| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185468 | | C 11/01/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHRISTIAN HEALTH CENTER - WEST, INC | 1015 MAGAZINE STREET LOUISVILLE, KY 40203 |

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| F 323 | Continued From page 35 an approved leave) were re-educated by a Unit Manager and the Director of Clinical Services on facility policies for: door alarm, door check, missing person, elopement, falls and smoking schedules for residents which included a post-test to ensure competency. The Administrator assured as needed staff or those that were on approved leave were called via telephone on 10/20/13 to inform them that they were not to work any further shifts until they were trained on the policies and must meet with the supervisor at the beginning of a scheduled shift.<br><br>10. On 10/21/13 the Administrator directed that a representative of the manufacturer of the Center's WanderGuard system be contacted for an onsite visit to re-check the functionality of all applicable doors and adjust the monitoring of sensitivity if needed. The testing and subsequent work was completed on 10/23/13 with the authorization to purchase an additional sensor on one interior door to heighten staff awareness to potential elopement in the corridor leading to the main entry door.<br><br>11. The Administrator conducted a Quality Assurance meeting on 10/21/13 to review the investigation findings and actions taken by the facility. The QA meeting included the Administrator, Medical Director, DON, Unit Manager, and the Director of Clinical Services. Audits were developed and directives were given to ensure compliance. The Elopement at Risk binders would be audited weekly by the Unit Manager. Documentation of the correct placement and functionality of all WanderGuard devices in use would be audited weekly by a licensed nurse. Ten percent of the resident elopement assessments would be audited weekly | F 323 | | |



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| F 323 | Continued From page 36 by the Unit Manager or DON. The DON or Unit Manager would ensure the care plan would be reviewed and revised as needed to reflect if a resident was found to be at risk for elopement. The Maintenance Director would audit all exit doors for function with a WanderGuard four (4) times weekly. All staff responsible for conducting the audits was trained as of 10/21/13.<br><br>12. All licensed nurses were educated on 10/21/13 by the DON that the WanderGuard computer monitor's volume level was not to be adjusted for any reason and was not to be turned off. The ability to change the monitor volume and the ability to turn the monitor on and off was disabled on 10/24/13 by the Senior Executive Director. The security staff would be audited three (3) times weekly by the Administrator on their competency and knowledge of the facility's door alarm and locking policy as well as all job-related requirements involving the use of the Elopement at Risk binder.<br><br>13. All audits listed which were developed on 10/21/13 would be gathered by the Unit Manager weekly and submitted to and reviewed by the DON. The DON will report the findings of the audits to the Administrator. The Administrator will present the audit results to the Quality Assurance Committee monthly for twelve (12) months. The Senior Executive Director will review the Quality Assurance minutes monthly and attend the QA meeting on a quarterly basis to monitor compliance.<br><br>14. The Unit Manager educated their total nursing staff of twenty-four (24) on 10/24/13 in person and via telephone on the revised Care Plan Revision Policy and Procedure. Unit | F 323 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| F 323 | Continued From page 37 Managers will audit care plans for correct revision five (5) days weekly based on new physician orders and assessment's completed from the preceding day. This will be a part of the daily clinical review meeting. Corrections needed would be made at that time. The DON will review the findings of these audits with the Administrator who will present the results to the QA committee.<br><br>15. The Senior Executive Director educated the Administrator on 10/24/13 of the Administrator's job responsibilities, duties and roles along with the company's Quality Assessment and Assurance policy to assure ongoing knowledge and performance of duties and responsibilities.<br><br>The State Survey Agency validated through record review and interview the Immediate Jeopardy was removed as follows:<br><br>1. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she was notified by the DON at approximately 8:00 AM by telephone on 10/20/13 of the elopement of Resident #1 after a facility wide search and determination Resident #1 was missing from the facility and immediate grounds. Interview with the DON, on 10/25/13 at 10:29 AM, revealed she was notified by RN #1 by telephone at approximately 7:50 AM on 10/20/13 of the elopement of Resident #1. Interview with RN #1, on 10/23/13 at 9:24 AM, LPN #2, on 10/22/13 at 3:25 PM, and LPN #3, on 10/23/13 at 2:12 PM, revealed they were directed to complete an accountability check for each resident on 10/20/13. Review of the nursing notes for 10/20/13 revealed the family and physician were notified by the DON at 8:50 AM. | F 323 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| F 323 | Continued From page 38<br><br>2. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she had directed a nurse to complete a fifteen (15) minute check on the resident and CNA sitter every fifteen minutes for twenty-four hours and then for staff to check the resident every thirty (30) minutes for twenty-four (24) hours. Review of the Check sheet dated 10/20/13 and 10/21/13, revealed staff monitored Resident #1 as directed. Review of the nursing documentation on 10/20/13, revealed LPN #2 documented the events from notification of resident missing to the resident's return and assessment completed.<br><br>3. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed an investigation was initiated by herself and the Director of Clinical Services. Review of the information gathered and documented interviews revealed the investigation had been initiated and was on-going. Review of the facility's investigation into Resident #1's elopement on 10/22/13, revealed staff interviews were done timely. Review of the Maintenance Supervisor report revealed all exit doors had been checked for function on 10/20/13 with no problems identified.<br><br>4. Review of the facility's video-surveillance tape and interview with Administrator, on 10/22/13 at 8:15 AM, revealed the Security Guard #6 had entered a bypass code at the front entrance (known as Main Street 2), on 10/20/13 at 5:37:21 AM, and allowed Resident #1 to exit the facility unsupervised. Review of the e-mail dated 10/23/13 from the facility to the Security Provider revealed the provider was informed of the termination of Security Guard #6 at the facility. | F 323 | | |



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NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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**LOUISVILLE, KY 40203**

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| F 323 | Continued From page 39<br><br>5. Record review and interview with the Administrator and the DON, on 10/22/13 at 8:15 AM, revealed they had checked the elopement at risk binder at the nursing station, on 10/20/13 to ensure all identifying information and a current photo was in the binder for the five (5) residents (to include Resident #1) who had been assessed at being at risk for elopement. Review of the facility's elopement binder on 10/22/13 revealed all residents who were at risk for elopement had their identifying information in the Security Communication binder. Record review on 10/22/13 revealed seventy-eight (78) residents had been reassessed for their elopement risks by the DON, Director of Clinical Services, and Unit Managers. Review of the Maintenance door check lists revealed the doors were checked weekly without concerns identified. Review of the TARs revealed the WanderGuards were checked daily for placement and weekly for function.<br><br>6. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she had identified the security guards scheduled to work and immediately in-serviced them on the policy and procedures to include the Elopement at Risk binder. She stated a post-test was completed and they had to pass with 100 percent. Review of the post-test for Security Guard #5, revealed the test had been administered on 10/20/13 and Security Guard #9's test was administered on 10/21/13 with both scoring 100%.<br><br>7. Record review and interview with the Administrator, on 10/24/13 at 3:30 PM, revealed corrective action was issued to LPN's #1 and #2, and CNA's #1 and #2 for failure to complete | F 323 | | |



