

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

*KY # 16772*  
PRINTED: 08/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185326</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/27/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLINTON-HICKMAN COUNTY NURSING FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>366 S. WASHINGTON ST. CLINTON, KY 42031</b>
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F 000	INITIAL COMMENTS  AMENDED  An abbreviated survey (KY #16772) was conducted on 07/26-27/11. The allegation was substantiated with Immediate Jeopardy determined to exist on 07/21/11 through 07/25/11. On 07/21/11 at 6:15 PM, Resident #1 removed his/her wanderguard and exited the facility without staff knowledge. Staff was unaware Resident #1 had left the facility until notified by a visitor. Resident #1 was found approximately one tenth of a mile from the facility. After the incident, the facility immediately developed and implemented interventions on 07/21/11 to correct the deficiency. It was determined the facility completed all corrective action prior to the State Agency initiating the investigation, thus resulting in the determination of Past Jeopardy. The facility was made aware of the Past Jeopardy on 07/27/11.	F 000		
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 observations, record review, facility policy review and interviews, it was determined the facility failed to have an effective system to	F 323		
			Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>ensure one resident (#1), in the selected sample of three, received adequate supervision to prevent elopement from the facility. On 07/21/11, Resident #1 removed his/her wander guard bracelet and left the facility without staff knowledge. A visitor observed the resident walking down the highway at approximately 6:15 PM and called the facility. The resident was found to be walking with his/her walker, on the right side of a two lane highway, approximately a tenth of a mile from the facility. The speed limit was 45 miles per hour and there was a ditch on the right side of the highway.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. The Immediate Jeopardy was determined to exist on 07/21/11 through 07/25/11. The facility implemented corrective action which was completed prior to the State Agency's investigation, thus it was determined Past Jeopardy.</p> <p>The findings include:</p> <p>A review of the facility's "Elopement" policy and procedures, revised 07/13/10, revealed "all residents would be assessed upon admission for his/her elopement potential. All residents were to be assessed quarterly and as needed for any changes in behavior or mental status."</p> <p>A record review revealed Resident #1 was admitted to the facility on 09/28/10 with diagnoses to include Alzheimer's Disease and Generalized Anxiety.</p> <p>A review of the Elopement Risk assessment,</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>dated 09/28/10, revealed the facility assessed the resident to be an elopement risk due to a history of elopement attempts at a prior nursing home. A review of the Comprehensive Care Plan, related to exit seeking behavior, dated 10/14/10, revealed interventions were to use a wander guard and check for placement every shift.</p> <p>A review of the Elopement Risk Assessment, dated 05/20/11, revealed the facility assessed the resident to continue to be an elopement risk due to a history of an elopement attempt at this nursing home. A review of the quarterly Minimum Data Set (MDS) assessment, dated 06/05/11, revealed the facility assessed Resident #1's decisions to be poor and he/she needed cues and supervision. The resident required supervision for transfer and ambulation and had wandering behaviors.</p> <p>A review of the Certified Nurse Aide (CNA) care plan, dated July 2011, revealed the resident was to wear a wander guard bracelet and was to be checked every shift for placement. A review of the Treatment Administration Record (TAR), dated July 2011, revealed Resident #1's wander guard was in place every shift from 07/01-21/11.</p> <p>A review of a nurse's note, dated 07/21/11 at 6:15 PM, revealed a resident's family member called the facility and made the nurse aware Resident #1 was outside the facility walking down the highway.</p> <p>An interview with Resident #4's daughter, on 07/27/11 at 10:50 AM, revealed she observed Resident #1 walking down the highway in front of the facility and she called the facility to make</p>	F 323			

