

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

PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185401</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C 11/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>EDMONSON CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>813 S. MAIN ST. BROWNSVILLE, KY 42210</b>		
(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 000}	INITIAL COMMENTS  An onsite Revisit Survey was conducted on 11/13/14 through 11/14/14 and determined the facility was in compliance on 10/02/14 as alleged in the acceptable PoC.	{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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NAME OF PROVIDER OR SUPPLIER  EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>An Abbreviated Survey Investigating complaint #KY22181 and #KY22221; and, a Partial Extended Survey was conducted on 09/05/14 through 09/18/14 to determine the facility's compliance with Federal requirements. Complaint #KY22221 was unsubstantiated with no deficiencies and Complaint #KY22181 was substantiated with deficiencies cited at a Scope and Severity of a "J".</p> <p>On 08/26/14, at approximately 5:10 PM, during the mealtime process, Resident #1 followed two (2) visitors through the East Nurse's Station doors into the front lobby area of the facility. The resident continued to follow the visitors out the main front doors onto the porch of the facility without staff knowledge. The facility's Investigation revealed another resident (a personal care resident, Unsampled Resident A), witnessed Resident #1 exit the East Nurse's Station, and then he/she turned off the door alarm after the resident walked through the door.</p> <p>The facility failed to ensure a system was in place to ensure other residents and visitors did not have the code to the doors which enabled Resident #1 to exit the building without the alarm sounding to alert staff.</p> <p>Immediate Jeopardy (IJ) was identified in the areas of CFR 483.20 Resident Assessment at F282; CFR 483.25 Quality of Care at F323. Substandard Quality of Care was identified at CFR 483.25 at F323. Immediate Jeopardy was identified on 09/10/14 and was determined to exist on 08/26/14. The facility was notified of the Immediate Jeopardy (IJ) on 09/10/14. An</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Carolyn Juence*

TITLE

*Administrator*

(X6) DATE

*10-30-14*

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

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F 000	Continued From page 1 acceptable Allegation of Compliance (AoC) was received on 09/18/14 and the State Survey Agency validated the Immediate Jeopardy was removed on 09/07/14, as alleged. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (PoC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.	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 observation, interview and record review, it was determined the facility failed to provide services by qualified personnel according to the written plan of care for one (1) of three (3) sampled residents (Resident #1) related to supervision.  The facility assessed and care planned Resident #1 at risk for elopement; however, on 08/26/14 at approximately 5:10 PM, Resident #1 followed two (2) visitors through the East Nurse's Station doors into the front lobby area of the facility. The resident continued to follow the visitors out the main front doors onto the front porch of the facility without staff knowledge. The resident's care plan revealed an intervention to redirect the resident when the security system sounds. However, the facility's investigation revealed a personal care	F 282	1.) On August 26, 2014, Resident #1 was assisted back into the facility by the Activities Director. The Licensed Practical Nurse returned Resident # 1 to his/her room.  Upon return to the resident's room, a head to toe body audit was completed by the Licensed Practical Charge Nurse. No new skin issues were identified and Resident #1 had no injury related to this event.  In addition, the licensed nurse (LPN) completed a Change in Condition document to include vital signs which were within usual range for Resident # 1. Resident #1 was observed by the LPN to be alert, calm, and cooperative and without complaints of pain or discomfort.	

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F 282	<p>Continued From page 2</p> <p>resident (Unsampled Resident A), witnessed Resident #1 exit the East Nurses' Station, and then he/she turned off the security system after Resident #1 walked through the door without staff's knowledge because the alarm was immediately turned off.</p> <p>The facility's failure to implement the care plan has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/10/14 and determined to exist on 08/26/14. The facility was notified of the Immediate Jeopardy on 09/10/14.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "NSG 102 Care Plans" last revised 01/02/14, revealed a comprehensive, individualized care plan would be developed by the interdisciplinary team for each patient. The care plan would include measurable objectives to meet patient needs and goals as identified by the assessment process.</p> <p>Review of the facility's policy titled, "Elopement of Patient" Section 1.3, last revised 05/15/14, revealed when a patient was identified as at risk, an interdisciplinary elopement prevention care plan would be developed with family and patient participation. Individual risk factors and patterns would be identified and addressed within the care plan.</p> <p>Record review revealed the facility admitted Resident #1 on 05/29/14 with diagnoses which included Anxiety Disorder, Dementia and Cognitive Loss. Review of the Quarterly Minimum Data Set (MDS) assessment, dated</p>	F 282	<p>Per BIMS score (4), resident is non-interviewable.</p> <p>Resident #1 was placed on direct line of observation beginning at 5:20p.m. on 8/26/14. This was conducted by the Activity Director, Administrator, R.N. Nurse Practice Educator, RN, LPN or Certified Nursing Assistants. These staff members were instructed to know the location of Resident #1 at all times as instructed by the Administrator.</p> <p>The Physician and Responsible Party were notified by the LPN on 8/26/14 at 7:00pm and 7:10pm respectively. No new physician orders were received at that time.</p> <p>The Nurse Practice Educator completed an updated Elopement Evaluation for Resident #1 on 08/26/14.</p> <p>Resident #1's Care Plan was updated on 8/26/14 by the R.N. Nurse Practice Educator to include review of elopement evaluation, walk resident to room after meals and direct line of observation. It was updated again on 8/27/14 by a registered nurse and licensed practical nurse following an interdisciplinary care plan meeting.</p>		

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F 282	<p>Continued From page 3</p> <p>07/17/14, revealed the facility assessed the resident's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of four (4) which indicated the resident was not interviewable.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 08/12/14, revealed the resident was considered at risk for elopement related to Dementia and Cognitive Loss. Further review revealed a goal of "Resident will not leave the building without an escort". Interventions included for staff to redirect the resident when the security system sounded and/or the resident attempted to leave the building. Staff was to utilize and monitor the resident's security bracelet per protocol.</p> <p>Interview with the Activity Assistant, on 09/09/14 at 11:25 AM, revealed she had been working in the dining room and had come to the front lobby looking for something and was standing at the reception desk. She stated a family member/visitor came to her and informed her that Resident #1 was sitting outside and he was not sure if the resident needed to be alone. She stated she immediately asked the resident to come inside with her and she took the resident to the nurse for observation. The Activity Assistant stated she did not hear an alarm sound when the resident exited the facility to alert her that a resident may have exited the facility.</p> <p>Interview with Certified Nursing Assistant (CNA) # 1, on 09/09/14 at 3:00 PM, revealed she was working in the Personal Care Dining Room at the time and did not hear the door alarm sound. She stated Resident #1 was in the big dining room across from where she was working, the last time</p>	F 282	<p>per care plan IDT notes &amp; care plan documentation to include an activity assessment completed by activity director with care plan update to include individualized activity approaches for Resident #1.</p> <p>2.) On August 26, 2014 the R.N. Nurse Practice Educator, who was in the building at the time of the event, instructed, the licensed charge nurses and Certified Nursing Assistants to complete a visual census check. All residents (88 of 88) were present inside the facility. This visual validation census form was signed by the Licensed Nurse on East and West Units.</p> <p>On August 26, 2014, the Administrator checked all egress doors (the east unit exit door was evaluated first). Upon review, the alarm function was found to be working properly. All other doors sensitivity &amp; alarms functioned properly.</p> <p>Residents residing in the center with elopement risk were reviewed by the R.N. nurse practice educator on 8/26/14 (2 of 2). The Elopement Risk Evaluations for at risk residents, care plans and care cards were reviewed and updated as indicated by a licensed practical nurse or registered nurse on 8/26/14. An additional resident was identified as at risk on 08/27/2014 related to a change in behavior including exit seeking. 3 of 3</p>		

