

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

*Acceptable*

PRINTED: 10/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/09/2014
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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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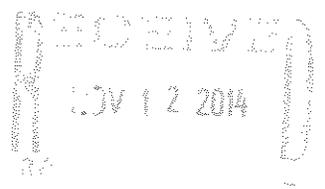
F 000 INITIAL COMMENTS

An Abbreviated/Partial Extended Survey investigating KY00022259 was initiated on 09/24/14 and concluded on 10/09/14. KY00022259 was substantiated with related deficiencies cited. Immediate Jeopardy (IJ) was identified on 09/30/14 and was determined to exist on 09/21/14 with deficiencies cited at 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 all at a Scope and Severity (S/S) of a "J". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, F-323. The facility was notified of the Immediate Jeopardy on 09/30/14.

Interview and record review revealed the facility was aware Resident #1 had a history of wandering and exit seeking behaviors, and had placed a Secure Care Bracelet on the resident and care planned the resident for these behaviors. However, on 09/21/14 Resident #1 became upset during the evening meal, went to another area of the facility obtained a six (6) inch paring knife which he/she used to cut the Secure Care Bracelet off with, and at approximately 6:32 PM the resident eloped from the facility without staff's knowledge. At 7:01 PM, Resident #1 was found by the police walking with a walker on a heavily traveled two (2) lane road without a shoulder or sidewalk, approximately three tenths of a mile from the facility. Facility staff escorted Resident #1 back to the facility at approximately 7:10 PM. Resident #1 was not assessed upon his/her return to the facility to determine if he/she had any injuries related to eloping from the facility and walking approximately three tenths of a mile with his/her rolling walker.

F 000

This Plan of Correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Charles Roberts</i>	TITLE Administrator	(X6) DATE 11/12/14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1  An acceptable credible Allegation of Compliance (AOC), related to the Immediate Jeopardy, was received on 10/07/14 alleging the Immediate Jeopardy was removed on 10/07/14. On 10/09/14, the State Survey Agency verified the Immediate Jeopardy was removed on 10/07/14 as alleged with remaining non-compliance at 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 all at a Scope and Severity 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 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	This Plan of Correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.  It is the policy of Bourbon Heights, Inc. to ensure that each resident has a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment; is 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 is periodically reviewed by a team of qualified persons after each assessment.		

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F 280 Continued From page 2

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure residents' Comprehensive Care Plans were reviewed and revised to implement interventions to provide adequate supervision for one (1) of twelve (12) sampled residents (Resident #1) who had a known history of wandering and exit seeking behaviors.

On 09/21/14, Resident #1 became agitated at the evening meal, obtained a six (6) inch paring knife from elsewhere in the facility, and at approximately 6:32 PM, successfully eloped from the facility without staff's knowledge. Resident #1 was found by police at 7:01 PM, approximately three tenths of a mile from the facility, on a two (2) lane heavily traveled road which had no sidewalk or shoulder. Staff escorted Resident #1 back to the facility at approximately 7:10 PM. Resident #1 was not assessed for injury after his/her return to the facility due to being "upset".

Interview and record review revealed Resident #1 had a history of wandering with verbal threats of removing of his/her Secure Care Bracelet and had successfully eloped from the facility previously. On 03/13/14, Resident #1 became upset over a conversation between the resident and the Social Worker and verbally threatened to remove his/her Secure Care Bracelet and leave the facility. Also, on 05/08/14, Resident #1 became upset after being informed he/she would require supervision in the courtyard with his/her

F 280 When notified that an immediate jeopardy situation had been identified to exist at Bourbon Heights, Inc., immediate steps were taken on 9/30/14 to investigate, correct, and rectify the situation, as well as steps to prevent future issues with care plans. Below is a comprehensive list of immediate corrective actions that have been taken. Items were accomplished by 10/6/14 and represent the Facility's continuing efforts toward improving quality of care and compliance.

Cause of the Immediate Jeopardy was identified

The Immediate Jeopardy finding related to resident #1 elopement from the facility. On 5/8/14, resident #1 removed secure care bracelet and went out the back door of the building, off duty staff identified and intervened in this incident and the resident remained on the grounds with one on one staff supervision until returning to her room for the night. The care plan was not updated after this event, nor at the next periodic review to reflect new interventions put into place after this event.

The facility has identified all residents that may be at potential risk for harm

To identify the residents who may have been at a potential risk for harm, the Assistant Director of Nursing (ADON), assessed all 13 residents with secure care bracelets to ensure the secure care bracelets were on the resident and functioning properly and to ensure that the resident care plans included the secure care bracelet. This was completed on 9/22/14 with no changes or updates required.

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F 280 Continued From page 3  
 spouse. Resident #1 was found approximately one (1) hour and twenty (20) minutes later that day by an off duty staff person, outside the facility in the parking lot without his/her Secure Care Bracelet in place. Staff found Resident #1's Secure Care Bracelet in the trash can in his/her room with a plastic knife. Although Resident #1 was placed on every fifteen (15) minute checks for seventy-two (72) hours following these incidents; there was no documented evidence the Comprehensive Care Plan was updated and revised regarding these incidents to ensure adequate supervision of the resident. (Refer to F-323)

The facility's failure to have an effective system in place to ensure residents' Comprehensive Care Plans were reviewed and revised to implement interventions to provide adequate supervision was likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on 09/30/14 and was determined to exit on 09/21/14.

An acceptable credible Allegation of Compliance (AOC) was received on 10/07/14 which alleged removal of the Immediate Jeopardy on 10/07/14. The Immediate Jeopardy was verified to be removed on 10/07/14 as alleged with the remaining non-compliance in the area of 42 CFR 483.20 Resident Assessment (F-280) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure care plans are reviewed and revised to implement interventions to provide adequate supervision.

The findings include:

F 280 The facility also assessed all residents for the risk of elopement on 9/30/14. The assessment of 107 residents for risk of elopement was completed by the Director of Nursing (DON), MDS Assistant, MDS Coordinator, ADON, Quality Assurance Director (QAD), and Infection control nurse (IC Nurse), which identified 4 residents that were identified to be at risk for elopement, these residents were reviewed and care plans were updated.

**Steps taken to remove the Immediate Jeopardy**

1. Resident #1 care plan was updated by MDS Coordinator 10/1/14.
2. Reviewed care plans on 13 residents with secure care bracelets with no revisions required by Assistant Director of Nursing (ADON) 9/22/14.
3. Assessed all 107 residents for risk of elopement and updated 4 care plans for the residents identified to accurately reflect the needs of the residents by MDS Coordinator and MDS Assistant 9/30/14.
4. Review of all care plans to ensure updates have been completed for any new orders received in the last 30 days with any issues identified and corrected at time of the audit. Completed by Infection Control Nurse (IC Nurse), ADON, QAD, Wound Care Nurse, RN House Supervisor, 2 other LPNs. Completed 10/6/14.
5. Developed screening tool to identify residents at risk for elopement 10/2/14.
6. New risk assessment tool implemented and completed on all residents with no new residents identified to be at risk for elopement completed 10/5/14.
7. Updated care signs to include risk for elopement 10/1/14 – educated and implemented 10/6/14.

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F 280 Continued From page 4

Review of the facility's policy titled, "Care Management" dated August 2012, revealed the plan of care should be continuously updated to reflect current resident needs at all times. Further review revealed updating the Plan of Care was the responsibility of all involved staff.

Record review revealed the facility admitted Resident #1 on 12/27/13, with multiple diagnoses which included Dementia. Continued review of the admission documentation revealed the facility obtained a consent authorizing the use of the Secure Care Bracelet, signed by Resident #1's son on 12/27/13. Review of the Admission Minimum Data Set (MDS) Assessment, dated 01/06/14 and the Quarterly MDS Assessment, dated 08/27/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate impairment. Further review of the MDS Assessments revealed the facility assessed Resident #1 to ambulate independently with the assist of a walker.

Review of Resident #1's Comprehensive Care Plan (CCP), dated 01/10/14, revealed Resident #1 was care planned for being at risk for wandering/unsupervised exit seeking behaviors due to the diagnosis of dementia and ambulating independently with his/her "Jazzy" (brand name) rolling walker. Review of the care plan revealed interventions which included placement of a monitoring device on the resident that would sound an alarm when the resident left the building, to alert staff to Resident #1's wandering behavior, observe resident for wandering away from unit, approach resident in a calm and accepting manner, and directed staff to stay with

F 280

8. In-service written by Director of Nursing(DON) for all employees to help to identify and diffuse potential situations that may arise when caring for Resident #1 and her spouse, who is also a resident of this facility. All employees educated and completed 10/6/14.
9. Monitoring policy and criteria for secure care bracelet placement to include monitoring would not be discontinued until review by the Quality Assurance Committee (which consists of the Director of Nursing, Quality Assurance Director, MDS Coordinator, Maintenance Director, Business Office Manager, Administrator, Dining Services supervisor, Activity Director, Therapy Director, Housekeeping Supervisor and Social Services Director) or physician recommendation, created by DON, Quality Assurance Director (QAD), and Administrator and implemented and educated by QAD, Quality Assurance Assistant (QAA), and Infection control nurse 10/6/14.
10. An in-service training on care plans, elopement, behaviors, supervision, new care signs for elopement being conducted by QAD, Infection Control Nurse, and QAA on 10/6/14. The facility uses no agency staff and any employee out on leave or work on an as needed basis will be in-serviced prior to returning to work.

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F 280 Continued From page 5  
the resident, converse and gently persuade Resident #1 to walk back to designated area.

Review of Resident #1's Nurse's Notes, dated 03/13/14, revealed Resident #1 became upset over a conversation between the resident and the Social Worker and he/she verbally threatened to remove the Secure Care Bracelet and leave the facility. Resident #1 was unable to be re-directed by staff and was placed on every fifteen (15) minute checks; however, review of the CCP revealed no documented evidence it was updated, revised and interventions implemented to reflect the behavior.

Interview, on 09/29/14 at 3:26 PM, with Licensed Practical Nurse (LPN) #1, who was assigned to Resident #1, revealed she was not aware of the incident on 03/13/14 where Resident #1 had threatened to remove his/her Secure Care Bracelet and leave the facility. LPN #1 revealed Resident #1's care plan should have been updated and revised to implement additional interventions related to monitoring Resident #1.

Interview with the Minimum Data Set (MDS) Coordinator, on 10/01/14 at 9:58 AM, revealed there were "set" interventions which were implemented for elopement risk residents; however, Resident #1's care plan should have been updated and revised for the incident on 03/13/14 to ensure the interventions were appropriate to provide adequate supervision of the resident.

Continued review of the Nurse's Note revealed on 05/08/14, Resident #1 became upset when informed he/she would require supervision in the courtyard with his/her spouse. Approximately one

F 280 The Facility has implemented system changes to ensure the jeopardy will not reoccur.

1. As of 10/6/14, the facility will have in-serviced all staff on identifying and documenting behaviors, supervision of residents, and updating care plans for resident changes, elopement and monitoring by QAD, IC Nurse, and QAA.
2. A 3-11 House Supervisor position was added to ensure adequate supervision throughout the evening hours with the role to help supervise and to investigate or review any resident information as directed by the DON.
3. The new employee orientation program was updated to include education on elopement, monitoring, behaviors, care plans, and supervision 10/6/14.
4. The new employee check off system was updated to include understanding of the policies of elopement and care plans, as well as their understanding of potential behaviors, reporting behaviors, and supervision of residents.
5. All nurses have the responsibility to update the care plans as resident changes occur, in order to help with this process, the nurses will continue to utilize the carbon two part order system, which consists of an area for the physician order and an area for a care plan update, so updates can be made immediately to care plans as resident changes are made. The MDS office will receive a carbon copy of all physician orders to check to ensure all updates are done daily Monday through Friday to

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F 280	<p>Continued From page 6</p> <p>(1) hour and twenty (20) minutes after Resident #1 became upset, he/she was found outside the facility, in the parking lot, without the Secure Care Bracelet, by off duty staff leaving the facility. Further review revealed Resident #1 refused to come back into the facility. Review of the Note revealed the Physician was notified and medications were ordered for agitation. Further review revealed the Secure Care Bracelet was found in Resident #1's room in the trash can with a plastic knife. However, review of the Comprehensive Care Plan revealed no documented evidence the Care Plan was updated or revised with interventions for this behavior.</p> <p>Interview on 09/30/14 with State Registered Nursing Assistant (SRNA) #3 at 4:30 PM, with SRNA #6 at 4:57 PM, and on 10/01/14 with SRNA #8 revealed they all knew Resident #1; however, were not aware of Resident #1 threatening to cut off his/her Secure Care Bracelet, or of the resident threatening to leave the facility or of him/her exiting the facility previously.</p> <p>Further interview on 09/29/14 at 3:26 PM, with LPN #1 revealed she had not been aware of the incident on 05/08/14 where Resident #1 had cut his/her Secure Care Bracelet off and eloped from the facility. She stated Resident #1's care plan should have been updated and revised to implement additional interventions for increased supervision and monitoring of Resident #1.</p> <p>Continued interview with the MDS Coordinator, on 10/01/14 at 9:58 AM, revealed Resident #1's care plan should have been updated and revised for the 05/08/14 incident to ensure the interventions were providing adequate</p>	F 280	<p>ensure accurate and timely updates.</p> <p>Orders from the weekend will be collected on Monday morning by the Director of Nursing and the MDS office will review these changes to ensure updates were completed timely on the weekends as well as during the week.</p> <p>6. The QA committee will continue to discuss all care plan changes in the daily QA meeting. When a member of QA is not in attendance, a copy of the report is left in a marked mailbox to ensure all QA Committee members are aware of all resident changes. The float nurse will review all resident changes on the weekend and give report to the DON on Monday. The MDS office will review and update care plans based on the daily QA notes, which includes information that occurred during the weekend. This will ensure that all resident changes are up to date on the care plan for each resident.</p> <p>7. All written physician orders are reviewed by the DON, then passed onto the MDS office. This is completed daily Monday through Friday. All orders from the weekend are reviewed by the float nurse and will be collected on Monday by the DON.</p> <p>8. MDS will review all orders; place a check and initial on the order after the updates have been verified and then pass the orders onto the QA Department. The QA Department will then conduct random audits of the orders to ensure all updates are being updated and checked by the MDS office.</p>	
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F 280 Continued From page 7 supervision of the resident.

