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

PRINTED: 11/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185423	A. BUILDING _____ B. WING _____	10/19/2010

RECEIVED NOV 10 2010 Division of Health Care Quality Enforcement Branch

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD ESTATES	195 BERRYMAN ROAD FRENCHBURG, KY 40322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated and partial extended survey (KY15438) was conducted on October 12-19, 2010. The allegation was substantiated. Immediate Jeopardy was identified on October 12, 2010, and determined to exist on October 10, 2010. The facility was notified of the Immediate Jeopardy on October 12, 2010. Deficiencies were cited at 483.20 Resident Assessment (F280), 483.25 Quality of Care (F323), and 483.75 Administration (F490) at a S/S of "J." Substandard Quality of Care (SQC) was identified in the area of 483.25 Quality of Care (F323). Additional deficiencies were cited at 483.20 Resident assessment (F272) at a S/S of "E." The facility provided an acceptable Allegation of Compliance (AOC) on October 19, 2010. Immediate Jeopardy was verified to be removed on October 16, 2010, with the S/S lowered to "D."	F 000		
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	**F272 COMPREHENSIVE ASSESSMENTS** ***The facility has ensured the following corrective action:*** Residents #1, 3, 4, 5, 6, and 7 were assessed for risk of wandering / elopement behaviors on 10/12/10 using the Elopement Risk Assessment tool. (Attachment #1a) per the Wandering Protocol (Attachment #1b). Resident #1 was identified to be at risk for elopement behavior. Residents #1, 3, 4, 5, 6 and 7's individual care plans were	

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

Anne Wills | 11/10/10

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

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F 272	Continued From page 1 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct accurate resident assessments utilizing the Resident Assessment Instrument (RAI) process for five (5) of eight (8) sampled residents (residents #3, #4, #5, #6, and #7) in order to develop a care plan for provision of care and services for each resident. The facility failed to identify residents who displayed wandering behavioral symptoms on the comprehensive assessment; therefore, the resident assessment protocols were not utilized to assess the nature of the condition, possible complication and risk factors, factors that must considered in developing an individual care plan, and need for referrals. Although residents #3, #4, #5, #6, and #7 were identified with wandering behaviors, the facility failed to identify these residents on the Minimum Data Set (MDS) assessments. The findings include:	F 272	• revised to reflect this risk as a problem area, and interventions were outlined. The completed Assessment was placed in Residents #1, 3, 4, 5, 6 and 7 's medical records. Review / reassessment will be accomplished at the quarterly Care Plan meeting as part of the comprehensive evaluation for the regularly scheduled MDS assessment, or as needed if a significant change of condition occurs. ***The facility has taken the following action to prevent this practice from affecting other residents:*** • All facility residents were assessed for risk of wandering / elopement behaviors on 10/12/10 using the Elopement Risk Assessment tool. (Attachment #1) Twelve residents were identified as being at risk for elopement behaviors and their individual care plans revised accordingly with interventions. The completed Assessments were placed in all facility residents' medical records. Review / reassessment will be accomplished at the quarterly Care Plan meeting as evaluation for the regularly scheduled MDS assessment.	

