

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

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JUN 13 2011

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

PRINTED: 08/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2011
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard and partial extended survey investigating KY00016422 was initiated on 05/13/11 and concluded on 05/16/11. Immediate Jeopardy was identified on 05/16/11, was found to exist on 05/10/11 and the facility was notified of Immediate Jeopardy on 05/16/11. KY00016422 was substantiated and deficiencies cited were 483.20 Resident Assessment, F282 at a scope and severity of an "J"; 483.25 Quality of Care, F323 at a scope and severity of an "J"; and 483.75 Administration, F490 at a scope and severity of an "J"; Substandard Quality of Care was identified at 483.25, F323.</p> <p>The facility provided a credible allegation of compliance (AOC) on 05/16/11. The state agency verified Immediate Jeopardy was removed 05/16/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.25 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors the effectiveness of the barriers and the new code alert system.</p> <p>An abbreviated Life Safety Code survey was initiated and concluded on 05/13/11, in conjunction with KY00016422, investigating KY00016427. KY00016427 was substantiated with deficiencies cited.</p>	F 000	<p>Green Meadows Health Care Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Green Meadows Health Care Center's response to the Statement of Deficiencies and Plan of Correction does not constitute an admission that any deficiency is accurate. Further Green Meadows Health Care Center reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceedings.</p>	
F 282 SS=J	<p>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282	<p>F282</p> <p>Fifteen minute checks were instituted on May 10, 2011 upon his return to the facility to ensure the location of Resident #1 was monitored. A staff</p>	05/27/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE _____

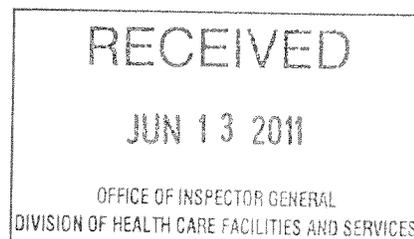
Wendy Ann Boyd Administrator 06/13/2011

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 282	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to follow the plan of care for one resident (#1) of the five (5) sampled residents. Resident #1 was careplanned to be monitored due to cognitive deficit and exit seeking behaviors. The facility failed to monitor the location of Resident #1 during construction of the front lobby. The resident exited the front entrance door without staff knowledge. The facility remained unaware of the residents location, until a citizen alerted the facility that the resident was found on the sidewalk of a busy street. The facility's failure to follow the plan of care placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident The facility provided a credible allegation of compliance (AOC) on 05/16/11. The state agency verified immediate jeopardy was removed 05/16/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.25 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors the effectiveness of the barriers and the new code alert system. The findings include: The facility did not provide a policy on following the plan of care.	F 282	member was assigned the duty of staying at the front entrance door on May 10, 2011 upon resident's return to the facility and remained in place throughout the 2 p.m. to 10 p.m. shift. Another staff member was assigned this responsibility for the 10 p.m. to 6 a.m. shift. The Director of Maintenance came into the facility and constructed a barrier on May 10, 2011 at approximately 9:15 p.m. that prohibited any access into the construction site and front exit door. All residents of the facility were identified as having the potential to exit the facility through the front entrance from the time period of 3:00 p.m. to 9:00 p.m. on May 10, 2011 without having to enter a code and without having an alarm to sound if the Code Alert System was activated if the resident was wearing a transponder. A review of the resident census was completed on May 10-11, 2011 to assess the elopement risk of the residents. No other residents were identified as being at risk for elopement.	



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F 282	Continued From page 2 Review of the clinical record revealed the facility admitted Resident #1 on 09/14/10 with diagnoses of Organic Brain Syndrome with Dementia, Macular Degeneration, Anemia, Urinary Retention, and Degenerative Joint Disease. On 09/27/10, the facility developed a plan of care for Wandering, Socially Inappropriate at times, and exit seeking behaviors. The facility implemented interventions for staff to: 1. place monitoring device on resident that sounds alarms when resident leaves building; 2. alert staff to resident's wandering behavior; and 3. note which exits resident favors for elopement from facility. Alert staff working near those areas. The facility implemented a code alert device and placed the device on the resident's ankle to alert facility staff should the resident attempt to exit the facility without staff knowledge. On 11/10/10, the facility reassessed Resident #1 as at high risk for elopement related to the resident's impaired cognition and exit seeking behaviors. Observations of Resident #1 on 05/13/11 at 11:05am, 11:27am, 1:20pm and on 05/16/11 at 11:30am and 1:10pm revealed the resident with a code alert bracelet to the ankle. The nursing staff were noted to be checking the resident's location and responding to the alarms. Interview, on 05/13/11 at 1:44pm, with LPN #5 revealed when the alarms sound, staff respond by following the sound, to see who needed help. Interview, on 05/13/11 at 2:30pm, with LPN #4 revealed the facility did not instruct her to increase supervision of the wandering residents when the construction was started or to monitor	F 282	All staff was provided education on the need to follow the residents' plan of care as it relates to their being at risk for elopement. The In-service training was initiated May 10, 2011 and continued through May 16, 2011. Staff training was reinforced by the Director of Nursing on June 9 and June 10, 2011 to ensure staff are aware of following the residents' plan of care as it relates to their being at risk for elopement. Direction was given that the barrier was not to be removed at any time by anyone without having notified the Administrator or Director of Nursing. A staff member was assigned to monitor the area when the contractors needed access to the area and had to temporarily move the barrier. The building superintendent and Administrator conducted a check of the renovation site at the conclusion of each work day to ensure the integrity of the barriers. Additionally nursing staff checked the barriers every 30-minutes while in place to ensure there	