Further review of the Nurse's Notes revealed on 09/21/14 at 6:55 PM, the facility received a call from an off duty staff person reporting Resident #1's elopement. Per the Note the Social Services Director, Administrator, Resident #1's son and Physician were notified of the elopement.

Review of the facility's self-reported "Final Report" Incident Letter, dated 09/24/14, revealed on 09/21/14, Resident #1 had removed his/her Secure Care Bracelet and exited the facility without staff's knowledge. Further review revealed Resident #1 was placed on every fifteen (15) minute checks while in his/her room and one on one (1:1) while out of his/her room.

However, continued review of the CCP revealed no documented evidence the care plan was updated and revised to include Resident #1's successful elopement from the facility on 09/21/14. Review revealed no documented evidence of the interventions implemented for increased supervision of Resident #1 for every fifteen (15) minute checks while in his/her room and one on one (1:1) while out of his/her room until 09/22/14.

Further interview, on 09/29/14 at 3:26 PM, with LPN #1 revealed Resident #1 was returned to the facility and one on one (1:1) supervision was implemented, then every fifteen (15) minute checks were implemented. However, review of the CCP revealed no documented evidence of the increased supervision of Resident #1 through one on one (1:1) supervision or every fifteen (15) minute checks until 09/22/14.

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9. The QA Department will conduct audits on all resident care plan updates on a quarterly basis following the MDS/Care Plan schedule. This process will ensure that all updates have been reflected at each quarterly review. QA Audits are turned into the Administrator each week to ensure compliance.

10. The QA committee will conduct weekly walk thrus to spot check 4 residents for updates to the care plans on various residents to ensure the system is functioning properly. During this spot check, the QA member will compare the physician orders to the care plan and to the smart charting information for the nursing assistants, as well verify that the care plan is being followed through observation of the resident and interventions that are in place. Identification of any issues of care plans not being updated on these 4 residents will be identified at the QA meeting during the review of the walk thru to discuss further measures needed to ensure compliance with care planning is maintained.

11. By making the changes to the policies, educating all employees, adding information on monitoring, care plans, elopement, behaviors, and supervision to the new employee orientation information, checking employees off on information after orientation, reviewing of all resident orders by the float nurse during the weekend and DON during the week, creating a daily double check system through MDS office to ensure all orders are updated on the care plans daily Monday

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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
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F 280	Continued From page 8  Further interview with the MDS Coordinator, on 10/01/14 at 9:58 AM, revealed all staff was responsible for updating and revising the care plans. Per interview, the care plan was the tool utilized for the care a resident was to receive and if the care plan was not revised and updated to reflect a resident's current needs the facility was unable to ensure the resident received the care they needed and required.  Interview with the Director of Nursing (DON), on 09/30/14 at 1:53 PM, revealed all nurses were responsible for updating and revising residents' care plans. She stated Resident #1's care plan should have been updated and revised with each of the incidents of threatening to cut off the Secure Care Bracelet and when he/she exited the facility without staff's knowledge on 05/08/14 and communicated to staff; however, this was not done. She indicated after the 09/21/14 elopement the care plan should have been updated and revised to include the every fifteen (15) minute checks which had been implemented upon Resident #1's return to the facility; however, this had not been done until 09/22/14.  Interview with the Administrator, on 09/30/14 at 1:17 PM, revealed she was aware of Resident #1's previous threats to remove the Secure Care Bracelet and of his/her unsupervised exit from the facility in May, 2014. Per interview, every fifteen (15) minute checks were implemented after each of these incidents for a seventy-two (72) hour period. According to the Administrator, Resident #1's care plan should have been updated and revised on 03/13/14 and 05/08/14 to reflect the incidents in order to implement interventions to ensure the resident's safety. The Administrator indicated Resident #1's care plan should have	F 280	through Friday and all weekend updates being reviewed by the float nurse and given to the DON and MDS on Monday, and QA audits of all resident care plans with the MDS/Care Plan Schedule with reports given to the Administrator weekly for identification of compliance issues, that systems are now in place to ensure that each resident has a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment; is 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 is periodically reviewed and revised by a team of qualified persons after each assessment.  <b><u>The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained.</u></b>  To assure that each resident has a comprehensive care plan developed within 7 days after the completion of the comprehensive assessment, monitoring through Quality Assurance committee weekly walk thrus will continue on an ongoing basis to ensure that care plans are updated in a timely and accurate manner. All findings from the weekly walk thrus		

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F 280 Continued From page 9  
been updated and revised on 09/21/14 after the resident's elopement, but this was not done until 09/22/14.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 10/06/14, which alleged removal of the Immediate Jeopardy (IJ), effective 10/07/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was placed on fifteen (15) minute observations on 09/21/14. Resident #1's room was searched for other objects that could be utilized to remove secure care bracelet or be utilized to harm self or others by staff on duty on 09/21/14 and then searched again on 09/25/14 by the Quality Assurance Director (QA) with a set of nail clippers removed from the closet area. A tamper resistant secure care bracelet was ordered by the Housekeeping Supervisor on 09/22/14. Resident #1 then went on a Leave of Absence from the facility with his/her son from 09/22/14 through 09/25/14.
2. All thirteen (13) residents, that had Secure Care Bracelets were reviewed for risk to ensure Secure Care Bracelets were in place, functioning properly, and were care planned appropriately with no changes or updates required by the Assistant Director of Nursing (ADON) on 09/22/14.
3. A 3:00 PM to 11:00 PM House Supervisor position was added, effective 09/24/14, with the role to help supervise and to investigate or review any resident information as directed by the Director of Nursing (DON).
4. On 09/30/14, all 107 residents were assessed

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will be reported to the Quarterly QA committee meetings, which consists of the Daily QA team, along with the Medical Director, pharmacy representative, Infection Control Nurse, Wound Care Nurse, and Restorative Nurse for follow up of education needed throughout the building. In addition, the Medical Director is apprised of any areas of concern and input sought to monitor on the ongoing concerns of the facility. The medical director's cell phone number is located on all units for easy access for consultation. Any areas of concern regarding the updates being completed accurately and timely will be reported to the Administrator for immediate action.

**The Facility has included dates of corrective action.**

The facility is confident that the situation creating immediate jeopardy was corrected by Monday, 10/6/14. In addition to the steps to remove the immediate jeopardy, the monitoring of the auditing of all care plans on a quarterly basis and the auditing of the care plans with the physician orders and daily QA report by the MDS staff, along with the random auditing of physician orders by the Quality Assurance Assistant over the past month with no new areas of concern identified ensures that the current system in place will ensure ongoing compliance.

Completion Date 11/11/14

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F 280 Continued From page 10  
for risk for elopement and four (4) care plans for the residents identified were updated to accurately reflect the needs of the resident by the MDS Coordinator, MDS Assistant, DON, QA Director, and the ADON. A screening tool, Elopement Risk Assessment Decision Tree, was developed to identify residents at risk for elopement on 10/02/14 by the DON and the QA Director. The Elopement Risk Assessment Decision Tree was implemented and completed, on 10/04/14 and 10/05/14, on all residents with no new residents identified to be at risk for elopement and was completed by the Infection Control Nurse, the Wound Care Nurse, and another Licensed Practical Nurse (LPN).

5. The DON, QA Director, and the Administrator created a monitoring policy and criteria for secure care bracelet placement to include monitoring would not be discontinued until review by the Quality Assurance Committee or Physician recommendation. The monitoring policy was created on 09/30/08. Implementation and Education of the new monitoring policy was completed by the QA Director, the Infection Control Nurse, and the Quality Assurance Assistant on 10/06/14.

6. All areas of the facility covered by the Secure Care System were searched for hazardous items which started on 10/01/14 and was completed on 10/03/14, by staff which included the QA Nurse, Housekeeping Director and MDS Coordinator.

7. Boards for identification of residents at risk for elopement were placed in the nursing stations on 10/02/14. Additional boards for identification of residents at risk for elopement were placed in the break rooms, including the area by the time clock,

F 280 Bourbon Heights is an excellent nursing facility with a committed staff and dedicated board of directors. The Facility remains committed to the providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Plan of Correction to be an admission of the finding of deficient practices.

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F 280 Continued From page 11 and at the front office, on 10/03/14 by the QA Assistant, to help all staff to identify residents at risk for elopement.

8. Education regarding leaving offices unattended or tools/supplies unsecured when out of offices and to ensure sharp objects are placed inside desk was given to Kitchen staff, Maintenance Department, Activities Department, front office staff, Social Services Department, Therapy Department, Quality Assurance Department, and the Nursing office staff starting 10/01/14 and completed on 10/03/14 and was given by Department Supervisors.

9. Resident #1's Comprehensive Care Plan was updated to include a new Elopement Care Plan by the Minimum Data Set (MDS) Coordinator on 10/01/14.

10. Employees were scheduled by the Scheduling Coordinator, on 10/02/14, to be responsible for a minimum of fifteen (15) minute monitoring for Resident #1 while in his/her room and one on one (1:1) supervision with Resident #1 while out of room with his/her spouse whom was also a resident of the facility. Also, one on one (1:1) supervision was to be done if Resident #1 was wanting to go off the unit until otherwise directed.

11. All care plans were reviewed to ensure updates had been completed for any new orders received in the last thirty (30) days with any issues identified and corrected at the time of the audit, starting on 10/03/14 and completed on 10/06/14, and was completed by the Infection Control Nurse, the Wound Care Nurse, the second shift House Supervisor, the ADON, and

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F 280	<p>Continued From page 12 another LPN.</p> <p>12. Resident Care signs located in each resident's room were updated to include risk for elopement on 10/01/14 and education on the Resident Care signs was given to all facility by the QA Director, the Infection Control Nurse and by the DON from 10/01/14 through 10/06/14.</p> <p>13. A new tamper resistant secure care bracelet was placed on Resident #1, on 10/06/14, by the Maintenance Director and QA Director.</p> <p>14. An in-service training was given to all staff on elopement to include the procedures on a Golden Alert announcement when an elopement occurs or is attempted by residents. In addition, all staff were given in-service training on behaviors and reporting and documentation of behaviors, supervision, new Resident Care signs for residents with elopement risk, and updating care plans for resident changes. All in-service training were completed by 10/06/14 by the QA Director, QA Assistant, and the Infection Control Nurse. All staff will also be receiving these in-service training annually.</p> <p>15. The facility included education on elopement, monitoring behaviors, care plans, and supervision in the new employee orientation program by 10/06/14. The QA Director and QA Assistant will incorporate into their current check off of new employees during orientation to determine understanding of the policies on elopement, care plans, potential behaviors, reporting of behaviors, and supervision of residents.</p> <p>16. The facility implemented plans to monitor its performance to ensure the residents'</p>	F 280		
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F 280 Continued From page 13  
environment remain as free from accident hazards as possible and that adequate supervision is in place by monitoring through the Quality Assurance Committee weekly walk through on an ongoing basis to identify areas of potential hazards and inadequate supervision. The Medical Director will have an on-going role in the monitoring of these solutions as both the medical director and as the personal physician for Resident #1. The facility's QA Committee members will review daily reports and investigations from each unit to identify potential accident hazards for tracking and trending purposes and report their findings during the daily QA Committee meeting and to the Quarterly QA Committee which includes the Medical Director. Any areas of potential harm identified will be reported to the Administrator for immediate attention.

