

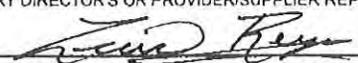
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/30/2012
NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066	

(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	INITIAL COMMENTS  An abbreviated survey (KY#18093) was conducted on 03/28/12 through 03/30/12. A partial extended survey was conducted 03/30/12. Immediate Jeopardy was identified on 03/29/12 and determined to exist on 03/25/12 at 42 CFR 483.20 Resident Assessment, F282; 42 CFR 483.25 Quality of Care, F323, 42 CFR 483.75 Administration, F490 at a scope of severity of a "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care. The facility was notified of the Immediate Jeopardy on 03/29/12.  Based on observation, interview, record review, Clinical Practice Guideline and Policy and Procedure reviews, it was determined the facility failed to ensure one resident (#1) in the selected sample of nine residents, received adequate supervision to prevent accidents. The facility failed to follow their Missing Resident/Resident Elopement policy. The facility failed to ensure care plan interventions utilized were functioning properly to alert staff to address Resident #1's wandering behaviors in an effort to provide adequate supervision. Additionally, the facility failed to follow the care plan for Resident #1 when staff observed this Resident, on 03/25/12 prior to 9:00 PM, wandering the perimeter of the interior of the facility without staff intervention to "inquire to the reason for wandering and to attempt to meet that need." The facility's system for supervision utilizing, the wanderguard assistive device for residents identified as wandering risk, was ineffective to ensure the safety of these residents. The facility had identified, assessed and care planned fifteen residents with wandering behaviors. Resident #1, who the facility had identified, assessed and care	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/22/12
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 4/23/12

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F 000	<p>Continued From page 1</p> <p>planned as having wandering behaviors, exited the facility on 03/25/12 after 9:00 PM without staff knowledge. The facility found Resident #1 off the facility campus sitting in an unknown car in the driver seat, asleep after 9:30 PM. Facility staff documented last seeing Resident #1 at 9:00 PM on 03/25/12. The facility had identified that staff was to utilize the wanderguard and conduct every fifteen minutes checks of Resident #1. Facility staff interviews identified that Resident #1 could walk through the facility very quickly within approximately two minutes and had a history of going door to door. Interviews with facility staff identified that they did not hear the audible wanderguard alarm while providing care to other residents at the time Resident #1 exited the building without staff knowledge. This failure to ensure adequate staff supervision of Resident #1 and the facility's failure to ensure the assistive device functioned adequately and effectively, prevented the facility from identifying Resident #1 was exit seeking on 03/25/12 in order to redirect him/her to safety.</p> <p>The facility's failure to ensure adequate supervision of residents the facility had identified as having wandering behaviors and/or at risk for elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/29/12 and determined to exist on 03/25/12 and Substandard Quality of Care was identified at 483.25. The Immediate Jeopardy was determined removed on 03/30/12 lowering the scope and severity to a "D", as the facility had not completed the Quality Assurance (QA) initiative related to staff monitoring, analysis of monitoring audit results and the development and</p>	F 000		
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<p>F 000</p> <p>F 282 SS=J</p>	<p>Continued From page 2 Implementation of the Plan of Correction (POC) to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and Clinical Practice Guideline review, it was determined the facility failed to ensure care was provided in accordance with the plan of care, for one resident (#1), of a selected sample of nine residents, related to behaviors of wandering and exit seeking. The facility failed to ensure care plan interventions utilized were functioning properly to alert staff to address a resident's wandering behaviors in an effort to provide adequate supervision. The facility failed to follow the care plan for Resident #1 when staff observed this resident on 03/25/12 prior to 9:00 PM wandering the perimeter of the interior of the facility without staff intervention to "inquire to the reason for wandering and to attempt to meet that need." Resident #1, who the facility had assessed as at risk for elopement, exited the facility without staff knowledge on 03/25/12 sometime after 9:00 PM. Sometime after 9:00 PM, the facility's wanderguard alarm was activated; however, nursing staff was unable to address the alert immediately as they were providing care to other</p>	<p>F 000</p> <p>F 282</p>	<p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p><b>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>It is the normal practice of Mills Health and Rehab to provide services in accordance with each residents written plan of care.</p> <p><u>Corrective Measures for Resident Identified in the deficiency:</u></p> <p>Resident #1 had a bed alarm placed on the bed on 3/25/12 and was put on 1:1 monitoring, which continues at this time. Resident # 1's care plan was reviewed by the unit nurse on 3/25/12 and updated to reflect the new interventions.</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>The care plans of residents who had previously been identified as being at risk for elopement, were reviewed for accuracy and implementation on 3/26/12 by the Director of Nursing , ADON and MDS Coordinators.</p>	<p>4/18/12</p>
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F 282	<p>Continued From page 3</p> <p>residents and could not hear the alarm in residents' rooms or throughout the facility. Once staff heard the alarm and identified the front door of the facility was alarming, they initiated the elopement procedures identifying that Resident #1 was missing. The facility found the resident off the facility campus, down the street, sitting in the driver's seat of a parked car. The facility assessed the resident as having no injuries noted.</p> <p>The facility's failure to ensure care plan interventions were followed and devices were functioning properly in order to provide adequate supervision of residents the facility had identified as having wandering behaviors and/or at risk for elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/29/12 and determined to exist on 03/25/12. The immediate Jeopardy was determined removed on 03/30/12 lowering the scope and severity to a "D", as the facility had not completed the Quality Assurance (QA) Initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the Plan of Correction (POC) to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.</p> <p>(Refer to F323)</p> <p>Findings include:</p> <p>Review of the "Exit Seeking Residents with Elopement Risk Clinical Practice Guideline," dated 02/15/10, revealed "7. In the event the</p>	F 282	<p>F 282(cont)</p> <p>The elopement care plans and elopement risk assessments of all other current residents in the facility were reviewed for accuracy on 3/27/12. This was conducted by the MDS Coordinators.</p> <p><b><u>Measures Implemented or Systems altered to Prevent Re-Occurrence:</u></b></p> <p>SRNA's were provided training regarding utilization and implementation of measures located on the Nurse Aide Data Sheet to address wandering behaviors. This training was provided by the Staff Development Nurse beginning on 4/4/12 and continuing with oncoming shifts until all complete. Staff not trained by 4/5/12 were sent certified letters to inform them that they cannot work until training is completed.</p> <p>The Interdisciplinary Care Plan team was provided with re-education on care plan review, validation of effective interventions, and assuring that interventions are implemented. This began on 4/9/12 continuing through 4/13/12 and was provided by the Quality Management Nurse. This education was extended to licensed nursing staff to include review of the interventions to validate they are implemented and effective for the residents with wandering/elopement behavior on 4/17/12. This education will be conducted</p>	
