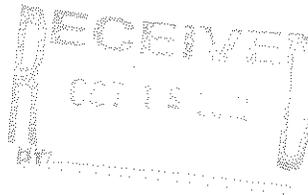


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/09/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/20/2012
NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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>AMENDED</p> <p>An Abbreviated Survey investigating KY#00019019 was conducted 09/10/12 through 09/14/12. Immediate Jeopardy was identified and a Partial Extended Survey was Initiated on 09/18/12 and concluded on 09/20/12. KY#00019019 was substantiated and Immediate Jeopardy was identified.</p> <p>The facility failed to provide adequate supervision and monitoring for Resident #1 who had been assessed by the facility as being at risk for elopement. On 09/01/12 at approximately 7:30 PM Resident #1 was left unsupervised by staff on the facility's front porch. Approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who told the facility they found Resident #1 walking in the neighborhood behind the facility approximately 1000 feet from the facility's front door. The facility failed to notify Resident #1's Physician of the incident and failed to conduct an investigation related to the elopement to implement adequate interventions to prevent Resident #1 from eloping from the facility again. The facility failed to revise the Plan of Care to include increased supervision and monitoring. On 09/03/12 sometime between 12:02 PM and 12:05 PM Resident #1 eloped again from the facility unsupervised and was located on the sidewalk getting ready to take a step onto the roadway of the "housing projects" located behind the facility, approximately 475 feet from the facility's front door.</p> <p>Immediate Jeopardy was Identified on 09/13/12 and was determined to exist on 09/01/12 with</p>	F 000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Susan Palmer*

TITLE

*Administrator*

(X6) DATE

10/15/12

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

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F 000	Continued From page 1 deficiencies cited at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-323; and 42 CFR 483.75 Administration, F-490 and F-493 at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care, F-323. In addition, deficiencies were cited at 42 CFR 483.15 Quality of Life, F-248 and 42 CFR 483.20 Resident Assessment, F-282 at a S/S of a "D".  An acceptable credible Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 09/17/12. On 09/20/12, the State Agency verified the Immediate Jeopardy was removed on 09/14/12, prior to exit, with remaining non-compliance at 42 CFR 483.10 Resident Rights, F-157; 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-323; and 42 CFR 483.75 Administration, F-490 and F-493 at a Scope and Severity (S/S) of a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance monitors the effectiveness of the systemic changes.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157	F157 1. Resident #1 no longer resides in the center. Medical Director was made aware of resident 9/1/12 out of center on 9/12/12 by the Director of Nursing. No new orders noted.  2. Director of Nursing, Regional Nurse Consultant, Assistant Director of Nursing; Education Training Director, and Administrator reviewed 100% of medical records for a 30 day look back period of 8/25/12 through 9/26/12 to identify any change in condition (mental, physical or psychosocial) that the family and physician was not notified of immediately. This was completed on 9/27/12.	

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F 157	<p>Continued From page 2</p> <p>status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure the Physician was notified related to changes in conditions/or need to alter treatment. In addition the facility failed to follow their policy entitled, "Notification of Resident Change in Condition" for one (1) of twelve (12) sampled residents (Resident #1).</p> <p>On 09/01/12 at approximately 7:30 PM, Resident #1, who had been assessed by the facility as being at risk for elopement and had a history of</p>	F 157	<p>All issues identified were immediately reported to the physician/family by the Director of Nursing, Regional Nurse Consultant, Assistant Director of Nursing or the Education Training Director.</p> <p>Director of Nursing, Assistant Director of Nursing, and the Administrator reviewed all 24 hour shift reports for a 30 day look back period from 8/25/12—9/26/12 to identify issues that was documented that was a change in condition or need for altered treatment that was not immediately reported to the physician/family. This was completed on 9/27/12.</p> <p>All issues identified were immediately reported to the physician/family by the Director of Nursing or the Assistant Director of Nursing, Social Services to review all records by 10/11/12 to identify any resident that does not have a legal representative and/or interested family member listed for contact, along with current address. Any issues identified will be immediately updated by the social service director.</p> <p>Director of Nursing, Assistant Director of Nursing, Administrator and/or Regional Nurse Consultant to audit all records five times per week beginning 9/28/12 to identify any physical, mental, or psychosocial change that was not reported to the physician/family. All issues identified will require Education Training Director; Director of Nursing, or Assistant Director of Nursing to complete on identified staff re-education and physician/family will be immediately notified of change.</p> <p>Director of Nursing, Assistant Director of Nursing and/or Regional Nurse Consultant to</p>		

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F 157	<p>Continued From page 3</p> <p>elopement was left unsupervised by staff on the facility's front porch. Approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who stated they found Resident #1 walking in the neighborhood behind the facility approximately 1000 feet from the facility's front door. The facility failed to notify Resident #1's Physician of the incident and the potential need to alter treatment for Resident #1 to prevent further elopement. On 09/03/12 sometime between 12:02 PM and 12:05 PM Resident #1 eloped again from the facility unsupervised and was located on a sidewalk getting ready to take a step onto the roadway of the "housing projects" located behind the facility, approximately 475 feet from the facility's front door. Resident #1 was placed on one to one (1:1) staffing and later sent to a psychiatric hospital for further evaluation. Resident #1 was not in the facility during the survey.</p> <p>Based on the above findings it was determined the facility's failure to ensure the Physician was notified related to a significant changes in a resident's condition and/or a need to alter treatment was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 09/13/12 and determined to exist on 09/01/12. The facility was notified of the Immediate Jeopardy on 09/13/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 with the facility alleging removal of the Immediate Jeopardy on 09/14/12. Immediate Jeopardy was verified to be removed on 09/14/12 prior to exiting the facility on 09/20/12 with remaining</p>	F 157	<p>review daily 24 hour report beginning 9/28/12 to identify any physical, mental or psychosocial change documented on the 24 hour shift report to ensure both physician and family have been notified. All issues identified will require identified staff re-education by the Education Training Director, Director of Nursing, or Assistant Director of Nursing. Physician and family will be immediately notified of change.</p> <p>3 Education Training Director to re-educate all staff by 10/15/12 regarding procedure for reporting of change in condition (mental, physical or psychosocial) to both family and physician. A written competency will be completed to validate competency.</p> <p>Administrator, Education Training Director, Director of Nursing, Assistant Director of Nursing and Regional Nurse Consultant to audit all records and 24 hour shift reports five times a week for six weeks beginning 9/27/12 to ensure any changes in condition (mental, physical, or psychosocial) that may alter the plan of care to be changed is reported to the physician and family timely. At the end of the six week monitoring period, all records will be audited by the Education Training Director, Director of Nursing, Assistant Director of Nursing, and/or Regional Nurse Consultant to ensure all changes in condition (mental, physical, psychosocial) that may alter the plan of care is reported to the physician and family timely four times a week for four weeks; then three times a week for three weeks or per Quality Assurance team <u>recommendations based on audit findings.</u></p>		

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F 157	Continued From page 4 non-compliance at 42 CFR 483.10 Resident Rights F-157 Notification of Change, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure appropriate notifications of residents' changes in conditions.  The findings include:  Review of the policy the facility utilized as a reference titled, "Notification of Resident Change in Condition", dated 07/01/12, revealed "Clinicians" would immediately inform the resident's Physician when there was a significant change in the resident's physical, mental, or psychosocial status.  Resident #1 was admitted to the facility, on 06/06/12, with diagnoses which included Aortic Aneurysm, Glaucoma, and Dementia. Review of an Admission Minimum Data Set (MDS) Assessment, dated 06/13/12, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of ten out of fifteen (10/15), indicating Resident #1 was moderately impaired with cognition. Review of Interdisciplinary Team (IDT) Notes, dated 06/13/12, revealed Resident #1 had exit seeking behaviors due to the desire to return home. Review of Physician's Orders, dated 06/13/12, revealed the Physician ordered for Resident #1 to wear a Wander Guard at all times (an assistive device which alarms at the exit doors to alert staff when residents attempt to leave the facility unsupervised).  Review of Nurses Notes (NN), dated 07/23/12,	F 157	Director of Nursing to audit 15 records weekly (ongoing) to ensure physician and family are notified timely of any change in condition (mental, physical or psychosocial) beginning 10/1/12. This will consist of random charts audited by the Assistant Director of Nursing, Education Training Director or Administrator for 6 weeks then, random records. Regional Nurse Consultant to audit 15 records weekly for three weeks then 10 records weekly for 4 weeks. Beginning 10/2/12 to ensure procedure for reporting changes in condition to physician/family is followed and that any change in condition that may require plan of care to be altered is reported timely to the physician and family.  4. Quality Assurance team consisting of the administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, will meet weekly times 6 weeks with medical director to review all audit findings, make additional recommendations and revisions to the plan related to findings beginning week of 10/1/12. At the end of 6 weeks, the Quality Assurance Committee consisting of administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, to meet with medical director every two week for four weeks at the end of the ten weeks the Quality Assurance committee will meet to discuss all audit findings with the medical director to review meeting frequency and make recommendations to meet no less than monthly.  5. Date of Compliance: 10/16/12	

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F 157	<p>Continued From page 5</p> <p>revealed Resident #1 continued to exit the facility's front door and sit on the rocking chair and was to be sent to a psychiatric facility for a psychiatric evaluation. Resident #1 returned to the facility on 07/30/12.</p> <p>Review of NN, dated 08/28/12 revealed Resident #1 exited the building three (3) times to the facility's front porch unsupervised and was redirected by staff back into the building. There was no documented evidence the Physician was notified of the resident's increased exit seeking behavior.</p> <p>Review of NN, dated 09/01/12, revealed Resident #1 exited the facility's front door to a housing area behind the facility and was "escorted back to the facility"; however, there was no documented evidence the Physician was notified.</p> <p>Interview, with State Registered Nursing Assistant (SRNA) #7, on 09/13/12 at 9:30 AM, revealed he was assigned to provide direct care to Resident #1 on 09/01/12 and at approximately 7:30 PM he responded to the Wander Guard alarm sounding at the front door. SRNA #7 stated he observed Resident #1 to sit down in a rocking chair on the front porch with unidentified visitors. SRNA #7 indicated he left Resident #1 on the front porch unsupervised by staff and went back into the facility. He continued that approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who told SRNA #7 they found Resident #1 walking in the neighborhood behind the facility (approximately 1000 feet from the facility's front door). Additional interview revealed he took Resident #1 to RN #1 and reported the incident to her.</p>	F 157			

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F 157	Continued From page 6  Interview; on 09/13/12 at 7:30 AM, with Licensed Practical Nurse (LPN) #4 who provided care to Resident #1 on 09/01/12 revealed she had just returned from her break at approximately 8:00 PM and was told by Registered Nurse (RN) #1 that Resident #1 had "gotten out" to the "housing projects" behind the facility and was brought back to the facility by two (2) unknown males. Further interview revealed RN #1 had told her to document what she was just told in the NNs.  Interview with RN #1, on 09/13/12 at 8:10 AM, revealed she could only recall that Resident #1 had opened the front door and was going towards the rocking chairs on 09/01/12. She stated she did not call Resident #1's Physician to notify him of the incident, but had called the Director of Nursing (DON) and informed her that Resident #1 had opened the front door and got out on the front porch.  Interview with the DON, on 09/13/12 at 10:55 AM, revealed she received a phone call from RN #1 on 09/01/12 at approximately 8:00 PM that Resident #1 went out on the front porch unsupervised by staff and she had instructed RN #1 to place Resident #1 on visual checks every fifteen minutes (Q15 checks). Further interview revealed if she had been informed Resident #1 had eloped from the facility for approximately twenty (20) minutes and was brought back to the facility by two (2) unknown males, she would have called Resident #1's Physician to obtain orders to alter treatment, such as assigning one (1) staff person to Resident #1 for constant visual checks (1:1) and requesting a Physician's order to have Resident #1 have further psychiatric	F 157			

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F 157	<p>Continued From page 7 evaluation.</p> <p>Further review of the NN, dated 09/03/12, revealed Resident #1 exited the facility again without staff's knowledge and was located on the sidewalk getting ready to take a step into the roadway of the "housing projects" located behind the facility (approximately 475 feet from the facility's front door).</p> <p>Continued interview with the DON, on 09/13/12 at 11:05 AM, revealed if the Physician had been notified of the 09/01/12 incident then maybe Resident #1 would not have eloped again on 09/03/12.</p> <p>Interview with Resident #1's Physician, on 09/19/12 at 11:30 AM, revealed Resident #1 was a high risk for elopement with a history of elopement and the facility was responsible for ensuring Resident #1 was adequately supervised to prevent elopement. Continued Interview revealed he was not notified Resident #1 had eloped from the facility on 09/01/12. Further interview revealed leaving Resident #1 on the front porch with some unknown visitors was not fair to the visitors because it put the responsibility on them when it should be the responsibility of staff. Additional interview revealed if he had been made aware of the elopement on 09/01/12 he would have instructed the facility to place Resident #1 on 1:1 staffing and ordered for Resident #1 be sent to a psychiatric hospital for evaluation and then there possibly wouldn't have been the elopement on 09/03/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 that</p>	F 157		

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F 157	Continued From page 8 alleged removal of the IJ effective 09/14/12, based on the following:  1) All staff in all departments were inserviced by the Assistant Director of Nursing on 09/03/12 and by the Education Director on 09/13/12 related to the following:  a. Definition of elopement, revised Elopement Management and Prevention Policies, Missing Resident Action Plan, Head Count Procedures and Care Plan Policy which were revised on 09/13/12; and approved by the QA committee consisting of Administrator, DON, Social Services Director, Activities Director, Maintenance Director, Referral Manager, Business Office Manager, Business Office Assistant and Regional Nurse. b. Alarm procedures/action which included who responds to the alarm, what to do when the alarm sounds, and level of supervision needed. c. All staff reeducated regarding the Elopement Risk Book on 09/13/12 by the Education Director/Department Manager. d. Notify the Charge Nurse immediately of missing or exit seeking resident and the Charge Nurse will immediately notify the Administrator, DON and Nurse Consultant. The Charge Nurse will update the plan of care and update staff verbally and in writing of the increased supervision on the twenty-four (24) hour shift report. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.  2) All elopement care plans were reviewed and revised on 09/13/12 by the DON, Administrator, Social Services, and Charge Nurse. All residents	F 157			

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F 157	Continued From page 9 were visualized by the DON and Education Nurse on 09/13/12 to identify mode of locomotion and staff interviews were conducted to better determine residents with elopement risk.  3) On 09/13/12, a Quality Assurance Meeting was held to discuss the steps to be taken to prevent further incidents to Resident #1 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.  4) License staff will complete the accident/incident report immediately for an elopement attempt or actual elopement and the education was completed by the Department Manager and or the Education Director by 09/14/12.  5) On 09/13/12, the DON and Administrator conducted an elopement drill to evaluate the staff response to alarms sounding.  6) Department Manager monitoring of the facility twenty four/seven (24/7) for ten days beginning 09/13/12 to include at least one random staff interview each shift to determine any resident changes as related to wander risk, monitoring and witnessing wander guard checks for function and placement, visualizing all residents, ensure staff response to door alarms, check function of all doors every shift to ensure all systems are functioning, ensure staff can complete head count properly and timely, Department Manager to complete a daily elopement drill, care plan updates, twenty four (24) hour report sheet completed. Any decrease in Department Manager	F 157			

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F 157	Continued From page 10 monitoring will be reviewed by the QA committee after ten days and then weekly for a decrease in monitoring, any issues identified and need for further education.  7) Twenty-four/seven 24/7 front door monitoring beginning at 12 noon on 09/13/12 until door is upgraded and function is verified on 2 shifts.  8) New employees are to be trained on the elopement system upon hire by the Education Director. The Elopement Risk Book will be reviewed during orientation of new staff. The revised elopement policies and procedures were included in the new hire orientation material beginning 09/13/12.  9) All activity care plans reviewed/revised 09/13/12 by the Life Enrichment Director, DON, Social Services, MDS Nurse and Regional Nurse Consultant to ensure activities were in place for all residents and identified residents' individual needs.  On 09/20/12 the State Survey Agency verified the Immediate Jeopardy was removed on 09/14/12 and the facility implemented corrective actions as alleged in the AOC, effective 09/13/12 based on the following:  Review of facility inservice records and attendance logs, dated 09/13/12, revealed staff was educated related to the facility's revise policies and procedures for elopement to include Elopement Management and Prevention, Head Count, Missing Resident, Care Plan Policies and notifications to be made if a resident attempted to exited the building unsupervised. Further review	F 157			