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F 282	<p>Continued From page 3</p> <p>the front door when the barrier wall was taken down. It was known by all staff that Resident #1 frequently walked the halls and would exit seek.</p> <p>Interview, on 05/13/11 at 3:07pm, with LPN #3 revealed the staff were to monitor Resident #1 due to wandering all over the facility according to the care plan. She last saw the resident at 7:00pm and thought the resident was going to his/her room. While the assigned nursing assistant was at dinner, the other staff on the unit were to monitor the resident. She indicated all staff are responsible for monitoring the wandering residents.</p> <p>Interview, on 05/13/11 at 3:30pm, with LPN #2 revealed she monitored the wandering resident through the elopement blinder and code alert checks done every shift. She assumed the supervision of wandering residents would be increased due to the construction; however, she never received any direction regarding this.</p> <p>Interview, on 05/13/11 at 3:40pm, with LPN #1 revealed although she was an LPN she was working as a nursing assistant that night. Resident #1 was not in her assigned group; however, she did see the resident between 5:30 and 6:00pm. She did not run into the resident again and thought the resident was in his/her room; however, she did not check to see where the resident was.</p> <p>Interview, on 06/14/11 at 12:54pm, with CNA #1 revealed she had gone to her dinner after helping in the dining room. During the meal she saw Resident #1 sitting in the dining room. At 6:10pm the resident was seen leaving the dining room.</p>	F 282	<p>was no access to the construction area and the front entrance door.</p> <p>A thorough inspection of the area being renovated was completed on May 16, 2011 by Department Heads and Administrative Staff. Additional measures were taken to enhance the security of the area by increasing the height of the barrier walls from four feet to eight feet.</p> <p>The Code Alert system was installed on May 23, 2011 and was completely operational on May 24, 2011. All residents identified as being at risk for elopement cannot pass through the front entrance without activating the system which will lock down the door denying access for a fifteen second time frame and an audible alarm sounds immediately at the front entrance and at the nurse's station on Transition Way. Also a visible alarm is activated at both nurse's stations identifying the door that has been activated.</p>	

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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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F 282	<p>Continued From page 4</p> <p>She came back from dinner at 6:45pm and started to put other residents to bed. She did not check where Resident #1 was until a nurse instructed her to help look for the resident.</p> <p>Interview, on 05/16/11 at 1:40pm, with CNA #2 revealed she monitored wandering residents by redirecting them back to their unit or calling the unit to come and get the resident. However, she did not remember if Resident #1 had been on her unit that evening and did not check on the resident until a visitor came to the facility and informed her the resident was outside.</p> <p>Review of the investigative report dated 05/10/11 and interview with the Director of Nursing on 05/13/11 at 2:40pm and the Administrator on 05/16/11 at 1:10pm revealed the facility took the following immediate action:</p> <ol style="list-style-type: none"> 1. The facility performed a physical assessment on Resident #1 and found no injuries. 2. Resident #1 was placed on every 15 minute checks until the new code alert system was installed on the front door. 3. An employee was stationed at the front entrance to monitor any resident activity. 4. All alarmed doors were checked. 5. All code alert bracelets were checked. 6. The maintenance department installed a rigid barrier to prevent access to the construction site. 7. The barriers were placed on every 30 minute 	F 282	<p>The barriers were removed on Friday, May 27, 2011 allowing residents to access the newly renovated area.</p> <p>The Code Alert system is tested on a weekly basis by the Director of Maintenance.</p> <p>A monthly report will be made by the Director of Maintenance to the Quality Assessment and Assurance Committee on the audits of the Code Alert system.</p> <p>The Director of Maintenance and Director of Nursing will monitor the facility's performance to ensure compliance.</p>	