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| F 323 | Continued From page 40 safety rounds as required. LPN #8 was terminated for turning off the computer monitor. Record review for the employees revealed the written reprimands were placed in the employee files, signed by the employees. Interviews with LPN # 8 revealed she had been terminated for turning off the computer monitor. Review of shift change walking rounds report completed by the LPN's at shift change on 11/01/13 revealed they were signed off by both staff indicating the walking round had been completed and all residents were accounted for. Interviews with CNA #5, on 10/31/13 at 12:50 AM, CNA #6, on 10/31/13 at 1:25 PM, LPN #1, on 10/22/13 at 3:57 PM,and LPN #2, on 10/22/13 at 3:25 PM, revealed the staff was to complete safety rounds at shift change and every two hours to ensure the residents were safe or if any care was needed.<br><br>8. Record review and interview with the Administrator and the Director of Clinical Services, on 11/01/13 at 11:00 AM revealed the DON, Unit Managers, Director of Clinical Services, and the Administrator had reviewed on 10/20/13, the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct with signatures and dates of the DON, Director of Clinical Services and Administrator. Interview with the Director of Clinical Services (DCS), on 11/01/13 at 11:00 PM, revealed the rest of the seventy-eight (78) residents' documents were reviewed with the Administrator and revisions were made as necessary. Review of the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement on 10/20/13 revealed | F 323 | | |



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DIVISION OF HEALTH CARE FACILITIES SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| F 323 | Continued From page 41 signatures and dates of review and revision by the DCS, DON, and the Administrator. Additional review of all the resident's admission assessments and care plans, CNA care records, assignment sheets, elopement, fall, and smoking at risk assessments began on 10/20/13 and completed on 10/24/13 were done.<br><br>9. Record review and interview with the DON, on 10/25/13 at 10:29 AM, revealed she had provided the in-services regarding facility policies for: elopement risk/assessment; interventions; and steps to be taken during an incident of a missing resident; door alarms; door checks; falls; and smoking schedules; which included a post-test to ensure the staff's competency. Interview with CNA #5, on 10/31/13 at 12:50 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident, falls, door check, smoking policy, safety rounds, which included a post-test on 10/20/13. Interview with CNA #6, on 10/31/13 at 1:25 PM, LPN #1, on 10/22/13 at 3:57 PM, and LPN #2, on 10/22/13 at 3:25 PM, revealed they received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident falls, door check, smoking policy, safety rounds, which included a post-test to ensure competency on 10/20/13. All in-service training content and staff sign-in sheets were reviewed on 10/31/13 to ensure all nursing staff had been re-trained per the AOC.<br><br>10. Record review and interview with the manufacturer's representative of the Center's WanderGuard system revealed an on-site visit was made to verify the function of all exit doors and adjust the monitoring of sensitivity. Interview | F 323 | | |



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| F 323 | Continued From page 42 with Representative, on 10/22/13 at 11:15 AM, revealed he was contacted by the Administrator on 10/20/13, of the resident elopement and the Maintenance Director was in the facility to check all exit doors. He stated he had checked all exit doors on 10/21/13 and they were working appropriately. He stated the inner door was working and he had added an extra sensor. He stated the inner door was not an exit; however, it was to make staff aware of resident's going through the door.<br><br>11. Record review and interview with the Administrator, on 11/01/13 at 8:30 AM, revealed a Quality Assurance (QA) meeting included the Medical Director, DON, Unit Managers, Director of Clinical Services, and Administrator on 10/21/13. She stated audits were developed and directives were given to ensure removal of Immediate Jeopardy. Review of the Elopement at Risk binders on 10/22-24/13 and 10/30-11/01/13, revealed they had been reviewed and updated with resident census and appointments. No additional residents had been identified at risk for elopement. Review of the facility's audit forms and interview with the DON, on 11/01/13 at 11:50 AM, revealed audits were developed for nursing to ensure walking rounds were done; audits to verify the function and placement of WanderGuards; resident elopement assessments; and care plan audits would be completed by the Nurse Managers and/or DON and given to the DON weekly. She stated she would review all information and report to the Administrator and QA. Interview with the Administrator, on 11/01/13 at 8:30 AM, revealed she would be auditing the Security Guards three (3) times a week to ensure competency and knowledge of the door alarm and locking | F 323 | | |



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|---|---|---|---|---|
| F 323 | Continued From page 43 requirements, and use of the Elopement Risk binder. She stated the Maintenance Director would continue to complete audits on the exit doors to ensure they were functioning appropriately.<br><br>12. Record review and interview with the DON on 10/31/13 at 11:50 AM, revealed she had in-serviced all nurses regarding the use of the computer monitor and to not touch or change the volume of the monitor system, on 10/24/13. She stated the computer was covered by the Executive Director to prevent the staff from turning it off. Interview with LPN #7, on 10/31/13 at 12:54 PM, and RN #3 at 1:12 PM, revealed they had been in-serviced on the purpose and use of the computer monitor and they were not allowed to adjust the volume or turn the monitor off. They said the alarm system on the doors was in place to keep residents safe and nurses had to verify the placement of the resident's WanderGuard and check the function of the WanderGuard weekly.<br><br>13. Record review and interview with the DON, on 10/31/13 at 1:18 AM, revealed she had in-serviced the Nurse Managers on the use and purpose of the audits developed to ensure on-going compliance with the facility policy's for: residents' elopement risks assessments; updating; and reviewing the Elopement binder. She stated she would gather all audits from the Unit Nurse Managers to review and submit to the Administrator. She stated the results of the information would be presented at the monthly QA meetings.<br><br>14. Record review of all in-service training content and staff sign-in sheets and interview with | F 323 | | |