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F 157	Continued From page 11 of the inservice records revealed staff received education and training related to responding to the Wander Guard alarms and procedures to be followed which included the completion of the incident report.  Record review revealed all resident's elopement care plans had been reviewed and revised on 09/13/12.  Review of the facilities QA meeting minutes revealed a meeting was held on 09/13/12 to implement plans of correction to remove the immediate jeopardy.  Review of the facility's monitoring log, dated 09/13/12 through 09/19/12, revealed staff had monitored the front door 24/7 until the front door was upgraded. Observation, on 09/18/12 at 3:10 PM, revealed the front door was secured when the Wander Guard was within four (4) feet and the door would not open for fifteen (15) seconds once the bar was pushed.  Review of the facility's elopement drill records revealed the DON and Administrator conducted an elopement drill on 09/13/12 to evaluate the staff response to alarms sounding. Further review of the elopement drill records revealed an elopement drill had been conducted daily at varying times and shifts from 09/13/12 through 09/18/12. Observation, on 09/19/12 at 10:15 AM, revealed an elopement drill was conducted by the Administrator. Further observation revealed staff immediately responded to the alarm by a nurse at the nurse's station going to the front door, dietary staff going out the side door and housekeeping going out the back doors and	F 157			

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F 157	Continued From page 12 checking the facility property, SRNA's, LPN's and activities doing a head count and checking behind doors and all areas of the facility until the Maintenance Director (who was placed behind a door in a bathroom as a resident) was located.  Interview with the Dietary Manager on 09/19/12 at 1:30 PM, Maintenance Director at 2:15 PM, Assistant Director of Nursing at 3:45 PM and on 09/20/12 at 11:00 AM with the Director of Nursing and the Administrator revealed they had been assigned rotating shifts to include visualizing all residents, ensure staff response to door alarms, care plans were updated, twenty four (24) hour report sheet completed and notifications made.  Observation, on 09/18/12 from 4:00 PM until 4:30 PM, revealed there were Elopement Risk Books on both the nursing units including the East and West Nurse's Station, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.  Interviews with staff including RN #4 on 09/19/12 at 12:55 PM, SRNA #8 at 1:00 PM, LPN #3 at 1:05 PM, LPN #6 at 1:15 PM, Dietary Manager at 1:30 PM, SRNA #9 at 1:45 PM, Housekeeper #2 at 2:00 PM, RN #1 at 2:25 PM, LPN #7 at 2:35 PM, LPN #8 at 2:45 PM, LPN #11 at 2:55 PM, SRNA #10 at 3:00 PM, SRNA # 11 at 3:10 PM, and Physical Therapy aide at 3:20 PM, revealed they had received inservice education and were aware of what an elopement was, the Elopement Risk Book and the elopement policy and procedure to include providing staff supervision as well appropriate notifications to be made if a resident attempted to leave the facility unsupervised, including notifying the physician.	F 157		

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F 157	Continued From page 13  They were also aware of the procedure in responding to the door alarm to include searching inside and outside the facility.  Record review revealed the Activities Director, Social Worker, DON and Regional Nurse Consultant reviewed and revised the activity assessments and activities care plans for all elopement risk residents by 09/13/12. Interview with the DON, Regional Nurse Consultant and Activities Director, on 09/20/12 at 9:20 AM, revealed they met as a group on 09/13/12 and reviewed and revised care plans and activities assessments of residents at risk for elopement to ensure those residents received routine time out side to meet their needs. Further interview revealed all residents care plans and activity assessments were being reviewed and revised. Further interview with the Administrator revealed the current Activities Director would become an Activities Assistant when the Dietary Manager completed the training course approved by the state.  Interview, on 09/19/12 at 3:25 PM, with the Education Director, revealed she had assisted with the changes in the new elopement policies and the policies would be reviewed with each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice. Review of the facility's revised orientation packet revealed orientation included review of the facility's revised elopement policies and procedures.  Interview with the Administrator, DON and	F 157			

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F 157	Continued From page 14 Regional Nurse and review of the new Elopement Management and Prevention Policies, on 09/20/12 at 11:00 AM, revealed the policies were updated 09/13/12 to include staff supervision of residents at elopement risk, reviewing and revising individualized care plan interventions to prevent elopement (such as enhanced recreational activities), responding to wander guard alarms, completing incident reports, and notifications to be made when a resident attempts to leave the facility unsupervised, to include notifying the physician.  The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC).	F 157			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy it was	F 248	F248  1. Resident #1 no longer resides at the center. Resident #8 activities assessment and care plan was revised on 10/4/12 by Activities Director. Medical Director was made aware of activity care plan and assessment revision by Director of Nursing on 10/5/12. No new orders noted. A new Life Enrichment Director has been appointed and educated by Regional Nurse Consultant regarding how to complete activity assessments, when to complete activity assessments, when to complete the activity care plan, how to revise the care plan as well as completion of activity calendar on 9/26/12.		

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F 248	Continued From page 15 determined the facility failed to provide an ongoing program of activities to meet the physical, mental, and psychosocial well-being for one (2) of twelve (12) sampled residents (Resident #1 and Resident #8). Resident #1 was assessed by the facility as an elopement risk and as having an interest of sitting on the porch outside; however the facility failed to ensure Resident #1 received routine supervised time outside to meet the physical, mental and psychosocial needs of Resident #1. The facility assessed Resident #8 to need sensory stimuli five (5) times per week; however, the facility failed to ensure Resident #8 received on-going sensory stimuli while the resident was in his/her room to meet the mental and psychosocial needs of the resident.  The findings include:  Review of the policy the facility utilized as a reference titled, "Activity Assessment", revised January 2011, revealed an activity assessment would be conducted to help develop an activities plan that reflected the choices and interest of the resident. Further review of the policy revealed the activity assessment was used to develop an Individual activities care plan that would allow the resident to participate in activities of his/her choice, reflect his/her individual needs and should be updated annually.  1. Review of Resident #1's medical record revealed the facility admitted Resident #1 on 06/06/12, with diagnoses which included Aortic Aneurysm, Glaucoma and Dementia. In an Admission Minimum Data Set (MDS) Assessment, dated 06/13/12, the facility	F 248	2. All activity care plans and activity assessments were reviewed by the Life Enrichment Director to identify any activity assessment and/or activity care plan that did not meet individual resident needs on 10/11/12. All activity care plans and activity assessments will be revised and residents reassessed to ensure that individual resident needs, preferences and choices are met.  3. Regional Nurse Consultant to re-educate Life Enrichment Director by 10/4/12, regarding how to complete activity assessments, how often to complete activity assessments, when and how to complete and update activity plan of care and development.  Education Training Director to re-educate all nursing, activity and administrative staff by 10/9/12 regarding activity assessments, how often to complete, when to complete and update; how often to update all care plans, with focus on activity care plans and that assessments and care plans must be individualized and implemented.  Assistant Director of Nursing and Director of Nursing will audit all new admits within 72 hours after admission to ensure the activity assessment and care plan are completed and that the plan of care is followed and developed according to the assessment; beginning week of 10/12/12 for 8 weeks.  Director of Nursing and Administrator will monitor and supervise that all activities are occurring on the calendar; five times a week for 4 weeks beginning week of 10/9/12; and monitor at least 5 residents 5 times a week to ensure activity plan of care is followed and individualized according to the assessment and is evaluated regularly.		

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F 248	<p>Continued From page 16</p> <p>assessed Resident #1 as being cognitively impaired with a Brief Interview for Mental Status (BIMS) score of ten (10) out of fifteen (15) and that going outside to get fresh air when the weather was good was very important to Resident #1.</p> <p>Review of Resident #1's Activities Assessment, dated 06/08/12, revealed sitting on the porch was very important to him/her. Review of an Activities Plan of Care, dated 06/13/12, noted sitting on the porch was one of Resident #1's favorite activities; however, there were no specified interventions listed identifying that Resident #1 would be provided opportunities to sit on the front porch or walk outside.</p> <p>Review of Interdisciplinary Team (IDT) Notes, dated 06/13/12, revealed Resident #1 had exit seeking behaviors due to the desire to return home. A Wander Guard was placed on Resident #1 as an assistive device to alarm at the exit doors to alert staff when Resident #1 attempted to leave the facility unsupervised.</p> <p>In a care conference held with Resident #1's Power of Attorney (POA), on 06/25/12, it was noted by the POA that Resident #1 often took walks in the woods and liked sitting outside at home. Review of an elopement plan of care, revised 06/25/12 revealed redirection was not effective and an intervention was added to encourage Resident #1 to go outside with smokers (even though Resident #1 was not a smoker) and give Resident #1 time outside. The interventions did not direct staff to establish a routine of going outside, nor did it specify who was responsible to ensure he/she was supervised</p>	F 248	<p>Regional Nurse Consultant to monitor at least 3 activities monthly to ensure schedule is followed and that in room one to one residents are receiving activities that correlate with their assessment. This is to begin 10/12/12.</p> <p>Regional Nurse Consultant to monitor at least 3 new admits monthly beginning 10/12/12 to ensure that activity assessment is in place within 72 hours; assessment is individualized and that the plan of care is in place and being followed.</p> <p>4. Quality Assurance team consisting of the administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services/director, dietary and activity director, business office manager, will meet weekly times 6 weeks with medical director to review all audit findings, make additional recommendations and revisions to the plan related to findings beginning week of 10/1/12. At the end of 6 weeks, the Quality Assurance Committee consisting of administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, to meet with medical director every two week for four weeks at the end of the ten weeks the Quality Assurance committee will meet to discuss all audit findings with the medical director to review meeting frequency and make recommendations to meet no less than monthly.</p> <p>5. Date of Compliance: 10/16/12</p>	

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F 248	<p>Continued From page 17 while outside.</p> <p>Review of Resident #1's Activity Participation Log for June 2012 revealed there was no documented evidence Resident #1 received an activity of going outside and sitting on the porch, from 06/25/12 through 06/30/12. Review of the Activity Participation Log for July 2012 revealed Resident #1 was given time to walk outside on 07/23/12 (Monday).</p> <p>Review of the Nurse's Notes, dated 07/23/12, revealed Resident #1 continued to exit the facility's front door and sit in the rocking chair. The Physician ordered for Resident #1 to be sent to a psychiatric facility for a psychiatric evaluation. Resident #1 returned to the facility on 07/30/12 with new care plan Interventions which included Resident #1 was to have Physical Therapy (PT).</p> <p>Review of PT notes revealed Resident #1 received PT from 07/30/12 through 08/24/12. During an interview with Physical Therapy Assistant #1, on 09/12/12 at 2:30 PM, she revealed Resident #1 would be taken outside for walks when the weather was nice as part of his/her therapy.</p> <p>Review of the August 2012 log revealed Resident #1 had an activity of sitting on the porch on 08/07/12 (Tuesday), 08/14/12 (Wednesday), 08/15/12 (Thursday), 08/21/12 (Tuesday), 08/22/12 (Wednesday), 08/23/12 (Thursday), 08/24/12 (Friday), and on 08/27/12 (Monday).</p> <p>Review of NN, dated 08/28/12, revealed three (3) days after PT was discontinued, Resident #1 exited the building three (3) times to the facility's</p>	F 248			

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F 248	<p>Continued From page 18</p> <p>front porch unsupervised and was redirected by staff back into the building. Review of the elopement plan of care revealed it was revised on 08/28/12 with an intervention to accompany resident outside and supervise sitting outdoors with family and staff; however the plan of care was not revised to specify how often Resident #1 was to go outside or how exactly the facility was going to ensure he/she received routine supervised time outside to ensure Resident #1's psychosocial needs were met.</p> <p>Further review of the August 2012 activity log revealed an activity of sitting on the porch was documented on 08/28/12 (Tuesday); and, on 08/29/12 (Wednesday).</p> <p>There was no documented evidence Resident #1 had supervised time out doors sitting on the porch on 08/30/12, 08/31/12, or 09/01/12. Review of the Nurse's Notes revealed on 09/01/12 at approximately 7:30 AM, Resident #1 was left unsupervised by staff on the facility's front porch and eloped from the facility without staff knowledge and was brought back to the facility approximately twenty (20) minutes later. However, there was no documented evidence staff provided Resident #1 with supervised time out doors after this incident.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 09/12/12 at 3:15 PM, revealed Resident #1 exited the front door to the front porch at least twice on the morning of 09/03/12. However, there was no evidence the resident received supervised time out doors. Review of the Nurse's Notes revealed Resident #1 eloped from the facility on 09/03/12 between 12:02 PM and 12:05</p>	F 248			

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F 248	Continued From page 19 PM without staff knowledge.  Interview with the Activities Director, on 09/12/12 at 3:45 PM, revealed Resident #1 always enjoyed sitting out on the front porch of the facility as he/she did at home. Further interview revealed she would take him/her outside to the front porch or even on a walk around the building if she had any spare time. She stated she could see where there was not a specific intervention for Resident #1, who was an elopement risk, to ensure Resident #1 received daily time outside as weather permitted (including weekend and holidays) to ensure Resident #1's activity needs were met.  2. Review of the medical record revealed the facility admitted Resident #8 on 04/28/11, with diagnoses which included Dementia, Alzheimer's Disease, Depression, Anxiety, and Paranoid Psychosis. Review of the facility's Recreation History and Assessment form, dated 05/05/11, revealed Resident #8 enjoyed music. Review of Activity Progress Notes, dated 06/29/11, 07/11/11 and one (1) undated, revealed Resident #8 stayed in bed most of the time and was to have one to one (1:1) activities to include sensory stimuli, singing, talking and reading. Review of a Quarterly MDS Assessment, dated 07/07/12, revealed the facility assessed Resident #8 to be severely impaired with cognition skills for daily decision making, as having physical and verbal behaviors towards others, as needing extensive assistance of two (2) staff with activities of daily living to include bed mobility and locomotion and that it was important for the resident to listen to music.	F 248			

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F 248	<p>Continued From page 20</p> <p>Review of Social Services Notes, dated 08/30/12, revealed Resident #8 was transferred across the hall to another room on 08/30/12 and did not have a roommate.</p> <p>Observation, on 09/18/12 at 12:45 PM, 2:00 PM and 3:40 PM, revealed Resident #8 was in his/her bed with eyes looking at a pale yellow ceiling or pale yellow wall. Further observations revealed no pictures on the walls and no other visuals for stimuli. On 09/19/12 at 9:20 AM, Resident #8 was observed in his/her bed and as the surveyor walked in the room he/she reached both arms out and began crying. Further observation revealed Resident #8 did not have a room-mate, a television, a radio or any other auditory or visual stimuli on the walls or ceilings.</p> <p>Review of Resident #8's Activities Plan of Care, dated 09/13/12, revealed Resident #8 would participate in sensory stimuli five (5) times per week. Interventions included Resident #8 was to have 1:1 activities of music and spiritual/religious activities; however, the care plan failed to include the provision sensory activities for Resident #8, who was in bed most of the day.</p> <p>Review of Resident #8's Activities logs for 07/01/12 through 09/18/12 revealed Resident #8 participated in either a religious or music group activity an average of two (2) times per week.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #8, on 09/19/12 at 1:00 PM, revealed she had provided care to Resident #8 and remembered when Resident #8 was in the room across the hall from the current room, a television would be on most of the day with country or</p>	F 248		

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F 248	<p>Continued From page 21</p> <p>gospel music playing. She indicated Resident #8 appeared to have less anxiety while the music was playing.</p> <p>Interview with LPN #3, on 09/19/12 at 1:05 PM, revealed Resident #8 did not currently have a room-mate and had no television. She further stated she had heard no music playing in the resident's room since Resident #8 was transferred to a new room on 08/30/12, approximately three weeks ago. She stated when Resident #8 was across the hall his/her room-mate's television would play music all evening and he/she would be more calm while listening to the music. Further interview revealed the facility must have overlooked the fact that Resident #8 did not have any sensory stimuli in his/her room when he/she was moved approximately three (3) weeks earlier.</p> <p>Interview with the Activities Director, on 09/19/12 at 4:00 PM, revealed Resident #8 used to be in a room across the hall, approximately three weeks ago and that his/her room-mate would have the television with music playing at times which seemed to calm Resident #8 down. Further interview revealed she should have identified that Resident #8 did not have any sensory stimuli in his/her room, such as a radio or pictures on the wall, after the resident was transferred to a new room on 08/30/12. Continued interview revealed this would have included listening to gospel music and providing visual sensory stimuli while Resident #8 was in bed, such as having pictures placed on the wall or providing a radio in the resident's room, and play gospel music while the resident was in bed and appeared anxious.</p>	F 248		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=J	Continued From page 22 PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to have an effective system to ensure the comprehensive plan of care was reviewed and revised for one (1) of twelve (12) sampled residents (Resident #1). The facility developed the elopement plan of care, dated 06/13/12, due to the resident's exit seeking behaviors to include interventions of placing a Wander Guard on the resident and to encourage	F 280	1. Resident #1 no longer resides at the center. Medical Director notified that care plan was not updated on 9/1/12 and no new orders noted.  2. Director of Nursing, Assistant Director of Nursing, Interdisciplinary Team and/or the Regional Nurse Consultant to audit all care plans, Certified Nurse Assistant assignment sheets, and medical records to identify any changes in condition, over the past 30 days from 9/7/12 through 10/8/12, that would require care plan update that is not reflected on the care plan. Any issues identified will be immediately corrected by the Director of Nursing, Assistant Director of Nursing, Interdisciplinary Team and/or the Regional Nurse Consultant.  Director of Nursing, Assistant Director of Nursing, Interdisciplinary Team to audit all care plans and compare Certified Nursing Assistant assignment sheets to care plan to identify any Certified Nursing Assistant assignments that do not reflect the resident's current individual needs from 9/7/12 to 10/8/12. This will be completed by 10/12/12. Any issues identified will be immediately corrected.  Director of Nursing, Assistant Director of Nursing, and Education Training Director to audit all 24 hour shift reports from a period of 9/7/12 to 10/8/12 to identify anything noted on the 24 hour shift report that would require a care plan update. Any issues identified will be immediately corrected. 3. Education Training Director to re-educate all nursing staff related to reporting changes in condition, updating care plans, updating Certified Nursing Assistant assignment sheet and 24 hour shift report by 10/15/12. This will be	