If continuation sheet Page 5 of 21

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F 282	Continued From page 5 checks to ensure they were intact. Additional measures were taken on 05/11/11: 1. Review of all residents identified as at risk for elopement to ensure supervision of their activities. 2. All alarmed doors were placed on weekly checks by maintenance and every shift checks by nursing when checking the code alert bracelets. 3. Elopement binders were reviewed, pictures and demographic information placed in binders for four (4) residents and placed at the new reception area. 4. Reviewed policy and procedures regarding wandering residents, elopement and missing residents for revisions. 5. Education of all staff regarding the wandering resident, elopement and missing resident 05/10/11, 05/12/11, 05/13/11, 05/14/11 and 05/15/11. 6. Education of the construction crew on 05/16/11 regarding the barriers were to remain in place until the construction was completed or code alert system was installed at the front door. Observation, on 05/16/11 at 11:30am, revealed Resident #1 sitting in the dining room at the table with other male residents. A code alert bracelet was noted on the right ankle. At 1:10pm the resident was in his/her room a code alert bracelet remained on the right ankle.	F 282		

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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
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F 282	Continued From page 8 Review of the clinical record for Resident #2, #3, #4 and #5 during the survey revealed the residents had been assessed for risk for elopement and had code alert bracelets on. Resident #5 was reassessed on 05/10/11 by the facility as improved and no longer required the code alert bracelet. Resident #5 was removed from the elopement binder. Resident's #2, #3, #4 and #5 had not eloped from the building. Interview with the Administrator on 05/16/11 at 1:10pm revealed informal meetings every morning had been held with staff to discuss the cause and action plan related to the elopement of Resident #1. A formal QA meeting would be held on Thursday 05/19/11. On 05/13/11 at 10:30am a check of all the alarmed doors (3) completed with the Director of Nurses revealed all checks had been completed and the alarms were functional. Validation of staff training May 10 - 15, 2011 via sign-in rosters revealed all staff attended with the exception of one, who was currently in the hospital. This staff person will receive training, prior to being assigned to work with the residents. Immediate Jeopardy was verified to be removed prior to exit on 05/18/11 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.25 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors the effectiveness of the barriers and the new code alert system.	F 282		
F 323 SS=J	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	<u>F323</u> Fifteen minute checks were instituted on May 10, 2011 upon his return to the facility to ensure the location of Resident #1 was monitored. A staff member was assigned the duty of staying at the front entrance door on May 10, 2011 upon resident's return to	05/27/11

