

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey and partial extended survey was initiated on 03/15/12 and concluded on 03/30/12 to investigate KY18024. KY18024 was substantiated and Immediate Jeopardy was identified on 03/22/12, and was determined to exist on 01/31/12. On 01/31/12, Resident #1 exited through a Code Alert door without staff knowledge, then self-propelled in a wheelchair through the parking lot and onto the street in front of the facility (Boxwood Run Road). Resident #1 fell out of his/her wheelchair as an off duty staff member approached the resident on the street, and returned the resident to the facility. The facility was notified of the Immediate Jeopardy on 03/22/12 with deficiencies cited at 42 CFR 483.13 Resident Behaviors and Facility Practices, F225 at a scope and severity of "J"; 42 CFR 483.20 Resident Assessment, F282 at a scope and severity of "J"; 42 CFR 483.25 Quality of Care, F323 at a scope and severity of "J"; and 42 CFR 483.75 Administration, F490 at a scope and severity of "J"; with Substandard Quality of Care identified at 42 CFR 483.13, F225 and 42 CFR 483.25, F323.</p> <p>The facility provided a credible Allegation of Compliance (AOC) on 03/30/12 alleging compliance as of 03/25/12. The State agency verified Immediate Jeopardy was removed on 03/25/12 prior to exit on 03/30/12, at 42 CFR 483.13 Resident Behaviors and Facility Practices, F225; 42 CFR 483.20 Resident Assessment, F282; 42 CFR 483.25 Quality of Care, F323; and 42 CFR 483.75 Administration, F490 which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to</p>	F 000	<p>Green Meadows Health Care Center 1 acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance. Green Meadows Health Care Center 1's response to the Statement of Deficiencies and Plan of Correction does not constitute an admission that any deficiency is accurate. Further Green Meadows Health Care Center 1 reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolutions, formal appeal process and/or any other administrative or legal proceedings.</p>	
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>William R. Brown</i>	TITLE Administrator	(X6) DATE 05/10/2012
--	------------------------	-------------------------

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 Continued From page 1
achieve and maintain compliance.

KY18025 and KY18078 were also investigated during the abbreviated survey. KY 18025 was not substantiated and no deficiencies were cited. KY18078 was not substantiated; however, a deficiency was identified at 42 CFR 483.13 Resident Behaviors and Facility Practices, F225.

F 000

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=J INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

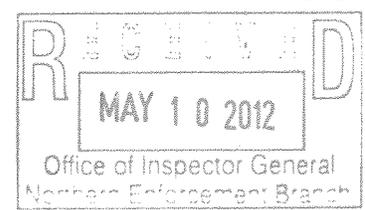
The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

F 225

1. The following actions were taken on January 31, 2012 for Resident #1. Assessed by Unit Manager for injuries, none noted. A new Code Alert transponder was placed on ankle and the original transponder, found to be properly working was placed on the wheelchair. The key-padded, double doors leading to the Therapy Department were closed to limit resident access to Therapy exits. All Code Alert equipped doors were checked by Director and Assistant Director of Maintenance and found to be properly functioning. On March 23, 2012 the exit to Therapy was converted to an emergency exit only and a fire box affixed to the door on April 02, 2012 to alarm when the door is opened. On April 02, 2012 the Code Alert bypass code was changed. Resident #14 was assessed per Unit Manager, Hosparus nurse and DON on March 19, 2012. Social Services Director and DON interviewed Resident #14 on March 19, 2012 and resident denied abuse caused injury and reported the injury was possibly caused as a result of being turned while in bed.

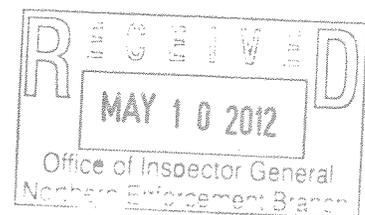
May 01, 2012



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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 225	<p>Continued From page 2</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation report and Abuse Prohibition Policy, it was determined the facility failed to report an elopement and an injury of an unknown source for two (2) of twenty (20) sampled residents. (Resident #1 and #14). On 01/31/12, Resident #1 exited through a Code Alert door without staff knowledge, then self-propelled in a wheelchair through the parking lot and onto the street in front of the facility (Boxwood Run Road). Resident #1 fell out of his/her wheelchair as an off duty staff member approached the resident on the street. The resident was returned to the facility and assessed to have no injuries. The facility failed to report Resident #1's elopement to the appropriate State Agencies. In addition, Resident #14 sustained a fracture of unknown source identified on 03/19/12, which was not reported to the State Agencies.</p> <p>The facility's failure to report the elopement placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/22/12</p>	F 225	<p>Resident #14's BIMS score was recorded as 14 on January 23, 2012 and as 15 on March 21, 2012. The physician was notified and x-ray obtained, family also notified on March 19, 2012. Resident was monitored for pain by nursing staff. Resident's care plan was reviewed and revised on March 19, 2012. Incident was reported to the appropriate State agencies on March 21, 2012.</p> <p>2. All residents' elopement risk assessments were audited and new assessments completed by March 23, 2012. During these reviews and assessments, the residents' care plan was audited, the previous elopement assessment score listed as well as the current elopement assessment score to compare. The Certified Nursing Assistant's care sheet was also reviewed / revised as needed. On March 22, 2012 the Administrator, Director of Nursing and QA Nurse audited the past three (3) months of Event Reports to determine if any included bruises or injuries of unknown source.</p> <p>3. A meeting was held on Thursday, March 22, 2012 with the following individuals attending: Everett Ben Bays, Administrator; Matthew Schneider, Director of Nursing; Betty Thompson, medical Records; AJ Holt, Rehab Services Manager; John Lott, Marketing/ Admissions Director; Ben Bleemel, Director of Maintenance; Holly Culver, Social Worker; Kathy Davis, Nurse</p>



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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 225 Continued From page 3 and was found to exist on 01/31/12.

The facility provided a credible Allegation of Compliance (AOC) on 03/30/12. The State Agency verified Immediate Jeopardy was removed on 03/25/12 as alleged prior to exit on 03/30/12; which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to achieve and maintain compliance.

The findings include:

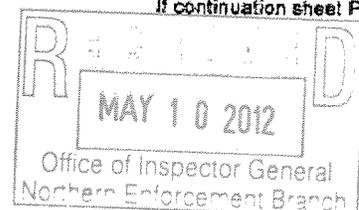
Review of the facility's Abuse Prohibition Policy, issued 07/2010, revealed it is the policy of this facility that parameters will be established regarding abuse in the areas of screening, training, prevention, identification, investigation, protection and reporting/response. All facility employees are to promptly report any suspected abuse, mistreatment, involuntary seclusion, neglect or misappropriations of property belonging to residents to the charge nurse immediately. The policy included a section listed as Reporting, which stated all incidents are reported and investigated as they occur.

Review of the facility's policy regarding Wandering and Elopement of Residents, dated May 2010, detailed the Director of Nursing (DON) or Administrator would notify the State Agency of an incident of elopement as required. However, the policy failed to define elopement.

1. Review of the facility Event Report, dated 01/31/12 revealed Resident #1 was outside and the wheelchair fell over in a grassy area. The

F 225

Scheduler/Central Supplies; Debbie Curtsinger, Activity Director; Nancy Thompson, Dietary Manager; Jackie Flynn, Restorative/Wound Nurse; Cortney Boggs, Staff Development Coordinator; Lori Shelden, House Supervisor 2p-10p; Darlene Hanson, House Supervisor 6a-2p; Shannon Davis, MDS Coordinator; Mandy Ward, Business Office Manager; Sue Hardin, MDS Coordinator; and Alice Hudson, Director of Housekeeping/Laundry. The purpose of the meeting was to review and revise policies for Resident safety, with a focus on elopement risks with staff providing input as education was provided. The outcome of this meeting was the creation of the facility's definition of an elopement, that being; an elopement occurs when a resident exits an exterior door without authorization (an MD order, Discharge, LOA, staff knowledge) and/or any necessary supervision to ensure safety. The procedure for responding to the Code Alert door alarms was created and presents that any response to the Code Alert alarm requires that the staff member(s) responding to the alarm identify exactly why the Code Alert alarm was activated. This entails opening the door to ensure no residents are outside the facility. Once it is determined who/what has activated the alarm, the staff member responding must document on the Code Alert Log that is located at all four doors equipped with Code Alert systems. Staff are to document the



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

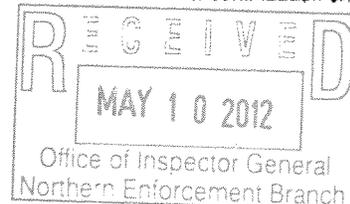
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 4
problem was identified on the Event Report as a "witnessed fall", and the immediate facility intervention was to change the Code Alert bracelet and apply a new bracelet to the left ankle, add a bracelet to the wheelchair, and Resident #1 remained on fifteen (15) minute tracking. The Post Event Investigation described the type of event as "witnessed fall, resident outside, wheelchair noted to fall over, and the facility intervention was: fifteen (15) minute tracking, Code Alert band on resident and wheelchair, continue tab alarm to bed and wheelchair, sensor pad to bed and wheelchair".

Review of the clinical record for Resident #1 revealed an admission date of 07/09/11 with diagnoses of Dementia, Anxiety, Depression, and Macular Degeneration. On 07/09/11, the facility assessed the resident at high risk for elopement related to cognitive deficit and exit seeking behavior. Resident #1 was care planned for wandering and exit seeking behavior and staff was to observe and document resident behaviors, and alert staff to wandering behaviors. The resident had a Code Alert bracelet to alert staff of an attempt to elope and the bracelet was to be checked for placement and function every shift. On 08/13/11, Resident #1 exited the facility, the Code Alert Alarm sounded, and the resident was returned to the facility from the parking lot. At that time Resident #1 was placed on and remained on fifteen (15) minute tracking. However, Resident #1 exited the facility on 01/31/12 without staff knowledge.