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F 282	<p>Continued From page 4</p> <p>she saw him/her. She stated she should have been able to hear the alarm sound and it would have alerted her to the resident's attempt to leave the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/05/14 at 2:20 PM, revealed she was working in the dining room at the time and did not hear the door alarm go off. She stated the resident would follow staff and visitors at times. LPN #1 stated she had seen Resident #1 right after the evening meal in the main dining room, and did not realize he/she was missing until the Activity Assistant brought him/her back to her. She stated, that if she heard the alarm she would have responded to it.</p> <p>Interview with the MDS Coordinator, on 09/05/14 at 4:00 PM, revealed the resident was assessed for risk of elopement on admission and then reassessed on 07/22/14 as at risk due to an increase in wandering behavior as the resident had followed a visitor into the bathroom. The resident was evaluated and interventions were put in place and a care plan was initiated on 07/22/14. She revealed an alarm was placed on the resident's ankle as an intervention on 07/22/14.</p> <p>Interview with the Maintenance Director, on 09/05/14 at 2:15 PM, revealed he thought that the residents and family members looked over staff's shoulder when they put the code in to get the code to the East Nurses' Station to the main lobby so they would not have to wait on staff to let them out. He stated the same code was used to open the door and reset the door alarm.</p> <p>Interview with the Administrator, on 09/05/14 at</p>	F 282	<p>residents identified at risk for elopement were placed on direct line of observation 8/27/14. These three residents also utilize a code alert bracelet.</p> <p>Current residents were reviewed on 08/27/2014 by a licensed practical nurse or registered nurse for elopement risks utilizing elopement risks evaluations. No other residents were identified for elopement risk.</p> <p>The door key codes were changed by the Maintenance Director on 08/27/2014. The Administrator implemented a bright red notification sign to notify visitors/families on all exit doors to please see staff before allowing anyone to exit these doors on 08/27/2014.</p> <p>On 8/27/14, the contractor for the Wander Guard system was contacted for a full system evaluation by the Maintenance Director. As an additional precaution, the two sensitivity antennas were replaced on the front east unit exit doors leading to the lobby area. An order was placed on 8/28/14 by the Administrator for an enunciator panel to be installed at each nurse's station.</p>		

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F 282	<p>Continued From page 5</p> <p>1:30 PM, revealed she received a call around 6:00 PM informing her Resident #1 has been found outside the facility by a visitor. The Administrator stated her investigation determined a Personal Care resident (Unsampled Resident A) was sitting at the East Nurses' Station and saw Resident #1 exit with the visitors and immediately reset the door alarm allowing the resident to exit the facility undetected by staff. She revealed the facility reset the door code every six (6) months or anytime it was determined necessary. The Administrator stated, prior to this incident, when they identified too many residents and visitors had access to the code she would have staff change the code at that time. She stated she determined through her investigation of the incident that other residents and family members observed the staff using the code and that was how the Personal Care Resident knew how to reset the door code alarm which prevented the staff from responding to the alarm.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. LPN #1 performed a head to toe assessment on Resident #1 with no injuries identified. LPN #1 completed a Change of Condition document to include vital signs and oxygen saturation. Resident #1 was placed on direct line of observation beginning at 5:20 PM on 08/26/14. The Physician and responsible party were notified of the resident's elopement on 08/26/14 at 7:00 PM and 7:10 PM. All staff members present were instructed by the Administrator to know the location of Resident #1 at all times.</li> <li>2. The Nurse Practice Educator completed an updated Elopement Evaluation for Resident #1</li> </ol>	F 282	<p>3.) 100% staff re-education was immediately initiated by the Nurse Practice Educator beginning on 8/26/14, and continued by Nutrition Director, Environmental Services Director, Rehab Program manager, Administrative Assistant, Regional Clinical Educator, Payroll/Benefit Coordinator, or Administrator, with completion on 8/29/14.</p> <p>Re-education included:</p> <ul style="list-style-type: none"> <li>• Center policies on elopement prevention &amp; management.</li> <li>• Expected employee response to a door alarm. Specific information regarding the doors at this facility and how each function (for example, with or without a wander guard, alarm, etc.</li> <li>• Instructions that alarm codes should not be given to residents or visitors</li> <li>• Each employee completed a post-test to validate learning which was validated at time of completion by the R.N. nurse practice educator. The results were 100% pass rate.</li> </ul> <p>All new employees will have elopement education provided during orientation.</p> <p>100 of 110 active employees completed re-education and post testing between 8/26/14 – 8/29/14.</p> <p>Employees not currently available during this time frame will have or have had education/ re-education noted above completed prior to returning or beginning work by the Administrator, Nurse Practice</p>		