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

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| F 323 | Continued From page 44<br>LPN #1, on 10/22/13 at 3:57 PM, LPN #2, on 10/22/13 at 3:25 PM, and RN #1 on 11/01/13 at 11:20 AM, revealed they were in-serviced on the revised care plan policy and assisted with the in-servicing of all the nurses. They were to review all new physician orders in the daily meeting and then audit the care plans for revisions. They stated the audits would go to the DON and QA.<br><br>15. Interview with the Administrator, on 11/01/13 at 1:30 PM, revealed she did have a job performance review with the Executive Director on 10/24/13 of the job responsibilities, duties and roles along with the company's Quality Assessment and Assurance policy to assure ongoing knowledge and performance of duties and responsibilities. | F 323 | **F490**<br>1. At 7:30 am on 10/20/13, LPN #2 directed all staff on duty to conduct a facility wide search of resident #1 and took a census to ensure that all other residents were accounted for. Upon determining that resident #1 was not in the center, on 10/20/13, a licensed nurse notified the NHA, DON, police, physician, and Resident #1's responsible party. On 10/20/13, the DON and a licensed nurse completed a full body assessment on Resident #1 upon his return to the facility with a CNA # 4 at 8:29am. On 10/20/13, the DON checked Resident #1's wander guard for placement and functionality and the wander guard devise worked appropriately. On 10/20/13, the Maintenance Director checked all exit doors for functionality and they were all noted to be operating appropriately.<br><br>On 10/20/13, the DON directed a licensed nurse to notify resident #1's responsible party and physician of his condition and safe return to the center. On 10/20/13, Resident #1's physician and/or ARNP ordered lab work. On 10/20/13, a licensed nurse reported the results of the lab work to the physician and/or ARNP and the results were noted unremarkable. On 10/21/13, Resident #1's physician completed an assessment of his condition and noted that Resident #1 was overall | |
| F 490<br>SS=J | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review, and review of facility's policies, investigation, and WanderGuard system, it was determined the facility's Administration failed to have an effective system to ensure policies were implemented related to the WanderGuard system and contracted security staff was educated on the policies. Interview with Administration revealed education of contract | F 490 | | |



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| F 490 | Continued From page 45<br>staff was the responsibility of the contract company, not the facility. There was no evidence the facility had a system in place to monitor and ensure the contracted staff was following facility policies. This failure affected (1) of eight (8) sampled residents, Resident #1.<br><br>On 10/20/13 at 5:37:21 (from the WanderGuard report) Resident #1 exited the facility without staff knowledge when the security guard entered an over ride code to open the front entrance door and allowed the resident to leave the facility. Resident #1 was found by a staff member ambulating on a sidewalk in front of a fast food restaurant 0.3 miles from the facility in a heavy traffic, four (4) lane street and was returned to the facility unharmed at approximately 8:29 AM on 10/20/13, approximately two (2) hours and fifty-two (52) minutes after he/she left the facility. Review of the National Weather Service archive temperature log revealed the temperature on 10/20/13 was 39 degrees Fahrenheit. Resident #1 was assessed by the facility as having no injuries. (Refer to F280 and F323)<br><br>The facility's failure to have an effective system to ensure its resources were used effectively and efficiently placed residents' at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death. The facility was notified on 10/24/13 of the Immediate Jeopardy.<br><br>An acceptable Allegation of Compliance (AOC) was received on 10/30/13 which alleged the Immediate Jeopardy was removed on 10/25/13. The State Survey Agency validated the removal of Immediate Jeopardy on 10/25/13 as alleged, prior to exit on 11/01/13 and the scope and | F 490 | stable.<br><br>On 10/20/13, the NHA and DON conducted a preliminary family meeting with resident #1's family members to inform the family of what the NHA and DON knew at present. On 10/20/13, the NHA and DON also scheduled a follow-up family meeting to be held on October 21, 2013 at 1:00PM to present more information.<br>On 10/20/13, the DON reviewed resident #1's elopement assessment dated 10/20/13. The DON also spoke with direct care givers to determine alternative interventions for Resident #1. Resident #1's exit seeking care plan was revised by a licensed nurse with new interventions on 10/20/13 following his return to the building that included increased supervision of 1:1 supervision for 24 hours. At 7:15PM on October 20, 2013, the NHA and DON assigned a licensed nurse to complete a check on resident #1 and his CNA sitter every 15 minutes for the next 24 hours. Resident #1's information sheet was audited by the Director of Clinical Support Services (DCSS) and found to be correct in the At Risk for Elopement binder at security, reception, and nursing station on 10/20/13. | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185468 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED C 11/01/2013 |
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| NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER - WEST, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MAGAZINE STREET LOUISVILLE, KY 40203 | |

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| F 490 | Continued From page 46 severity lowered to a "D" while the facility develops and implements a Plan of Correction and the facility's Quality Assurance program monitors the effectiveness of systemic changes to achieve and maintain substantial compliance.<br><br>The findings include:<br><br>Review of the facility's policy regarding Procedure for Door Alarm/Lock Policy (not dated) revealed all staff had the responsibility to assure that residents who wander would not leave the building unescorted. Staff was directed to respond when a door alarm sounds. The WanderGuard computer located at the nurse's station was not to be touched unless authorized. All staff that was in close proximity was responsible for going to the WanderGuard computer when an alarm sounded to alert others as to which door was alarming. Staff was directed that at no time was authorized personnel allowed to place a door alarm on bypass/silence. Unit Managers, DON, Maintenance and Administrator were the only ones authorized.<br><br>Interview and record review revealed Security Guard #6 entered a code to over ride the door alarm on 10/20/13 at approximately 5:37 AM and allowed Resident #1 to leave the facility unsupervised.<br><br>Telephone interview with Security Guard #6, on 10/23/13 at 10:51 AM, revealed he did not recognize the person as a resident. He stated Resident #1 had on regular clothes, a blue outfit, pants, shoes, shirt and looked like he/she was waiting for somebody. He revealed he did not review the elopement binder, he did not notify the nursing staff of the resident leaving the building | F 490 | On October 21, the NHA and DON directed the assigned, licensed nurse to check on resident #1 every 30 minutes for 24 hours.<br><br>On 10/24/13, Resident #1's exit seeking care plan was reviewed and revised by the DON to include every two hour safety checks. Resident #1's comprehensive care plan was reviewed by a licensed nurse on 10/24/13 to ensure the care plans included all information contained on the C.N.A. Care plans.<br><br>Resident #1's family was consulted on 10/25/13 by the DON to gather any further insight into appropriate interventions. On 10/25/13, Resident #1's family did not give the DON any further insight into appropriate interventions.<br>2. All 78 resident's elopement assessments were reviewed or reassessed by the DON, Unit Managers, Director of Clinical Support Services (DCSS), and the MDS Coordinator on 10/20/13. During the review on 10/20/13, the same 5 previously identified residents (Resident #1, #5, #6, #7, and #8) were assessed by a licensed nurse to be at risk for elopement. The DON checked and tested all resident wander guard devices for Resident #1, #5, #6, #7, and #8 for functionality and placement; which revealed that they worked appropriately on 10/20/13. On 10/20/13, the Maintenance | |