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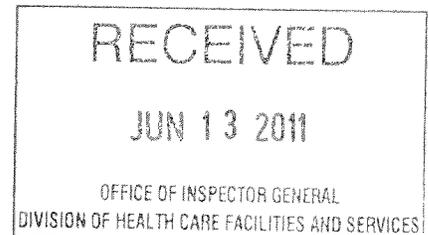
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F 323	<p>Continued From page 7</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observations, record review and review of the facility's policy on Wandering and Elopement of Residents and Missing Residents it was determined the facility failed to supervise one (1) resident (#1) of the five (5) sampled residents for exit seeking behaviors. The facility identified Residents' #1, #2, #3, #4, and #5 at risk for elopement. The facility failed to ensure all exit doors were monitored during construction when the code alert alarm was removed from the front exit door. The facility staff was unaware Resident #1 exited the facility without supervision on 05/10/11. The facility's failure to provide adequate supervision placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident</p> <p>The facility provided an acceptable allegation of compliance (AOC) on 05/16/11. The state agency verified Immediate Jeopardy was removed 05/16/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.25 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance</p>	F 323	<p>the facility and remained in place throughout the 2 p.m. to 10 p.m. shift. Another staff member was assigned this responsibility for the 10 p.m. to 6 a.m. shift. The Director of Maintenance came into the facility and constructed a barrier on May 10, 2011 at approximately 9:15 p.m. that prohibited any access into the construction site and front exit door.</p> <p>All residents of the facility were identified as having the potential to exit the facility through the front entrance from the time period of 3:00 p.m. to 9:00 p.m. on May 10, 2011 without having to enter a code and without having an alarm to sound if the Code Alert System was activated if the resident was wearing a transponder.</p> <p>A review of the resident census was completed on May 10-11, 2011 to assess the elopement risk of the residents. No other residents were identified as being at risk for elopement.</p> <p>All staff was provided education on the need to properly supervise residents</p>	
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F 323	<p>Continued From page 8 monitors the effectlveness of the barriers and the new code alert system.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding the Wandering and Elopement of Residents, dated 05/10, indicated precautions will be initiated for the residents determined to be at risk for elopement. All residents will be assessed, if at risk will be assigned a code alert bracelet, information placed in the elopement binder, and reviewed by the careplan team.</p> <p>Review of the facility's policy on the Missing Resident, dated 03/09, indicated if a resident is unaccounted for or missing a search would be initiated. The facility and grounds will be searched and if not found 911 will be called.</p> <p>Interview, on 05/13/11 at 2:40pm, with the Director of Nursing (DON) revealed when construction started there was a plywood wall from the floor to the ceiling. It had no access except by the construction crew through the front door. The temporary wall was removed on 05/10/11 at 3:00pm. The cones and caution tape were placed at each end of the lobby to block the hallway. Prior to construction the DON met with the supervisors regarding the renovations and told them to keep an eye on the residents. However, direct care staff was not given any instruction on increased supervision.</p> <p>Interview, on 05/13/11 at 3:30pm, with LPN #2 revealed the lobby had a temporary wall and she was not informed the wall had been removed.</p>	F 323	<p>who are identified as being at risk for elopement. This in-service training was initiated May 10, 2011 and continued through May 15, 2011.</p> <p>Staff training was reinforced by the Director of Nursing on June 9 and June 10, 2011 to ensure staff is aware of supervising the residents by following the residents' plan of care as it relates to their being at risk for elopement.</p> <p>Direction was given that the barrier was not to be removed at any time by anyone without having notified the Administrator or Director of Nursing. A staff member was assigned to monitor the area when the contractors needed access to the area and had to temporarily move the barrier. The building superintendent and Administrator conducted a check of the renovation site at the conclusion of each work day to ensure the integrity of the barriers. Additionally nursing staff checked the barriers every 30-minutes while in place to ensure there was no access to the construction area and the front entrance door.</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 323	<p>Continued From page 9</p> <p>There were only cones and caution tape. However, you could still get to the door and it was unlocked. An employee was placed in the area at this point until maintenance could secure the area. She did not receive instruction to increase supervision when the wall was taken down.</p> <p>Interview, on 06/14/11 at 12:54pm, with CNA #1 revealed she did not receive any instruction regarding the wandering residents need for increased supervision when the barrier wall was taken down.</p> <p>Interview, on 05/18/11 at 1:40pm, with CNA #2 revealed she did not receive any instruction on increased monitoring of the wandering residents only to keep more alert with the construction going on.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 09/14/10 with diagnoses of Macular Degeneration and Organic Brain Syndrome with Dementia. On 11/10/10, the facility assessed the resident as a high risk for elopement related to cognitive deficit and exit seeking behavior. The facility reassessed the resident on 03/01/11 and 05/10/11 at high risk for elopement. The facility care planned the resident for wandering and exit seeking behaviors and staff were to monitor the resident specifically during periods of anxiety dated 05/10/11. The resident was further care planned to have a code alert to alert staff of attempts to elope and check every shift for placement dated 01/06/11.</p> <p>Review of the facility's investigation, dated 05/11/11, revealed Resident #1 eloped from the facility on 06/10/11. A facility staff member</p>	F 323	<p>A thorough inspection of the area being renovated was completed on May 16, 2011 by Department Heads and Administrative Staff. Additional measures were taken to enhance the security of the area by increasing the height of the barrier walls from four feet to eight feet.</p> <p>The Code Alert system was installed on May 23, 2011 and was completely operational on May 24, 2011. All residents identified as being at risk for elopement cannot pass through the front entrance without activating the system which will lock down the door denying access for a fifteen second time frame and an audible alarm sounds immediately at the front entrance and at the nurse's station on Transition Way. Also a visible alarm is activated at both nurse's stations identifying the door that has been activated.</p> <p>The barriers were removed on Friday, May 27, 2011 allowing residents to access the newly renovated area.</p>