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F 282	<p>Continued From page 6</p> <p>on 08/26/14, and Resident # 1's Care Plan was updated and interventions were put in place. It was updated again on 08/27/14 after an Interdisciplinary Care Plan Meeting.</p> <p>3. The Licensed Charge Nurses and Certified Nursing Assistants completed a visual census check on all residents. Eighty-eight (88) of eighty-eight residents were present in the building. A visual validation census form was signed by the Licensed Nurse at each nursing station on 08/26/14 at 6:25 PM.</p> <p>4. On the evening of 08/26/14, the Administrator returned to the facility at approximately 6:00 PM and checked all egress doors. Upon review, the alarm function was found to be working properly. All other doors sensitivity and alarms functioned properly.</p> <p>5. Further Investigation including, resident interviews by the Administrator, determined that a resident from the Personal Care Unit was sitting outside of the East Lounge when Resident #1 exited the unit doors. The Personal Care Resident heard the alarm and immediately silenced the alarm by entering the code. The Administrator completed re-education at approximately 6:45 PM on 08/26/14, with the Personal Care Resident on the importance of not putting the code in for anyone and to notify staff for assistance with alarms.</p> <p>6. Residents residing in the Center, who were at risk for elopement, were reviewed by the Nurse Practice Educator on 08/28/14. The Elopement Risk Evaluations for at risk residents, care plans and care cards were reviewed and updated as indicated.</p>	F 282	<p>Educator, Director of Nurses, Assistant Director of Nurses, Nutrition Director, Environmental Services Director, or Rehab Program manager including a post test.</p> <p>The Personal care residents (18 of 18) were reeducated by the Nurse Practice educator, Administrator, and registered nurse beginning on 8/26/14 and completed on 8/28/14. The Skilled residents (39 of 39) with BIMS =&gt; 8 were reeducated by the Administrator on 08/28/2014.</p> <p>Resident A was reeducated by the Administrator on 08/26/2014 on importance of not putting code in for anyone and to notify staff for assistance with alarms.</p> <p>Resident Re-education included:</p> <ul style="list-style-type: none"> <li>• If the door alarm is sounding, do not attempt to turn the alarm off, notify staff for assistance.</li> <li>• If at any time you need assistance to exit the east unit please ask staff for assistance.</li> <li>• Please notify staff if you observe anyone other than staff entering door key code.</li> </ul> <p>4.) An AD HOC PI meeting with the Administrator, Director of Nursing, and the Medical Director was held on 8/27/14.</p>	

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F 282	Continued From page 7  7. The door key codes were changed by the Maintenance Director at approximately 10:35 AM on 08/27/14. The Administrator implemented a bright red notification sign to notify visitors/families on all exit doors to "Please see staff before allowing anyone to exit these doors" on 08/27/14. On 08/27/14, the Contractor for the Wander Guard system was contacted for a full system evaluation by the Maintenance Director. As an additional precaution, the two (2) sensitivity antennas were replaced on the front East Unit exit doors leading to the lobby area. An order was placed on 08/28/14 by the Administrator for an enunciator panel to be installed at each nurse's station.  8. 100% staff re-education was immediately initiated by the Nurse Practice Educator and all administrative staff, beginning on 08/26/14, and continuing with completion on 08/29/14. The re-education included, the Center's policies on elopement prevention and management, expected employee response to a door alarm, specific information regarding the doors at this facility and how each functions, instructions that alarm codes should not be given to residents or visitors. Each employee completed a post-test to validate learning with a 100% pass rate. 100 of 110 active employees completed re-education and post testing between 08/28/14 and 08/29/14. Employees not currently available during this time frame will have or have had education/re-education completed prior to returning or beginning work including a post test. All new employees will have elopement education provided during orientation.  9. The Personal Care Residents (18 of 18) were	F 282	Beginning on the day shift of 8/27/14, Nurse Practice Educator or Licensed Nurse completed an elopement drill on each shift through 8/29/14 to audit training compliance. No concerns were identified with these audits.  Alarm and Wander Guard function audits were completed on each shift beginning 8/26/14 and ending 8/29/14 by licensed nurses or Administrator. All door locking mechanisms and alarms were found to be working properly during these audits.  Alarm and Wander Guard function for all doors is tested daily by the Maintenance Director or Licensed Charge Nurse (LPN or RN). Any identified concerns are reported immediately to the Administrator, Director of Nursing or Director of Maintenance.  Licensed Staff or a Department Manager will complete an elopement drill on each shift monthly for 3 months (September, October, & November 2014), then quarterly for six months. Corrective action and/or re-education will be provided at point of discovery of identified audit concerns.	

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F 282	<p>Continued From page 8</p> <p>re-educated by the Nurse Practice Educator and/or Administrator beginning on 08/26/14 and completed on 08/28/14. The Skilled residents (39 of 39) with BIMS scores of eight (8) or higher were re-educated by the Administrator on 08/28/14. Resident re-education included, "If the door alarm is sounding, do not attempt to turn the alarm off, notify staff for assistance. If at any time you need assistance to exit the East Unit please ask staff for assistance and to please notify staff if you observe anyone other than staff entering the door key code."</p> <p>10. Beginning on the day shift of 08/27/14, the Nurse Practice Educator completed an elopement drill on each shift through 08/29/14 to audit training compliance. No concerns were identified with these audits. Alarm and wander guard function audits were completed on each shift beginning 08/26/14 and ending on 08/29/14 by Licensed Nurses or the Administrator. All door locking mechanisms and alarms were found to be working properly during these audits. Alarm and wander guard function for all doors was tested daily by the Maintenance Director or the Licensed Charge Nurse.</p> <p>11. No further elopements since implementing the original PI Plan on 08/26/14. Licensed staff or a department manager will complete an elopement drill on each shift monthly for three (3) months (September, October, November 2014), then quarterly for six (6) months. Corrective action and/or re-education will be provided at point of discovery of identified audit concerns. Findings will be reviewed by the Quality Improvement Committee (QIC), the QI Committee will make recommendations for additional audits based on audit outcomes.</p>	F 282	<p>Findings will be reviewed by the Quality Improvement Committee; the QI committee will make recommendations for additional audits based on audit outcomes.</p> <p>An AD HOC PI meeting was held on 9/2/14, 9/5/14, and 9/10/14 with the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Nurse Practice Educator and the Medical Director. AD HOC QI committee reviewed the progress of improvement plan including:</p> <p>Informational letter to 100% family members to be mindful of the alarms and seek staff assist when an alarm is sounding or resident may be trying to exit facility sent by Administrator on 9/6/14.</p> <p>Completion date:</p>	10/2/14	