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The State Survey Agency validated the implementation of the facility's AOC as follows:

1. Review of the "fifteen (15) minute monitoring form", on 09/21/14 revealed, Resident #1 was on one to one supervision with the Administrator upon return to the facility from 7:30 PM until 8:45 PM and fifteen (15) minute monitoring began at 8:45 PM on 09/21/14. Resident #1 remained on fifteen minute monitoring until 09/22/14 at 5:30 PM when he/she left the facility on a Leave of Absence with his/her son. Interview with Kentucky Medication Aide (KMA) #1, on 09/29/14 at 3:00 PM, revealed he searched Resident #1's room on 09/21/14 for objects that could be used to remove the secure care band but was not able to find anything in Resident #1's room other than the Secure Care Bracelet that he/she removed prior to eloping from the facility, which was found

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F 280	<p>Continued From page 14 in Resident #1's trash can.</p> <p>Interview with the QA Director, on 09/29/14 at 11:22 AM revealed she did a follow-up search of Resident #1's room.</p> <p>A late entry Nurses' Note written by the MDS Assistant, on 09/26/14 at 8:09 AM revealed Resident #1 returned to the facility on 09/25/14 at 6:00 PM and the Nurses' Note revealed staff was present when Resident #1 unpacked his/her belongings and there were no objects in the belongings to cut the Secure Care Bracelet off. Review of the "fifteen (15) minute monitoring form" revealed fifteen (15) minute monitoring resumed on 09/25/14 at 6:00 PM upon Resident #1's return to the facility and would continue fifteen (15) minute monitoring until the Administrator and QA team deemed unnecessary. Review of the purchase order revealed a tamper resistant Secure Care Bracelet was ordered on 09/22/14 by the Housekeeping Director.</p> <p>2. The check off sheet the ADON completed, on 09/22/14, regarding her review of all thirteen (13) residents with Secure Care Bracelets to ensure placement, proper functioning, and to ensure they were appropriately care planned was reviewed and a copy of the check off sheet was obtained. An interview with the ADON, on 10/01/14 at 10:50 AM, revealed she did complete a review of all thirteen (13) residents with Secure Care Bracelets to ensure placement and proper functioning was completed and all thirteen (13) residents with Secure Care Bracelets had care plans on 09/22/14.</p> <p>3. Review of the facility's staff schedule of</p>	F 280		
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F 280	<p>Continued From page 15</p> <p>Registered Nurse (RN) #1 revealed a House Supervisor position for 3:00 PM to 11:00 PM had been added and a copy of the schedule was obtained. A copy of the "Job Description" for the Nursing Supervisor position was also obtained and reviewed.</p> <p>Interviews, on 10/09/14, with the Infection Control Nurse at 9:00 AM, State Registered Nursing Assistant (SRNA) #8 at 9:30 AM, Unit Coordinator #1 at 10:48 AM, Unit Coordinator #2 at 12:55 PM, KMA #17 at 1:12 PM, SRNA #18 at 1:28 PM, and SRNA #16 at 1:50 PM confirmed that a House Supervisor position for 3:00 PM to 11:00 PM had been added and RN #1 was assigned to the position.</p> <p>4. Reviewed the screening tool, Elopement Risk Assessment Decision Tree instructions sheet, dated 10/2014, revealed the new screening tool was to be completed upon admission, quarterly, and with any significant change in condition/mental health status.</p> <p>Review of the facility's Elopement Risk Assessments revealed they were completed for the sampled and unsampled residents reviewed.</p> <p>Interview with the MDS Coordinator on 10/09/14 at 2:20 PM, the DON on 10/09/14 at 3:15 PM and the QA Director on 10/09/14 at 3:30 PM revealed the screening tool, Elopement Risk Assessment Decision Tree, was developed to identify residents at risk for elopement on 10/02/14 by the DON and the QA Director. They reported all one hundred and seven (107) residents were assessed for risk for elopement through use of the new screening tool with no residents determined to be at risk except the previous</p>	F 280		

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F 280	<p>Continued From page 16</p> <p>residents determined to be at risk. Four (4) residents' care plans required updating to accurately reflect the needs of the resident.</p> <p>5. Obtained and reviewed copies of the facility's new monitoring policy with the criteria for placement of the Secure Care Bracelet. Obtained and reviewed copies of the education provided to staff regarding the new policy with signatures.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education regarding the new policy.</p> <p>6. Review of the facility's maps provided by the Administrator revealed all areas of the facility covered by the Secure Care System were searched for hazardous items which started on 10/01/14 and was completed on 10/03/14, by staff which included the QA Nurse, Housekeeping Director and MDS Coordinator.</p> <p>Interview on 10/09/14, with the Infection Control Nurse at 9:00 AM and with the MDS Coordinator on 10/09/14 at 2:20 PM revealed they were involved in the facility wide search for hazardous items.</p> <p>7. Observation on 10/09/14 in the employee break room, time clock area, front office and nurses station revealed elopement boards in</p>	F 280		
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F 280	<p>Continued From page 17</p> <p>place as per the Allegation of Compliance. Further observation revealed the elopement boards included pictures of residents at risk for elopement, with the residents' room numbers.</p> <p>8. Obtained and reviewed a copy of education given to staff related to leaving offices unattended or tools/supplies unsecured with copies of signatures of staff in attendance completed on 10/03/14.</p> <p>Interview on 10/09/14 with Maintenance Director at 2:52 PM; House Keeping #18 at 2:58 PM; Maintenance #19 at 3:04 PM; Dietary #20 at 3:12 PM; and Dietary #21 at 3:17 PM revealed they all reported receiving the education.</p> <p>9. Review of Resident #1's care plan for potential for unsupervised exits from the facility revealed his/her care plan had been updated and a new care plan for potential for elopement had been added by the MDS Coordinator on 10/01/14 and included Resident #1's history of elopement. A copy of both the previous and new care plan related to elopement were obtained.</p> <p>10. Review of the "sitter schedule" from 10/02/14 through 10/21/14 for Resident #1 revealed an extra staff member was assigned to Resident #1 between the hours of 7:00 AM and 12:00 AM through those dates. Further review of Resident #1's sitter instruction sheet revealed the sitter must monitor Resident #1 for a minimum of fifteen (15) minute monitoring while Resident #1 was in his/her room and one to one (1:1) supervision while Resident #1 was out of his/her room. A copy of the "sitter schedule" and sitter instructions for monitoring sheet were obtained.</p>	F 280		
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F 280	<p>Continued From page 18</p> <p>11. Reviewed MD orders and care plan updates for the previous thirty (30) days to verify updates had been completed by 10/06/14 for seventeen (17) residents.</p> <p>12. Observation on 10/09/14, of the facility's identified elopement risk residents revealed the appropriate Resident Care signs in place in their room on the communication board or on the door to their room.</p> <p>The facility's Elopement Risk/Resident Care Sign Education was reviewed with copies obtained to include signatures of staff in attendance.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education.</p> <p>13. Observations of Resident #1, on 10/09/14 revealed a Secure Care Bracelet on the right ankle. Obtained a copy of the facility's Purchase Order #46614 and dated 09/22/14 that the tamper resistant Secure Care product had been ordered.</p> <p>Interview with the Administrator on 10/09/14 at 3:30 PM revealed Resident #1's Secure Care Bracelet had been replaced, a tamper resistant bracelet had been ordered and would be placed on the resident when available.</p> <p>14. Reviewed the "Golden Alert" in-service given to staff with copies obtained to include signature</p>	F 280		
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F 280: Continued From page 19  
of staff in attendance. Copy of in-service related to behaviors, reporting and documentation of behaviors, supervision, new care signs for elopement risk and updating care plans for resident changes was obtained with signatures of staff in attendance and completed by 10/06/14.

Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education related to the facility's "Golden Alert".

Interview on 10/09/14 with Maintenance Director at 2:52 PM; House Keeping #18 at 2:58 PM; Maintenance #19 at 3:04 PM; Dietary #20 at 3:12 PM; and Dietary #21 at 3:17 PM revealed they all reported receiving the education related to the facility's "Golden Alert".

15. New employee education packet was reviewed with copies obtained. Education included elopement, monitoring and reporting of behaviors, care plans, and supervision of residents.

16. Reviewed audits completed by QA committee members from weekly walk through with new areas identified on audit tool. Reviewed minutes of daily QA meeting that included areas of potential hazard and supervision issues. Interview with the Medical Director on 10/09/14, revealed the facility did report the elopement to him on the night of the incident. Further interview

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F 280	Continued From page 20 revealed he took an active role in the daily care of the residents and the facility kept him well informed. Further interview revealed he was fully participating in the decision making process of the facility. Interview with the Administrator on 10/09/14, revealed she was actively participating in the audits as well as reviewing the data from the audits and would continue to review audits making changes as needed based on the data and the needs of the residents of the facility.	F 280		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policies, Incident Reports, Investigations and Security Footage document, it was determined the facility failed to have an effective system in place to ensure a safe environment and adequate supervision for residents who had been assessed at risk for wandering and/or exit seeking behaviors for one (1) of twelve (12) sampled residents residents (Resident #1).  On 09/21/14, Resident #1 was agitated with staff's redirection, and at approximately 6:32 PM, Resident #1 cut off his/her Secure Care Bracelet	F 323	This Plan of Correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.  It is the policy of Bourbon Heights, Inc. to ensure the resident environment remains as free of accident hazards as is possible and for each resident to receive adequate supervision and assistance devices to prevent accidents.  When notified that an immediate jeopardy situation had been identified to exist at Bourbon Heights, Inc., immediate steps were taken on September 30, 2014 to investigate, correct and rectify the situation, as well as steps to prevent future issues with accident hazards and supervision. Below is a comprehensive list of immediate corrective actions that have been taken. Items were accomplished by October 6, 2014 and represent the Facility's continuing efforts toward improving quality of care and compliance.	

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F 323 Continued From page 21  
with a six (6) inch paring knife and eloped from the facility without staff's knowledge. Resident #1 was found by police at 7:01 PM, approximately three tenths of a mile from the facility, walking with a walker on a heavily traveled two (2) lane road, without a sidewalk or a shoulder, and escorted back into the facility by staff at approximately 7:10 PM.

Interview and record review revealed Resident #1 had a history of verbally threatening to remove the resident's Secure Care Bracelet and leave the facility and had previously exited the facility without staff knowledge. On 03/13/14, Resident #1 became upset and told the Social Worker (SW) he/she was going to remove the Secure Care Bracelet and leave the facility. On 05/08/14, Resident #1 became upset when informed he/she would require supervision in the courtyard with his/her spouse. Approximately one (1) hour and twenty (20) minutes later, staff leaving the facility found Resident #1 in the parking lot outside the facility, without his/her Secure Care Bracelet in place. The Secure Care Bracelet was found in Resident #1's room in the trash can with a plastic knife present also. However, there was no documented evidence the facility investigated the successful elopement incident on 05/08/14, and no documented evidence the facility increased supervision of Resident #1 prior to the resident eloping from the facility again on 09/21/14 without staff's knowledge. (Refer to F-280)

The facility's failure to have an effective system in place to ensure a safe environment and adequate supervision has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 09/30/14 and was determined to exit on 09/21/14.

F 323 Cause of the Immediate Jeopardy was identified.  
The Immediate Jeopardy finding related to a resident elopement from the facility. On May 8, 2014, Resident #1 removed secure care bracelet and went out the back door of the building, off duty staff identified and intervened in this incident and resident #1 remained on the grounds with one on one staff supervision until returning to her room for the night. On September 21, 2014, resident #1 utilized a paring knife to remove her bracelet and leave the facility. Resident #1 Was located approximately 3/10 of a mile from the facility after an off duty employee notified the facility of location of resident #1. Upon notification, employees returned resident #1 to the facility via personal vehicle and remained one on one with resident #1 for the evening until resident #1 went to sleep and then kept on 15 minute monitoring continuously throughout the stay.

The facility has identified all residents that may be at potential risk for harm.  
To identify the residents who may have been at potential risk for harm, the Assistant Director of Nursing(ADON) assessed all 13 residents with secure care bracelets to ensure the secure care bracelets were on the residents were on the resident and functioning properly and to ensure all resident care plans included the secure care bracelet. This was completed 9/22/14 with no changes or updates required.

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F 323 Continued From page 22

An acceptable credible Allegation of Compliance (AOC) was received on 10/07/14 which alleged removal of the Immediate Jeopardy on 10/07/14. The Immediate Jeopardy was verified to be removed on 10/07/14 as alleged with the remaining non-compliance at 42 CFR 483.25 Quality of Care (F-323) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure a safe environment and adequate supervision of residents.

The findings include:

Review of the facility's policy titled, "Wandering/Elopement Policy" dated 11/2010, revealed all residents with a diagnosis of Alzheimer's/Dementia or having a history of wandering would be screened upon admission and anytime nursing judgement warranted a screening. Further review revealed residents found to have a potential for wandering would be fitted with a Secure Care Bracelet. Continued review revealed should a resident elope or attempt elopement, the resident would be monitored every fifteen (15) minutes for seventy-two (72) hours then assessed for any "needed changes/interventions".

The State Survey Agency requested the tool utilized by staff upon admission and anytime nursing judgement warranted for screening residents as risk for wandering or elopement as per the facility's Wandering/Elopement Policy. However, interview with the Administrator on 09/26/14 at 12:38 PM, and the Director of Nursing

F 323 The facility also assessed all residents for the risk of elopement on 9/30/14. The assessment of 107 residents for risk of elopement was completed by the Director of Nursing, MDS Assistant, MDS Coordinator, Infection Control Nurse, Assistant Director of Nursing, and Quality Assurance Director, which identified 4 residents that were identified to be at risk for elopement, these residents were reviewed and care plans were updated.

Steps taken to remove the Immediate Jeopardy

1. Resident #1 was one on one approximately 4 hours with Administrator, Quality Assurance Director and Quality Assurance Assistant 5/8/14.
2. Resident#1 room searched by Quality Assurance Director 5/8/14 with no additional findings.
3. Resident #1 secure care bracelet reapplied by Quality Assurance Director 5/8/14.
4. Resident #1 placed on 15 minutes observations for 72 hours 5/8/14.
5. Resident #1 referred to Dr. Ghanta, psychiatrist by attending physician, Dr. Nathan Moore 5/14/14.
6. Resident #1 medication orders updated 5/15/14 as suggested by consulting physician.