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F 280	Continued From page 23 movement and exercise. On 06/25/12, the care plan was revised and indicated redirection was not effective. A new intervention was added to encourage resident to go outside with the smokers during designated smoke breaks (even though Resident #1 was not a smoker) and to give time out doors. However, the facility failed to revise the plan of care to include timetables and objectives in measurable outcomes to ensure Resident #1 received routine supervised time outside to prevent elopement.  On 09/01/12 at approximately 7:30 PM, Resident #1 was left unsupervised by staff on the facility's front porch. Approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who stated they found Resident #1 walking in the neighborhood behind the facility approximately 1000 feet from the facility's front door. The facility failed to revise Resident #1's elopement plan of care to include new interventions to prevent further elopement. On 09/03/12 between 12:02 PM and 12:05 PM Resident #1 eloped from the facility again unsupervised and was located on a sidewalk getting ready to take a step onto the roadway of the "housing projects" located behind the facility, approximately 475 feet from the facility's front door. Resident #1 was placed on one to one (1:1) staffing and sent to a psychiatric hospital for evaluation. Resident #1 was not in the facility during the survey.  Based on the above findings it was determined the facility's failure to revise the plan of care to include timetables and objectives in measurable outcomes to include new interventions to prevent further elopement was likely to cause risk for	F 280	are updated if change occurred; review 24 hour shift report to ensure any change is reflected on the care plan and that Certified Nursing Assistant assignment sheets is reflective of the care plan.  Regional Nurse Consultant to audit 10 medical records weekly for four weeks beginning week of 10/13/12; to ensure care plans are updated if change occurred; review 24 hour shift report to ensure any change is reflected on the care plan and that Certified Nursing Assistant assignment sheets is reflective of the care plan.  Assistant Director of Nursing to monitor 5 Certified Nursing Assistants providing care weekly for four weeks to ensure care plan updates reflect care needs and Certified Nursing Assistants are providing care per the plan of care.  Interdisciplinary team to review medical records with any change in physician orders for four weeks beginning 10/9/12; that any change in condition is reflected on the care plan.		

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F 280	<p>Continued From page 24</p> <p>serious injury, harm, impairment or death. The Immediate Jeopardy was identified on 09/13/12 and determined to exist on 09/01/12. The facility was notified of the Immediate Jeopardy on 09/13/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 with the facility alleging removal of the Immediate Jeopardy on 09/14/12. Immediate Jeopardy was verified to be removed on 09/14/12 prior to exiting the facility on 09/20/12 with remaining non-compliance at 42 CFR 483.20 Resident Assessment F-280, with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure care plans are revised.</p> <p>The findings include:</p> <p>Review of the policy the facility utilized as a reference titled, "Care Plans-Comprehensive", dated December 2010, revealed each resident's comprehensive care plan was designed to incorporate risk factors associated with identified problems, reflect the resident's expressed wishes regarding care and treatment goals, reflect treatment goals, timetables and objectives in measurable outcomes, identify the professional services that were responsible for each element of care. Further review of the policy revealed the IDT is responsible to ensure the care plan is revised when there is a significant change in the resident's condition and when the desired outcome is not met.</p> <p>Record review revealed the facility admitted</p>	F 280	<p>4. Quality Assurance team consisting of the administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, will meet weekly times 6 weeks with medical director to review all audit findings, make additional recommendations and revisions to the plan related to findings beginning week of 10/1/12. At the end of 6 weeks, the Quality Assurance Committee consisting of administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, to meet with medical director every two week for four weeks at the end of the ten weeks the Quality Assurance committee will meet to discuss all audit findings with the medical director to review meeting frequency and make recommendations to meet no less than monthly.</p> <p>5. Date of Compliance: 10/16/12</p>		

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F 280	<p>Continued From page 25</p> <p>Resident #1 on 06/06/12 with diagnoses which included Aortic Aneurysm, Glaucoma, and Dementia. An Admission Minimum Data Set (MDS) Assessment, dated 06/13/12, revealed the facility assessed Resident #1 as cognitively impaired with a score of 10/15 on the Brief Interview for Mental Status Exam. Review of Physician's Orders, dated 06/13/12, revealed the Physician ordered for Resident #1 to wear a Wander Guard at all times due to the resident's exit seeking behaviors. An Elopement Plan of Care was initiated on 06/13/12 to include the intervention of placing the Wander Guard on the resident and to encourage movement and exercise.</p> <p>Record review revealed during a care plan conference, dated 06/25/12, it was noted by the Power of Attorney (POA) that Resident #1 often took walks in the woods and liked sitting outside at home. On 06/25/12, the care plan was revised and a new intervention was added to encourage the resident to go outside with the smokers during designated smoke breaks (even though Resident #1 was not a smoker) and to give time out doors. Further review of the plan of care revealed there was no evidence the facility revised the plan of care to include timetables, measurable objectives, or what professional services were responsible to ensure Resident #1 received supervised time out doors.</p> <p>Review of the Nurses Notes (NN), dated 08/28/12, revealed Resident #1 exited the building three (3) times and was redirected back into the building. The plan of care was revised on that date to include supervised sitting out doors with family and staff. However, the facility failed</p>	F 280			

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F 280	<p>Continued From page 26</p> <p>to ensure the care plan was revised to include timetables, measurable objectives, or exactly what professional services were responsible to ensure Resident #1 received supervised time out doors.</p> <p>Review of NN, dated 09/01/12, revealed Resident #1 exited the facility's front door and two (2) unknown males in housing area behind the facility escorted Resident #1 back to the facility. Interview with State Registered Nursing Assistant (SRNA) #7, on 09/13/12 at 9:30 AM, revealed at approximately 7:30 PM he responded to the Wander Guard alarm sounding at the front door. SRNA #7 indicated he observed Resident #1 to sit down in a rocking chair on the front porch with unidentified visitors. SRNA #7 stated he knew Resident # 1 should not be outside on his/her own due to his/her elopement risk, but that he/she would be allowed to be outside with staff or family members per the plan of care. He indicated he left Resident #1 on the front porch with some visitors that were "someone's family members". Additional interview revealed approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who told SRNA #7 they found Resident #1 walking in the neighborhood behind the facility (approximately 1000 feet from the facility's front door).</p> <p>During an interview with Licensed Practical Nurse (LPN) #4, on 09/13/12 at 7:30 AM, she stated she had just returned from her break at approximately 8:00 PM and was told by Registered Nurse (RN) #1 that Resident #1 had "gotten out" to the "housing projects" behind the facility and was brought back to the facility by two</p>	F 280			

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F 280	<p>Continued From page 27</p> <p>(2) unknown males. She indicated RN #1 had told her to document what she was just told in NNs, but was never told by RN #1 to revise the care plan to include interventions of increased supervision. Additionally she stated she did not know it was her responsibility to revise the plan of care and thought it was the the MDS Coordinator's function.</p> <p>Interview with RN #1, on 09/13/12 at 8:10 AM, revealed she called the DON on 09/01/12 at approximately 8:00 PM and informed her that Resident #1 had opened the front door and went out on the front porch. She indicated she did not recall the incident with Resident #1 going to the "housing projects". She stated the DON had instructed her to place Resident #1 on every fifteen minute visual checks, but as far as revising the plan of care she "just didn't think about it".</p> <p>Interview with the MDS Coordinator, on 09/14/12 at 10:00 AM, revealed he developed the Comprehensive Plan of Care after the MDS was completed and revised the plan of care after Quarterly MDSs were completed. He indicated each discipline was responsible for developing and revising their own care plans related to their own discipline, such as Activities. Further interview revealed if there was a need to revise or add an intervention to any nursing plan of care it was the responsibility of the nurse who was assigned to provide care to that resident at the time of the incident.</p> <p>Interview with the DON, on 09/13/12 at 10:55 AM, revealed she received a phone call from RN #1 on 09/01/12 at approximately 8:00 PM that Resident #1 went out on the front porch</p>	F 280			

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F 280	<p>Continued From page 28</p> <p>unsupervised by staff and she had instructed RN #1 to place Resident #1 on visual checks every fifteen minutes (Q15 checks). Further interview revealed she did not know Resident #1 had eloped from the facility without staff knowledge, was gone for approximately twenty (20) minutes, and was brought back to the facility by two (2) unknown males. Additionally she stated had she known, she would have called Resident #1's Physician to obtain orders to alter treatment, such as assigning one (1) staff person to Resident #1 for constant visual checks (1:1) and requesting a Physician's order to have Resident #1 have further psychiatric evaluation.</p> <p>Interview with LPN #3, on 09/12/12 at 3:15 PM, revealed Resident #1 exited the facility through the front door at least two (2) times the morning of 09/03/12. However, the resident's level of supervision was not increased.</p> <p>Review of NN, dated 09/03/12, revealed Resident #1 exited the facility without staff's knowledge and was located on the sidewalk getting ready to take a step into the roadway of the "housing projects" located behind the facility (approximately 475 feet from the facility's front door). Further record review revealed Resident #1 was placed on 1:1 until he/she was sent to a psychiatric hospital for evaluation.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 that alleged removal of the IJ effective 09/14/12, based on the following:</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 that</p>	F 280			

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F 280	Continued From page 29 alleged removal of the IJ effective 09/14/12, based on the following:  1) All staff in all departments were Inserviced by the Assistant Director of Nursing on 09/03/12 and by the Education Director on 09/13/12 related to the following:  a. Definition of elopement, revised Elopement Management and Prevention Policies, Missing Resident Action Plan, Head Count Procedures and Care Plan Policy which were revised on 09/13/12; and approved by the QA committee consisting of Administrator, DON, Social Services Director, Activities Director, Maintenance Director, Referral Manager, Business Office Manager, Business Office Assistant and Regional Nurse. b. Alarm procedures/action which included who responds to the alarm, what to do when the alarm sounds, and level of supervision needed. c. All staff reeducated regarding the Elopement Risk Book on 09/13/12 by the Education Director/Department Manager. d. Notify the Charge Nurse immediately of missing or exit seeking resident and the Charge Nurse will immediately notify the Administrator, DON and Nurse Consultant. The Charge Nurse will update the plan of care and update staff verbally and in writing of the increased supervision on the twenty-four (24) hour shift report. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.  2) All elopement care plans were reviewed and revised on 09/13/12 by the DON, Administrator, Social Services, and Charge Nurse. All residents	F 280			

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F 280	Continued From page 30 were visualized by the DON and Education Nurse on 09/13/12 to identify mode of locomotion and staff interviews were conducted to better determine residents with elopement risk.  3) On 09/13/12, a Quality Assurance Meeting was held to discuss the steps to be taken to prevent further incidents to Resident #1 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.  4) License staff will complete the accident/incident report immediately for an elopement attempt or actual elopement and the education was completed by the Department Manager and or the Education Director by 09/14/12.  5) On 09/13/12, the DON and Administrator conducted an elopement drill to evaluate the staff response to alarms sounding.  6) Department Manager monitoring of the facility twenty four/seven (24/7) for ten days beginning 09/13/12 to include at least one random staff interview each shift to determine any resident changes as related to wander risk, monitoring and witnessing wander guard checks for function and placement, visualizing all residents, ensure staff response to door alarms, check function of all doors every shift to ensure all systems are functioning, ensure staff can complete head count properly and timely, Department Manager to complete a daily elopement drill, care plan updates, twenty four (24) hour report sheet	F 280			

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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 280	<p>Continued From page 31</p> <p>completed. Any decrease in Department Manager monitoring will be reviewed by the QA committee after ten days and then weekly for a decrease in monitoring, any issues identified and need for further education.</p> <p>7) Twenty-four/seven 24/7 front door monitoring beginning at 12 noon on 09/13/12 until door is upgraded and function is verified on 2 shifts.</p> <p>8) New employees are to be trained on the elopement system upon hire by the Education Director. The Elopement Risk Book will be reviewed during orientation of new staff. The revised elopement policies and procedures were included in the new hire orientation material beginning 09/13/12.</p> <p>9) All activity care plans reviewed/revise 09/13/12 by the Life Enrichment Director, DON, Social Services, MDS Nurse and Regional Nurse Consultant to ensure activities were in place for all residents and identified residents' individual needs.</p> <p>On 09/20/12 the State Survey Agency verified the Immediate Jeopardy was removed on 09/14/12 and the facility implemented corrective actions as alleged in the AOC, effective 09/13/12 based on the following:</p> <p>Review of facility inservice records and attendance logs, dated 09/13/12, revealed staff was educated related to the facility's revise policies and procedures for elopement to include Elopement Management and Prevention, Head Count, Missing Resident, Care Plan Policies and notifications to be made if a resident attempted to</p>	F 280			

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F 280	<p>Continued From page 32</p> <p>exited the building unsupervised. Further review of the Inservice records revealed staff received education and training related to responding to the Wander Guard alarms and procedures to be followed which included the completion of the incident report.</p> <p>Record review revealed all resident's elopement care plans had been reviewed and revised on 09/13/12.</p> <p>Review of the facilities QA meeting minutes revealed a meeting was held on 09/13/12 to implement plans of correction to remove the immediate jeopardy.</p> <p>Review of the facility's monitoring log, dated 09/13/12 through 09/19/12, revealed staff had monitored the front door 24/7 until the front door was upgraded. Observation, on 09/18/12 at 3:10 PM, revealed the front door was secured when the Wander Guard was within four (4) feet and the door would not open for fifteen (15) seconds once the bar was pushed.</p> <p>Review of the facility's elopement drill records revealed the DON and Administrator conducted an elopement drill on 09/13/12 to evaluate the staff response to alarms sounding. Further review of the elopement drill records revealed an elopement drill had been conducted daily at varying times and shifts from 09/13/12 through 09/18/12. Observation, on 09/19/12 at 10:15 AM, revealed an elopement drill was conducted by the Administrator. Further observation revealed staff immediately responded to the alarm by a nurse at the nurse's station going to the front door, dietary staff going out the side door and</p>	F 280			

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F 280	<p>Continued From page 33</p> <p>housekeeping going out the back doors and checking the facility property, SRNA's, LPN's and activities doing a head count and checking behind doors and all areas of the facility until the Maintenance Director (who was placed behind a door in a bathroom as a resident) was located.</p> <p>interview with the Dietary Manager on 09/19/12 at 1:30 PM, Maintenance Director at 2:15 PM, Assistant Director of Nursing at 3:45 PM and on 09/20/12 at 11:00 AM with the Director of Nursing and the Administrator revealed they had been assigned rotating shifts to include visualizing all residents, ensure staff response to door alarms, care plans were updated, twenty four (24) hour report sheet completed and notifications made.</p> <p>Observation, on 09/18/12 from 04:00 PM until 4:30 PM, revealed there were Elopement Risk Books on both the nursing units including the East and West Nurse's Station, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>interviews with staff including RN #4 on 09/19/12 at 12:55 PM, SRNA #8 at 1:00 PM, LPN #3 at 1:05 PM, LPN #6 at 1:15 PM, Dietary Manager at 1:30 PM, SRNA #9 at 1:45 PM, Housekeeper #2 at 2:00 PM, RN #1 at 2:25 PM, LPN #7 at 2:35 PM, LPN #8 at 2:45 PM, LPN #1 at 2:55 PM, SRNA #10 at 3:00 PM, SRNA # 11 at 3:10 PM, and Physical Therapy aide at 3:20 PM, revealed they had received inservice education and were aware of what an elopement was, the Elopement Risk Book and the elopement policy and procedure to include providing staff supervision as well appropriate notifications to be made if a resident attempted to leave the facility</p>	F 280		
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F 280	<p>Continued From page 34</p> <p>unsupervised, including notifying the physician. They were also aware of the procedure in responding to the door alarm to include searching inside and outside the facility.</p> <p>Record review revealed the Activities Director, Social Worker, DON and Regional Nurse Consultant reviewed and revised the activity assessments and activities care plans for all elopement risk residents by 09/13/12. Interview with the DON, Regional Nurse Consultant and Activities Director, on 09/20/12 at 9:20 AM, revealed they met as a group on 09/13/12 and reviewed and revised care plans and activities assessments of residents at risk for elopement to ensure those residents received routine time outside to meet their needs. Further interview revealed all residents care plans and activity assessments were being reviewed and revised. Further interview with the Administrator revealed the current Activities Director would become an Activities Assistant when the Dietary Manager completed the training course approved by the state.</p> <p>Interview, on 09/19/12 at 3:25 PM, with the Education Director, revealed she had assisted with the changes in the new elopement policies and the policies would be reviewed with each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice. Review of the facility's revised orientation packet revealed orientation included review of the facility's revised elopement policies and procedures.</p>	F 280			

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F 280	Continued From page 35 Interview with the Administrator, DON and Regional Nurse and review of the new Elopement Management and Prevention Policies, on 09/20/12 at 11:00 AM, revealed the policies were updated 09/13/12 to include staff supervision of residents at elopement risk, reviewing and revising individualized care plan interventions to prevent elopement (such as enhanced recreational activities), responding to wander guard alarms, completing incident reports, and notifications to be made when a resident attempts to leave the facility unsupervised, to include notifying the physician.  The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC).	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies it was determined the facility failed to ensure care plan interventions were implemented for one (1) of twelve (12) sampled residents (Resident #8). The facility had developed an Activity Care Plan	F 282	F282  1. Resident #1 no longer resides at the center. Resident #8 activities assessment and care plan was revised on 10/4/12 by Activities Director. Medical Director was made aware of activity care plan and assessment revision by Director of Nursing on 10/5/12. No new orders noted. A new Life Enrichment Director has been appointed and educated by Regional Nurse Consultant regarding how to complete activity assessments, when to complete activity assessments, when to complete the activity care plan, how to revise the care plan as well as completion of activity calendar on 9/26/12.	