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F 282	<p>Continued From page 9</p> <p>12. An AD HOC PI meeting was held on 09/02/14, and on 09/05/14 with the Administrator, Medical Director and all Department Managers to review the progress of the Improvement Plan including, informational letters to 100% family members to be mindful of the alarms and seek staff assist when an alarm is sounding or residents may be trying to exit facility on 09/06/14.</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 09/18/14 at 2:10 PM, revealed a change of condition document was initiated on 08/26/14 at 5:45 PM by LPN # 1. Vital signs were obtained along with a head to toe assessment. Documentation also revealed the resident was placed on direct line observation at that time. The Physician and family members were notified of the elopement on 08/26/14 at 7:00 PM and 7:10 PM by LPN #1. Interview with LPN #1, on 09/18/14 at 3:10 PM, revealed she was working the night Resident #1 was able to exit the building. LPN #1 completed a head to toe assessment on Resident #1 with no injuries noted.</p> <p>2. Interview with the Nurse Practice Educator, on 09/18/14 at 4:30 PM, revealed she updated Resident #1's care plan on 08/26/14 after re-evaluating his/her elopement assessment evaluation, and again on 08/27/14 after the Interdisciplinary Care Plan meeting.</p> <p>3. Interview with LPN #1, on 09/18/14 at 3:10 PM, revealed a Visual Validation Census Check was completed on all residents in the building on</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>08/26/14 at 6:35 PM. Review of the Visual Validation Census Check dated 08/26/14 confirmed this.</p> <p>4. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed she returned to the facility at 6:00 PM on 08/26/14, and started an investigation to determine how the resident was able to exit the building undetected. She stated she immediately checked all egress door alarms to make sure they were functioning properly.</p> <p>5. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed she returned to the facility at 6:00 PM on 08/26/14, and her investigation revealed a Personal Care Resident heard the alarm and immediately reset the alarm. The Administrator stated she re-educated the Personal Care Resident on the importance of not responding or resetting the door alarm on 08/26/14 at 6:45 PM.</p> <p>6. Interview with the Nurse Practice Educator, on 09/18/14 at 4:30 PM, revealed she updated Resident #1's care plan on 08/26/14 after re-evaluating his/her elopement assessment evaluation, and again on 08/27/14 after the Interdisciplinary Care Plan meeting. Further interview revealed she then reviewed all residents identified as an elopement risk and updated the assessment, care cards and care plans as indicated on 08/26/14.</p> <p>7. Observation on 09/18/14 at 2:00 PM, revealed the facility relocated the coded alarm system from the East Nurses Station to the front entrance of the facility. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed the door way was monitored daily from 7:00 AM until 7:00 PM. The</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>Administrator stated, the new system required that anyone entering the facility or exiting the facility must be buzzed in by the receptionist. The front door will automatically lock at 7:00 PM; to enter the facility you must go to the back entrance. She revealed the enunciator panels were installed on each nurses' station to alert the staff which door the resident was attempting to exit. Interview with Maintenance Director on 09/18/14 at 3:15 PM, revealed he demonstrated the alarm by opening the veranda doors and looking at the enunciator panel to verify the location of the alarm. Interview with LPN #1 on 09/18/14 at 3:10 PM, revealed she was knowledgeable of the new system that was put in place, and was able to explain the use of the enunciator panels. Interview with Activity Director on 09/18/14 at 2:59 PM, revealed she was aware of the new system changes with the door code alarm, she stated after 7:00 PM visitors could enter through the service entrance and ring a door bell. She further stated they had to be let in by the staff, and they were required to verify their identity before letting them in the facility.</p> <p>8. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed all staff was re-educated on the facility's policy for elopement. The re-education included the Center's policies on elopement prevention and management; expected employee response to a door alarm; specific information regarding the doors at this facility; and, how each functioned; and, instructions that alarm codes should not be given to residents or visitors. Each employee completed a post-test to validate learning with a 100% pass rate. 100 of 110 active employees completed re-education and post testing between 08/26/14 and 08/29/14. Employees not currently</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>available during this time frame will have or have had education/re-education completed prior to returning or beginning work including a post test. All new employees will have elopement education provided during orientation. Education was verified by viewing the Inservice sign-in sheets and post test packets were reviewed on 09/18/14.</p> <p>9. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed all Personal Care Residents (18-18) were re-educated on the importance of the door alarms and not to re-set the door alarms, and to notify staff if they see another resident exiting the doors when the alarm sounds. The Inservice was verified by a sign in sheet with Personal Care residents' signatures beginning 08/26/14 through 08/28/14.</p> <p>10. Interview with the MDS Coordinator on 09/18/14 at 3:23 PM, revealed her normal shift was 7:00 AM-4:00 PM. She stated she was inserviced on 08/26/14 by the Nurse Practice Educator on the Center's policy on elopement prevention, the new process for entering and exiting the building, importance of keeping the door code confidential. She stated she completed the post test with 100% accuracy.</p> <p>Interview with Employee #1 on 09/18/14 at 3:28 PM, revealed she also attended an inservice on 08/26/14. She stated her normal work shift was 5:30 AM-9:00 PM. She stated the inservice contained information about the facility's elopement policy and the new process for entering and exiting the building. She also completed a post test with 100% accuracy.</p> <p>Interview with Employee #2 on 09/18/14, revealed</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>she was employed as a Medication Tech and worked from 11:00 PM- 7:00 AM. She stated she also attended the inservice on 08/26/14 related to the elopement policy and the new process for entering and exiting the facility. She knew the importance of keeping the door code confidential and the use of the new alarm system. She indicated that she took a test with 100% accuracy after the training was completed.</p> <p>Interview with Employee #3 on 09/18/14 at 3:20 PM, revealed she was employed as a Certified Nurse Aide and worked from 2:00 PM -10:00 PM. She stated the inservice on 08/26/14 talked about the new door alarm system and the facility's policy on elopement. She was able to identify which residents were currently identified at risk for wandering and the importance of keeping the door code confidential. She also took a post test after the training with 100% accuracy.</p> <p>Interview with Employee #4 on 09/18/14 at 3:40 PM, revealed she attended the inservice on the facility's elopement policy on 08/27/14 and also participated in an elopement drill. She indicated the training covered the re-education on the elopement policy as well as the new door alarm system.</p> <p>Interview with Employee #5 on 09/18/14 at 2:34 PM, revealed she was inserviced on 08/27/14 at 8:00 PM on the new facility policy on elopement and also participated in an elopement drill. She stated she has a good understanding of the new door alarm system and realized the importance of keeping the code confidential.</p> <p>Interview with Resident #2 on 09/18/14 at 2:33 PM, revealed that he/she was not aware of the</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>new door alarm code. Interview with Resident #3 on 09/18/14 at 2:20 PM. revealed he/she was aware of the door alarm code prior to installing the new alarm system, but did not know the new door alarm code.</p> <p>Interview with Resident #3's family member on 09/18/14 at 2:20 PM, revealed that she was aware the facility has made changes with the alarm system, prior to the changes she was aware of the door alarm code but she did not know the new code.</p> <p>Interview with Personal Care Resident #4 on 08/18/14 at 4:09 PM, revealed the staff had taught him/her about the exit doors and staff let him/her out when he/she wanted to go out with his/her family. The resident stated he/she did not have access to the door code anymore.</p> <p>Interview with Personal Care Resident #5 on 09/18/14 at 4:12 PM, revealed he/she did not have the door code anymore, and the staff let him/her out when he/she needed to go with family. He/she continued to say that someone talked to him/her about the exit doors, and the importance of not letting anyone out the doors or turning off the alarms.</p> <p>11. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed that no further elopements had occurred. Licensed staff or a department manager would complete an elopement drill on each shift monthly for three (3) months (September, October, November 2014), then quarterly for six (6) months. Interview with the MDS Coordinator on 09/18/14 at 2:20 PM, revealed there has been no further elopements, and the new system was working properly.</p>	F 282			