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F 323	<p>Continued From page 23</p> <p>(DON), on 09/30/14 at 1:53 PM, revealed the facility did not have an elopement screening tool.</p> <p>Record review revealed the facility admitted Resident #1 on 12/27/13, with multiple diagnoses which included Dementia. Review of the Admission Minimum Data Set (MDS) Assessment, dated 01/06/14 and the Quarterly MDS Assessment, dated 08/27/14, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15), indicating moderate cognitive impairment. Continued review of the MDS Assessments revealed the facility assessed Resident #1 to ambulate independently with the assistance of a walker. Further review of the Admission and Quarterly MDS Assessments revealed no documented evidence the facility assessed Resident #1 to be at risk for wandering.</p> <p>Review of the Comprehensive Care Plan (CCP), dated 01/10/14, for Resident #1 revealed the facility care planned the resident for the potential for unsupervised exits from the facility due to his/her diagnosis of Dementia. Continued review of the CCP revealed interventions which included: alerting staff of the resident's wandering behaviors; placement of a monitoring device which would sound if Resident #1 left the facility; if he/she was observed to be wandering away from unit, staff were to stay with the resident approaching him/her in a calm and accepting manner, staying with the resident while conversing with him/her and gently persuading him/her to return to the designated area of the facility. Further review of the CCP revealed the facility care planned Resident #1 to ambulate independently with a "Jazzy" walker.</p>	F 323	<ol style="list-style-type: none"> <li>7. Resident #1 and all other residents with changes are discussed in morning QA meetings Monday through Friday – information from the weekend is included in the report on Monday. Report is copied and given to each department head, in their absence, a copy is placed in a folder located in the front office marked morning report. This is to ensure that all department heads have the same information. The float nurse gets weekend report and passes to the DON on Monday.</li> <li>8. Resident #1 encouraged to discuss items that cause frustrations 5/8/14 through present day.</li> <li>9. Placed resident #1 on 15 minute observations 9/21/14.</li> <li>10. Resident went Leave of Absence (LOA) with son from 9/22/14 through 9/25/14.</li> <li>11. 3-11 House Supervisor position added effective 9/24/14 with role to help supervise and to investigate or review any resident information as directed by Director of Nursing.</li> <li>12. Resident #1 room searched for other objects that could be utilized to remove secure care bracelet or be utilized to harm self or others by staff on duty 9/21/14 and 9/25/14 by Quality Assurance (QA) Director with set of nail clippers removed from closet area.</li> <li>13. Ordered tamper resident secure care bracelet 9/22/14.</li> <li>14. Reviewed all 13 residents with secure care bracelets for risk to ensure secure care bracelets in place, functioning properly and care planned appropriately with no changes or updates required – by ADON 9/22/14.</li> </ol>		

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F 323 Continued From page 24  
Continued record review revealed a consent authorizing the use of the Secure Care Bracelet to "promote the safety" of Resident #1, signed by Resident #1's son on 12/27/13. Additionally, record review revealed no documented evidence Resident #1 was screened on admission or at any other time prior to 09/21/14 for his/her wandering and elopement risk.

Review of the facility's self-reported "Final Report" Incident Letter, dated 09/24/14, revealed on 09/21/14, Resident #1 had been redirected by staff during the evening meal, for "being inappropriate towards his/her spouse" (also a resident). Review of the letter revealed Resident #1 removed his/her Secure Care Bracelet and left the facility without staff knowledge. Further review revealed the facility was notified by an off duty staff person. Continued review revealed the facility was unable to determine how long Resident #1 was out of the facility. Further review revealed Resident #1 was escorted back to the facility where a search of Resident #1's belongings revealed a small knife found hidden in the tissue box in the basket attached to the resident's "Jazzy" walker. Further review revealed Resident #1 was placed on every fifteen (15) minute checks while in his/her room and 1:1 while out of his/her room.

Review of the facility's document, "Review of Security Footage" of the Administrator's and Accounting Clerk's observation of the facility's video surveillance dated 10/07/14, revealed on 09/21/14 at 5:45 PM, Resident #1 went to his/her room with the Secure Care Bracelet in place. Review of the document revealed at 5:53 PM, Resident #1 exited his/her room with the Secure Care Bracelet in place, went to the Personal Care

- F 323
15. Completed investigation on where resident obtained knife – Administrator 9/30/14.
  16. Moved secure care system in unit 3 apartment hallway to include apartments not covered previously – completed 10/1/14 by Maintenance Department.
  17. Searched all areas of the building that are covered by the secure care system, including individual rooms in the nursing section and personal care section. The apartment sections were not searched individually as these residents are independent living residents and an alarm would sound if a secure care bracelet crosses the double doors leading into this area (as of 10/1/14) started 10/1/14 completed 10/3/14.
  18. Scheduling coordinator scheduled employees to be responsible for 15 minute monitoring of resident #1 if in room, otherwise one on one while out of room with husband and/or wanted to go off the unit until otherwise directed. 10/2/14.
  19. Developed screening tool (Elopement Risk Assessment Decision Tree) to identify residents at risk for elopement – Director of Nursing (DON), Quality Assurance Director (QAD), and Administrator. 10/2/14
  20. New risk assessment for elopement (Elopement Risk Assessment Decision Tree) implemented and completed on all residents with no new residents identified to be at risk for elopement by Infection Control Nurse, Wound Care Nurse and another LPN Completed 10/5/14.
  21. Updated care signs to include risk for elopement 10/1/14 – to be educated by QAD, Infection Control Nurse, and DON. Completed 10/6/14.

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F 323	Continued From page 25 elevator where he/she entered the elevator and went upstairs. At 6:00 PM review revealed Resident #1 ambulated through the double doors leading to the apartment section of the facility and at 6:17 PM, Resident #1 returned from the apartments, through the double doors and returned to his/her room at 6:22 PM. Continued review revealed at 6:29 PM, Resident #1 exited his/her room with a laptop computer on top of the seat on the rolling walker and ambulated by the Unit One Nurse's Station at 6:31 PM. Further review revealed Resident #1 exited out the front doors in the lobby area of the facility at 6:32 PM and was escorted by staff back into the building at 7:10 PM, thirty-eight (38) minutes later.  Review of the police department Master Call Table revealed, on 09/21/14 at 6:54 PM, an unknown caller reported an elderly person with a walker in traffic. Continued review revealed a police officer was dispatched to the area and arrived at 7:01 PM to find an elderly person in a black robe with a walker in traffic. Further review revealed the facility staff to arrive on scene at 7:05 PM. Additional review revealed the police officer to be enroute back to the facility at 7:09 PM.  Observation on 09/29/14, of the area Resident #1 was found on 09/21/14, revealed it was approximately three tenths of a mile from the facility on a heavily traveled roadway which had no sidewalk or shoulder.  Interview with Assistant Feeder (AF) #11, on 09/30/14 at 12:56 PM, revealed she was in the dining room on 09/21/14 during the evening meal. AF #11 revealed around 5:30 PM or 5:45 PM, she had served Resident #1 and his/her spouse their	F 323	22. Tamper resistant secure care bracelet placed on Resident #1 10/6/15 by Maintenance Director and QAD. 23. Created additional boards for identification of residents at risk for elopement to be placed in break rooms, including area by time clock, and at front office to help all staff identify residents that may be at risk, this was in addition to boards already in place in the nurses station. 10/3/14. 24. Educated kitchen, maintenance, activities, front office, social services, therapy, quality assurance, nursing office regarding leaving offices or tools/supplies unsecured when out of the office and to ensure sharp objects are placed inside desks – completed by department supervisors – completed 10/3/14. 25. Educated apartment residents regarding helping to ensure a safe living environment via letter – reviewed individually with apartment residents by Housekeeping supervisor completed 10/3/14. 26. Added letter to apartment residents to apartment lease agreement to educate all new apartment residents – completed 10/2/14 27. In-service prepared and given to all employees regarding Resident #1 to help identify and diffuse potential situations that may arise when caring for resident #1 and her spouse, who is also a resident of this facility. Completed 10/6/14.		

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F 323	<p>Continued From page 26</p> <p>meal trays and was monitoring the residents. Continued interview revealed she witnessed Resident #1 become upset with his/her spouse when the spouse did not move closer to the table and dropped food onto the floor. Per interview AF #11 redirected Resident #1 and reported her observations to the resident's nurse. Further interview revealed she returned to the dining room around 6:30 PM, at which time Resident #1 had already left the dining area.</p> <p>Interview, on 09/29/14 at 3:26 PM, with Licensed Practical Nurse (LPN) #1, responsible for Resident #1's care, revealed the resident had been observed becoming upset with his/her spouse during the evening meal in the dining room prior to his/her elopement from the facility. Continued interview revealed LPN #1 redirected Resident #1 by whispering to Resident #1 the facility could not "have that here". LPN #1 reported Resident #1 was quiet and didn't say anything more.</p> <p>Interview with Housekeeper (HK) #5, on 09/29/14 at 10:53 AM, revealed she was traveling home around 7:00 PM and saw Resident #1 with a walker on the roadway. HK #5 reported she immediately phoned the facility to advise of the elopement. Further interview revealed by the time she turned her vehicle around to go back to Resident #1, the police were already with the resident and directing traffic around him/her.</p> <p>Continued interview, on 09/29/14 at 3:26 PM with LPN #1 revealed she was unaware Resident #1 was out of the facility until she received a call from an off duty staff person. LPN #1 reported when she went to pick Resident #1 up, police were on the side of the road with the resident.</p>	F 323	<p>28. Monitoring policy created and criteria for secure care bracelet placement to include monitoring would not be discontinued until discussed by Quality Assurance Committee (consists of Administrator, Business Office Manager, Maintenance Director, Housekeeping Supervisor, Dining Services Supervisor, Director of Nursing, Therapy Director, Activity Director, Social Services, Director, and Quality Assurance Director) or physician recommendation 9/30/14 Implemented and education completed 10/6/14.</p> <p>29. In-service for staff on elopement, behaviors, supervision, new care signs for elopement completed by QAD, QAA, and infection Control Nurse completed 10/6/14. The facility uses no agency staff and any employees out on leave or work on an as needed basis will be in-serviced prior to returning to work.</p> <p><b><u>The facility has implemented systemic changes to ensure the jeopardy will not reoccur.</u></b></p> <p>1. As of 10/6/14, the facility will have implemented and educated all staff regarding new policies on monitoring to include language that a monitoring program will not be discontinued until reviewed by the QA Committee or recommendation by the physician.</p>	

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F 323 Continued From page 27

LPN #1 revealed upon return to the facility she did not conduct a head to toe assessment for injury of Resident #1 due to his/her being upset. However, interview with the DON, on 09/30/14 at 1:53 PM, revealed Resident #1 should have been assessed for injury after the elopement.

Interview, on 09/29/14 at 10:15 AM, with Resident #1 revealed he/she did not advise staff of the intent to leave the facility on 09/21/14. Resident #1 revealed he/she was not upset prior to leaving the facility. Continued interview revealed Resident #1 reported he/she "stole" a knife from a resident's room outside the "nursing unit" (indicating an apartment) and cut his/her Secure Care Bracelet off with it. Per interview, prior to leaving the facility, Resident #1 called his/her brother to request a ride to another brother's house. Resident #1 stated the brother he/she called did not "get here fast enough" so the resident left the facility walking with his/her "Jazzy" walker, lap top computer and cell phone. Resident #1 further reported, he/she had "planned to leave that day and had no plans on coming back but only to visit" his/her spouse.

Review of the Nurse's Notes revealed on 09/21/14 at 6:55 PM, the facility received a call from an off duty staff reporting Resident #1 had eloped from the facility. Further review revealed three (3) staff members left the facility to look for and retrieve Resident #1. Continued review revealed Resident #1 was transported back to the facility in a staff's personal vehicle and during transport, while stopped, Resident #1 attempted to unbuckle the seat belt. Further review revealed the SSD, Administrator, Resident #1's son and Physician were notified of the elopement.

- F 323
2. As of 10/6/14, the facility will have implemented and educated all staff on new policies regarding Elopement, including procedures on Golden Alert announcement when an elopement happens or is attempted by resident(s).
  3. As of 10/6/14, the facility will have in-serviced all staff on identifying and documenting behaviors, supervision of residents, and updating care plans for resident changes.
  4. All apartment residents were educated regarding safe living environment and securing sharp objects, as well as information was added to the Lease Agreement Packet for Apartment completed 10/3/14.
  5. A 3-11 House Supervisor position was added to ensure adequate supervision throughout the evening hours with role to help supervise and to investigate or review any resident information as directed by the DON - completed 9/24/14.
  6. The facility will include education on elopement, monitoring, behaviors, care plans, and supervision in the new employee orientation program. All employees will be educated by 10/6/14 and annually.
  7. The new employee orientation and check off of new employees will include determination of their understanding of the policies on Elopement, care plans, as well as their understanding of potential behaviors, reporting of behaviors, and supervision of residents.

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F 323 Continued From page 28

Interview with the SSD, on 09/26/14 at 10:45 AM, revealed she was not at the facility when Resident #1 eloped on 09/21/14. She stated staff called her to come back to the facility and she arrived around 7:30 PM to initiate the investigation. Continued interview revealed she requested written statements from staff who retrieved Resident #1 and talked with Resident #1 regarding the knife found in the basket attached to the walker. She stated Resident #1 was placed on one on one (1:1) monitoring until approximately 10:00 PM then on every fifteen (15) minute monitoring. Continued interview revealed on 09/21/14, she did not interview other residents, assess other residents for the risk of elopement or ensure other residents with Secure Care Bracelets had the bracelets in place as she "didn't see a need" to have done those things after Resident #1's elopement.

Further interview on 09/29/14 at 3:26 PM with, LPN #1 revealed the facility did not assess other residents at risk for wandering or elopement to ensure placement of their Secure Care Bracelets or complete a formal resident count to ensure no other residents had eloped until 09/22/14.

