STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 word-of-mouth from other CNA's or from a verbal nursing report at the beginning of each shift, however, she could not name the residents on the 'secure' unit who were at risk for elopement. 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 stated she was not required to document any supervision of the thirty-four (34) residents in her charge unless the resident was on every fifteen (15) minute, every thirty (30) minute, every one (1) hour checks, or one-to-one (1:1) supervision (one staff with the resident at all times). 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. In addition, she was not required to document this supervision. She further indicated she was not familiar with the intervention for Resident #1 of "Know Whereabouts At All Times Q (every) Day". 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	F 323	further monitoring to ensure problem is resolved. The Director of Nursing is responsible for validating that additional hall monitoring is completed on unit 1C throughout the internal construction. The Director of Nursing will complete routine audits to validate that residents identified as at risk for elopement are visualized hourly, residents not identified as at risk for elopement are visualized every shift as part of the construction safety program, and that staff adhere to the hall monitoring program. This audit will occur 5 x week for the duration of the internal construction. The audit consist of reviewing the documentation for accuracy. Issues or discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and further monitoring to ensure problem is resolved. The Director of Maintenance is responsible for monitoring that exterior doors are checked at a minimum twice	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 25 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. Interview with LPN #2 Unit Manager, on 11/16/11 at 2:00 PM, revealed she thought it was her 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. Review of the revised comprehensive plan of care, dated 11/03/11, revealed the resident was	F 323	daily by Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Second Shift Supervisor, Weekend Supervisor, or Maintenance Assistant. The Director of Maintenance will audit the documentation for the additional door checks 5 x week for the duration of interior construction. Issues or discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and further monitoring to ensure problem is resolved. 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 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.	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER: HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1705 STEVENS AVENUE, LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 placed on every fifteen (15) minutes checks by staff and was to be reassessed in forty-eight (48) hours. Interview, on 11/08/11 at 8:30 AM, with the DON revealed the alarm company came to assess the door and once it was deemed operational, the 15 minutes checks were discontinued. Continued interview with the DON, on 11/10/11 at 4:00 PM, revealed she thought the electrical failure of the door alarms was the root cause of the elopement and she thought the problem had been corrected as the facility had trained staff on elopement and responding to alarms. However, she indicated the inability of the staff to implement the elopement risk intervention for Resident #1 and the facility's lack of supervision of Resident #1 contributed to the elopement. Interview with the Administrator, on 11/10/11 at 4:35 PM, revealed the facility looked at safety weekly with the construction company foreman and had a safety committee meeting weekly but this did not prevent an elopement. She stated the lack of staff supervision contributed to the elopement of Resident #1. 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: 1. A resident count occurred immediately at 8:10 PM on 11/03/011. Resident #1 was initially placed on every fifteen (15) minute checks on his/her return. Resident #1's Plan of Care was	F 323	5) Facility alleges compliance on ~~January 2, 2012~~. 12-29-11 per Karole Hamilton, Adm. by PB 1-4-12.	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1705 STEVENS AVENUE
LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323	Continued From page 27 updated 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. 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. 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.	F 323		

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 28 7. Every one hour checks were 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. 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. 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. 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. 11. All non-high risk for elopement residents had every shift checks initiated on 11/15/11. 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. 13. The gray relay box which indicated power disruption to the exit doors will remain on	F 323		

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 29 continual surveillance through out the hours of construction as well as one hour after with documentation of checks initiated on 11/14/11. 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. 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 identified concern.. Immediate Jeopardy was verified to be removed on 11/17/11 which lowered the scope and severity to a "E" at 42 CFR 483.25 Quality of Care (F323), 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	F490 1). Resident #1 was returned 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 minute checks on return to Highlands and remained on 15 minute checks through 11/7/11. DON interviewed staff on the unit for their knowledge of residents risk of elopement and all staff interviewed stated that residents on the 1C unit are at risk for elopement. all were able to satisfactorily answer questions regarding hall monitoring. All staff knew where to find the care plans, and staff understood the purpose of the IAP, Nurse aide assignment sheet and the Elopement books. All understood per their verbalization that all of these areas provided information regarding the residents needs.	