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F 323	<p>Continued From page 10</p> <p>reported observing the resident walking on the sidewalk of a busy street. This staff member stayed with the resident until the facility was notified the resident was gone. Construction was currently taking place to the surrounding exit and the door with the code alert system had been removed leaving a non-code alert door accessible for exit.</p> <p>Interview, on 06/13/11 at 2:30pm, with LPN #4 revealed she was travelling east on Hwy. 44, and looked back at the facility, when she saw Resident #1 on the sidewalk. She turned around to get the resident at 7:50pm. The resident was taken back to the facility. The LPN stated the facility did not instruct her to increase supervision of the wandering residents when the construction was started or to monitor the front door when the barrier wall was taken down. It was known by all staff that Resident #1 frequently walked the halls and would exit seek.</p> <p>Interview, on 05/13/11 at 3:07pm, with LPN #3 revealed she was the supervisor on the evening shift of 05/10/11. When the resident was brought back to the facility, the code alert bracelet sounded upon entering the door to the transition unit. All doors were checked and were working except for the front door. It was found to be accessible to the outside by just opening the door. LPN #3 stated she last saw the resident at 7:00pm and talked about going to bed. The resident then headed towards his/her room away from the construction site. LPN #3 felt the area was secure until the wall came down. She found one wandering resident lifting the caution tape and they were redirected away. Resident #1 walked up to the tape and was redirected using</p>	F 323	<p>The Code Alert system is tested on a weekly basis by the Director of Maintenance.</p> <p>A monthly report will be made by the Director of Maintenance to the Quality Assessment and Assurance Committee on the audits of the Code Alert system.</p> <p>The Director of Maintenance and Director of Nursing will monitor the facility's performance to ensure compliance.</p>	

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F 323	<p>Continued From page 11</p> <p>the detour around the construction site. LPN #3 stated no one saw the resident after 7:00pm. In addllion, usually another nursing assistant or the nurses watch the residents while a staff member is at meal break; however, this was not done if the resident managed to get out of the building.</p> <p>Interview, on 05/13/11 at 3:30pm, with LPN #2 revealed around 8:00pm a man came in and said a resident was out on Hwy 44. She left the building and a nursing assistant was coming behind her with a wheelchair. She found an off duty employee walking the resident back towards the facility. All the doors were checked because the alarm sounded when the resident re-entered the facility. She did not hear an alarm sound before this. The front door did not have an alarm, otherwise it would have sounded until someone turned it off.</p> <p>Interview, on 05/13/11 at 1:44pm, with LPN #5 revealed when the resident's alarm sounds, the staff are to respond by following the sound to see who needs help.</p> <p>Interview, on 05/13/11 at 3:40pm, with LPN #1 revealed she worked as a nursing assistant that evening and not assigned to the group for Resident #1. She further stated she saw the resident between 5:30pm and 6:00pm and spoke to him/her. However, never checked on the location of the resident afterwards.</p> <p>Interview, on 05/14/11 at 12:54pm, with CNA #1 revealed she saw the resident in the dining room at supper time. The resident was seen leaving the dining room around 6:10pm. This CNA went on her meal break and when she returned</p>	F 323		

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F 323	Continued From page 12 proceeded to put residents to bed. She did not check on the location of Resident #1 until instructed by a nurse to help locate the resident. Review of the investigative report dated 05/10/11 and interview with the Director of Nursing on 05/13/11 at 2:40pm and the Administrator on 05/16/11 at 1:10pm revealed the facility took the following immediate action: 1. The facility performed a physical assessment on Resident #1 and found no injuries. 2. Resident #1 was placed on every 15 minute checks until the new code alert system was installed on the front door. 3. An employee was stationed at the front entrance to monitor any resident activity. 4. All alarmed doors were checked. 5. All code alert bracelets were checked. 6. The maintenance department installed a rigid barrier to prevent access to the construction site. 7. The barriers were placed on every 30 minute checks to ensure they were intact. Additional measures were taken on 05/11/11: 1. Review of all residents identified as at risk for elopement to ensure supervision of their activities. 2. All alarmed doors were placed on weekly checks by maintenance and every shift checks by	F 323		