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F 272	Continued From page 2 Interviews conducted on October 19, 2010, at 9:30 a.m. and 10:00 a.m., with the Social Services Director (SSD) revealed the SSD completed the Mood and Behavior section of the residents' MDS assessments. The interview revealed the SSD utilized each resident's Mood and Behavior Patterns form, nurse's notes, and visual observations to complete the resident's MDS assessments. The SSD stated nursing staff completed the Mood and Behavior Patterns form every day on each resident. Review of the Mood and Behavior Pattern form revealed resident behavioral symptoms, which are included on the MDS Assessment (e.g. wandering behavior, physical abuse, etc.), were not included on this form. The SSD was unaware the Mood and Behavior Patterns form tool the facility utilized to gather information only addressed the resident's Mood section of the MDS. Further review of the form utilized by the facility revealed nurses chose repetitive physical movement, pacing, to describe the residents' wandering throughout the facility. The interview revealed the SSD considered ambulating/propelling throughout the facility as pacing. The SSD stated a resident was identified as a wanderer only if the resident attempted to leave the facility. According to the SSD, all 12 residents utilizing wanderguard bracelets were assessed to have mood indicators of repetitive physical movements as pacing, rather than the behavior indicators of wandering. Therefore, the mood Resident Assessment Protocol (RAP) guidelines were utilized instead of the behavior RAP guidelines. Interview conducted on October 12, 2010, at 3:10 p.m., and on October 19, 2010, at 8:50 a.m. and 10:40 a.m., with the Director of Nursing (DON) revealed there were 12 residents assessed by the	F 272	• From the results of the Elopement Assessments, the facility compiled a resident "Identification Record" (Attachment #2) for those individuals identified at being at risk for wandering / elopement. The record includes identifying information and a picture of each resident. Copies of the record books were placed in the following locations: 1) North nurse station, 2) South nurse station, 3) Medical Records, and the 4) Business Office. A poster with the identified residents' pictures/names was placed in the employee break room as a pictorial reminder/ reference for staff. ***The facility has initiated the following systemic changes to prevent this practice from recurring:*** • Nursing staff were in-serviced on the Elopement Risk Assessment tool, the Identification Record Book for Wandering Residents Protocol, and the Nursing Evaluation checklist for the MDS 3.0 which includes daily mood / behavior care area assessment guidelines on 10/15/10.	

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F 272	Continued From page 3 facility to be at risk for wandering/elopement with wanderguard bracelets in place. According to the DON, residents #3, #4, #5, #6, and #7 wore wanderguard bracelets due to displaying wandering behavioral symptoms. The DON stated the facility did not identify wandering behavior as a care plan problem. The DON said the wanderguard bracelet was added as an intervention under another previously identified care plan problem. The DON was unaware that the Mood and Behavior Patterns form tool the facility utilized to gather information about the resident's Mood and Behaviors only addressed the resident's Mood section of the MDS. The form did not address the Behaviors such as Wandering, Verbal Abuse, Physical Abuse, Socially Inappropriate, or Resistant to Care, which are in the Behavior section of the MDS assessment. According to the MDS 2.0 User's Manual, wandering is locomotion with no discernible, rational purpose. Wandering may be manifested by walking or by wheelchair. The MDS manual stated repetitive physical movement is pacing, hand wringing, restlessness, fidgeting, or picking. An interview conducted on October 19, 2010, at 11:00 a.m., with LPN #2 revealed the LPN thought wandering was only when a resident attempted to leave the facility, and pacing was when a resident ambulated/propelled throughout the facility. An interview conducted on October 19, 2010, at 11:10 a.m., with LPN #5 revealed the LPN thought wandering was when a resident attempted to go out the doors, and pacing was when a resident ambulated/propelled up and	F 272	***The facility will sustain performance through the following monitoring practice:*** • All residents admitted to the facility will be assessed, upon admission and quarterly thereafter, and/or PRN as needed for a significant change in condition, for wandering risk as part of the comprehensive assessment. All resident records shall contain the completed Elopement Risk Assessment tool, indicating the individual's determined level of risk. The facility nursing staff shall use a daily, weekly and monthly summary of care area items evaluation checklist to identify resident behaviors, including wandering. (Attachment #3a-b) For all <u>*on-going*</u> resident assessments, the Director of Nursing or her designee (i.e., MDS staff nurse, ADON) shall utilize the Elopement Risk Assessment and behavior checklist reports for accurate coding on the MDS assessments as they are scheduled. Nursing staff were in-serviced on the evaluation forms on 10/15/10. COMPLETION DATE FOR F272: October 21, 2010	