Interview with the Administrator, on 09/26/14 at 12:38 PM, revealed she was notified by the facility on 09/21/14 of Resident #1's elopement. The Administrator revealed she came to the facility and talked with Resident #1 and initiated the investigation for the elopement. Continued interview revealed Resident #1's personal belongings and room were searched with a knife found in the basket of the "Jazzy" walker and the Secure Care Bracelet found in the trash can in the room. Resident #1 was placed on one on one (1:1) monitoring until approximately 10:00 PM

- F 323
8. All employees were educated to be on the lookout for sharp objects that could be used to harm self or others while completing their daily work and to remove or report these items to the charge nurse if found.
  9. The QA committee, which consists of all department supervisors, including the Administrator, Director of Nursing, Business Office Manager, Maintenance Director, Housekeeping Supervisor, Dining Services Director, Activity Director, Social Services Director, Quality Assurance Director and Therapy Director will complete walk thru of all resident rooms and all common areas to look for potential hazards that could cause accidents or could inhibit the amount of appropriate supervision throughout the building on a weekly basis to ensure that ongoing compliance with accident safety and supervision is maintained.
  10. Departmental Directors for Nursing, Housekeeping, Maintenance, Dining Services, Activities, and Quality Assurance complete daily walk thru of the building during their work day to ensure ongoing compliance, as well as the float nurses who would do walk thru during the weekend to ensure accident hazards and supervision remains in compliance.
  11. Risk for elopement boards with resident pictures and room numbers were placed in all break rooms and the front office for all staff to be aware of residents at risk, this was an addition to boards already in place in the nurses station.

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F 323 Continued From page 29 then on every fifteen (15) minute monitoring.

Interview and record review revealed Resident #1 had a history of verbally threatening to remove his/her Secure Care Bracelet and leave the facility and had previously exited the facility without staff knowledge on 05/08/14.

Record review of the Nurse's Notes, dated 03/13/14, revealed Resident #1 became upset over a conversation between the resident and the Social Worker and verbally threatened to remove the Secure Care Bracelet and leave the facility. Resident #1 was unable to be re-directed by staff. Continued review revealed on 05/08/14, Resident #1 became upset when informed he/she would require supervision in the courtyard with his/her spouse. Review revealed approximately one (1) hour and twenty (20) minutes after Resident #1 became upset, he/she was found outside the facility, in the parking lot, without the Secure Care Bracelet in place, by an off duty staff person leaving the facility. Continued review revealed Resident #1 refused to come back into the facility and remained outside the facility with staff for approximately three and one-half (3.5) hours before agreeing to return to the facility. Further review revealed the Secure Care Bracelet was found in Resident #1's room in the trash can with a plastic knife. However, even though the facility initiated every fifteen (15) minute checks of Resident #1 for seventy-two (72) hours after each of these incidents, there was no documented evidence the resident's CCP was updated or revised after the incidents, and no documented evidence the facility investigated the resident's elopement on 05/08/14.

Interview with Unit Coordinator #1, on 10/01/14 at

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12. The secure care system was relocated in the unit 3 apartment hallway to alert employees once a resident with a secure care bracelet enters the apartment section.

13. By making the changes to the policies, moving the secure care system, educating all apartment residents of ensuring a safe living environment, educating all employees, and adding in weekly monitoring in to the QA committee, along with educating and checking off new employees, adding additional supervisor to evening shift, systems are now in place to ensure the resident environment is as free from accident hazards as is possible and that adequate supervision is in place.

The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained.

To assure that the resident environment remains as free from accident hazards as is possible and that adequate supervision is in place, the facility will monitor through departmental supervisors completing daily walk thrus, along with the float nurses and through QA Committee weekly walk thrus on an ongoing basis to identify areas of potential hazards and inadequate supervision. This weekly walk thru will be the monitoring tool to ensure that employees are aware of the need to remove items that could cause danger to self or others and to identify any areas of concern for resident safety and or lack of supervision. The Medical

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F 323 Continued From page 30

11:23 AM, revealed she was aware Resident #1 was care planned for unsupervised exit seeking behaviors. However, she stated she was not aware Resident #1 had previously threatened to remove the Secure Care Bracelet and leave the facility or had actually cut the Secure Care Bracelet off and left the facility prior to the incident on 09/21/14.

Continued interview, on 09/30/14 at 10:52 PM with the SSD, revealed she was aware Resident #1 had an elopement history of verbal threats to remove the Secure Care Bracelet and leave the facility and had a history of actually cutting the Secure Care Bracelet off and exiting the facility. She revealed she did not investigate the incident on 05/08/14 when Resident #1 cut the Secure Care Bracelet off and exited the facility as Resident #1 did not get off the facility property. Further interview revealed she was unaware of any interventions implemented by the facility at that time, except the replacement of his/her Secure Care Bracelet.

Continued interview with the DON, on 09/30/14 at 1:53 PM, revealed she was aware prior to 09/21/14, Resident #1 had a history of threatening to remove the Secure Care Bracelet and leave the facility, and was aware the resident actually removed the Secure Care Bracelet and left the facility previously. She stated Resident #1's eloped from the facility on 05/08/14, but this was not investigated as the resident did not get off the facility property. Further interview revealed however, Resident #1's care plan should have been updated and revised at that time to accurately reflect the resident's history of unsupervised exit seeking behaviors with interventions implemented and education given to

F 323 Director will have an on-going role in the monitoring of these solutions as both the medical director and as the personal physician for Resident #1. The QA committee will review through daily reports and investigation from each unit to track and trend any potential accident hazards that may be identified and report such findings to the daily QA committee and the Quarterly QA committee (consists of the Daily QA team, along with the Medical Director, pharmacy representative, restorative nurse, infection control nurse, and wound care nurse). Any areas of potential harm identified will be reported to the Administrator for immediate action.

The facility has in place a policy and procedure on checking the secure care system for placement, functioning of the bracelet on the resident, and functioning of the alarm system at the doors and notification board as well. Employees will monitor the placement of the secure care bracelets at each shift for each resident and will check the functioning of each resident's bracelet once weekly. Maintenance will check the functioning of the door alarms and notification panel weekly as well to ensure proper functioning. This system helps to ensure that the Secure Care Bracelet system is functioning properly and maintains the monitoring of all residents at risk for elopement.

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F 323 Continued From page 31  
staff for monitoring and increased supervision.

Further interview with the Administrator, on 09/30/14 at 1:17 PM, revealed she was aware in March of 2014, Resident #1 had previously threatened to remove the Secure Care Bracelet and leave the facility. Per interview, she was aware in May, 2014, Resident #1 had cut the Secure Care Bracelet off and exited the facility without staff's knowledge. The Administrator revealed however, Resident #1's successful elopement on 05/08/14 was not investigated as the resident did not get off the facility property. Continued interview revealed Resident #1's care plan should have been updated and revised to reflect the resident's threats/attempts to remove the Secure Care Bracelet, or actual removal of the Secure Care Bracelet to alert staff to monitor him/her for this behavior with interventions implemented for increased monitoring of behaviors related to the unsupervised exit seeking behaviors. Further interview revealed the facility did not have an elopement screening tool nor a policy related to frequency of screening for wandering/elopement; however, her expectation was for staff to continuously screen residents based on behaviors and document the findings including updating and revising the care plan to accurately reflect the resident's needs.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 10/06/14, which alleged removal of the Immediate Jeopardy (IJ), effective 10/07/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was placed on fifteen (15) minute observations on 09/21/14. Resident #1's room was searched for other objects that could be

F 323 The Facility has included dates of corrective action.

The facility is confident that the situation creating immediate jeopardy was corrected by Monday, 10/6/14. In addition, in order to prevent any future issues regarding accident and supervision, the quality assurance committee has been and will continue to conduct weekly walk thrus to identify and correct any areas of accident hazards or that would prohibit appropriate supervision, no areas of concern have been identified to date from the weekly walk thrus. All staff have been trained to identify what may cause an accident or injury and are to report any findings to the charge nurse upon finding. The Quality Assurance Committee has been and will continue to discuss residents on monitoring programs and the ability to discontinue the monitoring program for each resident. The facility has been and will continue to ensure residents with secure care bracelets are being checked for placement and functioning and will continue to check for functioning of the secure care system each week by the maintenance department. The facility has since been monitoring the systems in place and as no new areas have been identified, Bourbon Heights, Inc. has implemented systems that continue to ensure that ongoing compliance is achieved.

Completion Date November 11, 2014

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F 323 Continued From page 32

utilized to remove secure care bracelet or be utilized to harm self or others by staff on duty on 09/21/14 and then searched again on 09/25/14 by the Quality Assurance Director (QA) with a set of nail clippers removed from the closet area. A tamper resistant secure care bracelet was ordered by the Housekeeping Supervisor on 09/22/14. Resident #1 then went on a Leave of Absence from the facility with his/her son from 09/22/14 through 09/25/14.

2. All thirteen (13) residents, that had Secure Care Bracelets were reviewed for risk to ensure Secure Care Bracelets were in place, functioning properly, and were care planned appropriately with no changes or updates required by the Assistant Director of Nursing (ADON) on 09/22/14.

3. A 3:00 PM to 11:00 PM House Supervisor position was added, effective 09/24/14, with the role to help supervise and to investigate or review any resident information as directed by the Director of Nursing (DON).

4. On 09/30/14, all 107 residents were assessed for risk for elopement and four (4) care plans for the residents identified were updated to accurately reflect the needs of the resident by the MDS Coordinator, MDS Assistant, DON, QA Director, and the ADON. A screening tool, Elopement Risk Assessment Decision Tree, was developed to identify residents at risk for elopement on 10/02/14 by the DON and the QA Director. The Elopement Risk Assessment Decision Tree was implemented and completed, on 10/04/14 and 10/05/14, on all residents with no new residents identified to be at risk for elopement and was completed by the Infection

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Bourbon Heights, Inc. is an excellent nursing facility with a committed staff and dedicated board of directors. The facility remains committed to the providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Plan of Correction to an admission of the finding of deficient practice.