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F 282	<p>Continued From page 4</p> <p>wandering alarm system is activated, the following response will occur: a) staff will immediately respond to the area in which the alarm was activated."</p> <p>Resident #1 was admitted to the facility on 01/31/12 with diagnoses to include Alzheimer's Disease, Dementia with Lewy Bodies and Impulse Control Disorder. On 02/02/12, the facility developed and initiated the initial admission care plan detailing Resident #1 has exhibited indicators of wandering inside to inappropriate places, making statements that they are leaving or exit seeking, displays behaviors and/or body language indicating an elopement may be forthcoming, attempts to exit the building, and is cognitively impaired. The facility detailed staff would provide basic needs, evaluate the reason for the resident's wandering/exit seeking and attempt to meet the resident's need, apply the wander alert safety bracelet to the resident, engage in diversional conversation with the resident, take the resident for a short walk, take the resident to an activity as possible, validate concerns and offer alternatives, engage family in diversional activities. On 02/05/12, the facility revised the care plan to reflect staff would conduct every 15 minute checks.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 02/07/12, revealed the facility assessed the resident as having impaired decision making and requiring the assistance of one for activities of daily living. He/she was ambulatory with a steady gait and ambulated about the facility per self. Review of the comprehensive care plan titled Wandering/Elopement, dated 02/10/12, revealed</p>	F 282	<p>F 282 (cont)</p> <p>prior to their next shift worked until all licensed nurses are re-educated. This education will be given by the Staff Development Nurse and the Quality Management Nurse and the Director of Nursing. The Director of Nursing or Staff Development Nurse will be responsible to provide education to those staff members who are are on leave.</p> <p>The MDS Coordinators will be responsible to review and revise the plan of care on admission, re-admission, quarterly, annually or significant change in status and when concerns are identified with the plan of care. On weekends and holidays the charge nurse on each unit will be responsible to update and revise the plan of care as indicated.</p> <p><u>Monitoring Measures implemented to maintain ongoing compliance:</u></p> <p>The Director of Nursing and/or MDS Coordinators will randomly review the care plans of five wandering residents every week times eight weeks then every two weeks times eight weeks, then monthly times six months to validate the care plan has current effective interventions in place and that they are implemented.</p>		

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F 282	<p>Continued From page 5</p> <p>the goal as "Resident will respond to being re-directed from wandering and attempts to exit the building". Interventions included "inquire of the reason for wandering/exit seeking and attempt to meet that need, if possible; wanderguard to right ankle; assess and provide basic needs (hunger, thirst, toileting needs,pain) when resident shows signs of wandering; and resident is on every 15 minute checks. Review of the Nurse Aide Data Sheet, dated 02/14/12, revealed nurse aides were to ensure the safety device (wanderguard) was secure to the resident's right ankle; behavioral interventions detailed to offer to talk on the phone with family, remind of upcoming events, call him/her by a specific name, see activity preference; special instructions included the resident is on 15 minute checks.</p> <p>An interview with RN #2, on 03/28/12 at 11:25 AM, revealed Resident #1 walked around the inside of the building and fifteen minute checks were documented. On 03/25/12, she had seen, prior to 9:00 PM, Resident #1 walking on the West short hall (resided on East), but thought nothing of it because he/she would pass through the West side of the building multiple times going through the dining room and on into the East side of the building. RN #2 did not intervene as the resident's behavior was to continuously wander throughout the building.</p> <p>An interview with RN #1, on 03/28/12 at 12:26 PM, revealed Resident #1 walked constantly. On 03/25/12 prior to 9:00 PM, RN #1 observed the resident attempting to enter the nursing station and lead him/her to his/her room without difficulty. No other intervention was attempted. Resident</p>	F 282	<p>F 282 (cont)</p> <p>If during the audit process a concern is identified the care plan will be revised/updated by the Director of Nursing and/or MDS Coordinators at the time it is identified.</p> <p>The findings of the audit/review will be reported to the monthly Quality Assessment and Assurance Committee for review and recommendations. If any findings indicate a concern, the frequency and or duration of the audit may increase. Any issues identified will have re-education provided to the individual staff member by the Director of Nursing and/or Staff Development Nurse.</p> <p>The 24 hour report will be utilized by the nursing staff to communicate any interventions that may need modification or revision and may require action by a non-nursing department. If the need is determined to require action before the next business day, the administrator will be notified by the nursing staff.</p> <p>The 24 hour report will be reviewed daily by the Director of Nursing. In her absence the ADON, unit managers and/or charge nurse will review. If issues are identified that require immediate action the Director of Nursing, ADON, unit manager and/or charge nurse will be authorized and responsible to revise the plan of care as indicated. On the weekends and holidays</p>		

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F 282	<p>Continued From page 6</p> <p>#1 usually wandered throughout the facility and nurses documented fifteen minute checks.</p> <p>The facility investigation regarding an incident involving Resident #1 occurring on 03/25/12, and interviews with: RN #2, on 03/28/12 at 11:25 AM; CNA #2, on 03/28/12 at 11:50 AM; CNA #1, on 03/28/12 at 12:08 PM and on 03/29/12 at 9:40 AM; RN #1, on 03/28/12 at 12:26 PM and on 03/29/12 at 2:00 PM; CNA #3, on 03/29/12 at 10:20 AM; and CNA #5, on 03/29/12 at 9:10 AM, revealed West Side RN #2 stated she had exited a resident's room on the long hall and as she approached the nursing station she heard a door alarm sounding sometime after 9:00 PM. After going in another direction she realized that the alarm was coming from the front door of the facility. RN #2 went out the front door and looked in every direction but did not see anyone and then went to the East hall to inform RN #1 they should have staff start a search. CNA #1 stated she was working on the West hall at the time and did not know the alarm was sounding. CNA #5 stated she was assisting another resident in his/her room and did not hear the alarm. RN #1 stated she was providing a treatment for a resident at the end of the long hall of the East unit and when she left the room RN #2 told her the alarm was sounding and someone was missing. RN #1 was not aware the alarm was sounding. The facility initiated a room search and determined Resident #1 could not be located. The facility staff searched outside and located Resident #1 down the street, sitting in the driver's seat of a car, off the facility's campus. The resident told the Night Shift Supervisor that he/she was going home. RN #1 assessed Resident #1 when he was assisted back into the facility and no injuries were</p>	F 282	<p>F 282 (cont)</p> <p>the nursing supervisor or charge nurse will be authorized and responsible to notify the administrator and/or Director of Nursing of any identified concerns that could indicate a need for immediate intervention. If the nursing department identifies any issues that would require additional support in order to be resolved the administrator will be notified to provide assistance with resolving the concern.</p> <p>Findings from the 24 hour report will be presented in the daily AQA meeting for review and recommendations by the administrative team. This will also be reviewed in the monthly Quality Assessment and Assurance meeting for any recommendations to verify on going compliance with the process. If any concerns with the process are identified education will be provided to the individual staff member by the Staff Development Nurse. In addition the frequency and/or duration of the care plan audit process may be increased if concerns are identified through the QA process.</p>	
