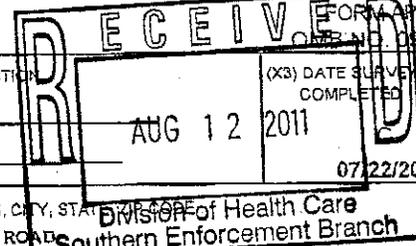


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2011  
FORM APPROVED  
DATE: 08-31-03  
ID: 0833-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/22/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE 200 GLENWAY ROAD WINCHESTER, KY 40391
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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
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F 000	<p>INITIAL COMMENTS</p> <p>***Amended-</p> <p>An abbreviated standard survey was initiated on 07/11/11, and concluded on 07/22/11.</p> <p>KY16678 and KY16687 were initiated on 07/11/11. KY16687 was unsubstantiated with no related deficiencies. KY16678 was substantiated and Immediate Jeopardy was identified on 07/14/11 and determined to exist on 07/02/11. The facility was notified on 07/14/11. A partial extended survey was conducted on 07/19-20/11.</p> <p>KY16755 and KY16762 were initiated on 07/20/11. Both complaints were substantiated with deficient practice identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225).</p> <p>KY16763 was initiated on 07/21/11, and was substantiated with deficient practice identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225).</p> <p>KY16764 and KY16766 were initiated on 07/22/11. Both complaints were substantiated with no deficient practice identified.</p> <p>Deficiencies were cited at 42 CFR 483.13 Resident Behavior and Facility Practices (F224 and F225), 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F224 and F225).</p> <p>An acceptable Allegation of Compliance was</p>	F 000	See attached POC	8/12/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Collins TITLE: Executive Director DATE: 8/12/2011

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.

Received Time Aug. 12, 2011 4:52PM No. 1324

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/22/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 000	Continued From page 1 received on 07/20/11, which alleged removal of Immediate Jeopardy on 07/21/11. The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.13 (F224 and F225), 42 CFR 483.25 (F323), and 42 CFR 483.75 (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	<i>See attached POC</i>	
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of policy and procedures, it was determined the facility failed to provide services necessary to avoid physical harm for one (1) of twenty-two (22) sampled residents (Resident #1). The facility failed to follow their policy and procedure by not identifying through their incident investigation that neglect occurred. The facility assessed Resident #1 as severely cognitively impaired as having multiple risk factors related to safety. On 07/02/11, staff assisted Resident #1 outside to smoke with peers during a supervised "smoke break." However, facility staff left the resident unsupervised outside after the smoke break was over. Resident #1 left facility grounds without the	F 224	<i>See attached POC</i>	8/12/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  1B5146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/22/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 224	<p>Continued From page 2</p> <p>facility's knowledge and without staff supervision. The facility did not become aware of the missing resident until a community member notified the facility. The facility's failure to protect the resident from neglect placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 07/02/11.</p> <p>An acceptable Allegation of Compliance was received on 07/20/11, which alleged removal of Immediate Jeopardy on 07/21/11. The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Abuse Prevention policy/procedure (revised 04/26/09), Abuse policy/procedure (revised 10/31/09), and Identification of an Event That May Constitute Abuse policy/procedure (revised 07/22/10), revealed neglect of residents was strictly prohibited. According to the policies, the facility would identify residents most at risk for neglect, such as those with dementia, and develop interventions to prevent and/or reduce occurrences including deployment of staff to meet the needs of residents, ensuring that assigned staff had knowledge of the individual resident's care needs, and ensuring staff had access to specific resident information. The policies/procedures also identified the need to assess, care plan, and monitor residents with needs and behaviors which might lead to conflict</p>	F 224	See attached POC	
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F 224	<p>Continued From page 3</p> <p>or neglect. The policies/procedures directed staff to determine the root cause of an event including any performance failures on the part of the staff to determine the direction of the investigation.</p> <p>A review of the facility's Accidents and Supervision to Prevent Accidents policy/procedure (revised 04/28/11) and Patient Supervision and Monitoring policy/procedure (revised 04/28/11) revealed the facility would provide supervision to each resident to prevent avoidable accidents, and assess residents to determine if supervision was necessary. The policies stated the facility would clearly define mechanisms and procedures which help to mitigate the risk of a resident leaving a safe area without staff supervision. The policies included center-focused and patient-directed approaches to evaluate accident risks as well as monitoring processes to ensure interventions were implemented and effective related to resident supervision, smoking, resident risks, and environmental hazards to include falls and unsafe wandering or elopement.</p> <p>A review of Resident #1's Care Area Assessment (CAA) and Comprehensive care plan both dated 06/29/11, and Minimum Data Set Assessment dated 06/29/11, revealed the facility assessed Resident #1 as severely cognitively impaired and having decreased safety awareness. Resident #1's diagnoses included Dementia, End-Stage Chronic Obstructive Pulmonary Disease, and Seizure Disorder.</p> <p>A review of the facility's investigation, interview with Licensed Practical Nurse (LPN) #1 on 07/11/11, at 5:00 PM, and interview with</p>	F 224	See attached POC	
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	
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F 224	<p>Continued From page 4</p> <p>Administrator #1 and the Director of Nursing (DON) on 07/12/11, at 3:25 PM, revealed although LPN #1 was not assigned to care for Resident #1 on 07/02/11, and was unfamiliar with the resident's care needs, the LPN opened the door and allowed Resident #1 to go outside to smoke with peers participating in a supervised smoke break supervised by CNA #27. According to Administrator #1 and the DON, CNA #27 was also unfamiliar with and unaware of Resident #1's health and safety needs. LPN #1 stated she had reservations about assisting Resident #1 outside due to not being familiar with the resident and his/her care needs, but stated she chose to do so anyway due to the Resident's repeated requests to go outside. LPN #1 stated she instructed CNA #27 to make sure Resident #1 was assisted back inside the building after the smoke break. However, according to LPN #1 and the facility's investigation, CNA #27 left Resident #1 alone outside unsupervised after the smoke break ended at approximately 4:45 PM.</p> <p>An interview conducted on 07/11/11, at 6:00 PM, with CNA #1 revealed she was outside on a personal smoke break at approximately 4:50 PM on 07/02/11, and encountered Resident #1 who asked the CNA for a cigarette. CNA #1 replied to the resident, "No, you have to wait to smoke during smoke breaks." CNA #1 voiced being unfamiliar with Resident #1, stating, "I knew [he/she] was a resident, but I had never seen [him/her] before," and stated she assumed the resident could be outside alone. CNA #1 returned inside the building also leaving Resident #1 outdoors alone and unsupervised. Based on the interview, CNA #1 made no attempt to contact staff assigned to care for Resident #1 to ensure</p>	F 224	See attached POC	

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F 224	<p>Continued From page 5</p> <p>they were aware of the resident's whereabouts or confirm that it was safe for the resident to be outside alone and unsupervised.</p> <p>An interview conducted on 07/12/11, at 12:36 PM, with CNA #3 and review of the facility's investigation revealed she had observed Resident #1 outside on 07/02/11, at approximately 5:00 PM, and asked staff at the nurses' station (unable to recall who) if Resident #1 was "OK to be outside." CNA #3 was informed that there was a staff member outside. However, none of the staff at the nurses' station or CNA #3 confirmed a staff member's presence outside with Resident #1.</p> <p>Interviews conducted on 07/12/11, with LPN #1 at 10:50 AM, and CNA #2 at 10:30 AM, and review of the facility's investigation, revealed both staff members had been assigned to provide care to Resident #1 on 07/02/11, but was not aware that Resident #1 had been outside the facility, and did not realize the resident was missing until approximately 5:15 PM, when community members began to come into/call the facility with reports of an elderly man/woman being on the highway in a wheelchair approximately three-tenths mile from the facility.</p> <p>A review of the facility's investigation revealed the findings of the investigation failed to recognize the circumstances of Resident #1's elopement as neglectful. Interviews conducted on 07/12/11, at 3:25 PM, with Administrator #1 and the DON, and on 07/13/11, at 10:15 AM, with the District Director of Clinical Operations (DDCO) revealed that, due to the facility having never assessed Resident #1 to require one to one supervision at any time, and the facility's investigation finding no</p>	F 224	See attached POC	
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F 224	<p>Continued From page 6</p> <p>evidence of "willful intent" to leave Resident #1 outside unattended, the facility "never suspected neglect and determined none had occurred." There was no evidence the facility had ensured the staff was knowledgeable regarding the facility's assessment that the resident had multiple risk factors related to safety and dementia to ensure appropriate supervision was provided for the resident to prevent potential elopement.</p> <p>Refer to F225 and F323.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>The facility revised Resident #1's comprehensive care plan on 07/02/11, and added interventions related to the resident's "risk for wandering and elopement." The interventions added to the resident's care plan included wander guard bracelet in place; 1:1 supervision; and adventure boards placed in wander/elopement book.</p> <p>The facility revised Resident #1's CNA Assignment Sheet on 07/03/11, and added the resident was at risk for elopement, required "1:1" supervision, and a Wanderguard would be utilized for the resident.</p> <p>On 07/02/11, the Staff Development Coordinator (SDC), Director of Nursing Services (DNS/DON), and Weekend Supervisor (WS) initiated education with all facility staff related to wandering, elopement, accident hazards, supervision, and policy change related to residents not going outside without staff supervision. According to the in-service, there</p>	F 224	See attached POC	
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F 224	<p>Continued From page 7</p> <p>would be one staff person to every five residents when outside. If there were six residents, there must be two staff persons. No staff person is to return inside the facility without bringing in the resident(s) or without changing out with another staff person. According to the AOC, there were no exceptions to this policy and education will be provided until all facility staff members have attended.</p> <p>On 07/03/11, the Assistant Executive Director (AED) posted signage at all facility entrance doors to notify visitors residents were not to be assisted outdoors and to check with staff for the code as it will change frequently.</p> <p>Effective 07/03/11, the Executive Director (ED)/Administrator will designate a Department Manager to monitor at least one resident smoke break on a daily basis. The designated Department Manager will monitor to ensure there is one staff person for every five residents and that any resident outside with a family member was signed out. Any concerns are to be corrected immediately. This monitoring will occur daily until deemed unnecessary by the Performance Improvement Committee (PIC) which included the ED, Assistant Executive Director (AED), DNS, Staff Development Coordinator (SDC), MD, SSD, Nutrition Services Manager (NSM), Registered Dietitian (RD), Activities Director (AD), Business Office Manager (BOM), Case Manager (CD), Reflections Program Director (RPD), and the TCUPD.</p> <p>On 07/07/11, the Activities Director (AD) educated residents on door alarms, resident safety, and the need for residents to seek staff</p>	F 224	<p><i>See attached POC</i></p>	
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F 224	<p>Continued From page 8 assistance with doors.</p> <p>Resident and family satisfaction surveys were initiated on 07/12/11, for each resident and/or responsible party. The questionnaires addressed multiple areas to include but were not limited to respect shown by staff, quality of care, adequate staffing, competency, resident safety, and security of personal belongings. The results of the survey will be sent to the ED for follow-up and resolution of any concern. The results will be reviewed in the Performance Improvement Committee (PIC).</p> <p>On 07/14/11, the State Director of Risk Management conducted education with the district Director of Operations (DO), District Director of Clinical Operations (DDCO), Executive Director, and the DNS regarding violations involving identification of neglect, including failure to answer a call light, leaving resident's unattended for long periods of time, etc.</p> <p>On 07/15/11, the SDC, Second Shift (SS) RN Nurse Supervisor, and Weekend Supervisor (WS) initiated re-education with all facility staff related to supervision and abuse/neglect. Education will be ongoing until all facility staff members have attended. No staff member was allowed to work without having been in-serviced.</p> <p>All event reports are reviewed daily by the ED and the DNS to identify any potential for neglect and/or abuse.</p> <p>Ad hoc PIC meetings were held on 07/04/11 and 07/15/11, to review the action plan.</p>	F 224	<p><i>See attached POC</i></p>	
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F 224	<p>Continued From page 9</p> <p>The PIC will meet weekly to ensure compliance and will discuss areas of concern identified through supervision and alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property. Corrective action plans will be developed/implemented for any areas of concern identified, with meetings weekly or more often as necessary.</p> <p>The surveyors validated the corrective action taken by the facility as follows:</p> <p>Record reviews conducted for Resident #1 revealed the resident's care plan was updated on 07/02/11, to include interventions for wandering and elopement. A review of the CNA assignment sheet for Resident #1 revealed the resident's assignment sheet was revised on 07/03/11, to include interventions for 1:1 staff supervision and a wander guard and to identify the resident as an elopement risk. Observations conducted for Resident #1 on 07/22/11, at 2:38 PM, revealed the resident was provided 1:1 staff supervision. Interview conducted with CNA #17 on 07/22/11, at 2:38 PM, revealed the resident was placed on 1:1 supervision due to being an elopement risk.</p> <p>A review of the attendance roster for staff in-service training related to supervision of residents outside the facility revealed staff was educated on the policy revision on 07/03-04/11, by the Staff Development Coordinator, the DON, and the Weekend Supervisor. Interviews conducted with CNAs, Nurses, and Unit Managers from 07/21/11, at 12:30 PM, to 07/22/11, at 3:30 PM, revealed staff was knowledgeable regarding supervision of residents</p>	F 224	See attached POC	