Interview, on 03/15/12 at 4:00 PM, by telephone, and further interview on 03/20/12 at 8:20 AM, with the Dietary Aide (DA) revealed he left work at the

F 225 date, time, reason and sign. Should they not be able to identify exactly why the Code Alert alarm has sounded, they are to immediately report this to the nurse supervisor so an accounting can be made of all residents to determine their location and ensure they are within the facility if not out of the facility with staff's knowledge. A form was created, *Acknowledgement of Risks/Criteria: Being outside Facility Unsupervised* that will be presented to residents and/or their responsible party if the resident wants to sit/go outside the facility. Staff is to make sure the doors they exit or enter shut completely and the magnetic lock has engaged to ensure there is no ability to exit/enter the facility without the entry of the code. Policies and Procedures reviewed include: *Missing Resident, Wandering and Elopement of Residents, Resident Tracking, and Exits with Key Pads*. A Missing Resident Quiz was created for staff's completion during in-service training. Staff training began on March 23, 2012, following facility's notification of findings of immediate jeopardy on March 22, 2012. The in-service training content includes: *Missing/Wandering Residents, Elopement of Residents, Exits with Key Pads, Resident Tracking, Missing Resident Quiz, Code Alert Log, Definition of Elopement, Acknowledgement of Risks Criteria form*. The method of training included presentation by Staff Development Coordinator, handouts



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

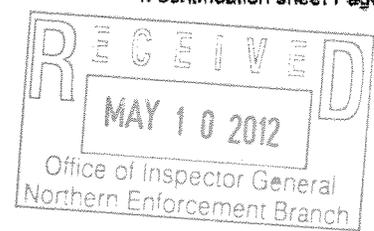
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225 Continued From page 5
end of his scheduled shift on 01/31/12 between 3:30 and 4:00 PM. The DA stated that he exited the building and went to his car at the lot behind the facility. As the DA was leaving the parking lot, he noticed a staff member who was pushing a male resident in a wheelchair. When the DA drove around the building to the front, he noticed Resident #1 in a wheelchair near the overhang of the Physical Therapy entrance. The DA thought Resident #1 was with the staff member and male resident seen behind the building, until the DA noticed Resident #1 continued to self-propel in the wheelchair toward the street in front of the facility (Boxwood Run Road), and the DA could not see the staff member with the male resident. Per interview, Resident #1 self propelled down the street; the wheel of the wheelchair slipped off the pavement; the wheelchair turned over; and, Resident #1 fell out of the wheelchair onto a grassy area. The DA returned Resident #1 to the wheelchair and returned the resident to the facility. The DA entered the Physical Therapy front entrance and did not hear an alarm when the resident was returned through the door.

Interview on 03/16/12 at 11:15 AM, with the Maintenance Director and the Assistant Maintenance Director said when Resident #1 exited the facility, it was not considered an elopement because a staff member (DA) was watching the resident and knew of the resident's location.

Interview, on 03/16/12 at 2:50 PM, with RN #1 revealed elopement was defined as a resident who was off of the facility grounds without someone supervising the resident. Per interview, RN #1 did not remember any education or

F 225 provided, and Question and Answer session. All employees will be provided training. The contingency plan for employees who may be on leave or unavailable for the training, requires that they be trained prior to returning to their assigned duties. All staff identified as being on leave or unavailable were contacted and made aware of the requirement for training before returning to work. Additionally the Department Head/Supervisors have been notified of the requirement for training prior to returning to work. Letters have been sent to the remaining staff as well informing them of the need for training. As of May 02, 2012, a total of 152 of 155 employees have been trained. The three (3) employees who have not been trained have been taken out of the payroll system. Beginning March 27, 2012, staff in-serviced on revision to abuse policy which included the following, "injuries of unknown source" are to be reported. An injury should be classified as an "injury of unknown source" when both of the following conditions are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and, 2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidents of injuries over time.



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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 225 Continued From page 6
training of staff regarding elopement since Resident #1 exited the facility on 01/31/12.

Interview, on 03/16/12 at 1:00 PM, with the Unit Manager (UM) of Orchard Way, revealed that the facility had not experienced any "true elopements" and said that some residents did get through the door into the parking lot, but no residents had left the facility property. The UM defined elopement as a resident who left the facility property.

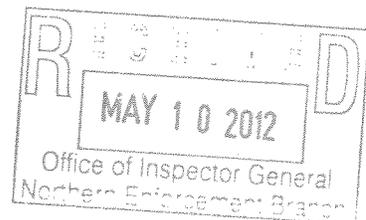
Interview, on 03/21/12 at 11:00 AM, with the Director of Nursing (DON) revealed that he was notified by the Staff Development Coordinator that Resident #1 had exited the facility on 01/31/12 without supervision. The DON did not consider the exit from the facility by Resident #1 to be an elopement and did not determine a cause, because the Dietary Aide had eyes on the resident the whole time. The DON said Resident #1 "was supervised, I know that."

Further interview with the DA on 03/20/12 at 8:20 AM revealed he was interviewed by the Director of Nursing (DON) and the Administrator and was told by the Administrator that the State Agency would be involved with the elopement of Resident #1.

Interview, on 03/21/12 at 3:35 PM, with the Administrator revealed he was responsible for reporting to the State Agencies. When Resident #1 exited the facility on 01/31/12 without staff supervision, the event was not considered an elopement, and therefore was not reported to the State Agency because the Administrator determined the resident was under supervision

F 225 On March 30, 2012 a special QA Meeting was held to discuss Immediate Jeopardy with the following individuals present: Matthew Schneider, Director of Nursing; Ben Bays, Administrator; Dr. Suresh Nair, Medical Director; Cortney Boggs, Staff Development Coordinator; Nancy Thompson, Dietary Manager; Betty Thompson, Medical Records Director; Alice Hudson, Housekeeping/Laundry Director; John Lott, Marketing Director; Debbie Curtsinger, Activities Director; Sue Hardin, MDS Coordinator; Barbara Vincent, QA Nurse; Jackie Flynn, Restorative/Wound Nurse; Holly Culver, Social Service Director, and Joey Curtsinger, Maintenance Assistant. The following policies and procedures were reviewed: Wandering and Elopement of Residents; Abuse Policy, Resident Tracking; Missing Residents, Exits with Key Pads, and Code Alert Logs.

4. All resident event reports are brought to Morning Meeting to be discussed by the Interdisciplinary Team. The Quality Assurance Committee will meet on a quarterly basis to see if a pattern or trend is noted with residents and use these findings to in-service staff in the mandatory in-services as appropriate. The Elopement Binders will be reviewed weekly in the Morning Meeting to ensure all information is accurate and up-to-date. Code Alert Logs will be reviewed in quarterly QA meeting to ensure information is entered accurately and see



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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
--------------------	--	---------------	---	----------------------

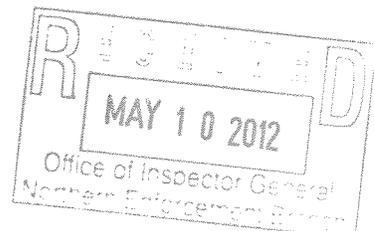
F 225 Continued From page 7

while outside of the facility. The Administrator said he did not wish to label the event as an elopement and said he would only state that Resident #1 was not witnessed crossing the threshold to exit the facility by anyone. The Administrator provided a hand written statement, dated 03/16/12 at 12:20 PM that stated, they had not had any elopements since May, 2011. They had residents exit seeking and exit the facility, but not any they consider elopements. The Administrator was the person responsible for investigating any incidents. The Administrator and Director of Nursing discussed the event together and make a joint decision it was not an elopement or reportable.

2. Review of the clinical record for Resident #14, revealed the facility admitted the resident on 03/01/11, with diagnoses of Osteoporosis and End Stage Renal Insufficiency. The facility completed a quarterly Minimum Data Set (MDS) assessment on the resident on 01/23/12 and determined the resident was alert and oriented. The facility assessed the resident as requiring extensive assistance for all care needs. The physician ordered hospice care on 05/22/11. An X-Ray on 03/19/12 revealed a displaced humeral neck oblique fracture and osteopenia was present.

Review of the facility's investigation of bruising of unknown origin for Resident #14, revealed staff was aware the resident had bruising and swelling from the resident's axilla to the fingertips on 03/17/12. The Director of Nursing (DON) was notified of the bruising to Resident #14 on 03/19/12. It was determined the investigation was thorough; however, it did not determined a cause.

F 225 if any pattern or trend is noted. All emergency exits, equipped with emergency fire boxes are checked and recorded once a day by the Director of Maintenance, Assistant Director of Maintenance, Director of Nursing and/or licensed nurse on Monday through Friday. The findings will be documented on a form created for that purpose. These exits will be checked by the nursing house supervisor on weekends once a day and their findings will be recorded on a form created for that purpose. Checks of the emergency exits will continue and their continuation or ending be determined by the QA&A Committee. The results of these checks will be presented at the quarterly QA meetings by the Director of Maintenance. The Assistant Director of Maintenance will present the findings of these audits, in the Director of Maintenance's absence. The Administrator will attend the QA&A Committee meetings and ensure investigations, interventions and staff education are completed as needed for the Event Reports. Administrator will confirm checks/audits of exits are completed and appropriate actions taken if concerns are identified. The QA&A Committee will review the findings of these audits and review/revise as deemed necessary. The next scheduled QA&A Committee meeting is Monday, May 21, 2012. The effectiveness and compliance with F225 requirements will be reviewed during that QA&A Meeting.



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 225 Continued From page 8

F 225

Interview with Certified Nurse Assistant (CNA) #2, on 03/27/12 at 2:00 PM, revealed she saw Resident #14's bruised arm on 03/17/12 and did not report this to anyone. She stated, she assumed it had already been reported.

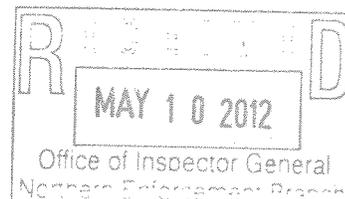
Interview with CNA #1, on 03/27/12 at 2:45 PM, revealed he saw Resident #14's bruised arm on 03/17/12 and thought for sure it must have been reported. He stated he should have reported it to the charge nurse.

Interview, with the DON, on 03/27/12 at 1:30 PM, revealed he took a quick look at the bruising, on 03/19/12 around 9:30 AM, and was not concerned it was possible abuse nor had he determined the cause of the bruising. He stated he was not sure if he looked at the resident's whole arm to determine the extent of the injury.

Continued review of the facility's investigation of Resident #14's bruising of the arm, revealed several staff members were aware of the resident's injury prior to 03/19/12.

Interview with the DON, on 03/27/12 at 1:30 PM, revealed he talked with hospice on 03/22/12 and discovered hospice was going to report the bruising of unknown origin identified on the arm of Resident #14. He stated, he told hospice he wanted to be the one to report to the state agencies. He stated, he decided to report the injury after he spoke with hospice. Per interview, the DON had not received training on how to recognize potential abuse or investigate.

