

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

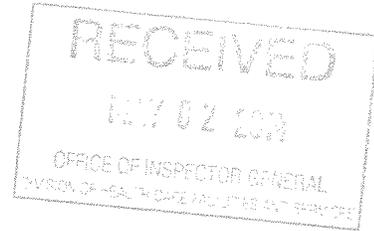
PRINTED: 04/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS	STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207
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F 000	<p>INITIAL COMMENTS</p> <p>Amended 04/25/14</p> <p>An Abbreviated Survey and Partial Extended Survey was initiated on 03/12/14 and concluded on 03/27/14 to investigate KY21435. The Division of Health Care substantiated the allegation with Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) identified on 03/17/14 and determined to exist on 03/09/14 at 42 CFR 483.20 Resident Assessment (F282 at S/S "J") and 42 CFR 483.25 Quality of Care (F323 at S/S "K"). Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F323).</p> <p>After consultation with the Centers for Medicaid and Medicare and quality review additional citations were identified at 42 CFR 483.20 Resident Assessment (F280 at S/S "E") and 42 CFR 483.75 Administration (F490 at S/S "K").</p> <p>Resident #4 was assessed by the facility to be at risk for elopement and was care planned to have a WanderGuard applied. On 03/09/14, Resident #4 was found by staff, at approximately 10:30 AM, with the WanderGuard (WG) device off. However, staff failed to replace the WG, and the resident exited the building without staff knowledge. The resident was observed by staff outside the facility on the sidewalk propelling self in the wheelchair at approximately 1:00 PM. The resident was returned to the facility and assessed to have no injury. The facility identified the resident did not have the WG on upon return to the facility.</p> <p>The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/14 alleging removal</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Allyson Shays, ED</i>	TITLE <i>Executive Director</i>	(X6) DATE 5/2/14
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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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F 000 Continued From page 1 of the Immediate Jeopardy (IJ) as of 03/15/14. The State Survey Agency (SSA) verified the IJ was removed on 03/15/14 as alleged at 42 CFR 483.20 Resident Assessment (F282) with the Scope and Severity lowered to a "D", and 42 CFR 483.25 Quality of Care (F323) and 42 CFR 483.75 Administration (F490) with the Scope and Severity lowered to an "E" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to achieve and maintain compliance.

F 280 Two additional complaints, KY 21433 and KY 21504, were also investigated during the abbreviated survey and were unsubstantiated with no deficiencies.

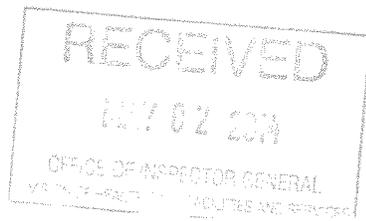
SS=E 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

F 000

F 280

F280 Right to participate Panning Care -Revise CP
Criteria 1
3/9/14

- Returned safely to Living Center by Licensed Nurse
- Assessment completed to rule out injury by the Licensed Nurse.
- Immediate investigation was initiated by the Unit Manager.
- Wander Guard tag was replaced by the Licensed Nurse. The device was verified to be in working order by the flashing light as indicated by manufacturers' directions by the Licensed Nurse. The Licensed Nurse documented incident with interventions on the DQI per policy.
- Care plan was reviewed by the Unit Manager. No revisions were deemed needed by the Unit Manager.
- System review, i.e., the Unit Manager manually checked all doors to ensure they were locking properly. All doors were working correctly. The Unit Manager checked the Wander Guard system by



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F 280

Continued From page 2

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to revise the comprehensive care plan for five (5) of fourteen (14) sampled residents. Residents #4, #5, #6, #7, and #8's comprehensive care plans for elopement contained an intervention to ensure a WanderGuard (WG) was in place on the resident; however, the care plans did not indicate the WG should be checked for placement and/or function and/or how frequently.

The facility failed to revise Resident #4, #5, #6, #7 and #8's care plan when the WG was initially applied to ensure the WG was checked for placement and function each shift and failed to ensure the resident care plans were updated to reflect that staff should check the battery life for Residents #4, #5, #6, #7, and #8.

The findings include:

Review of the facility's policy regarding Interdisciplinary Care Plans, revised October 2009, revealed the care plan was implemented to guide the facility in providing necessary care and services for a resident's well-being. The resident care plan would include historical issues that were currently being managed with interventions.

Review of the facility's policy regarding Elopement Guidelines, revised 2013, revealed the facility would develop a resident care plan that

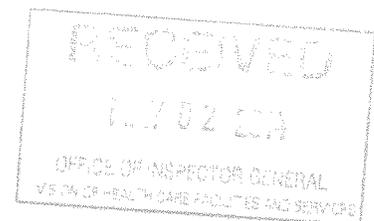
F 280

taking each resident with a device to an exit door. The system was working properly. Per manufacturers instructions the flashing light on the device ensures the battery is working properly. All Wander Guard tags in use were checked for the flashing light by the Unit Manager. A flashing light was not visible on one tag and the device was immediately replaced by the Unit Manager. The Licensed Nurse checked all 7 elopement binders to ensure this resident was included. This resident was included in all 7 binders.

- All doors and Wander Guard system was checked for proper functioning per Maintenance Director.

Criteria 2

- All residents have the potential to be affected.
- All nine residents currently assessed as elopement risk residents were verified they had a working Wander Guard tag in place by the Unit Manager. One device did not have a blinking light and was immediately replaced by the Unit Manager. The other 8 were functioning properly as verified by the Unit Manager.
- All residents confirmed safe within the Living Center by the Unit Manager and Licensed Nursing Staff doing a walking tour.
- All 7 elopement binders were reviewed by the Licensed Nursing Staff to ensure residents at elopement staff were identified. All residents identified were included in the elopement binders as determined by the Licensed Nursing Staff.
- On 3/9/14, the Maintenance Director manually re-checked all exit doors. All doors were working properly.
- On 3/9/14, the Maintenance Director re-checked the Wander Guard system by taking a device to each door. The system was working properly.



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F 280 Continued From page 3 addressed the resident's potential to wander or exit the center, with the measures taken to prevent the elopement. The WG device would be checked to ensure the device was in place, and batteries checked and replaced prior to the expiration date. Additionally, the resident would have a care plan for elopement in place and would have interventions confirmed through physical observation.

1. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 08/11/11 with diagnoses of Senile Dementia and Alzheimer's Disease. The facility completed a quarterly Minimum Data Set (MDS) assessment on 12/28/13 and assessed the resident with a Brief Interview Mental Status (BIMS) score of five (5). The facility developed an elopement care plan, dated 01/25/14, which stated the resident looked for people and things that were not there, was unable to make good safety decisions, and had attempted to open the front door to get a ride to go home. The care plan, dated 01/25/14, stated staff was to find something on the unit the resident would like to do to divert attention from the door; remind the resident the family would be visiting soon; talk to the resident to try and find out what the resident was looking for; and test the WanderGuard alarm to make sure it's working properly. However, the care plan did not indicate checking for placement, and/or frequency.

2. Review of Resident #5's clinical record revealed the facility re-admitted the resident on 04/05/12 with diagnoses of Alzheimer's Disease and Senile Dementia. The facility developed a risk for elopement care plan, on 04/26/13. The facility identified the resident as unable to make good safety decisions and wandering, as well as

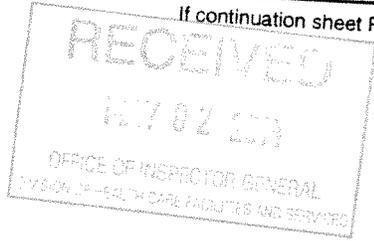
F 280

- All individual Wander Guard devices were checked for working order by verifying the flashing light per manufacturers' directions on 3/9/14 by the Unit Manager.
- On 3/10/14, the Director of Nursing reassessed all current residents for elopement risk. No new residents were added.
- On 3/10/14, the Director of Nursing and Social Services staff verified all elopement binders were correct. No discrepancies were noted. The Director of Clinical Education (DCE) initiated an elopement drill on 3/11/14.