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F 282	<p>Continued From page 7</p> <p>found. Interviews with facility staff revealed that while the Resident had the wanderguard bracelet on and they were conducting 15 minute checks, no staff observed or was knowledgeable to this resident's successful attempt to leave the building. No staff observed this resident going to the door and no staff was providing supervision at the time of the incident. The staff was providing care to other residents and could not hear the wanderguard alarm and could not state when the alarm began sounding.</p> <p>An interview conducted with the Administrator, on 03/27/12 at 8:30 AM, revealed Resident #1 was very active and could "walk the entire building in about two minutes". The resident had a wanderguard. He stated the alarm is designed to provide an audible alert that a person wearing the wanderguard bracelet is nearing an exit door and requires redirection. He stated the wanderguard had been tested and verified working and the door alarm had sounded and staff responded as expected. However, the facility was unable to provide evidence that staff was supervising Resident #1 at the time he/she exited the building to prevent elopement.</p> <p>Furthermore, on 03/29/12 at 8:45 AM, an observation with the DON was conducted in a resident room at the end of the long hall on the East unit. The door was closed and a maintenance staff triggered the front door alarm. The alarm was not audible. Upon exiting the room once the door was opened the alarm was barely detectable. The DON stated the alarm was not as loud as the call light tones but was a "different type of sound". Further observation revealed that when the wanderguard is activated</p>	F 282		
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F 282	<p>Continued From page 8</p> <p>the audible alarm can be heard at the door that has been activated and at the panel at the nursing station. Interview with staff revealed that the panel will light up to specify when a door alarm is activated and an audible alarm will sound at the panel. While the facility, had initiated one to one supervision of Resident #1 during awake hours, placed a bed alarm on Resident #1's bed after the incident, they had not identified through their investigation that the alarm was not audible throughout the building to alert staff to address the exit door and wanderguard system to ensure adequate supervision of wandering residents.</p> <p>The State Agency verified the following action taken by the facility to remove Immediate Jeopardy as of 03/30/12:</p> <p>Review of the facility's documentation revealed the facility held an Emergent Quality Assurance Meeting on 03/26/12 at 10:00 AM. The facility had sixteen staff attend which included key Administrative staff such as the Administrator, Director of Nursing, MDS Nurse, Social Services Director, Nursing Unit Manager, etc. The Quality Assurance Meeting Minutes detailed the topic discussed was a resident leaving the facility. The Committee Recommended the following: 1. to discuss discharge potential, inviting the family for care plan meeting with a follow-up on 03/29/12 at 10:30 AM; 2. Educate staff on wandering elopement, elopement policy, location of elopement books and to conduct ongoing in-servicing until all nursing staff have been trained; 3. Reviewed all potential elopement residents for accuracy and assessments, reviewed all fifteen elopement potential residents to ensure accuracy of assessment, care plans</p>	F 282		
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F 282	Continued From page 9 and wanderguards; 4. Validated wanderguards are working properly, conducting daily checks with the use of the Secure Care Tester; 5. Review all exit doors, testing all exit doors for alarm sounding and review on 03/26/12. Review of the in-service documentation verified the facility trained nursing staff, social services and admissions on 03/26/12 related wanderguards, elopement, resident assessment upon admission, wanderguard placement, wanderguard book location, picture on facesheet, wanderguard checked daily by staff, alarm panel at each nurses desk. The in-service was provided by the facility's Director of Nursing. Interviews on 03/30/12 with CNA #6, at 12:08 PM; LPN #1 at 12:15 PM; LPN #2 at 12:00 PM, Social Services at 12:05 PM, RN/MDS at 11:42 AM; RN #3 at 11:55 AM; CNA #7 at 11:25 AM; CNA #8 at 11:40 AM revealed all these staff had attended the training and validated their understanding of the facility's new system related responding to the audible wanderguard alarm, the door panel, elopement procedures, elopement books, etc.  Interview with the Administrator on 03/30/12, revealed the facility initiated a staff person to monitor the nursing station panel for the wanderguard which started on 03/29/12. These staff have been trained to make an announcement of which door is alarming so staff can respond timely, until the new annunciator can be installed to ensure the alarm can be audible throughout the building. Observation at this time revealed a staff person was at the nursing station monitoring the panel. The surveyor observed timely response by staff to the wanderguard alarming on this date 03/30/12. Further observation revealed Resident #1 was being	F 282			

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F 282	Continued From page 10 supervised by staff on one to one supervision.  Based on the above interviews, observation and record reviews, it was determined the Immediate Jeopardy was removed, effective 03/30/12, with the scope and severity lowered to a "D" as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, Clinical Practice Guideline and Policy and Procedure reviews, it was determined the facility failed to ensure one resident (#1), in the selected sample of nine residents, received adequate supervision to prevent accidents. The facility failed to follow their Missing Resident/Resident Elopement policy. The facility failed to ensure care plan interventions utilized were functioning properly to alert staff to address Resident #1's wandering behaviors in an effort to provide	F 323	<u>F-323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</u>  It is the normal practice of Mills Health and Rehab to 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.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  Resident # 1 had a bed alarm placed on the bed on 3/25/12 and was put on 1:1 monitoring. The care plan for Resident #1 was reviewed by the charge nurse on 3/25/12 and updated to reflect the new interventions reflecting the increased monitoring.	4/18/12