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| F 490 | Continued From page 47<br>as he was trained, and he did not verify if the resident was a visitor by comparing the sign in/out sheet. He further stated he was supposed to look at the elopement book and check it every so often; however, he had not reviewed the elopement binder for 4-5 weeks. Per interview, he accepted the responsibility, that he let Resident #1 exit the building unsupervised.<br><br>Review of the Elopement at Risk binder revealed two (2) in-service sheets had been signed by Security Guard #6, on 05/26/13 and 07/04/13 as directed by the Contracted Security Provider, indicating he was educated on the elopement at risk binder and was to check the elopement at risk binder daily.<br><br>Review of the daily shift report completed by Security Guard #6, dated 10/19/13, revealed he was in the facility at 7:00 PM and out at 7:15 AM on 10/20/13. Review of the visitors log sign in/out sheet revealed the second shift visitors had signed out at 7:46 PM on 10/19/13, with no visitors again until 10/20/13 at 9:12 AM.<br><br>Interview with the Administrator, on 10/22/13 at 8:15 AM, revealed review of the video surveillance tape disclosed Security Guard #6 had entered the reset code which allowed Resident #1, who was wearing a WanderGuard, to exit the building without supervision and without sounding the alarm. She stated Security Guard #6 thought the resident was a visitor and failed to contact the nurse or review the elopement binder, prior to letting the resident exit the building. Per interview, the facility did not provide education to the contracted security guards regarding facility policies and had left this responsibility up to the contract company. | F 490 | Director checked all exit doors for functionality and they were all noted to be operating appropriately<br><br>Resident #1, #5, #6, #7, and #8 also had their exit seeking care plans reviewed and revised as needed based on the most current elopement assessment by the Director of Nursing on 10/20/13 and again on 10/24/13. Resident #1, #5, #6, #7, and #8 care plans all include supervision by nursing staff. All residents assessed to be at risk for elopement are monitored Q2 hours. Resident #1, #5, #6, #7, and #8 comprehensive care plans were reviewed by a licensed nurse on 10/24/13 to ensure the care plans included all information contained on the C.N.A. Care plans and were accurate as to care provided.<br><br>3. On 10/20/13, the NHA reviewed The Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk policies and procedures. On 10/20/13 and 10/21/13, the DCSS and Unit Manager in-serviced all facility staff with the exception of as needed staff and those on illness/LOA on Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk Policies. The fall policy addresses supervision of the resident. As of 11/26/13, all remaining facility staff has been educated by the NHA, DON, Unit | |



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| F 490 | Continued From page 48<br>However, she stated it was her responsibility to ensure the contracted providers were informed of the facility policies and procedures regarding residents at risk for elopement and to ensure the safety of the residents in the facility.<br><br>However, interview with a Corporate Executive Director, on 10/23/13 at 2:00 PM, revealed the security company was ultimately responsible to train the security guards. He stated the facility provided the materials, and the "Elopement at Risk" binder to ensure they were aware of the expectations. He stated the facility did not monitor the contracted agency; the security company supervisors were to ensure their guards were complying with the facility requirements.<br><br>Interview with the Owner and Partner of the Security Company, on 10/23/13 at 12:40 PM, revealed the company only received the Elopement binder from the facility, and did not receive any policies related to the WanderGuard system. Per interview, the Elopement binder contained a list of elopement risk residents with a picture, appointments, census, and a signature sheet of acknowledgement that the guard had read and understood the facility's expectations. Review of the signature sheet revealed Security Guard #6 signed on 05/31/13 and again on 07/06/13. The Owner/Partner stated the guard was supposed to check the Elopement book each shift. In addition, the interview revealed a supervisor made daily rounds at the facility but this was to make sure the guard was on duty and to check if issues needed to be addressed.<br><br>Review of the acceptable AOC revealed the facility took the following actions to remove the Immediate Jeopardy: | F 490 | Manager, and/or licensed nurse on the Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk Policies.<br><br>On 10/20/13, the NHA notified Frederick's Security of the incident regarding Resident #1. At that time, the NHA informed Frederick Security that the Security Guard #6 is no longer able to work for any Christian Care Communities campus.<br><br>On 10/20/13, all Security staff working in the building was in-serviced by the DCSS on the Door Alarm/Lock Policy, Smoking Policy, Missing Resident, and Elopement and Fall Risk Policies. To ensure that the security guards are trained properly, as of 10/21/13, the NHA tests all security guard knowledge of the door alarm/lock policy by having them complete a post-test prior to working and pass at 100% in order to continue working for the center.<br><br>The Administrator or DON will audit all security staff three times weekly x 12 months on knowledge of Door Alarm/Lock Policy and the security At Risk for Elopement binder. The Security binder contains resident census, scheduled appointments, pending discharges, pending admissions and residents at risk for elopement. | |



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| F 490 | Continued From page 49<br><br>1. A facility wide search and resident census was taken by the charge nurse immediately on 10/20/13 at 7:30 AM, to determine if Resident #1 was missing and all other residents were present. The Administrator, DON, police, physician and family of Resident #1 were all notified by telephone.<br><br>2. After Resident #1's return to the facility at 8:29:31 AM by CNA #4, the DON and LPN #2 assessed the resident. They assigned a LPN to complete a check on the resident and CNA sitter every fifteen (15) minutes for twenty-four (24) hours. On 10/21/13 the Administrator and the Director of Nursing (DON) directed the assigned staff to check on the resident every thirty (30) minutes for twenty-four (24) hours.<br><br>3. An investigation was initiated by the DON and the Administrator, on 10/20/13 at approximately 8:45 AM with interviews of staff on duty and telephone interviews with staff from the previous shift, and review of the video-surveillance tape. All exit doors were checked for functionality by the Maintenance Supervisor on 10/20/13 and all exit doors alarming appropriately. The DON notified the physician and assessed the resident along with LPN #2.<br><br>4. On 10/20/13, after review of the surveillance video revealed the Security Guard #6, had entered the bypass code and allowed Resident #1 to exit the building, unsupervised. The Administrator contacted the Security Agency to obtain contact information for Security Guard #6. The facility notified the Security Agency on 10/20/13 that effective immediately Security Guard #6 was no longer authorized to work at the | F 490 | On 12/5/13, the Administrator developed a policy and procedure which details the responsibilities of the security guards and their role in keeping our residents safe. It also contains information on the expectation that all security guards must check the elopement at risk binder daily at the beginning of their shifts and as needed to keep our residents safe. In addition, it details the expectation that the security guard must communicate with a licensed nurse to ensure that the resident is signed out at the nurse's station and a licensed nurse is aware that they are leaving the center before allowing them to exit the center. A copy of the policy and procedure is attached for your review. (Exhibit One). Several members of the QA Committee (DON, Sen. Executive Director, and Administrator, Unit Manager, HR Director) reviewed the Security Policy via email on 12/5/13 to give feedback on the policy and to suggest additions/changes to the policy before implementing it. On 12/5/13, the above noted members of the QA committee agreed to implement the policy. | |