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F 282	Continued From page 36 for Resident #8 which stated the resident was to have sensory stimuli five (5) times per week with interventions that included music and religious activities. However, the facility failed to ensure implementation of this intervention.  The findings include:  Review of the policy the facility utilized as a reference titled, "Care Plans-Comprehensive", dated December 2010, revealed each resident's comprehensive care plan was designed to incorporate risk factors associated with identified problems, reflect the resident's expressed wishes regarding care and treatment goals, reflect treatment goals, timetables and objectives in measurable outcomes. Additional review of the policy revealed the care plan was designed as an aid in preventing or reducing decline in the resident's functional status and/or functional levels.  Review of the medical record revealed the facility admitted Resident #8, on 04/28/11, with diagnoses which included Dementia, Alzheimer's Disease, Depression, Anxiety, and Paranoid Psychosis. Review of a Quarterly MDS Assessment, dated 07/07/12, revealed the facility assessed Resident #8 to be severely impaired with cognition skills for daily decision making, as needing extensive assistance of two (2) staff with activities of daily living to include bed mobility and locomotion and Resident #8 enjoyed listening to music. Review of Activity Progress notes, dated 06/29/11, 07/11/11 and one undated, revealed Resident #8 stayed in bed most of the time and was to have one to one (1:1) activities to include sensory stimuli, singing, talking and reading.	F 282	2. All activity care plans and activity assessments were reviewed by the Life Enrichment Director to identify any activity assessment and/or activity care plan that did not meet individual resident needs on 10/11/12. All activity care plans and activity assessments will be revised and residents reassessed to ensure that individual resident needs, preferences and choices are met.  3. Regional Nurse Consultant to re-educate Life Enrichment Director by 10/4/12, regarding how to complete activity assessments, how often to complete activity assessments, when and how to complete and update activity plan of care and development.  Education Training Director to re-educate all nursing, activity and administrative staff by 10/9/12 regarding activity assessments, how often to complete, when to complete and update; how often to update all care plans, with focus on activity care plans and that assessments and care plans must be individualized and implemented.  Assistant Director of Nursing and Director of Nursing will audit all new admits within 72 hours after admission to ensure the activity assessment and care plan are completed and that the plan of care is followed and developed according to the assessment; beginning week of 10/12/12 for 8 weeks.  Director of Nursing and Administrator will monitor and supervise that all activities are occurring on the calendar, five times a week for 4 weeks beginning week of 10/9/12; and monitor at least 5 residents 5 times a week to ensure activity plan of care is followed and individualized according to the assessment and is evaluated regularly.		

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F 282	Continued From page 37  Review of Resident #8's Activities Plan of Care, dated 09/13/12, revealed Resident #8 would participate in sensory stimuli five (5) times per week. Interventions included music and spiritual/religious activities. Interventions included Resident #8 was to have 1:1 activities of music and spiritual/religious activities. However, review of Resident #8's Activities logs for 07/01/12 through 09/18/12 revealed Resident #8 participated in either a religious or music group activity an average of two (2) times per week, not five (5) times per week per the plan of care.  Observations, on 09/18/12 at 12:45 PM, 2:00 PM and 3:40 PM and on 09/19/12 at 9:20 AM, revealed Resident #8 was in his/her bed with eyes looking at a pale yellow ceiling or pale yellow wall with no pictures or any other visual or auditory sensory stimuli. Further observation revealed Resident #8 did not have a room-mate and no visual or auditory sensory stimuli was available for the resident, such as pictures on the wall, a television or radio in the resident's room.  Interview with the Activities Director (AD), on 09/19/12 at 4:00 PM, revealed she would go in to the resident's room and sing to the resident. However, there was no documented evidence this was being done routinely per the plan of care. Further interview revealed specific sensory stimuli for Resident #8 would include audio and visual stimuli, such as having pictures on the wall or placing a radio in the resident's room to meet Resident #8's activity needs. However, observations revealed this had not been provided for the resident.	F 282	Regional Nurse Consultant to monitor at least 3 activities monthly to ensure schedule is followed and that in room one to one residents are receiving activities that correlate with their assessment. This is to begin 10/12/12.  Regional Nurse Consultant to monitor at least 3 new admits monthly beginning 10/12/12 to ensure that activity assessment is in place within 72 hours; assessment is individualized and that the pan of care is in place and being followed.  4. Quality Assurance team consisting of the administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, will meet weekly times 6 weeks with medical director to review all audit findings, make additional recommendations and revisions to the plan related to findings beginning week of 10/1/12. At the end of 6 weeks, the Quality Assurance Committee consisting of administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, to meet with medical director every two week for four weeks at the end of the ten weeks the Quality Assurance committee will meet to discuss all audit findings with the medical director to review meeting frequency and make recommendations to meet no less than monthly.  5. Date of Compliance: 10/16/12		
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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F 323 SS=J	Continued From page 38 <b>HAZARDS/SUPERVISION/DEVICES</b>  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policies, it was determined the facility failed to have an effective system in place to provide adequate supervision and monitoring to prevent accidents for one (1) of twelve (12) sampled residents (Resident #1). The facility failed to ensure policy and procedures were implement for monitoring residents to ensure safety. In addition, the facility failed to ensure staff was trained and knowledgeable on how to adequately monitor and supervise residents at risk for elopement.  The facility assessed Resident #1 as being at risk for elopement and with a history of leaving the building unsupervised. On 09/01/12, Resident #1 was left unsupervised by staff on the facility's front porch at 7:30 PM. Approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who stated they found Resident #1 walking in the neighborhood behind the facility approximately 1000 feet from the facility's front door. The facility failed to notify the Director of Nursing (DON) of	F 323	F323  1. Resident #1 no longer resides in the center. Medical Director was made aware of resident 9/1/12 out of center on 9/12/12 by the Director of Nursing. No new orders noted.  2. All elopement care plans were reviewed by the Director of Nursing, Administrator, Regional Nurse Consultant, and Assistant Director of Nursing to identify any resident who was considered exit seeking that was not identified as exit seeking on 9/13/12. All residents were visualized by the Director of Nursing and Education Training Director to identify their mode of ambulation/transfer and locomotion on and off the unit; and random staff consisting of housekeeping, dietary, Certified Nursing Assistants, licensed nurses were interviewed by the Regional Nurse Consultant, Director of Nursing or Activity Director to better determine elopement risk on 9/13/12.  Any issues were immediately corrected by the Regional Nurse Consultant, Director of Nursing, or the Administrator on 9/13/12.  A one time audit was completed by the Regional Nurse Consultant, Director of Nursing, Assistant Director of Nursing and the Education Training Director on 10/10/12 of care plans and Certified Nursing Assistant assignment sheets; to identify any care plans not followed and to identify if Certified Nursing Assistant assignment sheet was reflective of care plan. Any issues were immediately corrected.	

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F 323	<p>Continued From page 39</p> <p>the incident per facility policy and failed to notify Resident #1's Physician of the incident in order to assess the need to alter treatment for Resident #1 to prevent further elopement. In addition, the facility failed to revise the plan of care to prevent further elopement. On 09/03/12, sometime between 12:02 PM and 12:05 PM Resident #1 eloped from the facility unsupervised and was located on a sidewalk getting ready to take a step on to the roadway of the "housing projects" located behind the facility, approximately 475 feet from the facility's front door. Resident #1 was placed on one to one (1:1) staffing and later sent to a psychiatric hospital for further evaluation. Resident #1 was not in the facility during the survey.</p> <p>Based on the above findings it was determined the facility's failure to ensure adequate supervision and monitoring was provided to prevent elopement was likely to cause risk for serious injury, harm, impairment or death. The Immediate Jeopardy (IJ) was identified on 09/13/12 and determined to exist on 09/01/12. The facility was notified of the Immediate Jeopardy on 09/13/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 with the facility alleging removal of the Immediate Jeopardy on 09/14/12. Immediate Jeopardy was verified to be removed on 09/14/12 prior to exiting the facility on 09/20/12 with remaining non-compliance at 42 CFR 483.25 Quality of Care F-323 Accidents and Supervision with a scope and severity of an "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to</p>	F 323	<p>A one time audit was conducted of all residents with Wanderguards was completed by the Director of Nursing and Assistant Director of Nursing on 10/12/12 to identify that all wanderguards were in place per order to prevent elopement. No issues were identified.</p> <p>All accident and incidents were reviewed by the Director of Nursing, Assistant Director of Nursing, and/or the Regional Nurse Consultant for a 30 day look back period (9/12/12—10/12/12) to identify any resident who fell and/or had an injury related to lack of supervision. This will be completed by 10/15/12. Any issues will be immediately corrected by the Regional Nurse Consultant, Director of Nursing or the Assistant Director of Nursing.</p> <p>3. Regional Nurse Consultant, Director of Nursing or Assistant Director of Nursing to audit all new admissions immediately to ensure elopement risk is assessed and if identified that a plan of care is immediately initiated; that staff are made aware; that the wanderguard is placed; the TAR is reflective of the use of wanderguard and that physician and family are notified and the 24 hour shift report is updated immediately.</p> <p>Director of Nursing, Social Services Director, Assistant Director of Nursing and/or Education Training Director to interview at least 5 staff members each week for 4 weeks beginning week of 10/10/12 to identify if any resident has been voicing exit seeking and exhibiting exit seeking behavior that has not been previously identified.</p>		

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F 323	Continued From page 40 monitor to ensure appropriate measures are put into place to provide adequate supervision to prevent accidents.  The findings include:  Review of the policy the facility utilized as a reference titled, "Wandering, Unsafe Resident", revised December 2007, revealed staff would identify residents at risk for harm because of unsafe wandering, including elopement. Further review of the policy revealed interventions to maintain safety would be included in the resident's care plan, nursing would document circumstances related to unsafe actions, staff would initiate a detailed monitoring plan, and notify the Administrator and Director of Nursing (DON) immediately and institute appropriate measures when a resident was discovered missing from the facility.  Review of the policy the facility utilized as a reference titled, "Elopements", revised December 2008, revealed staff should promptly report any resident who tried to leave the premises to the DON. Further review of the policy revealed when a departing resident returned to the facility the DON or Charge Nurse should examine the resident for injuries, notify the Physician, complete and incident/accident report, and document relevant information in the resident's medical record.  Review of the medical record revealed the facility admitted Resident #1 on 06/06/12, with diagnoses which included Aortic Aneurysm, Glaucoma, and Dementia. Review of an Admission Minimum Data Set (MDS)	F 323	All accident and incident reports will be reviewed by the Director of Nursing, Assistant Director of Nursing or Regional Nurse Consultant when accident or incident occurs either by home or in person to ensure root cause is established, immediate interventions are initiated and the plan of care was followed. This will begin week of 10/12/12 for 4 weeks then as recommended by the Quality Assurance Team.  Administrator, Director of Nursing, and Maintenance Director to complete a safety review of the center every week beginning 10/12/12 for 4 weeks to ensure any safety issues are addressed immediately. This will begin 10/12/12 for 4 weeks then as recommended by the Quality Assurance Team.  Department Managers will compare Certified Nursing Assistant assignment sheets to resident 5 times a week to ensure all safety devices are in place and on the Certified Nursing Assistant assignment sheet. This will begin 10/12/12 and then as recommended by the Quality Assurance Team.  Regional Nurse Consultant to audit 5 accident and incident reports weekly and 5 Certified Nursing Assistant assignment sheets to care plans weekly for 4 weeks to ensure all safety devices are in place and that residents are supervised to prevent accidents and incidents. This will begin week of 10/15/12 then as recommended by the Quality Assurance Team.		

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F 323	<p>Continued From page 41</p> <p>Assessment, dated 06/13/12, revealed the facility assessed Resident #1 to have a Brief Interview of Mental Status (BIMS) score of ten (10) out of fifteen (10/15), indicating Resident #1 was moderately impaired in cognition.</p> <p>Review of Interdisciplinary Team (IDT) Notes, dated 06/13/12, revealed Resident #1 had exit seeking behaviors due to the desire to return home. Review of Physician's Orders, dated 06/13/12, revealed the Physician ordered for Resident #1 to wear a Wander Guard at all times (an assistive device which alarms at the exit doors to alert staff when residents attempt to leave the facility unsupervised).</p> <p>Review of Resident #1's Comprehensive Plan of Care related to elopement, dated 06/13/12, revealed Resident #1 expressed the desire to leave, desire to return home and was independently mobile. Interventions for the elopement plan of care included to initiate "Wander Alert System", place resident information in the elopement risk book and encourage movement and exercise. Review of an Activities Plan of Care, dated 06/13/12, noted that sitting on the porch was one of Resident #1's favorite activities and interventions included to encourage participation of activities of interest during stay.</p> <p>Interview with the Activities Director, on 09/12/12 at 3:45 PM, revealed Resident #1 had frequently expressed the desire to go home and had a history of going out the front door unsupervised and sitting on the porch. She indicated whichever staff responded to the alarm would go outside and sit with him/her on the porch, but if staff didn't</p>	F 323	<p>In-Service training: content, staff attending, implementation: All staff being re-educated on 9/3/12 by ADON and on 9/13/12 by Education Director regarding the following: Elopement—definition Alarm procedures/action which includes the following: who responds to the alarm, exactly what to do when the alarm is checked by doing the following: All staff in center should respond at time the alarm sounds(housekeeping, dietary, Maintenance Department, nursing, Social Services, Activities and administrative staff) and search immediate environment surrounding which door alarm is sounding, if the resident who attempted exit is not identified staff should go outside and look in the immediate vicinity of the door that is sounding. If unable to find a resident then the Head Count policy would be immediately started. Level of supervision need was defined to ensure staff were able to identify residents at increased risk and as defined by the care plan. Missing resident action plan procedure (provides detailed step-by-step instructions for staff when a resident has exited.)See attachment Missing resident code (Code Wayne Pink is the code that alerts staff that a resident needs to be located).</p>	