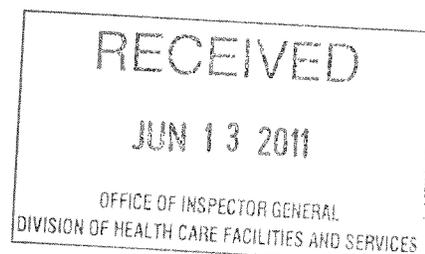
If continuation sheet Page 13 of 21

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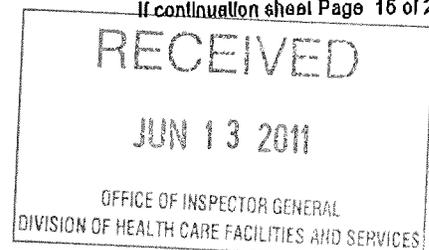
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F 323	<p>Continued From page 13 nursing when checking the code alert bracelets.</p> <p>3. Elopement binders were reviewed, pictures and demographic information placed in binders for four (4) residents and placed at new reception area.</p> <p>4. Reviewed policy and procedures regarding wandering residents, elopement and missing residents for revisions.</p> <p>5. Education of all staff regarding the wandering resident, elopement and missing resident 05/10/11, 05/12/11, 05/13/11, 05/14/11 and 05/15/11.</p> <p>6. Education of the construction crew on 05/16/11 regarding the barriers are to remain in place until the construction is completed or code alert system is installed at the front door.</p> <p>Observation, on 05/16/11 at 11:30am, revealed Resident #1 sitting in the dining room at the table with other male residents. A code alert bracelet was noted on the right ankle. At 1:10pm the resident was in his/her room a code alert bracelet remained on the right ankle.</p> <p>Review of the clinical record for Resident #2, #3, #4 and #5 during the survey revealed the residents had been assessed for risk for elopement and had code alert bracelets on. Resident #5 was reassessed on 05/10/11 by the facility as improved and no longer required the code alert bracelet. Resident #5 was removed from the elopement binder. Resident's #2, #3, #4 and #5 had not eloped from the building.</p>	F 323		



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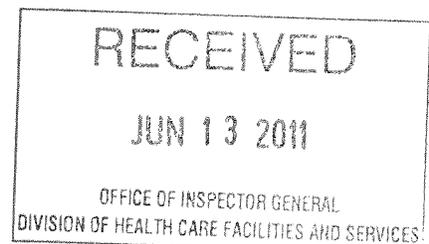
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F 323	<p>Continued From page 14</p> <p>Interview with the Administrator on 06/16/11 at 1:10pm revealed informal meetings every morning had been held with staff to discuss the cause and action plan related to the elopement of Resident #1. A formal QA meeting would be held on Thursday 05/19/11.</p> <p>On 05/13/11 at 10:30am a check of all the alarmed doors (3) completed with the Director of Nurses revealed all checks had been completed and the alarms were functional.</p> <p>Validation of staff training May 10 - 15, 2011 via sign-in rosters revealed all staff attended with the exception of one, who was currently in the hospital. This staff person will receive training, prior to being assigned to work with the residents.</p> <p>Observations of the front lobby area, on 05/13/11 at 10:16am, revealed a construction site with four foot (4ft.) tall cones and caution tape draped between them. Directly behind these were four foot by eight foot (4x8 ft) barriers on either side of the lobby blocking the hallways and entrance to the construction site.</p> <p>Observations of Resident #1, on 05/13/11 at 11:06am, 11:27am, 1:20pm and on 05/16/11 at 11:30am and 1:10pm revealed the resident had a code alert bracelet applied to the ankle, in his/her room or in the dining room.</p> <p>Immediate Jeopardy was verified to be removed prior to exit on 05/16/11 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.25 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance</p>	F 323		



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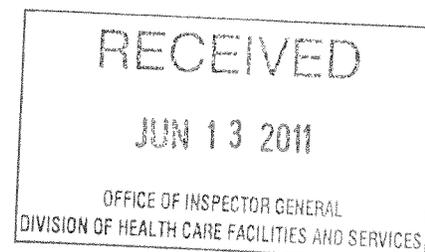
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F 323	Continued From page 15	F 323			
F 490 SS=J	monitors the effectiveness of the barriers and the new code alert system. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review of the facility's investigation, it was determined, the facility failed to ensure a safety plan was in place during the construction of the front lobby to prevent the elopement of one (1) resident (#1) of the five (5) sampled residents. Resident #1 eloped from the facility after a temporary wall was removed that prevented access to the construction site by the wandering residents. The exit door was not secured when the code alert system was removed and no measures were put in place to prevent the wandering residents from exiting the front door. The facility's failure to ensure a safety plan was in place during the construction phase placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident. The facility provided a credible allegation of compliance (AOC) on 06/16/11. The state agency verified immediate jeopardy was removed 06/16/11 prior to exit; which lowered the scope and severity to a "D" at 42 CFR 483.20 Resident	F 490	F490 Fifteen minute checks were instituted on May 10, 2011 upon his return to the facility to ensure the location of Resident #1 was monitored. A staff member was assigned the duty of staying at the front entrance door on May 10, 2011 upon resident's return to the facility and remained in place throughout the 2 p.m. to 10 p.m. shift. Another staff member was assigned this responsibility for the 10 p.m. to 6 a.m. shift. The Director of Maintenance came into the facility and constructed a barrier on May 10, 2011 at approximately 9:15 p.m. that prohibited any access into the construction site and front exit door. All residents of the facility were identified as having the potential to exit the facility through the front entrance from the time period of 3:00 p.m. to 9:00 p.m. on May 10, 2011 without having to enter a code and without having an alarm to sound if the	05/27/11	