Criteria 3

3/9/14:

- Immediate education was initiated by the Unit Manger for the Licensed Staff and Nursing Assistants:
- Care plans are designed to ensure the safety of residents.
- The Licensed Nurse is responsible to ensure:
- Care plans are followed as developed for each resident and monitored a minimum of every shift and more frequent, if indicated, with documentation on MARS/TARS. Care plans are reviewed daily on an ongoing basis during clinical start up and updated as indicated. Care Plans are reviewed quarterly, annually and with each significant change on an ongoing basis.
- Devices, such as wanderguards, are in place, if indicated. Devices are monitored a minimum of every shift and more frequent if indicated, with documentation on MARS/TARS. The Licensed Nurses will continue to check the devices every shift or more frequent, if indicated, on an ongoing basis.



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F 280 Continued From page 4
able to propel him/herself throughout the facility. A care plan intervention, initiated 04/26/13, included a WG in place on the resident. The facility completed a Significant Change MDS assessment on 02/27/14 and assessed the resident to have a BIMS score of zero (0) with no revisions to the at risk for elopement care plan. However, the care plan did not indicate checking for placement, function, and/or frequency.

3. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/05/14 with a diagnosis of Dementia with Behavioral Disturbance. The facility completed an initial MDS assessment on 01/10/14 and assessed the resident to have a BIMS score of two (2). The facility initiated a care plan, on 02/14/14, for risk of elopement related to the resident self-propelling to the doors and attempting to open the doors. The care plan included an intervention for the use of a WG on the resident's left ankle. However, the care plan did not indicate checking for placement, function, and/or frequency.

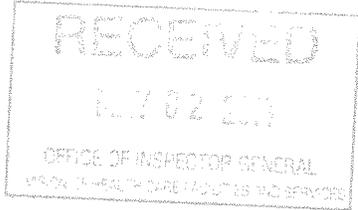
4. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 09/12/08 with diagnoses of Senile Dementia, Alzheimers Disease, Dementia with Behavioral Disturbances, Delusional Disorder and Depressive Disorder. The facility identified the resident with a history of wandering and tended to wander into other residents' rooms. An elopement risk care plan was developed on 03/29/11 with interventions of a WG in place, and to check that the WG battery was operating effectively every shift. However, the care plan did not indicate where the WG was to be placed, nor checking for placement.

F 280 3/10/14:
The Director of Clinical Education (DCE) continued education initiated by the Unit Manager. All Licensed Staff excluding PRN did receive education by 3/13/14. PRN staff was in-serviced prior to working. The center does not use agency staff. One on one education was provided with the assigned nurse at the time of the event, on 3/10/14 per the Director of Nursing.

3/10/14:
The Executive Director and Director of Nursing reviewed the Elopement Policy and Procedure and determined to be in place without need for revision. The Director of Nursing verified in Point Click Care (PCC) that care plans were in place for residents at risk for elopement. The care plans were reviewed for accuracy 3/10/14-3/12/14 and six of the nine were revised by the Director of Nursing. The DCE will continue to educate new hires during orientation and re-educate staff as needed on an ongoing basis.

Criteria 4
3/11/14
The IDT, i.e., Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Activities and Dietary representative, will monitor all care plans quarterly, with significant changes, or as needed on an ongoing basis. The Director of Nursing or ADNS will audit action items from Clinical Start-up meetings for care plan revisions or updates five times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 weeks, then monthly x 3 months. Results of the audit will be reported in the monthly QA Committee Meeting monthly x 3 months then quarterly. The QA Committee will evaluate and make recommendations. The DNS will report any issues identified from these audits to the IDT/Start up team at the next meeting. Re-education will be provided by the DCE or DNS on a one on one basis.

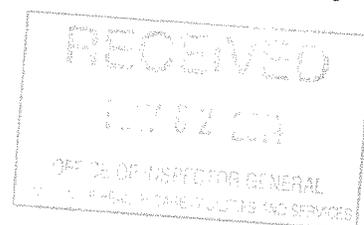
Members of the QA Committee held a meeting on 3/10/14 to discuss the event on 3/9/14 and developed a plan to prevent reoccurrence. The plan included to re-educate all staff regarding Elopement Policy. All staff education was completed on 3/14/14. Elopement binders were reviewed on 3/9/14 and were current. All care plans for patients with wanderguards were reviewed on 3/10/14. Audit of MARS/TARS were



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F 280	Continued From page 5 5. Review of Resident #8's clinical record revealed the facility admitted the resident on 10/21/10 with a diagnosis of Senile Dementia. The facility completed a quarterly MDS assessment on 02/21/14 and assessed the resident to have a BIMS score of three (3). The facility initiated a comprehensive care plan for risk of elopement, on 10/22/10, with a WG in place on the ankle, dated 11/18/13. The facility identified the resident at risk of elopement due to confusion related to his/her diagnosis and a history of removing the WG. However, the care plan did not indicate checking for placement, function, and/or frequency. In addition, review of the care plans for Residents #4, #5, #6, #7, and #8 revealed the care plan did not address monitoring the battery life of the WG. Interview, on 03/14/14 at 12:46 PM and on 03/24/14 at 1:57 PM, with the Unit Manager for the 100 Unit revealed resident care plans were updated by the Unit Managers and MDS Coordinators. She stated social services would also participate in updating the care plan if the resident exhibited behaviors. The Unit Manager indicated the nurses did not update the care plans and any interventions listed would have been added by the Unit Manager. Interview with MDS Coordinator #2, on 03/17/14 at 8:59 AM, revealed the MDS Coordinator was responsible to add interventions to an initial care plan when the resident was admitted to the facility. She stated the Unit Managers were responsible to initiate the care plan. The MDS Coordinator indicated nursing would be responsible to update the care plan related to	F 280	completed on 3/10/14. Wander Guard function and placement was completed on 3/9/14. An elopement drill was completed on 3/11/14 and will be quarterly, thereafter. The details were discussed with the Medical Director via telephone on 3/10/14. 03/12/14 The DNS created and initiated an audit tracking form. Information included on audit form: resident name with tag, date Wander Guard tag applied, site, weekly check of battery using the hand held device, date of last assessment, IPOC/care plan, MD order, and resident information in the Elopement Book. The use of this audit form is ongoing. Wander Guard orders and care plans related to elopement will be audited per DNS/ADNS for consistency, to include checking for placement and functioning, frequency of checks, and location of tag. The DNS/ADN will check battery life of tag weekly using hand held device as recommended by manufacturer. Spare Wander Guard tags, bands, and the hand held device used for activation of WG tags have been placed in the North med cart to facilitate access for nursing. Social Services continues to review and update the Elopement Binder weekly and as needed. Social Services created and continues to utilize an audit tool. Information included: resident name, serial number for ID tag, and where tag is placed. Maintenance or Manager on Duty continues to monitor all doors and Wander Guard system for proper functioning daily. The DCE continues to complete education with all newly hired staff related to the Wander Guard system and care plans. The DNS will re-educate staff as needed. A QA Committee meeting will be held weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly hereafter. QA meetings were held weekly. No problems identified. Elopement Binders, Door & Wander Guard System Audits, and Nursing Audits are reviewed at each QA Meeting. The QA meeting held on 1/27/14 recommended creation of an Elopement Emergency Kit. 4/3/14 The DNS created an Emergency Kit as recommended. 4/3/14 The committee recommended the removal of tags for Wander Guard		