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| F 490 | Continued From page 50 facility.<br><br>5. On 10/20/13, after Resident #1's elopement from the facility, the Administrator determined the Security Communication binder and Elopement at Risk binder was in place and up-to-date as of 10/20/13 with all identifying information and a current photo in the binder for the five (5) residents (to include Resident #1) who had been assessed as being at risk for elopement. On 10/20/13 the DON checked the five (5) residents who had been assessed as being at risk for elopement with WanderGuard bracelets to ensure the bracelets' placement and functionality. The Administrator and the DON had identified the same five (5) at risk residents of the seventy-eight (78) residents assessed. The Director of Clinical Services, the DON, and RN #1 reassessed all seventy-eight (78) residents for their elopement risks on 10/20-21/13.<br><br>6. The Administrator and the Director of Clinical Services determined which security guards were scheduled to work from 10/20/13 and subsequent shifts and re-educated them on the policies related to elopement and completed a competency quiz with a score of 100% before allowing them to work any further shifts. The competency quiz was administered to all two (2) security guards scheduled to work by the DCS on 10/21/13.<br><br>7. A minimum of every two hour facility safety rounds were continued by the staff to ensure resident safety. Corrective action was issued to all nursing staff members with responsibility for caring for the resident during third shift on 10/19/13 and first shift 10/20/13; up to and including termination of employment. On | F 490 | To ensure that all security guards understand the Security Policy and Procedure - Residents, as of 12/5/13, all security guards are required to take a post-test to ensure their Competency and understanding. The Administrator provided a copy of the policy to Frederick Security on 12/5/13 to ensure that all security guards working at our location are trained on this policy. Brian Frederick owner of Frederick Security is the supervisor of all security guards. Brian will ensure that Ben Shaw, his second in command and other Lead Security guards that check on center security guards daily during their shift to ensure that they are on post and do not have questions or concerns are educated on the policy and submit a statement to the Administrator to ensure that this is complete by 12/7/13. The Administrator or DON will also train the guard scheduled to work at the center on 12/5/13 on the new policy and procedure and will also administer a post-test to ensure competency and understanding. All subsequent security guards scheduled to work at the center will be trained by the Administrator and/or DON before being allowed to work at the center. | |



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| F 490 | Continued From page 51<br>10/21/13 directives by the Administrator and DON and the QA Committee for all nursing staff that safety rounds must be conducted for all shift changes. To ensure this standard of walking rounds at shift change is met the nursing staff must provide the DON a mutually-signed copy of the staff member's care records for their shift.<br><br>8. All seventy-eight (78) resident's elopement assessments were reviewed or reassessed by the DON, Unit Managers, and the Director of Clinical Services, and reviewed on 10/20/13 the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. In addition, all residents' admission assessments, care plans, CNA care records, assignment sheets, elopement, fall and smoking at risk assessments beginning on 10/20/13 and completed on 10/24/13 with revisions as indicated.<br><br>9. On 10/20/13 and 10/21/13, all current staff (with the exception of as-needed staff or those on an approved leave) were re-educated by a Unit Manager and the Director of Clinical Services on facility policies for: door alarm, door check, missing person, elopement, falls and smoking schedules for residents which included a post-test to ensure competency. The Administrator assured as needed staff or those that were on approved leave were called via telephone on 10/20/13 to inform them that they were not to work any further shifts until they were trained on the policies and must meet with the supervisor at the beginning of a scheduled shift.<br><br>10. On 10/21/13 the Administrator directed that a | F 490 | The DON and/or Unit Manager will educate all Nursing staff to notify the security guard of a wandering resident by 12/7/13. Beginning 12/5/13, The Administrator or DON will audit all security guards 3 x weekly x 12 months on the Security Policy and Procedure - Residents which details the requirements of their role and responsibilities in keeping our residents safe and from exiting the center unsupervised and without a licensed nurse's knowledge by administering a post-test to test the security guard's continued competency.<br><br>On 10/25/13, the Administrator began requiring Frederick Security to show evidence of security guard background checks before they work and ran Abuse registry checks on all guards on 12/05/13 that currently work at our location. On 12/5/13, Brian Frederick, owner of Frederick Security was given copies of all Abuse/Neglect, HIPPA Training Policy/Quiz, and Resident Rights Policy, to ensure that all security guards are aware of how to respond to the above noted policies and procedures. The Abuse/Neglect, HIPPA Training Quiz and Resident Rights Policy are all in addition to the Door Alarm/Door Lock Policy, Scheduled Smoking Times, Missing Resident, Falls Risk Policy and Elopement Policies that security guards have been | |



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| F 490 | Continued From page 52 representative of the manufacturer of the Center's WanderGuard system be contacted for an onsite visit to re-check the functionality of all applicable doors and adjust the monitoring of sensitivity if needed. The testing and subsequent work was completed on 10/23/13 with the authorization to purchase an additional sensor on one interior door to heighten staff awareness to potential elopement in the corridor leading to the main entry door.<br><br>11. The Administrator conducted a Quality Assurance meeting on 10/21/13 to review the investigation findings and actions taken by the facility. The QA meeting included the Administrator, Medical Director, DON, Unit Manager, and the Director of Clinical Services. Audits were developed and directives were given to ensure compliance. The Elopement at Risk binders would be audited weekly by the Unit Manager. Documentation of the correct placement and functionality of all WanderGuard devices in use would be audited weekly by a licensed nurse. Ten percent of the resident elopement assessments would be audited weekly by the Unit Manager or DON. The DON or Unit Manager would ensure the care plan would be reviewed and revised as needed to reflect if a resident was found to be at risk for elopement. The Maintenance Director would audit all exit doors for function with a WanderGuard four (4) times weekly. All staff responsible for conducting the audits was trained as of 10/21/13.<br><br>12. All licensed nurses were educated on 10/21/13 by the DON that the WanderGuard computer monitor's volume level was not to be adjusted for any reason and was not to be turned off. The ability to change the monitor volume and | F 490 | previously trained on since 10/20/13. On 12/5/13, the Administrator and/or DON in-serviced the security guards on the above noted policies and procedures and the security guard verbalized understanding and was given an opportunity to ask questions to ensure competency. Beginning 12/5/13, all subsequent security guards will be in-serviced on the above noted policies by the Administrator and/or DON before beginning their shifts. As of 12/5/13 Frederick Security was informed by the Administrator that all security guards must also be given a TB shot. The security guard scheduled to work on 12/5/13 was given a TB shot by a licensed nurse on 12/5/13.<br><br>Beginning on 12/5/13, subsequently scheduled security guards will also be given a TB shot by a licensed nurse before starting their shift.<br><br>CNA #1, CNA #2 and LPN #1 and LPN#2 respectively all had responsibility for caring for the resident during third shift on October 19, 2013 and first shift on October 20, 2013. On 10/20/13, the NHA and DON issued a corrective action to CNA #1, CNA #2 and LPN #1 and LPN#2 for not completing their safety rounds during their change of shift. | |