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F 224	<p>Continued From page 10 who were outside of the facility.</p> <p>Observation of the A and C Wing exit doors on 07/22/11, at 2:45 PM, revealed a sign was posted stating no resident was to be assisted outside the facility and to check with the staff as the code will change frequently.</p> <p>A review of the smoking monitoring tool revealed daily monitoring of one smoke break had been conducted from 07/03/11, and was ongoing. Observation of a smoke break on 07/22/11, at 2:35 PM, revealed one staff person with two residents smoking in the designated area. Interview with the interim DON on 07/22/11, at 3:15 PM, revealed the Department Managers were required to check the smoke breaks daily and had not identified any concerns with residents being outside unattended.</p> <p>A review of a resident council meeting conducted on 07/07/11, by the Activities Director revealed residents were in-serviced regarding codes to the door and resident safety. Interviews conducted on 07/21/11, with Resident #7 at 3:00 PM, Resident #9 at 2:00 PM, and with Resident #8 on 07/22/11, at 10:30 AM, revealed the residents had been instructed on the door codes and resident safety.</p> <p>A review of satisfaction surveys initiated on 07/12/11 and 07/20/11, for each resident/responsible party revealed no concerns that had not been addressed by the facility. Interviews on 07/21/11, with Resident #9 at 2:00 PM, Resident #7 at 3:00 PM, and Resident #30's family member at 1:15 PM, and with Resident #8 on 07/22/11, at 10:30 AM, revealed no concerns</p>	F 224	<p>See attached POC</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/22/2011
NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391	
(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 224	Continued From page 11 regarding resident care and treatment at the facility.  A review of documentation revealed the ED and the DNS were provided in-service training on 07/14/11, by the DDCO regarding neglect. Interview with the ED and the DNS on 07/22/11, at 3:00-3:15 PM, revealed they were knowledgeable of investigation requirements.  Interview with the Administrator and the DNS on 07/22/11, at 3:15 PM, revealed event reports are reviewed daily regarding accident hazards supervision. According to the Administrator and the DNS, the PIC met weekly to review all monitoring conducted for the action plan.  The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.	F 224	See attached POC	
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225	See attached POC	8/12/11

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F 225	<p>Continued From page 12</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure that violations involving mistreatment, neglect, or abuse, including injuries of unknown source for four (4) of twenty-two (22) sampled residents (Residents #1, #2, #5, and #6) were immediately reported to the administrator of the facility, or other officials in accordance with state law. Additionally, the facility failed to protect residents from further abuse allowing a perpetrator to continue working with residents. Although the</p>	F 225	<p>See attached POC</p>	
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F 225	<p>Continued From page 13</p> <p>facility conducted an investigation regarding Resident #1 leaving the facility grounds without staff knowledge, the facility failed to report the incident as an act of possible negligence to the appropriate state agencies as required. The facility failed to report allegations of abuse/injuries of unknown origin to the appropriate state agencies for Resident #5 and Resident #6 timely. Additionally, the facility failed to follow their policies and procedures when they allowed an alleged perpetrator to continue working with residents after receiving an allegation of abuse to Resident #2. Furthermore, the facility failed to notify the administrator and the state agencies timely. The facility's failure to ensure all violations were reported as required placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 07/02/11.</p> <p>An acceptable Allegation of Compliance was received on 07/20/11, which alleged removal of Immediate Jeopardy on 07/21/11. The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, and lowered the scope and severity to "D" level while the facility monitors the effectiveness of the systemic changes and conducts quality assurance activities.</p> <p>The findings include:</p> <p>1. A review of the facility's policies/procedures regarding Abuse (revised 10/31/09), Conducting an Investigation (revised 06/30/06), and Resident Elopement (revised 10/31/07) revealed all abuse/neglect investigations were to be reported to officials in accordance with state law, and the</p>	F 225	See attached POC	

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F 225	<p>Continued From page 14</p> <p>appropriate state agencies would be notified of resident elopements.</p> <p>A review of Resident #1's medical record and a facility investigation (undated completion) revealed facility staff failed to return Resident #1 inside the building after staff assisted the resident outside to smoke. The facility remained unaware of the resident's whereabouts for approximately 30 minutes until alerted by members of the community that Resident #1 was approximately three-tenths mile from the facility in a wheelchair on the highway.</p> <p>Interview with Administrator #1 and the Director of Nursing (DON) on 07/12/11, at 3:25 PM, revealed an investigation was immediately initiated into Resident #1's elopement on 07/02/11, to ensure no abuse/neglect had occurred, and CNA #27 was immediately suspended from employment at the facility pending the results of the investigation. Administrator #1 and the DON stated an investigation was initiated to rule out abuse/neglect and determined the incident should be reported to the appropriate state agencies. Administrator #1 and the DON stated prior to notifying the state agencies, Resident #1's elopement was reported to the facility's District Director of Clinical Operations (DDCO) who instructed the DON not to report the incident to the appropriate state agencies as required.</p> <p>Interview with the DDCO on 07/13/11, at 10:15 AM, revealed Resident #1's elopement on 07/02/11, was not reported to the state agency because there was "no regulation requiring elopements to be reported" and the incident "did</p>	F 225	<p>See attached POC</p>	
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F 225	<p>Continued From page 15</p> <p>not meet the intent of the (abuse/neglect) regulation." Additionally the DDCO stated at the conclusion of the investigation it was determined no abuse/neglect had occurred, and therefore the incident was not required to be reported.</p> <p>Refer to F224 and F323.</p> <p>2. Review of the medical record for Resident #5 revealed the resident was admitted to the facility on 02/27/07, with diagnoses of Paralysis Agitans, Anxiety, and Dementia. The facility assessed the resident on 06/14/11, as frequently incontinent of bowel and bladder. Review of Resident #5's care plan dated 06/20/11, determined that one staff person was to toilet/prompt Resident #5 with voiding every two hours. Record review also revealed that on 07/15/11, at 6:00 PM, CNA #10 transported Resident #5 to the dining room with wet clothing and refused to toilet the resident.</p> <p>An interview conducted with CNA #18 on 07/22/11, at 10:20 AM, revealed on 07/15/11, during the evening meal CNA #10 had transported Resident #5 to the dining room and had returned to the unit to transport another resident to the dining room. When CNA #10 returned to the dining room CNA #18 asked CNA #10 to assist Resident #5 to the Bathroom and the CNA refused, stating that the resident had just been toileted and had sat on the commode for thirty (30) minutes. Another CNA offered to toilet the resident and according to CNA #18 this incident was reported to LPN #9.</p> <p>An interview conducted with LPN #9 on 07/21/11, at 3:05 PM revealed the above incident was reported to LPN #9 on 07/15/11. LPN #9</p>	F 225	<p><i>See attached POC</i></p>	
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F 225	<p>Continued From page 16</p> <p>Instructed CNA #10 to toilet the resident and observed that the resident's pants were wet. LPN #9 then instructed the CNA to change the resident's clothing. According to the LPN the incident was reported to the facility social worker and the CNA was escorted to the time clock and was suspended from employment at the facility.</p> <p>An interview conducted with CNA #10 on 07/21/11, at 4:25 PM, revealed the CNA had taken Resident #5 to the dining room on 07/15/11, for the evening meal and was transporting another resident to the dining room when another CNA instructed CNA #10 to toilet Resident #5. According to CNA #10 the resident was toileted before going to the dining room and didn't use the bathroom. Further interview revealed that CNA #10 toileted Resident #5 after being told to do so by the supervisor.</p> <p>Interview with the facility Social Worker on 07/22/11, at 10:30 AM, revealed that LPN #9 reported CNA #10 for leaving Resident #5 in wet clothing after toileting the resident on 07/15/11, during the evening meal service. According to the Social Worker, the Administrator was contacted immediately and the CNA's employment at the facility was suspended. The Office of Inspector General was notified of the incident on 07/15/11, but the Social Worker was not aware of any notification to Adult Protective Services.</p> <p>A review of the facility investigation for the 07/15/11 incident regarding Resident #5 revealed no evidence Adult Protective Services was notified as required.</p>	F 225	<p><i>See attached POC</i></p>	
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F 225	<p>Continued From page 17</p> <p>An interview conducted with the Facility Administrator on 07/22/11, at 11:00 AM, revealed the Administrator was not aware that Adult Protective Services had not been notified of the 07/15/11 incident involving Resident #5.</p> <p>3. Resident #2 was an 87-year-old resident admitted to the facility on 04/13/08, with diagnoses of Alzheimer's disease and Depressive Disorder.</p> <p>A review of an initial report of an allegation of verbal abuse regarding Resident #2 revealed the allegation was forwarded to the required state agencies by the Facility Administrator on 07/20/11, at 5:40 PM. According to the initial report, CNA #11 was allegedly heard to tell Resident #2 to shut up (no date of incident noted).</p> <p>Interview with CNA #13 on 07/21/11, at 3:30 PM, revealed CNA #13 overheard CNA #11 tell Resident #2 to shut up on 07/19/11, at about 10:00 PM. CNA #13 stated this incident was reported to the Unit Supervisor (LPN #10).</p> <p>Interview with CNA #11 on 07/21/11, at 4:55 PM, revealed CNA #11 had provided care to Resident #2 but denied telling the resident to shut up. CNA #11 stated the CNA was not suspended from employment at the facility regarding this incident until 5:45 PM on 07/20/11.</p> <p>An interview conducted with LPN #10 on 07/21/11, at 4:05 PM, revealed the LPN reported the incident to the evening shift supervisor after LPN #10 became aware of the allegation.</p>	F 225	See attached POC	

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F 225	<p>Continued From page 18</p> <p>An interview conducted with the evening shift supervisor (RN #4) on 07/21/11, at 5:35 PM, revealed RN #4 started interviewing staff regarding the incident after the incident was reported to RN #4 on 07/19/11. RN #4 stated the Administrator was not immediately notified of the allegation and CNA #11 was not immediately suspended. RN #4 stated she left a note for the DON and the Administrator to inform them of the incident.</p> <p>An interview with the Administrator on 07/22/11, at 11:00 AM, revealed the Administrator was not made aware of the allegation of alleged abuse until 07/20/11, and was not aware that CNA #11 was not immediately suspended from employment after the incident was reported on 07/19/11.</p> <p>4. A review of Resident #6's medical record revealed the resident was admitted to the facility on 08/13/03, with diagnoses that included Stroke with hemiparesis, Contractures, Alzheimer's Disease, Diabetes, Osteoporosis, and Hypertension. Review of the nurse's notes and physician's orders for Resident #6 dated 07/16/11, at 10:30 PM, revealed the resident's family reported the resident had a yellow bruise and swelling to the resident's left hip extending to the left knee. The physician was notified and orders were received for an x-ray to be conducted of the resident's left hip on 07/17/11. The left hip x-ray was obtained with negative results on 07/17/11. Resident #6 continued to have bruising and edema to the left thigh and physician's orders were obtained on 07/20/11, to send Resident #6 for a CT scan of the left hip and thigh. Resident #6 was admitted to the hospital for a fractured left</p>	F 225	<p><i>See attached POC</i></p>	
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F 225	<p>Continued From page 19 hip on 07/20/11.</p> <p>Review of the facility investigation revealed an injury of unknown origin was identified for Resident #6 on 7/17/11; however, the appropriate state agencies were not notified of the injury of unknown origin until 07/20/11.</p> <p>Interviews with RN #3, LPN #8, SRNA #21, and SRNA #22 on 07/21/11, at 3:15 PM, 4:10 PM, 5:10 PM, and 5:20 PM, revealed Resident #6 had a bruise to the left hip identified by a family member on 7/16/11, at 10:30 PM. The staff was not aware of the cause of the injury. All staff was aware of the requirement to immediately report an incident of unknown origin to their supervisors. RN #3 reported the injury of unknown origin to the Director of Nursing on 07/17/11; however, the incident was not reported to the appropriate state agencies until 07/20/11.</p> <p>An interview with the Administrator on 07/22/11, at 11:00 AM, revealed the appropriate state agencies were not notified of the injury of unknown origin for Resident #6 until 07/20/11.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>On 07/14/11, the State Director of Risk Management conducted education with the district Director of Operations (DO), District Director of Clinical Operations (DDCO), Executive Director (ED)/Administrator, and the Director of Nursing Services (DNS/DON) regarding regulation F225 related to the immediate reporting of alleged violations involving mistreatment, neglect, or abuse, including injuries</p>	F 225	<p>See attached POC</p>	
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F 225	<p>Continued From page 20 of unknown source and misappropriation of resident property.</p> <p>On 07/04/11, the DO and DDCO conducted education with the ED and DNS on conducting an investigation.</p> <p>Resident and family interviews are required to be conducted for all residents every four months, which ask specific direct questions related to resident treatment and abuse. All allegations of abuse, neglect, or mistreatment are required to be immediately reported to the ED and DNS to ensure residents are protected from further potential abuse/neglect/mistreatment.</p> <p>All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to ensure appropriate reporting for neglect and/or abuse.</p> <p>The ED and DNS will review all grievance forms and interviews weekly to identify any alleged violations. The ED will also ensure appropriate reporting and implementation of the credible allegation of compliance.</p> <p>The DDCO will review three grievance forms or interviews weekly to identify any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. In addition, the DDCO will have oversight of the ED and DNS in the facility on a weekly basis to validate the implementation of the Credible Allegation of Compliance through review of audit and monitoring tools. The DDCO will also review all resident events with the DNS on a weekly basis to identify any potential</p>	F 225	See attached POC	

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F 225	<p>Continued From page 21</p> <p>accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.</p> <p>The ad hoc Performance Improvement Committee (PIC) will meet weekly to ensure alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are reported. Corrective action plans will be developed/implemented for any areas of concern identified, with meetings weekly or more often as necessary.</p> <p>Ad hoc PIC meetings were held on 07/04/11 and 07/15/11, to review the facility's action plan.</p> <p>The surveyors validated the corrective action taken by the facility as follows:</p> <p>A review of documentation revealed the ED, DNS, and DDCO were provided with in-service training on 07/14/11, regarding reporting requirements by the State Risk Management Director. Interviews with the DDCO, DNS, and ED, on 07/22/11, from 2:00 PM - 3:30 PM, revealed they were knowledgeable of reporting requirements related to mistreatment, abuse neglect, and injuries of unknown source and misappropriation of resident property.</p> <p>A review of documentation revealed the ED and the DNS were provided with in-service training regarding conducting facility investigations on 07/14/11, by the DDCO. Interview with the ED and the DNS on 07/22/11, at 3:00-3:15 PM revealed they were knowledgeable of investigation requirements.</p>	F 225	See attached POC	