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F 272	Continued From page 4 down the hallways. 1. Observations conducted on October 13, 2010, at 12:57 p.m., and on October 18, 2010, at 1:30 p.m., revealed resident #3 displayed wandering behavioral symptoms, ambulating in the resident's room or in the hallways of the facility. Interviews conducted on October 12, 2010, at 2:30 p.m., with SRNA #1, at 2:45 p.m., with RN #1, and at 2:58 p.m., with LPN #1, and on October 13, 2010, at 1:35 p.m., with LPN #2, at 2:10 p.m., with LPN #3, and at 2:40 p.m., with SRNA #6, revealed resident #3 ambulated throughout the hallways daily. SRNA #1 stated resident #3 ambulates throughout the hallways with resident #6 often. Record review revealed resident #3 was admitted to the facility with diagnoses of Senile Dementia, Depression, Hypertension, Tachycardia, Anemia, and Osteoporosis. Review of resident #3's medical record revealed the resident ambulated independently throughout the facility. Review of resident #3's Quarterly MDS assessments dated April 12, 2010 and July 6, 2010, and an Annual assessment dated September 22, 2010, revealed the resident was assessed to have repetitive physical movements of pacing coded as a mood indicator during the look-back periods. Review of resident #3's Mood and Behavior Patterns forms revealed the resident was pacing the hallways constantly. However, there was no documentation that the resident wandered throughout the facility; therefore, the facility did not code wandering as a behavior for resident #3. Review of resident #3's care plan revealed the resident had a wanderguard in place; however, no other interventions were implemented to address	F 272		

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F 272	Continued From page 5 the resident's wandering behaviors. 2. Observations conducted on October 13, 2010, at 3:15 p.m., revealed resident #4 standing in front of the closet shuffling through the clothes. Interviews conducted on October 13, 2010, at 2:25 p.m., with SRNA #4, and at 3:00 p.m., with LPN #4, revealed resident #4 attempted to leave the building out the side exit doors several times with staff redirecting the resident. Record review revealed resident #4 was admitted to the facility with diagnoses of Dementia with behavior disturbances, Hard of Hearing, and Anemia. Review of resident #4's medical record revealed the resident ambulated independently throughout the facility. Review of resident #4's Admission MDS assessment dated August 24, 2010, revealed the resident was assessed to have persistent anger with self or others as a mood indicator during the look-back period. A review of resident #4's RAPs revealed the resident refused to wear a wanderguard bracelet saying, "It will set every alarm in here off." However, the resident would keep the wanderguard bracelet in his pocket. A review of resident #4's nurse's notes revealed on October 6, 2010, the resident became combative and kept opening the facility side doors. The nurse's notes on October 7, 2010, stated the resident was ambulating throughout the facility. Review of resident #4's care plan revealed the resident had a wanderguard in place; however, no other interventions were implemented to address the resident's elopement attempts and wandering behaviors.	F 272		

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F 272	Continued From page 6 3. Observations conducted on October 18, 2010, at 1:20 p.m. and 3:50 p.m., revealed resident #5 displayed wandering behavioral symptoms, ambulating in the hallways throughout the facility. Interviews on October 12, 2010, at 2:30 p.m., with SRNA #1, and at 2:58 p.m., with RN #1, and on October 13, 2010, at 1:35 p.m., with LPN #1, at 2:10 p.m., with LPN #2, and at 2:40 p.m., with LPN #3 revealed resident #5 ambulated throughout the hallways daily. Record review revealed resident #5 was admitted to the facility with diagnoses of Alzheimer's, Hypertension, Anxiety, Multiple Deep Vein Thrombosis, and Aggressive Behaviors. Review of resident #5's medical record revealed the resident ambulates independently throughout the facility. Review of resident #5's Quarterly MDS assessments dated April 26, 2010 and August 3, 2010, and a Significant Change MDS assessment dated May 11, 2010, revealed the resident was assessed to have persistent anger with self or others and repetitive physical movements, pacing, as a mood indicator during the look-back period. A review of resident #5's RAPs revealed the resident had repetitive physical movements such as pacing in the hallway. A review of resident #5's Mood and Behavior Patterns forms for September 2010 and October 2010 revealed the resident was constantly pacing in the hallways. Review of resident #5's care plan revealed the resident had a wanderguard bracelet in place; however, no other interventions were	F 272		