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F 323	<p>Continued From page 42</p> <p>have time to sit with him/her, they would re-direct him/her back into the facility. Additional interview revealed she would take Resident #1 outside including going for walks on the facility property if she had "spare time". She stated she had developed the activity plan of care and indicated she had not specified when Resident #1 should go outside.</p> <p>Review of Resident #1's medical record revealed a care plan conference was held on 06/25/12 with Resident #1's Power of Attorney (POA) and at that time the POA told the facility that Resident #1 often took walks in the woods and liked sitting outside at home. On 06/25/12, the care plan was revised and a new intervention was added to encourage the resident to go outside with the smokers during designated smoke breaks (even though Resident #1 was not a smoker) and to give time out doors.</p> <p>Nurses Notes, dated 07/23/12, revealed Resident #1 continued to exit the facility's front door and sit on the rocking chair. Review of Physician's Orders, dated 07/23/12, revealed Resident #1 was to be sent to a psychiatric facility for a psychiatric evaluation. Resident #1 returned to the facility on 07/30/12 with new care plan interventions which included Resident #1 was to have Physical Therapy (PT). Review of PT notes revealed Resident #1 received PT from 07/30/12 through 08/24/12.</p> <p>Interview with Physical Therapy Assistant #1, on 09/12/12 at 2:30 PM, revealed Resident #1 would be taken outside for walks when the weather was nice as part of his/her therapy.</p>	F 323	<p>Head count procedures. See attachment</p> <p>Who to be notified of missing or exit seeking resident (any staff member can identify and report an exit seeking resident to the charge nurse who should immediately provide increased supervision and may assign another staff member to monitor, based on assessment a wander guard and increased staff supervision may be provided. At any time a resident is actively exit seeking after the resident is supervised the charge nurse should notify the Administrator, DON and/or the Nurse Consultant. The charge nurse will update the plan of care and update staff in writing and verbally of the increased supervision and then place this information on the 24 hour shift report. All elopement care plans reviewed/revised 9/13/12 by the DON, Administrator, Social Services, charge nurses, housekeeping, dietary department and Certified Nursing Assistants through interview. All residents were visualized by the DON and the Education Nurse to identify their individual mode of ambulation/transfer and locomotion on and off the unit, random staff consisting of housekeeping, dietary and nursing department staff were interviewed by the Regional Nurse Consultant, DON and/or the Dietary Manager regarding any resident that was exit seeking, making verbal statements about "leaving" and each residents locomotion on and off unit to better determine elopement risk. Presently the center has identified seven residents at risk and all identified have a care plan which indicates their risk, level of supervision and who resident can go "out with". Staff reeducate regarding.</p>		

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F 323	<p>Continued From page 43</p> <p>Review of NN, dated 08/28/12, revealed three (3) days after PT was discontinued, Resident #1 exited the building three (3) times to the facility's front porch unsupervised and was redirected by staff back into the building. Review of the elopement plan of care revealed it was revised on 08/28/12 with an intervention to accompany resident outside and supervise sitting outdoors with family and staff.</p> <p>Review of NN, dated 09/01/12, revealed Resident #1 exited the facility's front door and two (2) unknown males in housing area behind the facility escorted Resident #1 back to the facility. Interview with State Registered Nursing Assistant (SRNA) #7, on 09/13/12 at 9:30 AM, revealed at approximately 7:30 PM he responded to the Wander Guard alarm sounding at the front door. SRNA #7 indicated he observed Resident #1 to sit down in a rocking chair on the front porch with unidentified visitors. SRNA #7 stated he knew Resident #1 should not be outside on his/her own due to his/her elopement risk, but that he/she would be allowed to be outside with staff or family members per the plan of care. He indicated he left Resident #1 on the front porch with some visitors that were "someone's family members". Additional interview revealed approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who told SRNA #7 they found Resident #1 walking in the neighborhood behind the facility (approximately 1000 feet from the facility's front door).</p> <p>During an interview with Licensed Practical Nurse (LPN) #4, on 09/13/12 at 7:30 AM, she stated she had returned from her break at approximately</p>	F 323	<p>All activity care plans reviewed/revised 9/13/12 by the Life Enrichment Director, DON, Social Services, MDS nurse and Regional Nurse Consultant to ensure activities where in place for all residents and identified residents' individual need.</p> <p>Re-education for all staff with written competency to ensure all staff is aware of changes regarding the following: How often to check the wander guards for placement, function and expiration and where to locate this information. (All TARS checked by the DON on 9/13/2012 to identify that all residents with wander guards and identified as wander risks were noted on the TAR, that there was instruction on checking the wanderguard, the expiration and to ensure staff were documenting this. Staff educated on doing wander guard checks and how often.) Where wander guard risk residents are identified and where information is kept (all residents at risk are photographed and identifying information is recorded to ensure resident could be identified if missing.)</p> <p>Presently all wander guards being checked for placement and function by the Department Manager on Duty each shift and the licensed nurse and documented on the Department Manager Form (24/7 form) to ensure licensed nurse competency. Beginning 9/23/2012 this will be placed on the TAR for the licensed nurse to do and this is a system change.</p> <p>All staff made aware of care plan policy which includes who updates and to record any update on the 24 hour shift report.</p>		

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F 323 Continued From page 44

8:00 PM and was informed by Registered Nurse (RN) #1 that Resident #1 had "gotten out" to the "housing projects" behind the facility and was brought back to the facility by two (2) unknown males. She indicated RN #1 instructed her to document the incident in NNs.

Interview with RN #1, on 09/13/12 at 8:10 AM, revealed she called the DON on 09/01/12 at approximately 8:00 PM and informed her that Resident #1 had opened the front door and went out on the front porch. She indicated she did not recall the incident with Resident #1 going to the "housing projects". She stated the DON had instructed her to place Resident #1 on every fifteen (15) minute visual checks, but as far as revising the plan of care she "just didn't think about it".

Interview with the DON, on 09/13/12 at 10:55 AM, revealed she received a phone call from RN #1 on 09/01/12 at approximately 8:00 PM that Resident #1 went out on the front porch unsupervised by staff and she had instructed RN #1 to place Resident #1 on visual checks every fifteen minutes (Q15 checks). Further interview revealed if she had been informed Resident #1 had eloped from the facility for approximately twenty (20) minutes and was brought back to the facility by two (2) unknown males, she would have informed staff to conduct a head to toe skin assessment of Resident #1, have staff complete an Accident/Incident report for further investigation, and notified Resident #1's Physician per the facility's wander and elopement policies.

Review of NN, dated 09/03/12 with a clarification NN dated 09/04/12, revealed Resident #1 had

F 323 QA Team met to review findings 9/13/12 which included all education provided, 24/7 Department Manager monitoring and what it consists of, all changed policies (elopement, head count, missing resident action plan, elopement prevention plan, care plan policies, 24/7 door monitoring until front door upgraded, the definition of elopement which includes that elopement can occur inside or outside the center. 24/7 Department Manager monitoring X 10 days; beginning 9/13/12

At least one random staff interviewed each shift to determine any resident changes as relates to wander risk.

Monitoring and witness wander guard checks for function and placement.

Visualization of all residents

Ensure staff response to door alarms

Check function of all doors every shift to ensure all systems are functioning.

Ensure staff can complete head count properly and timely.

Department Manager to complete a daily elopement drill.

Ensure care plan updates and 24 hour report sheet updates.

Any decrease in Department Manager monitoring will be reviewed by the QA committee after day 10 and then weekly for a decrease in monitoring, any issues identified and need for further education.

24/7 Front door monitoring by the staff until door is upgraded beginning 12 noon 9/13/12 until door is upgraded and function is verified on 2 shifts. Door to be verified as functional 2 times a shift by a Department Manager for 5 days to ensure function.

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F 323	<p>Continued From page 45</p> <p>been visualized at 11:55 AM by staff during the every fifteen (15) minute checks. Further review of NN revealed staff had heard the alarm sounding, went to the exit door and did not visualize any residents. Continued review of NN revealed the alarm was silenced and at 12:10 PM a housekeeper informed a nurse that Resident #1 was outside ambulating to the apartments behind the facility. Additional review of NN revealed the Assistant Director of Nursing (ADON) left the facility and escorted Resident #1 back to the facility. The NN revealed the Physician and POA were notified, Resident #1 was placed on 1:1 staffing, and was later transferred to a psychiatric hospital for evaluation.</p> <p>Interview with LPN #3, on 09/12/12 at 3:15 PM, revealed Resident #1 exited the front door and got out onto the porch at least twice on the morning of 09/03/12. She stated that morning Resident #1 seemed more anxious and stated to her that he/she wanted to go out and find a "woman" to live with. She indicated one time when she responded to the alarm sounding at the front door, Resident #1 stated he/she was just outside "checking the weather." She stated she was on lunch break when Resident #1 eloped from the facility and that RN #1 was assigned to do the every fifteen (15) minute checks at that time. LPN #3 stated Resident #1 was already on every fifteen (15) minute checks and she didn't think about calling the DON or placing Resident #1 on 1:1 prior to Resident #1 exiting the facility and getting off the property around lunch time. She stated she was not aware of Resident #1's elopement that had occurred two (2) days earlier, on 09/01/12.</p>	F 323	<p>Elopement, head count, missing resident action plan, Elopement Prevention Plan and Care plan policy reviewed and revised on 9/13/12; and approved by QA committee consisting of Administrator, Director of Nurses, Social Services Director, Activities Director, Maintenance Director, Referral Manager, Business office Manager, Business Office Assistant and the Regional Nurse.</p> <p>All staff re educated that residents going outside with family must be signed out and signed in when returned and what adequate supervision of any resident at increased risk for monitoring is (their family versus any family). All staff also re educated regarding abuse and neglect policy by the Education Director beginning 9/13/2012</p> <p>All licensed nurses re educated by the Education Training Director and /or Regional Nurse Consultant, Director of Nursing, Administrator and or Department Manager that all changes and care plan updates will be documented on the 24 hour shift report.</p> <p>All staff reeducated regarding elopement risk book by the Education Director/Department Manager.</p> <p>Licensed staff will complete the accident/incident report immediately for an elopement attempt or actual elopement and this re education was completed by the Department Manager and /or the Education Director by 9/14/2012</p> <p>Elopement Drill conducted 9/13/12 by the DON/Administrator at 7:30pm to ensure staff compliance to education and evaluate any issue. No issues identified.</p> <p>All new hires will be educated regarding this abatement plan and all policies regarding elopement including elopement definition, alarms, what they mean, how to respond, where</p>	

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F 323 Continued From page 46  
During an interview with RN #1, on 09/10/12 at 2:10 PM, she stated she was aware Resident #1 had more attempts to exit the building by constantly opening the front door and sometimes getting out on the front porch before staff could get to him/her because he/she was "very fast". Additional interview revealed Resident #1 had expressed to her that he/she was looking for a woman. Further interview revealed she had last seen Resident #1 at approximately 11:55 AM sitting in the lobby by the front door. She stated she heard the alarm sounding at approximately 12:05 PM while she was in another resident's room providing a treatment. She indicated that by the time she finished giving her treatment and came out into the hall, she was informed by staff that Resident #1 had eloped and was found by the ADON in the "housing projects" behind the building. RN #1 stated she was not aware that Resident #1 had eloped from the facility on 09/01/12 and was only aware he/she had exited the front door and was on the front porch.

Observations, on 09/12/12 between from 10:30 AM until 10:55 AM, with the Maintenance Director revealed there were four (4) exit doors from the facility. Further observation revealed if a Wander Guard was within four (4) feet of each of the four doors, an alarm would sound for that door. Continued observation revealed while the alarm was sounding an individual could push on the bar to open the door and the door would open after a fifteen second delay for three (3) of the four (4) exit doors which included the door on the side of the building next to the kitchen and the two doors in the back of the facility. However, observation of the front door revealed there was not a fifteen second delay when an individual pushed the bar

F 323 wander risk book is located, reporting a resident that is exit seeking and or verbally saying or displaying exit seeking behaviors what is the wander guard, how doors function how to use C.N A care plan, where on the C.N A care plan the wander risk is located, definition and examples of abuse and neglect, head count policy, elopement risk policy, elopement prevention policy, care plan policy, missing resident action plan and how residents are supervised and that family supervision and means "their family".  
Beginning immediately on 9/13 2012 no staff could work until re educated regarding this entire abatement plan.  
Medical Director notified by the Administrator on 9/13/2012 of abatement plan and will be reviewed with medical director at least weekly beginning 9/13/2012.  
Quality Assurance Team will review, revise and evaluate all audits associated with each deficiency cited at least weekly for 6 weeks with the Regional Director of Operations and/or the Regional Nurse Consultant beginning 10/4/12. Quality Assurance meetings will be reduced only with recommendation of the Quality Assurance team and the Regional Director of Operations and/or the Regional Nurse Consultant approval and then will be on-going no less than monthly per policy.

All audits will be in writing to verify completion and Regional Director of Operations and/or Regional Nurse Consultant will review all audits to assist administrator in identification of change that may require policy revision and/or development. This will begin 10/1/12 and continue until the Quality Assurance Team, Medical Director and/or Regional Director of Operations and/or Regional Nurse Consultant make recommendations to decrease.

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F 323	Continued From page 47 to get out, allowing an individual to immediately open the door.  Observation, on 09/13/12 at 1:55 PM, of a reenactment of what LPN #2 did around noon on 09/03/12 and Interview with LPN #2 revealed she heard the front door alarm sounding at 12:00 PM as she was beginning her medication pass. Further observation and Interview revealed she pushed her medication cart against the wall, locked the medication cart, walked through the front lobby where no one else was and opened the front door which took thirty (30) seconds. She then went through the front door and half way down the front side walk, looked to the left and to the right which took an additional fifteen (15) seconds. Additional interview revealed as she was coming back into the facility and was going to initiate a head count to see if all residents were accounted for, she was informed by an SRNA that the ADON went out to get Resident #1 from the "housing projects" behind the building.  Interview with Housekeeper #1, on 09/12/12 at 11:50 AM, revealed she had clocked out at the time machine, located next to the front lobby, at 12:02 PM. She stated she had not heard an alarm sounding prior to clocking out. Further interview revealed she walked to the back of the building, went out the back door and as she was getting in her daughter's car her daughter described Resident #1 and asked her if he/she was a resident because she had seen him/her walk down the side road of the facility towards the housing area behind the facility. Additional interview revealed she went back to the back door and began "pounding" on the door until she got the attention of an SRNA who called to the	F 323	4. Quality Assurance team consisting of the administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, will meet weekly times 6 weeks with medical director to review all audit findings, make additional recommendations and revisions to the plan related to findings beginning week of 10/1/12. At the end of 6 weeks, the Quality Assurance Committee consisting of administrator, director of nursing, assistant director of nursing, clinical reimbursement coordinator, social services director, dietary and activity director, business office manager, to meet with medical director every two week for four weeks at the end of the ten weeks the Quality Assurance committee will meet to discuss all audit findings with the medical director to review meeting frequency and make recommendations to meet no less than monthly.  5. Date of Compliance: 10/16/12	
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F 323	<p>Continued From page 48</p> <p>ADON that Resident #1 was up the grassy Incline in between two houses.</p> <p>An interview with the ADON on 09/14/12 at 1:25 PM, revealed she went outside and got Resident #1 on 09/03/12 after SRNA #4 had called out down the hall that Housekeeper #1 had knocked on the back door reporting Resident #1 was out. The ADON went on to reveal a head count was conducted to ensure no other residents were unaccounted for, Resident #1 was assessed, and he/she was placed on 1:1 supervision until he/she could be sent out for a psychiatric evaluation. The ADON revealed she was unaware Resident #1 had eloped from the facility on 09/01/12 and was unaware he/she was on fifteen (15) minute checks.</p> <p>Interview with Resident #1's Physician, on 09/19/12 at 11:30 AM, revealed Resident #1 was a high risk for elopement with a history of elopement and the facility was responsible for ensuring Resident #1 was adequately supervised to prevent elopement. Continued interview revealed he was not notified Resident #1 had eloped from the facility on 09/01/12. Further Interview revealed leaving Resident #1 on the front porch with some unknown visitors was not fair to the visitors because it put the responsibility on them when it should be the responsibility of facility staff. Additional interview revealed if he had been made aware of the elopement on 09/01/12 he would have instructed the facility to place Resident #1 on 1:1 staffing and ordered for Resident #1 be sent to a psychiatric hospital for evaluation and then there possibly wouldn't have been the elopement on 09/03/12.</p>				

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The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 that alleged removal of the IJ effective 09/14/12, based on the following:

1) All staff in all departments were inserviced by the Asslstant Director of Nursing on 09/03/12 and by the Education Director on 09/13/12 related to the following:

a. Definition of elopement, revised Elopement Management and Prevention Policies, Missing Resident Action Plan, Head Count Procedures and Care Plan Policy which were revised on 09/13/12; and approved by the QA committee consisting of Administrator, DON, Social Services Director, Activities Director, Maintenance Director, Referral Manager, Business Office Manager, Business Office Assistant and Regional Nurse.

b. Alarm procedures/action which included who responds to the alarm, what to do when the alarm sounds, and level of supervision needed.

c. All staff reeducated regarding the Elopement Risk Book on 09/13/12 by the Education Director/Department Manager.

d. Notify the Charge Nurse immediately of missing or exit seeking resident and the Charge Nurse will immediately notify the Administrator, DON and Nurse Consultant. The Charge Nurse will update the plan of care and update staff verbally and in writing of the increased supervision on the twenty-four (24) hour shift report. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.