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F 225	<p>Continued From page 22</p> <p>A review of satisfaction surveys initiated on 07/12/11 and 07/20/11, for residents/responsible parties revealed no concerns that had not been addressed by the facility. Interviews on 07/21/11, with Resident #9 at 2:00 PM, Resident #7 at 3:00 PM, and Resident #30's family member at 1:15 PM, and with Resident #8 on 07/22/11, at 10:30 AM, revealed no concerns regarding resident care and treatment at the facility.</p> <p>Interview with the Administrator and the DNS on 07/22/11, at 3:15 PM, revealed event reports were reviewed daily regarding abuse/neglect to ensure appropriate reporting.</p> <p>An interview with the DNS on 07/22/11, at 3:00 PM, revealed the DNS reviewed all grievance forms and interview forms weekly for validation of alleged violations involving mistreatment, neglect/abuse, injuries of unknown source and misappropriation to ensure appropriate reporting.</p> <p>An interview with the DDCO on 07/22/11, at 2:00 PM, revealed resident/family interviews and grievance forms were reviewed weekly for identification of any alleged violations involving mistreatment, neglect, or abuse to ensure reporting as required.</p> <p>Further interview with the Administrator and DNS on 07/22/11, at 3:15 PM, revealed the PIC met weekly to review all monitoring that had been conducted for the action plan. According to the Administrator, the monitoring of this information was conducted to ensure appropriate reporting and implementation of the AOC.</p>	F 225	<p><i>See attached POC</i></p>	
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F 225	Continued From page 23 The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, and lowered the scope and severity to "D" level while the facility monitors the effectiveness of the systemic changes and conducts quality assurance activities.	F 225	See attached POC	
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 facility policies, it was determined the facility failed to ensure residents received adequate supervision to prevent accidents for two (2) of twenty-two (22) sampled residents (Residents #1 and #4). On 07/02/11, Resident #1, who the facility assessed as having Dementia and multiple safety risks, left facility grounds without facility staff's knowledge or supervision. The resident was found approximately three-tenths mile from the facility on the highway in a wheelchair. The facility failed to provide supervision as specified in their smoking policy to Resident #4 while smoking on 07/10/11. This failure prevented the facility from ensuring safety to its residents. Resident #4 was outdoors smoking unsupervised, and assisted an intoxicated drug-seeking individual to enter the	F 323	See attached POC	8/12/11

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F 323	<p>Continued From page 24</p> <p>facility without staff knowledge. These facility failures placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 07/02/11.</p> <p>An acceptable Allegation of Compliance was received on 07/20/11, which alleged removal of Immediate Jeopardy on 07/21/11. The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Accidents and Supervision to Prevent Accidents policy/procedure (revised 04/28/11), Patient Supervision and Monitoring policy/procedure (revised 04/28/11), and Smoking policy/procedure (revised 04/28/11) revealed the facility would provide supervision to each resident to prevent avoidable accidents, and assess residents to determine if supervision was necessary. The policies stated the facility would clearly define mechanisms and procedures which help to mitigate the risk of a resident leaving a safe area without staff supervision. The policies included center-focused and patient-directed approaches to evaluate accident risks as well as monitoring processes to ensure interventions were implemented and effective related to resident supervision, smoking, resident risks, and environmental hazards to include falls and unsafe wandering or elopement. The policies directed that residents would be provided supervision</p>	F 323	<p><i>See attached POC</i></p>	
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F 323	<p>Continued From page 25</p> <p>when smoking outdoors after sunset and before sunrise, and when the resident presented with conditions that placed themselves or others at risk for harm.</p> <p>1. Resident #1 was admitted to the facility on 03/30/11, with diagnoses including Dementia, Status Post Cerebrovascular Accident, end-stage Chronic Obstructive Pulmonary Disease, Seizure Disorder, and Advanced Debility. A review of Resident #1's Care Area Assessment (CAA) dated 04/12/11, and Minimum Data Set (MDS) assessment dated 06/29/11, revealed the facility assessed Resident #1 as severely cognitively impaired, only able to make simple wishes known, only able to sometimes understand, and to utilize a wheelchair for all mobility. Resident #1's Comprehensive Care Plan, dated 06/29/11, indicated the resident had decreased safety awareness, displayed crying and tearfulness, had repetitive questions/verbalizations, and voiced anxious complaints/concerns. The intervention listed on the Care Plan was to have staff assess Resident #1 for suicidal tendencies as indicated. In addition, the facility assessed Resident #1 to be at increased risk for falls, and staff was to observe the resident for attempts to self-transfer and provide the resident with increased and close supervision.</p> <p>Although the facility's comprehensive assessments identified numerous supervision and safety risk factors for Resident #1, a review of a Wander/Elopement Risk Evaluation completed on 04/03/11, for Resident #1 indicated the resident displayed no risk factors for elopement, which included assessing the resident to have no cognitive impairment or impaired</p>	F 323	See attached POC	
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F 323	<p>Continued From page 26</p> <p>decision-making skills that decreased his/her awareness of safety. The evaluation also indicated the resident expressed no desire to leave the facility. However, a review of the facility's investigation (undated completion) and interviews with LPN #1 on 07/11/11, at 5:00 PM, and 07/13/11, at 9:25 AM, on 07/12/11, at 10:30 AM, with CNA #2, and on 07/12/11, at 12:36 PM, with CNA #3 revealed Resident #1 had displayed behaviors of sitting by the C Wing exit doors frequently requesting to go out, attempting to go out when others would go in or out the doors, and at times push on the doors in an attempt to open them.</p> <p>The facility's investigation, interview with the Administrator and DON on 07/12/11, at 3:25 PM, and interview with LPN #1 on 07/11/11, at 5:00 PM, revealed LPN #1 was not assigned to care for Resident #1 on 07/2/11, but opened the door and assisted the resident outside to smoke while other residents were already outside smoking during a scheduled smoke break supervised by CNA #27. LPN #1 voiced being "concerned" about Resident #1 going outside to smoke due to being unfamiliar with Resident #1's needs. LPN #1 specifically recalled instructing CNA #27 to make sure Resident #1 was returned inside the building after smoking. However, CNA #27 reportedly failed to hear the nurse's instruction, and returned inside the building at approximately 4:45 PM, leaving Resident #1 outside unsupervised.</p> <p>The facility's investigation and interview with LPN #2 on 07/11/11, at 5:20 PM, revealed the facility failed to identify that Resident #1 had left facility property, and was unaware of the resident's</p>	F 323	<p><i>See attached POC</i></p>	
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F 323	<p>Continued From page 27</p> <p>whereabouts for approximately 30 minutes. LPN #2 stated that at approximately 5:15 PM, the facility began to receive numerous notifications from the community regarding an elderly individual "rolling down the highway" in a wheelchair. Interviews conducted with Police Officer #1 on 07/13/11, at 6:00 PM, and Police Officer #2 on 07/13/11, at 7:05 PM, detailed how at approximately 5:20 PM, the facility staff and Police located Resident #1 at approximately the same time, three-tenths mile from the facility on the highway in a wheelchair. Both Police Officers #1 and #2 described Resident #1's situation as "very dangerous" considering the facility's driveway was "downhill" and the resident "making it all the way" to the main highway. Police Officer #1 recounted having to escort Resident #1 back to the facility in a police cruiser due to the resident's refusal to cooperate with facility staff. Review of a Police Department Dispatching Report dated 07/02/11, revealed Resident #1 was returned to the facility at 5:30 PM on 07/02/11.</p> <p>Interview with Resident #1 on 07/11/11, at 4:15 PM, revealed the resident to be alert but unable to consistently answer questions appropriately. When questioned about the incident Resident #1 stated, "Honey, I wanted to go to [home town]," and indicated he/she had been "walking home." Resident #1 also voiced having made previous attempts to leave the facility "four or times." Resident #1 voiced a continued desire to leave the facility and return home firmly expressing, "No one is going to stop me."</p> <p>2. A review of Resident #4's medical revealed on 06/24/11, the facility assessed the resident as</p>	F 323	See attached POC	
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F 323	<p>Continued From page 28</p> <p>having no cognitive impairment. A review of the resident's smoking evaluation dated 07/06/11, revealed the resident was an "Independent Smoker." According to the evaluation, "Independent Smoker" meant the resident could smoke in designated smoking areas, must follow the facility's smoking policy, may not carry his/her own smoking materials, and smoking outdoors after sunset and before sunrise must be supervised by a staff member (within line of sight). However, a review of Resident #4's care plan dated 04/06/11, revealed the resident required staff to be in attendance during smoking and to provide supervision at all times.</p> <p>An interview on 07/13/11, at 4:05 PM, with Resident #4 confirmed he/she was outside, unsupervised, smoking when a male approached the facility. According to Resident #4, staff was aware the resident was outside. The resident stated he/she often smoked outside unsupervised late at night. The resident stated he/she would hide cigarettes and lighters or would obtain lighted cigarettes from the ash tray after staff had discarded the cigarette. Resident #4 explained the male that approached the facility asked if nurses were present in the building and when Resident #4 acknowledged there were, the male stated, "I need to see the head nurse." Resident #4 stated, "I told him to push the red button and go in; I thought he was a visitor or something, I didn't know he was a drug addict."</p> <p>LPN #7 confirmed in interview on 07/13/11, at 3:50 PM, that on 07/10/11, at approximately 12:30 AM, the LPN returned from the bathroom and found a man at the medication cart who stated that he was an addict and needed drugs.</p>	F 323	See attached POC	
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F 323	<p>Continued From page 29</p> <p>LPN #7 told the male there were no drugs in the facility and suggested he go to the hospital. LPN #7 voiced being "terrified" and called the police after the male had exited the building. LPN #7 discovered after the male had exited the building that Resident #4 had been outside smoking unsupervised, and had instructed the male on how to enter the building through C Wing doors without staff knowledge.</p> <p>Interview with a Police Department Dispatcher on 07/13/11, at 2:45 PM, and review of a Police Department Dispatching Report dated 07/10/11, revealed on 07/10/11, at 12:33 AM, the Police Department received a call from LPN #7, who the dispatcher described as "very upset" because she had discovered a "strange man" in the facility standing at her medication cart requesting drugs. The dispatcher stated LPN #7 voiced the male had exited the building but had "no idea how he got in" the facility. Interview with Police Officer #3, who was dispatched to the facility, revealed the male was found walking near the facility and arrested for alcohol intoxication on 07/10/11, at 12:41 AM. Police Officer #3 stated the male was "obviously" intoxicated. Further interview with the Dispatcher revealed the LPN was contacted at 12:45 AM, and notified the male was no longer a threat to the facility. At that time the Dispatcher questioned LPN #7 as to how the male was able to gain entrance into the facility, and LPN #7 reportedly told the Dispatcher that a resident was outside smoking unsupervised when the male approached the facility and the resident instructed the male on how to enter the building.</p> <p>Interview with the DON on 07/13/11, at 5:00 PM, revealed he was notified on 07/10/11, of the</p>	F 323	<p><i>See attached POC</i></p>	
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F 323	<p>Continued From page 30</p> <p>incident, but had not initiated an investigation as to why Resident #4 was smoking outside unsupervised or as to how the male had gained access into the facility. The DON stated that he did not feel any residents had been in danger, and no further action was taken.</p> <p>While the facility had developed a care plan that required that staff supervision be provided at all times for Resident #4 while smoking, the facility failed to ensure the supervision was provided and failed to ensure the smoking policy was implemented by staff.</p> <p>An interview was conducted on 07/19/11, at 11:05 AM, with the District Director (DO), District Director of Clinical Operations (DDCO), and the newly appointed Administrator (Administrator #2). During the interview, the DDCO insisted there was "no reason for anyone to question" how the male had entered the building on 07/10/11, at approximately 12:30 AM. The DDCO stated the facility was "not a prison" and anyone could come and go in the facility at any time, day or night. The DDCO stated that A Wing doors and C Wing doors were unlocked at all times, and the only requirement for entering the building would be to "push the big red button (adjacent to the doors) which anyone could see and figure it out." The facility failed to identify an intoxicated drug-seeking male entering the facility at approximately 12:30 AM on 07/10/2011, as a situation which placed facility residents in danger. Additionally, the facility took no action to ensure resident safety by continuing to allow unlimited, unsupervised access into the facility at all times, day or night. While the facility had developed a care plan that required staff supervision be</p>	F 323	<p><i>See attached POC</i></p>	
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F 323	<p>Continued From page 31</p> <p>provided at all times for Resident #4 while smoking, the facility failed to ensure the supervision was provided and failed to ensure the smoking policy was implemented by staff.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>On 07/02/11, a Licensed Practical Nurse (LPN) conducted a head to toe assessment of Resident #1 and no injuries were identified.</p> <p>On 07/02/11, Resident #1's comprehensive care plan was revised to include risk for wandering and elopement with interventions including a Wanderguard bracelet, 1:1 supervision; and being placed in the wander/elopement book. On 07/03/11, the Certified Nursing Assistant (CNA) Assignment Sheet was revised for Resident #1 to include risk for elopement, 1:1 supervision, and the implementation of a Wanderguard bracelet.</p> <p>On 07/02/11, the Medical Records Director (MRD) conducted an audit of all facility residents to validate that all assessments and care plans were current.</p> <p>On 07/03-04/11, the Director of Nursing Services (DNS), the Staff Development Coordinator (SDC), the Transitional Care Unit Program Director (TCUPD), Minimum Data Set Coordinator (MDSC), and Unit Managers (UMs) completed a wander/elopement risk evaluation and a safety risk assessment for all in-house patients. A smoking evaluation was conducted for all residents identified who smoke. Care plans were reviewed to ensure that all areas related to accident hazards/resident safety were</p>	F 323	See attached POC	
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F 323	<p>Continued From page 32 care planned with appropriate interventions.</p> <p>On 07/03-04/11, the Reflections Program Director (RPD) conducted interviews of staff to determine if any resident had exhibited exit-seeking behaviors within the past 30 days, and if so, that all appropriate steps were implemented.</p> <p>On 07/03/11, a policy change was made and implemented to ensure that all residents who wished to go outside were accompanied by staff and that no resident was outside unattended.</p> <p>On 07/05/11 and 07/08/11, assessments were conducted on residents who requested to go outside. On 07/14/11, residents who requested to go outside were re-assessed and a policy change was made. The change was to assess residents upon their request to determine their ability to go outside independently without staff supervision. The resident must be assessed and must meet the assessment criteria prior to being allowed to go outside unsupervised. In addition, no resident is allowed to be outside between the hours of 11:00 PM and 6:00 AM without supervision, regardless of assessment status.</p> <p>On 07/02/11, the SDC, DNS, and Weekend Supervisor (WS) initiated education with all facility staff related to wandering, elopement, accident hazards, supervision, and policy change related to residents going outside without staff supervision, as no resident was to be outside without staff supervision. Education will be ongoing until all facility staff members have attended. On 07/15/11, this in-service was repeated with staff to include a policy change related to residents going outside without staff</p>	F 323	See attached POC	