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F 323	<p>Continued From page 11</p> <p>adequate supervision. Additionally, the facility failed to follow the care plan for Resident #1 when staff observed this resident, on 03/25/12 prior to 9:00 PM, wandering the perimeter of the interior of the facility without staff intervention to "inquire to the reason for wandering and to attempt to meet that need." The facility's system for supervision utilizing, the wanderguard assistive device for residents identified as wandering risk, was ineffective to ensure the safety of these residents. The facility had identified, assessed and care planned fifteen residents with wandering behaviors. On 03/25/12 after 9:00 PM, Resident #1, who the facility had identified, assessed and care planned as having wandering behaviors, exited the facility without staff knowledge. The facility found Resident #1 off the facility campus sitting in an unknown car in the driver's seat, asleep after 9:30 PM. Facility staff documented last seeing Resident #1 at 9:00 PM on 03/25/12. The facility had identified that staff was to utilize the wanderguard and conduct every fifteen minutes checks of Resident #1. Facility staff interviews identified that Resident #1 could walk through the facility very quickly within approximately two minutes and had a history of going door to door. Interviews with facility staff identified that they did not hear the audible wanderguard alarm while providing care to other residents at the time Resident #1 exited the building without staff knowledge. This failure to ensure adequate staff supervision of Resident #1 and the facility's failure to ensure the assistive device functioned adequately and effectively, prevented the facility from identifying Resident #1 was exit seeking on 03/25/12 in order to redirect him/her to safety.</p>	F 323	<p>F 323 (cont)</p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>The elopement care plans, Nurse Aide Data Sheets and elopement assessments of all current residents in the facility were reviewed and revised as indicated to validate that all identified residents have accurate and current interventions. This was completed by the MDS Coordinators on 3/27/12. The Wandering / Elopement Risk Notebook was checked by Activities Director and administrator on 3/28/12 to verify that all wandering and elopement risk residents were identified.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>In-servicing on the elopement policy, the secure Care alarm system and response to alarms was initiated on 3/26/12 with staff present and was provided to oncoming staff on or before their next shift worked. The training was completed by the Director of Nursing, ADON and evening shift supervisor. Additional education regarding the temporary monitoring system being implemented and response requirements was initiated on 3/29/12 with all facility staff including the Nursing Assistants, Medication Aides, Administrative and Licensed Nurses, Administrator, Social Services, Activities,</p>	
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F 323	<p>Continued From page 12</p> <p>The facility's failure to ensure adequate supervision of residents the facility had identified as having wandering behaviors and/or at risk for elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/29/12 and determined to exist on 03/25/12 and Substandard Quality of Care was identified at 483.25. The Immediate Jeopardy was determined removed on 03/30/12 lowering the scope and severity to a "D", as the facility had not completed the Quality Assurance (QA) Initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the Plan of Correction (POC) to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.</p> <p>Findings include:</p> <p>A review of the facility policy and procedure titled MISSING RESIDENT/RESIDENT ELOPEMENT, dated 01/01/07 and revised 02/15/10, included: 1. Residents who exhibit exit seeking behaviors or elopement potential will be identified. 2. Residents who exhibit exit seeking behaviors or elopement potential will be evaluated by the interdisciplinary team and an individualized care plan will be developed to address the elopement risk. 3. Resident's response to interventions will be monitored, and revisions will be made as indicated. 4. In the event a resident exits the building or the wandering alarm system is activated, staff will respond. Review of the Exit Seeking Residents with Elopement Risk Clinical Practice Guideline, dated 02/15/10 revealed "7. In the event the wandering alarm system is</p>	F 323	<p>F 323 (cont)</p> <p>Dietary, Environmental Service, Housekeeping, and Laundry.</p> <p>Beginning on 3/29/12 a staff member from the facility's quality assessment and assurance committee was assigned to monitor the enunciation panel at the East nurses station, keeping it in visual and audible range at all times. This person remained positioned at the intersection of the two hallways and in view of the west front exit door, and in view of the doorway to the front entrance-way, providing additional supervision of those high resident traffic areas. A second team member was assigned to be readily available to respond in the event an alarm sounds. This person would respond to any door alarm to assure immediate supervision to any resident in the vicinity of the activated alarm.</p> <p>The staff assigned to this task were trained in the process on 3/29/12 prior to beginning the monitoring process by the Quality Management Nurses. This process was utilized before and during upgrade to the alarm system to provide monitoring of the alarm system, to assure that staff were alerted in the event an alarm was activated, and to provide an immediate responder in the event care givers couldn't hear the alarm prompting the need for immediate response and vigilant supervision. It was continued through 4/8/12.</p>	
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F 323	Continued From page 13 activated, the following response will occur: a) staff will immediately respond to the area in which the alarm was activated." Review of the "Checking Electronic Wandering Transmitting Devices Clinical Practice Guideline", dated 08/30/07, revealed "4. The designated individual will check the equipment and follow the manufacturer's instructions for the following: proper use, proper tone and volume, battery replacement, appropriate placement."  The facility admitted Resident #1 on 01/31/12 with diagnoses to include Alzheimer's Disease, Dementia with Lewy Bodies and Impulse Control Disorder. The facility developed and initiated the initial admission care plan, on 02/02/12, detailing Resident #1 has exhibited indicators of wandering inside to inappropriate places, making statements that they are leaving or exit seeking, displays behaviors and/or body language indicating an elopement may be forthcoming, attempts to exit the building, and is cognitively impaired. The facility detailed intervention that staff would provide basic needs, evaluate the reason for the resident's wandering/exit seeking and attempt to meet the resident's need, apply the wander alert safety bracelet to the resident, engage in diversional conversation with the resident, take resident for a short walk, take to an activity as possible, validate concerns and offer alternatives, engage family in diversional activities. The facility revised the care plan to reflect staff would conduct every 15 minute checks on 02/05/12.  An admission Minimum Data Set (MDS) assessment, dated 02/07/12, revealed the facility assessed Resident #1 as having impaired decision making and required the assistance of	F 323	F 323 (cont)  All emergency exit doors were checked daily by the Regional VP of operations and or the administrator to validate proper working order from 3/26/12 through 4/9/12.  Eight amplifiers were installed to increase the volume of the alarm so that it could be heard throughout the facility. Amplifiers were placed in a central location on the resident hallways, so it would be audible inside the resident rooms, facilitating immediate response and supervision/ intervention in the event an alarm is activated, to prevent elopement after installation of the ordered equipment. Additional alarms and enunciation panels were added to link alarms together for notification, and to facilitate prompt identification of the location of alarm activation. This was completed on 4/7/12.  An initial test was conducted of 100% of the resident rooms by the administrator and VP of operations to validate the alarms could be heard in each room, with the door closed.  Upon completion of the installation a test was conducted on each shift for three days from 4/7/12 through 4/9/12 to assure that staff are alerted to the new transition of the new alarm system.		