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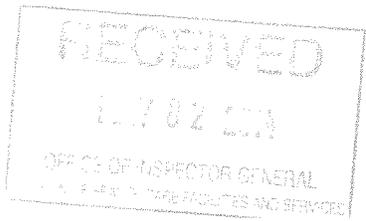
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F 280	<p>Continued From page 6 elopement.</p> <p>On 03/17/14 at 10:15 AM, interview with the interim DON revealed the Unit Managers were responsible to update resident care plans.</p> <p>Interview with the Administrator, on 03/25/14 at 9:33 AM, revealed care plans were updated by the MDS Coordinator, Unit Managers, or DON. She stated the morning meeting with the Interdisciplinary Team (IDT) would review when a WG was placed on a resident. The Administrator indicated the resident care plan would be updated during the clinical portion of the meeting, which she did not usually attend.</p> <p>A post survey interview with the Unit Manager for the 100 Unit, on 04/23/14 at 10:11 AM, revealed the resident's nurse and unit managers were responsible to update the resident's care plans whenever there was a change in the resident's condition. The Unit Manager stated a care plan for risk of elopement would include interventions. An intervention the facility would use could include using a WG. She indicated the care plan for Resident #4, #5, #6, #7, and #8 would not specify to check function of the WG. However, she indicated the date the WG was applied should be on the care plan for monitoring. The Unit Manager further indicated to check placement and function of the WG would be a physician order which would also show on the eMAR/eTAR. She stated she had been trained by the facility how to update the care plan. The Unit Manager indicated the way she monitored how care plans were updated was in the morning clinical meeting when something had occurred with a resident, then the care plan would be updated.</p>	F 280	<p>two patients due to change of condition, and were removed per Nursing. 4/10/14 QA meeting was held. No issues were identified. 4/17/14 No issues identified. The QA Committee will review compliance with education related to care plan training. The DCE will monitor and report percentages of training completed to the QA Committee quarterly. 3/17/14 The DCE reports that all nursing staff have completed Care Plan training. If the Medical Director is unavailable in person on a weekly basis, he will review progress by telephone with the Executive Director and/or DNS. To date the Medical Director has been either present for all meetings or on phone conference line during the meeting.</p>	<p>F280 5/10/2014</p>
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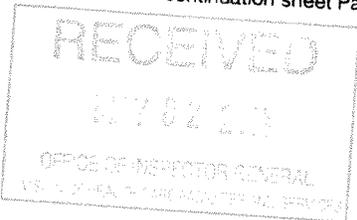
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F 280	<p>Continued From page 7</p> <p>On, 04/23/14 at 10:27 AM, a post survey interview with MDS Coordinator #1 revealed resident care plans were updated by the nurses at the time something occurred with a resident. She stated during the morning clinical meeting, resident care plans were reviewed. She indicated the care plan could specify to check placement and function; however, checking the WG was usually on the eMAR by a physician's order. The MDS Coordinator further indicated if the resident did not have an order listed on the eMAR and did not have to specify to check the WG placement and function on the care plan, the nurse would rely on the elopement book and shift notes to be aware the WG would need to be checked for function and placement. She stated if the resident care plan was not updated the resident had the potential to elope from the facility.</p> <p>A post survey interview, on 04/23/14 at 10:42 AM, with the Social Services Director (SSD) revealed the Nurses, Unit Managers or herself were responsible to update a resident care plan. She stated the resident's nurse would initiate a care plan and the care plan would then be discussed in the clinical morning meeting. The SSD indicated the care plan for risk of elopement should specify to check the WG to ensure the WG was working. She indicated she could not recall if she participated in updating the care plans for Residents #4, #5, #6, #7, and #8. The SSD further indicated the care plans should specify to check the WG; however, the need to check the WG could be in a physician's order. She stated if the resident did not have an order to check placement and function, the nurse would not be aware to check the WG. However, she indicated even without an order, if the care plan</p>	F 280		
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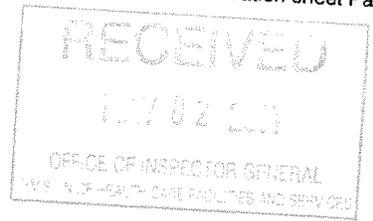
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F 280	<p>Continued From page 8</p> <p>specified to check the WG for function, the nurse would know to check the WG. The SSD did not specify what could happen to a resident if the care plan was not updated and stated she hoped everything would be communicated with staff.</p> <p>A post survey interview, on 04/23/14 at 10:53 AM, with the ADON revealed multiple team members were responsible to update the care plans for residents, including social services, unit managers, ADON, and DON. She stated the intervention for a WG in place for Residents #4, #5, #6, #7, and #8 should also include to check the WG. However, staff did not check the battery life of the WG. The ADON indicated if the care plan did not reflect the need to check the WG for function, there would not be any record the nurses were checking the WG function, or when. She stated if the care plan was not updated to reflect the need to check the WG the nurses would have to be specifically asked if they were checking the WG for function. She indicated the nurses would be aware of the WG through shift report communication. The ADON further indicated the purpose of the care plan was to implement what the resident needed. She stated she had been trained by the facility how to update care plans. The ADON also stated she did not monitor care plan updates for timeliness or accuracy.</p> <p>On 04/23/14 at 11:22 AM, a post survey interview with the interim DON revealed the Nurses and the Unit Managers updated the resident's care plans as soon as there was a change in the resident. She stated the care plans for Residents #4, #5, #6, #7, and #8 should specify the WG was in place, but it was not necessary to indicate to check function as the physician order should</p>
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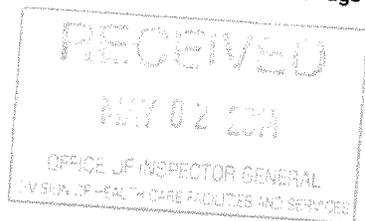
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F 280 Continued From page 9 specify to check WG function. She stated the physician order would then list to check function of the WG on the eMAR/eTAR. The DON indicated if the care plan did not specify to check the WG for function and there was no physician order to check the WG's function, the nurse would know to check the WG for function through verbal report. However, checking function did not mean monitoring battery life or expiration date. She stated the purpose of the care plan was to communicate to staff the care a resident needs. The DON stated if the care plan was not updated the resident would not receive the care the facility needed to provide to the resident. She indicated the monitored care plans were updated by reviewing care plans quarterly and annually with changes, and care plans were reviewed during the morning clinical meeting. She further indicated if a care plan needed to be updated during the morning meeting, it was completed by the ADON, DON, or Unit Manager at that time.

A post survey interview with the Administrator, on 04/23/14 at 11:41 AM, revealed care plans could be updated by nursing, social services, ADON, or DON. She stated the care plan intervention which included a WG in place did not need to specify where the WG was placed or to check function. She indicated the care plans for Residents #4, #5, #6, #7, and #8 did not need additional information related to checking the WG for function. The Administrator stated it was possible to specify check WG function on the care plan; however, indicating the WG in place was the same message. She indicated the purpose of the care plan was to communicate the care for a resident. She stated if the care plan did not specify to check the WG for function the nurse would still be aware to check the WG as a result