2) All elopement care plans were reviewed and

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F 323	Continued From page 50 revised on 09/13/12 by the DON, Administrator, Social Services, and Charge Nurse. All residents were visualized by the DON and Education Nurse on 09/13/12 to identify mode of locomotion and staff interviews were conducted to better determine residents with elopement risk.  3) On 09/13/12, a Quality Assurance Meeting was held to discuss the steps to be taken to prevent further incidents to Resident #1 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.  4) License staff will complete the accident/incident report immediately for an elopement attempt or actual elopement and the education was completed by the Department Manager and or the Education Director by 09/14/12.  5) On 09/13/12, the DON and Administrator conducted an elopement drill to evaluate the staff response to alarms sounding.  6) Department Manager monitoring of the facility twenty four/seven (24/7) for ten days beginning 09/13/12 to include at least one random staff interview each shift to determine any resident changes as related to wander risk, monitoring and witnessing wander guard checks for function and placement, visualizing all residents, ensure staff response to door alarms, check function of all doors every shift to ensure all systems are functioning, ensure staff can complete head count properly and timely, Department Manager	F 323			

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F 323	<p>Continued From page 51</p> <p>to complete a daily elopement drill, care plan updates, twenty four (24) hour report sheet completed. Any decrease in Department Manager monitoring will be reviewed by the QA committee after ten days and then weekly for a decrease in monitoring, any issues identified and need for further education.</p> <p>7) Twenty-four/seven 24/7 front door monitoring beginning at 12 noon on 09/13/12 until door is upgraded and function is verified on 2 shifts.</p> <p>8) New employees are to be trained on the elopement system upon hire by the Education Director. The Elopement Risk Book will be reviewed during orientation of new staff. The revised elopement policies and procedures were included in the new hire orientation material beginning 09/13/12.</p> <p>9) All activity care plans reviewed/revised 09/13/12 by the Life Enrichment Director, DON, Social Services, MDS Nurse and Regional Nurse Consultant to ensure activities were in place for all residents and identified residents' individual needs.</p> <p>On 09/20/12 the State Survey Agency verified the Immediate Jeopardy was removed on 09/14/12 and the facility implemented corrective actions as alleged in the AOC, effective 09/13/12 based on the following:</p> <p>Review of facility inservice records and attendance logs, dated 09/13/12, revealed staff was educated related to the facility's revise policies and procedures for elopement to include Elopement Management and Prevention, Head</p>	F 323		
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F 323	<p>Continued From page 52</p> <p>Count, Missing Resident, Care Plan Policies and notifications to be made if a resident attempted to exited the building unsupervised. Further review of the Inservice records revealed staff received education and training related to responding to the Wander Guard alarms and procedures to be followed which included the completion of the Incident report.</p> <p>Record review revealed all resident's elopement care plans had been reviewed and revised on 09/13/12.</p> <p>Review of the facilities QA meeting minutes revealed a meeting was held on 09/13/12 to implement plans of correction to remove the immediate jeopardy.</p> <p>Review of the facility's monitoring log, dated 09/13/12 through 09/19/12, revealed staff had monitored the front door 24/7 until the front door was upgraded. Observation, on 09/18/12 at 3:10 PM, revealed the front door was secured when the Wander Guard was within four (4) feet and the door would not open for fifteen (15) seconds once the bar was pushed.</p> <p>Review of the facility's elopement drill records revealed the DON and Administrator conducted an elopement drill on 09/13/12 to evaluate the staff response to alarms sounding. Further review of the elopement drill records revealed an elopement drill had been conducted daily at varying times and shifts from 09/13/12 through 09/18/12. Observation, on 09/19/12 at 10:15 AM, revealed an elopement drill was conducted by the Administrator. Further observation revealed staff immediately responded to the alarm by a nurse</p>	F 323		

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F 323	<p>Continued From page 53</p> <p>at the nurse's station going to the front door, dietary staff going out the side door and housekeeping going out the back doors and checking the facility property, SRNA's, LPN's and activities doing a head count and checking behind doors and all areas of the facility until the Maintenance Director (who was placed behind a door in a bathroom as a resident) was located.</p> <p>Interview with the Dietary Manager on 09/19/12 at 1:30 PM, Maintenance Director at 2:15 PM, Assistant Director of Nursing at 3:45 PM and on 09/20/12 at 11:00 AM with the Director of Nursing and the Administrator revealed they had been assigned rotating shifts to include visualizing all residents, ensure staff response to door alarms, care plans were updated, twenty four (24) hour report sheet completed and notifications made.</p> <p>Observation, on 09/18/12 from 04:00 PM until 4:30 PM, revealed there were Elopement Risk Books on both the nursing units including the East and West Nurse's Station, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>Interviews with staff including RN #4 on 09/19/12 at 12:55 PM, SRNA #8 at 1:00 PM, LPN #3 at 1:05 PM, LPN #6 at 1:15 PM, Dietary Manager at 1:30 PM, SRNA #9 at 1:45 PM, Housekeeper #2 at 2:00 PM, RN #1 at 2:25 PM, LPN #7 at 2:35 PM, LPN #8 at 2:45 PM, LPN #1 at 2:55 PM, SRNA #10 at 3:00 PM, SRNA # 11 at 3:10 PM, and Physical Therapy aide at 3:20 PM, revealed they had received inservice education and were aware of what an elopement was, the Elopement Risk Book and the elopement policy and procedure to include providing staff supervision</p>	F 323		

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F 323	Continued From page 54 as well appropriate notifications to be made if a resident attempted to leave the facility unsupervised, including notifying the physician. They were also aware of the procedure in responding to the door alarm to include searching inside and outside the facility.  Record review revealed the Activities Director, Social Worker, DON and Regional Nurse Consultant reviewed and revised the activity assessments and activities care plans for all elopement risk residents by 09/13/12. Interview with the DON, Regional Nurse Consultant and Activities Director, on 09/20/12 at 9:20 AM, revealed they met as a group on 09/13/12 and reviewed and revised care plans and activities assessments of residents at risk for elopement to ensure those residents received routine time out side to meet their needs. Further interview revealed all residents care plans and activity assessments were being reviewed and revised. Further interview with the Administrator revealed the current Activities Director would become an Activities Assistant when the Dietary Manager completed the training course approved by the state.  Interview, on 09/19/12 at 3:25 PM, with the Education Director, revealed she had assisted with the changes in the new elopement policies and the policies would be reviewed with each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice. Review of the facility's revised orientation packet revealed orientation included review of the facility's revised	F 323			

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F 323	Continued From page 55 elopement policies and procedures.  Interview with the Administrator, DON and Regional Nurse and review of the new Elopement Management and Prevention Policies, on 09/20/12 at 11:00 AM, revealed the policies were updated 09/13/12 to include staff supervision of residents at elopement risk, reviewing and revising Individualized care plan interventions to prevent elopement (such as enhanced recreational activities), responding to wander guard alarms, completing incident reports, and notifications to be made when a resident attempts to leave the facility unsupervised, to include notifying the physician.  The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC).	F 323			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or	F 490	F490  1. Resident #1 no longer resides in the center. Medical Director and all physicians were notified by the Director of Nursing of risk of elopement, survey findings and plan of correction. No new orders were noted.  2. Regional Nurse Consultant completed a one time audit of all Quality Assurance minutes for the last 6 months on 10/10/12 to identify any issues that were not addressed and resolved. Any issues identified were immediately corrected. All education for all staff was reviewed by the Regional Nurse Consultant was reviewed by the Regional Nurse Consultant on 10/10/12 to identify needed education regarding		

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F 490	Continued From page 56 maintain the highest practicable physical, mental, and psychological well-being of each resident.  The facility failed to have an effective system to ensure supervision to prevent accidents related to residents who were identified at risk for elopement/wandering. The facility's Administration failed to have an effective system to ensure the Physician was notified related to residents who eloped from the facility in order to alter treatment to prevent further elopement; failed to have an effective system to ensure staff was knowledgeable of residents who had eloped from the facility and what measures were put into place to prevent elopement, including activities; failed to have an effective system to ensure staff was trained to adequately respond to the facility's Wander Guard alert system to protect residents who were assessed to be an elopement risk; and, failed to have an effective system to ensure the Comprehensive Plans of Care were revised to include effective interventions and ensure continuous supervision and monitoring to prevent elopement. (Refer to F-157, F-248, F-280 and F-323).  On 09/01/12 at approximately 7:30 PM, Resident #1 was left unsupervised by staff on the facility's front porch. Approximately twenty (20) minutes later, Resident #1 was brought back to the facility by two (2) unknown males who stated they found Resident #1 walking in the neighborhood behind the facility approximately 1000 feet from the facility's front door. The facility failed to notify Resident #1's Physician, failed to revise the plan of care, and failed to provide adequate supervision to prevent further elopement. On 09/03/12 sometime between 12:02 PM and 12:05	F 490	elopement, care planning process, who should update care plans, and activities policy. Any issues identified were immediately corrected. Regional Nurse Consultant interviewed 20 staff members 10/11/12 from all departments regarding policy and procedure for elopement, activity care plan process, Quality Assurance, reporting changes in resident condition, notification of physician and family when change occurs. Any issues identified were immediately corrected.  Regional Director of Operations reviewed elopement policy and procedure; care planning policy and procedure; activities policy and procedure; and Quality Assurance policy and procedure with administrator on 10/12/12 to identify if administration had complete knowledge of these policies and procedures. No issues were identified. Regional Nurse Consultant reviewed elopement policy and procedure; care planning policy and procedure; activities policy and procedure; and Quality Assurance policy and procedure with Director of Nursing and Assistant Director of Nursing on 10/12/12 to identify if administration had complete knowledge of these policies and procedures. No issues were identified.  3. Regional Nurse Consultant and Regional Director of Operations re-educated administrator and all administrative team members on 10/10/12 regarding policy and procedure for care planning: who should update care plans, when care plans should be updated, elopement policy and procedure; policy for resident supervision, activities policy and procedure and what to report to the Regional Nurse Consultant.		

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F 490	Continued From page 57 PM Resident #1 eloped from the facility unsupervised and was located on a sidewalk getting ready to take a step into the roadway of the "housing projects" located behind the facility, approximately 475 feet from the facility's front door. Resident #1 was placed on one to one (1:1) staffing and later sent to a psychiatric hospital for further evaluation. Resident #1 was not in the facility during the survey.  Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 09/13/12 and determined to exist on 09/01/12.  The findings include:  Review of the policy the facility utilized as a reference titled "Wandering, Unsafe Resident", revised December 2001, revealed staff would identify residents at risk for harm because of unsafe wandering, including elopement. Further review of the policy revealed interventions to maintain safety would be included in the resident's care plan, nursing would document circumstances related to unsafe actions, staff would initiate a detailed monitoring plan, and notify the Administrator and Director of Nursing immediately and institute appropriate measures when a resident was discovered missing from the facility.  Review of the policy the facility utilized as a reference titled "Elopements", revised December	F 490	The Regional Nurse Consultant and Regional Director of Operations telephone numbers are posted at each nursing station, dietary, laundry and in the locked case in the lobby to allow staff members, family members and residents means to report concerns. These were posted 10/9/12.  Regional Director of Operations or Regional Nurse Consultant will attend weekly Quality Assurance Committee meetings for 6 weeks beginning 10/4/12 with at least the Administrator, Director of Nursing, Social Services Director, Activity Director, one online staff, and Medical Director.  Beginning week of 11/19/12 all Quality Assurance meetings will be evaluated by the Regional Nurse Consultant and Quality Assurance Team to determine if Quality Assurance meeting should be continued weekly or decreased. Regional Director of Operations and/or Regional Nurse Consultant will be attending monthly Quality Assurance Meetings for 6 months, beginning December 2012.  Education Training Director re-educated all staff by written competency regarding care planning process, developing and updating care plans; policy and procedure for notifying physician and family; resident supervision, and elopement policy and procedure; activity policy and procedure and ensuring activity needs are individually assessed. This was completed by 10/11/12. Education Training Director re-educated all staff regarding activity policy and procedure and activity care planning needs. This was completed by 10/11/12.		

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F 490	<p>Continued From page 58</p> <p>2008, revealed Staff should promptly report any resident who tries to leave the premises to the DON. Further review of the policy revealed when a departing resident returns to the facility the DON or charge nurse should examine the resident for injuries, notify the Physician, complete and Incident/accident report, and document relevant information in the resident's medical record.</p> <p>Resident #1 was assessed by the facility to be moderately cognitively impaired, an elopement risk, and a wander guard device was applied on 06/13/12. On 09/01/12, Resident #1 eloped from the facility without staff knowledge and was gone for approximately twenty minutes. The Director of Nursing (DON) was only notified that Resident #1 had exited the building unsupervised to the front porch and had instructed staff to place Resident #1 on every fifteen (15) minute visual checks. The facility failed to notify the Physician of the incident, failed to revise the plan of care to put new interventions in place to prevent elopement, and failed to ensure all staff were knowledgeable of the incident and of the every fifteen (15) minute checks to prevent further elopement. The facility failed to conduct an investigation related to the elopement to implement adequate interventions to prevent Resident #1 from eloping from the facility again. Although Resident #1 was on every fifteen (15) minute visual checks, Resident #1 eloped from the facility again on 09/03/12 sometime between 12:02 PM and 12:05 PM. Interviews with staff revealed not all staff was aware Resident #1 was on every fifteen (15) minute checks or knowledgeable related to fully responding to the Wander Alarm system sounding. Staff interviews revealed</p>	F 490	<p>All newly hired staff will be education by the Education Training Director regarding the following:</p> <ul style="list-style-type: none"> <li>• Elopement Policy and Procedure</li> <li>• Supervision of Residents Policy and Procedure</li> <li>• Policy for reporting change of condition to physician and family</li> <li>• Notification of Director of Nursing, Administrator, Regional Nurse Consultant and Regional Director of Operations</li> <li>• Care Planning Policy and Procedure including updating and developing care plans</li> <li>• Activity Policy and Procedure</li> <li>• Wanderguard and door check policy and procedure</li> <li>• Reporting exit seeking or wandering behaviors</li> <li>• Head Count policy and procedure</li> </ul> <p>Administrator to audit all new hire education to ensure all education is completed for the plan of correction beginning 10/4/12. Regional Nurse Consultant will audit all new hires weekly beginning 10/4/12 to ensure all education is completed per the plan of correction.</p> <p>Regional Director of Operations and/or Regional Nurse Consultant to visit center two times per week beginning 10/1/12 for 8 weeks to review/audit that care plans policy and procedure and process for updating and development care plans is in place; elopement policy and procedure is begin followed; that elopement drills are performed at least weekly, activities are occurring and assessments are completed timely;</p>	
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/20/2012
NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
(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 59</p> <p>inconsistencies regarding how to accurately monitor, supervise, and respond to residents at risk for or who had a history of elopement.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7, on 09/13/12 at 9:30 AM, revealed although he was aware Resident #1 was an elopement risk he left Resident #1 on the front porch with some visitors that were "someone's family members" and was not aware that Resident #1 should be continuously monitored and supervised by the facility to prevent elopement.</p> <p>Interview with SRNA #1, on 09/11/12 at 1:10 PM, revealed although she was aware Resident #1 was at risk for elopement and had eloped on 09/01/12, she was unaware he was on every fifteen minute visual checks on 09/01/12 because the nurses "handle that".</p> <p>Interview with SRNA #3, on 09/11/12 at 1:45 PM, revealed she was unaware Resident # 1 had eloped from the facility on 09/01/12 and was unaware he was on every fifteen minute visual checks.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 09/13/12 at 7:30 AM, revealed she had been employed at the facility for approximately two months and was unaware of any facility policy related to elopements or that the nurse responsible for providing care to a resident was responsible for ensuring the care plan was revised. Additional interview revealed whomever was close to the door that alarmed should respond immediately and do a quick sweep of the building and was not aware of any head count</p>	F 490	<p>Regional Director of Operations and/or Regional Nurse Consultant to have at least daily calls with the Administrator and/or Director of Nursing and/or charge nurse when not in the center to ensure policy and procedures are being followed; that any change of condition is addressed and to assist with daily operations of the center. This began on 10/3/12 and will continue for 3 weeks; then Regional Director of Operations and/or Regional Nurse Consultant will call the Administrator, Director of Nursing, and/or charge nurse when not in the building three times a week for 3 weeks; and then at least weekly.</p> <p>This call and at least 2 weekly center visits by the Director of Operations and/or the Regional Nurse Consultant will continue until the Quality Assurance Team and Regional Team considers oversight is no longer needed.</p> <p>Regional Nurse Consultant will be notified of any resident identified as an elopement risk immediately by phone or in person for 3 months beginning 10/1/12 to ensure all policies and procedures are followed and to provide oversight.</p> <p>Any issues identified in the Quality Assurance meetings that require policy changes or policy development will be reviewed and revised and/or developed with assistance of the Regional Director of Operations and/or the Regional Nurse Consultant and the Quality Assurance Team to provide oversight to ensure all aspects of the concern is addressed and education for the staff is provided timely. This began on 10/1/12 and is on-going.</p>		