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F 282	Continued From page 15  12. Verification of the AD HOC PI meeting was obtained through interview on 09/18/14 at 2:10 PM with the Administrator, she revealed the facility started the Performance Improvement for the Elopement on 08/26/14 with the Investigation process to assist the team with determining the root cause of the elopement. She stated they met again to include the Medical Director in the discussion on 08/27/14, and the entire team met again on 09/10/14. A copy of the notification letters mailed on 09/06/14, to all family members was reviewed during the interview on 09/18/14 at 2:10 PM. The Administrator continued to reveal that she has been in constant communication with the Medical Director through out the entire investigation either in meetings or phone conversations.	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 observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to provide adequate supervision and assistive devices to prevent accidents for one (1) of three (3) residents (Resident #1).	F 323	1.) On August 26, 2014, Resident #1 was assisted back into the facility by the Activities Director. The Licensed Practical Nurse returned Resident # 1 to his/her room around 5:30p.m.  Upon return to the resident's room, a head to toe body audit was completed by the Licensed Practical Charge Nurse. No new skin issues were identified and Resident #1 had no injury related to this event.		

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F 323	<p>Continued From page 16</p> <p>On 08/26/14, during the mealtime process, Resident #1, who was assessed by staff as an elopement risk, followed two (2) visitors through the East Nurse's Station doors into the front lobby area of the facility and continued to follow them out the main front doors onto the porch of the facility without staff knowledge. The facility's investigation revealed a Personal Care Resident (Unsampled Resident A), witnessed Resident #1 exiting the East Nurses' Station, and turned off the door alarm after he/she walked through it. The facility was aware residents and visitors knew the code but had taken no action to make sure residents did not have access to the code.</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 09/05/14 and determined to exist on 08/26/14.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Elopement of Patient", last revised 05/15/14, revealed residents will be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Elopement occurs when a resident leaves the premises without authorization and/or any necessary supervision to do so, and the purpose of the policy was to provide a process for managing residents at risk for elopement.</p> <p>Record review revealed the facility admitted</p>	F 323	<p>In addition, the licensed nurse (LPN) completed a Change in Condition document to include vital signs which were within usual range for Resident # 1. Resident #1 was observed by the LPN to be alert, calm, and cooperative and without complaints of pain or discomfort.</p> <p>Per BIMS score (4), resident is non-Interviewable.</p> <p>Resident #1 was placed on direct line of observation beginning at 5:20p.m. on 8/26/14. This was conducted by the Activity Director, Administrator, R.N. Nurse Practice Educator, RN, LPN or Certified Nursing Assistants. These staff members were instructed to know the location of Resident #1 at all times as instructed by the Administrator.</p> <p>The Physician and Responsible Party were notified by the LPN on 8/26/14 at 7:00pm and 7:10pm respectively. No new physician orders were received at that time.</p> <p>The Nurse Practice Educator completed an updated Elopement Evaluation for Resident #1 on 08/26/14.</p>		

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F 323	<p>Continued From page 17</p> <p>Resident #1 was admitted to the facility on 05/29/14 with diagnoses which included Anxiety Disorder, Dementia and Cognitive Loss.</p> <p>Review of Resident #1's Elopement Risk Assessment, dated 07/22/14, revealed the facility assessed the resident as at risk for elopement due to his/her increase in wandering behavior.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 08/12/14, revealed a goal that the resident would not leave the building without an escort and Interventions Included for staff to redirect the resident when the security system sounded and/or the resident attempted to leave the building and staff was to utilize and monitor the resident's security bracelet per protocol.</p> <p>Interview with a Visitor, on 09/05/14 at 3:00 PM, revealed he was sitting on the porch with his family members when he saw Resident #1 exit the building with two (2) women. He stated he first thought they were together and then he noticed the two (2) women walked to the parking lot and got in their car. He stated he asked Resident #1 if he/she was with the women and the resident did not answer. The Visitor stated the resident then started walking away in the direction of the parking lot. He stated he noticed the bracelet on the resident's ankle, and realized he/she was a resident, and thought the resident may not be allowed outside unsupervised. He then asked the resident to sit with him and visit, and then he went inside the facility to find someone to help. The Visitor stated the resident was outside unsupervised for four (4) or five (5) minutes and he was not sure what would have happened if he had not been out there, because the resident was walking in the direction of the</p>	F 323	<p>Resident #1's Care Plan was updated on 8/26/14 by the R.N. Nurse Practice Educator to include review of elopement evaluation, walk resident to room after meals and direct line of observation. It was updated again on 8/27/14 by a registered nurse and licensed practical nurse following an Interdisciplinary care plan meeting, per care plan IDT notes &amp; care plan documentation to include an activity assessment completed by activity director with care plan update to include individualized activity approaches for Resident #1.</p> <p>2.) On August 26, 2014, the R.N. Nurse Practice Educator, who was in the building at the time of the event, instructed, the licensed charge nurses and Certified Nursing Assistants to complete a visual census check. All residents (88 of 88) were present inside the facility. This visual validation census form was signed by the Licensed Nurse on East and West Units.</p>		

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F 323	<p>Continued From page 18</p> <p>parking lot and no one had come out of the facility to check on him/her.</p> <p>Interview with Activity Assistant, on 09/09/14 at 11:25 AM, revealed she had been working in the dining room and went to the front lobby looking for something and was standing at the reception desk. She stated a Family Member/Visitor came to her and said Resident #1 was sitting outside and he was not sure if the resident needed to be alone. She stated there was no one working at the reception desk at that time of day, and she was not sure how long the resident was outside. She stated she immediately asked the resident to come inside with her and she took the resident to the nurse for observation. She stated she did not hear an alarm sound when the resident exited the facility.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, who was responsible for Resident #1, on 09/05/14 at 2:20 PM, revealed she was working in the dining room at the time and did not hear the alarm go off. She stated the resident did not have a history of trying to leave the building but would follow staff and visitors at times. LPN #1 stated she had seen Resident #1 right after the evening meal in the main dining room, and she did not realize he/she was missing until the Activity Assistant brought him/her back to her.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 who was responsible for Resident #1, on 09/09/14 at 3:00 PM, revealed she was working in the Personal Care dining room at the time and did not hear the door alarm go off. She stated Resident #1 was in the big dining room across from where she was working, the last time she saw him/her. She stated she should have been</p>	F 323	<p>On 8/26/14, the Administrator returned to the facility at approximately 6:00p.m. and checked all egress doors (the east unit exit door was evaluated first). Upon review, the alarm function was found to be working properly. All other doors sensitivity &amp; alarms functioned properly.</p> <p>Residents residing in the center with elopement risk were reviewed by the R.N. nurse practice educator on 8/26/14 (2 of 2). The Elopement Risk Evaluations for at risk residents, care plans and care cards were reviewed and updated as indicated by a licensed practical nurse or registered nurse on 8/26/14. An additional resident was identified as at risk on 08/27/2014 related to a change in behavior including exit seeking. 3 of 3 residents identified at risk for elopement were placed on direct line of observation 8/27/14. These three residents also utilize a code alert bracelet.</p>		