F 280

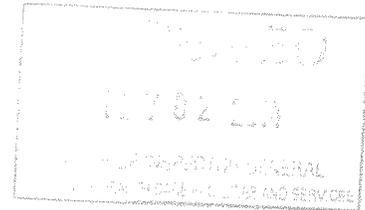


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F 280	Continued From page 10 from facility training. The Administrator indicated if Resident #7's care plan did not specify to check the WG for function, and it was not listed on the eMAR/eTAR to check for function, the nurse would know to check for function through the shift report and assignment sheets. However, the staff did not check the battery life of the WG. She stated if the care plan was not updated for risk of elopement, the potential outcome could be a break in communication. The Administrator indicated she monitored care plan updates through the morning meeting with the IDT.	F 280		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to have an effective system in place to ensure the staff followed the care plan for two (2) of fourteen (14) sampled residents (Resident #4 and #7). The facility's elopement care plan for Resident #4 included interventions for the resident to have a WanderGuard (WG) and the facility's elopement care plan for Resident #7 included the intervention of a WG on 02/14/14; however, there was no evidence it was applied or monitored until 03/27/14. Resident #4 was assessed by the facility to be at risk for elopement and was care planned to have	F 282	F282 Criteria 1 3/9/14 <ul style="list-style-type: none"> • Returned safely to Living Center by Licensed Nurse • Assessment completed to rule out injury by the Licensed Nurse. • Immediate investigation was initiated by the Unit Manager. • Wander Guard tag was replaced by the Licensed Nurse. The device was verified to be in working order by the flashing light as indicated by manufacturers' directions by the Licensed Nurse. The Licensed Nurse documented incident with interventions on the DQI per policy. • Care plan was reviewed by the Unit Manager. No revisions were deemed needed by the Unit Manager. • System review, i.e., the Unit Manager manually checked all doors to ensure they were locking properly. All doors were working correctly. The Unit Manager checked the Wander Guard system by taking each resident with a device to an exit door. The system was working properly. Per manufacturers instructions the flashing light on the device ensures the battery is working properly. All Wander Guard tags in use were checked for the flashing light by 	



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F 282 Continued From page 11
a WanderGuard applied. On 03/09/14, Resident #4 was found by staff, at approximately 10:30 AM, with the WanderGuard (WG) device off. However, staff failed to replace the WG, and the resident exited the building without staff knowledge. The resident was observed by staff outside the facility on the sidewalk propelling self in the wheelchair at approximately 1:00 PM. The resident was returned to the facility and assessed to have no injury. The facility identified the resident did not have the WG on upon return to the facility. (Refer to F323)

The facility's failure to have an effective system in place to ensure the staff followed resident care plans to ensure residents were free from elopement placed residents at risk in a situation that has caused or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/17/14 and determined to exist on 03/09/14. The facility was notified of the Immediate Jeopardy on 03/17/14.

The facility provided an acceptable Allegation of Compliance (AOC) on 03/24/14 alleging removal of the IJ on 03/15/14 and the State Survey Agency (SSA) validated the Immediate Jeopardy was removed on 03/15/14, as alleged. The scope and severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.

The findings include:

Review of the facility's policy regarding Elopement Guidelines, revised 2013, revealed

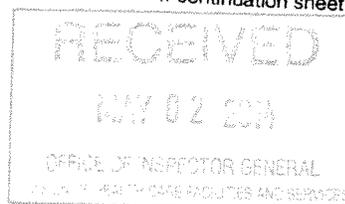
F 282

the Unit Manager. A flashing light was not visible on one tag and the device was immediately replaced by the Unit Manager. The Licensed Nurse checked all 7 elopement binders to ensure this resident was included. This resident was included in all 7 binders.

- All doors and Wander Guard system was checked for proper functioning per Maintenance Director.

Criteria 2

- All residents have the potential to be affected.
- All nine residents currently assessed as elopement risk residents were verified they had a working Wander Guard tag in place by the Unit Manager. One device did not have a blinking light and was immediately replaced by the Unit Manager. The other 8 were functioning properly as verified by the Unit Manager.
- All residents confirmed safe within the Living Center by the Unit Manager and Licensed Nursing Staff doing a walking tour.
- All 7 elopement binders were reviewed by the Licensed Nursing Staff to ensure residents at elopement staff were identified. All residents identified were included in the elopement binders as determined by the Licensed Nursing Staff.
- On 3/9/14, the Maintenance Director manually re-checked all exit doors. All doors were working properly.
- On 3/9/14, the Maintenance Director re-checked the Wander Guard system by taking a device to each door. The system was working properly.
- All individual Wander Guard devices were checked for working order by verifying the flashing light per manufacturers' directions on 3/9/14 by the Unit Manager.
- On 3/10/14, the Director of Nursing reassessed all current residents for elopement risk. No new residents were added.



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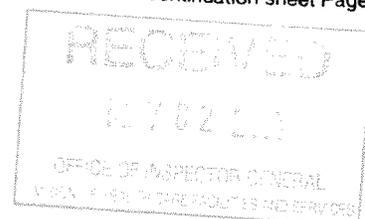
F 282	<p>Continued From page 12</p> <p>the facility would develop a resident care plan that addressed the resident's potential to wander or exit the center, with the measures taken to prevent the elopement. The WG device would be checked to ensure the device was in place. Additionally, the resident would have a care plan for elopement in place and would have interventions confirmed through physical observation.</p> <p>Review of the facility's policy regarding Interdisciplinary Care Plans, revised October 2009, revealed the care plan was implemented to guide the facility in providing necessary care and services for a resident's well-being. The resident's care plan would include historical issues that were currently being managed with interventions.</p> <p>1. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 08/11/11 with diagnoses of Senile Dementia and Alzheimer's Disease. The facility completed a quarterly Minimum Data Set (MDS) assessment on 12/28/13 and assessed the resident with a Brief Interview Mental Status (BIMS) score of five (5). A Nurse's Note, dated 01/24/14, revealed Resident #4 exhibited exit seeking behavior and was observed by staff to attempt to open the front door of the facility. A WG was then placed on the resident's ankle. The facility developed an elopement care plan, dated 01/25/14, which stated the resident looked for people and things that were not there, was unable to make good safety decisions, and had attempted to open the front door to get a ride to go home. The care plan, dated 01/25/14, stated staff were to find something on the unit the resident would like to do to divert attention from the door; remind the resident the family would be visiting soon; talk to</p>	F 282	<ul style="list-style-type: none"> On 3/10/14, the Director of Nursing and Social Services staff verified all elopement binders were correct. No discrepancies were noted. The Director of Clinical Education (DCE) initiated an elopement drill on 3/11/14. <p>Criteria 3</p> <p>3/9/14:</p> <ul style="list-style-type: none"> Immediate education was initiated by the Unit Manger for the Licensed Staff and Nursing Assistants: Care plans are designed to ensure the safety of residents. The Licensed Nurse is responsible to ensure: Care plans are followed as developed for each resident and monitored a minimum of every shift and more frequent, if indicated, with documentation on MARS/TARS. Care plans are reviewed daily on an ongoing basis during clinical start up and updated as indicated. Care Plans are reviewed quarterly, annually and with each significant change on an ongoing basis. Devices, such as wandguards, are in place, if indicated. Devices are monitored a minimum of every shift and more frequent if indicated, with documentation on MARS/TARS. The Licensed Nurses will continue to check the devices every shift or more frequent, if indicated, on an ongoing basis. <p>3/10/14: The Director of Clinical Education (DCE) continued education initiated by the Unit Manager. All Licensed Staff excluding PRN did receive education by 3/13/14. PRN staff was in-serviced prior to working. The center does not use agency staff. One on one education was provided with the assigned nurse at the time of the event, on 3/10/14 per the Director of Nursing.</p> <p>3/10/14: The Executive Director and Director of Nursing reviewed the Elopement Policy and Procedure and determined to be in place without need for revision. The Director of Nursing verified in Point Click Care</p>	
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F 282	<p>Continued From page 13</p> <p>the resident to try and find out what the resident was looking for; and test the WanderGuard alarm to make sure it was working properly. Review of the Certified Nursing Assistant (CNA) care sheet revealed the resident had a WG. Review of the electronic Treatment Administration Record (eTAR), dated March 2014, revealed the resident's WG should be checked every shift for placement and function. A Nurse's Note, dated 03/09/14, revealed Resident #4 exited the facility and was found outside. The resident had stated he/she wanted to go home.</p> <p>Interview, on 03/13/14 at 1:18 PM, with CNA #4 revealed she assisted the resident, on 03/09/14 at 10:30 AM, saw the WG on the resident's dresser and immediately informed Registered Nurse (RN) #3 the resident's WG was off the resident. She indicated the nurses were responsible to put the WG on the resident, ensure the WG was in place, and working.</p> <p>On 03/13/14 at 1:52 PM and 03/17/14 at 9:55 AM, interview with RN #3 revealed she was Resident #4's nurse on 03/09/14 at the time the resident left the facility. The RN stated she had checked Resident #4's WG that morning during med pass, around 8:15 AM, and the WG was in place and functioning. Per interview, CNA #4 reported to her sometime that morning that Resident #4 was not wearing the WG. However, she did not place the WG back on the resident. Further interview with RN #3 revealed the purpose of the WG was to maintain the resident's safety. The nurse stated if the resident's care plan was not followed regarding the use of the WG, the resident could elope from the facility and get hurt.</p> <p>Interview with Licensed Practical Nurse (LPN) #3,</p>	F 282	<p>(PCC) that care plans were in place for residents at risk for elopement. The care plans were reviewed for accuracy 3/10/14-3/12/14 and six of the nine were revised by the Director of Nursing. The DCE will continue to educate new hires during orientation and re-educate staff as needed on an ongoing basis.</p> <p>Criteria 4</p> <p>3/11/14 The IDT, i.e., Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Unit Manager, Activities and Dietary representative, will monitor all care plans quarterly, with significant changes, or as needed on an ongoing basis. The Director of Nursing or ADNS will audit action items from Clinical Start-up meetings for care plan revisions or updates five times a week x 4 weeks, then 3 times a week x 4 weeks, then one time a week x 4 weeks, then monthly x 3 months. Results of the audit will be reported in the monthly QA Committee Meeting monthly x 3 months then quarterly. The QA Committee will evaluate and make recommendations. The DNS will report any issues identified from these audits to the IDT/Start up team at the next meeting. Re-education will be provided by the DCE or DNS on a one on one basis.</p> <p>Members of the QA Committee held a meeting on 3/10/14 to discuss the event on 3/9/14 and developed a plan to prevent reoccurrence. The plan included to re-educate all staff regarding Elopement Policy. All staff education was completed on 3/14/14. Elopement binders were reviewed on 3/9/14 and were current. All care plans for patients with wanderguards were reviewed on 3/10/14. Audit of MARS/TARS were completed on 3/10/14. Wander Guard function and placement was completed on 3/9/14. An elopement drill was completed on 3/11/14 and will be quarterly thereafter. The details were discussed with the Medical Director via telephone on 3/10/14.</p> <p>03/12/14 The DNS created and initiated an audit tracking form. Information included on audit form: resident name with tag, date Wander Guard tag applied, site, weekly check of battery using the hand held device, date of last assessment, IPOC/care plan, MD order, and resident information in the Elopement Book. The use of this audit form is ongoing. 3/12/14 Spare</p>	