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F 323	<p>Continued From page 33</p> <p>supervision, based on their individual resident assessment. Education will be ongoing until all facility staff members have attended.</p> <p>On 07/07/11, the Activities Director (AD) educated residents on door alarms, resident safety, and the need for residents to seek staff assistance with doors.</p> <p>On 07/02/11, the Maintenance Assistant (MA) audited all facility doors and Wanderguard bracelets to validate proper functioning.</p> <p>On 07/03/11, the MA changed the code for the door system and the Assistant Executive Director (AED) posted signage at all facility entrance doors to notify visitors that no resident was to be assisted outside the facility and to check with staff for the code, as it will change frequently.</p> <p>After 9:00 PM, all facility entrance doors have been and continue to be on a timed lock, except for A Wing and C Wing doors to allow staff and emergency entrance. Effective 07/20/11, the A Wing and C Wing outside entrance button will be disabled between 9:00 PM and 6:00 AM daily, until these entrance doors can be engineered with a timed lock during these hours. A doorbell has been installed at the entrance to A Wing and C Wing to be utilized by visitors and emergency personnel. The Maintenance Director (MD) initiated education with all facility staff on 07/20/11, related to the change in the door system.</p> <p>The Executive Director (ED)/Administrator will also validate through the weekly PIC meeting by review of the smoke time supervision audits,</p>	F 323	See attached POC	
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F 323	<p>Continued From page 34</p> <p>review of the wander/elopement audits, review of any environmental rounds, and implementation of the credible allegation.</p> <p>All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to identify any potential accident hazard related to environment and supervision.</p> <p>The District Director of Clinical Operations (DDCO) also reviews all resident events with the DNS on a weekly basis to identify any potential accident hazard related to environment and supervision.</p> <p>Effective 07/03/11, at least one resident smoke time is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times there is one staff person to five residents, that other outside areas have no unattended residents, that any resident outside with a family member is signed out, and to identify any outside accident hazards. Any concerns were corrected immediately. This monitoring will occur daily until deemed unnecessary by the Performance Improvement Committee (PIC).</p> <p>Effective 07/03/11, the DNS or the SDC, or designee will conduct one wander elopement drill per month (alternating shifts) until deemed unnecessary by the PIC.</p> <p>The PIC will meet weekly or more often as necessary until the facility has demonstrated sustained compliance of the corrective actions described in the AOC. Members of the PIC include, but are not limited to, the ED, AED, DNS,</p>	F 323	See attached POC	
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F 323	<p>Continued From page 35</p> <p>SDC, MD, SSD, Nutrition Services Manager (NSM), Registered Dietitian (RD), AD, BOM, Case Manger (CM), RPD, and the TCUPD.</p> <p>Ad hoc PIC meetings were held on 07/04/11 and 07/15/11, to review the implemented corrective action.</p> <p>The surveyors validated the corrective action taken by the facility as follows:</p> <p>A review of the progress notes revealed a head to toe assessment was conducted for Resident #1 on 07/02/11, at 5:45 PM, with no injuries noted to the resident.</p> <p>A review of Resident #1's medical record revealed the resident's care plan was updated on 07/02/11, to include interventions for wandering and elopement. Observations conducted for Resident #1 on 07/22/11, at 2:38 PM, revealed the resident was being provided one to one supervision. An interview conducted with CNA #17 on 07/22/11, at 2:38 PM, revealed the resident was receiving one to one supervision due to being an elopement risk.</p> <p>A review of Resident #1's assignment sheet revealed interventions were implemented on 07/03/11, for one to one supervision and implementation of a Wanderguard bracelet. Interview conducted with CNA #17 on 07/22/11, at 2:38 PM, revealed the CNA was aware of the level of supervision and elopement risk for Resident #1.</p> <p>A review of the Wander/Elopement Risk Evaluations and Safety Risk assessment tools</p>	F 323	See attached POC	
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F 323	<p>Continued From page 36</p> <p>revealed a form had been completed for each resident on 07/03/11 and 07/04/11. Each resident who smoked had a smoking evaluation form completed and an updated care plan with interventions for smoking safety. An interview with the DDCO and the Administrator on 07/22/11, at 1:10 PM, revealed Wander/Elopement and Safety Risk Assessments had been completed on all residents. In addition, the DDCO and Administrator stated smoking evaluations had been completed on residents who smoked and the residents' care plans were updated.</p> <p>A review of staff interviews conducted by the facility revealed staff was interviewed regarding exit-seeking behaviors displayed by residents.</p> <p>A review of the facility policy dated 07/02/11, revealed the policy had been revised to reflect no resident was to be outside without family/staff supervision. Further review revealed staff was educated on the policy revision on 07/03-04/11. Review of attendance rosters revealed an in-service was initiated on 07/15/11, regarding policy changes related to residents going outside without supervision based on individual resident assessments. All working staff members were in-serviced and education was ongoing for employees who were off work. Staff was not allowed to work without first being in-serviced. Interviews conducted with CNAs, nurses, and Unit Managers on 07/21/11, at 12:30 PM, to 07/22/11, at 3:30 PM, revealed staff was knowledgeable regarding residents going outside without supervision.</p> <p>A review of Resident Outside/Outdoors Facility</p>	F 323	See attached POC	
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F 323

Continued From page 37

Assessments dated 07/05/11, 07/08/11, and 07/14/11, revealed assessments were completed for all residents who express a desire to go outside. A review of the record for Resident #4 revealed a resident outside/outdoors assessment was completed on 07/14/11, and the resident was assessed to be outdoors independently. Observations conducted on 07/22/11, at 2:39 PM, revealed Resident #4 was outside the facility waiting for transportation for a shopping trip with facility staff.

A review of the attendance roster for in-service related to wandering/elopement, accident hazards, and supervision regarding residents being outside without staff supervision revealed staff was educated on the policy revision on 07/03-04/11, by the Staff Development Coordinator, the DON, and the Weekend Supervisor. Further review of interviews conducted with CNAs, nurses, and Unit Managers from 07/21/11, at 12:30 PM, to 07/22/11, at 3:30 PM, revealed staff was knowledgeable of the policy regarding wandering/elopement, accident hazards, and the supervision of residents outside of the facility.

A review of a resident council meeting conducted on 07/07/11, by the Activities Director revealed residents were in-serviced regarding codes to the door and resident safety. Interviews conducted on 07/21/11, with Resident #7 at 3:00 PM, Resident #9 at 2:00 PM, and with Resident #8 on 07/22/11, at 10:30 AM, revealed the residents had been instructed on the door codes and resident safety.

A review of the wandering resident alarm/lock

F 323

*See attached POC*

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F 323	<p>Continued From page 38</p> <p>system audit completed on 07/02/11, revealed facility staff checked the doors/Wanderguard system for proper functioning.</p> <p>On 07/22/11, at 2:45 PM, an environmental tour with the Maintenance Director revealed all doors were secure and functioning properly. Observation of the exit doors on the A and C Wings revealed a sign was posted stating no resident was to be assisted outside the facility and to check with the staff as the code will change frequently. A Wanderguard bracelet was checked on the D Wing at the exit door and was observed to be functioning properly. Interview with the Maintenance Director on 07/22/11, at 2:30 PM, revealed the door codes were changed frequently to ensure resident safety. Further interview with the Maintenance Director revealed the A and C Wing doors are disabled between the hours of 9:00 PM and 6:00 AM daily.</p> <p>A doorbell was installed at the A and C Wing doors to alert staff when visitors and emergency personnel need to enter during those hours. An observation of the A and C Wing doors on 07/22/11, at 3:30 PM, revealed the doors were equipped with a lock system and a doorbell was on the outside of A and C Wing doors.</p> <p>A review of an in-service attendance roster dated 07/20/11, revealed staff had attended an in-service regarding policy change of A and C Wing doors being locked between 9:00 PM and 6:00 AM.</p> <p>Interview with the Administrator on 07/22/11, at 3:15 PM, revealed the PIC met weekly to review all monitoring that is conducted for the action</p>	F 323	See attached POC	
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F 323	<p>Continued From page 39</p> <p>plan. Further interview revealed the Administrator was responsible for monitoring accident hazards, resident supervision, and assistive devices to prevent accidents, environmental audits for smoke time monitoring, and wander/elopement drills/audits to ensure implementation of the AOC.</p> <p>Interview with the Administrator and the DNS, on 07/22/11, at 3:15 PM, revealed event reports are reviewed daily regarding accident hazards supervision.</p> <p>An interview with the DDCO on 07/22/11, at 2:00 PM, revealed she reviews event reports weekly.</p> <p>A review of the smoking monitoring tool revealed daily monitoring of one smoke break had been conducted on 07/03/11, and was ongoing. Observation of a smoke break on 07/22/11, at 2:35 PM, revealed one staff person with two residents smoking in the designated area. Interview with the interim DON on 07/22/11, at 3:15 PM, revealed the Department Managers were required to check the smoke breaks daily and had not identified any concerns with residents being outside unattended.</p> <p>A review of documentation revealed a wander elopement drill was conducted on 07/06/11.</p> <p>Interview with the Administrator and the DNS on 07/22/11, at 3:15 PM, revealed the PIC met weekly to review all monitoring conducted for the action plan. A review of ad hoc attendance rosters revealed meetings were conducted on 07/07/11, 07/20/11, and 07/21/11. A review of Performance Improvement (PI) Meeting</p>	F 323	See attached POC

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F 323 Continued From page 40  
Attendance and Agendas revealed PI meetings were conducted on 07/07/11 and 07/15/11.  
  
The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.

F 323

*See attached POC*

F 490 SS-J 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, it was determined the Administrator failed to effectively administer the facility in a manner that promoted the highest physical wellbeing of each resident. The facility's administration failed to have an effective system in place to ensure policies/procedures were implemented. The facility's Administrator failed to identify, through their investigation, that neglect occurred, failed to protect residents from abuse, and failed to report allegations of abuse to the appropriate state agencies. The facility's Administration failed to ensure residents received adequate supervision to prevent accidents, and failed to provide an environment as free from accident hazards as possible.

F 490

*See attached POC*

*8/12/11*

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F 490	<p>Continued From page 41</p> <p>On 07/02/11, Resident #1, a cognitively impaired resident, eloped from the facility. The facility failed to recognize the resident was missing from the facility until alerted by community members that the resident was on the highway in a wheelchair. Although facility Administration initiated an investigation to ensure the elopement was not the result of abuse and neglect, the facility failed to report the elopement as a possible negligent act in accordance with state law as required. The facility's Administration also failed to ensure Resident #4 abided by the facility's smoking policy, and failed to ensure the environment inside the facility remained as safe for residents as was possible. Resident #4 was outside unsupervised at approximately 12:30 AM on 07/10/11. The staff failed to recognize Resident #4 was smoking unattended, and Resident #4 assisted an intoxicated drug-seeking individual into the facility without staff knowledge.</p> <p>These facility failures placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care were determined to exist on 07/02/11.</p> <p>An acceptable Allegation of Compliance was received on 07/20/11, which alleged removal of Immediate Jeopardy on 07/21/11. The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>A review of the facility's Accidents and</p>	F 490	See attached POC	

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Supervision to Prevent Accidents policy/procedure (revised 04/28/11), Patient Supervision and Monitoring policy/procedure (revised 04/28/11), Resident Elopement policy/procedure (revised 10/31/07), and Smoking policy/procedure (revised 04/28/11) revealed the facility would provide supervision to each resident to prevent avoidable accidents, and provide an environment that was free of accident hazards over which the facility had control. The policies/procedures directed staff to determine the root cause of an event including any performance failures which could indicate neglect on the part of the staff to determine the direction of the investigation. The policies/procedures also detailed how all abuse/neglect investigations would be reported to officials in accordance with state law, and the appropriate state agencies would be notified of resident elopements. The policies/procedures also indicated smoking outdoors after sunset and before sunrise would be supervised.

On 07/02/11, Resident #1, who the facility assessed as having Dementia and multiple safety risks, left facility grounds without facility staff's knowledge and without staff supervision. The resident was found approximately three-tenths mile from the facility on the highway in a wheelchair.