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F 323	<p>Continued From page 33</p> <p>Control Nurse, the Wound Care Nurse, and another Licensed Practical Nurse (LPN).</p> <p>5. The DON, QA Director, and the Administrator created a monitoring policy and criteria for secure care bracelet placement to include monitoring would not be discontinued until review by the Quality Assurance Committee or Physician recommendation. The monitoring policy was created on 09/30/08. Implementation and Education of the new monitoring policy was completed by the QA Director, the Infection Control Nurse, and the Quality Assurance Assistant on 10/06/14.</p> <p>6. All areas of the facility covered by the Secure Care System were searched for hazardous items which started on 10/01/14 and was completed on 10/03/14, by staff which included the QA Nurse, Housekeeping Director and MDS Coordinator.</p> <p>7. Boards for identification of residents at risk for elopement were placed in the nursing stations on 10/02/14. Additional boards for identification of residents at risk for elopement were placed in the break rooms, including the area by the time clock, and at the front office, on 10/03/14 by the QA Assistant, to help all staff to identify residents at risk for elopement.</p> <p>8. Education regarding leaving offices unattended or tools/supplies unsecured when out of offices and to ensure sharp objects are placed inside desk was given to Kitchen staff, Maintenance Department, Activities Department, front office staff, Social Services Department, Therapy Department, Quality Assurance Department, and the Nursing office staff starting 10/01/14 and completed on 10/03/14 and was</p>	F 323		
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F 323	<p>Continued From page 34 given by Department Supervisors.</p> <p>9. Resident #1's Comprehensive Care Plan was updated to include a new Elopement Care Plan by the Minimum Data Set (MDS) Coordinator on 10/01/14.</p> <p>10. Employees were scheduled by the Scheduling Coordinator, on 10/02/14, to be responsible for a minimum of fifteen (15) minute monitoring for Resident #1 while in his/her room and one on one (1:1) supervision with Resident #1 while out of room with his/her spouse whom was also a resident of the facility. Also, one on one (1:1) supervision was to be done if Resident #1 was wanting to go off the unit until otherwise directed.</p> <p>11. All care plans were reviewed to ensure updates had been completed for any new orders received in the last thirty (30) days with any issues identified and corrected at the time of the audit, starting on 10/03/14 and completed on 10/06/14, and was completed by the Infection Control Nurse, the Wound Care Nurse, the second shift House Supervisor, the ADON, and another LPN.</p> <p>12. Resident Care signs located in each resident's room were updated to include risk for elopement on 10/01/14 and education on the Resident Care signs was given to all facility by the QA Director, the Infection Control Nurse and by the DON from 10/01/14 through 10/06/14.</p> <p>13. A new tamper resistant secure care bracelet was placed on Resident #1, on 10/06/14, by the Maintenance Director and QA Director.</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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F 323	<p>Continued From page 35</p> <p>14. An in-service training was given to all staff on elopement to include the procedures on a Golden Alert announcement when an elopement occurs or is attempted by residents. In addition, all staff were given in-service training on behaviors and reporting and documentation of behaviors, supervision, new Resident Care signs for residents with elopement risk, and updating care plans for resident changes. All in-service training were completed by 10/06/14 by the QA Director, QA Assistant, and the Infection Control Nurse. All staff will also be receiving these in-service training annually.</p> <p>15. The facility included education on elopement, monitoring behaviors, care plans, and supervision in the new employee orientation program by 10/06/14. The QA Director and QA Assistant will incorporate into their current check off of new employees during orientation to determine understanding of the policies on elopement, care plans, potential behaviors, reporting of behaviors, and supervision of residents.</p> <p>16. The facility implemented plans to monitor its performance to ensure the residents' environment remain as free from accident hazards as possible and that adequate supervision is in place by monitoring through the Quality Assurance Committee weekly walk through on an ongoing basis to identify areas of potential hazards and inadequate supervision. The Medical Director will have an on-going role in the monitoring of these solutions as both the medical director and as the personal physician for Resident #1. The facility's QA Committee members will review daily reports and investigations from each unit to identify potential accident hazards for tracking and trending</p>	F 323		
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F 323	<p>Continued From page 36</p> <p>purposes and report their findings during the daily QA Committee meeting and to the Quarterly QA Committee which includes the Medical Director. Any areas of potential harm identified will be reported to the Administrator for immediate attention.</p> <p>The State Survey Agency validated the implementation of the facility's AOC as follows:</p> <ol style="list-style-type: none"> <li>1. Review of the "fifteen (15) minute monitoring form", on 09/21/14 revealed, Resident #1 was on one to one supervision with the Administrator upon return to the facility from 7:30 PM until 8:45 PM and fifteen (15) minute monitoring began at 8:45 PM on 09/21/14. Resident #1 remained on fifteen minute monitoring until 09/22/14 at 5:30 PM when he/she left the facility on a Leave of Absence with his/her son. Interview with Kentucky Medication Aide (KMA) #1, on 09/29/14 at 3:00 PM, revealed he searched Resident #1's room on 09/21/14 for objects that could be used to remove the secure care band but was not able to find anything in Resident #1's room other than the Secure Care Bracelet that he/she removed prior to eloping from the facility, which was found in Resident #1's trash can.</li> </ol> <p>Interview with the QA Director, on 09/29/14 at 11:22 AM revealed she did a follow-up search of Resident #1's room.</p> <p>A late entry Nurses' Note written by the MDS Assistant, on 09/26/14 at 8:09 AM revealed Resident #1 returned to the facility on 09/25/14 at 6:00 PM and the Nurses' Note revealed staff was present when Resident #1 unpacked his/her belongings and there were no objects in the belongings to cut the Secure Care Bracelet off.</p>	F 323		
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F 323	<p>Continued From page 37</p> <p>Review of the "fifteen (15) minute monitoring form" revealed fifteen (15) minute monitoring resumed on 09/25/14 at 6:00 PM upon Resident #1's return to the facility and would continue fifteen (15) minute monitoring until the Administrator and QA team deemed unnecessary. Review of the purchase order revealed a tamper resistant Secure Care Bracelet was ordered on 09/22/14 by the Housekeeping Director.</p> <p>2. The check off sheet the ADON completed, on 09/22/14, regarding her review of all thirteen (13) residents with Secure Care Bracelets to ensure placement, proper functioning, and to ensure they were appropriately care planned was reviewed and a copy of the check off sheet was obtained. An interview with the ADON, on 10/01/14 at 10:50 AM, revealed she did complete a review of all thirteen (13) residents with Secure Care Bracelets to ensure placement and proper functioning was completed and all thirteen (13) residents with Secure Care Bracelets had care plans on 09/22/14.</p> <p>3. Review of the facility's staff schedule of Registered Nurse (RN) #1 revealed a House Supervisor position for 3:00 PM to 11:00 PM had been added and a copy of the schedule was obtained. A copy of the "Job Description" for the Nursing Supervisor position was also obtained and reviewed.</p> <p>Interviews, on 10/09/14, with the Infection Control Nurse at 9:00 AM, State Registered Nursing Assistant (SRNA) #8 at 9:30 AM, Unit Coordinator #1 at 10:48 AM, Unit Coordinator #2 at 12:55 PM, KMA #17 at 1:12 PM, SRNA #18 at 1:28 PM, and SRNA #16 at 1:50 PM confirmed</p>	F 323		
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F 323	<p>Continued From page 38</p> <p>that a House Supervisor position for 3:00 PM to 11:00 PM had been added and RN #1 was assigned to the position.</p> <p>4. Reviewed the screening tool, Elopement Risk Assessment Decision Tree instructions sheet, dated 10/2014, revealed the new screening tool was to be completed upon admission, quarterly, and with any significant change in condition/mental health status.</p> <p>Review of the facility's Elopement Risk Assessments revealed they were completed for the sampled and unsampled residents reviewed.</p> <p>Interview with the MDS Coordinator on 10/09/14 at 2:20 PM, the DON on 10/09/14 at 3:15 PM and the QA Director on 10/09/14 at 3:30 PM revealed the screening tool, Elopement Risk Assessment Decision Tree, was developed to identify residents at risk for elopement on 10/02/14 by the DON and the QA Director. They reported all one hundred and seven (107) residents were assessed for risk for elopement through use of the new screening tool with no residents determined to be at risk except the previous residents determined to be at risk. Four (4) residents' care plans required updating to accurately reflect the needs of the resident.</p> <p>5. Obtained and reviewed copies of the facility's new monitoring policy with the criteria for placement of the Secure Care Bracelet. Obtained and reviewed copies of the education provided to staff regarding the new policy with signatures.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit</p>	F 323		
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F 323	Continued From page 39 Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education regarding the new policy.  6. Review of the facility's maps provided by the Administrator revealed all areas of the facility covered by the Secure Care System were searched for hazardous items which started on 10/01/14 and was completed on 10/03/14, by staff which included the QA Nurse, Housekeeping Director and MDS Coordinator.  Interview on 10/09/14, with the Infection Control Nurse at 9:00 AM and with the MDS Coordinator on 10/09/14 at 2:20 PM revealed they were involved in the facility wide search for hazardous items.  7. Observation on 10/09/14 in the employee break room, time clock area, front office and nurses station revealed elopement boards in place as per the Allegation of Compliance. Further observation revealed the elopement boards included pictures of residents at risk for elopement, with the residents' room numbers.  8. Obtained and reviewed a copy of education given to staff related to leaving offices unattended or tools/supplies unsecured with copies of signatures of staff in attendance completed on 10/03/14.  Interview on 10/09/14 with Maintenance Director at 2:52 PM; House Keeping #18 at 2:58 PM;	F 323		
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F 323	<p>Continued From page 40</p> <p>Maintenance #19 at 3:04 PM; Dietary #20 at 3:12 PM; and Dietary #21 at 3:17 PM revealed they all reported receiving the education.</p> <p>9. Review of Resident #1's care plan for potential for unsupervised exits from the facility revealed his/her care plan had been updated and a new care plan for potential for elopement had been added by the MDS Coordinator on 10/01/14 and included Resident #1's history of elopement. A copy of both the previous and new care plan related to elopement were obtained.</p> <p>10. Review of the "sitter schedule" from 10/02/14 through 10/21/14 for Resident #1 revealed an extra staff member was assigned to Resident #1 between the hours of 7:00 AM and 12:00 AM through those dates. Further review of Resident #1's sitter instruction sheet revealed the sitter must monitor Resident #1 for a minimum of fifteen (15) minute monitoring while Resident #1 was in his/her room and one to one (1:1) supervision while Resident #1 was out of his/her room. A copy of the "sitter schedule" and sitter instructions for monitoring sheet were obtained.</p> <p>11. Reviewed MD orders and care plan updates for the previous thirty (30) days to verify updates had been completed by 10/06/14 for seventeen (17) residents.</p> <p>12. Observation on 10/09/14, of the facility's identified elopement risk residents revealed the appropriate Resident Care signs in place in their room on the communication board or on the door to their room.</p> <p>The facility's Elopement Risk/Resident Care Sign Education was reviewed with copies obtained to</p>	F 323		
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F 323	<p>Continued From page 41 include signatures of staff in attendance.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education.</p> <p>13. Observations of Resident #1, on 10/09/14 revealed a Secure Care Bracelet on the right ankle. Obtained a copy of the facility's Purchase Order #46614 and dated 09/22/14 that the tamper resistant Secure Care product had been ordered.</p> <p>Interview with the Administrator on 10/09/14 at 3:30 PM revealed Resident #1's Secure Care Bracelet had been replaced, a tamper resistant bracelet had been ordered and would be placed on the resident when available.</p> <p>14. Reviewed the "Golden Alert" in-service given to staff with copies obtained to include signature of staff in attendance. Copy of in-service related to behaviors, reporting and documentation of behaviors, supervision, new care signs for elopement risk and updating care plans for resident changes was obtained with signatures of staff in attendance and completed by 10/06/14.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA</p>	F 323		
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F 323	Continued From page 42 #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education related to the facility's "Golden Alert".  Interview on 10/09/14 with Maintenance Director at 2:52 PM; House Keeping #18 at 2:58 PM; Maintenance #19 at 3:04 PM; Dietary #20 at 3:12 PM; and Dietary #21 at 3:17 PM revealed they all reported receiving the education related to the facility's "Golden Alert".  15. New employee education packet was reviewed with copies obtained. Education included elopement, monitoring and reporting of behaviors, care plans, and supervision of residents.  16. Reviewed audits completed by QA committee members from weekly walk through with new areas identified on audit tool. Reviewed minutes of daily QA meeting that included areas of potential hazard and supervision issues. Interview with the Medical Director on 10/09/14, revealed the facility did report the elopement to him on the night of the incident. Further interview revealed he took an active role in the daily care of the residents and the facility kept him well informed. Further interview revealed he was fully participating in the decision making process of the facility. Interview with the Administrator on 10/09/14, revealed she was actively participating in the audits as well as reviewing the data from the audits and would continue to review audits making changes as needed based on the data and the needs of the residents of the facility.	F 323			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490			

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F 490 Continued From page 43

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 have an effective system in place to ensure policies and procedures were developed and/or implemented to provide quality resident care. The facility's Administration failed to develop written policies to ensure safety and supervision of residents assessed to have wandering/exit seeking behaviors. The facility's Administration failed to have an effective system in place to ensure residents were monitored for exit seeking behaviors to ensure their safety, and failed to ensure residents' Comprehensive Care Plans were updated and revised to reflect residents' needs.

Resident #1 became upset on 09/21/14, when being re-directed by staff, obtained a six (6) inch paring knife to cut off his/her Secure Care Bracelet with, and at approximately 6:32 PM, the resident eloped from the facility without staff's knowledge. The police found Resident #1 at 7:01 PM, on a heavily traveled two (2) lane road which had no shoulder or sidewalk, almost three tenths of a mile from the facility. Resident #1 was taken back to the facility at approximately 7:10 PM and was not assessed for injury related to being upset.

F 490 This Plan of Correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.

It is the policy of Bourbon Heights, Inc. to ensure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable, physical and/or psychosocial well-being of each resident, on an individual basis, as well as residents as a whole.

Further, it is the policy of Bourbon Heights, Inc. to have an effective system in place to ensure programs, policies, and procedures are implemented.

Cause of the Immediate Jeopardy was identified.

The Immediate Jeopardy finding related to Resident #1 elopement from the facility, which was a repeat behavior for resident #1. After being made aware of exit seeking behaviors, there was no evidence of monitoring to ensure there was no repeat of the behavior.

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F 490 Continued From page 44

Interview and record review revealed Resident #1 had a history of verbally threatening to remove the resident's Secure Care Bracelet and leaving the facility on 03/13/14, and had previously exited the facility without staff's knowledge on 05/08/14 after cutting his/her Secure Care Bracelet off. Even though interview with the Administrator revealed the facility's Administration was aware of the incident on 03/13/14, and Resident #1's elopement on 05/08/14, the facility's Administration failed to investigate and ensure the resident's care plan was updated and revised to include increased supervision and to ensure his/her safety. (Refer to F-280 and F-323)

The facility's Administration's failure to an effective system in place to policies and procedures were developed and/or implemented to provide quality resident care and ensure the safety and supervision of residents was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 09/30/14, and determined to exist on 09/21/14.

An acceptable credible Allegation of Compliance (AOC) was received on 10/07/14 which alleged removal of the Immediate Jeopardy on 10/07/14. The Immediate Jeopardy was verified to be removed on 10/07/14 as alleged with the remaining non-compliance at 42 CFR 483.75 Administration (F-490) at a Scope and Severity of a "D" while the facility develops and implements a Plan of Correction (POC), and the facility's Quality Assurance monitors the effectiveness of the systemic changes to ensure implementation of policies and procedures to provide a safe environment and adequate supervision of residents.

F 490 The facility has identified all residents that may be at potential risk for harm

Bourbon Heights determined that all residents have the potential to be affected by the deficient practice. As such policies on Elopement and Monitoring have been revised or created, and education on elopement, monitoring, behaviors, supervision, care plans, and a new risk assessment tool have been created. All employees have been educated on the need to monitor the residents and their surroundings and to identify items that could be used to harm self or others and to remove or report these items immediately. The QA committee will observe through weekly walk thrus of the building to ensure adequate supervision and identification of accident hazards have been identified and that updates to care plans are being completed accurately and timely.