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F 323	<p>Continued From page 19 able to hear the alarm go off.</p> <p>Interview with the Maintenance Director, on 09/05/14 at 2:15 PM, revealed the last time the door alarms were checked, prior to the elopement, was on 08/23/14 with no concerns identified. He stated the alarms were checked weekly. The Maintenance Director stated he thought the residents and family members looked over the shoulder of the staff when they use the code to obtain the code to get out of the East Nurses' station to the main lobby without waiting for staff to let them out. He stated the same code was used to open the door and reset the door alarm.</p> <p>Interview with the Administrator, on 09/05/14 at 1:30 PM, revealed she received a call around 6:00 PM informing her Resident #1 has been found outside the facility by a visitor. She stated the resident followed two (2) visitors through the doors and continued out the main door to the porch area and was found by a visitor/family member. The Administrator stated her investigation determined a Personal Care Resident (Unsampled Resident A) was sitting at the East Nurses' Station and saw Resident #1 exit with the visitors and immediately reset the door alarm allowing the resident to exit the facility undetected by staff. She revealed the facility reset the door code every six (6) months or anytime it was determined necessary. She stated, prior to this incident, when they identified too many residents and visitors had access to the code she would have staff change the code at that time. She stated she determined through her investigation of the incident other residents and family members observed the staff using the code and that was how Unsampled Resident A</p>	F 323	<p>Current residents were reviewed on 08/27/2014 by a licensed practical nurse or registered nurse for elopement risks utilizing elopement risks evaluations. No other residents were identified for elopement risk.</p> <p>The door key codes were changed by the Maintenance Director on 8/27/14. The Administrator implemented a bright red notification sign to notify visitors/families on all exit doors to please see staff before allowing anyone to exit these doors on 8/27/14.</p> <p>On 8/27/14, the contractor for the Wander Guard system was contacted for a full system evaluation by the Maintenance Director. As an additional precaution, the two sensitivity antennas were replaced on the front east unit exit doors leading to the lobby area. An order was placed on 8/28/14 by the Administrator for an enunciator panel to be installed at each nurse's station.</p>		

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F 323	<p>Continued From page 20 knew how to reset the door code alarm.</p> <p>The facility implemented the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. LPN #1 performed a head to toe assessment on Resident #1 with no injuries identified. LPN #1 completed a Change of Condition document to include vital signs and oxygen saturation. Resident #1 was placed on direct line of observation beginning at 5:20 PM on 08/26/14. The Physician and responsible party were notified of the resident's elopement on 08/26/14 at 7:00 PM and 7:10 PM. All staff members present were instructed by the Administrator to know the location of Resident #1 at all times.</li> <li>2. The Nurse Practice Educator completed an updated Elopement Evaluation for Resident # 1 on 08/26/14, and Resident # 1's Care Plan was updated and interventions were put in place. It was updated again on 08/27/14 after an Interdisciplinary Care Plan Meeting.</li> <li>3. The Licensed Charge Nurses and Certified Nursing Assistants completed a visual census check on all residents. Eighty-eight (88) of eighty-eight residents were present in the building. A visual validation census form was signed by the Licensed Nurse at each nursing station on 08/26/14 at 6:25 PM.</li> <li>4. On the evening of 08/26/14, the Administrator returned to the facility at approximately 6:00 PM and checked all egress doors. Upon review, the alarm function was found to be working properly. All other doors sensitivity and alarms functioned properly.</li> </ol>	F 323	<p>3.) 100% staff re-education was immediately initiated by the Nurse Practice Educator beginning on 8/26/14, and continued by Nutrition Director, Environmental Services Director, Rehab Program manager, Administrative Assistant, Regional Clinical Educator, Payroll/Benefit Coordinator, or Administrator, with completion on 8/29/14.</p> <p>Re-education included:</p> <ul style="list-style-type: none"> <li>• Center policies on elopement prevention &amp; management.</li> <li>• Expected employee response to a door alarm. Specific information regarding the doors at this facility and how each function (for example, with or without a wander guard, alarm, etc.</li> <li>• Instructions that alarm codes should not be given to residents or visitors. Each employee completed a post-test to validate learning which was validated at time of completion by the R.N. nurse practice educator. The results were 100% pass rate.</li> </ul> <p>All new employees will have elopement education provided during orientation.</p> <p>100 of 110 active employees completed re-education and post testing between 8/26/14 – 8/29/14.</p>		

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F 323	<p>Continued From page 21</p> <p>5. Further investigation including, resident interviews by the Administrator, determined that a resident from the Personal Care Unit was sitting outside of the East Lounge when Resident #1 exited the unit doors. The Personal Care Resident heard the alarm and immediately silenced the alarm by entering the code. The Administrator completed re-education at approximately 6:45 PM on 08/26/14, with the Personal Care Resident on the importance of not putting the code in for anyone and to notify staff for assistance with alarms.</p> <p>6. Residents residing in the Center, who were at risk for elopement, were reviewed by the Nurse Practice Educator on 08/26/14. The Elopement Risk Evaluations for at risk residents, care plans and care cards were reviewed and updated as indicated.</p> <p>7. The door key codes were changed by the Maintenance Director at approximately 10:35 AM on 08/27/14. The Administrator implemented a bright red notification sign to notify visitors/families on all exit doors to "Please see staff before allowing anyone to exit these doors" on 08/27/14. On 08/27/14, the Contractor for the Wander Guard system was contacted for a full system evaluation by the Maintenance Director. As an additional precaution, the two (2) sensitivity antennas were replaced on the front East Unit exit doors leading to the lobby area. An order was placed on 08/28/14 by the Administrator for an enunciator panel to be installed at each nurse's station.</p> <p>8. 100% staff re-education was immediately initiated by the Nurse Practice Educator and all administrative staff, beginning on 08/26/14, and</p>	F 323	<p>Employees not currently available during this time frame will have or have had education/ re-education noted above completed prior to returning or beginning work by the Administrator, Nurse Practice Educator, Director of Nurses, Assistant Director of Nurses, Nutrition Director, Environmental Services Director, or Rehab Program manager including a post test.</p> <p>The Personal care residents (18 of 18) were reeducated by the Nurse Practice educator, Administrator, and registered nurse beginning on 8/26/14 and completed on 8/28/14. The Skilled residents (39 of 39) with BIMS =&gt; 8 were reeducated by the Administrator on 08/28/2014.</p> <p>Resident A was reeducated by the Administrator on 08/26/2014 on importance of not putting code in for anyone and to notify staff for assistance with alarms.</p> <p>Resident Re-education Included:</p> <ul style="list-style-type: none"> <li>If the door alarm is sounding, do not attempt to turn the alarm off, notify staff for assistance.</li> </ul>		