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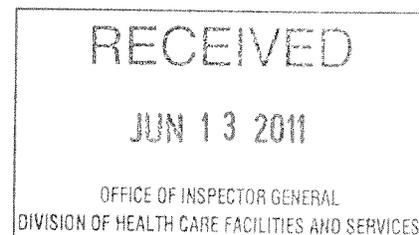
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F 490	<p>Continued From page 18</p> <p>Assessment, F282, 42 CFR 483.25 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors the effectiveness of the barriers and the new code alert system.</p> <p>The findings include:</p> <p>Record review of the facility's investigation for elopement revealed Resident #1 exited the building on 05/10/11 sometime between 7:00pm and 8:00pm without staff knowledge. The resident was found ambulating on the sidewalk of a busy street by a staff member who was off duty. The facility was notified and the resident was returned to the facility.</p> <p>Interview, on 05/13/11 at 2:40pm, with the Director of Nursing (DON) revealed the direct care staff were not given any direction/instruction to increase supervision of the wandering residents when the barrier wall was taken down. It was the responsibility of the DON and Administrator to ensure the safety of the residents during construction. Additionally, it was the responsibility of the DON and Administrator to inform the construction crew of the potential dangers for the wandering residents if equipment was left lying around and exit doors were left open and unattended. The construction crew was not made aware of this by him.</p> <p>Interview, on 05/16/11 at 11:10am, with the Maintenance Director revealed the construction area was contained with a temporary wall. On 05/10/11 at 3:00pm the temporary wall was taken out due to trim work needed to be done. The</p>	F 490	<p>Code Alert System was activated if the resident was wearing a transponder.</p> <p>A review of the resident census was completed on May 10-11, 2011 to assess the elopement risk of the residents. No other residents were identified as being at risk for elopement.</p> <p>All staff was provided education on the need to properly supervise residents who are identified as being at risk for elopement. This in-service training was initiated May 10, 2011 and continued through May 16, 2011. Staff were educated on the need to ensure the safety of the facility from resident elopement and that should a situation arise where an alarmed door system fails or is being temporarily out of service, a staff member will be assigned to monitor the area until the system is again functional.</p> <p>Staff training was reinforced by the Director of Nursing on June 9 and June 10, 2011 to ensure staff is aware of supervising the residents by following</p>	



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F 490	<p>Continued From page 17</p> <p>cones and caution tape had always been there and were put there by the construction crew. In addition, the crew were told they would be held accountable for locking the front door when they left for the evening. However, the front door could be opened from the inside even if it was locked. Nothing was put in place by the facility to prevent the residents from going out the front door in the construction area. The Maintenance Director felt it was overlooked by everyone.</p> <p>Interview, on 05/16/11 at 1:10pm, with the Administrator revealed the temporary wall was erected when the alarm system was removed with the front door. The wall was removed on 05/10/11. The cones and caution tape were left in place; however, no other safety measures were put in place to prevent the wandering residents from entering the construction site. The Administrator stated he did not know how, but he never thought of the immediate danger for the residents when the wall was removed. He indicated there was a safety meeting held with the construction supervisor. However, no check list or safety system was utilized to ensure the site was secure at all times once the wall was taken down.</p> <p>Review of the investigative report dated 05/10/11 and interview with the Director of Nursing on 05/13/11 at 2:40pm and the Administrator on 05/16/11 at 1:10pm revealed the facility took the following immediate action:</p> <ol style="list-style-type: none"> 1. The facility performed a physical assessment on Resident #1 and found no injuries. 2. Resident #1 was placed on every 15 minute checks until the new code alert system was 	F 490	<p>the residents' plan of care as it relates to their being at risk for elopement.</p> <p>Direction was given that the barrier was not to be removed at any time by anyone without having first notified the Administrator or Director of Nursing. A staff member was assigned to monitor the area when the contractors needed access to the area and had to temporarily move the barrier. The building superintendent and Administrator conducted a check of the renovation site at the conclusion of each work day to ensure the integrity of the barriers. Additionally nursing staff checked the barriers every 30-minutes while in place to ensure there was no access to the construction area and the front entrance door.</p> <p>A thorough inspection of the area being renovated was completed on May 16, 2011 by Department Heads and Administrative Staff. Additional measures were taken to enhance the security of the area by increasing the height of the barrier walls from four feet to eight feet.</p>	