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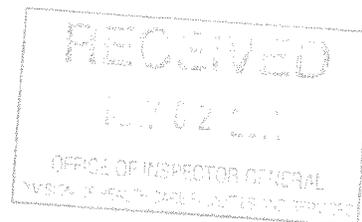
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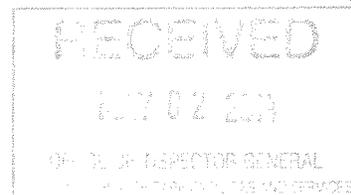
F 282	<p>Continued From page 14</p> <p>on 03/13/14 at 5:01 PM and 03/24/14 at 10:22 AM, revealed she observed Resident #4 outside Unsampled A's bedroom window and saw Resident #4 self-propel on the sidewalk around 1:00 PM. She immediately went outside to the resident, and returned the resident to the facility. Per interview, Resident #4 did not have a WG applied when brought back into the facility, per the resident's plan of care. Further interview revealed the WG system would not work if the resident did not have on the WG.</p> <p>On 03/17/14 at 10:15 AM, interview with the Interim Director of Nursing (DON) revealed Resident #4's care plan was not implemented. Continued interview, on 03/24/14 at 2:46 PM, with the interim DON revealed she monitored the implementation of resident care plans through the morning clinical meeting. She stated the clinical team would review care plan interventions and if additional interventions were needed the care plan and CNA care plan would be updated. The DON stated she would ensure all interventions were on the care plans and visually ensure what was on the care plan was being implemented by the staff. She indicated there was not a schedule or time frame in which she monitored care plan interventions. Additionally, the DON stated she supervised the Unit Managers to ensure the care plan interventions for residents were also listed on the CNA care plan.</p> <p>Interview with the Administrator, on 03/17/14 at 1:33 PM, revealed Resident #4 had talked about going home in the past. She stated the resident's judgement was altered and the care plan identified the use of the WG. She further indicated if the WG was not in place then the resident could leave the facility. She indicated</p>	F 282	<p>Wander Guard tags, bands, and the hand held device used for activation of WG tags have been placed in the North med cart to facilitate access for nursing. Social Services continues to review and update the Elopement Binder weekly and as needed. Social Services created and continues to utilize an audit tool. Information included: resident name, serial number for ID tag, and where tag is placed. Maintenance or Manager on Duty continues to monitor all doors and Wander Guard system for proper functioning daily. The DCE continues to complete education with all newly hired staff related to the Wander Guard system and care plans. The DNS will re-educate staff as needed.</p> <p>A QA Committee meeting will be held weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly thereafter. QA meetings were held weekly. No problems identified. Elopement Binders, Door & Wander Guard System Audits, and Nursing Audits are reviewed at each QA Meeting. The QA meeting held on 3/27/14 recommended creation of an Elopement Emergency Kit. 4/3/14 The DNS created an Emergency kit as recommended. 4/3/14 The committee recommended the removal of tags for Wander Guard two patients due to change of condition, and were removed per Nursing. 4/10/14 QA meeting was held. No issues were identified. 4/17/14 No issues identified. The QA Committee will review compliance with education related to care plan training. The DCE will monitor and report percentages of training completed to the QA Committee quarterly. 3/17/14 The DCE reports that all nursing staff have completed Care Plan training. If the Medical Director is unavailable in person on a weekly basis, he will review progress by telephone with the Executive Director and/or DNS. To date the Medical Director has been either present for all meetings or on phone conference line during the meeting.</p>	F282 5/10/2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/27/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 15 the nurses were responsible to check the resident's WG was in place and functioning. Continued interview with the Administrator, on 03/25/14 at 9:33 AM, revealed the nurses were responsible to monitor the resident care plans for use of the WG. She stated the Unit Managers and the DON monitored the implementation of the resident care plans. The Administrator indicated if the facility assessed the resident to require the WG, the resident's behavior and use of the WG would be discussed in the morning clinical meeting. She further indicated she usually did not attend the clinical portion of the morning meeting. 2. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/05/14 with a diagnosis of Dementia with Behavioral Disturbance. The facility completed an initial MDS assessment on 01/10/14 and assessed the resident to have a BIMS score of two (2). The facility initiated a care plan, on 02/14/14, for risk of elopement related to the resident self-propeling to the doors and attempting to open the doors. The care plan included an intervention for the use of a WG on the resident's left ankle. However, the facility could not confirm the WG was placed on 02/14/14 and review of the physician orders and eTAR (electronic Treatment Administration Record), dated February 2014, revealed no physician order to check the WG each shift. The physician orders and eTAR for March 2014 revealed an order, dated 03/12/14, to check Resident #7's WG for placement and function each shift. The eTAR for March 2014 revealed the facility began to check the resident's WG for placement and function on 03/12/14.	F 282			