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| F 490 | Continued From page 53 the ability to turn the monitor on and off was disabled on 10/24/13 by the Senior Executive Director. The security staff would be audited three (3) times weekly by the Administrator on their competency and knowledge of the facility's door alarm and locking policy as well as all job-related requirements involving the use of the Elopement at Risk binder.<br><br>13. All audits listed which were developed on 10/21/13 would be gathered by the Unit Manager weekly and submitted to and reviewed by the DON. The DON will report the findings of the audits to the Administrator. The Administrator will present the audit results to the Quality Assurance Committee monthly for twelve (12) months. The Senior Executive Director will review the Quality Assurance minutes monthly and attend the QA meeting on a quarterly basis to monitor compliance.<br><br>14. The Unit Manager educated their total nursing staff of twenty-four (24) on 10/24/13 in person and via telephone on the revised Care Plan Revision Policy and Procedure. Unit Managers will audit care plans for correct revision five (5) days weekly based on new physician orders and assessment's completed from the preceding day. This will be a part of the daily clinical review meeting. Corrections needed would be made at that time. The DON will review the findings of these audits with the Administrator who will present the results to the QA committee.<br><br>15. The Senior Executive Director educated the Administrator on 10/24/13 of the Administrator's job responsibilities, duties and roles along with the company's Quality Assessment and Assurance policy to assure ongoing knowledge | F 490 | On 10/21/13, the NHA and DON directed all nursing staff that safety rounds must be conducted for all shift changes. On 10/21/13, the DON also re-educated all nursing staff on center procedures that direct a check of each resident every 2 hours at minimum. To ensure this standard of walking rounds at shift change is met, as of 10/21/13, the nursing staff must provide the DON a mutually-signed copy of the nursing staff member's care records for their shift daily.<br><br>On 10/21/13, LPN #8 received corrective action up to and including termination for turning the security system monitor off on 10/19/13. LPN #8 is no longer employed at the center. On 10/23/13, the DON conducted an education session for all licensed nurses; providing directions that the wander guard computer monitor's volume level may not be adjusted for any reason.<br><br>On 10/23/13, the DON also provided instruction that the monitor must not be turned off. To ensure that the monitor volume level remained as directed by the NHA and DON, the ability to change the | |



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| F 490 | Continued From page 54 and performance of duties and responsibilities.<br><br>The State Survey Agency validated through record review and interview the Immediate Jeopardy was removed as follows:<br><br>1. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she was notified by the DON at approximately 8:00 AM by telephone on 10/20/13 of the elopement of Resident #1 after a facility wide search and determination Resident #1 was missing from the facility and immediate grounds. Interview with the DON, on 10/25/13 at 10:29 AM, revealed she was notified by RN #1 by telephone at approximately 7:50 AM on 10/20/13 of the elopement of Resident #1. Interview with RN #1, on 10/23/13 at 9:24 AM, LPN #2, on 10/22/13 at 3:25 PM, and LPN #3, on 10/23/13 at 2:12 PM, revealed they were directed to complete an accountability check for each resident on 10/20/13. Review of the nursing notes for 10/20/13 revealed the family and physician were notified by the DON at 8:50 AM.<br><br>2. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she had directed a nurse to complete a fifteen (15) minute check on the resident and CNA sitter every fifteen minutes for twenty-four hours and then for staff to check the resident every thirty (30) minutes for twenty-four (24) hours. Review of the Check sheet dated 10/20/13 and 10/21/13, revealed staff monitored Resident #1 as directed. Review of the nursing documentation on 10/20/13, revealed LPN #2 documented the events from notification of resident missing to the resident's return and assessment completed. | F 490 | monitor volume was disabled on October 24, 2013 by the Senior Executive Director. On 10/24/13, the Senior Executive Director also disabled the ability to turn the monitor on and off.<br><br>The Maintenance Director checked all exit doors on 10/20/13. To ensure that all doors consistently operate appropriately, the NHA directed that a representative of RF Technologies, manufacturer of the center's wander guard system, be contacted on October 21, 2013 to request an onsite visit to re-check the functionality of all applicable doors and adjust the monitoring sensitivity if determined to be needed. This testing and subsequent work was completed by RF Technologies on October 22, 2013 and October 23, 2013 with the NHA authorizing the purchase of an additional sensor on one, interior door to heighten staff awareness to a potential elopement in the corridor leading to the main entry door.<br><br>The NHA conducted a focused quality assurance meeting on October 21, 2013 to review the investigation findings and subsequent actions taken by the center. This quality assurance meeting included the NHA, DON, Unit Manager, Director of Clinical Support and the Medical Director. | |