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F 323	<p>Continued From page 22</p> <p>continuing with completion on 08/29/14. The re-education included, the Center's policies on elopement prevention and management, expected employee response to a door alarm, specific information regarding the doors at this facility and how each functions, instructions that alarm codes should not be given to residents or visitors. Each employee completed a post-test to validate learning with a 100% pass rate. 100 of 110 active employees completed re-education and post testing between 08/26/14 and 08/29/14. Employees not currently available during this time frame will have or have had education/re-education completed prior to returning or beginning work including a post test. All new employees will have elopement education provided during orientation.</p> <p>9. The Personal Care Residents (18 of 18) were re-educated by the Nurse Practice Educator and/or Administrator beginning on 08/28/14 and completed on 08/28/14. The Skilled residents (39 of 39) with BiMS scores of eight (8) or higher were re-educated by the Administrator on 08/28/14. Resident re-education included, "if the door alarm is sounding, do not attempt to turn the alarm off, notify staff for assistance. If at any time you need assistance to exit the East Unit please ask staff for assistance and to please notify staff if you observe anyone other than staff entering the door key code."</p> <p>10. Beginning on the day shift of 08/27/14, the Nurse Practice Educator completed an elopement drill on each shift through 08/29/14 to audit training compliance. No concerns were identified with these audits. Alarm and wander guard function audits were completed on each shift beginning 08/26/14 and ending on 08/29/14</p>	F 323	<p>If at any time you need assistance to exit the east unit please ask staff for assistance.</p> <ul style="list-style-type: none"> <li>Please notify staff if you observe anyone other than staff entering door key code.</li> </ul> <p>4.) An AD HOC PI meeting with the Administrator, Director of Nursing, and the Medical Director was held on 8/27/14.</p> <p>Beginning on the day shift of 8/27/14, Nurse Practice Educator or Licensed Nurse completed an elopement drill on each shift through 8/29/14 to audit training compliance. No concerns were identified with these audits.</p> <p>Alarm and Wander Guard function audits were completed on each shift beginning 8/26/14 and ending 8/29/14 by licensed nurses or Administrator. All door locking mechanisms and alarms were found to be working properly during these audits.</p> <p>Alarm and Wander Guard function for all doors is tested daily by the Maintenance Director or Licensed Charge Nurse (LPN or RN). Any identified concerns are reported immediately to the Administrator, Director of Nursing or Director of Maintenance.</p> <p>Licensed Staff or a Department Manager will complete an elopement drill on each shift monthly for 3</p>		

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F 323	<p>Continued From page 23</p> <p>by Licensed Nurses or the Administrator. All door locking mechanisms and alarms were found to be working properly during these audits. Alarm and wander guard function for all doors was tested daily by the Maintenance Director or the Licensed Charge Nurse.</p> <p>11. No further elopements since implementing the original PI Plan on 08/26/14. Licensed staff or a department manager will complete an elopement drill on each shift monthly for three (3) months (September, October, November 2014), then quarterly for six (6) months. Corrective action and/or re-education will be provided at point of discovery of identified audit concerns. Findings will be reviewed by the Quality Improvement Committee (QIC), the QI Committee will make recommendations for additional audits based on audit outcomes.</p> <p>12. An AD HOC PI meeting was held on 09/02/14, and on 09/05/14 with the Administrator, Medical Director and all Department Managers to review the progress of the Improvement Plan including, informational letters to 100% family members to be mindful of the alarms and seek staff assist when an alarm is sounding or residents may be trying to exit facility on 09/06/14.</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 09/18/14 at 2:10 PM, revealed a change of condition document was initiated on 08/26/14 at 5:45 PM by LPN # 1. Vital signs were obtained along with a head to toe assessment. Documentation also revealed the resident was placed on direct line</p>	F 323	<p>months (September, October, &amp; November 2014), then quarterly for six months. Corrective action and/or re-education will be provided at point of discovery of identified audit concerns.</p> <p>Findings will be reviewed by the Quality Improvement Committee; the QI committee will make recommendations for additional audits based on audit outcomes.</p> <p>An AD HOC PI meeting was held on 9/2/14, 9/5/14, and 9/10/14 with the Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Nurse Practice Educator and the Medical Director. AD HOC PI committee reviewed the progress of improvement plan including:</p> <p>Informational letter to 100% family members to be mindful of the alarms and seek staff assist when an alarm is sounding or resident may be trying to exit facility sent by Administrator on 9/6/14.</p> <p>Completion date:</p>	10/2/14	

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F 323	<p>Continued From page 24</p> <p>observation at that time. The Physician and family members were notified of the elopement on 08/26/14 at 7:00 PM and 7:10 PM by LPN #1. Interview with LPN #1, on 09/18/14 at 3:10 PM, revealed she was working the night Resident #1 was able to exit the building. LPN #1 completed a head to toe assessment on Resident #1 with no injuries noted.</p> <p>2. Interview with the Nurse Practice Educator, on 09/18/14 at 4:30 PM, revealed she updated Resident #1's care plan on 08/26/14 after re-evaluating his/her elopement assessment evaluation, and again on 08/27/14 after the Interdisciplinary Care Plan meeting.</p> <p>3. Interview with LPN #1, on 09/18/14 at 3:10 PM, revealed a Visual Validation Census Check was completed on all residents in the building on 08/26/14 at 6:35 PM. Review of the Visual Validation Census Check dated 08/26/14 confirmed this.</p> <p>4. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed she returned to the facility at 6:00 PM on 08/26/14, and started an investigation to determine how the resident was able to exit the building undetected. She stated she immediately checked all egress door alarms to make sure they were functioning properly.</p> <p>5. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed she returned to the facility at 6:00 PM on 08/26/14, and her investigation revealed a Personal Care Resident heard the alarm and immediately reset the alarm. The Administrator stated she re-educated the Personal Care Resident on the importance of not responding or resetting the door alarm on</p>	F 323			