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F 272	Continued From page 7 implemented to address the resident's wandering behaviors. 4. Observation conducted on October 18, 2010, at 3:55 p.m., revealed resident #6 displayed wandering behavioral symptoms, ambulating in the hallway throughout the facility with another resident. Interviews conducted on October 12, 2010, at 2:30 p.m., with SRNA #1, and at 2:58 p.m., with RN #1, and on October 13, 2010, at 1:35 p.m., with LPN #1, and at 2:40 p.m., with LPN #2 revealed resident #6 ambulated throughout the hallways daily. Record review revealed resident #6 was admitted to the facility with diagnoses of Senile Dementia, Atrial Fibrillation, Hypertension, Vitamin B deficiency, Chronic Constipation, and Depression. Review of resident #6's medical record revealed the resident ambulated independently throughout the facility. Review of resident #6's Annual MDS assessment dated October 30, 2009, and a Quarterly MDS assessment dated July 9, 2010, revealed the resident was assessed to have insomnia and repetitive physical movements, pacing, as mood indicators during the look-back period. A review of resident #6's Mood and Behavior Patterns form for October 2010 revealed the resident was constantly pacing in the hallways. Review of resident #6's care plan revealed the resident had a wanderguard bracelet in place; however, no other interventions were implemented to address the resident's wandering behaviors.	F 272		

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F 272	Continued From page 8	F 272		

5. Observation conducted on October 18, 2010, at 5:25 p.m., revealed resident #7 displayed wandering behavioral symptoms and independently propelled a wheelchair out of the dining room into the hallway.

Interviews conducted on October 12, 2010, at 2:30 p.m., with SRNA #1, and at 2:58 p.m., with RN #1, and on October 13, 2010, at 1:35 p.m., with LPN #1, and at 2:40 p.m., with LPN #2 revealed resident #7 propels the wheelchair throughout the hallways daily. SRNA #1 stated the resident goes to the front door looking for the resident's son.

Record review revealed resident #7 was admitted to the facility with diagnoses of Senile Dementia, Hypertension, Bipolar with Paranoid Delusions, Gastroesophageal Laceration, Osteoporosis, and Schizophrenia. Review of resident #7's medical record revealed the resident independently propelled a wheelchair throughout the facility.

Review of resident #7's Admission MDS assessment dated January 12, 2010, and Quarterly MDS assessments dated July 3, 2010 and September 29, 2010, revealed the resident was assessed to have repetitive verbalizations and repetitive physical movements, pacing, as mood indicators during the look-back period. A review of resident #7's Mood and Behavior Patterns forms for September 2010 and October 2010 revealed the resident propelled up and down the hallway looking for family members.

Review of resident #7's care plan revealed the resident had a wanderguard bracelet in place; however, no other interventions were

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F 272	Continued From page 9 implemented to address the resident's wandering behaviors. The failure of the facility to accurately assess the resident's wandering behaviors led to the failure to develop a care plan addressing the resident's wandering behaviors.	F 272		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the comprehensive plan of care was revised for one (1) of eight (8) sampled residents (resident #1). On September 26, 2010, resident #1 attempted to open the front door of the facility and stated	F 280	**F280 RIGHT TO PARTICIPATE PLANNING CARE - REVISE CP** ***The facility has ensured the following corrective action:*** • The individual care plan for Residents #1, identified as being at risk for wandering/ elopement behavior, was revised on 10/13/10. The care plan revision includes wandering / elopement risk as a problem area, and outlined interventions for staff use. Examples of interventions include, but are not limited to: notification of physician; the placement of a wander guard device if ordered by physician; offering of alternate activities, such as toileting, snacks, group activity; Psychiatric consult,; and/or 1:1 supervision as needed.	

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F 280	Continued From page 10 he/she wanted to find his/her car. Although the facility placed a wanderguard bracelet on the resident, there was no evidence the facility revised the resident Care Plan to include additional interventions for supervision to prevent elopement. In addition, even though the resident exhibited wandering behavior, there was no evidence the facility revised the Care Plan to include interventions for the behavior. On October 10, 2010, at 10:45 a.m., resident #1 exited the facility without staff knowledge. The resident was found outside the facility in a parking lot by a staff member 35 minutes later. This facility's failure to implement additional interventions placed the resident at risk for serious harm, injury, impairment, or death. The findings include; Observation conducted on October 13, 2010, at 12:57 p.m., revealed resident #1 in a wheelchair displaying wandering behavior, as defined by the MDS 2.0 User's Manual to include locomotion with no discernible, rational purpose, which can be manifested by walking or wheelchair. The resident was propelling self in the hallway of the facility. Further observation on October 13, 2010, at 1:14 p.m., revealed resident #1 propelled down to the nurses' station and past the station down the hallway of the facility. Review of resident #1's medical record revealed the resident propelled independently in the wheelchair throughout the facility. According to resident #1's nurse's notes dated September 26, 2010, resident #1 was attempting to open the front door of the facility; the resident stated, "I'm want to look for my car." The nurse's notes	F 280	***The facility has taken the following action to prevent this practice from affecting other residents:*** • All residents identified as being at risk for wandering / elopement behavior (12 residents) received a revision to their Individual Care Plans on 10/13/10 to include this risk as a problem area. Interventions were added for each resident to address the behavior. Examples of interventions include, but are not limited to: notification of physician; the placement of a wander guard device if ordered by physician; offering of alternate activities, such as toileting, snacks, group activity; 1:1 supervision as needed. • An Elopement Risk Assessment was completed for all facility residents on 10/12/10 and will be completed for future residents upon admission to the facility. The Assessments were filed in all individual residents' medical records. Each Assessment sheet includes notation area for four (4) quarterly reviews.	