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F 323	<p>Continued From page 14</p> <p>one for activities of daily living. He/she was ambulatory with a steady gait and ambulated about the facility per self. Review of the comprehensive care plan, dated 02/10/12, revealed the facility implemented the following interventions to address Resident #1's Wandering/Elopement risk: wandeguard device; secure bracelet to resident's right ankle, name on wander alert log, check wandergaurd to evaluate operating status; approach the resident by a specific name; assess and provide basic needs; engage in diversional conversation with resident; provide diversional activity; validate concerns and offer alternatives; "inquire of the reason for wandering/exit seeking and attempt to meet that need, if possible"; and resident is on every 15 minutes checks.</p> <p>An interview with Certified Nursing Assistant (CNA) #5, on 03/29/12 at 9:10 AM, revealed Resident #1 walks the hall of the East and West units and that he/she would try to open exit doors at the ends of the halls and then walk back up the hall. Interview with CNA #2, on 03/28/12 at 11:50 AM, revealed Resident #1 walked all the time, usually around the facility in a circle and went door to door at times. An interview with Registered Nurse (RN) #1, on 03/28/12 at 12:26 PM and on 03/29/12 at 2:00 PM, revealed Resident #1 did not normally say much and was "usually in [his/her] zone" and that he/she went door to door at times.</p> <p>A review of the facility Compressed Behavior Report, dated 01/31/12 through 03/25/12, revealed only one entry for wandering altered was documented for 02/13/12. A review of the facility's Behavior Management 15 Minute</p>	F 323	<p>F 323 (cont)</p> <p>In addition, supplemental education on wandering/elopement behaviors, including location and operation of new alarm additions, has been provided to all facility staff. This was initiated on 4/3/12 by the Staff Development Nurse and was completed on 4/12/12. Education will be provided to any staff who were not present, prior to their next shift worked. Certified letters were sent to employees who had not completed training by 4/5/12 informing them that they cannot work until the training has been completed. The Director of Nursing will be responsible to provide or arrange for the education for these employees.</p> <p>A post test and/or return verbal understanding was used to validate understanding of the education provided. This education was added to the general orientation by the Quality Management Nurse.</p> <p><b><u>Monitoring Measures implemented to maintain ongoing compliance:</u></b></p> <p>Eight amplifiers were installed to increase the volume of the alarm so that it could be heard throughout the facility. Amplifiers were placed in a central location on the resident hallways, so it would be audible inside the resident rooms, facilitating immediate response and supervision/intervention in the event an alarm is</p>	
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F 323	<p>Continued From page 15</p> <p>Monitoring Form, dated March 25, 2012, revealed RN #1 documented seeing Resident #1 at 9:00 PM. Review of nursing notes, dated 03/25/12 at 9:15 PM, revealed Registered Nurse #1 documented "front door alarm sounding, began search for Resident #1. Checked each resident's room, bathroom, dining area, fina dining area, breakroom, lobby and throughout building". Further review of the Behavior Management 15 Minute Monitoring Form, dated March 25, 2012, revealed RN #1 had documented "missing" for 9:15 PM and 9:30 PM. Review of the nursing notes, on 03/25/12 at 9:30 PM, RN #1 documented "resident found outside of building, sitting in the driver's seat of a vehicle, sleeping, by Night Shift Supervisor. When asked resident what he/she was doing he/she stated "trying to get home. Resident was then escorted back to facility".</p> <p>A review of the facility's investigation of the 03/25/12 event, and interviews with: RN #2, on 03/28/12 at 11:25 AM; CNA #2, on 03/28/12 at 11:50 AM; CNA #1, on 03/28/12 at 12:08 PM and on 03/29/12 at 9:40 AM; RN #1, on 03/28/12 at 12:26 PM and on 03/29/12 at 2:00 PM; CNA #3, on 03/29/12 at 10:20 AM; and CNA #5, on 03/29/12 at 9:10 AM, revealed West Side RN #2 stated she exited a resident's room on the long hall and as she approached the nursing station she heard a door alarm sounding sometime after 9:00 PM. She realized after going in another direction that the alarm was coming from the front door of the facility. RN #2 went out the front door and looked in every direction but did not see anyone. She then went to the East hall to inform RN #1 they should have staff start a search. CNA #1 stated she did not know the alarm was</p>	F 323	<p>F 323 (cont)</p> <p>activated, to prevent elopement after installation of the ordered equipment. Additional alarms and enunciation panels were added to link alarms together for notification, and to facilitate prompt identification of the location of alarm activation. This was completed on 4/7/12.</p> <p>An unannounced golden alert/missing resident drill will be conducted on a weekly basis on all shifts for the next four weeks, then will be conducted monthly on each shift for twelve months. The first weekly drill was conducted on 4/12/12 The drills will be conducted by the Plant Service Manager and/or ADON. The administrator will be responsible to assure that drills occur at the scheduled intervals.</p> <p>The response to the drills will be reviewed in the facility's monthly Quality Assessment and Assurance for evaluation of the process. If findings indicate any concern re-education will be provided and the frequency or duration of the drills may increase. If any issues are identified, re-education will be provided to the individual staff member(s) by the Staff Development Nurse and/or Plant Service Director.</p> <p>The testing of the alarm system will be conducted monthly to verify that alarms remain audible in a sampling of resident</p>		

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F 323	<p>Continued From page 16</p> <p>sounding as she was working on the West Hall at the time of the incident. CNA #5 stated she was assisting another resident in his/her room and did not hear the alarm. RN #1 stated she was performing a treatment for a resident in his/her room at the end of the long East unit hall. After exiting the resident's room, RN #1 stated RN #2 told her the alarm was sounding and someone was missing. RN #1 was not aware the alarm was sounding. The facility initiated a room search and determined Resident #1 could not be located. The facility staff searched outside and located Resident #1 down the street, sitting in the driver's seat of a car, off the facility's campus. The resident told the Night Shift Supervisor that he/she was going home. RN #1 assessed Resident #1 when he/she was assisted back into the facility and no injuries were found.</p> <p>Observation of Resident #1, on 03/28/12 at 11:15 AM, revealed the resident ambulated with a steady, slow gait, had a blank expression and answered only "yes" to questions. The resident continued to ambulate from one side of the building through the dining room to the other side completing a circle. The resident was observed at 11:30 AM, 11:45 AM, 12:02 PM, 12:10 PM, and 12:30 PM, walking the same circular path through the building. A staff member was within arm's reach at all times as the facility had initiated one to one monitoring while awake since 03/25/12.</p> <p>An interview conducted with the Administrator, on 03/27/12 at 8:30 AM, revealed Resident #1 was very active and could "walk the entire building in about two minutes". The resident had a wanderguard. He stated the wanderguard alarm is designed to provide an audible alert to staff</p>	F 323	<p>F 323 (cont)</p> <p>rooms on each hallway, utilizing rooms that are distant from the amplifiers. A minimum of eight rooms will be checked each month. Any concerns identified will be reported to the administrator for immediate intervention to resolve the concern.</p> <p>The findings of the tests will also be reported to the monthly Quality Assessment and Assurance Committee for review and recommendations. If any findings indicate a concern, the frequency and or duration of the audit may increase.</p>	