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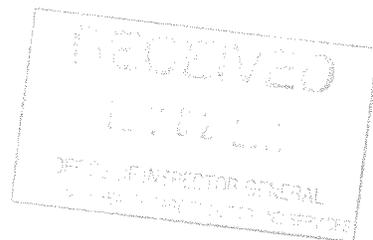
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F 282	<p>Continued From page 16</p> <p>Interview with LPN #3, on 03/13/14 at 5:01 PM, 03/14/14 at 9:29 AM, and 03/24/14 at 10:22 AM, revealed there was no way to know if the WG was being checked each shift if the WG checks were not listed on the eTAR. The LPN further indicated the purpose of the WG was to protect the resident from leaving the facility on their own if the resident was mentally confused, as it was unsafe for the resident.</p> <p>On 03/24/14 at 10:44 AM, interview with RN #3 revealed a physician order was required for the WG checks to be transcribed onto the eTAR; however, the facility did not need a physician's order to place a WG on a resident. She stated if there was not a physician's order for the WG checks the order would not show on the eTAR. The nurse indicated the eTAR was the only record of the WG checks. She further indicated the resident was at risk for elopement if the WG was not being checked for placement and function.</p> <p>Interview with LPN #6, on 03/24/14 at 11:15 AM, revealed the eTAR for March 2014 documentation began 03/12/14 to check the resident's WG for placement and function each shift. She further indicated she had worked with Resident #7 in the past; however, could not remember if she had checked the resident's WG for placement and function prior to the order and eTAR update on 03/12/14. LPN #6 stated if the WG was not checked each shift the resident could wander out of the facility and could become lost, or hurt.</p> <p>Interview with the Unit Manger, on 03/24/14 at 1:57 PM, revealed the nurse who placed the WG on Resident #7 was responsible to ensure the</p>	F 282		
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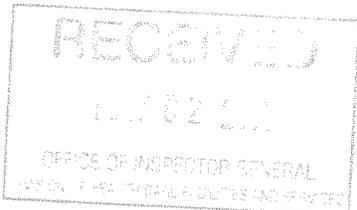
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F 282	<p>Continued From page 17</p> <p>WG checks were on the resident's eTAR. The Unit Manager indicated if the WG checks were not listed on the eTAR there was the potential that the WG was not being checked for placement and function each shift. Additionally, the WG had the potential of not working if the WG was not checked each shift. She further indicated the facility was unable to manually enter the WG checks onto the eTAR without a physician order. She indicated she attended the morning clinical meeting and would have discussed new orders, including the WG, in that meeting. She further indicated she was unaware how Resident #7's eTAR for 02/14/14 through 03/12/14 for WG checks was not updated to include the WG checks each shift. The Unit Manger stated it was not possible to determine if the WG was checked for placement and function each shift from 02/14/14 through 03/12/14. She indicated if the WG checks were not documented then they were not completed.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 03/24/14 at 2:23 PM, revealed use of the WG was nursing judgment; however, a physician's order was necessary to ensure the WG checks were on the eTAR. The ADON indicated when the facility placed a WG on a resident the resident's need for the WG would be discussed in the morning clinical meeting. She further indicated she was unable to recall if Resident #7's WG placement was discussed in the meeting. The ADON stated it was not possible to know if the nurses were checking the WG each shift for placement and function if the WG checks were not listed on the eTAR. Additionally, the ADON stated if the WG was not listed on the eTAR the nurse would not know a resident had a WG on unless the nurse visually saw the WG.</p>	F 282		



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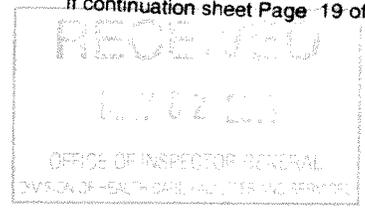
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F 282	<p>Continued From page 18</p> <p>She indicated the DON was responsible to ensure the WG order was in place and on the eTAR. The ADON further indicated she was unaware Resident #7 had a WG and had not been informed of the placement of the WG on the resident and did not have record of the WG placement. She stated she had not followed up to ensure the physician's order was completed because she was unaware of Resident #7's WG.</p> <p>On 03/24/14 at 2:46 PM, interview with the interim DON revealed the purpose of the physician's order for the WG was to ensure the WG printed onto the eTAR and ensure the physician was aware the resident had a WG placed by the facility. She indicated the morning clinical meeting would not be aware of the new placement of the WG on the resident if there was not an order entered into the computer. The DON further indicated there was no way to know if Resident #7's WG was checked for placement and function each shift by the nurses prior to the physician order dated 03/12/14. She stated there was no other documentation of the WG checks. She also stated it was unknown if the nurses were aware the resident had a WG and the WG may not be checked for placement and function each shift if the WG checks were not listed on the eTAR. The DON indicated if the WG was not checked, the resident could remove the WG or the WG could stop working and staff would not be aware.</p> <p>Interview with the Administrator, on 03/25/14 at 9:33 AM, revealed use of a WG for a resident was nursing judgment and did not require a physician's order to use the WG; however, a physician order was necessary to generate on the eTAR. She stated the nurse would document on the eTAR if the WG was being checked for</p>	F 282		
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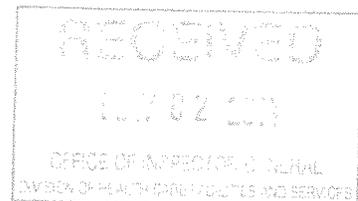
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F 282	<p>Continued From page 19</p> <p>placement and function each shift. The Administrator indicated Resident #7 was cognitively impaired and self-propelled around the facility in his/her wheelchair independently. She further indicated there was no way to know the nurses were checking the resident's WG unless she visually observed the nurse doing so if the WG check was not listed on the eTAR. She stated resident behaviors were discussed in the morning clinical meeting, which she did not usually attend. The Administrator stated she could not recall if Resident #7 was discussed in the morning meeting for placement of the WG in February.</p> <p>The facility provided an Allegation of Compliance (AOC) on 03/24/14 alleging the Immediate Jeopardy (IJ) was removed on 03/15/14; the facility took the following immediate steps to remove the IJ:</p> <ol style="list-style-type: none"> 1. The resident was immediately returned to the facility on 03/09/14. 2. An assessment was completed on 03/09/14 by LPN #3 with no injuries reported. 3. An investigation was started on 03/09/14 by the Unit Manager. 4. The WG was replaced by LPN #3 on 03/09/14. The device was verified to be working by the flashing red light and documented the incident on the incident report (DQI). 5. The care plan was reviewed by the Unit Manager (UM) on 03/09/14. 6. The UM checked all doors to ensure they were 	F 282		
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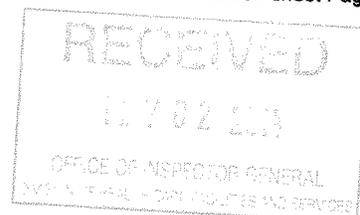
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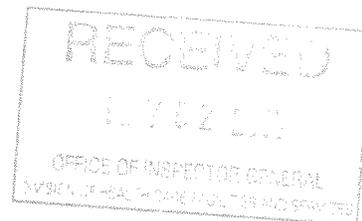
F 282	<p>Continued From page 20</p> <p>locking properly on 03/09/14. The UM checked the WG system taking each resident with a WG to an exit door and found the system to work properly. All WG in use were checked for the red flashing light. The red flashing light was not visible on one (1) WG device and was immediately replaced by the UM. All elopement binders were checked by the UM to ensure the resident was included.</p> <p>7. The resident's family and physician were notified by RN #3 on 03/09/14.</p> <p>8. All residents were assessed on 03/09/14 for risk of elopement with nine (9) residents currently at risk and WG verified in place and working.</p> <p>9. All residents were confirmed in the facility by the UM on 03/09/14.</p> <p>10. All elopement binders were reviewed by the nursing staff on 03/09/14 to ensure all identified residents were in the binder.</p> <p>11. The Maintenance Director checked all doors on 03/09/14.</p> <p>12. The Maintenance Director checked the WG system on 03/09/14.</p> <p>13. All resident WGs were checked by the UM on 03/09/14 for the red flashing light.</p> <p>14. The DON assessed all residents on 03/10/14 for risk of elopement with no new residents added.</p> <p>15. The DON and Social Services staff verified elopement binders were correct on 03/10/14.</p>	F 282		
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F 282	<p>Continued From page 21</p> <p>16. The Director of Clinical Education (DCE) initiated an elopement drill on 03/11/14.</p> <p>17. Education was initiated by the UM on 03/09/14 for nurses and CNAs that included: A. Care plans were to ensure resident safety B. Care plans were followed as developed for each resident and monitored every shift or more frequent if indicated with documentation on the eMAR/eTAR. Care plans were updated quarterly, with significant changes, or as needed. CNA assignment sheets were updated daily and as needed. C. WG devices in place if indicated and monitored each shift and more frequent if indicated with documentation on the eMAR/eTAR or according to the care plan.</p> <p>18. The DCE continued education on 03/10/14 initiated by the UM. All licensed staff except PRN staff received education by 03/13/14. PRN staff will be in-serviced prior to working.</p> <p>19. The Administrator and DON reviewed the Elopement Policy and Procedures on 03/10/14 with no changes made.</p> <p>20. The DON verified on 03/10/14 the resident care plans were in place for residents at risk for elopement. The care plans were reviewed for accuracy 03/10/14 through 03/12/14 with six (6) of nine (9) revised.</p> <p>21. The DON, ADON, and/or UM will: A. Audit placement of the WG on individual residents five (5) times a week for four (4) weeks to begin 03/10/14, followed by three (3) times a week for four (4) weeks, and weekly ongoing.</p>	F 282		