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	185423	A. BUILDING _____ B. WING _____	C 10/19/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD ESTATES	196 BERRYMAN ROAD FRENCHBURG, KY 40322

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F 280	Continued From page 11 stated a wanderguard bracelet was applied at the time. Review of resident #1's comprehensive Care Plan dated November 15, 2008, revealed the resident's wandering behavioral symptoms were not addressed as a care need on resident #1's care plan. The plan of care included an update on September 26, 2010, which stated the resident had attempted to open the front door. The goal was listed as "free from elopement." The only interventions listed were to notify the physician and apply a wanderguard. No further supervision interventions were identified. There was no evidence the wandering behavior was identified as a care problem, and no interventions included in the Care Plan to address the behavior. Interview conducted on October 12, 2010, at 3:10 p.m., and on October 19, 2010, at 8:50 a.m. and 10:40 a.m., with the Director of Nursing (DON) revealed there were 12 residents assessed by the facility to be at risk for wandering/elopement with wanderguard bracelets in place. According to the DON, these 12 residents wore wanderguard bracelets due to displaying wandering behavioral symptoms. The DON stated a resident's wandering behavior was not identified as a care plan problem. The DON said the wanderguard bracelet was usually added as an intervention under another previously identified care plan problem. Observation on October 12, 2010, revealed only the facility's front door was equipped a wanderguard alarm system. However, three additional exit doors were observed, accessible to resident #1, which were not equipped with the wanderguard system. Observation of the three	F 280	***The facility has initiated the following systemic changes to prevent this practice from recurring:*** • The Elopement Risk Assessment shall be reviewed by the multidisciplinary team each quarter during the Care Planning process for changes or needed updates. The assessor shall sign the Assessment sheet at each review. Other staff participation shall be noted by signature on a Care Plan Meeting summary sheet. ***The facility will sustain performance through the following monitoring practice:*** • The Director of Nursing, or nurse designee (I.e., MDS staff nurse, ADON), shall ensure that a quarterly review of the Elopement Risk Assessment sheets will be completed by the multidisciplinary team during the quarterly Care Planning process for all residents. The DON shall ensure that changes are reflected on the resident plan of care and coded on the scheduled MDS for all resident assessments. • The Director of Nursing will review all Elopement Attempt Report sheets (Attachment #4)	

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F 280	Continued From page 12 side exit doors revealed all of the door alarms sounded when opened; however, the alarms did not sound with the intensity of the wanderguard alarm system at the facility's front door. Review of the nurse's notes dated October 10, 2010, at 11:50 a.m., and the facility investigation report dated October 10, 2010, revealed resident #1 exited the facility, without staff knowledge, and was found by SRNA #1 in the employee parking lot at the side of the building 35 minutes later. **An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was submitted by the facility on October 19, 2010, which alleged removal of Immediate Jeopardy effective October 16, 2010. A partial extended survey was conducted on October 18-19, 2010, which determined the Immediate Jeopardy was removed on October 16, 2010. Interviews with the Administrator and the Director of Nursing (DON) and review of the facility records on October 18-19, 2010, revealed the facility reassessed all residents in the facility on October 12, 2010, utilizing an Elopement Risk Assessment. Other than the 12 residents previously assessed to be at risk for elopement, no other residents were identified as an elopement risk. The facility implemented new Elopement care plans for each of the 12 residents assessed to be at risk for elopement with multiple interventions to be implemented to include visual checks every two hours. Observations revealed the residents' care plans were followed and all interventions related to wandering/elopement for residents were implemented. Review of the facility's in-service records and	F 280	after each alarm occurrence. The Director of Nursing will present a summary of the reports, including the following reviews, as an *ongoing* monthly Quality Assurance review for the nursing department: 1. The number (#) of residents identified to be at risk for wandering / elopement. 2. The number (#) of elopement attempts made during the month. 3. The resident outcome of any elopement attempts. (Attachment #5) COMPLETION DATE FOR F280: October 21, 2010	

