

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

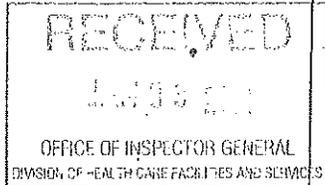
PRINTED: 12/05/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/17/2011
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey KY #17359 was initiated on 11/07/11 and concluded on 11/14/11 and a partial extended survey was initiated on 11/14/11 and concluded on 11/17/11. The allegation was substantiated with Immediate Jeopardy identified on 11/10/11 and determined to exist on 11/02/11. The facility was notified of Immediate Jeopardy at 42 CFR 483.25 Quality of Care (F323), 42 CFR 483.20 Resident Assessment (F282), and 42 CFR 483.75 Administration (F490) and (F520) on 11/10/11.</p> <p>The facility was also notified of Substandard Quality of Care on 11/10/11 in the area of 42 CFR 483.25 Quality of Care (F323).</p> <p>The facility assessed Resident #1 as high risk for elopement with the need to "Know Whereabouts At All Times Q (every) Day" as the first intervention for elopement risk on the resident's comprehensive plan of care. Resident #1 left a 'secure' (locked and alarmed) unit and a facility exit door on 11/02/11 (during a major construction project at the facility) without supervision or staff knowledge and was gone from the facility for approximately forty-five (45) minutes. Resident #1 was found sitting on the ground by a four (4) lane road several blocks from the facility by a citizen and returned to the facility unharmed. The facility failed to follow their policy and procedure and ensure their staff was knowledgeable regarding resident elopement plans. Additionally the facility's assistive devices used for audible alarm to alert staff when a resident exits a door failed to operate appropriately during major construction. The facility failed to ensure the assistive devices were functional during</p>	F 000	<p>Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged, or the correctness of the conclusions set forth in the statement of deficiencies. the plan of correction is prepared and submitted solely because of the requirement's of the law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Karol Hamilton

Administrator

12-29-2011

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
construction. The facility's failure to provide adequate supervision of cognitively impaired individuals with known elopement risk and failure to ensure assistive devices were operational placed residents at risk for elopement which was likely to cause serious injury, harm, impairment, or death.

An acceptable Allegation of Compliance (AOC) was received on 11/16/11 and the Immediate Jeopardy was removed on 11/17/11 which lowered the scope and severity to a "E" for 42 CFR 483.25 Quality of Care (F323), CFR 483.20 Resident Assessment (F282), and CFR 483.75 Administration (F490 & F520) while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of increased staffing, utilization of tools developed, and revisions to policies and procedures.

F 282 SS=K 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, review of the facility's Minimum Data Set Coordinator position description, the facility's investigation and facility policies: Elopement Prevention; Resident Safety Checks; and

F 000

F 282

F-282

1). At approximately 7:55pm on 11/2/11, Highlands was notified that resident #1 was at Nazareth's Home having been transported there by a citizen. The Director of Nursing was notified of this residents location by the 3-11 supervisor. The Director of Nursing returned to the facility to direct the immediate interventions and the investigation. After completing the head count, and the exterior door checks the 3-11 supervisor transported resident #1 from Nazareth's Home to Highlands Nursing and Rehab, returning her to the 1C unit which is a secured unit. A head to toe physical assessment of resident #1 was completed on 11/2/11 by the 3-11 supervisor and charge nurse. There were no injuries noted and resident #1 was at baseline as indicated by her calm demeanor.

Resident #1 was initially placed on 15 check on return to Highlands and remained on 15 minute checks through 11/7/11.

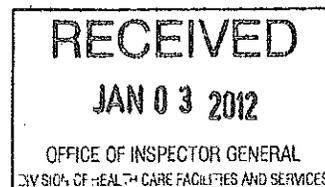
On 11/3/11 Resident #1's care plan and elopement assessment was updated by

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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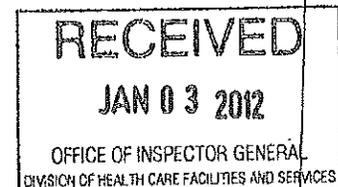
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F 282	<p>Continued From page 2</p> <p>Resident Individual Supervision, It was determined the facility failed to in-service and implement an intervention for elopement prevention on the comprehensive care plan for one (1) of seven (7) sampled residents, Resident #1. The intervention of "Know Whereabouts At All Times Q (every) Day" was not in-serviced to all staff caring for Resident #1, it was not listed on the Certified Nurse Aide (CNA) assignment sheet, and it was not implemented on the date of Resident #1's elopement from the 'secure' (locked) unit and the facility's property. The facility's failure to in-service and implement the comprehensive plan of care placed residents at risk for elopement which was likely to cause serious injury, harm, impairment, or death.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 11/16/11 and the Immediate Jeopardy was removed on 11/17/11 which lowered the scope and severity to a "E" for CFR 483.20 Resident Assessment (F282), while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed, and revisions to policies and procedures.</p> <p>The findings include:</p> <p>Review of the facility policy Elopement Prevention, (undated), revealed the resident's Plan of Care should include possible causes for wandering and development of individualized, interdisciplinary interventions and goals to reduce wandering. The policy indicated these interventions should be communicated to the</p>	F 282	<p>Social Service Director, Unit Managers, Program Director and MDS coordinators to reflect this event and q15 minute checks. The Interdisciplinary Team, (members listed above) recommended review of plan of care and interventions in 48 hours. This review was completed on 11/4/11, and again on 11/7/11. 15-minute checks were D/C on 11/7/11 by the IDT team as no exit seeking behaviors noted.</p> <p>On 11/15/11 resident was placed on hourly checks as part of the AOC as were all residents whom were identified as at risk for elopement. Resident #1 care plan was updated to show hourly checks. The intervention "know wereabouts at all times" was removed from resident #1's care plan by the Unit Manager.</p> <p>2). An immediate head count of all residents was done on 11/2/11 and all residents were accounted for.</p> <p>On 11/3/11 the Director of Nursing, the Social Service Director, the Program Director, the Unit Manager and the MDS coordinator reviewed all residents</p>	