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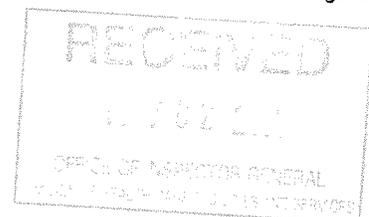
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F 282	Continued From page 22 B. Audit of eMARs/eTARs to ensure elopement documentation is complete five (5) times a week for four (4) weeks beginning 03/12/14, followed by three (3) times a week for four (4) weeks, and weekly ongoing. C. Check doors daily and ongoing by Maintenance or Manager on Duty to ensure the system was working. 22. Licensed staff are responsible to check WG placement and function each shift or as stated on the resident care plan with the device identified as functioning by evidence of a flashing red light on the resident's individual WG device. 23. The Maintenance Director will be responsible to conduct elopement drills quarterly, beginning 03/11/14. 24. The Interdisciplinary Team (IDT) will monitor all care plans quarterly, with significant changes, or as needed and will utilize the checklist with the elopement policy. 25. A QAPI meeting was held on 03/10/14 to discuss the incident on 03/09/14 and develop a plan to prevent re-occurrence. The plan included re-education of all staff regarding the elopement policy. All staff re-education was completed on 03/14/14. Elopement binders were reviewed 03/09/14; all care plans for resident with WGs were reviewed on 03/10/14; audit of eMARs/eTARs was completed 03/10/14; WG placement and function was completed 03/09/14; an elopement drill was completed 03/11/14 and will be quarterly thereafter. Details were discussed with the Medical Director by phone on	F 282		
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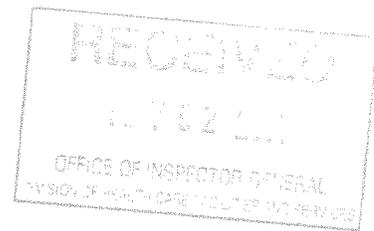
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F 282	Continued From page 23 03/10/14. 26. A QAPI meeting will be held weekly x4, then bi-weekly x4, then monthly. The committee will review compliance with education related to care plan training. If the Medical Director was not available, he would receive progress by telephone from the Administrator or DON. QAPI members include the Administrator, DON, ADON, UM, DCE, MDS Coordinator, Social Services, Dietary, Activities, Business Office, Consultant Pharmacist, and Medical Director. Through observation, interview, and record review the State Survey Agency (SSA) validated the AOC, on 03/26/14 through 03/27/14 prior to exit as follows: 1. Review of the clinical record for Resident #4 and the DQI revealed the resident was last seen at 12:35 PM leaving the north dining room. The resident was seen at 12:45 PM outside the building by the steps. Interview with RN #3, on 03/27/14 at 9:02 AM, revealed Resident #4 was returned to the facility at 12:45 PM. 2. Review of Resident #4's clinical record revealed a head to toe assessment was completed on 03/09/14 with no injuries noted. Interview with RN #3, on 03/27/14 at 2:01 PM, revealed she conducted a head to toe assessment for Resident #4 upon return to the facility with no injuries found. 3. Review of the facility DQI, dated 03/09/14, revealed an investigation was begun on 03/09/14. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she initiated the elopement investigation immediately after Resident #4 was returned to the	F 282		
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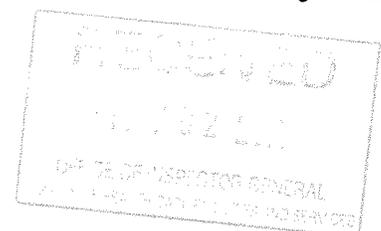
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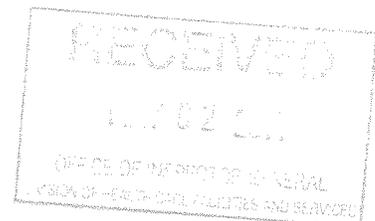
F 282	<p>Continued From page 24 facility.</p> <p>4. Review of the clinical record revealed RN #3 completed the DQI on 03/09/14. Interview, on 03/27/14 at 2:01 PM, with RN #3 revealed she placed the WG back on the resident and verified the WG was functioning, and completed the DQI after Resident #4 was returned to the facility. Review of the facility's Daily Maintenance Rounds, dated Monday 03/03/14 through Friday 03/07/14, revealed all the exit doors were checked and operating correctly. Review of the Weekend Manager Checklist, dated 03/08/14 and 03/09/14, revealed door alarms and the WG system were working. Duties completed on 03/09/14 by the Weekend Manager included a tour for potential customers, assist to monitor call lights, dining room oversight during meals, seek out and interact with residents and families, and assist with answering the telephone.</p> <p>5. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she reviewed Resident #4's care plan on 03/09/14. Review of the risk for elopement care plan for Resident #4 revealed the care plan was revised on 03/09/14.</p> <p>6. Review of the facility's Daily Maintenance Rounds and the Wanderguard List revealed the UM checked all exit doors and individual resident WG devices on 03/09/14. One (1) WG was replaced for Resident #7 by the UM. The UM reviewed all seven (7) elopement binders. Review of the elopement binder revealed all nine (9) residents with a WG were listed with a picture and informational face sheet. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she checked all the doors after the elopement and found all doors to be working. The UM stated she</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS			STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 25</p> <p>checked all the residents with a WG and found Resident #7's WG was not working and immediately replaced the WG. She indicated she also checked all the elopement binders and verified all residents at risk of elopement were in the binders.</p> <p>7. Review of Resident #4's clinical record revealed the physician and family were notified of the elopement on 03/09/14. Interview, on 03/27/14 at 2:01 PM, with RN #3 revealed she notified the physician and family about the elopement on 03/09/14.</p> <p>8. Review of the facility's Elopement Assessments revealed all residents were assessed 03/10/14 and 03/11/14 by the DON. Interview with the UM, on 03/27/14 at 1:26 PM, revealed one (1) WG was not working, Resident #7, and immediately replaced the WG. Interview with the DON, on 03/27/14 at 2:10 PM, revealed she assessed all residents for risk of elopement on 03/10/14 through 03/12/14. She stated nine (9) residents were assessed at risk for elopement with a WG in place and working.</p> <p>9. Review of the facility daily census for 03/09/14 revealed all residents were accounted for on 03/09/14 by the UM. Interview with RN #3, on 03/27/14 at 2:01 PM, revealed she assisted on 03/09/14 to ensure all residents were present and accounted for in the facility. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she ensured all residents were present and accounted for in the facility on 03/09/14.</p> <p>10. Review of the facility investigation revealed all seven (7) elopement binders were reviewed by the UM on 03/09/14. Interview, on 03/27/14 at</p>	F 282			