Review of the Allegation of compliance (AOC)



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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
--------------------	--	---------------	---	----------------------

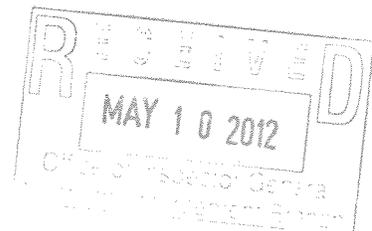
F 225 Continued From page 9
revealed the facility took the following immediate actions:

1. The facility educated the staff on 03/24/12 to include policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads including elopement definition and reporting of incidents.
2. Department Heads and Administrative staff were provided education and the facts of the incident by the Administrator on 03/22/12.
3. The Resident Safety Policy was reviewed and revised with a new definition of elopement, response to alarms, checking the area around the alarm, determining the cause of the alarm to sound and documentation on the code alert log and reporting. In addition, a form was created, Acknowledgement of Risks/Criteria: Being Outside Facility Unsupervised that will be presented to residents and/or their responsible parties. Policies reviewed: Missing Resident, Wandering and Elopement of Residents; Resident Tracking and Exits with Key Pads. A missing resident quiz was created for staff to complete during inservice training.
4. The Administrator received training by the Governing Body on 03/22/12 and 03/23/12 in response to the survey findings regarding supervision, wandering, elopement and reporting of incidents.

The State Agency validated the AOC as follows:

1. The State agency validated documentation of education provided to staff which included

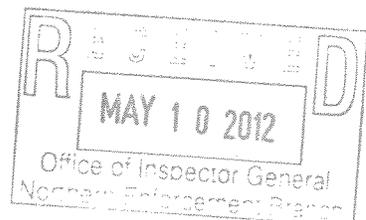
F 225



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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)
F 225	Continued From page 10 policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads. The facility staff roster indicated there were one-hundred and fifty-five (155) staff and one-hundred and forty-two (142) had been educated by 03/24/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remainder of the staff prior to their date of return to work. 2. Interviews on 03/30/12 at 6:30 PM with five (5) CNA's, three (3) RN's, two (2) LPN's, one (1) dietary staff, and one (1) medical records staff revealed that all staff members were able to identify elopement and were knowledgeable of reporting incidents. 3. Interview with the Administrator, on 03/30/12 at 10:50 AM, revealed he had received training in supervision, wandering residents, elopement-definition, and policies specific to the facility's needs. 4. The State Agency validated education of the Department Heads through interview with Staff Development, Activities, Medical Records, and Social Services, on 03/30/12 between 5:20 PM and 6:00 PM.	F 225	
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.	F 282	1. Resident #1 care plan was reviewed and revised on March 22, 2012. The tracking policy was reviewed and revised on March 22, 2012 and revisions were made to the tracking log that nurses are to complete on each individual resident. 2. By March 23, 2012 all residents' elopement risk assessments were
			May 01, 2012



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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
--------------------	--	---------------	---	----------------------

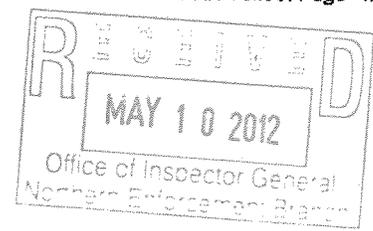
F 282 Continued From page 11
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to implement the facility interventions on the Comprehensive Care Plan for one (1) of twenty (20) sampled residents (Resident #1) regarding elopement risk. The Comprehensive Care Plan detailed interventions to address elopement and wandering for Resident #1 to include: Fifteen (15) minute tracking including observation and documentation of resident behavior as it occurred, use of the Code Alert bracelet with check of function and placement every eight (8) hours, elopement assessment per policy schedule, and alert staff to resident's wandering behavior. Resident #1 had a history of exiting the facility on 08/13/11, a Code Alert alarm sounded, and the resident was returned to the facility from the parking lot. Resident #1 exited the facility on 01/31/12 without staff supervision or knowledge and self-propelled in a wheelchair through the parking lot onto a residential street in front of the facility (Boxwood Run Road). The residents wheelchair tipped over and the resident fell into a grassy area on the side of the road. Resident #1 was returned to the facility by an off-duty staff member. The facility's failure to follow the plan of care placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/22/12 and was found to exist on 01/31/12.

The facility provided a credible Allegation of Compliance (AOC) on 03/30/12 and the State Agency verified Immediate Jeopardy was removed on 03/25/12 prior to exit on 03/30/12, at

F 282 audited and new assessments completed. During the course of the audits eight (8) residents were identified for the need of fifteen (15) minute tracking, three (3) of which were not identified as at risk for elopement. During these reviews and assessments, the resident's care plans were audited, the previous elopement assessment score listed as well as the current elopement assessment score listed to compare and the Certified Nursing Assistant's care sheet was also reviewed and revised as needed. The C.N.A. care sheets were updated to reflect the elopement and tracking needs on March 23, 2012.

3. Beginning March 23, 2012, staff was in-serviced on, including but not limited to, revised Resident Tracking policy. On April 12, 2012 in-servicing initiated included but not limited to completing revised tracking form to accurately record time and location of residents. Completed Resident Tracking forms are gathered by Medical Records Director and given to Director of Social Services. Any concerns with documentation are discussed with the Director of Nursing and/or Staff Development Coordinator and education provided to staff as needed. The Comprehensive Care Plan policy was reviewed and revised.

4. The resident tracking forms will be brought to the quarterly QA&A meetings by the Director of Social Services for



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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 12
42 CFR 483.13 Resident Behavior and Facility Practices; 42 CFR 483.20 Resident Assessment, F282; 42 CFR 483.25 Quality of Care, F323; and 42 CFR 483.75 Administration, F490 which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to achieve and maintain compliance.

The findings include:

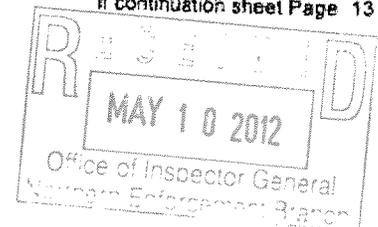
The facility did not have a policy on following the Comprehensive Care Plan.

Record review of the facility's policy for Resident Tracking, dated December 2011, revealed residents who were in need of increased supervision would be placed on 15 minute tracking. The policy detailed that the nurse would initiate a tracking sheet for residents who needed increased supervision, and the residents "position" would be documented in fifteen (15) minute intervals. The Resident Tracking policy also stated the nurse assigned to the resident was responsible to complete the documentation on the tracking form.

Record Review of the facility's policy for Wandering and Elopement of Residents, dated 05/10, revealed all residents would be assessed upon admission by use of the Elopement Risk Assessment form. Each resident was to be assessed quarterly, and as needed thereafter.

Record review of the Resident Tracking Sheet regarding Wandering, dated 03/24/12 through 03/25/1, revealed the documentation did not include the exact time or location of the resident

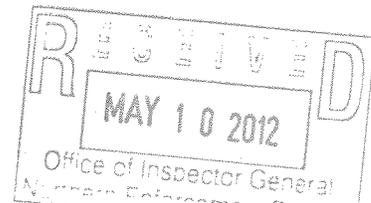
F 282 for review to ensure forms include, among other items; accurate times and locations of residents. The QA Nurse will bring the resident tracking forms to the QA&A Committee in the absence of the Director of Social Services. The Administrator will attend the QA&A Committee meetings and ensure resident tracking is properly completed and documented. Administrator will ensure staff education is completed as needed. Administrator will confirm appropriate actions taken if concerns are identified. The QA&A Committee will review the findings of these audits and review/revise as deemed necessary. The next scheduled QA&A Committee meeting is Monday, May 21, 2012. The effectiveness and compliance with F282 requirements will be reviewed during that QA&A Meeting.



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012	
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(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 13</p> <p>each time an observation of Resident #1 was made.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident, with diagnoses of Dementia, Anxiety, Macular Degeneration on 07/09/11. The facility's elopement risk assessments revealed the facility reassessed Resident #1 for continued risk of elopement on 07/10/11, 10/12/11, 01/01/12, and 02/20/12 and the facility found the resident to be at high risk for elopement related to cognitive deficit and exit seeking behavior.</p> <p>Review of the care plan, dated 07/19/11, for Resident #1, revealed facility interventions to perform the elopement assessment quarterly and as needed, and to check the Code Alert bracelet function and placement every eight hours or every shift. A care plan to address wandering and exit seeking behaviors was implemented by the facility for Resident #1 and detailed the staff was responsible to observe and document resident behaviors and be alert to the resident wandering. Resident #1 had fifteen (15) minute tracking reordered on 08/13/11 after Resident #1 exited the building on that date and continued.</p> <p>Interview, on 03/20/12 at 4:03 PM, with Certified Nurse Assistant #4 (CNA #4), revealed the nurse was responsible to ensure the fifteen (15) minute tracking was documented. CNA #4 said the facility did not provide any education/training regarding resident elopement as a result of the exit from the facility on 01/31/12 by Resident #1.</p> <p>Interview, on 03/20/12 at 3:50 PM, with CNA #3</p>	F 282		

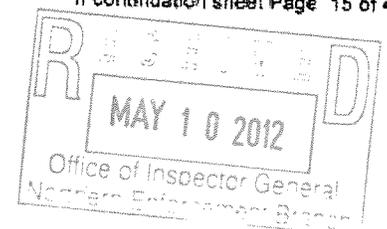


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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 14</p> <p>revealed she was aware Resident #1 was on fifteen (15) minute tracking and stated the nurse was responsible to complete the tracking sheet, and the CNA assignment sheet included notification to the CNA of the need for constant monitoring of Resident #1. CNA #3 said the facility did not provide education/training regarding resident elopement as a result of the exit from the facility on 01/31/12 by Resident #1.</p> <p>Interview, on 03/30/12 at 4:00 PM, with the Unit Manager (UM) revealed staff were expected to document on the Resident Tracking Sheet every fifteen (15) minutes, and said it was not acceptable to document in groups of observations by a line through the grid on the form to the end of a nursing shift, because it would not reflect the exact time of the resident observation.</p> <p>Interview, on 03/28/12 at 10:25 AM, with the DON revealed the Resident Tracking Sheets were supposed to be completed by each nurse, every fifteen (15) minutes to validate the resident's current location, if the resident required redirection, if the resident posed a problem, and the nurse's initials.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. Elopement assessments which included the complete resident census of one-hundred three (103) beginning the assessments on 03/22/12 and completed on 03/23/12. The facility determined thirteen (13) residents to be at risk for 	F 282
-------	---	-------