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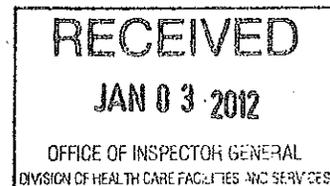
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F 282	<p>Continued From page 3</p> <p>care giving team, the interventions should be evaluated, and the effectiveness of the interventions documented. The policy also indicated all staff should be in-serviced to assure awareness of the resident's care plan system and what steps should be taken to prevent or interrupt elopement attempts.</p> <p>Review of the facility policy Resident Individual Supervision (one to one supervision), (undated), revealed the decision to place a resident on one to one supervision may be determined by nursing administration, the Administrator and/or attending physician and/or the Medical Director.</p> <p>Review of the facility policy Resident Safety Checks (For Increased Supervision), (undated), revealed POLICY: It is the policy of this facility to initiate and perform with documentation Q15 (every 15 minute), Q30, and Q1 hour etc. checks when deemed necessary for an individual resident for safety and/or behavior reasons. PROCEDURE: The checks may be instituted for any reason that might jeopardize the safety of any resident. The checks may be instituted by nursing or administrative judgement or by physician orders.</p> <p>Review of the facility position description for the Minimum Data Set (MDS) Coordinator (undated) revealed this staff was to: Assist the Director of Nursing Services and relevant directors/ supervisors of other departments in ensuring that all personnel involved in providing care to the resident are aware of the resident's care plan and that nursing personnel refer to the resident's care plan prior to administering daily care to the</p>	F 282	<p>for risk of elopement The Elopement Risk tool was used and residents who were identified as at risk for elopement were reviewed.</p> <p>No additional residents where identified as at risk for elopement. Two residents who had been previously considered at risk where determined by the assessment review to no longer be at risk and were removed from the elopement logs. Those residents who were identified as at risk were reassessed, and their elopement assessments, care plans, and safety logs were found to be appropriate. No new interventions were added at that time.</p> <p>The Director of Social Services validated that all elopement books were up to date and available at all nursing units. Elopement books were reviewed by the Social Service Director, the Program Director, the Unit Manager(s) and the MDS coordinator(s). This review validated that all residents identified as at risk for elopement were in the elopement books, and that</p>	



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F 282	<p>Continued From page 4</p> <p>resident. Interview with the Director of Nursing (DON), on 11/10/11 at 5:00 PM, revealed training of the comprehensive care plan interventions was the responsibility of any member of the interdisciplinary care planning team to include the MDS Coordinators and the unit manger of each unit.</p> <p>1. Review of Resident #1's record revealed the facility admitted the resident on 03/24/11 with diagnoses to include Alzheimer's Dementia. The facility assessed Resident #1 with moderately impaired cognition and as a high risk for elopement. In addition, the facility assessed the resident with the ability to ambulate independently, and as requiring minimal assistance with bathing and dressing. Resident #1's record revealed nursing documentation of his/her exit-seeking behaviors on 03/24/11, 03/25/11, 03/28/11, 03/31/11, 04/03/11 and 08/20/11.</p> <p>Review of the comprehensive care plan for Resident #1 revealed a focus which stated the resident was at risk of elopement with the following interventions to prevent elopement: 1. "Know Whereabouts At All Times Q (every) Day; and 2. Resident #1 to live on the facility's 'secured unit' (locked).</p> <p>Review of the facility's investigation into the elopement of Resident #1 revealed Resident #1 left the 'secure' (locked) unit and the facility unsupervised and without staff knowledge on 11/02/11. Review of the investigation also revealed Resident #1 was returned to the facility unharmed after having been found by a citizen several blocks from the facility sitting on the</p>	F 282	<p>information was up to date, and that pictures were reflective of the residents current physical appearance. (Note; All residents previously identified as at risk for elopement live on the 1C secured unit, and no room changes were necessary). On 11/15/2011 Hourly checks were initiated on all resident identified as @ risk for elopement by the Director of Nursing. These hourly checks will be completed by licensed nursing staffs. The care plans for the residents identified as @ risk for elopement were updated by Unit Manager to add hourly checks during internal construction.</p> <p>Additional Hall Monitoring was initiated on 11/15/11 on the 1C unit. The monitoring will occur on the East and West wind of the 1C secured unit. This consist of adding one (1) hall monitor to the 1C secured unit. This hall monitoring addition would mean a total of two (2) hall monitors would be in place as long as internal construction continued.</p>	



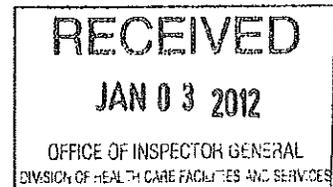
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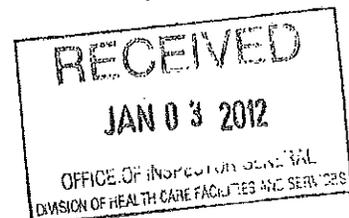
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F 282	Continued From page 5 ground near a busy four-lane street. Interview with CNA #2 (the 'secure' [locked] unit hall monitor on 11/02/22), on 11/09/11 at 1:50 PM, revealed she did not hear an exit door alarm on the evening of Resident #1's elopement. CNA #2 also revealed she was unaware Resident #1 had eloped until she was asked to participate in a 'head count' of residents at about 8:00 PM on 11/02/11. Interview with LPN #4 (charge nurse for the 'secure' unit on the evening of 11/02/11), on 11/09/11 at 3:55 PM, revealed Resident #1 was at the nursing station about 6:00 PM on 11/02/11 to request to use a phone. She stated Resident #1 left the station toward his/her room about five (5) minutes later and LPN #4 did not know Resident #1 had left the unit until the nursing supervisor called and asked her to do a head count. Interview with CNA #7 (assigned to Resident #1 on 11/02/11 at time of elopement), on 11/09/11 at 4:28 PM, revealed she did not hear an exit door alarm on the evening of Resident #1's elopement and she was unaware the resident had eloped. CNA #7 stated she thought she had last seen Resident #1 about 6:50 PM on 11/02/11. Interview with Resident #1, on 11/07/11 at 3:00 PM, revealed the resident was alert and pleasantly confused as to his/her location, date or time of day and Resident #1 did not remember having eloped from the unit or the facility; however, further interview with Resident #1, on 11/10/11 at 10:30 AM, revealed the resident did remember an "adventure" of leaving the unit and remembered he/she got tired and sat on the ground to rest. Interview with Certified Nursing Assistant (CNA) #2, on 11/07/11 at 3:00 PM, revealed Resident #1 was on routine supervision which was every two	F 282	11/9/11 Grey relay box was placed on hourly checks for function. This was to be completed by the IB nursing staff and documented. the Relay box monitoring on the IB unit was increased from checking its function every hour, to 1x1 during hours of internal constitution and one hour after construction ceases. This monitoring will be documented and staff responsible for the monitoring will be as assigned by the Administrator/DON from one of the Highlands departments of Nursing, Dietary, MDS, Staff Development, Medical Records, Social Services, Activities, Admissions, Human Resources, Business Office, Housekeeping, Therapy, Central Supply or Staffing. Education provided to floor staff by Unit Manger on 11/15/11 as	