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F 323	<p>Continued From page 17</p> <p>that a person wearing the wanderguard bracelet is nearing an exit door and requires redirection. Resident #1 was determined missing about 9:00 PM on 03/25/12 and was found sleeping in a car down the street a few minutes later. The resident was returned to the facility, had no injury and the facility had initiated one to one supervision. The wanderguard had been tested and verified working and the door alarm had sounded and staff responded as expected. However, the facility was unable to provide evidence that staff was supervising Resident #1 at the time he/she exited the building to prevent elopement.</p> <p>On 03/29/12 at 8:45 AM, an observation with the DON was conducted in a resident room at the end of the long hall on the East unit. The resident room door was closed and a maintenance staff triggered the front door alarm. The alarm was not audible while in the resident's room. Upon exiting the room, once the door was opened, the alarm was barely detectable. The DON stated the alarm was not as loud as the call light tones but was a "different type of sound". Further observation revealed that when the wanderguard is activated the audible alarm can be heard at the door that has been activated and at the panel at the nursing station. Interview with these staff revealed that the panel will light up to specify when a door alarm is activated and an audible alarm will sound at the panel. While the facility, had initiated one to one supervision of Resident #1 during awake hours, placed a bed alarm on Resident #1's bed, they had not identified through their investigation that the alarm was not audible throughout the building to alert staff to address residents wandering near the exit doors. This failure prevented the facility from ensuring</p>	F 323		
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F 323	<p>Continued From page 18</p> <p>assistive devices used to adequately supervise wandering residents was functioning effectively to alert staff to address the needs of wandering residents.</p> <p>The State Agency verified the following action taken by the facility to remove Immediate Jeopardy as of 03/30/12:</p> <p>Review of the facility's documentation revealed the facility held an Emergent Quality Assurance Meeting on 03/26/12 at 10:00 AM. The facility had sixteen staff attend which included key Administrative staff such as the Administrator, Director of Nursing, MDS Nurse, Social Services Director, Nursing Unit Manager, etc. The Quality Assurance Meeting Minutes detailed the topic discussed was a resident leaving the facility. The Committee Recommended the following: 1. to discuss discharge potential, inviting the family for care plan meeting with a follow-up on 03/29/12 at 10:30 AM; 2. Educate staff on wandering elopement, elopement policy, location of elopement books and to conduct ongoing in-servicing until all nursing staff have been trained; 3. Reviewed all potential elopement residents for accuracy and assessments, reviewed all fifteen elopement potential residents to ensure accuracy of assessment, care plans and wanderguards; 4. Validated wanderguards are working properly, conducting daily checks with the use of the Secure Care Tester; 5. Review all exit doors, testing all exit doors for alarm sounding and review on 03/26/12. Review of the in-service documentation verified the facility trained nursing staff, social services and admissions on 03/26/12 related wanderguards, elopement, resident assessment upon admission,</p>	F 323		
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F 323	<p>Continued From page 19</p> <p>wanderguard placement, wanderguard book location, picture on facesheet, wanderguard checked daily by staff, alarm panel at each nurses desk. The in-service was provided by the facility's Director of Nursing. Interviews on 03/30/12 with CNA #6, at 12:08 PM; LPN #1 at 12:15 PM; LPN #2 at 12:00 PM, Social Services at 12:05 PM, RN/MDS at 11:42 AM; RN #3 at 11:55 AM; CNA #7 at 11:25 AM; CNA #8 at 11:40 AM revealed all these staff had attended the training and validated their understanding of the facility's new system related responding to the audible wanderguard alarm, the door panel, elopement procedures, elopement books, etc.</p> <p>Interview with the Administrator on 03/30/12 at approximately 8:00 AM, revealed the facility initiated a staff person to monitor the nursing station panel for the wanderguard which started on 03/29/12. These staff have been trained to make an announcement of which door is alarming so staff can respond timely, until the new annunciator can be installed to ensure the alarm can be audible throughout the building. Observation at this time revealed a staff person was at the nursing station monitoring the panel. The surveyor observed timely response by staff to the wanderguard alarming on this date 03/30/12. Further observation revealed Resident #1 was being supervised by staff on one to one supervision.</p> <p>Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 03/30/12, with the scope and severity lowered to a "D" as the facility had not completed the QA Initiative related to staff monitoring, analysis of monitoring audit</p>	F 323		
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F 323	Continued From page 20 results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 323		
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, record review, review of the Job Description for Facility Administrator, and review of Clinical Practice Guidelines and Policies and Procedures, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident (#1), in a selected sample of nine residents. The facility failed to ensure adequate supervision to prevent accidents was provided for one resident (#1). Resident #1, who the facility had assessed as having wandering/exit seeking behaviors and determined was an elopement risk, exited the facility on 03/25/12 without staff knowledge and was found in a parked car on the street off the facility campus.  The facility had assessed and identified fifteen residents with wandering behaviors and had	F 490	F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  It is the normal practice of Mills Health and Rehab to be administered in a manner that enable it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.  <u>Corrective Measures for Resident Identified in the deficiency:</u>  Resident #1 had a bed alarm placed on the bed on 3/25/12 and was put on 1:1 monitoring. The care plan for Resident #1 was reviewed by the unit nurse on 3/25/12 and updated to reflect the new interventions and increased supervision.  <u>How other residents who may have been affected by this practice were identified:</u>  The care plans and elopement risk assessments of residents with elopement potential were reviewed for accuracy and implementation on 3/26/12 by the Director of Nursing, ADON, MDS Coordinator.	4/18/12

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F 490	<p>Continued From page 21</p> <p>Implemented wanderguard devices as an intervention. The facility failed to ensure Resident #1 was supervised adequately to prevent elopement. The facility admitted Resident #1 with diagnoses to include to include Alzheimer's Disease, Dementia with Lewy Bodies and Impulse Control Disorder. The facility developed and implemented a care plan for elopement initiating the use of the wanderguard device and staff checks every fifteen minutes due to wandering behaviors. On 03/25/12 sometime after 9:00 PM, Resident #1 exited the building through the front door without staff knowledge. At 9:30 PM, the facility found the resident down the street in the driver's seat of a car off the facility's campus. The resident was missing approximately thirty minutes based on the facility's medical record documentation. Interview with five facility staff revealed they did not hear the Secure Care Alarm System sounding, on the evening of 03/25/12, which prevented staff from addressing the resident's wandering behavior in an effort to redirect him/her to safety. The facility failed to identify through their investigation, staff's failure to follow the care plan interventions and the inability for staff to hear the wanderguard audible alarm throughout the facility while providing care. However, the facility staff, on the evening of 03/25/12, were unable to hear the Secure Care audible alarm while providing care to other residents, which prevented them from immediately responding to the alarm, per the facility's policy. This prevented the facility from providing necessary supervision to Resident #1 who was successful in eloping from the facility without staff knowledge.</p> <p>The facility's failure to ensure adequate</p>	F 490	<p>F 490 (cont)</p> <p>The elopement care plans and assessments of all current residents in the facility were reviewed for accuracy on 3/27/12. This was conducted by the MDS Coordinators.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>The Interdisciplinary Care Plan team was provided with re-education on care plan review and validation of the effectiveness and implementation of interventions, beginning on 4/9/12 continuing through 4/13/12.</p> <p>This training was provided by the Quality management Nurse. This education was extended to licensed nursing staff to include review of the interventions to validate they are implemented and functioning for the residents with wandering/elopement behavior on 4/17/12.</p> <p>This education will be conducted prior to their next shift worked until all licensed nurses are re-educated. This re-education will be given by the Staff Development Nurse, Quality Management Nurse and the Director of Nursing. The Director of Nursing and/or staff development will be responsible to provide education to those staff members who are are on leave.</p> <p>The MDS Coordinators will be responsible to review and revise the plan of care on</p>	