Steps taken to remove the Immediate Jeopardy

1. Upon notification that there was a jeopardy situation at Bourbon Heights, Inc., the Administrator worked with the Director of Nursing (DON) and Quality Assurance Director (QAD) to determine the cause of the jeopardy and to ensure that Resident #1 was safe and all residents remained safe and as free from accident hazards as possible.
2. In addition, the Administrator involved additional staff to ensure that Resident #1 and all other residents were adequately supervised.
3. The Administrator allocated resources to allow for a complete audit of all resident care plans and to develop and implement a Resident Screening Tool for Risk of Elopement.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 490	<p>Continued From page 45</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Wandering/Elopement Policy" dated 11/2010, revealed all residents with a diagnosis of Alzheimer's/Dementia or having a history of wandering would be screened upon admission and anytime nursing judgement warranted a screening. Further review revealed, residents found to have a potential for wandering would be fitted with a secure care bracelet. Continued review revealed should a resident elope or attempt elopement, the resident would be monitored every 15 minutes for seventy-two (72) hours then assessed for any needed changes/interventions.</p> <p>Interview with the Administrator on 09/26/14 at 12:38 PM, revealed the facility did not have an elopement screening tool.</p> <p>Review of the facility's policy titled, "Care Management" dated 08/20/12, revealed the plan of care should be continuously updated to reflect current resident needs at all times. Further review revealed updating the Plan of Care was the responsibility of all involved staff.</p> <p>Resident #1 was admitted by the facility on 12/27/13 and assessed at the time of admission to be at risk for wander/exit seeking behaviors with placement of a Secure Care Bracelet at that time. Record review revealed Resident #1 had a history of verbally threatening to remove his/her Secure Care Bracelet and leave the facility on 03/13/14. However, there was no documented evidence Resident #1's care plan was updated or revised to address the need for increased</p>	F 490	<ol style="list-style-type: none"> <li>4. Resident #1 was one on one approximately 4 hours with Administrator, QAD and Quality Assurance Assistant (QAA) on 5/8/14.</li> <li>5. Administrator allocated resources to include a 3-11 House Supervisor position eff. 9/24/14</li> <li>6. Tamper resistant secure care bracelet was ordered 9/22/14. Placed on resident 10/6/14.</li> <li>7. Investigation completed utilizing resources available to identify how resident obtained paring knife to remove secure care bracelet completed by Administrator 9/30/14.</li> <li>8. Administrator directed maintenance staff to move apartment secure care system in hallway to ensure no resident with a secure care bracelet could enter the apartment section without alerting staff. 10/1/14.</li> <li>9. Involved personnel to search all areas of the building including individual rooms in the nursing section and personal care section to ensure removal of all sharp objects to prohibit any resident obtaining items to remove secure care bracelets. Completed 10/3/14</li> <li>10. Allowed additional staff resources to be responsible for 15 minute of resident #1 and one on one while out of room with husband and/or wanting to go off the unit until otherwise directed. 10/2/14.</li> <li>11. Screening tool (Elopement Risk Assessment Decision Tree) developed by DON, QAD, and Administrator 10/2/14.</li> <li>12. New risk assessment for elopement implemented and completed on all residents with no new residents identified to be at risk for elopement 10/5/14.</li> </ol>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/09/2014
NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
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F 490	<p>Continued From page 46</p> <p>supervision. On 05/08/14, Resident #1 cut the Secure Care Bracelet off, exited the the facility without staff knowledge and was found on the facility's property by staff leaving the facility. However, there was no documented evidence Resident #1's care plan was updated or revised to address the need for increased supervision or monitoring. On 09/21/14, Resident #1 cut the Secure Care Bracelet off with a paring knife and eloped from the facility without staff's knowledge. Resident #1 was found by police walking with his/her walker on a heavily traveled roadway with no shoulder or sidewalk approximately three tenths of a mile from the facility. However, there was no documented evidence Resident #1's care plan was updated or revised to address the need for increased supervision or monitoring until 09/22/14.</p> <p>Interviews with direct care staff revealed not all of them were aware of Resident #1's history of elopement or behaviors which potentially lead up to unsupervised exit seeking behaviors.</p> <p>Interview with the Director of Nursing (DON), on 09/30/14 at 4:20 PM, revealed the facility did not have a wandering/elopement risk screening tool for nurses to utilize. She stated when a resident was admitted and family or the transferring facility reported a history of wandering/elopement risk the facility staff "just would put one on" (Secure Care Bracelet) the newly admitted resident.</p> <p>Interview with the Administrator, on 09/30/14 at 1:17 PM, revealed prior to 09/21/14, she was aware Resident #1 had verbally threatened to cut the Secure Care Bracelet off and leave the facility on 03/08/14. Per interview she was also aware Resident #1 had cut the Secure Care Bracelet off</p>	F 490	<p>13. Updated care signs to include risk for elopement 10/1/14 education and implementation 10/6/14.</p> <p>14. Created additional boards for identification of residents at risk for elopement to be placed in break rooms, including area by time clock, and at front office to help all staff to identify residents that may be at risk, this was in addition to boards already placed in the nurses station 10/2/14 placed in break rooms and front office by QAA 10/3/14.</p> <p>15. Educated all staff regarding leaving offices or tools/supplies unsecured when out of the office and to ensure sharp objects are placed inside desks – completed 10/3/14.</p> <p>16. Educated all employees on monitoring for sharp objects and maintaining a safe environment free of accident hazards as well as information on monitoring of residents and supervision.</p> <p>17. Letter written to current apartment residents for education of safe living environment and added to new apartment lease agreements. 10/2/14.</p> <p>18. In-serviced all employees on how to handle situations that may arise between resident #1 and husband completed 10/6/14.</p> <p>19. In-service training for all employees on elopement, behaviors, supervision, new care signs for elopement being conducted by QAD, QAA and IC Nurse completed 10/6/14.</p>		

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F 490 Continued From page 47  
and left the facility without staff knowledge on 05/14/14. Further interview revealed the facility should have performed and completed an investigation for the incident of 05/14/14; however, she stated she did not perceive this to be an elopement due to the resident being found on the facility property. Further interview revealed the care plan should have been updated and revised to accurately reflect the needs of the resident to ensure safe supervision and monitoring of the resident. Additionally, the Administrator reported the facility had a wandering/elopement policy requiring residents to be screened for wandering/elopement risks; however, the facility did not have a wandering/elopement risk screening tool or specific policy on when the screenings should occur.

The facility provided an acceptable, credible Allegation of Compliance (AOC) on 10/06/14, which alleged removal of the Immediate Jeopardy (IJ), effective 10/07/14. Review of the AOC revealed the facility implemented the following:

1. Resident #1 was placed on fifteen (15) minute observations on 09/21/14. Resident #1's room was searched for other objects that could be utilized to remove secure care bracelet or be utilized to harm self or others by staff on duty on 09/21/14 and then searched again on 09/25/14 by the Quality Assurance Director (QA) with a set of nail clippers removed from the closet area. A tamper resistant secure care bracelet was ordered by the Housekeeping Supervisor on 09/22/14. Resident #1 then went on a Leave of Absence from the facility with his/her son from 09/22/14 through 09/25/14.

F 490 The Facility has implemented systemic changes to ensure the jeopardy will not reoccur.

1. As of 10/6/14, the Facility will have implemented and educated all staff regarding new policies on monitoring to include language that a monitoring will not be discontinued until reviewed by the QA Committee or recommendation by the physician. In addition, education and implementation of new policies on Elopement, including a Golden Alert announcement, education on behaviors, care plans, monitoring the environment for accident hazards and sharp objects and supervision of residents.
2. All apartment residents were educated regarding safe living environment and securing sharp objects, along with new education included in the new apartment lease agreement.
3. A 3-11 House supervisor position was added to ensure adequate supervision throughout the evening hours with role to help supervise and to investigate or review any resident information as directed by the DON.
4. The new employee orientation program was updated to include elopement, supervision, behaviors, care plans, monitoring, to include a check off of understanding of said information 10/6/14f.
5. QA walk thrus were updated to include monitoring for safety and accident hazards, care plan audits, and supervision.
6. Elopement boards were updated and added to all break rooms and the front office to help with all staff ability to recognize those that wander.

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F 490 Continued From page 48

2. All thirteen (13) residents, that had Secure Care Bracelets were reviewed for risk to ensure Secure Care Bracelets were in place, functioning properly, and were care planned appropriately with no changes or updates required by the Assistant Director of Nursing (ADON) on 09/22/14.

3. A 3:00 PM to 11:00 PM House Supervisor position was added, effective 09/24/14, with the role to help supervise and to investigate or review any resident information as directed by the Director of Nursing (DON).

4. On 09/30/14, all 107 residents were assessed for risk for elopement and four (4) care plans for the residents identified were updated to accurately reflect the needs of the resident by the MDS Coordinator, MDS Assistant, DON, QA Director, and the ADON. A screening tool, Elopement Risk Assessment Decision Tree, was developed to identify residents at risk for elopement on 10/02/14 by the DON and the QA Director. The Elopement Risk Assessment Decision Tree was implemented and completed, on 10/04/14 and 10/05/14, on all residents with no new residents identified to be at risk for elopement and was completed by the Infection Control Nurse, the Wound Care Nurse, and another Licensed Practical Nurse (LPN).

5. The DON, QA Director, and the Administrator created a monitoring policy and criteria for secure care bracelet placement to include monitoring would not be discontinued until review by the Quality Assurance Committee or Physician recommendation. The monitoring policy was created on 09/30/08. Implementation and Education of the new monitoring policy was

F 490

7. The secure care system was relocated in the Unit 3 apartment hallway to alert employees once a resident with a secure care bracelet enters the apartment section.

8. All nurses are responsible for updating the care plans for the residents and thus will continue to utilize the carbon 2 part order system that includes an area for physician order and an area for a care plan update to ensure that updates can be made immediately. A new system was added to double check these updates by MDS after the DON daily review Monday through Friday. The float nurse will review orders from the weekend and review resident changes. All orders from the weekend are collected on Monday for review by the DON and MDS staff. In addition, the QA Department will conduct random audits on the order copies to ensure the system is functioning properly. Any areas of concern will be brought to the attention of the Administrator immediately.

9. The QA committee will continue to discuss all care plan resident changes in the daily QA meeting. A marked box is available for extra reports for those not attending the morning QA meeting to ensure that all department heads have the same information on the resident changes. Information from the weekend will be included in Mondays report to ensure that resident changes are captured 7 days a week.

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F 490	<p>Continued From page 49</p> <p>completed by the QA Director, the Infection Control Nurse, and the Quality Assurance Assistant on 10/06/14.</p> <p>6. All areas of the facility covered by the Secure Care System were searched for hazardous items which started on 10/01/14 and was completed on 10/03/14, by staff which included the QA Nurse, Housekeeping Director and MDS Coordinator.</p> <p>7. Boards for identification of residents at risk for elopement were placed in the nursing stations on 10/02/14. Additional boards for identification of residents at risk for elopement were placed in the break rooms, including the area by the time clock, and at the front office, on 10/03/14 by the QA Assistant, to help all staff to identify residents at risk for elopement.</p> <p>8. Education regarding leaving offices unattended or tools/supplies unsecured when out of offices and to ensure sharp objects are placed inside desk was given to Kitchen staff, Maintenance Department, Activities Department, front office staff, Social Services Department, Therapy Department, Quality Assurance Department, and the Nursing office staff starting 10/01/14 and completed on 10/03/14 and was given by Department Supervisors.</p> <p>9. Resident #1's Comprehensive Care Plan was updated to include a new Elopement Care Plan by the Minimum Data Set (MDS) Coordinator on 10/01/14.</p> <p>10. Employees were scheduled by the Scheduling Coordinator, on 10/02/14, to be responsible for a minimum of fifteen (15) minute monitoring for Resident #1 while in his/her room</p>	F 490	<p>10. QA will conduct audits on all resident care plan updates on a quarterly basis following the MDS/Care Plan schedule. The audits will be completed and given to the Administrator for review to ensure that the facility remains in compliance.</p> <p>11. The QA Committee will conduct weekly walk thrus to spot check 4 residents for updates to the care plans on various residents to ensure the system is functioning properly. These findings will be documented on the QA walk thru forms weekly. The Administrator will be a part of the walk thrus each week and will review the findings each week with the QA committee to ensure the facility remains in compliance.</p> <p>12. The Administrator will review QA Audits weekly to review all issues identified and allow for resources to be used appropriately to re-educate employees on recurring issues identified to ensure resources are used appropriately to ensure compliance and ensure resident needs are met.</p> <p>13. The Administrator will review weekly walk thrus and allow for resources to be utilized to correct any accident hazards that are identified.</p> <p>14. The Administrator will continue to have an open door policy with availability to all staff, residents, and visitors and will encourage the use of such to report any issues or concerns that may arise.</p>		