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F 323	Continued From page 25 08/26/14 at 6:45 PM.  6. Interview with the Nurse Practice Educator, on 09/18/14 at 4:30 PM, revealed she updated Resident #1's care plan on 08/26/14 after re-evaluating his/her elopement assessment evaluation, and again on 08/27/14 after the Interdisciplinary Care Plan meeting. Further interview revealed she then reviewed all residents identified as an elopement risk and updated the assessment, care cards and care plans as indicated on 08/26/14.  7. Observation on 09/18/14 at 2:00 PM, revealed the facility relocated the coded alarm system from the East Nurses Station to the front entrance of the facility. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed the door way was monitored daily from 7:00 AM until 7:00 PM. The Administrator stated, the new system required that anyone entering the facility or exiting the facility must be buzzed in by the receptionist. The front door will automatically lock at 7:00 PM; to enter the facility you must go to the back entrance. She revealed the enunciator panels were installed on each nurses' station to alert the staff which door the resident was attempting to exit. Interview with Maintenance Director on 09/18/14 at 3:15 PM, revealed he demonstrated the alarm by opening the veranda doors and locking at the enunciator panel to verify the location of the alarm. Interview with LPN #1 on 09/18/14 at 3:10 PM, revealed she was knowledgeable of the new system that was put in place, and was able to explain the use of the enunciator panels. Interview with Activity Director on 09/18/14 at 2:59 PM, revealed she was aware of the new system changes with the door code alarm, she stated after 7:00 PM visitors could	F 323			

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F 323	<p>Continued From page 26</p> <p>enter through the service entrance and ring a door bell. She further stated they had to be let in by the staff, and they were required to verify their identity before letting them in the facility.</p> <p>8. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed all staff was re-educated on the facility's policy for elopement. The re-education included the Center's policies on elopement prevention and management; expected employee response to a door alarm; specific information regarding the doors at this facility; and, how each functioned; and, instructions that alarm codes should not be given to residents or visitors. Each employee completed a post-test to validate learning with a 100% pass rate. 100 of 110 active employees completed re-education and post testing between 08/26/14 and 08/29/14. Employees not currently available during this time frame will have or have had education/re-education completed prior to returning or beginning work including a post test. All new employees will have elopement education provided during orientation. Education was verified by viewing the inservice sign-in sheets and post test packets were reviewed on 09/18/14.</p> <p>9. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed all Personal Care Residents (18-18) were re-educated on the importance of the door alarms and not to re-set the door alarms, and to notify staff if they see another resident exiting the doors when the alarm sounds. The inservice was verified by a sign in sheet with Personal Care residents' signatures beginning 08/26/14 through 08/28/14.</p> <p>10. Interview with the MDS Coordinator on</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>09/18/14 at 3:23 PM, revealed her normal shift was 7:00 AM-4:00 PM. She stated she was inserviced on 08/26/14 by the Nurse Practice Educator on the Center's policy on elopement prevention, the new process for entering and exiting the building, importance of keeping the door code confidential. She stated she completed the post test with 100% accuracy.</p> <p>Interview with Employee #1 on 09/18/14 at 3:28 PM, revealed she also attended an inservice on 08/26/14. She stated her normal work shift was 5:30 AM-9:00 PM. She stated the inservice contained information about the facility's elopement policy and the new process for entering and exiting the building. She also completed a post test with 100% accuracy.</p> <p>Interview with Employee #2 on 09/18/14, revealed she was employed as a Medication Tech and worked from 11:00 PM- 7:00 AM. She stated she also attended the inservice on 08/26/14 related to the elopement policy and the new process for entering and exiting the facility. She knew the importance of keeping the door code confidential and the use of the new alarm system. She indicated that she took a test with 100% accuracy after the training was completed.</p> <p>Interview with Employee #3 on 09/18/14 at 3:20 PM, revealed she was employed as a Certified Nurse Aide and worked from 2:00 PM -10:00 PM. She stated the inservice on 08/26/14 talked about the new door alarm system and the facility's policy on elopement. She was able to identify which residents were currently identified at risk for wandering and the importance of keeping the door code confidential. She also took a post test after the training with 100% accuracy.</p>	F 323			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/18/2014
NAME OF PROVIDER OR SUPPLIER  EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
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F 323	<p>Continued From page 28</p> <p>Interview with Employee #4 on 09/18/14 at 3:40 PM, revealed she attended the inservice on the facility's elopement policy on 08/27/14 and also participated in an elopement drill. She indicated the training covered the re-education on the elopement policy as well as the new door alarm system.</p> <p>Interview with Employee #5 on 09/18/14 at 2:34 PM, revealed she was inserviced on 08/27/14 at 8:00 PM on the new facility policy on elopement and also participated in an elopement drill. She stated she has a good understanding of the new door alarm system and realized the importance of keeping the code confidential.</p> <p>Interview with Resident #2 on 09/18/14 at 2:33 PM, revealed that he/she was not aware of the new door alarm code. Interview with Resident #3 on 09/18/14 at 2:20 PM, revealed he/she was aware of the door alarm code prior to installing the new alarm system, but did not know the new door alarm code.</p> <p>Interview with Resident #3's family member on 09/18/14 at 2:20 PM, revealed that she was aware the facility has made changes with the alarm system, prior to the changes she was aware of the door alarm code but she did not know the new code.</p> <p>Interview with Personal Care Resident #4 on 08/18/14 at 4:09 PM, revealed the staff had taught him/her about the exit doors and staff let him/her out when he/she wanted to go out with his/her family. The resident stated he/she did not have access to the door code anymore.</p>	F 323			

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F 323	<p>Continued From page 29</p> <p>Interview with Personal Care Resident #5 on 09/18/14 at 4:12 PM, revealed he/she did not have the door code anymore, and the staff let him/her out when he/she needed to go with family. He/she continued to say that someone talked to him/her about the exit doors, and the importance of not letting anyone out the doors or turning off the alarms.</p> <p>11. Interview with the Administrator on 09/18/14 at 2:10 PM, revealed that no further elopements had occurred. Licensed staff or a department manager would complete an elopement drill on each shift monthly for three (3) months (September, October, November 2014), then quarterly for six (6) months. Interview with the MDS Coordinator on 09/18/14 at 2:20 PM, revealed there has been no further elopements, and the new system was working properly.</p> <p>12. Verification of the AD HOC PI meeting was obtained through interview on 09/18/14 at 2:10 PM with the Administrator, she revealed the facility started the Performance Improvement for the Elopement on 08/26/14 with the investigation process to assist the team with determining the root cause of the elopement. She stated they met again to include the Medical Director in the discussion on 08/27/14, and the entire team met again on 09/10/14. A copy of the notification letters mailed on 09/06/14, to all family members was reviewed during the interview on 09/18/14 at 2:10 PM. The Administrator continued to reveal that she has been in constant communication with the Medical Director through out the entire investigation either in meetings or phone conversations.</p>	F 323			