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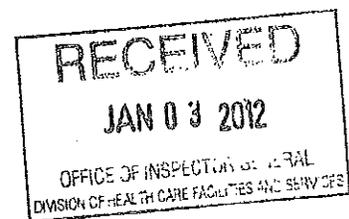
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F 282	Continued From page 6 (2) hours as standard practice for CNA's. In addition, she stated the CNA's on the 'secure' unit usually checked on their residents more often than every two hours. Interview with LPN #6, on 11/10/11 at 11:25 AM, revealed she was in charge of the 'secure' unit with four (4) CNAs (to include one (1) hall monitor) for thirty-four residents. She indicated all high risk residents were identified to staff verbally and she made sure she saw all high risk residents often (could not define often) during the shift; however, she stated was not familiar with the care plan intervention that staff was to "Know Whereabouts At All Times Q (every) Day" for Resident #1. Interview with LPN #4, on 11/09/11 at 3:55 PM, indicated she knew Resident #1 was an elopement risk but was unaware of the care plan intervention for Resident #1 to "Know Whereabouts At All Times Q (every) Day". Interview with CNA #2, on 11/09/11 at 1:50 PM, revealed she had not been trained on an intervention for Resident #1 to "Know Whereabouts At All Times Q (every) Day" and in fact was not aware of this intervention. She stated this intervention was not on the CNA assignment sheet nor was any resident listed as high risk for elopement on the CNA assignment sheet. She said she did not know how the intervention could be implemented unless the resident was on one-to-one (1:1) supervision. CNA #2 stated she was aware of some residents who were high risk for elopement either through word-of-mouth from other CNA's or from a verbal nursing report at the beginning of each shift;	F 282	3). Policy's and Process The Administrative staff, to included the Administrator, Regional Nurse Consultant, Director of Nursing, Human Resource Director, Director of Maintenance, Regional Nurse, and Activities Assistant participated in a QA meeting on 11/2/11 8:30pm to 1:30 am to address immediate safety concerns and a root cause analyses. The Elopement Policy was reviewed at this time and no changes to the policy where necessary. The processes for construction safety was reviewed and modifications were made. The modifications included -all exterior doors will be checked a minimum twice daily by Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Second Shift Supervisor, Weekend Supervisor, or Maintenance Assistant starting 11/2/11. Director of Nursing reviewed policy, POC and education with Medical Director on 11/16/11. No changes were made.		



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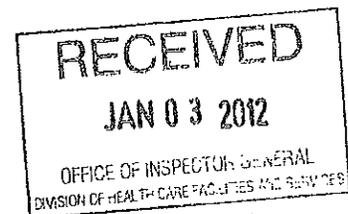
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F 282	<p>Continued From page 7</p> <p>however, she could not name the residents on the 'secure' unit who were at risk for elopement.</p> <p>Interview with the Minimum Data Set (MDS) Nurse #1, on 11/10/11 at 3:40 PM, revealed he did not know exactly how the intervention of "Know Whereabouts At All Times Q (every) Day" for Resident #1 could be implemented and he could not remember who suggested the intervention for Resident #1's elopement risk. He stated the intent of the intervention was the CNA could identify the where-a-bouts of the resident if asked at random. He stated the comprehensive care plan for each resident was not viewed by each member of the interdisciplinary team during the care plan review meeting and no one in Resident #1's care plan review meeting questioned how the intervention would be implemented. MDS Nurse #1 revealed he was not aware if the CNA's had been trained on the intervention and he also stated the intervention was not implemented at the time Resident #1 eloped from the facility. He indicated it was the responsibility of the nurse unit manager to train the CNA's on care plan interventions and he did not know if these interventions were listed on the CNA assignment sheet. Interview with MDS Nurse #2, on 11/14/11 at 2:40 PM, revealed it was her understanding it was not her responsibility to in-service CNA's on the resident's comprehensive care plan. She stated the intervention "Know Whereabouts At All Times Q (every) Day" was an "unrealistic goal" and she was surprised high risk elopement was not indicated for those residents at risk on the CNA assignment sheet.</p> <p>Interview with LPN #2 Unit Manager, on 11/15/11 at 2:00 PM, revealed she thought it was her</p>	F 282	<p>Immediate education was initiated on the evening of 11/2/11 by Director of Nursing regarding resident safety, secured unit door codes on 1C. this education was to the Janitorial Staff.</p> <p>The Director of Nursing, Assistant Director of Nursing, Staff Developer, Second Shift Supervisor and Weekend Supervisor have provided education to all departments regarding Elopement risk and care plans, Elopement codes, Elopement books, staff responsibility for supervision, and hall monitoring /door panel responsibility. This education occurred 11/3/11 through 11/14/11.</p> <p>11/9/11 Education was provided to licensed nursing staff on 1B regarding the hourly checks of the door alarm relay box. This education was completed by the 1B unit manager.</p> <p>On 11/10/11 the Staff Development coordinator and the Regional Nurse consultant provided education to the administrative staffs. (Administrative staff members included Medical Records, Assistant Director of Nursing,</p>



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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
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F 282	<p>Continued From page 8</p> <p>responsibility to update the CNA assignment sheets and she had just never put "Know Whereabouts At All Times Q (every) Day" on the CNA assignment sheets. She stated this would be impossible to do unless the resident was on 1:1 supervision. She also stated she did not indicate which residents were high risk for elopement on the CNA care plan because she thought her charge nurses were passing on the information regarding residents at high risk for elopement through the verbal nursing report at the beginning of each shift.</p> <p>Review of the facility investigation and interview with the Director of Nursing (DON) on 11/08/11 at 8:30 AM, who completed the investigation, revealed the facility investigation concluded the root cause of the elopement of Resident #1 was a faulty electrical system resulting in an absence of door alarms and had determined that some of the door alarms were not operational. This faulty electrical system was occurring due to ongoing facility construction. The facility had initiated direct supervision of all of the exit doors after the elopement until all of the doors were checked by the alarm company and assessed as operational on 11/03/11 (no time indicated). After the doors were determined operational on 11/01/11, the facility suspended the direct supervision of the exit doors. While the facility investigation revealed the alarm company was to increase visits to monthly to ensure operation of locked/alarmed exit doors during the construction and the nursing staff was to monitor an electrical relay box hourly to ensure there were no power disruptions to the door alarms there was no documented evidence that the facility identified that staff was not providing supervision of</p>	F 282	<p>Director of Nursing, Social Service, Unit Manager, Housekeeping Supervisor, Director of Human Resources, therapist, Maintenance Director, Administrator, MDS Coordinators, and the Activity Director) This education included safety interventions, a review of the Elopement Policy, IJ findings, and care plan interventions.</p> <p>On 11/14/11 the Director of Nursing continued with education regarding the increased hall monitoring program, and relay door alarms. This education was provided to all departments.</p> <p>11/15/11, the grey relay door panel, which indicates power disruption to the exit doors, went to 1x1 surveillance during hours of construction, and to continue one hour post construction. This monitoring will be completed by line staff and reviewed by the Administrator. Following the hours of active construction the relay box is checked hourly by the IB nursing staff. The relay box observations will continue until all internal construction is completed.</p>		