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185454	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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 15 elopement.</p> <p>2. The facility audited and revised the Certified Nursing Assistant (CNA) sheets on 03/23/12 for the thirteen (13) residents that were found to be a risk for elopement.</p> <p>3. The facility educated the staff on 03/24/12 to include policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads including elopement definition and reporting of incidents.</p> <p>4. The facility initiated Resident Tracking Sheets for the residents determined to require every fifteen minute checks. Staff are to document at fifteen (15) minute intervals at the time the resident is observed.</p> <p>5. The facility closed the double doors between the Therapy Addition and Transition Way Unit and staff were directed to leave the doors closed. This door requires a coded entry.</p> <p>6. The Director of Nurses and Maintenance Director checked all doors and alarms to ensure they were functioning properly.</p> <p>7. The Unit Manager provided education to the staff on duty regarding every 15 minute checks.</p> <p>8. Department Heads and Administrative staff were provided education and the facts of the incident by the Administrator on 03/22/12.</p> <p>9. The elopement binder is to be reviewed weekly on Fridays by the Administrator to ensure the photographs and face sheets are in the binder.</p>	F 282	



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 16

F 282

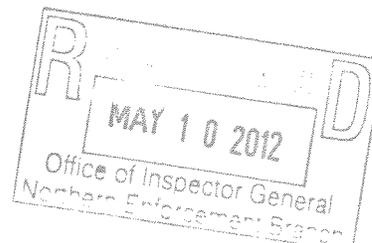
10. The Resident Safety Policy was reviewed and revised with a new definition of elopement, response to alarms, checking the area around the alarm, determining the cause of the alarm to sound and documentation on the code alert log and reporting incidents. In addition, a form was created, Acknowledgement of Risks/Criteria: Being Outside Facility Unsupervised that will be presented to residents and/or their responsible parties. Policies reviewed: Missing Resident, Wandering and Elopement of Residents; Resident Tracking and Exits with Key Pads. A missing resident quiz was created for staff to complete during inservice training.

11. The Administrator received training by the Governing Body on 03/22/12 and 03/23/12 in response to the survey findings including elopement and reporting of incidents.

The State Agency validated the AOC as follows:

1. The State agency validated documentation of elopement assessments which included the complete resident census of one-hundred three (103). The resident Elopement assessment scores were documented, and it was determined that thirteen (13) of one-hundred three (103) residents were at risk for elopement. The facility began the assessments on 03/22/12, and were completed on 03/23/12. It was verified on 03/30/12, that the facility reviewed and updated care plans for all thirteen (13) residents determined by the facility to be at risk for elopement

2. The State agency validated documentation of



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

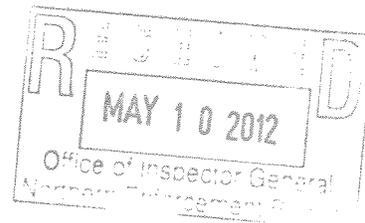
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 17
audits comparing CNS sheets to assessments and careplans and revisions to the Certified Nursing Assistant (CNA) sheets that was completed on 03/23/12 for the thirteen (13) residents that were found to be a risk for elopement. It was verified by review of all thirteen (13) CNA sheets for residents at risk for elopement, the revisions were completed on 03/23/12.

F 282

3. The State agency validated documentation of education provided to staff which included policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads. The facility staff roster indicated there were one-hundred and fifty-five (155) staff and one-hundred and forty-two (142) had been educated by 03/24/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remainder of the staff prior to their date of return to work.

4. The State agency validated on 03/30/12, by observation of four (4) residents who were found to be at risk for elopement, that each resident had a Resident Tracking Sheet which accompanied each resident as they moved through the facility to Activities, Dining, etc. It was determined by observation, staff were documenting on the Resident Tracking Sheets in fifteen (15) minute intervals at the time of the resident observation. Interview with a staff member on 03/30/12 at 6:20 PM, revealed when a resident with fifteen (15) minute tracking moved to another area of the facility, documentation on the Resident Tracking sheet was completed by the staff member who accompanied the resident to that area.



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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 18

5. Interviews on 03/30/12 at 6:30 PM with five (5) CNA's, three (3) RN's, two (2) LPN's, one (1) dietary staff, and one (1) medical records staff revealed that all staff members were able to state the steps staff were responsible for when a resident was missing, responsibilities of staff when a resident is on Resident Tracking, and a resident who wandered near a facility exit door. In addition, staff were able to identify elopement and were knowledgeable of reporting incidents.

6. Interview with the Administrator, on 03/30/12 at 10:50 AM, revealed he had received training in supervision, wandering residents, elopement-definition, and policies specific to the facility's needs.

7. The State Agency validated education of the Department Heads through interview with Staff Development, Activities, Medical Records, and Social Services, on 03/30/12 between 5:20 PM and 6:00 PM

F 323 483.25(h) FREE OF ACCIDENT
SS=J HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

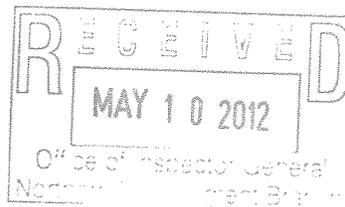
This REQUIREMENT is not met as evidenced by:

F 282

F 323

1. The following actions were taken on January 31, 2012 for Resident #1. Assessed by Unit Manager for injuries, none noted. A new Code Alert transponder was placed on resident's ankle and the original transponder, found to be working properly was placed on the wheelchair. The key-padded double doors leading to the Therapy Department were closed to limit resident access to Therapy exits. All Code Alert equipped doors were checked by Director and Assistant Director of Maintenance and found to be properly functioning. On March 23, 2012 the exit to Therapy was

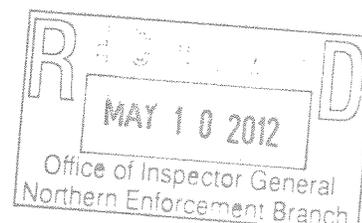
May 01, 2012



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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)
F 323	<p>Continued From page 19</p> <p>Based on observation, interview, record review, and review of the facility's policy on Wandering and Elopement of Residents and Resident Tracking, it was determined the facility failed to provide adequate supervision for one (1) of twenty (20) sampled residents for elopement and exit seeking behaviors. Resident #1 was assessed by the facility to be at high risk for elopement; was monitored with a Code Alert bracelet; and placed on fifteen (15) minute tracking to ensure the safety of the resident due to exit seeking behavior. On 01/31/12, Resident #1 exited through a Code Alert door without staff knowledge, then self-propelled in a wheelchair through the parking lot and onto the street in front of the facility (Boxwood Run Road). Resident #1 fell out of his/her wheelchair as an off duty staff member approached the resident on the street, and returned the resident to the facility. Resident #1 sustained no injuries.</p> <p>The facility's failure to provide adequate supervision placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/22/12 and was found to exist on 01/31/12.</p> <p>The facility provided a credible Allegation of Compliance (AOC) on 03/30/12. The State Agency verified Immediate Jeopardy was removed on 03/25/12 as alleged, prior to exit on 03/30/12; which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to achieve and maintain compliance.</p>	F 323	<p>converted to an emergency exit only and a fire box affixed to the door on April 02, 2012 to alarm whenever the door is opened. On April 2, 2012 the Code Alert bypass code was changed. Resident #1's care plan was reviewed and revised on March 22, 2012. The tracking policy was reviewed and revised on March 22, 2012 and revisions were made to the tracking log that nurses are to complete on each individual resident.</p> <p>2. By March 23, 2012, all residents' elopement risk assessments were audited and new assessments completed. During these reviews and assessments, the residents' care plan was audited, the previous elopement assessment score listed as well as the current elopement assessment score listed to compare and the Certified Nursing Assistant's care sheet was also reviewed and revised as needed.</p> <p>3. A meeting was held on Thursday, March 22, 2012 with the following individuals attending: Everett Ben Bays, Administrator; Matthew Schneider, Director of Nursing; Betty Thompson, Medical Records; AJ Holt, Rehab Services Manager; John Lott, Marketing /Admissions Director; Ben Bleemel, Director of Maintenance; Holly Culver, Social Worker; Kathy Davis, Nurse Scheduler/Central Supplies; Debbie Curtsinger, Activity Director; Nancy Thompson, Dietary Manager; Jackie Flynn, Restorative/Wound Nurse; Cortney Boggs,</p>



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 323 Continued From page 20
The findings include:

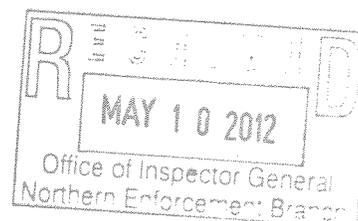
Review of the facility's policy regarding Wandering and Elopement of Residents, dated May 2010, detailed all residents would be assessed upon admission for elopement risks, quarterly, and as the need was determined. The policy also revealed a resident identified at risk for elopement would be identified in elopement binders on each unit, and would be assigned a Code Alert bracelet. The policy revealed the Director of Nursing (DON) or Administrator would notify the State Agency of an incident of elopement as required. However, the policy failed to define elopement.

Review of the facility's policy regarding Resident Tracking, dated December 2011, revealed residents needing increased supervision were placed on fifteen (15) minute tracking, and the nurse was responsible to document the resident's "position" in fifteen (15) minute intervals, and all staff assigned to the resident were to be notified of the tracking function.

Review of the clinical record for Resident #1 revealed an admission date of 07/09/11 with diagnoses of Dementia, Anxiety, Depression, and Macular Degeneration. On 07/09/11, the facility assessed the resident at high risk for elopement related to cognitive deficit and exit seeking behavior. The Elopement Risk Assessments revealed the facility reassessed Resident #1 to be at high risk of elopement on 07/10/11, 10/12/11, 01/01/12, and 02/20/12. Resident #1 was care planned for wandering and exit seeking behavior and staff was to observe and document resident behaviors, and alert staff to wandering behaviors.

