17/14. She stated she saw Resident #1 at approximately 5:45 PM, when he/she set off the back door alarms trying to exit the building. She revealed the resident has tried to get out of the building but has never gotten outside before because the alarms always go off and we are able to stop him/her. She stated she did not notice if his/her wander guard alarm was in place at the time, but she responded to the alarm as always.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/23/14 at 2:50 PM, revealed at the beginning of her shift, Resident #1 had been sent to the emergency room and we were advised in report that the wander guard sensor was removed from the resident. She stated the resident's family brought him/her back to the facility at around 5:20 PM and asked for a wheelchair to assist the resident back into the building. She stated Resident #1 had tried to exit the south exit doors after finishing his/her meal and the door alarm alerted staff, and we were able to redirect him/her back to the hallway. She stated he/she was propelling through the hallways in the wheelchair.</p> <p>Interview with LPN #2, on 09/24/14 at 9:30 AM, revealed the resident returned to the facility at about 5:20 PM on 09/17/14, and she was his/her Charge Nurse that night. She stated the resident's family members had requested a wheelchair to help transfer him back into the facility. She revealed it was meal time and the resident's tray was served, so she rolled him/her up to the table to eat and left him/her in the wheelchair. She stated she forgot to put the</p>	F 323			

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F 323	<p>Continued From page 21</p> <p>wander guard bracelet back on him/her and does not know why she left the resident in the wheelchair. She continued to state that no other type of assessment was required to be completed for this type of admission. She stated, she was only required to chart the resident back in the facility and to check the resident to make sure he/she was okay.</p> <p>Interview with the DON, on 09/22/14 at 4:45 PM, revealed the resident was assessed and sent to the hospital Emergency Room for evaluation of chest pain on 09/17/14 at 1:45 PM, and his/her wander guard bracelet was removed at that time. She stated during the shift change report at 2:30 PM, report was given to the Charge Nurse that the resident's bracelet had been removed and would need to be replaced if he/she returned to the facility. She stated it was the Charge Nurse's responsibility to assess the resident upon readmission to the facility and put the wander guard bracelet back on the resident. Further interview with the DON, on 09/23/14 at 8:30 AM, revealed prior to the elopement on 09/17/14, the facility did not have a policy or protocol in place for short term or less than twenty-four (24) hour discharge from the facility as related to assessment on re-admission. She stated she expected LPN #2 to have completed an assessment and obtained vital signs upon Resident #1's return from the hospital. She also stated she would have expected her to reapply the wander guard bracelet as soon as he/she was brought back in the building.</p> <p>Interview with the Administrator, on 09/24/14 at 10:45 AM, revealed they had a system in place and report was given at shift change to remind the staff to replace the wander guard when the</p>	F 323			

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F 323	<p>Continued From page 22</p> <p>resident returned to the facility. He stated everyone knew the resident was at risk for elopement and the staff member failed to put the wander guard back on the resident upon readmission to the facility.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> 1. On 09/17/14, Resident #1 was returned to his/her room by LPN #2, and a head to toe assessment was completed. Documentation revealed abraded areas to the right elbow, and left knee and top of the right hand. Resident #1's physician was notified of the elopement and injuries with new orders noted by LPN #2. LPN #2 replaced Resident #1's wander guard bracelet on his/her ankle and checked it to ensure it was functioning correctly on 09/17/14. 2. Resident #1's Physician came to the facility to see the resident on 09/18/14. 3. The DON and Administrator started the investigation process upon entering the facility on 09/17/14. Event statements were collected from all staff members on 09/17/14 and 09/18/14 by the Administrator and the DON. A time line was completed beginning with the resident being sent out to the hospital, and ending with him/her being brought back to his/her room after the occurrence on 09/17/14 by the DON. 4. All fourteen (14) residents with wander guards were assessed for placement and proper functioning. All were found to be in place and functioning correctly on 09/17/14. All forty-three (43) residents were viewed to verify they were in the facility by the DON and LPN #2 on 09/17/14. 	F 323			