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F 282

Continued From page 9

Resident #1 as indicated per the care plan at the time of the elopement. Furthermore there was no evidence that the facility had identified that staff was not knowledgeable and had not been trained to the resident's care plan. Additionally, the facility had not identified that all staff was not aware of all ten residents the facility had identified as an elopement risk on 11/03/11 per the elopement meeting documentation. There was no evidence the facility implemented interventions to address supervision of the residents determined at risk for elopement or effective interventions to prevent elopement recurrence while construction continued at the facility after 11/03/11.

Review of the comprehensive plan of care revealed the revised care plan, dated 11/03/11, directed the staff to conduct every 15 minutes checks of Resident #1 and would be reviewed again in 48 hours.

Observation of Resident #1, on 11/07/11 at 2:35 PM, revealed the resident walking in the corridor of the 'secure' unit with three (3) other residents in the hallway and one (1) staff interacting verbally with one (1) of the other residents. Observation of the secure unit revealed no staff was present monitoring the exit doors.

Additionally, observation of Resident #1, on 11/10/11 at 10:25 AM, revealed the resident resting on a small couch in his/her bedroom with no staff present. Observation of the secure unit at this time revealed no staff was present monitoring the exit doors.

Interview with CNA #8, on 11/10/11 at 11:40 AM

F 282

The Director of Nursing and Assistant Director of Nursing provided education to Unit Managers, Second Shift supervisor, MDS Coordinators, Staff Developer, and Program Director on 11/15/11 to include care plan interventions, Elopement Protocols, Elopement logs/care plans, increased Hall Monitor coverage, relay box monitoring, enumerating residents at risk for elopement Q one hour, and all other residents every shift.

4). Auditing
The Administrator and the DON will complete ten random a week to determine if direct care giving staff can describe the care, services, and expected outcomes of the care they provide, and to determine if staff have a general knowledge of care and services provided by others and an understanding of the expected outcomes of this care.

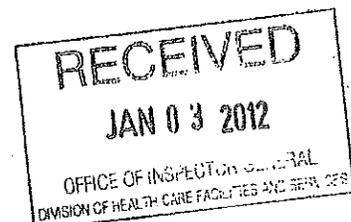
The results of these audits will be presented to the QA&A team on December 28th, 2011 in formal QA. the QAA team, which consist of at least the



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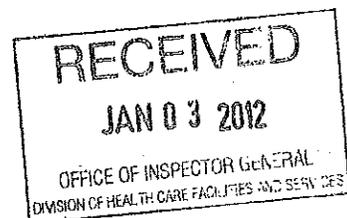
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F 282	<p>Continued From page 10</p> <p>revealed Resident #1 was on routine supervision at that time which to her meant observing the resident at least every two (2) hours. CNA #8 stated she would observe Resident #1 more often than that; however, could not detail how often.</p> <p>Interview with the Director of Nursing (DON), on 11/08/11 at 8:30 AM, on 11/10/11 at 9:00 AM and at 5:00 PM, revealed she did not know how the Intervention "Know Whereabouts At All Times Q (every) Day" would be implemented unless the resident was placed on 1:1 supervision. She stated training of the comprehensive care plan interventions was the responsibility of any member of the Interdisciplinary care planning team to include the MDS Coordinators and the unit manager of each unit. She further revealed that while the comprehensive care plan stated Resident #1 was to be monitored by staff every 15 minutes, these every 15 minute checks were discontinued once the alarm company assessed the doors as operational on 11/03/11. The DON stated she had not identified that staff had not provided supervision per the comprehensive care plan and had not identified that staff was unaware of the resident's care plan interventions. She indicated the lack of implementation of the care plan intervention "Know Whereabouts At All Times Q (every) Day" for Resident #1 could have contributed to the resident's elopement.</p> <p>Interview with the Administrator, on 11/10/11 at 5:10 PM, revealed the facility looked at safety issues weekly with the construction company foreman since the start of the facility construction project (July 5) and had a safety committee meeting weekly but this did not prevent an elopement. She stated the facility did not</p>	F 282	<p>Medical Director, Administrator, Director of Nursing, and one or more of the following Unit Managers, Therapy, Activities, Housekeeping, Assistant Director of Nursing, Maintenance, Dietary staff, RAI Coordinators, Activities, and Certified staff members. The QA&A committee will determine if additional education or auditing is required.</p> <p>5) Facility alleges compliance on January 2, 2012 12-29-11 per Karole Hamilton, Adm by PB 1-4-12</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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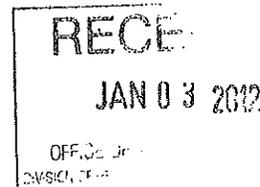
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F 282	<p>Continued From page 11</p> <p>recognize staff was unaware of care plan interventions or any lack of resident supervision. She also stated a lack of supervision could have contributed to the elopement of Resident #1.</p> <p>Review of the Allegation of Compliance dated 11/16/11 and interview with the DON and Administrator, on 11/17/11 at 10:00 AM, revealed the facility took the following immediate actions in response to an elopement:</p> <ol style="list-style-type: none"> 1. A resident count occurred immediately at 8:10 PM on 11/02/11. Resident #1 was initially placed on every fifteen (15) minute checks on his/her return. Resident #1's Plan of Care was updated on 11/03/11. 2. Exterior doors were checked by the LPN House Supervisor at 8:35 PM on 11/02/11. 3. On 11/2/11 at 8:30 PM until 1:30 AM on 11/03/11, an extensive meeting was held regarding resident safety. It was attended by the facility Administrator, the Maintenance Director, and the Human Resources Director. 4. Resident and facility safety was assessed. Three exit doors were placed on visual supervision from 11/02/11 at 10:30 PM to 11/03/11 at 11:00 AM when the General Alarm technician had assessed and corrected mechanical door alarm failure. All facility exterior doors have been evaluated by the alarm company and deemed secured. 5. All facility residents were re-assessed for elopement potential on 11/03/11. This action was completed by the Social Service Directors. 	F 282		