F 323

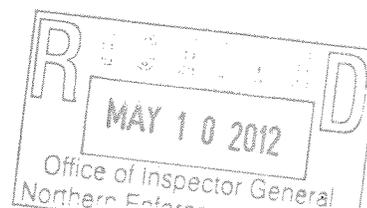
Staff Development Coordinator; Lori Shelden, House Supervisor 2p-10p; Darlene Hanson, House Supervisor 6a-2p; Shannon Davis, MDS Coordinator; Mandy Ward, Business Office Manager; Sue Hardin, MDS Coordinator; and Alice Hudson, Director of Housekeeping /Laundry. The purpose of the meeting was to review and revise policies for Resident safety, with a focus on elopement risks with staff providing input as education was provided. The outcome of this meeting was the creation of the facility's definition of an elopement, that being; an elopement occurs when a resident exits an exterior door without authorization (an MD order, Discharge, LOA, staff knowledge) and/or any necessary supervision to ensure safety. Procedure for responding to the Code Alert door alarms was created and presents that any response to the Code Alert that requires the staff member(s) responding to the alarm identify exactly why the Code Alert alarm was activated. This entails opening the door to ensure no residents are outside the facility. Once it is determined who/what has activated the alarm, the staff member responding must document on the Code Alert Log form that is located at all four (4) doors equipped with the Code Alert systems. They are to document the date, time, reason and sign. Should they not be able to identify exactly why the Code Alert alarm has sounded, they are to immediately report this to the nurse supervisor so an accounting can be made of all residents to determine their location and ensure they are within the facility if not out of the facility with staff's



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

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

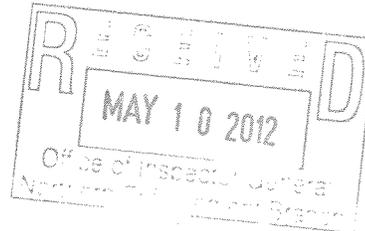
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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 323	<p>Continued From page 21</p> <p>The resident had a Code Alert bracelet to alert staff of an attempt to elope and the bracelet was to be checked for placement and function every shift. On 08/13/11, Resident #1 exited the facility, the Code Alert Alarm sounded, and the resident was returned to the facility from the parking lot. At that time Resident #1 was placed on and remained on fifteen (15) minute tracking.</p> <p>Review of the facility Event Report, dated 01/31/12 detailed that Resident #1 was outside at 1445 (2:45 PM) and the wheelchair fell over in a grassy area. The problem was identified on the Event Report as a witnessed fall, and the immediate facility intervention was to change the Code Alert bracelet, apply a new bracelet to the left ankle, add a bracelet to the wheelchair, and continue Resident #1 on fifteen (15) minute tracking. The Post Event Investigation described the type of event as a "Witnessed fall, resident outside, wheelchair noted to fall over," and the facility intervention was: "fifteen (15) minute tracking, Code Alert band on resident and wheelchair....."</p> <p>Review of the Morning Meeting Notes dated 02/01/12 and documented by the Administrator, revealed discussion of Resident #1 incident on 01/31/12 was described in terms of a "fall."</p> <p>Review of the investigation notes signed by the Administrator on 01/31/12, revealed the DA (Dietary Aide) told the Administrator when he parked in the lot at the end of Boxwood Run Road, he saw Resident #1 "wheeling self down Boxwood Run (Road) toward the Veterinarian Clinic (at the end of the road which intersected Highway 44)." The statement detailed how the</p>	F 323	<p>knowledge. A form was created, <i>Acknowledgement of Risks/Criteria: Being Outside Facility Unsupervised</i> that will be presented to residents and/or their responsible party if the resident wants to sit/go outside the facility. Staff is to make sure the doors they exit or enter shut completely and the magnetic lock has engaged to ensure there is no ability to exit/enter the facility without the entry of the code. Policies and Procedures reviewed include: <i>Missing Resident, Wandering and Elopement of Residents, Resident Tracking, and Exits with Key Pads.</i> A Missing Resident Quiz was created for staff's completion during in-service training. Staff training began on March 23, 2012, following facility's notification of findings of immediate jeopardy on March 22, 2012. The in-service training content includes: <i>Missing/Wandering Residents, Elopement of Residents, Exits with Key Pads, Resident Tracking, Missing Resident Quiz, Code Alert Log, Definition of Elopement, Acknowledgement of Risks Criteria form.</i> The method of training included presentation by Staff Development Coordinator, handouts provided, and Question and Answer session. All employees will be provided training. The contingency plan for employees who may be on leave or unavailable for the training, requires that they be trained prior to returning to their assigned duties. All staff identified as being on leave or unavailable were</p>



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

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

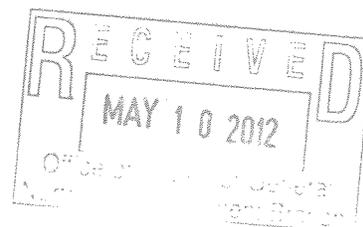
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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)
F 323	<p>Continued From page 22</p> <p>wheelchair tilted off of the pavement as the DA approached Resident #1 and the resident fell out of the wheelchair onto the grass. The investigation documented the transponder for Resident #1 was tested (result of test was not documented) and two (2) new transponders were assigned to the resident, one (1) to the ankle and one (1) to the wheelchair.</p> <p>Interview, on 03/15/12 at 4:00 PM, by telephone, and on 03/20/12 at 8:20 AM, with the Dietary Aide (DA) revealed he left work at the end of his scheduled shift on 01/31/12 between 3:30 PM and 4:00 PM. The DA stated that he exited the building and went to his car in the lot behind the facility. As the DA was leaving the parking lot, he noticed a staff member who was pushing a male resident in a wheelchair. When the DA drove around the building to the front, he noticed Resident #1 in a wheelchair near the Physical Therapy entrance. The DA thought Resident #1 was with the staff member and male resident seen behind the building, until the DA noticed Resident #1 continued to self-propel in the wheelchair toward the street in front of the facility (Boxwood Run Road). The DA said Resident #1 was always in sight from the rear view mirror in the car, and said two (2) cars passed the resident in the wheelchair on Boxwood Run Road. The DA continued to drive to the end of Boxwood Run Road and parked. The DA said Resident #1 was moving fast toward Highway 44 which intersected with Boxwood Run Road. The DA moved toward Resident #1 to return the resident to the facility; however, upon his approach, a wheel to the chair went off of the pavement and the wheelchair rolled over. Resident #1 fell out of the wheelchair into a grassy area. The DA assisted Resident #1</p>	F 323	<p>contacted and made aware of the requirement for training before returning to work. Additionally the Department Head/Supervisors have been notified of the requirement for training prior to returning to work. Letters have been sent to the remaining staff as well informing them of the need for training. As of May 02, 2012, a total of 152 of 155 employees have been trained. The three (3) employees who have not been trained have been taken out of the payroll system.</p> <p>4. The Elopement Binders will be reviewed weekly in the Morning Meeting to ensure all information is accurate and up-to-date. Any concerns identified during the review will be addressed by the Director of Nursing who will see that concerns are corrected and staff education provided as needed. Changes necessary to Elopement Binders will be made by the Director of Nursing. The Code Alert Logs will be reviewed in quarterly QA meeting to ensure information is entered accurately and see if any pattern or trend is noted. All emergency exits, equipped with emergency fire boxes are checked and recorded once a day by the Director of Maintenance, Assistant Director of Maintenance, Director of Nursing and/or licensed nurse on Monday through Friday. The findings will be documented on a form created for that purpose. These exits will be checked by the Nursing House Supervisor on weekends once a day and their findings will be recorded on a form</p>



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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)
F 323	<p>Continued From page 23</p> <p>to the wheelchair and returned the resident to the facility. The DA entered the facility through the Physical Therapy front entrance and did not hear an alarm sound when the resident was returned through the door. The DA said he showed the DON the location where Resident #1 slipped off of the pavement on Boxwood Run Road.</p> <p>Interview, on 03/16/12 at 1:35 PM, with the Staff Development Coordinator (SDC) revealed she was working on the Transitional Unit when the DA returned Resident #1 to the facility on 01/31/12. The SDC reported the incident involving Resident #1 to the Administrator and DON and assigned the UM to perform a physical assessment. Further interview, with the SDC on 03/21/12 at 10:45 AM, revealed the SDC cut the Code Alert bracelet off of Resident #1 and took the bracelet to the employee entrance at the back of the building and checked the function of the Code Alert Alarm in the presence of the Maintenance Director. The SDC said the alarm sounded and she requested the Maintenance Director and the Assistant Maintenance Director to check the other three (3) Code Alert doors. The SDC was told all the Code Alert doors were functioning as a result of the cursory check. The SDC said the Code Alert band was not checked with the wand/checker from the medication cart because her first instinct was to cut the bracelet and check it with the Code Alarm doors.</p> <p>Interview, on 03/21/12 at 11:00 AM, with the Director of Nursing (DON) revealed that he was notified by the SDC that Resident #1 had exited the facility on 01/31/12 without supervision. The DON said he was not present when the Code Alert bracelet was removed from Resident #1.</p>	F 323	<p>created for that purpose. Checks of the emergency exits will continue and their continuation or ending be determined by the QA&A Committee. The results of these checks will be presented at the quarterly QA meetings by the Director of Maintenance. The Assistant Director of Maintenance will present the findings of these audits in the Director of Maintenance's absence. The Administrator will attend the QA&A Committee meetings and ensure investigations, interventions and staff education are completed as needed for the event Reports. Administrator will confirm checks/audits of exits are completed and appropriate actions taken if concerns are identified. The QA&A Committee will review the findings of these audits and review/revise as deemed necessary. The next scheduled QA&A Committee meeting is Monday, May 21, 2012. The effectiveness and compliance with F323 requirements will be reviewed during that QA&A Meeting.</p>



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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 323 Continued From page 24

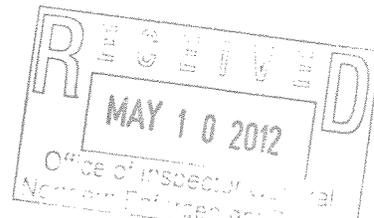
The DON said the SDC told him all four (4) Code Alert doors were checked with the bracelet removed from Resident #1 and the door alarms were found to be functional. The DON said he was told the bracelet had been thrown into the trash. However, since the bracelet was found to be functional, it was retrieved from the trash and placed on the wheelchair of Resident #1. A new Code Alert bracelet was applied to the resident's ankle. The DON said he interviewed the DA upon return of Resident #1 to the facility on 01/31/12, then walked outside of the facility and requested the DA to identify where the resident was seen self-propelling in the wheelchair. The DON said the DA showed him Resident #1 was on Boxwood Run Road.