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| F 490 | Continued From page 55<br><br>3. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed an investigation was initiated by herself and the Director of Clinical Services. Review of the information gathered and documented interviews revealed the investigation had been initiated and was on-going. Review of the facility's investigation into Resident #1's elopement on 10/22/13, revealed staff interviews were done timely. Review of the Maintenance Supervisor report revealed all exit doors had been checked for function on 10/20/13 with no problems identified.<br><br>4. Review of the facility's video-surveillance tape and interview with Administrator, on 10/22/13 at 8:15 AM, revealed the Security Guard #6 had entered a bypass code at the front entrance (known as Main Street 2), on 10/20/13 at 5:37:21 AM, and allowed Resident #1 to exit the facility unsupervised. Review of the e-mail dated 10/23/13 from the facility to the Security Provider revealed the provider was informed of the termination of Security Guard #6 at the facility.<br><br>5. Record review and interview with the Administrator and the DON, on 10/22/13 at 8:15 AM, revealed they had checked the elopement at risk binder at the nursing station, on 10/20/13 to ensure all identifying information and a current photo was in the binder for the five (5) residents (to include Resident #1) who had been assessed at being at risk for elopement. Review of the facility's elopement binder on 10/22/13 revealed all residents who were at risk for elopement had their identifying information in the Security Communication binder. Record review on 10/22/13 revealed seventy-eight (78) residents | F 490 | 4. As a result of the NHA's investigation and quality assurance meeting, the following audits were developed on October 21, 2013 by the DCSS, DON and/or NHA to ensure compliance.<br><br>All At Risk for Elopement Binders located at the reception, security and nurse's station will be audited one time weekly x 12 months for accuracy by the DON and/or Unit Managers.<br><br>Documentation of placement and function of the Wander guards will be audited one time weekly x 12 months by the DON and/Unit Managers. This audit will include visualization of the licensed nurse checking placement and function of the wander guard bracelet.<br><br>Ten percent of residents' Elopement assessments will be audited weekly x 12 months by the DON and/or Unit Managers. If resident is found to be at risk, the corresponding care plan will be reviewed and revised by the DON, Unit Manager and/or licensed nurse if needed. | |



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| F 490 | Continued From page 56 had been reassessed for their elopement risks by the DON, Director of Clinical Services, and Unit Managers. Review of the Maintenance door check lists revealed the doors were checked weekly without concerns identified. Review of the TARs revealed the WanderGuards were checked daily for placement and weekly for function.<br><br>6. Record review and interview with the Administrator, on 10/22/13 at 8:15 AM, revealed she had identified the security guards scheduled to work and immediately in-serviced them on the policy and procedures to include the Elopement at Risk binder. She stated a post-test was completed and they had to pass with 100 percent. Review of the post-test for Security Guard #5, revealed the test had been administered on 10/20/13 and Security Guard #9's test was administered on 10/21/13 with both scoring 100%.<br><br>7. Record review and interview with the Administrator, on 10/24/13 at 3:30 PM, revealed corrective action was issued to LPN's #1 and #2, and CNAs #1 and #2 for failure to complete safety rounds as required. LPN #8 was terminated for turning off the computer monitor. Record review for the employees revealed the written reprimands were placed in the employee files, signed by the employees. Interviews with LPN # 8 revealed she had been terminated for turning off the computer monitor. Review of shift change walking rounds report completed by the LPN's at shift change on 11/01/13 revealed they were signed off by both staff indicating the walking round had been completed and all residents were accounted for. Interviews with CNA #5, on 10/31/13 at 12:50 AM, CNA #6, on 10/31/13 at 1:25 PM, LPN #1, on 10/22/13 at 3:57 | F 490 | The Administrator or DON will audit all security staff three times weekly x 12 months on knowledge of Door Alarm/Lock Policy and the security At Risk for Elopement binder. The Security binder contains resident census, scheduled appointments, pending discharges, pending admissions and residents at risk for elopement.<br><br>On 12/5/13, the Administrator developed a policy and procedure which details the responsibilities of the security guards and their role in keeping our residents safe. It also contains information on the expectation that all security guards must check the elopement at risk binder daily at the beginning of their shifts. In addition, it details the expectation that the security guard must communicate with a licensed nurse to ensure that the resident is signed out at the nurse's station and a licensed nurse is aware that they are leaving the center before allowing them to exit the center. A copy of the policy and procedure is attached for your review. (Exhibit One). Several members of the QA Committee (DON, Sen. Executive Director, and Administrator, Unit Manager, HR Director) reviewed the Security Policy via email on 12/5/13 to give feedback on the policy and to suggest additions/changes to the policy | |



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| F 490 | Continued From page 57 PM,and LPN #2, on 10/22/13 at 3:25 PM, revealed the staff was to complete safety rounds at shift change and every two hours to ensure the residents were safe or if any care was needed.<br><br>8. Record review and interview with the Administrator and the Director of Clinical Services, on 11/01/13 at 11:00 AM revealed the DON, Unit Managers, Director of Clinical Services, and the Administrator had reviewed on 10/20/13, the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct with signatures and dates of the DON, Director of Clinical Services and Administrator. Interview with the Director of Clinical Services (DCS), on 11/01/13 at 11:00 PM, revealed the rest of the seventy-eight (78) residents' documents were reviewed with the Administrator and revisions were made as necessary. Review of the elopement assessments and care plans of the five (5) residents the facility had assessed as being at risk for elopement on 10/20/13 revealed signatures and dates of review and revision by the DCS, DON, and the Administrator. Additional review of all the resident's admission assessments and care plans, CNA care records, assignment sheets, elopement, fall, and smoking at risk assessments began on 10/20/13 and completed on 10/24/13 were done.<br><br>9. Record review and interview with the DON, on 10/25/13 at 10:29 AM, revealed she had provided the in-services regarding facility policies for: elopement risk/assessment; interventions; and steps to be taken during an incident of a missing resident; door alarms; door checks; falls; and | F 490 | before implementing it. On 12/5/13, the above noted members of the QA committee agreed to implement the policy.<br>To ensure that all security guards understand the Security Policy and Procedure - Residents, as of 12/5/13, all security guards are required to take a post-test to ensure their Competency and understanding. The Administrator provided a copy of the policy to Frederick Security on 12/5/13 to ensure that all security guards working at our location are trained on this policy. Brian Frederick owner of Frederick Security is the supervisor of all security guards. Brian will ensure that Ben Shaw, his second in command and other Lead Security guards that check on center security guards daily during their shift to ensure that they are on post and do not have questions or concerns are educated on the policy and submit a statement to the Administrator to ensure that this is complete by 12/7/13. The Administrator or DON will also train the guard scheduled to work at the center on 12/5/13 on the new policy and procedure and will also administer a post-test to ensure | |



