

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2011
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
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<p>F 000</p> <p>F 323 SS=E</p>	<p>INITIAL COMMENTS</p> <p>An abbreviated survey investigating ARO # KY00017150 was conducted 09/26/11-09/29/11 with the highest scope/severity of a "E". ARO # KY00017150 was substantiated with a related deficiency cited.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure residents received adequate supervision and failed to ensure an environment free of accidental hazards. The facility failed to ensure staff were aware of residents who had been assessed as being at risk for elopement and failed to identify the alarm on exit door #8, which was accessible by all residents, was audible from the nurses station and the Skilled Nursing Unit. This failure effected one (1) of six (6) sampled residents, Resident #1 and eleven (11) other residents the facility had identified as being at risk for elopement/wandering.</p> <p>The facility admitted Resident #1 on 09/23/11 and at approximately 3:15 AM on 09/24/11 the</p>	<p>F 000</p> <p>F 323</p>	<p>Bracken County Nursing and Rehabilitation enter does not believe and does not admit that any deficiencies existed before, during or after the survey. Facility reserves the rights to contest the survey findings through Informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Facility, reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance, or self critical examination privilege which Facility, does not waive and reserves the right to assert any administrative, civil or criminal claim, action or proceeding. Facility, offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.</p> <p>F323</p> <p><u>Immediate Interventions:</u> Resident #1 was returned to the facility at 3:30pm on 9/24/11 by a facility State Registered Nursing Assistant (SRNA). An assessment was completed by the charge nurse and determined that there was no injury to resident #1.</p>	<p>10/11/11</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Adura Moore</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/22/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 323	<p>Continued From page 1</p> <p>resident used exit door #6 to exit the facility without staff knowledge. A resident from the Personal Care Unit used his/her wheelchair to propel approximately 280 feet from his/her room to the nurses station and then into the dining room behind the nurses station to alert staff Resident #1 had exited the building and the alarm was sounding. Interview with the staff working in the facility on 09/24/11, at the time of Resident #1's elopement, revealed they were unable to hear the alarm sounding.</p> <p>The findings include:</p> <p>Review of the facility's Elopement Risk/Wanderers Master List, not dated, revealed the facility had identified eleven (11) residents as being at risk for elopement and/or wandering.</p> <p>Record review revealed the facility admitted Resident #1 on 09/23/11 with diagnoses which included Progressive Dysphagia, Gait Disorder, Hypertension, Osteoporosis and Right Frontal Lobe Tumor. Interview with the Director of Nursing (DON), on 09/27/11 at 11:30 AM, revealed no exit seeking behaviors were noted on the day of admission. She further stated the resident was assessed as being a low risk for elopement.</p> <p>Continued interview with the DON, on 09/27/11 at 11:30 AM, revealed on 09/24/11, staff had been in Resident #1's room at 3:00 AM and Resident #1 was in his/her bed. She further stated a resident from the Personal Care Unit notified staff at 3:15 AM that Resident #1 had exited the facility through exit door #6 and the alarm was sounding. She further stated since the incident, the facility</p>	F 323	<p><i>Cont'd</i></p> <p><u>Identification of the residents with potential to be affected:</u> The Director of Nursing and MDS Coordinator completed a count of all residents in the facility based on the census list. All residents were accounted for and determined to be safe.</p> <p><u>Measures to Prevent Recurrence:</u> All residents were re-assessed for their risk of elopement on 9/24/11 by the Director of Nursing and MDS Coordinator. No new residents were identified as being at risk for elopement. An elopement risk assessment will be completed on admission, quarterly, and with initiation of exit seeking behavior for all residents. A binder containing pictures and characteristics of Residents identified as being at risk for elopement is maintained at the Reception desk and at the Nurses' Station. This will be updated as indicated and reviewed weekly by the Social Services Director. Beginning 9/26/11, an aide is designated to provide 24/7 supervision of residents on the Personal Care Unit. In-service education was completed for staff by the Director of Nursing for all facility staff by 9/26/11 regarding the facility elopement and missing resident policy. All exit doors and alarms were reviewed by the Director of Plant Operations on 9/24/11, and were found to be functioning properly. The Director of Plant Operations completed</p>	