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F 280	Continued From page 13 interviews with the Administrator and DON on October 18-19, 2010, revealed staff was re-educated on October 15, 2010, by the DON on the facility's new Elopement Risk Assessment, the new 3.0 MDS assessment forms and the new Elopement care plan to include visual checks every two hours. Interviews with staff on October 19, 2010, confirmed staff attended the in-service trainings and was knowledgeable of the information regarding the new Elopement resident assessment and care plan information. Based on the above findings, it was determined on October 19, 2010, the Immediate Jeopardy was removed effective October 16, 2010. Noncompliance continued with the scope and severity lowered to "D" based on the facility's need to evaluate the effectiveness of quality assurance activities related to assessment of residents' needs as they relate to wandering/elopement, and implementation of interventions to ensure elopements do not occur.	F 280		
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 and record	F 323	**F 323 FREE OF ACCIDENT - HAZARDS / SUPERVISION / DEVICES** ***The facility has ensured the following corrective action:*** On 10/10/10, following the resident elopement, a complete resident head count was initiated to account for all facility residents. All residents were noted to be present in the facility. Head counts ensued six times	

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F 323	Continued From page 14 review, it was determined the facility failed to provide adequate supervision and monitoring to prevent accidents for one (1) of eight (8) sampled residents (resident #1) who displayed wandering and elopement behavioral symptoms. Resident #1 was identified by the facility as a risk for elopement on September 26, 2010, and a wanderguard bracelet was placed on the resident at that time. However, no other care plan interventions were developed to address the risk of elopement from the facility. On Sunday, October 10, 2010, at 10:45 a.m., resident #1 exited the facility without staff knowledge, utilizing a side exit door on the North Unit. Resident #1 was located at 11:20 a.m. on October 10, 2010, in the employee parking lot, at the side of the facility, by facility staff. The resident was absent from the facility and unsupervised by facility staff for 35 minutes. The failure to ensure adequate supervision and monitoring placed residents in the facility at risk for serious injury, harm, impairment, or death. The findings include: Observation on October 12, 2010, revealed only the facility's front door was equipped with the wanderguard alarm system. Three side exit doors which were accessible by mobile residents were equipped with alarms. However, the side exit doors were not equipped with the wanderguard alarm system. The observation of the three side exit doors revealed all of the door alarms sounded when opened; however, the alarms did not sound with the intensity of the wanderguard alarm system at the facility's front door.	F 323	daily until the placement of additional alarms on all exit doors. • On 10/12/10 a staff member was placed at each nurses station, or in a centrally located area where the three exit doors are visible, at all times for visual and auditory monitoring of the exit doors. The daily charge nurse at each station is responsible for assigning staff to complete the monitoring, and to coordinate a centrally located monitor in the event both nurses are required to be away from their stations. Each charge nurse dates and initials the completion of this assignment on the daily shift report sheets provided to the DON. • In addition to the existing alarms on each of the facility's exit fire doors (an alarm that activates a light at the nurse station once the door is opened, and is re-set by a button on the enunciator panel at the nurse station), a temporary, secondary alarm was placed on all exit doors on 10/13/10. A permanent secondary alarm was placed on all exit doors on 10/16/10. Each alarm sounds continuously at 105 dB until re-set. A shut off of the alarm requires a manually keyed re-set at the site (each door) where the	