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F 490	Continued From page 22 supervision of residents the facility had identified as having wandering behaviors and/or at risk for elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/29/12 and determined to exist on 03/25/12 and Substandard Quality of Care was identified at 483.25. The Immediate Jeopardy was determined removed on 03/30/12 lowering the scope and severity to a "D", as the facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the Plan of Correction (POC) to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.  (Refer to F282 and F323)  The findings include:  A review of the facility Job Description-Facility Administrator, no date, revealed the Job Summary: Oversees patient/resident care, manages overall operation, employee management, fiscal management, and ensure compliance with State and Federal regulations. Job Responsibilities included: Provision of quality patient services consistent with the philosophy; and standards of the company by means of adequately trained personnel and implementation of company procedures. Insure that the facility is free of any unsafe conditions and participate in monthly safety meetings. Responsible for overseeing risk management activities that focus on risk reduction and preventative strategies for residents, visitors and staff. Reviews, monitors and follows-up on incident reports, adverse	F 490	F 490 (cont)  admission, re-admission, quarterly, annually or significant change in status and when concerns are identified with the plan of care. On weekends and holidays the charge nurse on each unit will be responsible to update and revise the plan of care as indicated.  The administrator participated in and provided oversight of the installation, implementation and training of improvements in the alarm system which provides an audible alert in the most distant resident rooms, when the doors are closed. This was completed on 4/7/12.  The administrator was provided re-education by the Regional Vice President of Operations from the facility's resource team. This oversight and education was initiated on 3/26/12. A review session was held with the administrator on 4/17/12 with review of the requirements of the administrator to administer the facility in a manner that enables it to use its resources effectively and effectively to attain or maintain the highest practicable physical, mental and psychosocial well-being for each resident.  The training included the need to oversee the investigative process for incidents and accidents, effectively identify contributing factors and utilize the facilities resources to validate that interventions are		

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F 490	<p>Continued From page 23</p> <p>incidents, resident grievances, and deficiencies cited by the agency. Develops plans of action to correct and respond to identified quality and risk issues.</p> <p>A review of the facility policy and procedure titled MISSING RESIDENT/RESIDENT ELOPEMENT, dated 01/01/07 and revised 02/15/10, included: 1. Residents who exhibit exit seeking behaviors or elopement potential will be identified. 2. Residents who exhibit exit seeking behaviors or elopement potential will be evaluated by the interdisciplinary team and an individualized care plan will be developed to address the elopement risk. 3. Resident's response to interventions will be monitored, and revisions will be made as indicated. 4. In the event a resident exits the building or the wandering alarm system is activated, staff will respond. Review of the Exit Seeking Residents with Elopement Risk Clinical Practice Guideline, dated 02/15/10 revealed "7. In the event the wandering alarm system is activated, the following response will occur: a) staff will immediately respond to the area in which the alarm was activated." Review of the "Checking Electronic Wandering Transmitting Devices Clinical Practice Guideline", dated 08/30/07, revealed "4. The designated individual will check the equipment and follow the manufacturer's instructions for the following: proper use, proper tone and volume, battery replacement, appropriate placement."</p> <p>A review of Resident #1's record revealed he/she was admitted to the facility 01/31/12 with diagnoses to include Alzheimer's Disease, Dementia with Lewy Bodies and Impulse Control Disorder. The facility assessed and identified</p>	F 490	<p>F 490 (cont)</p> <p>developed, care planned, communicated and implemented. It also includes overseeing policies and practices to avoid instances of abuse or neglect. As leader of the facility's Quality Assessment and Assurance Committee, the administrator leads the group and supports them in implementing processes to identify areas of quality that may be deficient and to develop action plans to achieve desired quality and monitor the effectiveness of plans.</p> <p><u>Monitoring Measures implemented to maintain ongoing compliance:</u></p> <p>The Director of Nursing and/or MDS Coordinators will randomly review the care plans of five wandering residents every week times eight weeks then every two weeks times eight weeks, then monthly times six months to validate the care plan has current effective interventions in place and that they are implemented.</p> <p>If during the audit process a concern is identified the care plan will be revised/updated by the Director of Nursing and/or MDS Coordinators at the time it is identified.</p> <p>The findings of the audit/review will be reported to the monthly Quality Assessment and Assurance Committee for</p>	
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F 490	<p>Continued From page 24</p> <p>Resident #1 as having wandering behaviors and at risk for elopement on 02/02/12 per the facility's admission wander/elopement at risk care plan. An interview with RN #1 on 03/28/12 at 12:26 PM, and with RN #2, on 03/28/12 at 11:25 AM, revealed Resident #1 walked constantly around the inside of the building and fifteen minute checks were documented. RN#1 stated, that on 03/25/12 prior to 9:00 PM, she observed the resident attempting to enter the nursing station and led him/her to his/her room without difficulty. No other intervention was attempted. RN #2 stated, that on 03/25/12 prior to 9:00 PM, she had seen Resident #1 walking on the West short hall (resided on East), but thought nothing of it because he/she would pass through the West side of the building multiple times going through the dining room and on into the East side of the building. RN #2 did not intervene as the resident's behavior was to continuously wander throughout the building. Per the facility's investigation, on 03/25/12 sometime after 9:00 PM, Resident #1 exited the building without staff knowledge. The facility staff initiated elopement procedures once they heard the wanderguard alarm. Facility staff conducted a search outside and found the resident off the facility campus, sitting in the driver's seat of a parked car. The facility assessed Resident #1 with no injury identified.</p> <p>Review of the facility's investigation revealed the facility had not identified that the wanderguard alarm was not audible when staff was in resident's rooms with the door shut.</p> <p>Interviews with: RN #2, on 03/28/12 at 11:25 AM; CNA #2 on 03/28/12 at 11:50 AM; CNA #1, on 03/28/12 at 12:08 PM and on 03/29/12 at 9:40</p>	F 490	<p>F 490 (cont)</p> <p>review and recommendations. If any findings indicate a concern, the frequency and or duration of the audit may increase. Any issues identified will have re-education provided to the individual staff member by the Director of Nursing and/or staff development nurse.</p> <p>The 24 hour report will be utilized by the nursing staff to communicate any interventions that may need modification or revision and may require action by a non nursing department. If the need is determined to require action before the next business day, the administrator will be notified by the nursing staff.</p> <p>The 24 hour report will be reviewed daily by the Director of Nursing. In her absence the ADON, unit managers and/or charge nurse will review. If issues are identified that require immediate action the Director of Nursing, ADON, unit manager and/or charge nurse will be authorized and responsible to revise the plan of care as indicated. On the weekends and holidays the nursing supervisor or charge nurse will be authorized and responsible to notify the administrator or Director of Nursing of any identified concerns that could indicate a need for immediate intervention. If the nursing department identifies any issues that would require additional support in order to be resolved the administrator will be notified to provide assistance with</p>	