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F 323	<p>Continued From page 2</p> <p>had been unable to find an alarm which was loud enough to be heard at the nurses station.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #6, on 09/27/11 at 8:40 PM, revealed she was in a resident's room and did not hear the door alarm sounding on 09/24/11 when Resident #1 eloped. She stated she saw Licensed Practical Nurse (LPN) #1 and SRNA #8 running down the hallway towards the dining room/Personal Care Unit. Further interview with SRNA #6 revealed Resident #1 did not appear to be confused. She continued to state that exit door #6 was on the Personal Care Unit and the facility did not assign staff to that Unit at night.</p> <p>Interview with LPN #1, on 09/28/11 at 9:00 PM, revealed Resident #1 was a new admission on her shift and she further indicated the resident was alert and oriented. She stated she completed the assessments on Resident #1 and did not have any indication the resident was an elopement risk. She stated Resident #1 was noted to be walking down the hallway some time between 12:30 AM and 1:00 AM on 09/24/11, towards the Personal Care Unit/Dining Room and was easily redirected, however appeared to be confused. Further interview revealed Resident #1 was observed in bed at 2:30 AM. She stated she and SRNA #8 took their lunch break in the dining room behind the Nurse's station when another resident from the Personal Care Unit wheeled his/her wheelchair into the dining room and stated a white haired resident had pressed a button and walked out the door near his/her room. LPN #1 stated she and SRNA #8 ran to exit door #6 and she could not hear the alarm until she was almost to the area, just past the Physical Therapy</p>	F 323	<p><i>Cont'd</i></p> <p>wiring on exit door #6 that causes the alarm to sound at exit door #3 on the Skilled Nursing Unit. On 9/24/11, video monitors that monitor all exits were moved by the Director of Plant Operations from the Administrator's office to the Nursing Station to allow viewing of each exit immediately, should a door alarm sound. On 9/25/11, additional alarms were installed by the Director of Plant Operations on all exit doors. The alarm requires a code to silence the alarm should the door be opened. On 9/29/11, door alarms that sound at 85 decibels, and can be heard readily throughout the facility, were installed on exits #3, exit #4, exit #6, and exit #7. These alarms sound continuously when the exit door is opened, and will continue to sound until it is disarmed with keys that are maintained by the SRNAs and the Charge Nurse. The Director of Plant Operations completed in-service education, with all facility staff receiving the in-service by 10/10/11 regarding the alarms at exit doors. An interview will be conducted by the Staff Development Coordinator, Social Services Director, Administrator, and Weekend Manager for 3 staff members weekly for 8 weeks regarding the elopement and missing resident policy and door alarm process, to include identification of residents who have been assessed to be</p>	
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F.323	<p>Continued From page 3</p> <p>department. She indicated because of the description given by the other resident, she and SRNA #6 checked Resident #1's room first before counting all residents and SRNA #8 went out the exit door #6. She further indicated SRNA #8 called the facility telephone stating she had located the resident and she was attempting to encourage the resident to come back to the facility. LPN #1 stated she sent SRNA #6 out to assist SRNA #8 with Resident #1 and she notified the administrative person on call and began filling out the paper work. Continued interview, on 09/28/11 at 9:18 PM, revealed the administrative staff said the alarm should have sounded through the whole building.</p> <p>Interview with SRNA #8, on 09/28/11 at 8:56 AM revealed she was on her lunch break at 3:15 AM and had been in Resident #1's room ten (10) to fifteen (15) minutes prior to taking her break. She further stated SRNA #6 was doing checks on the Skilled Unit and LPN #1 was also on her lunch break in the dining room behind the Nurse's station. She stated another resident came into the dining room behind the Nurse's station and was trying to tell LPN #1 something, she could not understand the resident so LPN #1 asked SRNA #8 to come in from outside the dining room to see if she could understand what the resident was saying. She indicated the resident said a person with white hair went out the door and the alarm was sounding. SRNA #8 stated she was unable to hear the alarm sounding until she got to about where the phone was located in the hallway closest to the Personal Care Unit. Further interview revealed SRNA #8 went out exit door #6 and once outside was able to locate Resident #1. She stated Resident #1 appeared confused, was</p>	F.323	<p><i>cont'd</i></p> <p>at risk for elopement. The Director of Plant Operations or the Weekend Manager will monitor exit doors for proper alarm function daily.</p> <p><u>Monitoring:</u> Findings of the above stated audits will be reviewed in the Quality Assurance meeting monthly for recommendations and further follow-up as indicated. The Quality Assurance Committee consists of the following members: Medical Director, Administrator, Director of Nursing, Business Office Manager, Human Resources Coordinator, Social Services Director, Admissions Coordinator, MDS Coordinator, Medical Records Coordinator, Dietary Manager, Housekeeping/Laundry Manager, Plant Operations Director, Staff Development Coordinator, Quality of Life Director, Chaplain, Consulting Pharmacist, Consulting Dietician, and the Rehabilitation Services Manager.</p>	