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F 323	Continued From page 23 5. The housekeeping supervisor returned to the facility on 09/17/14 to complete an audit of all twelve (12) doors to ensure they were functioning properly. All twelve doors were functioning properly. 6. Charts for all fourteen (14) residents with wander guards were audited for care plans, Certified Nurse Aide (CNA) Care Plans, Elopement Assessments, and Treatment Administration Records (TARs) for proper documentation. Wander guard interventions were noted on all fourteen care plans, and elopement assessments had been completed correctly for all fourteen residents. Documentation on the TARs noted placement of wander guards had been checked every shift for all fourteen residents was completed. Documentation on the TAR noting all fourteen wander guards were checked daily for proper functioning was completed for all fourteen residents. Audits were completed by the DON and LPN #3 on 09/18/14. 7. The Safety Committee met and discussed the incident and recommended adding a secure door lock system, and began quarterly drills for missing residents on 09/18/14. A Secure Care Advantage 1000 DE lock was placed at the front lobby door allowing no one to exit the facility without a code on 09/19/14. 8. The Employee (LPN #2) involved was suspended for seven (7) days for non-placement of the wander guard and not completing an immediate assessment upon return to the facility by DON and Administrator on 09/19/14. 9. A facility policy, along with a check list for the	F 323		

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F 323	<p>Continued From page 24</p> <p>nurses to complete, was implemented for any resident who returns from the hospital in less than twenty four (24) hours. Notation of head to toe assessments, vital signs, cognitive status, mood and behavior, pain, safety devices, wander guards, updating of care plans as needed, any medication changes phoned to pharmacy, and Nurses' Notes documentation are to be completed by the Charge Nurse. Check off sheets are to be placed in the DON's mail box after completion, and was completed on 09/18/14 by the DON.</p> <p>10. Oral and written in-service reviewing: wander guard system, missing residents, Explorer Club was provided by the DON and the Administrator on 09/18/14 and 09/19/14 to all facility employees.</p> <p>Training was provided to all licensed nursing staff regarding the new policy and procedure of residents returning to the facility after less than twenty four (24) hour discharge by the DON on 09/19/14.</p> <p>Training of the use of wander guards and Explorer Club will be given upon hiring of all new employees prior to providing care, and the new process regarding the return of residents from hospital in less than twenty four (24) hours will be placed in the orientation process for any new licensed staff hired, revised 09/19/14 by the DON.</p> <p>11. The monitoring of the wander guard system and their functioning properly will be performed by the DON/Assistant Director of Nursing (ADON) weekly times four (4) weeks then monthly times twelve (12) months. The monitoring to ensure</p>	F 323		

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F 323	<p>Continued From page 25</p> <p>compliance with policy and procedure regarding residents who return to facility in less than twenty four (24) hours will be performed by the DON/ADON/Supervisor weekly times four (4) weeks then monthly times twelve (12) months. Monitoring to ensure check off sheets are completed upon return from the hospital will be monitored daily by the DON/ADON or by the Charge Nurse if the DON/ADON is not available. The monitoring of implementing the care plans will be performed weekly times four (4) weeks then monthly times twelve (12) months by the DON and the ADON.</p> <p>12. The monitoring of the doors and their functioning properly will be performed by housekeeping supervisor and or assistant weekly times four (4) weeks then monthly times twelve (12) months.</p> <p>Actions taken related to issues based on findings from the monitoring: Human errors will be handled through disciplinary actions by Department Heads/Administrator. Process errors will be reviewed immediately through the Quality Assurance (QA) process for causative factors and corrections by the QA Committee.</p> <p>All audits/monitoring will be reviewed by the QA Committee quarterly for ongoing compliance and improvement. QA committee consisting of but not limited to the DON, Administrator, Medical Director, Social Services, and Maintenance.</p> <p>The State Survey Agency validated the corrective actions taken by the facility as follows:</p> <p>1. Review of Resident #1's chart, on 09/29/14 at 12:00 PM, revealed Resident #1 was taken to</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>his/her room and a head to toe skin assessment was completed and injuries documented, vital signs were assessed and the resident was placed on fifteen (15) minute security checks after replacing the wander guard and checking for proper function. The Administrator, DON, Physician, and Family members were all notified as documented in the Nurse's Notes.</p> <p>2. Review of Resident #1's medical record revealed a progress note, dated 09/18/14 by Resident #1's Medical Doctor, indicating he was aware of the elopement and no serious injuries were noted.</p> <p>3. Interview with the DON, on 09/29/14 at 12:00 PM, revealed she started the investigation on 09/17/14 interviewing employees that were still in the facility, and completed her interviews on 09/18/14. She stated she was able to put together a time line of the incident after she completed her interviews. She stated the time line was completed beginning with the resident being sent to the emergency room, ending with him/her being found outside, and then brought back to his/her room after the elopement. Review of employee interviews and documentation of the time line was completed on 09/19/14 with no concerns.</p> <p>4. Documentation completed, on 09/17/14 by the DON and LPN #2, revealed all fourteen (14) residents identified as at risk for elopement were identified and their wander guards were checked to ensure they were working properly, all were found to be working properly. A head count of all forty three (43) residents in the building was completed by the DON on 09/17/14 with no concerns found.</p>	F 323			