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F 490	<p>Continued From page 25</p> <p>AM; RN #1, on 03/28/12 at 12:26 PM and on 03/29/12 at 2:00 PM; CNA #3, on 03/29/12 at 10:20 AM; and CNA #5, on 03/29/12 at 9:10 AM revealed West Side RN #2 stated she had exited a resident's room on the long hall and as she approached the nursing station she heard a door alarm sounding sometime after 9:00 PM. CNA #1 stated she was working on the West hall at the time and did not know the alarm was sounding. CNA #5 stated she was assisting another resident in his/her room and did not hear the alarm. RN #1 stated she was providing a treatment for a resident at the end of the long hall of the East unit and when she left the room RN #2 told her the alarm was sounding and someone was missing. RN #1 was not aware the alarm was sounding. While the facility staff responded appropriately once they heard the alarm, the facility could not provide evidence that they provided adequate supervision to prevent elopement as the assistive device used to aid staff was not audible while staff was providing care in resident rooms. This prevented the facility from addressing Resident #1's wandering behavior in order to prevent elopement.</p> <p>Observation revealed, on 03/29/12, the Secure Care Alarm was not audible in the resident's room with the door shut and could barely be heard when standing in the hallway outside the resident room.</p> <p>The Administrator, on 03/27/12 at 8:30 AM, stated Resident #1 was very active and could "walk the entire building in about two minutes". The resident had a wanderguard. The Administrator detailed the front exit door locked and alarmed when a wanderguard was placed near the exit</p>	F 490	<p>F 490 (cont)</p> <p>resolving the concern.</p> <p>Findings from the 24 hour report will be presented in the daily AQA meeting for review and recommendations by the administrative team. This will also be reviewed in the monthly Quality Assessment and Assurance meeting for any recommendations to verify on going compliance with the process. If any concerns with the process are identified education will be provided to the individual staff member by the Staff Development Nurse. In addition the frequency and/or duration of the care plan audit process may be increased if concerns are identified through the QA process.</p> <p>An unannounced golden alert/missing resident drill will be conducted on a weekly basis on all shifts for the next four weeks, then will be conducted monthly on each shift for twelve months. The first weekly drill was conducted on 4/12/12 The drills will be conducted by the Plant Service Director and ADON. The administrator will be responsible to assure that drills occur at the scheduled intervals.</p> <p>The response to the drills will be reviewed in the facility's monthly Quality Assessment and Assurance for evaluation of the process. If findings indicate any concern re-education will be provided and the frequency or duration of the drills may</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 03/30/2012
NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066		
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F 490	Continued From page 26 door; however, when the panic bar of the exit door was compressed for approximately fifteen seconds, the door lock released and the door would open. They stated the system was used to alert staff of wandering residents who were within approximately four feet of the exit door so they could redirect them. The Administrator validated that Resident #1 had successfully eloped at about 9:00 PM on 03/25/12 and was found sleeping in a car down the street a few minutes later. The resident was returned to the facility, had no injury and was now on one to one supervision. The wanderguard had been tested and verified working and the door alarm had sounded and staff responded as expected. However, during testing for the ability to hear the wanderguard alarm, observation of the last East unit resident room, on 03/29/12 at 8:45 AM, revealed that both the State Agency Surveyor and the Director of Nursing (DON), after maintenance staff triggered the front door alarm, could not hear the alarm in the resident's room. Upon exiting the room, once the door was opened, the alarm was barely detectable. Further observation revealed that when the wanderguard is activated, the audible alarm can be heard at the door that has been activated and at the panel at the nursing station. Interview with these staff revealed that the panel will light up to specify when a door alarm is activated and an audible alarm will sound at the panel. While the facility had initiated one to one supervision of Resident #1 during awake hours, placed a bed alarm on Resident #1's bed, they had not identified through their investigation that the alarm was not audible throughout the building to alert staff to address wandering resident's who were nearing an exit door. This failure prevented the facility from ensuring assltsive devices used	F 490	F 490 (cont)  increase.  Testing of the alarm system will be conducted monthly to verify that alarms remain audible in a sampling of resident rooms on each hallway of each unit. Rooms that are the farthest away from the amplifiers will be included. The alarm sound in eight rooms, at minimum will be tested monthly. Any concern identified will be reported immediately for correction. Findings of the tests will be reported to the facility's Quality Assurance and Assessment Committee for review and recommendations. Based on findings of any concerns identified by the committee the frequency of the drills may be increased to validate the on-going compliance.  The regional vice president of operations from the resource team will provide oversight to the administrator monthly for 3 months then quarterly for 6 months to validate ongoing compliance.		

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F 490	<p>Continued From page 27</p> <p>to adequately supervise wandering residents was functioning effectively to alert staff to address the needs of wandering residents. Furthermore, the facility was unable to provide evidence that staff was supervising Resident #1 at the time he/she exited the building to prevent elopement.</p> <p>The State Agency verified the following action taken by the facility to remove Immediate Jeopardy as of 03/30/12:</p> <p>Review of the facility's documentation revealed the facility held an Emergent Quality Assurance Meeting on 03/26/12 at 10:00 AM. The facility had sixteen staff attend which included key Administrative staff such as the Administrator, Director of Nursing, MDS Nurse, Social Services Director, Nursing Unit Manager, etc. The Quality Assurance Meeting Minutes detailed the topic discussed was a resident leaving the facility. The Committee Recommended the following: 1. to discuss discharge potential, inviting the family for care plan meeting with e follow-up on 03/29/12 at 10:30 AM; 2. Educate staff on wandering elopement, elopement policy, location of elopement books and to conduct ongoing in-servicing until all nursing staff have been trained; 3. Reviewed all potential elopement residents for accuracy and assessments, reviewed all fifteen elopement potential residents to ensure accuracy of assessment, care plans and wanderguards; 4. Validated wanderguards are working properly, conducting daily checks with the use of the Secure Care Tester; 5. Review all exit doors, testing all exit doors for alarm sounding and review on 03/26/12. Review of the in-service documentation verified the facility trained nursing staff, social services and</p>	F 490		
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F 490	<p>Continued From page 28</p> <p>admissions on 03/26/12 related wanderguards, elopement, resident assessment upon admission, wanderguard placement, wanderguard book location, picture on facesheet, wanderguard checked daily by staff, alarm panel at each nurses desk. The in-service was provided by the facility's Director of Nursing. Interviews on 03/30/12 with CNA #6, at 12:08 PM; LPN #1 at 12:15 PM; LPN #2 at 12:00 PM, Social Services at 12:05 PM, RN/MDS at 11:42 AM; RN #3 at 11:55 AM; CNA #7 at 11:25 AM; CNA #8 at 11:40 AM revealed all these staff had attended the training and validated their understanding of the facility's new system related responding to the audible wanderguard alarm, the door panel, elopement procedures, elopement books, etc.</p> <p>Interview with the Administrator, on 03/30/12 at approximately 8:00 AM, revealed the facility initiated a staff person to monitor the nursing station panel for the wanderguard which started on 03/29/12. These staff have been trained to make an announcement of which door is alarming so staff can respond timely, until the new annunciator can be installed to ensure the alarm can be audible throughout the building. Observation at this time revealed a staff person was at the nursing station monitoring the panel. The surveyor observed timely response by staff to the wanderguard alarming on this date 03/30/12. Further observation revealed Resident #1 was being supervised by staff on one to one supervision.</p> <p>Based on the above interviews and record reviews, it was determined the Immediate Jeopardy was removed, effective 03/30/12, with the scope and severity lowered to a "D" as the</p>	F 490		

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F 490	Continued From page 29 facility had not completed the QA initiative related to staff monitoring, analysis of monitoring audit results and the development and implementation of the POC to ensure interventions are effective and will prevent recurrence, in order to achieve and maintain compliance.	F 490			