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NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069	
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F 490	Continued From page 60 policy.  Interview with Registered Nurse (RN) #1, on 09/13/12 at 8:10 AM, revealed she had been employed at the facility for approximately seven months and was unaware who was responsible for ensuring the care plan was revised to ensure all staff were knowledgeable of new measures. She indicated nurses were responsible for ensuring the fifteen minute checks were completed.  An interview with the Assistant Director of Nursing (ADON) on 09/14/12 at 1:25 PM, revealed she was the charge nurse on 09/03/12 and at that time was unaware Resident #1 had eloped from the facility on 09/01/12 and was unaware he/she was on fifteen (15) minute checks.  Interview, on 09/19/12 at 3:25 PM, with the Education Director, revealed prior to the identification of the Immediate Jeopardy, new employees were walked through the building and shown all the doors, given the codes to the doors, shown the elopement books in each department, shown what a Wander Guard was and the need to respond to the alarm and given the different emergency codes, such as "Code Wayne Pink" for elopement. Further interview revealed there was no facility specific policies and procedures discussed related elopement or responding to the alarm to ensure continuous supervision of residents at risk for elopement.  Interview with the Administrator, the Director of Nursing and the Corporate Nurse, on 09/13/12 at 10:55 AM and 09/19/12 at 1:15 PM, revealed the facility had changed ownership effective 07/01/12	F 490	4. Quality Assurance Team will review, revise and evaluate all audits associated with each deficiency cited at least weekly for 6 weeks with the Regional Director of Operations and/or the Regional Nurse Consultant beginning 10/4/12. Quality Assurance meetings will be reduced only with recommendation of the Quality Assurance team and the Regional Director of Operations and/or the Regional Nurse Consultant approval and then will be on-going no less than monthly per policy.  All audits will be in writing to verify completion and Regional Director of Operations and/or Regional Nurse Consultant will review all audits to assist administrator in identification of change that may require policy revision and/or development. This will begin 10/1/12 and continue until the Quality Assurance Team, Medical Director and/or Regional Director of Operations and/or Regional Nurse Consultant make recommendations to decrease.  5. Date of Completion: 10/16/12	

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F 490	<p>Continued From page 61</p> <p>and the company that owned the facility prior to 07/01/12 took all the facility specific policies. Further interview revealed the new company sent policies and procedures that were not specific to include detailed measures to ensure residents at risk for elopement received continuous supervision and monitoring and care plans were revised to prevent further elopement. Additional interview revealed they had started developing individualized policies and procedures but had not developed any facility specific elopement policies and procedures to ensure continuous monitoring and supervision of residents who were identified to be at risk for elopement.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 that alleged removal of the IJ effective 09/14/12, based on the following:</p> <p>1) All staff in all departments were Inserviced by the Assistant Director of Nursing on 09/03/12 and by the Education Director on 09/13/12 related to the following:</p> <p>a. Definition of elopement, revised Elopement Management and Prevention Policies, Missing Resident Action Plan, Head Count Procedures and Care Plan Policy which were revised on 09/13/12; and approved by the QA committee consisting of Administrator, DON, Social Services Director, Activities Director, Maintenance Director, Referral Manager, Business Office Manager, Business Office Assistant and Regional Nurse.</p> <p>b. Alarm procedures/action which included who responds to the alarm, what to do when the alarm sounds, and level of supervision needed.</p>	F 490		

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F 490	<p>Continued From page 62</p> <p>c. All staff reeducated regarding the Elopement Risk Book on 09/13/12 by the Education Director/Department Manager.</p> <p>d. Notify the Charge Nurse Immediately of missing or exit seeking resident and the Charge Nurse will immediately notify the Administrator, DON and Nurse Consultant. The Charge Nurse will update the plan of care and update staff verbally and in writing of the increased supervision on the twenty-four (24) hour shift report. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.</p> <p>2) All elopement care plans were reviewed and revised on 09/13/12 by the DON, Administrator, Social Services, and Charge Nurse. All residents were visualized by the DON and Education Nurse on 09/13/12 to identify mode of locomotion and staff interviews were conducted to better determine residents with elopement risk.</p> <p>3) On 09/13/12, a Quality Assurance Meeting was held to discuss the steps to be taken to prevent further incidents to Resident #1 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.</p> <p>4) License staff will complete the accident/incident report immediately for an elopement attempt or actual elopement and the education was completed by the Department Manager and or the Education Director by 09/14/12.</p> <p>5) On 09/13/12, the DON and Administrator</p>	F 490			

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F 490	<p>Continued From page 63</p> <p>conducted an elopement drill to evaluate the staff response to alarms sounding.</p> <p>6) Department Manager monitoring of the facility twenty four/seven (24/7) for ten days beginning 09/13/12 to include at least one random staff interview each shift to determine any resident changes as related to wander risk, monitoring and witnessing wander guard checks for function and placement, visualizing all residents, ensure staff response to door alarms, check function of all doors every shift to ensure all systems are functioning, ensure staff can complete head count properly and timely, Department Manager to complete a daily elopement drill, care plan updates, twenty four (24) hour report sheet completed. Any decrease in Department Manager monitoring will be reviewed by the QA committee after ten days and then weekly for a decrease in monitoring, any issues identified and need for further education.</p> <p>7) Twenty-four/seven 24/7 front door monitoring beginning at 12 noon on 09/13/12 until door is upgraded and function is verified on 2 shifts.</p> <p>8) New employees are to be trained on the elopement system upon hire by the Education Director. The Elopement Risk Book will be reviewed during orientation of new staff. The revised elopement policies and procedures were included in the new hire orientation material beginning 09/13/12.</p> <p>9) All activity care plans reviewed/revised 09/13/12 by the Life Enrichment Director, DON, Social Services, MDS Nurse and Regional Nurse</p>	F 490			

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F 490	<p>Continued From page 64</p> <p>Consultant to ensure activities where in place for all residents and identified residents' individual needs.</p> <p>On 09/20/12 the State Survey Agency verified the Immediate Jeopardy was removed on 09/14/12 and the facility implemented corrective actions as alleged in the AOC, effective 09/13/12 based on the following:</p> <p>Review of facility inservice records and attendance logs, dated 09/13/12, revealed staff was educated related to the facility's revise policies and procedures for elopement to include Elopement Management and Prevention, Head Count, Missing Resident, Care Plan Policies and notifications to be made if a resident attempted to exited the building unsupervised. Further review of the inservice records revealed staff received education and training related to responding to the Wander Guard alarms and procedures to be followed which included the completion of the incident report.</p> <p>Record review revealed all resident's elopement care plans had been reviewed and revised on 09/13/12.</p> <p>Review of the facilities QA meeting minutes revealed a meeting was held on 09/13/12 to implement plans of correction to remove the Immediate jeopardy.</p> <p>Review of the facility's monitoring log, dated 09/13/12 through 09/19/12, revealed staff had monitored the front door 24/7 until the front door was upgraded. Observation, on 09/18/12 at 3:10 PM, revealed the front door was secured when</p>	F 490		

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F 490	<p>Continued From page 65</p> <p>the Wander Guard was within four (4) feet and the door would not open for fifteen (15) seconds once the bar was pushed.</p> <p>Review of the facility's elopement drill records revealed the DON and Administrator conducted an elopement drill on 09/13/12 to evaluate the staff response to alarms sounding. Further review of the elopement drill records revealed an elopement drill had been conducted daily at varying times and shifts from 09/13/12 through 09/18/12. Observation, on 09/19/12 at 10:15 AM, revealed an elopement drill was conducted by the Administrator. Further observation revealed staff immediately responded to the alarm by a nurse at the nurse's station going to the front door, dietary staff going out the side door and housekeeping going out the back doors and checking the facility property, SRNA's, LPN's and activities doing a head count and checking behind doors and all areas of the facility until the Maintenance Director (who was placed behind a door in a bathroom as a resident) was located.</p> <p>Interview with the Dietary Manager on 09/19/12 at 1:30 PM, Maintenance Director at 2:15 PM, Assistant Director of Nursing at 3:45 PM and on 09/20/12 at 11:00 AM with the Director of Nursing and the Administrator revealed they had been assigned rotating shifts to include visualizing all residents, ensure staff response to door alarms, care plans were updated, twenty four (24) hour report sheet completed and notifications made.</p> <p>Observation, on 09/18/12 from 04:00 PM until 4:30 PM, revealed there were Elopement Risk Books on both the nursing units including the East and West Nurse's Station, Dietary</p>	F 490			

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F 490	<p>Continued From page 66 Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>Interviews with staff including RN #4 on 09/19/12 at 12:55 PM, SRNA #8 at 1:00 PM, LPN #3 at 1:05 PM, LPN #6 at 1:15 PM, Dietary Manager at 1:30 PM, SRNA #9 at 1:45 PM, Housekeeper #2 at 2:00 PM, RN #1 at 2:25 PM, LPN #7 at 2:35 PM, LPN #8 at 2:45 PM, LPN #1 at 2:55 PM, SRNA #10 at 3:00 PM, SRNA # 11 at 3:10 PM, and Physical Therapy aide at 3:20 PM, revealed they had received inservice education and were aware of what an elopement was, the Elopement Risk Book and the elopement policy and procedure to include providing staff supervision as well appropriate notifications to be made if a resident attempted to leave the facility unsupervised, including notifying the physician. They were also aware of the procedure in responding to the door alarm to include searching inside and outside the facility.</p> <p>Record review revealed the Activities Director, Social Worker, DON and Regional Nurse Consultant reviewed and revised the activity assessments and activities care plans for all elopement risk residents by 09/13/12. Interview with the DON, Regional Nurse Consultant and Activities Director, on 09/20/12 at 9:20 AM, revealed they met as a group on 09/13/12 and reviewed and revised care plans and activities assessments of residents at risk for elopement to ensure those residents received routine time out side to meet their needs. Further interview revealed all residents care plans and activity assessments were being reviewed and revised. Further Interview with the Administrator revealed the current Activities Director would become an</p>	F 490		

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F 490	Continued From page 67 Activities Assistant when the Dietary Manager completed the training course approved by the state.  Interview, on 09/19/12 at 3:25 PM, with the Education Director, revealed she had assisted with the changes in the new elopement policies and the policies would be reviewed with each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice. Review of the facility's revised orientation packet revealed orientation included review of the facility's revised elopement policies and procedures.  Interview with the Administrator, DON and Regional Nurse and review of the new Elopement Management and Prevention Policies, on 09/20/12 at 11:00 AM, revealed the policies were updated 09/13/12 to include staff supervision of residents at elopement risk, reviewing and revising individualized care plan interventions to prevent elopement (such as enhanced recreational activities), responding to wander guard alarms, completing incident reports, and notifications to be made when a resident attempts to leave the facility unsupervised, to include notifying the physician.  The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC).	F 490			
F 493 SS-J	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN	F 493	F 493  1. Resident #1 no longer resides in the center. Medical Director and all physicians were notified by the Director of Nursing of risk of elopement, survey findings and plan of correction. No new ordered were noted.		

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F 493	<p>Continued From page 68</p> <p>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to ensure the governing body established and implemented policies regarding the management and operation of the facility. The governing body failed to provide adequate oversight to ensure policy and procedures were implemented to ensure adequate supervision and monitoring to prevent accidents for a resident with a known risk for elopement and a history of leaving the building unsupervised. The facility also failed to ensure policy and procedures were implemented to revise the resident's care plan to address the resident's increased exit seeking behavior, and to ensure physician notification of a resident's condition change and potential need to alter treatment. In addition, the facility failed to ensure staff was trained and knowledgeable on how to adequately monitor and supervise residents at risk for elopement.</p> <p>On 09/01/12, the facility failed to provide continuous supervision of Resident #1, who had been exhibiting exit seeking behaviors, when</p>	F 493	<p>2. Area Vice President, Regional Director of Operations, and Regional Nurse Consultant reviewed plan of correction progress toward goals on 10/1/12 with administrator to identify if all citations were addressed that the Quality Assurance meetings are being completed and that any issues are being addressed timely.</p> <p>Regional Nurse Consultant completed a one time audit of all Quality Assurance minutes for the last 6 months on 10/10/12 to identify any issues that were not addressed and resolved. Any issues identified were immediately corrected. All education for all staff was reviewed by the Regional Nurse Consultant was reviewed by the Regional Nurse Consultant on 10/10/12 to identify needed education regarding elopement, care planning process, who should update care plans, and activities policy. Any issues identified were immediately corrected. Regional Nurse Consultant interviewed 20 staff members 10/11/12 from all departments regarding policy and procedure for elopement, activity care plan process, Quality Assurance, reporting changes in resident condition, notification of physician and family when change occurs. Any issues identified were immediately corrected.</p> <p>Regional Director of Operations reviewed elopement policy and procedure; care planning policy and procedure; activities policy and procedure; and Quality Assurance policy and procedure with administrator on 10/12/12 to identify if administration had complete knowledge of these policies and procedures. No issues were identified. Regional Nurse Consultant reviewed elopement policy and procedure; care planning policy and procedure;</p>	

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F 493	<p>Continued From page 69</p> <p>SRNA #7 left Resident #1 on the front porch unsupervised by staff. Approximately twenty minutes later, Resident #1 was brought back to the facility by two (2) unknown males who told SRNA #7 they found Resident #1 walking in the neighborhood behind the facility. On 09/03/12, Resident #1 eloped from the facility again sometime between 12:02 PM and 12:06 PM. Resident #1 was located on the sidewalk getting ready to take a step onto the roadway of the "housing projects" located behind the facility, approximately 475 feet from the facility's front door. Interviews with staff revealed not all staff was knowledgeable of how to respond to the Wander Guard alarm system sounding. Staff interviews revealed inconsistencies regarding how to accurately supervise and monitor residents at risk for or who had a history of elopement.</p> <p>Immediate Jeopardy was identified at 42 CFR 483.10 Residents Rights F-157; 42 CFR 483.20 Resident Assessment F-280; 42 CFR 483.25 Quality of Care F-323; and 42 CFR 483.75 Administration F-490. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F-323.</p> <p>The facility's failure to ensure the governing body established and implemented policies regarding the management and operation of the facility has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy and Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care on 09/13/12 and determined to exist on 09/01/12.</p> <p>The facility provided an acceptable credible</p>	F 493	<p>activities policy and procedure; and Quality Assurance policy and procedure with Director of Nursing and Assistant Director of Nursing on 10/12/12 to identify if administration had complete knowledge of these policies and procedures. No issues were identified.</p> <p>3. Area Vice President, Regional Director of Operations and Regional Nurse Consultant was in center on 10/5/12 to ensure policy and procedures were in place for care planning, elopement, activities, Quality Assurance and approved this entire plan of correction. Regional Director of Operations and Regional Nurse Consultant to report policy and procedure revisions and development of new policies and procedures; and facility Quality Assurance process and progress to the Area Vice President at least weekly for 4 weeks beginning 10/1/12. Regional Nurse Consultant and Regional Director of Operations to interview at least 5 staff members weekly for 4 weeks to ensure any issues are addressed, focusing on care plan policy and procedure; elopement policy and procedure and activities policy and procedure. Regional Director of Operations and Regional Nurse Consultant will be directly involved in this plan of correction.</p> <p>Regional Director of Operations and/or Regional Nurse Consultant to complete re-education with the administrator by 10/12/12 regarding policy and procedures and policy and procedures for the center to identify any needed changes to policies and procedures to ensure any center specific needs is addressed accordingly to Quality Assurance identification.</p>		