Administration initiated an investigation into Resident #1's elopement in an effort to determine if abuse/neglect had occurred; however, the facility failed to recognize multiple failures of staff to be aware of Resident #1's safety needs, and failures to take action when Resident #1 was observed to be in a situation that was likely to

F 490

*See attached POC*

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F 490	<p>Continued From page 43 cause harm to the resident.</p> <p>Interview on 07/13/11, at 10:15 AM, with the District Director of Clinical Operations (DDCO) revealed that due to the facility never assessing Resident #1 to require one to one supervision at any time, and the investigation finding no evidence of "willful intent" to leave Resident #1 outside unattended, the facility "never suspected neglect and determined none had occurred."</p> <p>Interview with Administrator #1 and the Director of Nursing (DON) on 07/12/11, at 3:25 PM, revealed that although an investigation was initiated to rule out abuse/neglect and determined the incident should be reported to the appropriate state agencies, the facility's District Director of Clinical Operations (DDCO), who was notified of Resident #1's elopement on 07/02/11, instructed the DON not to report the incident to the appropriate state agencies as required.</p> <p>On 07/10/11, at 12:33 AM, Resident #4 was outside smoking, unsupervised, and assisted an intoxicated drug-seeking individual to enter the facility without staff knowledge.</p> <p>Interview with the DON on 07/13/11, at 5:00 PM, revealed he had been made aware of the incident on 07/10/11, but did not initiate an investigation into the incident and took no action to prevent reoccurrence or ensure resident safety. Per interview, the DON did not feel residents were in danger.</p> <p>Interview with the DDCO on 07/19/11, at 11:50 AM, revealed the facility was "not a prison" and anyone could come and go in the facility at any</p>	F 490	See attached POC	

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F 490	<p>Continued From page 44</p> <p>time, day or night. The DDCO stated that A Wing doors and C Wing doors are unlocked at all times, and anyone could enter through them at any time.</p> <p>There was no evidence the facility reported allegations of abuse/injuries of unknown origin to the appropriate state agencies for Resident #5 and Resident #6 timely. Additionally, the facility failed to follow their policies and procedures when they allowed an alleged perpetrator to continue working with residents after receiving an allegation of abuse to Resident #2. Furthermore, the facility failed to notify the Administrator and the state agencies timely.</p> <p>An interview conducted with the Facility Administrator on 07/22/11, at 11:00 AM, revealed the Administrator was not aware the facility's established abuse policies/procedures had not been followed related to the incidents which occurred involving Residents #2, #5, and #6.</p> <p>A review of the allegation of compliance revealed the following:</p> <p>On 07/14/11, the State Director of Risk Management conducted education with the district Director of Operations (DO), District Director of Clinical Operations (DDCO), Executive Director (ED)/Administrator, and the Director of Nursing Services (DNS/DON) regarding regulation F225 related to the identification and immediate reporting of alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property.</p>	F 490	See attached POC	
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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
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F 490	<p>Continued From page 45</p> <p>On 07/04/11, the DO and DDCO conducted education with the ED and DNS on conducting an investigation.</p> <p>On 07/03/11, a policy change was made and implemented to ensure that all residents who wished to go outside were accompanied by staff and that no resident was outside unattended. On 07/05/11 and 07/08/11, assessments were conducted on residents who requested to go outside. On 07/14/11, residents who requested to go outside were re-assessed and a policy change was made. The change was to assess residents upon their request to determine their ability to go outside independently without staff supervision. The resident must be assessed and must meet the assessment criteria prior to being allowed to go outside unsupervised. In addition, no resident is allowed to be outside between the hours of 11:00 PM and 6:00 AM without supervision, regardless of assessment status.</p> <p>On 07/02/11, the SDC, DNS, and Weekend Supervisor (WS) initiated education with all facility staff related to wandering, elopement, accident hazards, supervision, and policy change related to residents going outside without staff supervision, as no resident was to be outside without staff supervision. Education will be ongoing until all facility staff members have attended. On 07/15/11, this in-service was repeated with staff to include a policy change related to residents going outside without staff supervision, based on their individual resident assessment. Education will be ongoing until all facility staff members have attended.</p> <p>On 07/07/11, the Activities Director (AD)</p>	F 490	See attached POC	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/22/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 490	<p>Continued From page 46</p> <p>educated residents on door alarms, resident safety, and the need for residents to seek staff assistance with doors.</p> <p>After 9:00 PM, all facility entrance doors have been and continue to be on a timed lock, except for A Wing and C Wing doors to allow staff and emergency entrance. Effective 07/20/11, the A Wing and C Wing outside entrance button will be disabled between 9:00 PM and 6:00 AM daily, until these entrance doors can be engineered with a timed lock during these hours. A doorbell has been installed at the entrance to A Wing and C Wing to be utilized by visitors and emergency personnel. The Maintenance Director (MD) initiated education with all facility staff on 07/20/11, related to the change in the door system.</p> <p>Effective 07/03/11, at least one resident smoke time is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times there is one staff person to five residents, that other outside areas have no unattended residents, that any resident outside with a family member is signed out, and to identify any outside accident hazards. Any concerns were corrected immediately. This monitoring will occur daily until deemed unnecessary by the Performance Improvement Committee (PIC).</p> <p>Resident and family interviews are required to be conducted for all residents every four months, which ask specific direct questions related to resident treatment and abuse. All allegations of abuse, neglect, or mistreatment are required to be immediately reported to the ED and DNS to</p>	F 490	See attached POC	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185146	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/22/2011
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NAME OF PROVIDER OR SUPPLIER  FOUNTAIN CIRCLE HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GLENWAY ROAD WINCHESTER, KY 40391
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F 490	<p>Continued From page 47</p> <p>ensure residents are protected from further potential abuse/neglect/mistreatment.</p> <p>All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to identify any potential accident hazard related to environment and supervision.</p> <p>The ED and DNS will review all grievance forms and interviews weekly to identify any alleged violations. The ED will also ensure appropriate reporting and implementation of the credible allegation of compliance.</p> <p>The DDCO will review three grievance forms or interviews weekly to identify any alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. In addition, the DDCO will have oversight of the ED and DNS in the facility on a weekly basis to validate the implementation of the Credible Allegation of Compliance through review of audit and monitoring tools. The DDCO will also review all resident events with the DNS on a weekly basis to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.</p> <p>The ED will also validate through the weekly PIC meeting by review of the smoke time supervision audits, review of the wander/elopement audits, review of any environmental rounds, and implementation of the credible allegation.</p> <p>The PIC will meet weekly or more often as necessary until the facility has demonstrated</p>	F 490	See attached POC.	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 48</p> <p>sustained compliance of the corrective actions described in the AOC. Members of the PIC include, but are not limited to, the ED, AED, DNS, SDC, MD, SSD, Nutrition Services Manager (NSM), Registered Dietitian (RD), AD, BOM, Case Manager (CM), RPD, and the TCUPD.</p> <p>Ad hoc PIC meetings were held on 07/04/11 and 07/15/11, to review the implemented corrective action.</p> <p>The surveyors validated the corrective action taken by the facility as follows:</p> <p>A review of documentation revealed the ED, DNS, and DDCO were provided with in-service training on 07/14/11, regarding reporting requirements by the State Risk Management Director. Interviews with the DDCO, DNS, and ED on 07/22/11, from 2:00 PM - 3:30 PM, revealed they were knowledgeable of reporting requirements related to mistreatment, abuse, neglect, and injuries of unknown source and misappropriation of resident property.</p> <p>A review of documentation revealed the ED and the DNS were provided with in-service training regarding conducting facility investigations on 07/14/11, by the DDCO. Interview with the ED and the DNS on 07/22/11, at 3:00-3:15 PM, revealed they were knowledgeable of investigation requirements.</p> <p>A review of the facility policy dated 07/02/11, revealed the policy had been revised to reflect no resident was to be outside without family/staff supervision. Further review revealed staff was educated on the policy revision on 07/03-04/11.</p>	F 490	See attached POC	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	<p>Continued From page 49</p> <p>Review of attendance rosters revealed an in-service was initiated on 07/15/11, regarding policy changes related to residents going outside without supervision based on individual resident assessments. All working staff members were in-serviced and education was ongoing for employees who were off work. Staff was not allowed to work without first being in-serviced. Interviews conducted with CNAs, nurses, and Unit Managers from 07/21/11, at 12:30 PM, to 07/22/11, at 3:30 PM, revealed staff was knowledgeable regarding residents going outside without supervision.</p> <p>A review of attendance roster for in-service related to wandering/elopement, accident hazards, and supervision regarding residents being outside without staff supervision, revealed staff was educated on the policy revision on 07/03-04/11, by the Staff Development Coordinator, the DON, and the Weekend Supervisor. Further review of staff in-services revealed the in-service was repeated on 07/14/11. Further review of interviews conducted with CNAs, nurses, and Unit Managers from 07/21/11, at 12:30 PM, to 07/22/11, at 3:30 PM, revealed staff was knowledgeable of the policy regarding wandering/elopement, accident hazards, and the supervision of residents outside of the facility.</p> <p>A review of a resident council meeting conducted on 07/07/11, by the Activities Director revealed residents were in-serviced regarding codes to the door and resident safety. Interviews conducted with Residents #7, #8, and #9 from 07/21/11, at 2:00 PM, to 07/22/11, at 11:00 AM, revealed the residents had been instructed on the door codes</p>	F 490	See attached POC	
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F 490	<p>Continued From page 50 and resident safety.</p> <p>An observation of the A and C Wing doors on 07/22/11, at 3:30 PM, revealed the doors were equipped with a lock system and a doorbell was on the outside of the A and C Wing doors. Interview with the Maintenance Director on 07/22/11, at 2:30 PM, revealed the A and C Wing doors were disabled between the hours of 9:00 PM and 6:00 AM daily.</p> <p>A review of an in-service attendance roster dated 07/20/11, revealed staff had attended an in-service regarding a policy change of A and C Wing doors being locked between 9:00 PM and 6:00 AM.</p> <p>A review of the smoking monitoring tool revealed daily monitoring of one smoke break had been conducted from 07/03/11, and was ongoing. Observation of a smoke break on 07/22/11, at 2:35 PM, revealed one staff person with two residents smoking in the designated area. Interview with the interim DON on 07/22/11, at 3:15 PM, revealed the Department Managers were required to check the smoke breaks daily and had not identified any concerns with residents being outside unattended.</p> <p>A review of satisfaction surveys initiated on 07/12/11 and 07/20/11, for residents/responsible parties revealed no concerns had been addressed by the facility. Interviews with Residents #7, #8, and #9, and family of Resident #30, from 07/21/11, at 2:00 PM, to 07/22/11, at 11:00 AM, revealed no concerns regarding resident care and treatment at the facility.</p>	F 490	See attached POC	
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F 490	<p>Continued From page 51</p> <p>Interview with the Administrator and the DNS on 07/22/11, at 3:15 PM, revealed event reports are reviewed daily regarding accident hazards supervision and to ensure appropriate reporting of abuse/neglect. In addition, all grievance forms and interview forms were reviewed weekly for validation of alleged violations involving mistreatment, neglect/abuse, injuries of unknown source, and misappropriation to ensure appropriate reporting.</p> <p>An interview with the DDCO on 07/22/11, at 2:00 PM, revealed resident/family interviews, grievance forms, and event reports were reviewed weekly for identification of any alleged violations involving mistreatment, neglect, or abuse to ensure reporting as required.</p> <p>Interview with the Administrator and DNS on 07/22/11, at 3:15 PM, revealed the PIC met weekly to review all monitoring that was conducted for the action plan. Further interview revealed the Administrator was responsible for monitoring accident hazards, resident supervision, and assistive devices to prevent accidents, environmental audits for smoke time monitoring, wander/elopement drills/audits, all grievance forms and interview forms, employee suspensions, and end of shift contacts for validation of alleged violations involving mistreatment, neglect/abuse, injuries of unknown source, and misappropriation to ensure appropriate reporting and implementation of the AOC.</p> <p>A review of ad hoc attendance rosters revealed meetings were conducted on 07/07/11, 07/20/11, and 07/21/11. A review of Performance</p>	F 490	See attached POC	
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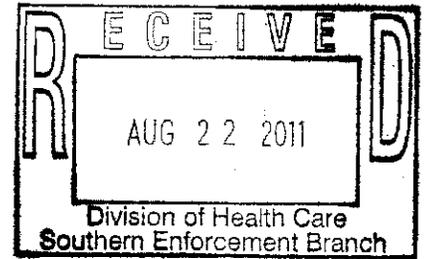
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 490	<p>Continued From page 52 Improvement (PI) Meeting Attendance and Agendas revealed PI meetings were conducted on 07/07/11 and 07/15/11.</p> <p>The State Agency determined the Immediate Jeopardy was removed on 07/21/11, prior to exit, which lowered the scope and severity to "D" while the facility monitors the effectiveness of the systemic changes and quality assurance activities.</p>	F 490	See attached POC	
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*This Plan of Correction is the center's credible allegation of compliance.*

*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law*

**Fountain Circle Health and Rehabilitation  
Plan of Correction for Survey Exit 7/22/11  
Attachment**



**F224**

**Residents Affected:**

An Admission Minimum Data Set (MDS) completed 4/12/11 revealed Resident #1 did not exhibit any wandering behaviors.

A MDS completed 6/29/11 again revealed she did not exhibit any wandering behaviors.

Review of the Resident Progress Notes from 3/30/11, date of admission, through 7/2/11 revealed there were no documented episodes of wandering or exit seeking behaviors from 3/30/11 through 7/2/11.

A Wander/Elopement Risk Evaluation completed on 4/3/11 revealed Resident #1 was not at risk for wandering and was not at risk for elopement. The Wander/Elopement Risk Evaluation was revised on 7/2/11 to reflect residents wandering behavior from unit to unit and exit from the facility. The Evaluation identified the resident at risk for wandering and at risk for elopement on 7/2/11.

The Comprehensive Care Plan was revised on 7/2/11 with a Problem of Resident at Risk for Wandering and Elopement. Interventions included: Wanderguard bracelet in place; 1:1 supervision; adventure boards; placed in wander/elopement book.

On 7/3/11, the resident's CNA Assignment Sheet was revised to include risk for elopement, 1:1 supervision and Wanderguard.

On 7/2/11, the Social Services Director (SSD) conducted a BIMS Summary Score for Resident #1. The resident was assessed at 11. The SSD again conducted a BIMS Summary Score on 7/3/11. The resident was assessed at 13. On 7/2/11, the licensed nurse conducted a head-to-toe assessment of the resident. No injuries were identified. She was then placed on fifteen minute checks beginning on 8/5/11 at 1500 to current.

On 7/2/11, the licensed nurse notified the resident's attending physician and the Medical Director of the resident's absence. The licensed nurse attempted to make family notification; however, the phone numbers were not working. On

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7/3/11, the Director of Nursing Services (DNS) attempted to make family notification; however, the phone numbers were not working. The Social Services Director (SSD) had previously sent the family a certified letter related to current contact information.

On 7/2/11, Resident #1 was placed on each shift documentation for 72 hours related to wander/elopement behaviors.

The Office of Inspector General initiated an onsite investigation on July 11, 2011, after the facility had investigated and implemented corrective action.