Interview, on 03/30/12 at 4:00 PM, with the Administrator revealed the Maintenance Director measured the distance from the main Physical Therapy entrance to the location where Resident #1 fell out of the wheelchair on Boxwood Run Road on 01/31/12. The Maintenance Director found the distance Resident #1 traveled in the wheelchair to be five- hundred and ten (510) feet.

Interview, on 03/27/12 at 10:30 AM, with LPN #2 revealed she was the desk nurse working on the Transition Way Unit, which intersects with the therapy unit, on 01/31/12. LPN #2 did not see Resident #1 attempt to enter the Physical Therapy Unit, and did not hear a Code Alert alarm on 01/31/12 when Resident #1 exited the facility.

Interview, on 03/27/12 at 11:10 AM, with the Human Resources Director (HRD) revealed she was working on 01/31/12 when Resident #1 exited the facility. The HRD stated her office was

F 323



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 323

Continued From page 25

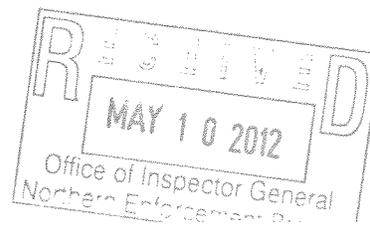
next to the Code Alert door at the main entrance to the Physical Therapy door where the facility surmised Resident #1 exited on 01/31/12. The HRD said on that day, she did not hear an alarm from the Code Alert door, and stated if she heard an alarm, she would go to the Code Alert door immediately to determine the reason for the alarm. The HRD said the occurrence was to be reported to Nursing Administration and documented.

Interview, on 03/16/12 at 2:50 PM, with Registered Nurse (RN) #1 revealed Resident #1 was seen by RN #1 self-propelling in the hall moving toward the main dining area (in front of the main entrance) at about 2:35 PM on 01/31/12. RN #1 did not hear a Code Alert Alarm as Resident #1 exited or re-entered the facility on 01/31/12. RN #1 did not know if Resident #1 had exited the facility before 01/31/12.

Interview and observation, on 03/16/12 at 11:15 AM, with the Maintenance Director with a demonstration of the function of the Code Alert door, found that the Code Alert alarm would sound when a resident wearing a Code Alert transponder was within six (6) feet of the Code Alert door. The Maintenance Director said the DON requested him to check all of the Code Alert doors on 01/31/12, and he found the alarms on all four (4) Code Alert doors to be functioning. The Maintenance Director and the Assistant Maintenance Director said when Resident #1 exited the facility, it was not considered an elopement because a staff member was watching the resident and knew of the resident's location.

Interview, on 03/16/12 at 1:00 PM, with the Unit

F 323



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

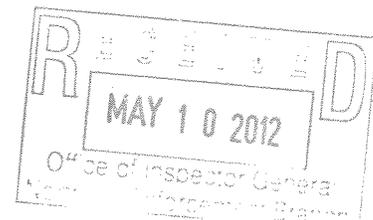
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 26 F 323

Manager (UM) of Orchard Way, revealed that the facility had not experienced any "true elopements". The UM defined elopement as a resident who left the "facility property." The UM said as a result of Resident #1 exiting the facility on 01/31/12, fifteen minute tracking was continued for the resident. The UM was not aware of any further interventions to avoid elopement for Resident #1 since the resident exited the facility on 01/31/12.

Continued interview, on 03/16/12 at 2:50 PM, with RN #1 revealed elopement was defined as a resident who was off of the facility grounds without someone supervising the resident. RN #1 said the facility added interventions to avoid future elopements, but was not sure what the interventions were, and did not remember any education or training of staff regarding elopement since Resident #1 exited the facility on 01/31/12. RN #1 said Resident #1 was at risk for injury when the resident was outside of the facility on 01/31/12.

Continued interview, on 03/21/12 at 11:00 AM, with the Director of Nursing (DON) revealed elopement was described as unwitnessed or unsupervised exit of the property. The DON said he did not want to speculate about what potential hazards Resident #1 faced on Boxwood Run Road; however, when asked if Resident #1 could have been hit by a car, he replied, "That is a potential," because the DA was not in arms reach of Resident #1 while driving on Boxwood Run Road. The DON did not consider the exit from the facility by Resident #1 to be an elopement because the DA had eyes on the resident "the whole time." The DON said Resident #1 "was



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

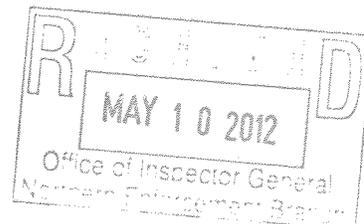
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 27 supervised, I know that." F 323

Interview, on 03/21/12 at 3:35 PM, with the Administrator revealed when Resident #1 exited the facility on 01/31/12 without staff supervision, the event was not considered an elopement, and therefore was not reported to the State Agency. The Administrator said he did not wish to label the event as an elopement and said he would only state that Resident #1 "was not witnessed crossing the threshold to exit the facility by anyone." The Administrator said he interviewed the DA and was told by the DA that Resident #1 was on the sidewalk when the wheelchair overturned with the resident. The Administrator said the DA showed the DON where Resident #1 was found, and he could not remember if the DON told him the resident had been on the sidewalk or on Boxwood Run Road when the DA reached the resident in the grass. The Administrator did not witness the function check of the Code Alert bracelet removed from Resident #1, but was told by the DON that the transponder was working. The Administrator said Resident #1 was at no greater risk of injury or accident outside of the facility in the parking lot, on the sidewalk, or on the street in front of the facility.

Interview, on 03/16/12 at 11:30 AM, with the Administrator revealed the facility did not report any elopements since 05/2011. The Administrator stated "we have not had any elopements since May, 2011. We have had residents exit seeking and exit facility, but not any we considered elopements".

Review of the Allegation of Compliance (AOC) revealed the facility took the following immediate



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	--	--	---

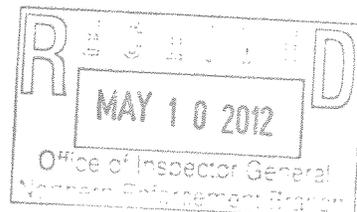
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
--	---

(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 323 : Continued From page 28 actions:

1. Elopement assessments, which included the complete resident census of one-hundred three (103), were completed on 03/23/12. The facility determined thirteen (13) residents to be at risk for elopement.
2. The facility audited and revised the Certified Nursing Assistant (CNA) sheets on 03/23/12 for the thirteen (13) residents that were found to be a risk for elopement.
3. The facility educated the staff on 03/24/12 to include policies for Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads including elopement definition and reporting.
4. The facility initiated Resident Tracking Sheets for the residents determined to require every fifteen minute checks. Staff are to document at fifteen (15) minute intervals at the time the resident is observed.
5. The facility closed the double doors between the Therapy Addition and Transition Way Unit and staff were directed to leave the doors closed. This door requires a coded entry.
6. The Director of Nurses and Maintenance Director checked all doors and alarms to ensure they were functioning properly.
7. The Unit Manager provided education to the staff on duty regarding every 15 minute checks.
8. Department Heads and Administrative staff

F 323



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 323	Continued From page 29 were provided education and the facts of the incident by the Administrator on 03/22/12.	F 323		
-------	---	-------	--	--

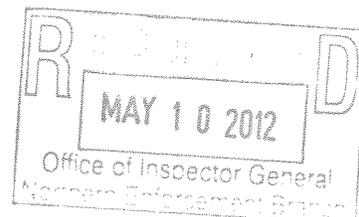
9. The elopement binder is to be reviewed weekly on Fridays by the Administrator to ensure the photographs and face sheets are in the binder.

10. The Resident Safety Policy was reviewed and revised with a new definition of elopement, response to alarms, checking the area around the alarm, determining the cause of the alarm to sound and documentation on the code alert log. In addition, a form was created, Acknowledgement of Risks/Criteria: Being Outside Facility Unsupervised that will be presented to residents and/or their responsible parties. Policies reviewed: Missing Resident; Wandering and Elopement of Residents; Resident Tracking and Exits with Key Pads. A missing resident quiz was created for staff to complete during inservice training.

11. The Administrator received training by the Governing Body on 03/22/12 and 03/23/12 in response to the survey findings including elopement and reporting of incidents.

The State Agency validated the AOC as follows:

1. The State Agency validated documentation of elopement assessments which included the complete resident census of one-hundred three (103). The resident Elopement assessment scores were documented, and it was determined that thirteen (13) of one-hundred three (103) residents were at risk for elopement. The facility began the assessments on 03/22/12, and were completed on 03/23/12. It was verified on



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

[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 323 Continued From page 30

03/30/12, that the facility reviewed and updated care plans for all thirteen (13) residents determined by the facility to be at risk for elopement.

2. The State Agency validated documentation of audits of audits comparing CNS sheets to assessments and careplans and revisions to the Certified Nursing Assistant (CNA) sheets that was completed on 03/23/12 for the thirteen (13) residents that were found to be a risk for elopement. It was verified by review of all thirteen (13) CNA sheets for residents at risk for elopement, that the revisions were completed on 03/23/12.

3. The State Agency validated documentation of education provided to staff which included policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads. The facility staff roster indicated there were one-hundred and fifty-five (155) staff and one-hundred and forty-two (142) had been educated by 03/24/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remainder of the staff prior to their date of return to work.

4. The State Agency validated on 03/30/12, by observation of four (4) residents who were found to be at risk for elopement, that each resident had a Resident Tracking Sheet which accompanied each resident as they moved through the facility to Activities, Dining, etc. It was determined by observation, staff were documenting on the Resident Tracking Sheets in fifteen (15) minute intervals at the time of the resident observation.

F 323



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 323 Continued From page 31

Interview with a staff member on 03/30/12 at 6:20 PM, revealed when a resident with fifteen (15) minute tracking moved to another area of the facility, documentation on the Resident Tracking sheet was completed by the staff member who accompanied the resident to that area.

5. Interviews on 03/30/12 at 6:30 PM with five (5) CNA's, three (3) RN's, two (2) LPN's, one (1) dietary staff, and one (1) medical records staff revealed that all staff members were able to state the steps staff was responsible for when a resident was missing, responsibilities of staff when a resident is on Resident Tracking, and a resident who wandered near a facility exit door. In addition, staff were able to identify elopement and were knowledgeable of reporting incidents.