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F 323	Continued From page 15 Review of the facility policy entitled "Door Alarms" dated January 24, 2004, revealed when an exterior door alarm sounded staff was required to complete a visual check of the exterior and interior areas to determine if a resident exited the door. Observation conducted on October 13, 2010, at 12:57 p.m., revealed resident #1 in a wheelchair propelling self in the hallway of the facility. Further observation on October 13, 2010, at 1:14 p.m., revealed resident #1 propelled down to the nurses' station and continued down the hallway past the nursing station. Interviews conducted on October 12, 2010, at 2:30 p.m., with SRNA #1, at 2:45 p.m., with RN #1, and at 2:58 p.m., with LPN #1, and on October 13, 2010, at 1:35 p.m., and with LPN #2 at 2:40 p.m., revealed resident #1 propelled the wheelchair up and down the hallways in the facility daily. Review of nurse's notes dated September 26, 2010, revealed resident #1 was attempting to open the front door of the facility, and the resident stated, "I'm want to look for my car." The nurse's notes stated a wanderguard bracelet was applied; however, no other interventions were implemented at that time. Review of the nurse's notes dated October 10, 2010, at 11:50 a.m., revealed resident #1 was found outside the facility by SRNA #1. Review of the facility's investigation dated October 10, 2010, into resident #1's elopement revealed the facility's exterior video surveillance showed resident #1 exited the North Unit side	F 323	alarm is placed. (Attachment #6) ***The facility has taken the following action to prevent this practice from affecting other residents:*** • To ensure accurate response to an activated door alarm, a revision was made to the Door Alarm Policy (Attachment #6a)on 10/13/10 that requires a complete resident head count be performed in the event any door alarm is sounded. All employees were in-serviced on the revised policy and new alarms on 10/13/10. • In addition to the existing alarms on each of the facility's exit fire doors (an alarm that activates a light at the nurse station once the door is opened, and is re-set by a button on the enunciator panel at the nurse station), a temporary, secondary alarm was placed on all exit doors on 10/13/10. A permanent secondary alarm was placed on all exit doors on 10/16/10. Each alarm sounds continuously at 105 dB until re-set. A shut off of the alarm requires a manually keyed re-set at the site (each door) where the	

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F 323	Continued From page 16 door on October 10, 2010, at 10:46 a.m. The investigation stated SRNA #1 found resident #1 in the employee parking lot at 11:30 a.m., when SRNA #1 went to lunch. The investigation revealed SRNA #2 heard the North Unit side door alarm, observed resident #3 with the resident's hand on the door handle, redirected the resident away from the door, reset the door alarm, and clocked out for lunch. The investigation concluded that SRNA #2 did not perform an exterior inspection as per door alarm protocol, and had assumed resident #3 pushed on the door handle sounding the side door alarm. Review of the facility investigation revealed the resident was absent from the facility, and unsupervised by facility staff, for at least 35 minutes. An interview conducted on October 12, 2010, at 2:30 p.m., with SRNA #1, revealed on October 10, 2010, the SRNA exited the facility through the front door and walked around the side of the building to the employee parking lot. The SRNA found resident #1 in a wheelchair just off the sidewalk from the North Unit side door. An interview conducted on October 12, 2010, at 2:45 p.m., with RN #1 revealed on October 10, 2010, the RN returned from lunch about the time SRNA #1 was bringing resident #1 back into the facility. RN #1 stated resident #1's wanderguard bracelet and all door alarms were checked and functioning properly. The RN indicated an investigation was initiated and staff told her that another staff member heard the North Unit door alarm but thought a different resident had pushed on the door, so the staff did not perform a visual inspection of the exterior. An interview conducted on October 13, 2010, at	F 323	alarm is placed. (Attachment #6b) ***The facility has initiated the following systemic changes to prevent this practice from recurring:*** • A copy and review of the Elopement Risk Assessment and Door Alarm Policy shall be provided to each employee upon hire, and annually thereafter, as general orientation to the facility practice regarding wandering / elopement behavior. ***The facility will sustain performance through the following monitoring practice:*** • Charge Nurse staff shall date and initial the daily shift sheets for the visual inspection of the alarm panels to ensure they are lit and operational. (Attachment #7) The daily reports will be reviewed by the Director of Nursing upon receipt. A summary of the door alarm reports shall be included as and *ongoing* part of the Director of Nursing's Quality Assurance monthly review for the nursing department. (Attachment #5) • The Director of Environmental Services, or Maintenance staff designee, shall inspect the secondary alarms on a weekly	

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