**Residents with Potential to be Affected:**

On 7/2/11, a head count was completed by the licensed nurses and Certified Nursing Assistants (CNAs) at approximately 5:15 PM. All facility residents were accounted for except for Resident #1. Another head count was conducted by the licensed nurses and CNAs at 5:25 PM. All facility residents were accounted for except for Resident #1. A head count was conducted by the Assistant Executive Director (AED), DNS, and Staff Development Coordinator (SDC) at approximately 11:20 PM. All facility residents were present and accounted for.

On 7/2/11, the Medical Records Director (MRD) conducted an audit of all facility residents to validate that all assessments were current, care plans were current, and adventure board was current.

On 7/2/11, the Maintenance Assistant (MA) audited all facility doors to validate proper functioning and audited all Wanderguard bracelets to validate proper functioning.

Effective 7/3/11, at least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents; that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns were corrected immediately.

On 7/3/11, a policy change was made and implemented to ensure that all residents who wished to go outside were accompanied by staff and that no resident was outside of the facility unattended.

On 7/3/11, the MA validated that all facility windows are secured with only a 6-inch opening.

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On 7/3/11, the MA changed the code to the door system.

On 7/3/11, the AED posted signage at all facility entrance doors to notify visitors that no resident is to be assisted outside of the facility and to check with the staff for the code as it will change frequently.

On 7/3-4/11, the DNS, SDC, Transitional Care Unit Program Director (TCU PD), Minimum Data Set Coordinators (MDSC) Unit Managers (UMs) completed a Wander/Elopement Risk Evaluation and a Safety Risk Assessment (see attached) for all in-house residents. A Smoking Evaluation was conducted for all residents identified who smoke. Care Plans were reviewed to ensure that all areas r/t accident hazards / resident safety were care planned with appropriate interventions. Any concerns were corrected immediately.

On 7/3/11, the Assistant Executive Director (AED), Reflections Program Director (RPD), Staff Development Assistant (SDA), Maintenance Assistants (MA), Business Office Manager (BOM) conducted an environmental audit of the internal and external environment to identify any accident hazards in the environment. Any concerns identified were corrected immediately.

On 7/5/11, the shift validation tool utilized by administrative staff was revised to include questioning r/t wandering/elopement and/or exit seeking behaviors. This tool is utilized by administrative staff to contact the facility prior to the end of each shift to validate resident safety.

On 7/3-4/11, the RPD conducted interviews of staff to determine if any resident had exhibited exit seeking behaviors within the past 30 days and, if so, if all appropriate steps were implemented.

On 7/4/11, the MRD conducted an audit of all residents at risk for wandering/elopement to validate that all assessments conducted on 7/3-4/11 were completed and that all appropriate supplemental interventions were in place to be implemented.

On 7/5/11 and 7/8/11 all residents who expressed a desire to go outdoors were assessed by licensed nurse staff, and the assessments were then reviewed by the Interdisciplinary Team, (consisting of the DNS, Unit Managers, Registered Dietician and Activities), to determine ability to go outdoors independently. Residents assessed to be independent in going outside were provided with a walkie-talkie radio. These residents were again assessed on 7/14/11 to determine ability to go outdoors independently.

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On 7/7/11, the Activity Director (AD) educated residents on door alarms, walkie-talkie radios, and resident safety and for residents to seek staff assistance with doors and that residents would not be provided the code to the door.

On 7/19/11, the ED reviewed all employee suspensions for the previous 60 days and validated that all employee suspensions related to abuse, neglect, injuries of unknown source and/or misappropriation of resident property were reported to officials in accordance with State law (including to the State survey and certification agency).

In addition, the Department Manager or designee review all grievances filed in the center to ensure resolution. Abaqis resident and family interviews are conducted for all residents every 4 months, which ask specific direct questions related to resident dignity, treatment and abuse. All concerns identified through the Abaqis process are addressed through the grievance process. All allegations of abuse, neglect or mistreatment are immediately reported to the ED and DNS and resident protection is ensured.

All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.

After 9 PM, all facility entrance doors have been and continue to be on a timed lock, except for A Wing and C Wing to allow staff and emergency entrance. Effective 7/20/11, The A Wing and C Wing outside entrance button will be disabled between 9 PM and 6 AM, daily, until these entrance doors can be engineered with a timed lock for these hours. A doorbell has been installed at the entrance to A Wing and C Wing to notify staff of visitor and emergency personnel need for entrance between 9 PM and 6 AM. The Maintenance Director (MD) initiated education with all facility staff on 7/20/11 related to the change in the door system.

On 7/20/11, interviews were conducted with all residents with a BIMS Summary Score of 12-15 to identify abuse, neglect or mistreatment. For residents with a

BIMS Summary Score of less than 12 family contacts were made to identify abuse, neglect or mistreatment.

### **Systemic Changes:**

On 7/2/11, the SDC, DNS and Weekend Supervisor (WS) initiated education with all facility staff related to wandering, elopement, accident hazards, supervision,

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and on the policy change related to residents going outside without staff supervision, as no resident was to be outside without staff supervision. Education will be ongoing until all facility staff has attended.

On 7/14/11, the State Director of Risk Management conducted education with the District Director of Operations (DO), District Director of Clinical Operations (DDCO), Executive Director (ED) and the DNS on the regulation F225 reporting alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property.

On 7/14/11, the DO and DDCO conducted education with the ED and DNS on conducting an investigation.

On 7/15/11, the SDC, Second Shift RN Nurse Supervisor (SS) and WS initiated re-education with all facility staff related to wandering, elopement and supervision. In addition, education was initiated on policy change related to residents going outside without staff supervision, based on their individual resident assessment and on Abuse and Neglect, to include reporting. Education will be ongoing until all facility staff has attended.

No staff member was allowed to work without having been in-serviced. The facility does not employ agency staff; however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working.

### **Monitoring:**

The following action/Interventions have been put into place to ensure ongoing compliance:

1. The facility is utilizing an "Accident Hazard/Supervision/Smoking Monitoring Tool" to monitor the outdoor grounds of the building in order to ensure that supervision and safety of residents is maintained. At least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents; that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns are corrected immediately. This monitoring will occur daily until deemed unnecessary by the Performance Improvement Committee (PIC) to determine need for continuance.
2. The facility has implemented the use an "Outside/Outdoor Resident Safety Assessment" as an assessment tool to determine resident safety needs for going outdoors. The tool is completed by licensed staff, and then

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- reviewed by the IDT. The "Outside/Outdoor Resident Safety Assessment" is completed upon a resident's request, to determine their ability to be outside independently without staff supervision. The resident must be assessed and must meet the assessment criteria prior to being allowed to be outside unsupervised.
3. Members of the PIC include, but are not limited to, the ED, AED, DNS, SDC, MD, SSD, Nutrition Services Manager (NSM), Registered Dietician (RD), AD, Business Office Manager (BOM), Case Manager (CM), Reflections Program Director (RPD) and Transitional Care Unit Program Director (TCUPD).
  4. Routine monitoring is ongoing through the daily review of "Condition Change Forms" and "Event Reports" by the IDT, during the "Morning Clinical Meeting" in order to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.
  5. The facility will use the "Environmental Audit" tool to conduct three "Environmental Audits" per week in order to identify any accident hazards in the environment. The ED or designee will conduct the audit. This audit tool will continue to be used to conduct three environmental per week until the PIC determines unnecessary.
  6. The Medical Records Director, or designee, will conduct a "Wander/Elopement Audit" weekly (Wednesday), in order to identify any potential wander/elopement safety hazards. The "Wander/Elopement Audit" will continue to be completed weekly until deemed unnecessary by the PIC.
  7. The DNS or SDC or designee will conduct 1 wander/elopement drill per month (alternating shifts) until deemed unnecessary by the PIC.
  8. The PIC will assume responsibility to validate monitoring and evaluation of the environment to ensure it remains as free from accident hazards as possible and to ensure each resident receives adequate supervision and assistive devices to prevent accidents. Validation will occur through review of the smoke time monitoring, review of the wander/elopement audits and drills, review of each shift contact to identify any potential hazards and by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting.

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The PIC will review all grievance forms and Abaqis interviews weekly to identify any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. The monitoring/review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

9. The Executive Director will also validate, through the weekly PIC Meeting, by review of the smoke time supervision audits, review of the wander/elopement audits to identify any potential hazards, review of the environmental rounds, by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property and by review of all employee suspensions, to ensure appropriate reporting and implementation of the Credible Allegation of Compliance and Plan of Correction. The Executive Director/Administrator will then return to routine monitoring of the facility systems each month as specified in the Facility Performance Improvement policy and procedure.

The ED will review all grievance forms and Abaqis interviews weekly to identify any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. Result will be reviewed weekly by the PIC. The monitoring/review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

The facility PIC will meet weekly (Thursday) to review grievances, Abaqis interviews, accidents, supervision, reporting of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property. The PIC review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

Additionally, a corrective action plan will be developed for any areas identified as not in compliance with the Credible Allegation of Compliance and/or Plan of Correction. The facility will then return to routine monthly PIC meetings.

**Date of final correction: 8/12/11**

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## **F225**

### **Residents Affected:**

✓ An Admission Minimum Data Set (MDS) completed 4/12/11 revealed Resident #1 did not exhibit any wandering behaviors.

✓ A MDS completed 6/29/11 again revealed she did not exhibit any wandering behaviors.

✓ Review of the Resident Progress Notes from 3/30/11, date of admission, through 7/2/11 revealed there were no documented episodes of wandering or exit seeking behaviors from 3/30/11 through 7/2/11.

✓ A Wander/Elopement Risk Evaluation completed on 4/3/11 revealed Resident #1 was not at risk for wandering and was not at risk for elopement. The Wander/Elopement Risk Evaluation was revised on 7/2/11 to reflect residents wandering behavior from unit to unit and exit from the facility. The Evaluation identified the resident at risk for wandering and at risk for elopement on 7/2/11.

The Comprehensive Care Plan was revised on 7/2/11 with a Problem of Resident at Risk for Wandering and Elopement. Interventions included: Wanderguard bracelet in place; 1:1 supervision; adventure boards; placed in wander/elopement book.

✓ On 7/3/11, the resident's CNA Assignment Sheet was revised to include risk for elopement, 1:1 supervision and Wanderguard.

✓ On 7/2/11, the Social Services Director (SSD) conducted a BIMS Summary Score for Resident #1. The resident was assessed at 11. The SSD again conducted a BIMS Summary Score on 7/3/11. The resident was assessed at 13.

On 7/2/11, the licensed nurse conducted a head-to-toe assessment of the resident. No injuries were identified.

On 7/2/11, the licensed nurse notified the resident's attending physician and the Medical Director of the resident's absence. The licensed nurse attempted to make family notification; however, the phone numbers were not working. On 7/3/11, the Director of Nursing Services (DNS) attempted to make family notification; however, the phone numbers were not working. The Social Services Director (SSD) had previously sent the family a certified letter related to current contact information.

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On 7/2/11, Resident #1 was placed on each shift documentation for 72 hours related to wander/elopement behaviors.

On 7/21/11, after facility administrator was notified, the CNA involved in the allegation re: Resident #2, was immediately suspended. At the conclusion of the investigation, it was determined that the allegation was unsubstantiated. No other alert and oriented resident or staff reported any concerns with care provided by Carrie Toller, SRNA. The OIG reviewed the allegation while at the facility on 7/22/11. The final results of the investigation were forwarded to OIG and Adult Protective Services (APS) on 7/22/11.

On 7/15/11, in response to the allegation re: Resident #5, OIG was notified. Physician, DNS, and Executive Director were notified. On 7/19/11 APS was notified of the allegation. The alleged perpetrator was suspended immediately pending the outcome of the investigation. At the conclusion of the investigation it was determined that the allegation was substantiated. The SRNA was terminated. OIG reviewed the allegation while at the facility on 7/22/11.

On 7/20/11, the appropriate state agencies were notified of the injury of unknown origin for Resident #6, when the facility became aware of the Left hip fracture and initiated an investigation. The resident was transferred to the hospital on 7/20/11 and underwent a surgical repair for the fracture. She has since returned to the facility. The final investigation results were sent to OIG and APS on 7/21/11. OIG was in the facility to review allegation. Abuse, neglect and mistreatment were unsubstantiated.

^ The Office of Inspector General initiated an onsite investigation on July 11, 2011, after the facility had investigated and implemented corrective action.

#### **Residents with Potential to be Affected:**

On 7/2/11, a head count was completed by the licensed nurses and Certified Nursing Assistants (CNAs) at approximately 5:15 PM. All facility residents were accounted for except for Resident #1. Another head count was conducted by the licensed nurses and CNAs at 5:25 PM. All facility residents were accounted for except for Resident #1. A head count was conducted by the Assistant Executive Director (AED), DNS, and Staff Development Coordinator (SDC) at approximately 11:20 PM. All facility residents were present and accounted for.

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On 7/2/11, the Medical Records Director (MRD) conducted an audit of all facility residents to validate that all assessments were current, care plans were current, and adventure board was current.

On 7/2/11, the Maintenance Assistant (MA) audited all facility doors to validate proper functioning and audited all Wanderguard bracelets to validate proper functioning.

Effective 7/3/11, at least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents; that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns were corrected immediately.

On 7/3/11, a policy change was made and implemented to ensure that all residents who wished to go outside were accompanied by staff and that no resident was outside of the facility unattended.

On 7/3/11, the MA validated that all facility windows are secured with only a 6-inch opening.

On 7/3/11, the MA changed the code to the door system.

On 7/3/11, the AED posted signage at all facility entrance doors to notify visitors that no resident is to be assisted outside of the facility and to check with the staff for the code as it will change frequently.

On 7/3-4/11, the DNS, SDC, Transitional Care Unit Program Director (TCU PD), Minimum Data Set Coordinators (MDSC) Unit Managers (UMs) completed a Wander/Elopement Risk Evaluation and a Safety Risk Assessment (see attached) for all in-house residents. A Smoking Evaluation was conducted for all residents identified who smoke. Care Plans were reviewed to ensure that all areas r/t accident hazards / resident safety were care planned with appropriate interventions. Any concerns were corrected immediately.