6. Interview with the Administrator, on 03/30/12 at 10:50 AM, revealed he had received training in supervision, wandering residents, elopement-definition, and policies specific to the facility's needs.

7. The State Agency validated education of the Department Heads through interview with Staff Development, Activities, Medical Records, and Social Services, on 03/30/12 between 5:20 PM and 6:00 PM.

F 323

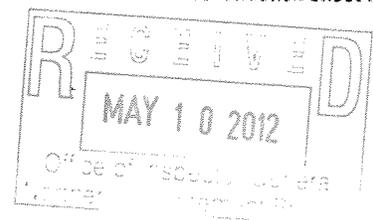
F 490 483.75 EFFECTIVE
SS-J ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

F 490

1. The following actions were taken on January 31, 2012 for Resident #1. Assessed by Unit Manager for injuries, none noted. A new Code Alert transponder was placed on resident's ankle and the original transponder, found to be properly working was placed on

May 01, 2012



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 490 Continued From page 32

This REQUIREMENT is not met as evidenced by:
Based on interview, review of the facility's investigation and policies it was determined the facility's Administration failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, or psychosocial well-being of each resident. The facility failed to ensure policy and procedures were implemented to provide adequate supervision of residents identified to be at high risk for elopement for one (1) of twenty (20) sampled residents. Resident #1 exited the facility without staff knowledge or supervision on 01/31/12, and self-propelled a wheelchair along the residential street in front of the facility (Boxwood Run Road). The wheelchair slipped off of the pavement as an off-duty staff approached Resident #1 on Boxwood Run Road, and the wheelchair rolled over and the resident fell out of the wheelchair and onto the grass at the roadside. The resident was returned to the facility uninjured. The facility failed to ensure staff received training regarding elopement after the incident and failed to report the incident to the appropriate State Agencies. (Refer to F225, F282, F323)

The facility's failure to be administered effectively placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 03/22/12 and was found to exist on 01/31/12.

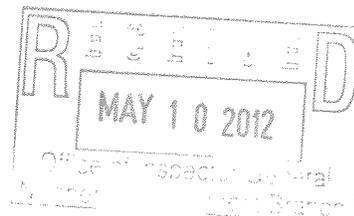
F 490

the wheelchair. The key-padded double doors leading to the Therapy Department were closed to limit resident access to Therapy exits. All Code Alert equipped doors were checked by Director and Assistant Director of Maintenance and found to be properly functioning.

On March 23, 2012 the exit to Therapy was converted to an emergency exit only and a fire box affixed to the door on April 02, 2012 to alarm whenever the door is opened. On April 2, 2012 the Code Alert bypass code was changed. Resident #1's care plan was reviewed and revised on March 22, 2012. The tracking policy was reviewed and revised on March 22, 2012 and revisions were made to the tracking log that nurses are to complete on each individual resident.

By March 23, 2012 all residents' elopement risk assessments were audited and new assessments completed. During these reviews and assessments, the residents' care plan was audited, the previous elopement assessment score listed as well as the current elopement assessment score listed to compare and the Certified Nursing Assistant's care sheet was also reviewed/revised as needed.

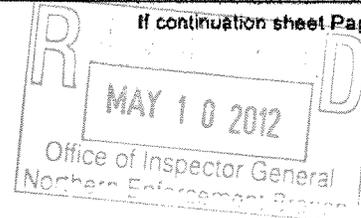
3. A meeting was held on Thursday, March 22, 2012 with the following individuals attending: Everett Ben Bays, Administrator; Matthew Schneider, Director of Nursing; Betty Thompson, Medical Records; AJ Holt, Rehab Services Manager;



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

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

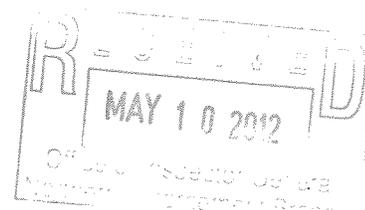
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047		
(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 490	<p>Continued From page 33</p> <p>The facility provided a credible Allegation of Compliance (AOC) on 03/30/12. The State Agency verified Immediate Jeopardy was removed on 03/25/12 prior to exit on 03/30/12; which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans and training to achieve and maintain compliance.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Prohibition Policy, issued 07/2010, revealed it is the policy of this facility that parameters will be established regarding abuse in the areas of screening, training, prevention, identification, investigation, protection and reporting/response. All facility employees are to promptly report any suspected abuse, mistreatment, involuntary seclusion, neglect or misappropriations of property belonging to residents to the charge nurse immediately. The policy included a section listed as Reporting, which stated all incidents are reported and investigated as they occur.</p> <p>Review of the facility policy for Elopement, dated May 2010, detailed all residents were assessed on admission for elopement risk, then quarterly, and as needed thereafter. Residents found to be at risk for elopement were assigned a Code Alert bracelet. Residents who wandered outside or eloped from the facility property were reported to the State Agency 'as required' by the Director of Nursing (DON) or the Administrator. The policy did not include a definition of elopement.</p>	F 490	<p>John Lott, Marketing /Admissions Director; Ben Bleemel, Director of Maintenance; Holly Culver, Social Worker; Kathy Davis, Nurse Scheduler/Central Supplies; Debbie Curtsinger, Activity Director; Nancy Thompson, Dietary Manager; Jackie Flynn, Restorative/Wound Nurse; Cortney Boggs, Staff Development Coordinator; Lori Shelden, House Supervisor 2p-10p; Darlene Hanson, House Supervisor 6a-2p; Shannon Davis, MDS Coordinator; Mandy Ward, Business Office Manager; Sue Hardin, MDS Coordinator; Alice Hudson, Director of Housekeeping/Laundry. The purpose of the meeting was to review and revise policies for Resident safety, with a focus on elopement risks with staff providing input as education was provided. The outcome of this meeting was the creation of the facility's definition of an elopement, that being; an elopement occurs when a Resident exits an exterior door without authorization (an MD order, Discharge, LOA, staff knowledge) and/or any necessary supervision to ensure safety. Procedure for responding to the Code Alert door alarms was created and presents that any response to the Code Alert that alarms requires that the staff member(s) responding to the alarm identify exactly why the Code Alert alarm was activated. This entails opening the door to ensure no residents are outside the facility. Once it is determined who/what has activated the alarm, the staff member responding must document on the Code Alert Log that is located at all four doors equipped with the Code Alert systems. They are to</p>	



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	
(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)
F 490	<p>Continued From page 34</p> <p>Review of the facility policy for Fifteen (15) Minute tracking, dated December 2011, revealed residents who required increased supervision were monitored by staff on fifteen (15) minute intervals to observe and document the resident's position in the facility.</p> <p>Review of the facility Investigation Report, which included the Morning Meeting Notes dated 08/15/11, revealed the SDC was assigned to "look at the event report on resident getting out." Review of the Morning Meeting Notes dated 08/16/11, revealed a safety discussion regarding the Physical Therapy Main Entrance hours of access due to Resident #1, exit of the facility on 08/13/11.</p> <p>Review of the Event Report, dated 01/31/12, detailed that Resident #1 was "outside, the w/c was noted to fall over in a grassy area, resident alarm attached, resident on right side". The Event Report documented the incident as a "witnessed fall", with an immediate need for a care plan update to address a witnessed fall with facility interventions identified to be: neuro checks, change of the resident's Code Alert bracelet, and placement of a new Code Alert bracelet to the left ankle.</p> <p>Interview, on 03/15/12 at 4:00 PM, by telephone, and further interview on 03/20/12 at 8:20 AM, with the Dietary Aide (DA) revealed he left work at the end of his scheduled shift on 01/31/12 between 3:30 PM and 4:00 PM noticed Resident #1 in a wheelchair near the Physical Therapy entrance. Resident #1 continued to self-propel in the wheelchair toward the street in front of the facility (Boxwood Run Road). The DA said Resident #1</p>	F 490	<p>document the date, time, reason and sign. Should they not be able to identify exactly why the Code Alert alarm has sounded, they are to immediately report this to the nurse supervisor so an accounting can be made of all residents to determine their location and ensure they are within the facility if not out of the facility with staff's knowledge. A form was created, <i>Acknowledgement of Risks/Criteria: Being Outside Facility Unsupervised</i> that will be presented to residents and/or their responsible party if the resident wants to sit/go outside the facility. Staff is to make sure the doors they exit or enter shut completely and the magnetic lock has engaged to ensure there is no ability to exit/enter the facility without the entry of the code. Policies and Procedures reviewed include: <i>Missing Resident, Wandering and Elopement of Residents, Resident Tracking and Exits with Key Pads.</i> A Missing Resident Quiz was created for staff's completion during in-service training. Staff training began on March 23, 2012, following facility's notification of findings of immediate jeopardy on March 22, 2012. The in-service training content includes: <i>Missing/Wandering Residents, Elopement of Residents, Exits with Key Pads, Resident Tracking, Missing Resident Quiz, Code Alert Log, Definition of Elopement, Acknowledgement of Risks Criteria form.</i> The method of training included presentation by Staff Development Coordinator, handouts provided and Question and Answer</p>



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	

(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
--------------------	--	---------------	---	----------------------

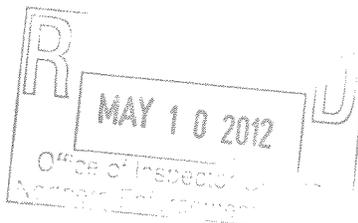
F 490 Continued From page 35

was always in sight from the rear view mirror in the car, and said two (2) cars passed the resident in the wheelchair on Boxwood Run Road. The DA continued to drive to the end of Boxwood Run Road and parked. The DA said Resident #1 was moving fast toward Highway 44 which intersected with Boxwood Run Road. The DA moved toward Resident #1 to return the resident to the facility; however, upon approach, a wheel of the chair went off of the pavement and rolled over, and Resident #1 fell out of the wheelchair into a grassy area. The DA returned Resident #1 to the wheelchair and returned the resident to the facility. The DA entered the Physical Therapy front entrance and did not hear an alarm when the resident was returned through the door.