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F 323	<p>Continued From page 4</p> <p>trying to hit SRNA #8, saying no to everything SRNA #8 said and stating he/she was trying to get home.</p> <p>Interview with Registered Nurse (RN) #2, on 09/28/11 at 8:00 AM, revealed it was difficult to hear the alarm sounding from exit door #6. She further stated she was not aware of any residents who were assessed to be elopement risks/wanderers. Further interview revealed depending on how the schedule was made, there was typically no staff scheduled for the Personal Care Unit, which was where exit door #6 was located, from 8:00 PM or 10:00 PM until 6:00 AM.</p> <p>Interview with RN #3, on 09/28/11 at 8:46 AM, revealed the facility did not usually schedule staff to work on the Personal Care Unit at night and staff would do an hourly check where they walked down the unit and did a count of the residents.</p> <p>Interview with the Maintenance Director, on 09/28/11 at 8:18 AM, revealed he was not aware the alarms on the Personal Care/dining room side of the facility were difficult to hear at the Nurse's Station. He further stated he was notified on Saturday, 09/24/11, the administrative staff wanted to have a more audible sound through the building. He indicated he wired the alarm on exit door #6 to the alarm on exit door #3 on 09/24/11 and then on 09/25/11 he wired the alarm on exit door #5 and on exit door #7 to sound at exit door #3. He further stated staff was aware when he was checking alarms on the doors and no one had made him aware the alarms in that area of the facility could not be heard from the Nurse's station.</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>Interview with SRNA #7, on 09/29/11 at 2:29 PM revealed she was only able to identify one (1) of the eleven (11) residents who were identified by the facility to be at risk for elopement/wandering.</p> <p>Interview with SRNA #8, on 09/29/11 at 2:50 PM revealed she was only able to identify two (2) of eleven (11) residents who the facility identified to be at risk for elopement/wandering.</p> <p>Interview with Certified Medication Technician (CMT) #1, on 09/29/11 at 3:09 PM, revealed she was able to identify eight (8) of the eleven (11) residents who the facility identified to be at risk for elopement/wandering. She further indicated, before the incident with Resident #1, there was no staff scheduled to be on the Personal Care Unit at night and the aides who were scheduled to work on the Skilled Unit did checks on the Personal Care Unit every two (2) hours.</p> <p>Interview with Registered Nurse (RN) #1, on 09/28/11 at 3:35 PM, revealed he started eight (8) weeks ago and was unaware of an elopement risk book and he further stated he would need to ask the DON.</p> <p>Observation, on 09/28/11 at 3:45 PM, revealed the Administrator was at the nursing station asking staff if they were able to hear the alarm, which was being sounded for a test. Four (4) SRNAs stated they were unable to hear the alarms and one (1) RN stated she was unable to hear the alarm. The Administrator indicated this was the alarm from exit door #6, which was sounding through the alarm on exit door #3, which was at the end of the Skilled Nursing Unit.</p>	F 323		
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F 323	<p>Continued From page 6</p> <p>Interview with RN #1, on 09/28/11 at 3:50 PM, revealed before the camera monitor was placed at the nurses station and staff heard an alarm they would just have to go looking for where the alarm was sounding from to find out which door was alarming.</p> <p>Interview with SRNA #2, on 09/28/11 at 4:05 PM, revealed if the alarm could not be heard at the nurses station, staff would definitely be unable to hear it in a resident's room with the door closed. Further interview revealed she was only able to identify five (5) of the eleven (11) residents who had been identified by the facility as being elopement risks/wanderers.</p> <p>Interview with SRNA #3, on 09/28/11 at 4:25 PM, revealed she was only able to identify two (2) of the eleven (11) residents who were identified as being at risk for elopement/wandering. She further stated she did not feel the door alarm, which sounded during the test was loud enough. Further interview revealed she had never seen the Elopement Risk/Wanderers book, which listed residents who were at risk for elopement/wandering.</p> <p>Interview with SRNA #4, on 09/28/11 at 4:45 PM, revealed she was only able to identify two (2) of the eleven (11) residents who were identified as being at risk for elopement/wandering. She further indicated she did not hear the alarm, which sounded during the test, while standing at the nurses station.</p> <p>Interview with SRNA #5, on 09/28/11 at 5:05 PM, revealed she was unable to identify any of the eleven (11) residents who were identified as</p>	F 323		

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F 323	<p>Continued From page 7</p> <p>being at risk for elopement/wandering. She further indicated she could hear the alarm which sounded during the test, however, stated no one would be able to hear the alarm behind a closed door in the residents rooms. She further stated the facility had not informed her of residents who were at risk for elopement.</p> <p>Interview with the Maintenance Director, on 09/29/11 at 5:18 PM, revealed it was approximately 165 feet from the end of the Skilled Nursing Facility Unit to exit door #6 on the Personal Care Unit room and approximately 290 feet from the Nurses Station to exit door #6.</p>	F 323		