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F 490	<p>Continued From page 50</p> <p>and one on one (1:1) supervision with Resident #1 while out of room with his/her spouse whom was also a resident of the facility. Also, one on one (1:1) supervision was to be done if Resident #1 was wanting to go off the unit until otherwise directed.</p> <p>11. All care plans were reviewed to ensure updates had been completed for any new orders received in the last thirty (30) days with any issues identified and corrected at the time of the audit, starting on 10/03/14 and completed on 10/06/14, and was completed by the Infection Control Nurse, the Wound Care Nurse, the second shift House Supervisor, the ADON, and another LPN.</p> <p>12. Resident Care signs located in each resident's room were updated to include risk for elopement on 10/01/14 and education on the Resident Care signs was given to all facility by the QA Director, the Infection Control Nurse and by the DON from 10/01/14 through 10/06/14.</p> <p>13. A new tamper resistant secure care bracelet was placed on Resident #1, on 10/06/14, by the Maintenance Director and QA Director.</p> <p>14. An in-service training was given to all staff on elopement to include the procedures on a Golden Alert announcement when an elopement occurs or is attempted by residents. In addition, all staff were given in-service training on behaviors and reporting and documentation of behaviors, supervision, new Resident Care signs for residents with elopement risk, and updating care plans for resident changes. All in-service training were completed by 10/06/14 by the QA Director, QA Assistant, and the Infection Control Nurse. All</p>	F 490	<p>15. The Administrator has daily meetings Monday through Friday with all department supervisors, at which any issues or concerns within their department can be addressed. The Administrator will act upon any known issues on resident safety and/or resident changes immediately with proper approval from the Board of Directors if required. In addition, the Administrator is available via phone 24 hours per day, 7 days per week to ensure that adequate supervision and resources are available at all times.</p> <p><u>The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained.</u></p> <p>To assure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable, physical, and/or psychosocial well-being of each resident, on an individual basis, as well as residents as a whole, the Quality Assurance committee members will meet daily to review and discuss all aspects of resident care and any significant changes to include any areas of concern for accident hazard and/or updates to care plan to help maintain the effective and efficient management of the facility's resources. The Administrator will continue to attend these meetings to ensure availability to all members of management have the availability to report any needed changes within the meeting. However, the Administrator will be available to all staff 24 hours per day, 7 days per week via phone for any issues that may arise. The Administrator will act upon any issues on resident safety and/or changes immediately with proper approval from the Board of Directors if required.</p>	
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F 490	Continued From page 51 staff will also be receiving these in-service training annually.  15. The facility included education on elopement, monitoring behaviors, care plans, and supervision in the new employee orientation program by 10/06/14. The QA Director and QA Assistant will incorporate into their current check off of new employees during orientation to determine understanding of the policies on elopement, care plans, potential behaviors, reporting of behaviors, and supervision of residents.  16. The facility implemented plans to monitor its performance to ensure the residents' environment remain as free from accident hazards as possible and that adequate supervision is in place by monitoring through the Quality Assurance Committee weekly walk through on an ongoing basis to identify areas of potential hazards and inadequate supervision. The Medical Director will have an on-going role in the monitoring of these solutions as both the medical director and as the personal physician for Resident #1. The facility's QA Committee members will review daily reports and investigations from each unit to identify potential accident hazards for tracking and trending purposes and report their findings during the daily QA Committee meeting and to the Quarterly QA Committee which includes the Medical Director. Any areas of potential harm identified will be reported to the Administrator for immediate attention.  The State Survey Agency validated the implementation of the facility's AOC as follows:  1. Review of the "fifteen (15) minute monitoring	F 490	The Administrator has worked and will continue to work hand in hand with the DON and QAD, MDS Coordinator, MDS Assistant, Infection Control Nurse, ADON to ensure that all policies and procedures in correcting the Immediate Jeopardy situation and to allow for adequate human resources to be utilized to ensure the situation is remedied. The Administrator remains available to all staff with an open door policy and address any issues immediately upon notification.  The Administrator has allowed for additional staff to be utilized to ensure Resident #1 safety since the elopement on 9/21/14, along with additional staff to help audit care plans and perform assessments and education on the new policies and procedures.  The Administrator has an open door policy to all staff, residents, and families and encourages the use of such policy. In addition, the Administrator will continue to make walking rounds to ensure availability to all residents, staff, and visiting family members, also to ensure the environment is free from accident hazards and to ensure adequate supervision and resources are available to ensure compliance.  The Administrator will review audit information upon completion from Quality Assurance for all care plan updates and weekly walk thrus to ensure the effectiveness of all policies and allow for needed resources to be managed effectively.		

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F 490 Continued From page 52  
form", on 09/21/14 revealed, Resident #1 was on one to one supervision with the Administrator upon return to the facility from 7:30 PM until 8:45 PM and fifteen (15) minute monitoring began at 8:45 PM on 09/21/14. Resident #1 remained on fifteen minute monitoring until 09/22/14 at 5:30 PM when he/she left the facility on a Leave of Absence with his/her son. Interview with Kentucky Medication Aide (KMA) #1, on 09/29/14 at 3:00 PM, revealed he searched Resident #1's room on 09/21/14 for objects that could be used to remove the secure care band but was not able to find anything in Resident #1's room other than the Secure Care Bracelet that he/she removed prior to eloping from the facility, which was found in Resident #1's trash can.

Interview with the QA Director, on 09/29/14 at 11:22 AM revealed she did a follow-up search of Resident #1's room.

A late entry Nurses' Note written by the MDS Assistant, on 09/26/14 at 8:09 AM revealed Resident #1 returned to the facility on 09/25/14 at 6:00 PM and the Nurses' Note revealed staff was present when Resident #1 unpacked his/her belongings and there were no objects in the belongings to cut the Secure Care Bracelet off. Review of the "fifteen (15) minute monitoring form" revealed fifteen (15) minute monitoring resumed on 09/25/14 at 6:00 PM upon Resident #1's return to the facility and would continue fifteen (15) minute monitoring until the Administrator and QA team deemed unnecessary. Review of the purchase order revealed a tamper resistant Secure Care Bracelet was ordered on 09/22/14 by the Housekeeping Director.

F 490 All department heads report any changes or needed resources to the Administrator daily and as needed. All staff have the ability to contact the Administrator 24 hours a day, 7 days per week.

**The Facility has included dates of corrective action.**

The facility is confident that the situation creating immediate jeopardy was corrected by Monday, 10/6/14.

In addition, the Administrator has been and will continue to review chart audits and walk thrus, along with policies and procedures required to effectively and efficiently operate the facility and manage resources available. The Administrator has allowed and is continuing the resources to provide staff one on one with Resident #1 while out of room and 15 minute monitoring while resident is in the room. The systems put into place to remove the immediate jeopardy and to ensure continued compliance have been monitored since implementation with changes made if needed. These systems will continue to be monitored to ensure continued compliance in all areas.

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Completion date 11/11/14

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F 490	<p>Continued From page 53</p> <p>2. The check off sheet the ADON completed, on 09/22/14, regarding her review of all thirteen (13) residents with Secure Care Bracelets to ensure placement, proper functioning, and to ensure they were appropriately care planned was reviewed and a copy of the check off sheet was obtained. An interview with the ADON, on 10/01/14 at 10:50 AM, revealed she did complete a review of all thirteen (13) residents with Secure Care Bracelets to ensure placement and proper functioning was completed and all thirteen (13) residents with Secure Care Bracelets had care plans on 09/22/14.</p> <p>3. Review of the facility's staff schedule of Registered Nurse (RN) #1 revealed a House Supervisor position for 3:00 PM to 11:00 PM had been added and a copy of the schedule was obtained. A copy of the "Job Description" for the Nursing Supervisor position was also obtained and reviewed.</p> <p>Interviews, on 10/09/14, with the Infection Control Nurse at 9:00 AM, State Registered Nursing Assistant (SRNA) #8 at 9:30 AM, Unit Coordinator #1 at 10:48 AM, Unit Coordinator #2 at 12:55 PM, KMA #17 at 1:12 PM, SRNA #18 at 1:28 PM, and SRNA #16 at 1:50 PM confirmed that a House Supervisor position for 3:00 PM to 11:00 PM had been added and RN #1 was assigned to the position.</p> <p>4. Reviewed the screening tool, Elopement Risk Assessment Decision Tree instructions sheet, dated 10/2014, revealed the new screening tool was to be completed upon admission, quarterly, and with any significant change in condition/mental health status.</p>	F 490	<p>Bourbon Heights is an excellent nursing facility with a committed staff and dedicated board of directors. The facility remains committed to providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Plan of correction to be an admission of the finding of deficient practice.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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Review of the facility's Elopement Risk Assessments revealed they were completed for the sampled and unsampled residents reviewed.

Interview with the MDS Coordinator on 10/09/14 at 2:20 PM, the DON on 10/09/14 at 3:15 PM and the QA Director on 10/09/14 at 3:30 PM revealed the screening tool, Elopement Risk Assessment Decision Tree, was developed to identify residents at risk for elopement on 10/02/14 by the DON and the QA Director. They reported all one hundred and seven (107) residents were assessed for risk for elopement through use of the new screening tool with no residents determined to be at risk except the previous residents determined to be at risk. Four (4) residents' care plans required updating to accurately reflect the needs of the resident.

5. Obtained and reviewed copies of the facility's new monitoring policy with the criteria for placement of the Secure Care Bracelet. Obtained and reviewed copies of the education provided to staff regarding the new policy with signatures.

Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education regarding the new policy.

6. Review of the facility's maps provided by the Administrator revealed all areas of the facility

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F 490	<p>Continued From page 55</p> <p>covered by the Secure Care System were searched for hazardous items which started on 10/01/14 and was completed on 10/03/14, by staff which included the QA Nurse, Housekeeping Director and MDS Coordinator.</p> <p>Interview on 10/09/14, with the Infection Control Nurse at 9:00 AM and with the MDS Coordinator on 10/09/14 at 2:20 PM revealed they were involved in the facility wide search for hazardous items.</p> <p>7. Observation on 10/09/14 in the employee break room, time clock area, front office and nurses station revealed elopement boards in place as per the Allegation of Compliance. Further observation revealed the elopement boards included pictures of residents at risk for elopement, with the residents' room numbers.</p> <p>8. Obtained and reviewed a copy of education given to staff related to leaving offices unattended or tools/supplies unsecured with copies of signatures of staff in attendance completed on 10/03/14.</p> <p>Interview on 10/09/14 with Maintenance Director at 2:52 PM; House Keeping #18 at 2:58 PM; Maintenance #19 at 3:04 PM; Dietary #20 at 3:12 PM; and Dietary #21 at 3:17 PM revealed they all reported receiving the education.</p> <p>9. Review of Resident #1's care plan for potential for unsupervised exits from the facility revealed his/her care plan had been updated and a new care plan for potential for elopement had been added by the MDS Coordinator on 10/01/14 and included Resident #1's history of elopement. A copy of both the previous and new care plan</p>	F 490		
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F 490	<p>Continued From page 56</p> <p>related to elopement were obtained.</p> <p>10. Review of the "sitter schedule" from 10/02/14 through 10/21/14 for Resident #1 revealed an extra staff member was assigned to Resident #1 between the hours of 7:00 AM and 12:00 AM through those dates. Further review of Resident #1's sitter instruction sheet revealed the sitter must monitor Resident #1 for a minimum of fifteen (15) minute monitoring while Resident #1 was in his/her room and one to one (1:1) supervision while Resident #1 was out of his/her room. A copy of the "sitter schedule" and sitter instructions for monitoring sheet were obtained.</p> <p>11. Reviewed MD orders and care plan updates for the previous thirty (30) days to verify updates had been completed by 10/06/14 for seventeen (17) residents.</p> <p>12. Observation on 10/09/14, of the facility's identified elopement risk residents revealed the appropriate Resident Care signs in place in their room on the communication board or on the door to their room.</p> <p>The facility's Elopement Risk/Resident Care Sign Education was reviewed with copies obtained to include signatures of staff in attendance.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education.</p>	F 490		
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F 490	<p>Continued From page 57</p> <p>13. Observations of Resident #1, on 10/09/14 revealed a Secure Care Bracelet on the right ankle. Obtained a copy of the facility's Purchase Order #46614 and dated 09/22/14 that the tamper resistant Secure Care product had been ordered.</p> <p>Interview with the Administrator on 10/09/14 at 3:30 PM revealed Resident #1's Secure Care Bracelet had been replaced, a tamper resistant bracelet had been ordered and would be placed on the resident when available.</p> <p>14. Reviewed the "Golden Alert" in-service given to staff with copies obtained to include signature of staff in attendance. Copy of in-service related to behaviors, reporting and documentation of behaviors, supervision, new care signs for elopement risk and updating care plans for resident changes was obtained with signatures of staff in attendance and completed by 10/06/14.</p> <p>Interview on 10/09/14 with LPN #15 at 9:00 AM; LPN #8 at 9:20 AM; SRNA #8 at 9:30 AM; Unit Coordinator #1 at 10:48 AM; SRNA #12 at 11:05 AM; Unit Coordinator #2 at 12:55 PM; KMA #17 at 1:12 PM; SRNA #18 at 1:28 AM; SRNA #16 at 1:50 PM; Unit Coordinator #3 at 3:35 PM; SRNA #19 at 3:50 PM; SRNA #20 at 4:10 PM; KMA #21 at 4:27 PM; and SRNA #22 at 4:35 PM revealed they all reported receiving the education related to the facility's "Golden Alert".</p> <p>Interview on 10/09/14 with Maintenance Director at 2:52 PM; House Keeping #18 at 2:58 PM; Maintenance #19 at 3:04 PM; Dietary #20 at 3:12 PM; and Dietary #21 at 3:17 PM revealed they all reported receiving the education related to the facility's "Golden Alert".</p>	F 490		
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F 490	Continued From page 58	F 490		
	<p>15. New employee education packet was reviewed with copies obtained. Education included elopement, monitoring and reporting of behaviors, care plans, and supervision of residents.</p>			
	<p>16. Reviewed audits completed by QA committee members from weekly walk through with new areas identified on audit tool. Reviewed minutes of daily QA meeting that included areas of potential hazard and supervision issues. Interview with the Medical Director on 10/09/14, revealed the facility did report the elopement to him on the night of the incident. Further interview revealed he took an active role in the daily care of the residents and the facility kept him well informed. Further interview revealed he was fully participating in the decision making process of the facility. Interview with the Administrator on 10/09/14, revealed she was actively participating in the audits as well as reviewing the data from the audits and would continue to review audits making changes as needed based on the data and the needs of the residents of the facility.</p>			