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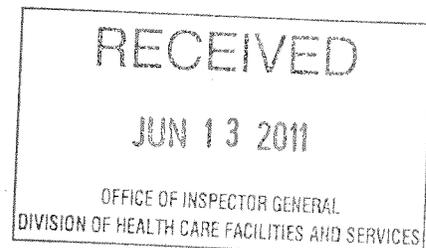
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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
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F 490	<p>Continued From page 18 Installed on the front door.</p> <p>3. An employee was stationed at the front entrance to monitor any resident activity.</p> <p>4. All alarmed doors were checked.</p> <p>5. All code alert bracelets were checked.</p> <p>6. The maintenance department installed a rigid barrier to prevent access to the construction site.</p> <p>7. The barriers were placed on every 30 minute checks to ensure they were intact.</p> <p>Additional measures were taken on 05/11/11:</p> <p>1. Review of all residents identified as at risk for elopement to ensure supervision of their activities.</p> <p>2. All alarmed doors were placed on weekly checks by maintenance and every shift checks by nursing when checking the code alert bracelets.</p> <p>3. Elopement binders were reviewed, pictures and demographic information placed in binders for four (4) residents and placed at new reception area.</p> <p>4. Reviewed policy and procedures regarding wandering residents, elopement and missing residents for revisions.</p> <p>6. Education of all staff regarding the wandering resident, elopement and missing resident 05/10/11, 05/12/11, 05/13/11, 05/14/11 and 05/15/11.</p>	F 490	<p>The Code Alert system was installed on May 23, 2011 and was completely operational on May 24, 2011. All residents identified as being at risk for elopement cannot pass through the front entrance without activating the system which will lock down the door denying access for a fifteen second time frame and an audible alarm sounds immediately at the front entrance and at the nurse's station on Transition Way. Also a visible alarm is activated at both nurse's stations identifying the door that has been activated.</p> <p>The barriers were removed on Friday, May 27, 2011 allowing residents to access the newly renovated area.</p> <p>Should any alarmed exit door(s) have the Code Alert system removed or not function properly, a staff member will be assigned the task of staying present by the exit door(s) until the system is repaired or replaced. A safety plan will be created, staff educated and the safety plan implemented to ensure the safety of all residents during</p>		

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

PRINTED: 06/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/16/2011
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 490	Continued From page 19 8. Education of the construction crew on 05/16/11 regarding the barriers were to remain in place until the construction was completed or code alert system was installed at the front door. Observation, on 05/16/11 at 11:30am, revealed Resident #1 sitting in the dining room at the table with other male residents. A code alert bracelet was noted on the right ankle. At 1:10pm the resident was in his/her room a code alert bracelet remained on the right ankle. Review of the clinical record for Resident #2, #3, #4 and #5 during the survey revealed the residents had been assessed for risk for elopement and had code alert bracelets on. Resident #5 was reassessed on 05/10/11 by the facility as improved and no longer required the code alert bracelet. Resident #5 was removed from the elopement binder. Resident's #2, #3, #4 and #5 had not eloped from the building. Interview with the Administrator on 05/16/11 at 1:10pm revealed informal meetings every morning had been held with staff to discuss the cause and action plan related to the elopement of Resident #1. A formal QA meeting would be held on Thursday 05/19/11. On 05/13/11 at 10:30am a check of all the alarmed doors (3) completed with the Director of Nurses revealed all checks had been completed and the alarms were functional. Validation of staff training May 10 - 15, 2011 via sign-in rosters revealed all staff attended with the exception of one, who was currently in the	F 490	construction or temporary lack of a Code Alert system. The Quality Assessment and Assurance Committee will determine the need for and develop a safety plan for events predicating additional security measures to ensure the safety of all residents. The Code Alert system is tested on a weekly basis by the Director of Maintenance. A monthly report will be made by the Director of Maintenance to the Quality Assessment and Assurance Committee on the audits of the Code Alert system. Based on review of his report, the Quality Assessment and Assurance Committee, actions plans will be developed and implemented if warranted to ensure residents' safety. The Director of Maintenance, Director of Nursing, and Administrator will monitor the facility's performance to ensure compliance.		



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NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1			STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 20 hospital. This staff person will receive training, prior to being assigned to work with the residents. Immediate Jeopardy was verified to be removed prior to exit on 05/18/11 with remaining non-compliance at 42 CFR 483.20 Resident Assessment, F282, 42 CFR 483.26 Quality of Care, F323, and 42 CFR 483.75 Administration, F490, while the facility's Quality Assurance monitors the effectiveness of the barriers and the new code alert system.	F 490		

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