On 7/3/11, the Assistant Executive Director (AED), Reflections Program Director (RPD), Staff Development Assistant (SDA), Maintenance Assistants (MA), Business Office Manager (BOM) an environmental audit was conducted of the internal and external environment to identify any accident hazards in the environment. Any concerns identified were corrected immediately.

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On 7/3-4/11, the RPD conducted interviews of staff to determine if any resident had exhibited exit seeking behaviors within the past 30 days and, if so, if all appropriate steps were implemented.

On 7/4/11, the MRD conducted an audit of all residents at risk for wandering/elopement to validate that all assessments conducted on 7/3-4/11 were completed and that all appropriate supplemental interventions were in place to be implemented.

On 7/5/11 and 7/8/11 all residents who expressed a desire to go outdoors were assessed to determine ability to go outdoors independently. Residents assessed to be independent in going outside were provided with a walkie-talkie radio. These residents were again assessed on 7/14/11 to determine ability to go outdoors independently.

On 7/7/11, the Activity Director (AD) educated residents on door alarms, walkie-talkie radios, resident safety and for residents to seek staff assistance with doors and that residents would not be provided the code to the door.

On 7/19/11, the ED reviewed all employee suspensions for the previous 60 days and validated that all employee suspensions related to abuse, neglect, injuries of unknown source and/or misappropriation of resident property were reported to officials in accordance with State law (including to the State survey and certification agency).

In addition, the Department Manager or designee review all grievances filed in the center to ensure resolution. Abaqis resident and family interviews are conducted for all residents every 4 months, which ask specific direct questions related to resident dignity, treatment and abuse. All concerns identified through the Abaqis process are addressed through the grievance process. All allegations of abuse, neglect or mistreatment are immediately reported to the ED, DNS and required state agencies (Office of Inspector General and Adult Protective Services) and resident protection is ensured.

All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.

After 9 PM, all facility entrance doors have been and continue to be on a timed lock, except for A Wing and C Wing to allow staff and emergency entrance. Effective 7/20/11, The A Wing and C Wing outside entrance button will be

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disabled between 9 PM and 6 AM, daily, until these entrance doors can be engineered with a timed lock for these hours. A doorbell has been installed at

the entrance to A Wing and C Wing to notify staff of visitor and emergency personnel need for entrance between 9 PM and 6 AM. The Maintenance Director (MD) initiated education with all facility staff on 7/20/11 related to the change in the door system.

On 7/20/11, interviews were conducted with all residents with a BIMS Summary Score of 12-15 to identify abuse, neglect or mistreatment. For residents with a BIMS Summary Score of less than 12 family contacts were made to identify abuse, neglect or mistreatment.

#### **Systemic Changes:**

On 7/2/11, the SDC, DNS and Weekend Supervisor (WS) initiated education with all facility staff related to wandering, elopement, accident hazards, supervision, and on the policy change related to residents going outside without staff supervision, as no resident was to be outside without staff supervision. Education will be ongoing until all facility staff has attended. On 7/2/11, the See attached.

On 7/14/11, the State Director of Risk Management conducted education with the District Director of Operations (DO), District Director of Clinical Operations (DDCO), Executive Director (ED) and the DNS on the regulation F225 reporting alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property.

On 7/14/11, the DO and DDCO conducted education with the ED and DNS on conducting an investigation. See attached.

On 7/15/11, the SDC, Second Shift RN Nurse Supervisor (SS) and WS initiated re-education with all facility staff related to wandering, elopement and supervision. In addition, education was initiated on policy change related to residents going outside without staff supervision, based on their individual resident assessment and on Abuse and Neglect, to include reporting. Education will be ongoing until all facility staff has attended.

No staff member was allowed to work without having been in-serviced. The facility does not employ agency staff; however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working.

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### **Monitoring:**

The following action/Interventions have been put into place to ensure ongoing compliance:

1. The facility is utilizing an "Accident Hazard/Supervision/Smoking Monitoring Tool" to monitor the outdoor grounds of the building in order to ensure that supervision and safety of residents is maintained. At least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents; that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns are corrected immediately. This monitoring will occur daily until deemed unnecessary by the Performance Improvement Committee (PIC) to determine need for continuance.
2. The facility has implemented the use an "Outside/Outdoor Resident Safety Assessment" as an assessment tool to determine resident safety needs for going outdoors. The tool is completed by licensed staff, and then reviewed by the IDT. The "Outside/Outdoor Resident Safety Assessment" is completed upon a resident's request, to determine their ability to be outside independently without staff supervision. The resident must be assessed and must meet the assessment criteria prior to being allowed to be outside unsupervised.
3. Members of the PIC include, but are not limited to, the ED, AED, DNS, SDC, MD, SSD, Nutrition Services Manager (NSM), Registered Dietician (RD), AD, Business Office Manager (BOM), Case Manager (CM), Reflections Program Director (RPD) and Transitional Care Unit Program Director (TCUPD).
4. Routine monitoring is ongoing through the daily review of "Condition Change Forms" and "Event Reports" by the IDT, during the "Morning Clinical Meeting" in order to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.
5. The facility will use the "Environmental Audit" tool to conduct three "Environmental Audits" per week in order to identify any accident hazards in the environment. The ED or designee will conduct the audit. This audit

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tool will continue to be used to conduct three environmental per week until the PIC determines unnecessary.

6. The Medical Records Director, or designee, will conduct a "Wander/Elopement Audit" weekly (Wednesday), in order to identify any potential wander/elopement safety hazards. The "Wander/Elopement Audit" will continue to be completed weekly until deemed unnecessary by the PIC.
7. The DNS or SDC or designee will conduct 1 wander/elopement drill per month (alternating shifts) until deemed unnecessary by the PIC.
8. The PIC will assume responsibility to validate monitoring and evaluation of the environment to ensure it remains as free from accident hazards as possible and to ensure each resident receives adequate supervision and assistive devices to prevent accidents. Validation will occur through review of the smoke time monitoring, review of the wander/elopement audits and drills, review of each shift contact to identify any potential hazards and by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting.

The PIC will review all grievance forms and Abaqis interviews weekly to identify any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. The monitoring/review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

9. The Executive Director will also validate, through the weekly PIC Meeting, by review of the smoke time supervision audits, review of the wander/elopement audits to identify any potential hazards, review of the environmental rounds, by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property and by review of all employee suspensions, to ensure appropriate reporting and implementation of the Credible Allegation of Compliance and Plan of Correction. The Executive Director/Administrator will then return to routine monitoring of the facility systems each month as specified in the Facility Performance Improvement policy and procedure.

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The ED will review all grievance forms and Abaqis interviews weekly to identify any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and

misappropriation of resident property to ensure appropriate reporting. Result will be reviewed weekly by the PIC. The monitoring/review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

The facility PIC will meet weekly (Thursday) to review grievances, Abaqis interviews, accidents, supervision, reporting of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property. The PIC review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

Additionally, a corrective action plan will be developed for any areas identified as not in compliance with the Credible Allegation of Compliance and/or Plan of Correction. The facility will then return to routine monthly PIC meetings.

**Date of final correction: 8/12/11**

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## **F323**

### **Residents Affected:**

An Admission Minimum Data Set (MDS) completed 4/12/11 revealed Resident #1 did not exhibit any wandering behaviors.

A MDS completed 6/29/11 again revealed she did not exhibit any wandering behaviors.

Review of the Resident Progress Notes from 3/30/11, date of admission, through 7/2/11 revealed there were no documented episodes of wandering or exit seeking behaviors from 3/30/11 through 7/2/11.

A Wander/Elopement Risk Evaluation completed on 4/3/11 revealed Resident #1 was not at risk for wandering and was not at risk for elopement. The Wander/Elopement Risk Evaluation was revised on 7/2/11 to reflect residents wandering behavior from unit to unit and exit from the facility. The Evaluation identified the resident at risk for wandering and at risk for elopement on 7/2/11.

The Comprehensive Care Plan was revised on 7/2/11 with a Problem of Resident at Risk for Wandering and Elopement. Interventions included: Wanderguard bracelet in place; 1:1 supervision; adventure boards; placed in wander/elopement book.

On 7/3/11, the resident's CNA Assignment Sheet was revised to include risk for elopement, 1:1 supervision and Wanderguard.

On 7/2/11, the Social Services Director (SSD) conducted a BIMS Summary Score for Resident #1. The resident was assessed at 11. The SSD again conducted a BIMS Summary Score on 7/3/11. The resident was assessed at 13.

On 7/2/11, the licensed nurse conducted a head-to-toe assessment of the resident. No injuries were identified.

On 7/2/11, the licensed nurse notified the resident's attending physician and the Medical Director of the resident's absence. The licensed nurse attempted to make family notification; however, the phone numbers were not working. On 7/3/11, the Director of Nursing Services (DNS) attempted to make family notification; however, the phone numbers were not working. The Social Services

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Director (SSD) had previously sent the family a certified letter related to current contact information.

On 7/2/11, Resident #1 was placed on each shift documentation for 72 hours related to wander/elopement behaviors.

On 7/5/11, Resident #4 was assessed to be outside/outdoors independently. He was assessed to utilize a walkie-talkie radio when outside unsupervised. He had his radio on his person on 7/10/11. Staff assigned to Resident #4 were aware of his location on 7/10/11 as this was the resident's routine activity to sit outside at night. Staff were aware the resident had his radio on his person. In addition, Resident #4 was on every 15 minute check supervision on 7/10/11 due to his behaviors. On 7/14/11, Resident #4 was reassessed to be outside/outdoors independently. The care plan and CNA Assignment Sheet were updated with interventions to ensure safety.

The Office of Inspector General initiated an onsite investigation on July 11, 2011, after the facility had investigated and implemented corrective action.

#### **Residents with Potential to be Affected:**

On 7/2/11, a head count was completed by the licensed nurses and Certified Nursing Assistants (CNAs) at approximately 5:15 PM. All facility residents were accounted for except for Resident #1. Another head count was conducted by the licensed nurses and CNAs at 5:25 PM. All facility residents were accounted for except for Resident #1. A head count was conducted by the Assistant Executive Director (AED), DNS, and Staff Development Coordinator (SDC) at approximately 11:20 PM. All facility residents were present and accounted for.

On 7/2/11, the Medical Records Director (MRD) conducted an audit of all facility residents to validate that all assessments were current, care plans were current, and adventure board was current.

On 7/2/11, the Maintenance Assistant (MA) audited all facility doors to validate proper functioning and audited all Wanderguard bracelets to validate proper functioning.

Effective 7/3/11, at least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents; that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns were corrected immediately.

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On 7/3/11, a policy change was made and implemented to ensure that all residents who wished to go outside were accompanied by staff and that no resident was outside of the facility unattended.

On 7/3/11, the MA validated that all facility windows are secured with only a 6-inch opening.

On 7/3/11, the MA changed the code to the door system.

On 7/3/11, the AED posted signage at all facility entrance doors to notify visitors that no resident is to be assisted outside of the facility and to check with the staff for the code as it will change frequently.

On 7/3-4/11, the DNS, SDC, Transitional Care Unit Program Director (TCU PD), Minimum Data Set Coordinators (MDSC) Unit Managers (UMs) completed a Wander/Elopement Risk Evaluation and a Safety Risk Assessment (see attached) for all in-house residents. A Smoking Evaluation was conducted for all residents identified who smoke. Care Plans were reviewed to ensure that all areas r/t accident hazards / resident safety were care planned with appropriate interventions. Any concerns were corrected immediately.

On 7/3/11, the Assistant Executive Director (AED), Reflections Program Director (RPD), Staff Development Assistant (SDA), Maintenance Assistants (MA), Business Office Manager (BOM) conducted an environmental audit of the internal and external environment to identify any accident hazards in the environment. Any concerns identified were corrected immediately.

On 7/5/11, the shift validation tool utilized by administrative staff was revised to include questioning r/t wandering/elopement and/or exit seeking behaviors. This tool is utilized by administrative staff to contact the facility prior to the end of each shift to validate resident safety.

On 7/3-4/11, the RPD conducted interviews of staff to determine if any resident had exhibited exit seeking behaviors within the past 30 days and, if so, if all appropriate steps were implemented.

On 7/4/11, the MRD conducted an audit of all residents at risk for wandering/elopement to validate that all assessments conducted on 7/3-4/11 were completed and that all appropriate supplemental interventions were in place to be implemented.

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On 7/5/11 and 7/8/11 all residents who expressed a desire to go outdoors were assessed, by licensed nurse staff, and the assessments were then reviewed by

the Interdisciplinary Team, (consisting of the DNS, Unit Managers, Registered Dietician and Activities), to determine ability to go outdoors independently. Residents assessed to be independent in going outside were provided with a walkie-talkie radio. These residents were again assessed on 7/14/11 to determine ability to go outdoors independently.

On 7/7/11, the Activity Director (AD) educated residents on door alarms, walkie-talkie radios, resident safety and for residents to seek staff assistance with doors and that residents would not be provided the code to the door.

On 7/19/11, the ED reviewed all employee suspensions for the previous 60 days and validated that all employee suspensions related to abuse, neglect, injuries of unknown source and/or misappropriation of resident property were reported to officials in accordance with State law (including to the State survey and certification agency).

In addition, the Department Manager or designee review all grievances filed in the center to ensure resolution. Abaqis resident and family interviews are conducted for all residents every 4 months, which ask specific direct questions related to resident dignity, treatment and abuse. All concerns identified through the Abaqis process are addressed through the grievance process. All allegations of abuse, neglect or mistreatment are immediately reported to the ED and DNS and required state agencies (Office of Inspector General and Adult Protective Services) and resident protection is ensured.

All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.

After 9 PM, all facility entrance doors have been and continue to be on a timed lock, except for A Wing and C Wing to allow staff and emergency entrance. Effective 7/20/11, The A Wing and C Wing outside entrance button will be disabled between 9 PM and 6 AM, daily, until these entrance doors can be engineered with a timed lock for these hours. A doorbell has been installed at the entrance to A Wing and C Wing to notify staff of visitor and emergency personnel need for entrance between 9 PM and 6 AM. The Maintenance Director (MD) initiated education with all facility staff on 7/20/11 related to the change in the door system.