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F 282	<p>Continued From page 26</p> <p>1:36 PM, with the UM revealed she checked all the elopement binders to ensure all residents that were supposed to be listed were in the binders. Review of the elopement binder revealed all nine (9) residents with a WG were included with a picture and informational face sheet.</p> <p>11. Review of the facility Daily Maintenance Rounds, dated 03/09/14, revealed the Maintenance Director checked all of the exit doors. Interview with the Maintenance Director, on 03/27/14 at 8:26 AM, revealed he was called to the facility and checked all of the exit doors on 03/09/14 and found all doors working.</p> <p>12. Review of the facility's Daily Maintenance Rounds, dated 03/09/14, revealed the Maintenance Director checked all of the exterior doors WG system with all doors verified to be working. Interview, on 03/27/14 at 8:26 AM, with the Maintenance Director revealed he checked the WG system on 03/09/14 and found the system working.</p> <p>13. Review of the facility's Wanderguard List revealed the UM checked each resident with a WG to ensure it was working on 03/09/14. Resident #7's WG was replaced on 03/09/14. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she checked each resident's WG for the red flashing light on 03/09/14. She stated Resident #7's WG was not flashing and was immediately replaced. Observation, on 03/24/14 at 9:04 AM, 9:27 AM, and 10:08 AM, revealed Resident #7 self-propelled in his/her wheelchair toward the 100 Unit entrance doors and looked out the windows. The resident had a WG to his/her left ankle with the red light blinking.</p>	F 282		
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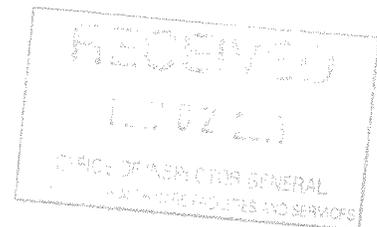
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F 282	<p>Continued From page 27</p> <p>14. Review of the facility's Elopement Assessments revealed all residents were assessed for risk of elopement 03/10/14 through 03/11/14. Interview with the DON, on 03/27/14 at 2:10 PM, revealed she conducted resident risk of elopement assessments beginning 03/10/14 and completed on 03/12/14 with nine (9) residents found at risk of elopement and no additional residents required the use of a WG.</p> <p>15. Review of the facility's Wanderguard Audit Tool, dated 03/10/14 - 03/12/14, revealed the elopement binders were checked by the DON to verify each resident at risk for elopement with a WG was listed in the book. Review of the Elopement Book Audit Log, dated 03/11/14, revealed each book was checked for residents listed and if any new residents and who were added. Interview with the DON, on 03/27/14 at 2:10 PM, revealed she audited all seven (7) elopement binders on 03/11/12. She stated the elopement binders were up to date. Interview with the Director of Social Services, on 03/27/14 at 3:16 PM, revealed she assisted the DON to audit the elopement binders on 03/11/14 for resident picture, information sheet, and if anyone needed to be added.</p> <p>16. Review of the facility's education records and staff signature sheet, dated 03/11/14, revealed thirteen (13) staff participated in an elopement drill including LPN #2, CNA #10, and CNA #5. Interview, on 03/27/14 at 2:47 PM, with the DCE revealed she conducted an elopement drill on 03/11/14. Interviews with LPN #2 on 03/27/14 at 9:28 AM; CNA #10 on 03/27/14 at 9:46 AM; and CNA #5 on 03/27/14 at 9:53 AM revealed they had been trained on the WG system and the Elopement policy and knew what to do if a</p>	F 282		
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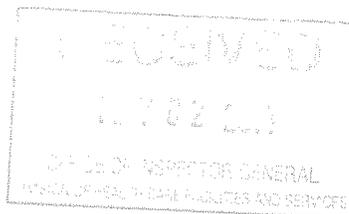
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F 282	<p>Continued From page 28 resident eloped from the facility.</p> <p>17. Observations, on 03/27/14 at 11:00 AM, revealed all nine (9) residents and designated wheelchairs for two (2) of the residents listed on the facility's Wanderguard List had WGs in place. Interview with RN #3, on 03/27/14 at 9:02 AM, revealed she was in-serviced on 03/09/14 to check that the resident WGs were in place and functioning, document that on the eTAR, and resident care plans and CNA assignment sheets should be reviewed and revised for new orders or any type of incident. Interview with CNA #5, on 03/27/14 at 9:53 AM, revealed she was working 03/09/14 and received training that day about elopement procedures and the CNA assignment sheet which would have pertinent information about the resident. Interview with the UM, on 03/27/14 at 1:36 PM, revealed she immediately began training with staff on 03/09/14 with nurses and CNAs that WG devices should be in place and monitored each shift and documented on the resident's eMAR/eTAR. Interview, on 03/27/14 at 2:10 PM, with the DON revealed CNA assignment sheets and resident care plans were updated for six (6) of nine (9) residents who were at risk of elopement.</p> <p>Observation, 03/13/14 at 4:42 PM, revealed a WG with a red blinking light was on the wheelchair for Resident #4. On 03/14/14 at 9:06 AM, observation revealed Resident #4 had a WG on the right ankle and on the wheelchair, both with a red blinking light. Observation on 03/14/14 at 11:37 AM, revealed the resident was in an exercise group in the west dining room, a WG was visible on the right ankle over the resident's sock. Continued observation of Resident #4, at 11:33 AM, revealed the resident self-propelled</p>	F 282		
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F 282	<p>Continued From page 29</p> <p>him/herself independently from the exercise group to the north dining room for lunch service. The resident was again observed to self-propel from the north dining room at 12:29 PM past the front doors and was observed to look in the direction of the front doors; however, continued past the entrance toward the resident's hallway.</p> <p>18. Review of staff education revealed training continued on 03/10/14 and was completed on 03/14/14 by the DCE for one hundred fifteen (115) employees, with one (1) staff on a leave of absence. Education included elopement guidelines, the WG system, placement of the WG, and documentation on the eMAR/eTAR. Interviews with the CNA #9 on 03/27/14 at 8:44 AM; RN #5 on 03/27/14 at 8:52 AM; LPN #2 on 03/27/14 at 9:28 AM; CNA #10 on 03/27/14 at 9:46 AM; Dietary Aide #1 on 03/27/14 at 3:51 PM; and Housekeeper #4 on 03/27/14 at 3:56 PM, all revealed they had been trained on the WG system and elopement procedures, ensuring the WG was in place and the nurses were to document on the eMAR/eTAR. Interview with the DCE, on 03/27/14 at 2:47 PM, revealed all staff were educated by 03/14/14, including PRN staff educated by telephone, except for one CNA on medical leave who would be in-serviced prior to working. The DCE stated staff education included elopement guidelines, elopement binders, the WG system, checking the WG for placement and function each shift, documentation in the eMAR/eTAR, updating and implementing the resident's elopement care plans. She indicated all staff who received training received an elopement packet that included the policy, including staff who were educated by phone and staff who were</p>	F 282		
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