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F 323	Continued From page 27 5. Record review and interview with the House Keeping Supervisor, on 09/29/14 at 2:00 PM, revealed she came back to the facility and checked all twelve (12) door alarms on 09/17/14 and found no problems with the doors. Review of the door alarm test log, dated 09/17/14, revealed all twelve (12) door alarms were checked on 09/17/14 and all were working correctly with no concerns. 6. Record review revealed no concerns with Documentation, Care Plan Assessments, and Medication Administration records related to the fourteen (14) residents identified at risk for elopement. Record review completed on 09/29/14, revealed all fourteen charts were reviewed with no concerns noted. 7. Interview with the Administrator, on 09/29/14 at 12:55 PM, revealed the Safety Committee met on 08/18/14, the sign in sheet was reviewed, which covered the discussion of elopements. He stated they decided to install a better locking system to the front lobby door, and planned to start quarterly drills for missing residents. He also stated they plan to rotate them to different shifts each quarter, and all staff members present during the drill would be required to participate. Record review revealed the first drill was completed on 09/25/14 on first shift. He stated the next Safety Meeting was scheduled for 10/16/14 to discuss the results of the drill and schedule the second drill. The new door locks were installed on 09/19/14; the locks require an code to exit the facility. The wander guard alarm was still connected to the lobby door. Observation, on 09/29/14, revealed the new door alarm panel was in place on the front lobby door,	F 323			