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F 323	<p>Continued From page 3 them aware.</p> <p>Interviews with Licensed Practical Nurse (LPN) #1 and LPN #2, on 07/26/11 at 2:55 PM and on 07/27/11 at 9:37 AM, revealed they immediately ran outside the South porch exit door and went around the side of the building and then toward the front of the building. When they arrived in front of the building, they observed Resident #4's daughter on the side road waving them over. The LPNs stated when they got to the edge of the highway, they could see Resident #1 walking down the side of the highway with his/her walker. Resident #4's daughter drove them down the road to pick Resident #1 up. When the resident entered the car, the LPNs immediately checked for Resident #1's wander guard. The wander guard was not present on the resident's ankle. The LPNs stated they assessed the resident upon return to the facility and found no injuries or any evidence that he/she fell while outside. When they entered Resident #1's room, they found the resident's wander guard on the bed side table and the bracelet was unsnapped. When the bracelet was snapped it was easily unsnapped by applying a small amount of pressure.</p> <p>Interviews with LPN #1, LPN #2, CNA #1, CNA #2, CNA #3 and CNA #4, on 07/26/11 at 2:45 PM, 2:55 PM and 3:30 PM, and on 07/27/11 at 9:37 AM, 9:50 AM and 10:55 AM, revealed the last time they observed Resident #1 was at approximately 6:00 PM, when the resident and his/her spouse walked back to their room from the dining room after they ate supper. None of the staff on duty saw the resident walk toward any of the exit doors. The staff revealed they were</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>aware the resident had a wander guard and was at risk for elopement. LPN #1 revealed she checked the resident's ankle at approximately 3:00 PM and the wander guard was in place.</p> <p>An interview with Resident #5 (Resident #1's spouse), on 07/26/11 at 4:00 PM, revealed he/she and Resident #1 walked back to their room from the dining room after supper on 07/21/11. He/she stated Resident #1 sat in the recliner for a few minutes, then got up and stated he/she was going for a walk. Resident #5 stated the next thing he/she knew, staff brought Resident #1 back into the room and stated the resident left the facility. Resident #5 revealed he/she did not observe Resident #1 remove his/her wander guard.</p> <p>Interview with the Director of Nursing, on 07/27/11 at 3:30 PM, revealed the CNAs should note if the wander guard bracelet is in place every time they provide care for the resident and the CMAs and Licensed Staff should check every shift for placement.</p> <p>An interview with the Administrator, on 07/27/11 at 11:15 AM, revealed Resident #1 should not be able to exit the building without the staff's knowledge. He stated they chose to install the wander guard system so the staff knew when residents, which required supervision, tried to exit the facility. Residents who were able to go outside without supervision were still able to exit the building without asking staff to let him/her out.</p> <p><b>**The facility implemented the following actions to correct the deficiency:</b></p>	F 323	/		

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F 323	<p>Continued From page 5</p> <p>*A new wander guard bracelet was placed on Resident #1 and the resident was placed on 15 minute checks on 07/21/11. A Elopement Assessment was completed on 07/21/11. Resident #1's care plan was revised, on 07/21/11, to include the removal of the wander guard bracelet by the resident and interventions were added to check the bracelets every shift to ensure the snap was securely closed and to monitor the resident every 15 minutes. In addition, an intervention was added for a wander guard on his/her walker on 07/25/11.</p> <p>*The resident's room was searched for any item that could be used to remove the bracelet on 07/21/11. A nail file, clippers and scissors were found and the items were sent home with the family.</p> <p>*The wander guards of all residents, assessed as an elopement risk, were checked to ensure wander guards were in place and the snap closure was secured on 07/21/11. The care plans of all residents with wander guards were revised to include the intervention to check snap closure every shift to ensure it was securely closed.</p> <p>*The Treatment Administration Records of Resident #1, and all residents with wander guard bracelets, were updated on 07/22/11 with the intervention to check the wander guard bracelets every shift to ensure the snaps were secured.