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

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F 282	<p>Continued From page 12</p> <p>Participating in the assessments were unit managers. Residents found with the potential for elopement were identified, assessments updated and elopement protocols followed to include Elopement Book identifiers and photos. No new elopement risks were identified.</p> <p>6. All high risk elopement residents are now residing on the secured unit and all residents had been reviewed on 11/03/11 to determine risk for elopement. Care plans and elopement logs were updated as needed. Elopement logs, nurse aide assignment sheets, and care plans were updated as indicated.</p> <p>7. Every one hour checks was initiated on 11/15/11 by licensed nursing staff on all residents identified as high risk for elopement for the remainder of internal construction of the roof top HVAC vent placement.</p> <p>8. All high risk for elopement residents are in the Elopement Log on 11/09/11 which was located at each nurses station and at the receptionist's desk.</p> <p>9. The secure unit will continue with the hall monitor programs. An additional hall monitor was added on 11/15/11 to increase supervision until internal construction is complete. One hall monitor will be located on the east wing the second on the west.</p> <p>10. Each hall monitor received additional education on 11/16/11 to include supervision, responding to alarms, visualizing/checking the exit doors, and responding to residents trying to exit.</p>	F 282		



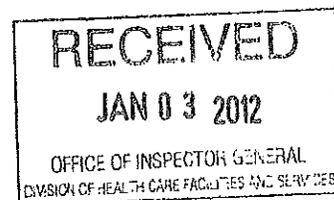
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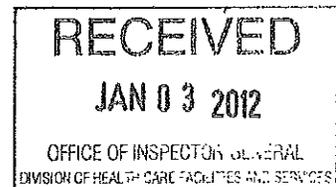
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F 282	<p>Continued From page 13</p> <p>11. All non-high risk for elopement residents had every shift checks initiated on 11/15/11.</p> <p>12. All staff received training beginning 11/03/11 at 1:00 AM through 11/16/11 at 11:00 PM regarding elopement risk, elopement protocols, code yellow (which indicates an elopement), expected responses, elopement logs and their purpose, and nurse aide assignment sheets which identify those who are high risk for elopement.</p> <p>13. The gray relay box which indicated power disruption to the exit doors will remain on continual surveillance through out the hours of construction as well as one hour after with documentation of checks initiated on 11/14/11.</p> <p>Record review, on 11/16/11, of all documentation regarding the Allegation of Compliance to include staffing logs, other new or revised documentation tools, staff training records, and revised policies/procedures revealed all had been completed as alleged.</p> <p>Interviews, on 11/17/11, with three (3) CNA's, two (2) LPN's, the 'secure' unit Program Director, one (1) housekeeping staff, and the Maintenance Director all verified staff knowledge of new documentation tools to be utilized regarding resident head counts, how to accomplish those, and who is responsible for those duties. These staff were also knowledgeable regarding addition of a second hall monitor to the 'secure unit' and the position description of same, how to identify and respond to a missing resident and the revisions to policies/procedures related to this</p>	F 282		



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

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F 282	Continued From page 14 identified concern.	F 282	F 323	
F 323 SS=K	<p>Immediate Jeopardy was verified to be removed on 11/17/11 which lowered the scope and severity to a "E" at 42 CFR 483.20 Resident Assessment (F282), and while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed, and revisions to policies and procedures.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies: Resident Safety Checks; Resident Individual Supervision Policy; Elopement Defined; and Elopement Prevention, it was determined the facility failed to adequately supervise cognitively impaired individuals with known elopement risk for one (1) of seven (7) sampled residents, Resident #1. The facility failed to follow their policies and procedures related to resident elopement, safety checks and individual supervision. The facility failed to ensure staff was</p>	F 323	<p>1). At approximately 7:55pm on 11/2/11, Highlands was notified that resident #1 was at Nazareth's Home having been transported there by a citizen. Note; The citizen who assisted the resident chose the Nazareth's Home as it was the only long term care center location she was familiar with. There is minimal information to identify were resident #1 was first seen by the citizen, because she did not leave her name with Nazareth home. She simply stated that she was a student in the area. Our investigation indicates resident #1 was located within 1-2 blocks of Highlands and therefore Highlands was in closer proximity than the Nazareth Home. The Director of Nursing was notified of this residents location by the 3-11 supervisor immediately following his notification by Nazareth's Home. The Director of Nursing requested an immediate head count of all residents, a check of all exterior doors, and a head-to-toe assessment of resident #1 upon her return. After completing the head count, and the exterior door checks the 3-11 supervisor transported the resident</p>	



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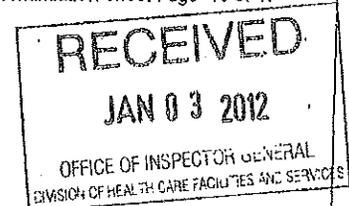
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knowledgeable regarding all residents identified as elopement risk and their individualized supervision plans, and the facility failed to ensure all assistive devices used for resident safety were functional and in good repair. The facility identified Resident #1 at risk for elopement. On 11/02/11 staff was unaware Resident #1 eloped from the 'secure' (locked) unit and from the facility without supervision. Resident #1 was returned to the facility unharmed within approximately forty-five (45) minutes by a citizen after being found several blocks from the facility sitting on the ground by a busy four (4) lane street. The facility identified ten (10) residents requiring supervision due to elopement prevention who resided on the secure unit. Additionally, the facility's investigation failed to identify all causal factors of the elopement which prevented the facility from implementing effective interventions to prevent further elopement recurrence. The facility's failure to provide adequate supervision of cognitively impaired individuals with known elopement risk placed residents at risk for elopement which was likely to cause serious injury, harm, impairment, or death.

An acceptable Allegation of Compliance (AOC) was received on 11/16/11 and the Immediate Jeopardy was removed on 11/17/11 which lowered the scope and severity to a "E" at 42 CF 483.25 Quality of Care (323), while the facility develops and implements a plan of correction to achieve substantial compliance with regulation and while the facility's Quality Assurance continues to monitor the effectiveness of staff education, utilization of tools developed, and revisions to policies and procedures.

F 323

from Nazareth's Home to Highlands, returning her to the IC unit which is a secured unit. A head to toe physical assessment of resident #1 was completed on 11/2/11 by the 3-11 supervisor and charge nurse. There were no injuries noted and resident #1 was at baseline as indicated by her calm demeanor. Resident #1 was initially placed on 15 minute checks on return to Highlands and remained on 15 minute checks through 11/7/11.