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On 7/20/11, interviews were conducted with all residents with a BIMS Summary Score of 12-15 to identify abuse, neglect or mistreatment. For residents with a BIMS Summary Score of less than 12 family contacts were made to identify abuse, neglect or mistreatment.

### **Systemic Changes:**

On 7/2/11, the SDC, DNS and Weekend Supervisor (WS) initiated education with all facility staff related to wandering, elopement, accident hazards, supervision, and on the policy change related to residents going outside without staff supervision, as no resident was to be outside without staff supervision. Education will be ongoing until all facility staff have attended.

On 7/14/11, the State Director of Risk Management conducted education with the District Director of Operations (DO), District Director of Clinical Operations (DDCO), Executive Director (ED) and the DNS on the regulation F225 reporting alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property.

On 7/14/11, the DO and DDCO conducted education with the ED and DNS on conducting an investigation.

On 7/15/11, the SDC, Second Shift RN Nurse Supervisor (SS) and WS initiated re-education with all facility staff related to wandering, elopement and supervision. In addition, education was initiated on policy change related to residents going outside without staff supervision, based on their individual resident assessment and on Abuse and Neglect, to include reporting. Education will be ongoing until all facility staff have attended.

No staff member was allowed to work without having been in-serviced. The facility does not employ agency staff; however, if the facility should employ agency staff, the agency staff will receive the in-service prior to working.

### **Monitoring:**

The following action/Interventions have been put into place to ensure ongoing compliance:

1. The facility is utilizing an "Accident Hazard/Supervision/Smoking Monitoring Tool" to monitor the outdoor grounds of the building in order to ensure that supervision and safety of residents is maintained. At least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents;

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that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns are corrected immediately. This

monitoring will occur daily until deemed unnecessary by the Performance Improvement Committee (PIC) to determine need for continuance.

2. The facility has implemented the use an "Outside/Outdoor Resident Safety Assessment" as an assessment tool to determine resident safety needs for going outdoors. The tool is completed by licensed staff, and then reviewed by the IDT. The "Outside/Outdoor Resident Safety Assessment" is completed upon a resident's request, to determine their ability to be outside independently without staff supervision. The resident must be assessed and must meet the assessment criteria prior to being allowed to be outside unsupervised.
3. Members of the PIC include, but are not limited to, the ED, AED, DNS, SDC, MD, SSD, Nutrition Services Manager (NSM), Registered Dietician (RD), AD, Business Office Manager (BOM), Case Manager (CM), Reflections Program Director (RPD) and Transitional Care Unit Program Director (TCUPD).
4. Routine monitoring is ongoing through the daily review of "Condition Change Forms" and "Event Reports" by the IDT, during the "Morning Clinical Meeting" in order to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.
5. The facility will use the "Environmental Audit" tool to conduct three "Environmental Audits" per week in order to identify any accident hazards in the environment. The ED or designee will conduct the audit. This audit tool will continue to be used to conduct three environmental per week until the PIC determines unnecessary.
6. The Medical Records Director, or designee, will conduct a "Wander/Elopement Audit" weekly (Wednesday), in order to identify any potential wander/elopement safety hazards. The "Wander/Elopement Audit" will continue to be completed weekly until deemed unnecessary by the PIC.
7. The DNS or SDC or designee will conduct 1 wander/elopement drill per month (alternating shifts) until deemed unnecessary by the PIC.

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8. The PIC will assume responsibility to validate monitoring and evaluation of the environment to ensure it remains as free from accident hazards as possible and to ensure each resident receives adequate supervision and assistive devices to prevent accidents.

Validation will occur through review of the smoke time monitoring, review of the wander/elopement audits and drills, review of each shift contact to identify any potential hazards and by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting.

The PIC will review all grievance forms and Abaqis interviews weekly to identify any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. The monitoring/review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

9. The Executive Director will also validate, through the weekly PIC Meeting, by review of the smoke time supervision audits, review of the wander/elopement audits to identify any potential hazards, review of the environmental rounds, by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property and by review of all employee suspensions, to ensure appropriate reporting and implementation of the Credible Allegation of Compliance and Plan of Correction. The Executive Director/Administrator will then return to routine monitoring of the facility systems each month as specified in the Facility Performance Improvement policy and procedure.

The ED will review all grievance forms and Abaqis interviews weekly to identify any alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property to ensure appropriate reporting. Result will be reviewed weekly by the PIC. The monitoring/review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

The facility PIC will meet weekly (Thursday) to review grievances, Abaqis interviews, accidents, supervision, reporting of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident

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property. The PIC review of as detailed above will continue weekly until the PIC determines that it is no longer necessary.

Additionally, a corrective action plan will be developed for any areas identified as not in compliance with the Credible Allegation of Compliance and/or Plan of Correction. The facility will then return to routine monthly PIC meetings.

**Date of final correction: 8/12/11**

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## **F490**

### **Residents Affected:**

An Admission Minimum Data Set (MDS) completed 4/12/11 revealed Resident #1 did not exhibit any wandering behaviors.

A MDS completed 6/29/11 again revealed she did not exhibit any wandering behaviors.

Review of the Resident Progress Notes from 3/30/11, date of admission, through 7/2/11 revealed there were no documented episodes of wandering or exit seeking behaviors from 3/30/11 through 7/2/11.

A Wander/Elopement Risk Evaluation completed on 4/3/11 revealed Resident #1 was not at risk for wandering and was not at risk for elopement. The Wander/Elopement Risk Evaluation was revised on 7/2/11 to reflect residents wandering behavior from unit to unit and exit from the facility. The Evaluation identified the resident at risk for wandering and at risk for elopement on 7/2/11.

The Comprehensive Care Plan was revised on 7/2/11 with a Problem of Resident at Risk for Wandering and Elopement. Interventions included: Wanderguard bracelet in place; 1:1 supervision; adventure boards; placed in wander/elopement book.

On 7/3/11, the resident's CNA Assignment Sheet was revised to include risk for elopement, 1:1 supervision and Wanderguard.

On 7/2/11, the Social Services Director (SSD) conducted a BIMS Summary Score for Resident #1. The resident was assessed at 11. The SSD again conducted a BIMS Summary Score on 7/3/11. The resident was assessed at 13.

On 7/2/11, the licensed nurse conducted a head-to-toe assessment of the resident. No injuries were identified.

On 7/2/11, the licensed nurse notified the resident's attending physician and the Medical Director of the resident's absence. The licensed nurse attempted to make family notification; however, the phone numbers were not working. On 7/3/11, the Director of Nursing Services (DNS) attempted to make family

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notification; however, the phone numbers were not working. The Social Services Director (SSD) had previously sent the family a certified letter related to current contact information.

On 7/2/11, Resident #1 was placed on each shift documentation for 72 hours related to wander/elopement behaviors.

On 7/21/11, after facility administrator was notified, the CNA involved in the allegation re: Resident #2, was immediately suspended. At the conclusion of the investigation, it was determined that the allegation was unsubstantiated. No other alert and oriented resident or staff reported any concerns with care provided by Carrie Toller, SRNA. The OIG reviewed the allegation while at the facility on 7/22/11. The final results of the investigation were forwarded to OIG and Adult Protective Services (APS) on 7/22/11.

On 7/5/11, Resident #4 was assessed to be outside/outdoors independently. He was assessed to utilize a walkie-talkie radio when outside unsupervised. He had his radio on his person on 7/10/11. Staff assigned to Resident #4 were aware of his location on 7/10/11 as this was the resident's routine activity to sit outside at night. Staff were aware the resident had his radio on his person. In addition, Resident #4 was on every 15 minute check supervision on 7/10/11 due to his behaviors. On 7/14/11, Resident #4 was reassessed to be outside/outdoors independently.

On 7/15/11, in response to the allegation re: Resident #5, OIG was notified. Physician, DNS, and Executive Director were notified. On 7/19/11 APS was notified of the allegation. The alleged perpetrator was suspended immediately pending the outcome of the investigation. At the conclusion of the investigation it was determined that the allegation was substantiated. The SRNA was terminated. OIG reviewed the allegation while at the facility on 7/22/11.

On 7/20/11, the appropriate state agencies were notified of the injury of unknown origin for Resident #6, when the facility became aware of the Left hip fracture and initiated an investigation. The resident was transferred to the hospital on 7/20/11 and underwent a surgical repair for the fracture. She has since returned to the facility. The final investigation results were sent to OIG and APS on 7/21/11. OIG was in the facility to review allegation. Abuse, neglect and mistreatment was unsubstantiated.

The Office of Inspector General initiated an onsite investigation on July 11, 2011, after the facility had investigated and implemented corrective action.

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### **Residents with Potential to be Affected:**

On 7/2/11, a head count was completed by the licensed nurses and Certified Nursing Assistants (CNAs) at approximately 5:15 PM. All facility residents were accounted for except for Resident #1. Another head count was conducted by the licensed nurses and CNAs at 5:25 PM. All facility residents were accounted for except for Resident #1. A head count was conducted by the Assistant Executive Director (AED), DNS, and Staff Development Coordinator (SDC) at approximately 11:20 PM. All facility residents were present and accounted for.

On 7/2/11, the Medical Records Director (MRD) conducted an audit of all facility residents to validate that all assessments were current, care plans were current, and adventure board was current.

On 7/2/11, the Maintenance Assistant (MA) audited all facility doors to validate proper functioning and audited all Wanderguard bracelets to validate proper functioning.

Effective 7/3/11, at least one resident smoke time (6 AM, 9 AM, 11 AM, 2 PM, 4 PM, 7 PM and 9 PM) is monitored daily by a Department Manager, as designated by the ED, to ensure that during smoke times, there is one staff for every five residents; that other outside areas have no unattended residents; that any resident outside with a family member was signed out; and to identify any outside accident hazards. Any concerns were corrected immediately.

On 7/3/11, a policy change was made and implemented to ensure that all residents who wished to go outside were accompanied by staff and that no resident was outside of the facility unattended.

On 7/3/11, the MA validated that all facility windows are secured with only a 6-inch opening.

On 7/3/11, the MA changed the code to the door system.

On 7/3/11, the AED posted signage at all facility entrance doors to notify visitors that no resident is to be assisted outside of the facility and to check with the staff for the code as it will change frequently.

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On 7/3-4/11, the DNS, SDC, Transitional Care Unit Program Director (TCU PD), Minimum Data Set Coordinators (MDSC) Unit Managers (UMs) completed a Wander/Elopement Risk Evaluation and a Safety Risk Assessment (see attached) for all in-house residents. A Smoking Evaluation was conducted for all residents identified who smoke. Care Plans were reviewed to ensure that all

areas r/t accident hazards / resident safety were care planned with appropriate interventions. Any concerns were corrected immediately.

On 7/3/11, the Assistant Executive Director (AED), Reflections Program Director (RPD), Staff Development Assistant (SDA), Maintenance Assistants (MA), Business Office Manager (BOM) an environmental audit was conducted of the internal and external environment to identify any accident hazards in the environment. Any concerns identified were corrected immediately.

On 7/5/11, the shift validation tool utilized by administrative staff was revised to include questioning r/t wandering/elopement and/or exit seeking behaviors. This tool is utilized by administrative staff to contact the facility prior to the end of each shift to validate resident safety.

On 7/3-4/11, the RPD conducted interviews of staff to determine if any resident had exhibited exit seeking behaviors within the past 30 days and, if so, if all appropriate steps were implemented.

On 7/4/11, the MRD conducted an audit of all residents at risk for wandering/elopement to validate that all assessments conducted on 7/3-4/11 were completed and that all appropriate supplemental interventions were in place to be implemented.

On 7/5/11 and 7/8/11 all residents who expressed a desire to go outdoors were assessed to determine ability to go outdoors independently. Residents assessed to be independent in going outside were provided with a walkie-talkie radio. These residents were again assessed on 7/14/11 to determine ability to go outdoors independently.

On 7/7/11, the Activity Director (AD) educated residents on door alarms, walkie-talkie radios, resident safety and for residents to seek staff assistance with doors and that residents would not be provided the code to the door.

On 7/19/11, the ED reviewed all employee suspensions for the previous 60 days and validated that all employee suspensions related to abuse, neglect, injuries of unknown source and/or misappropriation of resident property were reported to officials in accordance with State law (including to the State survey and certification agency).

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In addition, the Department Manager or designee review all grievances filed in the center to ensure resolution. Abaqis resident and family interviews are conducted for all residents every 4 months, which ask specific direct questions related to resident dignity, treatment and abuse. All concerns identified through the Abaqis process are addressed through the grievance process. All allegations of abuse, neglect or mistreatment are immediately reported to the ED, DNS and to the appropriate state agencies (OIG, APS) and resident protection is ensured.

All event reports are reviewed daily by the ED and the DNS. Event reports are reviewed to identify any potential accident hazard related to environment and supervision, to include the potential for neglect and/or abuse and to ensure appropriate reporting.

After 9 PM, all facility entrance doors have been and continue to be on a timed lock, except for A Wing and C Wing to allow staff and emergency entrance. Effective 7/20/11, The A Wing and C Wing outside entrance button will be disabled between 9 PM and 6 AM, daily, until these entrance doors can be engineered with a timed lock for these hours. A doorbell has been installed at the entrance to A Wing and C Wing to notify staff of visitor and emergency personnel need for entrance between 9 PM and 6 AM. The Maintenance Director (MD) initiated education with all facility staff on 7/20/11 related to the change in the door system.

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9. The Executive Director will also validate, through the weekly PIC Meeting, by review of the smoke time supervision audits, review of the wander/elopement audits to identify any potential hazards,

review of the environmental rounds, by review of any event of alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property and by review of all employee suspensions, to ensure appropriate reporting and implementation of the Credible Allegation of Compliance and Plan of Correction. The Executive Director/Administrator will then return to routine monitoring of the facility systems each month as specified in the Facility Performance Improvement policy and procedure.

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