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F 493	<p>Continued From page 70</p> <p>Allegation of Compliance (AOC) on 09/17/12 with the facility alleging removal of the Immediate Jeopardy on 09/14/12. Immediate Jeopardy was verified to be removed on 09/14/12 prior to exiting the facility on 09/20/12 with remaining non-compliance at 42 CFR 483.75 Administration F-493, with a scope and severity of a "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure the governing body implements policies regarding the management and operation of the facility.</p> <p>The findings include:</p> <p>(Refer to F157, F280, F323 and F490) The facility had assessed Resident #1 to enjoy having time out doors but also as having exit seeking behaviors and applied a Wander Guard device on 06/13/12. The facility failed to ensure the plan of care was revised to include interventions to ensure Resident #1 received supervised time out doors to help decrease the resident's exit seeking behaviors. On 07/23/12, Resident #1 continually exited out the front door and was sent to psychiatric hospital due to behaviors and returned to the facility on 07/28/12. On 08/28/12 Resident #1 exited the building three (3) times to the facility's front porch unsupervised and was redirected by staff back into the building. The resident's plan of care was revised to include supervised sitting out doors with family and staff. However, the facility failed to ensure the care plan detailed who was responsible to ensure continuous supervision of Resident #1 to prevent elopement and failed to ensure staff was knowledgeable related to the level of supervision required. On 09/01/12, Resident #1 was left</p>	F 493	<p>Regional Director of Operations and/or Regional Nurse Consultant to re-educate Administrator and Director of Nursing by 10/12/12 regarding what to report to Regional Director of Operations and/or Regional Nurse Consultant to ensure all issues and identified concerns are reported for suggestions and guidance if needed to ensure all residents receive optimal care and all regulations are followed to meet federal guidelines.</p> <p>Regional Nurse Consultant and Regional Director of Operations re-educated administrator and all administrative team members on 10/10/12 regarding policy and procedure for care planning; who should update care plans, when care plans should be updated, elopement policy and procedure; policy for resident supervision, activities policy and procedure and what to report to the Regional Nurse Consultant.</p> <p>The Regional Nurse Consultant and Regional Director of Operations telephone numbers are posted at each nursing station, dietary, laundry and in the locked case in the lobby to allow staff members, family members and residents means to report concerns. These were posted 10/9/12.</p> <p>Regional Director of Operations or Regional Nurse Consultant will attend weekly Quality Assurance Committee meetings for 6 weeks beginning 10/4/12 with at least the Administrator, Director of Nursing, Social Services Director, Activity Director, one online staff, and Medical Director.</p>	

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F 493	<p>Continued From page 71</p> <p>outside without staff supervision and eloped from the facility without staff knowledge. Although the Director of Nursing (DON) was notified that Resident #1 had exited the building unsupervised to the front porch and had instructed staff to place Resident #1 on every fifteen (15) minute visual checks, the facility failed to notify the Physician of the incident, failed to revise the plan of care to put new interventions in place to prevent elopement, and failed to ensure all staff were knowledgeable of the incident and the every fifteen (15) minute checks to prevent further elopement. The facility also failed to conduct an investigation related to the elopement to identify and implement adequate interventions to prevent Resident #1 from eloping from the facility again. On 09/03/12, Resident #1 eloped from the facility without staff knowledge.</p> <p>Policy review and interview with the Administrator, the Director of Nursing, and the Corporate Nurse on 09/13/12 at 10:55 AM and on 09/19/12 at 1:15 PM, revealed the facility had changed ownership effective 07/01/12 and the governing body sent policies and procedures that were not specific and they had been instructed to develop policies specific to the facility. Further interview revealed they had started developing some facility specific policies and procedures but had not developed any facility specific elopement policies and procedures to ensure continuous monitoring and supervision of residents who were identified to be at risk for elopement.</p> <p>An interview with The Facility Consultant, on 09/19/12 at 1:25 PM, revealed it varied how often she was at the facility, but she tried to come at least weekly. Further interview revealed she</p>	F 493	<p>Beginning week of 10/19/12 all Quality Assurance meetings will be evaluated by the Regional Nurse Consultant and Quality Assurance Team to determine if Quality Assurance should be continued weekly or decreased. Regional Director of Operations and/or Regional Nurse Consultant will be attending monthly Quality Assurance Meetings for 6 months, beginning December 2012.</p> <p>Education Training Director re-educated all staff by written competency regarding care planning process, developing and updating care plans. Policy and procedure for notifying physician and family; resident supervision, and elopement policy and procedure; activity policy and procedure and ensuring activity needs are individually assessed. This was completed by 10/11/12. Education Training Director re-educated all staff regarding activity policy and procedure and activity care planning needs. This was completed by 10/11/12.</p> <p>All newly hired staff will be education by the Education Training Director regarding the following:</p> <ul style="list-style-type: none"> <li>• Elopement Policy and Procedure</li> <li>• Supervision of Residents Policy and Procedure</li> <li>• Policy for reporting change of condition to physician and family</li> <li>• Notification of Director of Nursing; Administrator; Regional Nurse Consultant and Regional Director of Operations</li> <li>• Care Planning Policy and Procedure including updating and developing care plans</li> </ul>	

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F 493	<p>Continued From page 72</p> <p>became an employee of the new governing body effective 07/01/12 and was to assist with developing facility specific policies and procedures. She indicated they had developed policies and procedures related to pressure sores and medications, but had not developed facility specific policies and procedures related to elopement, including staff responding to the Wander Guard and ensuring residents received adequate supervision to prevent elopement.</p> <p>During an interview with the Interim Regional Vice President, on 09/20/12 at 10:15 AM, he indicated he was out of Texas and had been to Kentucky several times prior to and since the company took over as governing body on 07/01/12. He stated there had been orientation and trainings held in Lexington and/or at the facility in Springfield on 06/01/12, 06/15/12 through 06/16/12, 07/09/12 through 07/11/12 and 08/28/12 through 08/30/12. Additional Interview revealed it was the governing body's philosophy to follow state and federal regulations and that the facility was given a manual of generic policies to use as a reference point in developing facility specific policies and procedures. Continued interview revealed as issues came up or as problems were identified through the Quality Assurance meetings at the facility, policies would be developed.</p> <p>While the Governing Body visited the facility on a routine basis, there was no documented evidence these professionals identified, through their reviews and audits, these quality problems nor was there evidence of action taken to correct the systems failures at the time the survey was initiated.</p>	F 493	<ul style="list-style-type: none"> <li>• Activity Policy and Procedure</li> <li>• Wanderguard and door check policy and procedure</li> <li>• Reporting exit seeking or wandering behaviors</li> <li>• Head Count policy and procedure</li> </ul> <p>Administrator to audit all new hire education to ensure all education is completed for the plan of correction beginning 10/4/12. Regional Nurse Consultant will audit all new hires weekly beginning 10/4/12 to ensure all education is completed per the plan of correction.</p> <p>Regional Director of Operations and/or Regional Nurse Consultant to visit center two times per week beginning 10/1/12 for 8 weeks to review/audit that care plans policy and procedure and process for updating and development care plans is in place; elopement policy and procedure is begin followed; that elopement drills are performed at least weekly, activities are occurring and assessments are completed timely; to ensure any issue is addressed timely to meet the individual needs of all residents.</p> <p>Regional Director of Operations and/or Regional Nurse Consultant to have at least daily calls with the Administrator and/or Director of Nursing and/or charge nurse when not in the center to ensure policy and procedures are being followed; that any change of condition is addressed and to assist with daily operations of the center. This began on 10/3/12 and will continue for 3 weeks; then Regional Director of Operations and/or Regional Nurse Consultant will call the Administrator, Director of Nursing, and/or charge nurse when not in the building three times a week for 3 weeks; and then at least weekly.</p>		

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F 493	Continued From page 73 The facility provided an acceptable credible Allegation of Compliance (AOC) on 09/17/12 that alleged removal of the IJ effective 09/14/12, based on the following:  1) All staff in all departments were inserviced by the Assistant Director of Nursing on 09/03/12 and by the Education Director on 09/13/12 related to the following:  a. Definition of elopement, revised Elopement Management and Prevention Policies, Missing Resident Action Plan, Head Count Procedures and Care Plan Policy which were revised on 09/13/12; and approved by the QA committee consisting of Administrator, DON, Social Services Director, Activities Director, Maintenance Director, Referral Manager, Business Office Manager, Business Office Assistant and Regional Nurse. b. Alarm procedures/action which included who responds to the alarm, what to do when the alarm sounds, and level of supervision needed. c. All staff reeducated regarding the Elopement Risk Book on 09/13/12 by the Education Director/Department Manager. d. Notify the Charge Nurse immediately of missing or exit seeking resident and the Charge Nurse will immediately notify the Administrator, DON and Nurse Consultant. The Charge Nurse will update the plan of care and update staff verbally and in writing of the increased supervision on the twenty-four (24) hour shift report. Subsequent shifts, in all departments were not allowed to work until they completed the inservice.  2) All elopement care plans were reviewed and	F 493	This call and at least 2 weekly center visits by the Director of Operations and/or the Regional Nurse Consultant will continue until the Quality Assurance Team and Regional Team considers oversight is no longer needed.  Regional Nurse Consultant will be notified of any resident identified as an elopement risk immediately by phone or in person for 3 months beginning 10/1/12 to ensure all policies and procedures are followed and to provide oversight.  Any issues identified in the Quality Assurance meetings that require policy changes or policy development will be reviewed and revised and/or developed with assistance of the Regional Director of Operations and/or the Regional Nurse Consultant and the Quality Assurance Team to provide oversight to ensure all aspects of the concern is addressed and education for the staff is provided timely. This began on 10/1/12 and is on-going.  4. Quality Assurance Team will review, revise and evaluate all audits associated with each deficiency cited at least weekly for 6 weeks with the Regional Director of Operations and/or the Regional Nurse Consultant beginning 10/4/12. Quality Assurance meetings will be reduced only with recommendation of the Quality Assurance team and the Regional Director of Operations and/or the Regional Nurse Consultant approval and then will be on-going no less than monthly per policy.		

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F 493	Continued From page 74 revised on 09/13/12 by the DON, Administrator, Social Services, and Charge Nurse. All residents were visualized by the DON and Education Nurse on 09/13/12 to identify mode of locomotion and staff interviews were conducted to better determine residents with elopement risk.  3) On 09/13/12, a Quality Assurance Meeting was held to discuss the steps to be taken to prevent further incidents to Resident #1 and other residents. Also, during the meeting, the incident, investigation, actions taken, and the effectiveness of the actions taken were discussed. The Medical Director was contacted by phone.  4) License staff will complete the accident/incident report immediately for an elopement attempt or actual elopement and the education was completed by the Department Manager and or the Education Director by 09/14/12.  5) On 09/13/12, the DON and Administrator conducted an elopement drill to evaluate the staff response to alarms sounding.  6) Department Manager monitoring of the facility twenty four/seven (24/7) for ten days beginning 09/13/12 to include at least one random staff interview each shift to determine any resident changes as related to wander risk, monitoring and witnessing wander guard checks for function and placement, visualizing all residents, ensure staff response to door alarms, check function of all doors every shift to ensure all systems are functioning, ensure staff can complete head count properly and timely, Department Manager	F 493	All audits will be in writing to verify completion and Regional Director of Operations and/or Regional Nurse Consultant will review all audits to assist administrator in identification of change that may require policy revision and/or development. This will begin 10/1/12 and continue until the Quality Assurance Team, Medical Director and/or Regional Director of Operations and/or Regional Nurse Consultant make recommendations to decrease.  5. Date of Completion: 10/16/12		

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F 493	<p>Continued From page 75</p> <p>to complete a daily elopement drill, care plan updates, twenty four (24) hour report sheet completed. Any decrease in Department Manager monitoring will be reviewed by the QA committee after ten days and then weekly for a decrease in monitoring, any issues identified and need for further education.</p> <p>7) Twenty-four/seven 24/7 front door monitoring beginning at 12 noon on 09/13/12 until door is upgraded and function is verified on 2 shifts.</p> <p>8) New employees are to be trained on the elopement system upon hire by the Education Director. The Elopement Risk Book will be reviewed during orientation of new staff. The revised elopement policies and procedures were included in the new hire orientation material beginning 09/13/12.</p> <p>9) All activity care plans reviewed/revised 09/13/12 by the Life Enrichment Director, DON, Social Services, MDS Nurse and Regional Nurse Consultant to ensure activities were in place for all residents and identified residents' individual needs.</p> <p>On 09/20/12 the State Survey Agency verified the Immediate Jeopardy was removed on 09/14/12 and the facility implemented corrective actions as alleged in the AOC, effective 09/13/12 based on the following:</p> <p>Review of facility inservice records and attendance logs, dated 09/13/12, revealed staff was educated related to the facility's revise policies and procedures for elopement to include Elopement Management and Prevention, Head</p>	F 493			

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F 493	<p>Continued From page 76</p> <p>Count, Missing Resident, Care Plan Policies and notifications to be made if a resident attempted to exited the building unsupervised. Further review of the inservice records revealed staff received education and training related to responding to the Wander Guard alarms and procedures to be followed which included the completion of the incident report.</p> <p>Record review revealed all resident's elopement care plans had been reviewed and revised on 09/13/12.</p> <p>Review of the facilities QA meeting minutes revealed a meeting was held on 09/13/12 to implement plans of correction to remove the immediate jeopardy.</p> <p>Review of the facility's monitoring log, dated 09/13/12 through 09/19/12, revealed staff had monitored the front door 24/7 until the front door was upgraded. Observation, on 09/18/12 at 3:10 PM, revealed the front door was secured when the Wander Guard was within four (4) feet and the door would not open for fifteen (15) seconds once the bar was pushed.</p> <p>Review of the facility's elopement drill records revealed the DON and Administrator conducted an elopement drill on 09/13/12 to evaluate the staff response to alarms sounding. Further review of the elopement drill records revealed an elopement drill had been conducted daily at varying times and shifts from 09/13/12 through 09/18/12. Observation, on 09/19/12 at 10:15 AM, revealed an elopement drill was conducted by the Administrator. Further observation revealed staff immediately responded to the alarm by a nurse</p>	F 493			

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F 493	<p>Continued From page 77</p> <p>at the nurse's station going to the front door, dietary staff going out the side door and housekeeping going out the back doors and checking the facility property, SRNA's, LPN's and activities doing a head count and checking behind doors and all areas of the facility until the Maintenance Director (who was placed behind a door in a bathroom as a resident) was located.</p> <p>Interview with the Dietary Manager on 09/19/12 at 1:30 PM, Maintenance Director at 2:15 PM, Assistant Director of Nursing at 3:45 PM and on 09/20/12 at 11:00 AM with the Director of Nursing and the Administrator revealed they had been assigned rotating shifts to include visualizing all residents, ensure staff response to door alarms, care plans were updated, twenty four (24) hour report sheet completed and notifications made.</p> <p>Observation, on 09/18/12 from 04:00 PM until 4:30 PM, revealed there were Elopement Risk Books on both the nursing units including the East and West Nurse's Station, Dietary Department, Housekeeping Office, Laundry Department, and the Front Office.</p> <p>Interviews with staff including RN #4 on 09/19/12 at 12:55 PM, SRNA #8 at 1:00 PM, LPN #3 at 1:05 PM, LPN #6 at 1:15 PM, Dietary Manager at 1:30 PM, SRNA #9 at 1:45 PM, Housekeeper #2 at 2:00 PM, RN #1 at 2:25 PM, LPN #7 at 2:35 PM, LPN #8 at 2:45 PM, LPN #1 at 2:55 PM, SRNA #10 at 3:00 PM, SRNA # 11 at 3:10 PM, and Physical Therapy aide at 3:20 PM, revealed they had received inservice education and were aware of what an elopement was, the Elopement Risk Book and the elopement policy and procedure to include providing staff supervision</p>	F 493			

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

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STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/20/2012
NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 493	Continued From page 78 as well appropriate notifications to be made if a resident attempted to leave the facility unsupervised, including notifying the physician. They were also aware of the procedure in responding to the door alarm to include searching inside and outside the facility.  Record review revealed the Activities Director, Social Worker, DON and Regional Nurse Consultant reviewed and revised the activity assessments and activities care plans for all elopement risk residents by 09/13/12. Interview with the DON, Regional Nurse Consultant and Activities Director, on 09/20/12 at 9:20 AM, revealed they met as a group on 09/13/12 and reviewed and revised care plans and activities assessments of residents at risk for elopement to ensure those residents received routine time outside to meet their needs. Further interview revealed all residents care plans and activity assessments were being reviewed and revised. Further interview with the Administrator revealed the current Activities Director would become an Activities Assistant when the Dietary Manager completed the training course approved by the state.  Interview, on 09/19/12 at 3:25 PM, with the Education Director, revealed she had assisted with the changes in the new elopement policies and the policies would be reviewed with each new hire. She further stated most current staff had been inserviced on the new policy and if they had not received the inservice, they were not to clock in until they had been inserviced and signed that they had received the inservice. Review of the facility's revised orientation packet revealed orientation included review of the facility's revised	F 493			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/20/2012
NAME OF PROVIDER OR SUPPLIER  SPRINGFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069		
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F 493	Continued From page 79 elopement policies and procedures.  Interview with the Administrator, DON and Regional Nurse and review of the new Elopement Management and Prevention Policies, on 09/20/12 at 11:00 AM, revealed the policies were updated 09/13/12 to include staff supervision of residents at elopement risk, reviewing and revising individualized care plan interventions to prevent elopement (such as enhanced recreational activities), responding to wander guard alarms, completing Incident reports, and notifications to be made when a resident attempts to leave the facility unsupervised, to include notifying the physician.  The facility remained out of compliance at a lower scope and severity of a "D", an isolated deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (POC).	F 493			