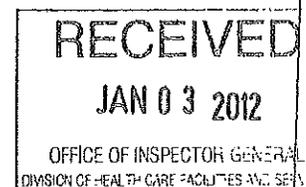
Administrative staff, to included the Administrator, Director of Nursing, Human Resource Director, Director of Maintenance, and Regional Nurse, where contacted, and immediately reported to the facility on the evening of 11/2/11. A second exterior door check was completed at that time. Initially all ground floor doors were noted as working appropriately, but on the third round of door observations three doors were noted as malfunctioning. The three doors that were noted as malfunctioning were immediately placed on one on one supervision, conducted by line staff. The remaining five ground floor doors were placed on q 30 minutes checks



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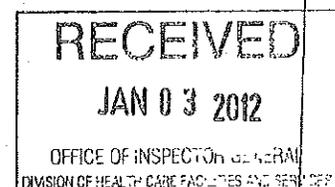
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F 323	<p>Continued From page 16 The findings include:</p> <p>Review of the facility policy Elopement Defined, (undated), revealed elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so. The center will maintain a plan to prevent elopement through components that may include, but are not limited to, the following: protected list of names and photographs of those at risk for elopement; regular rounds; structured group activities; environmental modifications; staff supervision and interventions; and resident and family education.</p> <p>Review of the facility policy Elopement Prevention, (undated), revealed the resident's Plan of Care should include possible causes for wandering and development of individualized, interdisciplinary interventions and goals to reduce wandering. The policy indicated these interventions should be communicated to the care giving team, the interventions should be evaluated, and the effectiveness of the interventions documented. The policy also indicated all staff should be in-serviced to assure awareness of the resident's care plan system and what steps should be taken to prevent or interrupt elopement attempts.</p> <p>Review of the facility's position description for the Minimum Data Set (MDS) Coordinator (undated) revealed this staff was to: Assist the Director of Nursing Services and relevant directors/supervisors of other departments in ensuring that all personnel involved in providing care to the resident are aware of the resident's care plan and</p>	F 323	<p>as a preventative measure. The Director of Maintenance contacted General Alarm Company at approximately 11:30pm on 11/2/11 and requested an expedited service call to determine why the doors were malfunctioning. All ground floor doors were maintained on direct one on one observation, or q30 minutes checks by line staff through the night of 11/2/11 to 11/3/11. General Alarm Co. reviewed all exterior doors on 11/3/11 and gradually released doors from the monitoring scheduled, satisfied there were no further concerns with security.</p> <p>This review was completed on 11/3/11 at approximately 5:45pm. It was determined that the equipment failure was likely due to the vibrations caused during construction when the HVAC vents were moved from 2B to 1B. (Note the door alarm control/relay box is located on 1B and the construction vibrations with this event were more than minimal)</p>	



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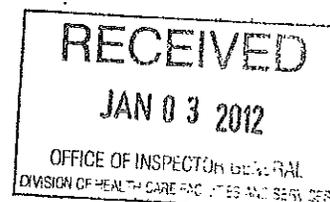
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F 323	<p>Continued From page 17</p> <p>that nursing personnel refer to the resident's care plan prior to administering daily care to the resident.</p> <p>Interview with the Director of Nursing (DON), on 11/10/11 at 5:00 PM, revealed training of the comprehensive care plan interventions was the responsibility of any member of the interdisciplinary care planning team to include the MDS Coordinators and the unit manager of each unit.</p> <p>Review of Resident #1's record revealed on 03/24/11, the facility admitted the resident on 03/24/11 with diagnoses to include Alzheimer's Dementia. The facility assessed Resident #1 with moderately impaired cognition and at high risk for elopement. The facility developed a comprehensive plan of care with the following interventions: 1. "Know Whereabouts At All Times Q (every) Day" and 2. Resident #1 to live on the facility's 'secured unit' (locked). Resident #1's record revealed nursing documentation of his/her exit-seeking behaviors on 03/24/11, 03/25/11, 03/28/11, 03/31/11, 04/03/11 and 08/20/11.</p> <p>Observation of Resident #1, on 11/07/11 at 2:35 PM, revealed the resident walking in the corridor of the 'secure' unit with two (2) residents seated in wheelchairs in the corridor and five (5) residents seated in the alcove television area of the unit.</p> <p>Observation of Resident #1, on 11/10/11 at 10:25 AM, revealed the resident resting on a small couch in his/her bedroom with a call light and water within reach, appropriate, clean clothing, clean hair and skin, and a clear path to the bathroom.</p>	F 323	<p>On 11/3/11 Resident #1's care plan and elopement assessment was updated by Social Service Director, Unit Managers, Program Director and MDS coordinators to reflect this event and q15 minute checks. The Interdisciplinary Teams, members listed above, recommendation was to review plan of care again in 48 hours. This review was completed on 11/4/11, again on 11/7/11. 15-minute checks were D/C on 11/7/11 by the IDT team as no exit seeking behaviors noted.</p> <p>2). An immediate head count of all residents was done on 11/2/11 and all residents were accounted for. On 11/3/11 the Director of Nursing, the Social Service Director, the Program Director, the Unit Manager and the MDS coordinator reviewed all residents for risk of elopement The Elopement Risk tool was used and residents who were identified as at risk for elopement were reviewed. No new residents were identified as at risk for elopement. Those residents who were identified as at risk previously to this review were reassessed, and their</p>		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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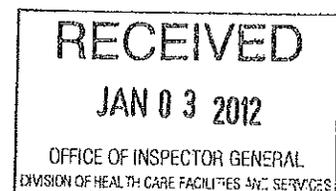
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/17/2011
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F 323	Continued From page 18 Interview with Resident #1, on 11/07/11 at 3:00 PM, revealed the resident was alert and pleasantly confused as to his/her location or date or time of day and Resident #1 did not remember having eloped from the unit and the facility. Further interview with Resident #1, on 11/10/11 at 10:30 AM, revealed the resident did remember an "adventure" of leaving the unit and the facility to go to St. James Court in Louisville (Resident #1 did not remember the day/date) but he/she got tired and sat on the ground to rest. Resident #1 stated he/she did not remember having been picked up by a citizen and returned to the facility. Review of the facility's investigation into the elopement of Resident #1 revealed Resident #1 left the 'secure' (locked) unit and the facility unsupervised and without staff knowledge on 11/02/11. Review of the investigation also revealed Resident #1 was returned to the facility unharmed after having been found by a citizen several blocks from the facility sitting on the ground near a busy four-lane street. The facility investigation revealed initial checks of the unit exit door and facility exit door alarms were all operative, however, a check of all exit doors approximately two (2) hours later revealed some of the door alarms were not operational. The facility had a staff placed on direct supervision of all of the exit doors after the elopement until all of the doors were checked by the alarm company and assessed as operational on 11/03/11 (no time indicated). After that assessment the direct supervision of the exit doors was suspended. The facility investigation also revealed the alarm company was to increase visits to monthly to ensure operation of locked/alarmed exit doors	F 323	elopement assessments, care plans, and safety logs were found to be appropriate. No new interventions were added at that time. The Director of Social Services validated that all elopement books were up to date and available at all nursing units. Elopement books were reviewed by the Social Service Director, the Program Director, the Unit Manager(s) and the MDS coordinator(s). This review validated that all residents identified as at risk for elopement were in the elopement books, and that information was up to date, and that pictures were reflective of the residents current physical appearance. (Note; All resident previously identified as at risk for elopement live on the IC secured unit, and no room changes were necessary). On 11/15/2011 Hourly checks were initiated on all resident identified as @ risk for elopement by the Director of Nursing. These hourly checks will be completed by licensed nursing staffs. The care plans for the residents identified as @ risk for elopement were updated by Unit Managers to add hourly checks during	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 19</p> <p>during the construction and the nursing staff was to monitor an electrical relay box hourly to ensure there were no power disruptions to the door alarms. However, the facility's investigation failed to identify that the facility failed to ensure staff provided appropriate supervision to Resident #1 and other residents at high risk for elopement. In addition, the facility had no interventions in place to ensure implementation of increased supervision as outlined on the comprehensive plan of care for Resident #1 and others at risk for elopement from 11/02/11 until 11/16/11. Additionally, the facility had not identified that all staff was not aware of all ten residents the facility had identified as an elopement risk on 11/03/11 per the elopement meeting documentation. There was no evidence the facility implemented interventions to address supervision of the residents determined at risk for elopement or effective interventions to prevent elopement recurrence while construction continued at the facility after 11/03/11.</p> <p>Interview with the Director of Nursing (DON) on 11/08/11 at 8:30 AM, who completed the investigation, revealed the facility investigation concluded the root cause of the elopement of Resident #1 was a faulty electrical system resulting in an absence of door alarms. The DON stated the focus of the immediate problem correction was to ensure the door alarms were in working order and remained in working order.</p> <p>Interview with CNA #2 (assigned as hall monitor on evening shift of 11/02/11), on 11/09/11 at 1:50 PM, revealed she saw Resident #1 at the unit nursing station about 6:00 PM on 11/02/11. She</p>	F 323	<p>internal construction. The intervention "know were-abouts at all times" was removed from resident #1's care plan by the Unit Manager, and at risk residents care plan was reviewed for that care plan intervention as it is</p> <p>On 11/15/11 The Relay box monitoring on the 1B unit was increased from checking its function every hour, to 1x1 during hours of internal constitution and one hour after construction ceases. This monitoring will be documented and staff responsible for the monitoring will be as assigned by the Administrator/DON from one of the Highlands departments of Nursing, Dietary, MDS, Staff Development, Medical Records, Social Services, Activities, Admissions, Human Resources, Business Office, Housekeeping, Therapy, Central Supply or Staffing.</p> <p>Additional Hall Monitoring was initiated on 11/15/11 on the IC unit. The</p>	