Interview, on 03/21/12 at 11:00 AM, with the Director of Nursing (DON) revealed the facility investigation did not identify any staff who heard the Code Alert alarm on 01/31/12 when Resident #1 exited the facility. The DON said the facility determined Resident #1 likely exited from the Physical Therapy Entrance. The DON said the facility determined that fifteen (15) minute Tracking had been an effective intervention to provide adequate supervision for Resident #1. The DON defined elopement as unwitnessed or unsupervised exit of the property, and said Resident #1 did not elope on 01/31/12 because the DA had eyes on Resident #1 during the duration of the event, though the facility investigation did not identify any staff who saw Resident #1 exit the facility. The DON said Resident #1 was not at a risk of serious injury, harm, impairment, or death while self-ambulating in a wheelchair on Boxwood Run Road. However, the DON said it was a potential that

F 490

Session. All employees will be provided training. The contingency plan for employees who may be on leave or unavailable for the training, requires that they be trained prior to returning to their assigned duties. All staff identified as being on leave or unavailable were contacted and made aware of the requirement for training before returning to work. Additionally the Department Head/Supervisors have been notified of the requirement for training prior to returning to work. As of May 02, 2012, a total of 152 of the 155 employees have been trained. The three (3) employees who have not been trained have been taken out of payroll system. A QA&A Committee meeting was held on March 30, 2012 where the facility's policies on Supervision of Residents to Prevent Accidents and the policy on Reporting Injuries of Unknown Origin were reviewed with revisions made. Input was provided by the facility's Medical Director at this QA&A Committee meeting. Staff education was provided on the revised policies and procedures related to reporting on April 12 and 13, 2012. Staff education was provided on the revised policies and procedures related to reporting on April 12 and 13, 2012. Staff education provided on supervision of residents on March 22-24, 2012. Consultation with the Governing Body on March 22, 2012 entailed education being provided to the Director of Nursing and Administrator with



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 490 Continued From page 36
Resident #1 could have been hit by a car on Boxwood Run Road.

Interview, on 3/16/12 at 12:20 PM, with the Administrator revealed the facility had not experienced any resident elopements since May, 2011. The Administrator provided a signed and dated statement: "We have not had any elopements since May 2011. We have had residents exit seeking, and exit facility but not any we consider elopements." Interview, on 03/21/12 at 6:01 PM, with the Administrator revealed the facility was capable of meeting the needs of Resident #1 at the facility, and said the only intervention the facility had not attempted was a one-to-one observation by staff.

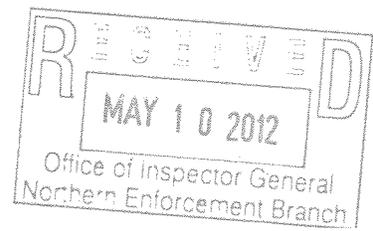
Interview, on 03/30/12 at 10:50 AM, with the Administrator revealed his most recent training regarding elopement was provided by the Governing Body/President/Owner of the facility on 03/22/12 and 03/23/12 via telephone conference call and was done as a result of survey findings. Interview on 03/28/12 with the Administrator revealed facility management staff were not trained on supervision of residents until prior to the review and audit of care plans and CNA care sheets conducted 03/22- 23/12.

Review of the Allegation of compliance (AOC) revealed the facility took the following immediate actions:

1. Elopement assessments which included the complete resident census of one-hundred three (103) beginning the assessments on 03/22/12 and completed on 03/23/12. The facility determined thirteen (13) residents to be at risk for

F 490 reference to SOM Appendix PP, §483.13(c) Staff Treatment of Residents and §483.25(h) Accidents as a resource. If audits, meetings and discussions about reporting and supervision reveal concerns, the Administrator will review and revise policies and provide education to the Department Heads and Administrative Staff and the Staff Development Coordinator will provide education to all other staff. The Plan of Correction will be monitored by the Administrator to ensure actions are implemented and compliance is maintained. A report will be provided to the Governing Body on a weekly basis reflecting the status of the implementation of the Plan of Correction.

4. The Elopement binders will be reviewed weekly in Morning Meeting to ensure all information is accurate and up-to-date. Administrator will ensure correctness of Elopement binders. Code Alert logs will be presented by the Director of Maintenance and in his absence the Assistant Director of Maintenance to quarterly QA&A meetings for review to ensure information is entered accurately and see if any pattern or trend is noted. All emergency exits, equipped with emergency fire boxes, are checked and recorded once a day by the Director of Maintenance, Assistant Director of Maintenance, Director of Nursing and/or



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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
--------------------	--	---------------	---	----------------------

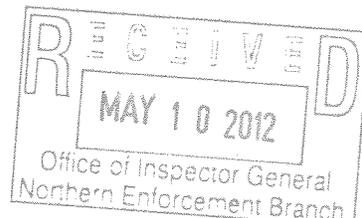
F 490

Continued From page 37 elopement.

2. The facility audited and revised the Certified Nursing Assistant (CNA) sheets on 03/23/12 for the thirteen (13) residents that were found to be a risk for elopement.
3. The facility educated the staff on 03/24/12 to include policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads including elopement definition and reporting.
4. The facility initiated Resident Tracking Sheets for the residents determined to require every fifteen minute checks. Staff are to document at fifteen (15) minute intervals at the time the resident is observed.
5. The facility closed the double doors between the Therapy Addition and Transition Way Unit and staff were directed to leave the doors closed. This door requires a coded entry.
6. The Director of Nurses and Maintenance Director checked all doors and alarms to ensure they were functioning properly.
7. The Unit Manager provided education to the staff on duty regarding every 15 minute checks.
8. Department Heads and Administrative staff were provided education and the facts of the incident by the Administrator on 03/22/12.
9. The elopement binder is to be reviewed weekly on Fridays by the Administrator to ensure the photographs and face sheets are in the binder.

F 490

licensed nurse on Monday through Friday. The findings will be documented on a form created for that purpose. These exits will be checked by the Nursing House Supervisor on weekends once a day and their findings will be recorded on a form created for that purpose. Checks of the emergency exits will continue and their continuation or ending be determined by the QA&A Committee. The results of these checks will be presented at the quarterly QA meetings by the Director of Maintenance. The Assistant Director of Maintenance will present the findings of these audits, in the Director of Maintenance's absence. The Administrator will attend the QA&A Committee meetings and ensure checks/audits of exits are completed and appropriate actions taken if concerns are identified. The QA&A Committee will review the findings of these audits and review/revise as deemed necessary. The next scheduled QA&A Committee meeting is Monday, May 21, 2012. The effectiveness and compliance with F490 requirements will be reviewed during that QA&A meeting.

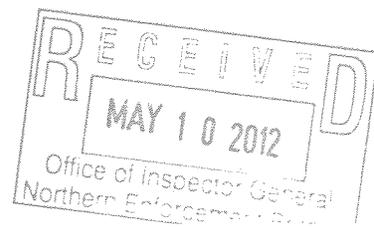


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	

(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 490	<p>Continued From page 38</p> <p>10. The Resident Safety Policy was reviewed and revised with a new definition of elopement, response to alarms, checking the area around the alarm, determining the cause of the alarm to sound and documentation on the code alert log. In addition, a form was created, Acknowledgement of Risks/Criteria: Being Outside Facility Unsupervised that will be presented to residents and/or their responsible parties. Policies reviewed: Missing Resident; Wandering and Elopement of Residents; Resident Tracking and Exits with Key Pads. A missing resident quiz was created for staff to complete during inservice training.</p> <p>11. The Administrator received training by the Governing Body on 03/22/12 and 03/23/12 in response to the survey findings including elopement and reporting.</p> <p>The State Agency validated the AOC as follows:</p> <p>1. The State agency validated documentation of elopement assessments which included the complete resident census of one-hundred three (103). The resident Elopement assessment scores were documented, and it was determined that thirteen (13) of one-hundred three (103) residents were at risk for elopement. The facility began the assessments on 03/22/12, and were completed on 03/23/12. It was verified on 03/30/12, that the facility reviewed and updated care plans for all thirteen (13) residents determined by the facility to be at risk for elopement</p> <p>2. The State agency validated documentation of</p>	F 490		



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1		STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047	

(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
--------------------	--	---------------	---	----------------------

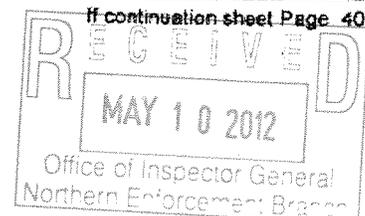
F 490 Continued From page 39

audits of audits comparing CNS sheets to assessments and careplans and revisions to the Certified Nursing Assistant (CNA) sheets that was completed on 03/23/12 for the thirteen (13) residents that were found to be a risk for elopement. It was verified by review of all thirteen (13) CNA sheets for residents at risk for elopement, that the revisions were completed on 03/23/12.

3. The State agency validated documentation of education provided to staff which included policies for: Wandering and Elopement of Residents, Resident Tracking, Missing Residents, and Exits and Key Pads. The facility staff roster indicated there were one-hundred and fifty-five (155) staff and one-hundred and forty-two (142) had been educated by 03/24/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remainder of the staff prior to their date of return to work.

4. The State agency validated on 03/30/12, by observation of four (4) residents who were found to be at risk for elopement, that each resident had a Resident Tracking Sheet which accompanied each resident as they moved through the facility to Activities, Dining, etc. It was determined by observation, staff were documenting on the Resident Tracking Sheets in fifteen (15) minute intervals at the time of the resident observation. Interview with a staff member on 03/30/12 at 6:20 PM, revealed when a resident with fifteen (15) minute tracking moved to another area of the facility, documentation on the Resident Tracking sheet was completed by the staff member who accompanied the resident to that area.

F 490



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185464	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GREEN MEADOWS HEALTH CARE CENTER 1	STREET ADDRESS, CITY, STATE, ZIP CODE 310 BOXWOOD RUN ROAD MOUNT WASHINGTON, KY 40047
---	---

(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 490 Continued From page 40

F 490

5. Interviews on 03/30/12 at 6:30 PM with five (5) CNA's, three (3) RN's, two (2) LPN's, one (1) dietary staff, and one (1) medical records staff revealed that all staff members were able to state the steps staff were responsible for when a resident was missing, responsibilities of staff when a resident is on Resident Tracking, and a resident who wandered near a facility exit door. In addition, staff were able to identify elopement and were knowledgeable of reporting such.

6. Interview with the Administrator, on 03/30/12 at 10:50 AM, revealed he had received training in supervision, wandering residents, elopement-definition, and policies specific to the facility's needs.

7. The State Agency validated education of the Department Heads through interview with Staff Development, Activities, Medical Records, and Social Services, on 03/30/12 between 5:20 PM and 6:00 PM.