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| F 490 | Continued From page 58 smoking schedules; which included a post-test to ensure the staff's competency. Interview with CNA #5, on 10/31/13 at 12:50 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident, falls, door check, smoking policy, safety rounds, which included a post-test on 10/20/13. Interview with CNA #6, on 10/31/13 at 1:25 PM, LPN #1, on 10/22/13 at 3:57 PM, and LPN #2, on 10/22/13 at 3:25 PM, revealed they received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident falls, door check, smoking policy, safety rounds, which included a post-test to ensure competency on 10/20/13. All in-service training content and staff sign-in sheets were reviewed on 10/31/13 to ensure all nursing staff had been re-trained per the AOC.<br><br>10. Record review and interview with the manufacturer's representative of the Center's WanderGuard system revealed an on-site visit was made to verify the function of all exit doors and adjust the monitoring of sensitivity. Interview with Representative, on 10/22/13 at 11:15 AM, revealed he was contacted by the Administrator on 10/20/13, of the resident elopement and the Maintenance Director was in the facility to check all exit doors. He stated he had checked all exit doors on 10/21/13 and they were working appropriately. He stated the inner door was working and he had added an extra sensor. He stated the inner door was not an exit; however, it was to make staff aware of resident's going through the door.<br><br>11. Record review and interview with the Administrator, on 11/01/13 at 8:30 AM, revealed a | F 490 | competency and understanding. All subsequent security guards scheduled to work at the center will be trained by the Administrator and/or DON before being allowed to work at the center. The DON and/or Unit Manager will educate all Nursing staff to notify the security guard of a wandering resident by 12/7/13.<br><br>Beginning 12/5/13, The Administrator or DON will audit all security guards 3 x weekly x 12 months on the Security Policy and Procedure - Residents which details the requirements of their role and responsibilities in keeping our residents safe and from exiting the center unsupervised and without a licensed nurse's knowledge by administering a post-test to test the security guard's continued competency.<br><br>On 10/25/13, the Administrator began requiring Frederick Security to show evidence of security guard background checks before they work and ran Abuse registry checks on all guards on 12/05/13 that currently work at our location. On 12/5/13, Brian Frederick, owner of Frederick Security was given copies of all Abuse/Neglect, HIPPA Training Policy/Quiz, and Resident Rights Policy, to ensure that all security guards are aware of how to respond to the above noted policies and procedures. The Abuse/Neglect, HIPPA | |



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| F 490 | Continued From page 59 Quality Assurance (QA) meeting included the Medical Director, DON, Unit Managers, Director of Clinical Services, and Administrator on 10/21/13. She stated audits were developed and directives were given to ensure removal of Immediate Jeopardy. Review of the Elopement at Risk binders on 10/22-24/13 and 10/30-11/01/13, revealed they had been reviewed and updated with resident census and appointments. No additional residents had been identified at risk for elopement. Review of the facility's audit forms and interview with the DON, on 11/01/13 at 11:50 AM, revealed audits were developed for nursing to ensure walking rounds were done; audits to verify the function and placement of WanderGuards; resident elopement assessments; and care plan audits would be completed by the Nurse Managers and/or DON and given to the DON weekly. She stated she would review all information and report to the Administrator and QA. Interview with the Administrator, on 11/01/13 at 8:30 AM, revealed she would be auditing the Security Guards three (3) times a week to ensure competency and knowledge of the door alarm and locking requirements, and use of the Elopement Risk binder. She stated the Maintenance Director would continue to complete audits on the exit doors to ensure they were functioning appropriately.<br><br>12. Record review and interview with the DON on 10/31/13 at 11:50 AM, revealed she had in-serviced all nurses regarding the use of the computer monitor and to not touch or change the volume of the monitor system, on 10/24/13. She stated the computer 's on/off button was covered by the Executive Director to prevent the staff from turning it off. Interview with LPN #7, on 10/31/13 | F 490 | Training Quiz and Resident Rights Policy are all in addition to the Door Alarm/Door Lock Policy, Scheduled Smoking Times, Missing Resident, Falls Risk Policy and Elopement Policies that security guards have been previously trained on since 10/20/13. On 12/5/13, the Administrator and/or DON in-serviced the security guards on the above noted policies and procedures and the security guard verbalized understanding and was given an opportunity to ask questions to ensure competency. Beginning 12/5/13, all subsequent security guards will be in-serviced on the above noted policies by the Administrator and/or DON before beginning their shifts. As of 12/5/13 Frederick Security was informed by the Administrator that all security guards must also be given a TB shot. The security guard scheduled to work on 12/5/13 was given a TB shot by a licensed nurse on 12/5/13.<br><br>Beginning on 12/5/13, subsequently scheduled security guards will also be given a TB shot by a licensed nurse before starting their shift.<br><br>The Maintenance Director will continue to check exit doors for functionality a minimum of 4 times weekly.<br><br>The DON and/or Unit Managers will audit | |



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| F 490 | Continued From page 60 at 12:54 PM, and RN #3 at 1:12 PM, revealed they had been in-serviced on the purpose and use of the computer monitor and they were not allowed to adjust the volume or turn the monitor off. They said the alarm system on the doors was in place to keep residents safe and nurses had to verify the placement of the resident's WanderGuard and check the function of the WanderGuard weekly.<br><br>13. Record review and interview with the DON, on 10/31/13 at 1:18 AM, revealed she had in-serviced the Nurse Managers on the use and purpose of the audits developed to ensure on-going compliance with the facility policy's for: residents' elopement risks assessments; updating; and reviewing the Elopement binder. She stated she would gather all audits from the Unit Nurse Managers to review and submit to the Administrator. She stated the results of the information would be presented at the monthly QA meetings.<br><br>14. Record review of all in-service training content and staff sign-in sheets and interview with LPN #1, on 10/22/13 at 3:57 PM, LPN #2, on 10/22/13 at 3:25 PM, and RN #1 on 11/01/13 at 11:20 AM, revealed they were in-serviced on the revised care plan policy and assisted with the in-servicing of all the nurses. They were to review all new physician orders in the daily meeting and then audit the care plans for revisions. They stated the audits would go to the DON and QA.<br><br>15. Interview with the Administrator, on 11/01/13 at 1:30 PM, revealed she did have a job performance review with the Executive Director on 10/24/13 of the job responsibilities, duties and | F 490 | Care plans for correct revision 5 days weekly x 12 months based on new physician orders and assessment's completed from the preceding day. This will take place as a part of the daily clinical review meeting. Any needed corrections will be made at this time. The DON will review the findings of these audits with the NHA.<br><br>All of the above listed audits and checks will be submitted to the Administrator and reported to the QA Committee monthly x 12 for further review and recommendations. The Senior Executive Director will review the QA minutes monthly and attend a QA meeting on a quarterly basis to monitor compliance.<br><br>5. All corrective measures will be completed by 12/08/13. | |



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| F 490 | Continued From page 61 roles along with the company's Quality Assessment and Assurance policy to assure ongoing knowledge and performance of duties and responsibilities. | F 490 | | |



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