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F 323	<p>Continued From page 28</p> <p>and working properly. Observations were made of residents and visitors using the door code to exit as indicated with no concerns. An invoice, dated 09/19/14, was reviewed to verify the placement of the two Secure Care Doors as indicated on 09/29/14.</p> <p>8. Review of an Employee Counseling Statement, dated 09/19/14, revealed LPN #2 was counseled related to failure to perform an admission assessment and to reapply the wander guard to Resident #1 upon readmission to the facility as per his/her plan of care. LPN #2 was suspended for seven (7) working days, to return to work on 10/01/14. Interview with the DON, on 09/29/14, verified the suspension.</p> <p>9. Interview with the DON, on 09/29/14 at 1:30 PM, revealed a new process was put in place for all residents returning from the hospital with less than a twenty-four (24) hour stay on 09/18/14. She stated that all licensed staff was inserviced on the new policy on 09/18/14. Review of sign in sheets, and interview with licensed staff revealed the inservice was completed. The new policy and the check sheet that has been put in place for less than twenty-four (24) hour re-admissions was reviewed with no concerns. The DON stated the new policy and check sheet for less than twenty four hour re-admissions to the facility has been added to the new orientation packet, as well as education and training on the use of wander guards, and the Explorer Club will be given upon hiring of all employees prior to providing care.</p> <p>10. Interview with the ADON, on 09/29/14 at 12:27 PM, revealed they had an inservice on 09/18/14 to discuss the new policy and check sheet related to less than twenty-four (24) hour</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>readmission to the facility with all licensed staff, and again on 09/19/14 with all staff members to discuss the process to search for a missing resident. They also reviewed the wander guard system and discussed the new door code to exit the lobby door.</p> <p>Interview with Registered Nurse (RN) #1, on 09/29/14 at 12:45 PM, revealed she was aware of the new check sheet and policy change put in place for readmission to the facility if the resident was out less than twenty-four (24) hours. She stated she attended the inservices on 09/18/14 and again on 09/19/14. RN #1 stated, she also participated in the missing resident drill completed last week.</p> <p>Interview with the ADON, on 09/29/14 at 12:27 PM, revealed she will be assisting the DON in performing the audits to make sure the wander guards were checked each shift and the door alarms were functioning properly. They would also be auditing resident care plans to make sure everything was in place. She also stated the new policy and procedure was added to the new employee orientation process.</p> <p>Interview with Housekeeping Aide #1, on 09/29/14 at 1:32 PM, revealed she was inserviced on the two (2) new door codes installed. She was also given the code to use to exit the facility. Housekeeping Aide #1 stated the inservice discussed wander guards, missing residents, and the Explorer Club.</p> <p>Interview with LPN #3, on 09/29/14 at 1:30 PM, revealed she had been inserviced on the new policy for assessment, and use of the check sheet if a resident was readmitted to facility after</p>	F 323			

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F 323	<p>Continued From page 30</p> <p>less than 24 hour discharge. She stated she was inserviced on the wander guard system, missing residents, and the Explorer Club drills.</p> <p>All inservice sign in sheets were reviewed and discussed with the DON, on 09/29/14 at 1:30 PM, with no concerns. The new policy and the check sheet that has been put in place for the less than twenty-four (24) hour readmission was reviewed with no concerns. The DON stated that the new policy and check sheet for less than twenty four hour re-admission to the facility had been added to the new orientation packet as well as education and training on the use of wander guards and, the Explorer Club was given upon hiring of all employees prior to providing care.</p> <p>11. Interview with the DON, on 09/29/14 at 1:30 PM, revealed the monitoring of the wander guards and their functioning properly will be performed by the DON or ADON weekly times four (4) weeks then monthly time twelve (12) months. She stated the monitoring to ensure compliance with Policy and Procedure regarding residents who return to facility in less than twenty-four (24) hours, and monitoring the implementation of care plans would be performed by the DON and the ADON during the week and the Charge Nurse will complete the audits on the weekends; and, will also be completed weekly times four (4) weeks then monthly times twelve (12) months. She stated the monitoring to ensure check off sheets were completed upon return from the hospital in less than twenty-four (24) hours would be monitored daily by the DON, ADON, or Charge Nurse, if the DON was not available.</p> <p>Interview with the House Keeping Supervisor, on</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>09/29/14 at 1:10 PM, revealed she does the door alarm checks every day using the test box. She stated should a door fail to alarm, she immediately notifies maintenance and a complete head count is done of all residents in the building. She also stated that anyone wearing a wander guard cannot get on the elevator. She stated she was called to return to the facility by the Administrator on the night of 09/17/14 to check all the door alarms to ensure they were all working properly and documented in the door alarm log. She stated the monitoring of the doors and their functioning properly would be performed by the Housekeeping Supervisor, and/or the Assistant, weekly times four (4) weeks then monthly times twelve (12) months. A tour was completed with the Housekeeping Supervisor and all twelve (12) doors were checked and working properly on 09/29/14.</p> <p>Interview with the Administrator and DON, on 09/29/14 at 1:30 PM, revealed all audits/monitoring will be reviewed by the QA Team quarterly for ongoing compliance and improvement. The Administrator stated, human errors will be handled through disciplinary actions by the Department Heads and Administration, and process errors will be reviewed immediately through the QA process for causative factors and corrections by the QA Committee.</p>	F 323		