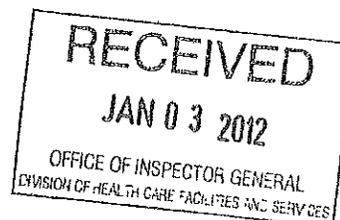


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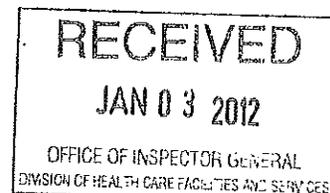
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F 323	<p>Continued From page 20</p> <p>stated she saw Resident #1 leave the nursing station in the direction of his/her room and did not see Resident #1 again until his/her return to the facility. CNA #2 stated she did not hear an exit door alarm that evening and was unaware Resident #1 had eloped from the 'secure' unit. She also stated it was impossible to view the entire hall of rooms for thirty-four residents at all times. CNA #2 indicated she had not been in-serviced or trained on Resident #1's care plan interventions for elopement and she primarily knew which residents were at risk for elopement by word-of-mouth from other CNA's.</p> <p>Interview with LPN #4 (charge nurse for the 'secure' unit on the evening of 11/02/11), on 11/09/11 at 3:55 PM, revealed Resident #1 was at the nursing station about 6:00 PM to request to use a phone. She stated Resident #1 left the station toward his/her room about five (5) minutes later and LPN #4 did not know Resident #1 had left the unit until the nursing supervisor called and asked her to do a head count. LPN #4 indicated she knew Resident #1 was an elopement risk but was unaware of the care plan intervention for Resident #1 to "Know Whereabouts At All Times Q (every) Day".</p> <p>Interview with CNA #7 (assigned to Resident #1 on 11/02/11 evening shift), on 11/09/11 at 4:28 PM, revealed she was in the dining room of the 'secure' unit from 5:30 PM until 7:30 PM on the evening of 11/02/11 and she thought Resident #1 was on the unit for most of that time. She stated she was assigned to nine (9) other residents on the evening of 11/02/11 and they were not all in the dining room while she was there. She stated she relied on other staff to supervise her</p>	F 323	<p>monitoring will occur on the East and West wind of the 1C secured unit. This consist of adding one (1) hall monitor to the 1C secured unit. This hall monitoring addition would mean a total of two (2) hall monitors would be in place as long as internal construction continued.</p> <p>3). Policy's and Process The Administrative staff, to included the Administrator, Regional Nurse Consultant, Director of Nursing, Human Resource Director, Director of Maintenance, Regional Nurse, and Activities Assistant participated in a QA meeting on 11/2/11 8:30pm to 1:30 am to address immediate safety concerns and a root cause analyses. The Elopement Policy was reviewed at this time and no changes to the policy where necessary. The processes for construction safety was reviewed and modifications were made. The modifications included -all exterior doors will be checked a minimum twice daily by Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Second Shift Supervisor, Weekend Supervisor, or Maintenance Assistant starting 11/2/11.</p>	