</p> <p>*The Wander Guard monitoring policy was revised on 07/22/11 to include checking alarm bracelets for secure snap closure every shift.</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>*An inservice was held with all licensed staff from 07/22-25/11 to educate them on the need to check the wander guards every shift to ensure they were in place and the snap was secure.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>A review of Resident #1's "Elopement Risk Assessment," revealed the resident was reassessed on 07/21/11 and was at risk for elopement. An interview with LPN #2, on 07/27/11 at 9:37 AM, revealed she conducted the Elopement Risk Assessment after Resident #1 returned to the facility on 07/21/11. She stated he/she remained at risk for elopement.</p> <p>Observations of Resident #1, on 07/26/11 at 12:30 PM, 1:30 PM, 3:00 PM and 4:00 PM, and on 07/27/11 at 9:40 AM and 10:45 AM, revealed the resident had a wander guard alarm on his/her left ankle and walker.</p> <p>Observations, on 07/27/11 from 9:30 AM until 10:45 AM, revealed the licensed staff checked to see where Resident #1 was located every 15 minutes. A review of the 15 minute monitoring forms revealed Resident #1 was monitored every 15 minutes, since 07/21/11 at 6:30 PM. He/she remained on 15 minute checks at this time.</p> <p>Interviews with Registered Nurse (RN) #1, LPN #1, LPN #2, LPN #3, CNA #1, CNA #2, CNA #3, CNA #6, CNA #7 and CNA #8, on 07/27/11 at 2:35 PM, 2:40 PM, 2:45 PM, 2:50 PM, 2:55 PM, 3:00 PM, 3:05 PM, 3:10 PM, 3:15 PM and 3:20 PM, revealed the staff physically checked the resident every 15 minutes, and documented the resident's location and whatever he/she did, on</p>	F 323		
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F 323	<p>Continued From page 7 the 15 minute check sheet.</p> <p>Observations, on 07/26/11 at 11:00 AM, and on 07/27/11 at 10:00 AM and 10:05 AM, revealed Residents #1, #2 and #3's wander guard bracelets were in place and the snaps were securely snapped.</p> <p>A review of Resident #1's, Resident #2's and Resident #3's Comprehensive Care Plans and July 2011 TARs, revealed updates were included to check the wander guard bracelets every shift to ensure the snaps were secured.</p> <p>An observation, on 07/27/11 at 3:00 PM, revealed LPN #1 checked the residents' wander guards for placement and tugged on the snaps to ensure the bracelets were secured.</p> <p>Interviews with RN #1, LPN #2 and LPN #3, on 07/27/11 at 2:35 PM, 2:45 PM, 3:15 PM and 3:20 PM, revealed they checked the wander guards for placement and ensured the snap was secured at the beginning of every shift.</p> <p>/ A review of the facility's "Wander guard" policy, dated 07/22/11, revealed it was revised to include the check of the wander guard snap to ensure it was secured every shift.</p> <p>A review of inservices, dated 07/22-25/11, revealed all licensed staff were educated on how to check the wander guards every shift to ensure they were in place and the bracelet snap was secured.</p> <p>Interviews with RN #1, LPN #2 and LPN #3, on 03/27/11 at 2:45 PM, 3:15 PM and 3:20 PM,</p>	F 323		/
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F 323	<p>Continued From page 8</p> <p>revealed they received an inservice to ensure the residents' wander guards were in place and the snap was secure. They stated the Assistant Director of Nursing (ADON) showed them Resident #1's old bracelet and demonstrated how they needed to tug on the bracelet snap to ensure it was secured every shift.</p> <p>A review of the facility's Quality Assurance checks for wander guards, revealed the Director of Nursing (DON) checked the wander guards twice a day for placement, ensured the snap was secured and checked the TARs to ensure nurses' initialed the TAR to indicate wander guards were checked every shift. An interview with the DON, on 07/27/11 at 3:30 PM, revealed she continued the checks two times a day for one week, and if no concerns were identified, decreased the checks to once a week for one month, then once every three months for one year.</p> <p>An interview with the Administrator, on 07/27/11 at 11:15 AM, revealed the DON, ADON and himself went to two different facilities to see the security systems on 07/25/11. He stated he contacted the security company and a representative was supposed to come to the facility on 08/02/11 at 10:00 AM. The representative would conduct an appraisal to upgrade the alarm system, so the exit doors required a code to exit out of the building.</p>	F 323		
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