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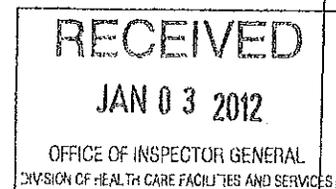
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F 323	<p>Continued From page 21</p> <p>assigned residents while she was in the dining room. She further explained the one (1) hall monitor was to supervise the residents in the corridor and monitor the exit doors for loitering of residents with exit-seeking behaviors on the evening shift. She stated she did not see Resident #1 exit the unit on the evening of 11/02/11 and she did not hear any exit door alarms.</p> <p>Interview with the DON, on 11/07/11 at 2:40 PM, revealed Resident #1 was on routine supervision at that time which meant the resident was to be observed at least every two hours. The DON also revealed there was no expectation that routine supervision would be documented any where and it was expected that the staff on the 'secure' unit would observe their assigned residents more frequently (no defined time) than every two (2) hours. She stated it was not documented that the staff would observe the residents more frequently than every two (2) hours, it was just known, and there was no policy regarding routine supervision.</p> <p>Review of the hall monitor job description revealed: "The hall monitor's was focused on safety (monitoring residents to ensure their safety), prevention (preventing residents from being involved in incidents and accidents), and documentation".</p> <p>Interview with CNA #3, on 11/09/11 at 4:20 PM, revealed the CNAs rotated assignment as the hall monitor. Her understanding of that job was to ensure the safety of the residents on the unit and the integrity of the exit doors by opening the doors to see if they would alarm. She stated</p>	F 323	<p>The Elopement Policy was reviewed by the Administrator, Regional Nurse consultant and Director of Nursing on 11/2/11 and no revisions to the policy where necessary.</p> <p>Starting on 11/3/11 to 11/17/11 The Director of Nursing, Assistant Director of Nursing, Staff Developer, Second Shift Supervisor and Weekend Supervisor have provided education to staff regarding Elopement risk and care plans, Elopement codes, Elopement books, staff responsibility for supervision, and hall monitoring /door panel responsibility.</p> <p>The Administrator monitors the process for door checks, relay box panels, hall monitoring and construction in morning meetings and through the contractor meetings.</p> <p>Director of Nursing reviewed policy , POC, and staff education with Medical Director on 11/16/11. No changes were made, and Medical director agreed with the staff education.</p>	



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F 323	<p>Continued From page 22</p> <p>(there was a lot of traffic on the hall since the start of the construction (July 5) and a lot of confusion with all of the people coming and going. CNA #3 also revealed there was no facility rule or policy regarding supervision of the residents on the unit unless they were on every fifteen (15) minute, every thirty (30) minute, or one (1) hour checks, or one-to-one (1:1) supervision (one staff with the resident at all times).</p> <p>Interview with CNA #8, on 11/10/11 at 11:40 AM revealed Resident #1 was on routine supervision at that time which meant observing the resident at least every two (2) hours. CNA #8 stated she would observe Resident #1 more often than that (could not define) but would not document this anywhere.</p> <p>Review of the facility policy Resident Individual Supervision (one to one supervision), (undated), revealed the decision to place a resident on one to one supervision may be determined by nursing administration, the Administrator and/or attending physician and/or the Medical Director.</p> <p>Interview with the Director of Nursing (DON), on 11/10/11 at 9:00 AM, revealed she did not know how the intervention "Know Whereabouts At All Times Q (every) Day" would be implemented unless the resident was placed on 1:1 supervision.</p> <p>Review of the facility policy Resident Safety Checks (For Increased Supervision), (undated), revealed POLICY: It is the policy of this facility to initiate and perform with documentation Q15, Q30, and Q1 hour etc. checks when deemed necessary for an individual resident for safety</p>	F 323	<p>Immediate education was initiated on the evening of 11/2/11 by Director of Nursing regarding resident safety, to the Janitorial Staff to include secured unit door codes on IC..</p> <p>11/9/11 Education was provided to licensed nursing staff on 1B regarding the hourly checks of the door alarm relay box. This education was completed by the 1B unit manager.</p> <p>On 11/10/11 the Staff Development coordinator and the Regional Nurse consultant provided education to the administrative staffs. (Administrative staff members included Medical Records, Assistant Director of Nursing, Director of Nursing, Social Service, Unit Manager, Housekeeping Supervisor, Director of Human Resources, therapist, Maintenance Director, Administrator, MDS Coordinators, and the Activity Director) This education included safety interventions, a review of the Elopement Policy, IJ findings, and care plan interventions.</p>	



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F 323	<p>Continued From page 23</p> <p>and/or behavior reasons. PROCEDURE: The checks may be instituted for any reason that might jeopardize the safety of any resident. The checks may be instituted by nursing or administrative judgement or by physician orders.</p> <p>Interview with LPN #4, on 11/09/11 at 3:55 PM, indicated she knew Resident #1 was an elopement risk but was unaware of the care plan intervention for Resident #1 to "Know Whereabouts At All Times Q (every) Day".</p> <p>Interview with CNA #7, on 11/09/11 at 4:28 PM, revealed the intervention of "Know Whereabouts At All Times Q (every) Day" for Resident #1 was not on her assignment sheet with other care plan interventions and she was not trained on Resident #1's elopement risk interventions. She stated she received information regarding which residents were elopement risk by word-of-mouth from other staff and she did not know how the intervention of "Know Whereabouts At All Times Q (every) Day" could be implemented except by one-to-one (1:1) supervision.</p> <p>Interview with CNA #2, on 11/09/11 at 1:50 PM, revealed she had not been trained on an intervention for Resident #1 to "Know Whereabouts At All Times Q (every) Day" and in fact was not aware of this intervention. She stated this intervention was not on the CNA assignment sheet nor was any resident listed as high risk for elopement on the CNA assignment sheet. She said she did not know how the intervention could be implemented unless the resident was on one-to-one (1:1) supervision. CNA #2 stated she was aware of some residents who were high risk for elopement either through</p>	F 323	<p>The Director of Nursing and Assistant Director of Nursing provided additional education to Unit Managers, Second Shift supervisor, MDS Coordinators, Staff Developer, and Program Director on 11/15/11 to include care plan interventions, Elopement Protocols, increased Hall Monitor coverage, relay box monitoring, enumerating residents at risk for elopement Q one hour, and all other residents every shift.</p> <p>4). Auditing</p> <p>The Administrator is responsible for validating that staff are appropriately documenting relay box monitoring during and post construction hours. In addition the Administrator will audit all documentation regarding the relay/panel box a minimum of 3xweek for the duration of construction. The audit will include validation that any concerns with the control panel are documented and reported immediately. Issues or discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and</p>	