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that	F 490		

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 30 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 facility policy Elopement Prevention, it was determined the facility failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one (1) of seven (7) sampled residents, Resident #1. The facility failed to in-service and implement comprehensive care plan interventions for Resident #1, supervise cognitively impaired individuals with known elopement risk, and identify quality deficiencies. In addition, the facility failed to develop appropriate plans of action to correct identified quality deficiencies. On 11/02/11 Resident #1 eloped from the 'secure' (locked) unit and the facility's property during a major construction project 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's failure to utilize it's resources effectively and in-service and implement the comprehensive care plan; to provide adequate supervision of cognitively impaired individuals with known elopement risk; and develop appropriate plans of action to correct identified deficiencies placed residents at risk for elopement which was likely to	F 490	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. 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.	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 31 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 483.75 Administration (F490) 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. Refer to F282, F323 substandard quality of care, and F520. The findings include: 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. 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	F 490	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. 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 by the Administrator, Regional Nurse Consultant, and Director of Nursing on	

RECEIVED
JAN 0 3 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER: HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 1705 STEVENS AVENUE, LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 32 impaired cognition, the ability to ambulate independently and a high risk for elopement. The comprehensive plan of care directed the facility staff to prevent Resident #1's elopement from the facility by: 1. "Know Whereabouts At All Times Q (every) Day" and 2. Resident #1 to reside on the 'secured unit' (locked). Nursing documentation revealed Resident #1 displayed exit-seeking behaviors on 03/24/11, 03/25/11, 03/28/11, 03/31/11, 04/03/11 and 08/20/11. Review of the facility investigation on 11/08/11 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. Interviews with nursing staff (CNA #2 on 11/09/11 at 1:50 PM; LPN #4 on 11/09/11 at 3:55 PM; LPN #6 on 11/10/11 at 11:25 AM; CNA #8 on 11/10/11 at 11:40 AM; MDS Nurse #1 on 11/10/11 at 3:40 PM; MDS Nurse #2 on 11/14/11 at 2:40 PM; and LPN #2 on 11/15/11 at 2:00 PM) revealed staff was not aware of all residents that the facility had identified as an elopement risk and staff had no knowledge that they were to know the whereabouts of Resident #1 at all times per the care plan. Additionally, these staff stated they had not been trained to Resident #1's care plan. Interview with nursing staff confirmed they had no trained staff regarding Resident #1's care plan. Interview with the 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 and the unit manager of each unit. The facility investigation identified the cause of the elopement was the facility's exit door alarms were not functional due to intermittent electrical surges related to the construction occurring at the facility.	F 490	11/2/11 and no revisions to the policy where necessary. On 11/2/11 The processes for construction safety was reviewed by the Administrator, Director of Nursing and Director of Maintenance 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, protocols, education and POC with Medical Director on 11/16/11. No changes were made. 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. On 11/3/11 education was continued to reinforce staff knowledge of elopement policy, care plans, and supervision of	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SURVEYS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1706 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 33 However, further review revealed no evidence the facility had identified lack of appropriate supervision, staff having no knowledge of the care planned supervision requirements. 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. Interview with the Administrator, on 11/10/11 at 5:10 PM, revealed the facility did not recognize staff were unaware of care plan interventions. She also stated that lack of supervision and lack of implementation of the comprehensive care plan could have contributed to the elopement of Resident #1. While the facility implemented corrective action related to door alarms and having checks completed of the electrical relay box, there was no evidence the facility had implemented interventions specific to supervision of residents at risk for elopement from 11/02/11 through 11/16/11. Continued 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 and had a safety committee meeting weekly but this did not prevent an elopement. The concern related to staff knowledge of care plan intervention and lack of supervision of residents identified at risk for elopement had not been identified and was not discussed as a concern with the Quality	F 490	residents. This education was presented to all departments by the Staff Development Coordinator and Administrative Nursing Staff under the guidance of the Director of Nursing. Staff were reminded that the care plan is located in the nursing stations and that the nurse aide assignment sheets, and IAPs are extensions of the care plan. Education was completed on 11/17/11 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. 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	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 34 Assurance Committee. 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: 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. Participating in the assessments were unit managers. Residents found with the potential for elopement were identified, assessments updated	F 490	Director) This education included construction safety interventions, a review of the Elopement Policy, IJ findings, and care plan interventions. On 11/14/11 the Director of Nursing continued with education regarding the hall monitoring program, and relay door alarms. This education was provided to all departments. As noted in the AOC dated 11/16/11, the grey relay door panel, which indicates power disruption to the exit doors, will remain on continual surveillance through out the hours of construction, and to continue one hour post construction. This monitoring will be complected by line staff and reviewed by the Administrator. Following the hours of active construction the relay box is checked hourly by the 1B nursing staff. The relay box observations will continue until all internal construction is completed. The Director of Nursing, Assistant Director of Nursing, Staff Developer, Second Shift Supervisor and Weekend	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1705 STEVENS AVENUE
LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 35 and elopement protocols followed to include Elopement Book identifiers and photos. No new elopement risks were identified. 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. 7. Every one hour checks were initiated on 11/15/11 to be completed by the licensed nursing staff on all residents identified as high risk for elopement for the remainder of internal construction of the roof top HVA vent placement. 8. All high risk for elopement residents are in the Elopement Log, as of 11/09/11, which was located at each nurses station and at the receptionist's desk. 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. 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. 11. All non-high risk for elopement residents had every shift checks initiated on 11/15/11.	F 490	Supervisor have provided education to staff regarding the relay door panel, the hours of supervision, documentation and the staff members responsibilities. 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, 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 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	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1706 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 36 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. 13. The gray relay box which indicated power disruption to the exit doors will remain on continual surveillance, initiated 11/14/11, through out the hours of construction as well as one hour after. 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. Observations of the residents on the secured unit, on 11/16/11 10:00 AM, wanderguards were in place, staff were visible on the units interacting with the residents in activities or in the hallway. The residents were dressed appropriately for the season. 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	F 490	discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and further monitoring to ensure problem is resolved. The Director of Nursing is responsible for validating that additional hall monitoring is completed on unit 1C throughout the internal construction. The Director of Nursing will complete routine audits to validate that residents identified as at risk for elopement are visualized hourly, residents not identified as at risk for elopement are visualized every shift as part of the construction safety program, and that staff adhere to the hall monitoring program. This audit will occur 5 x week for the duration of the internal construction. The audit consist of reviewing the documentation for accuracy. Issues or discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and further monitoring to ensure problem is resolved. The Director of Maintenance is	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 490	Continued From page 37 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 identified concern. Immediate Jeopardy was verified to be removed on 11/17/11 which lowered the scope and severity to a "E" at 42 CF 483.75 Administration (490) 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 490	responsible for monitoring that exterior doors are checked at a minimum twice daily by Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Second Shift Supervisor, Weekend Supervisor, or Maintenance Assistant. The Director of Maintenance will audit the documentation for the additional door checks 5 x week for the duration of interior construction. Issues or discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and further monitoring to ensure problem is resolved.	
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520	The results of these audits will be presented to the QA&A team on December 20th, 2011 in formal QA. the QAA team, which consist of at least the 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.	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1706 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 38 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy Quality Assurance and Assessment Program and observation, it was determined the facility failed to identify issues for which quality assessment and assurance activities were necessary; and failed to develop and implement appropriate plans of action to correct identified quality deficiencies for one (1) of seven (7) sampled residents, Resident #1. The facility assessed Resident #1 as high risk for elopement requiring staff to know the resident's whereabouts at all times everyday. On 11/02/11, during major facility construction, Resident #1 successfully eloped from the 'secure' (locked) unit and the facility's property without staff supervision or knowledge. A citizen found Resident #1 sitting on the ground by a busy four (4) lane street several blocks from the facility. The facility's investigation failed to identify all causal factors of the elopement which prevented the facility from initiating corrective measures related to all causal factors. The facility identified 10 (ten) residents who were cognitively impaired and requiring supervision due to elopement risk. The facility's failure to identify issues for quality assessment and assurance, failure to in-service and implement appropriate plans of action to correct identified quality deficiencies, and failure to provide adequate supervision of cognitively impaired individuals with known elopement risk	F 520	The Regional Nurse consultant will validate education and auditing monthly via a QAA process. Any concerns that are identified by her will be addressed to the Administrator and DON. The QAA committee will be asked to reconvene and review the deficits, and implementing an updated plan. 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 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. 5) Facility alleges compliance on ~~January 2, 2012~~. 12-29-11 per Karole Hamilton, Adm by PB 1-4-12	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 39 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 483.75 Administration (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 tools developed, and revisions to policies and procedures. Refer to F282, F323 substandard quality of care, and F490. The findings include: Review of the facility's policy, Quality Assurance and Assessment (QAA) Program, revealed STANDARD 1. The QAA sets expectations, develops plans, and implements procedures to assess and improve the quality of the facility's governance, management, clinical, and support processes. The policy also revealed PROCEDURES 5. . . .situations in which an evaluation of the performance of care is indicated are readily identified. Review of Resident #1's record revealed the facility admitted the resident on 03/24/11 with diagnoses to include Alzheimer's Dementia and assessed Resident #1 as high risk for elopement. The comprehensive plan of care directed the facility staff to prevent Resident #1's elopement	F 520	F520 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 as representative of the QAA team returned to the facility to direct the immediate interventions and the investigation. The resident was returned safely to Highlands, no negative outcomes per assessment. #2) 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. Head counts, and door checks were immediate actions, and direction to assess all residents for	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 40 from the facility by: 1. "Know Whereabouts At All Times Q (every) Day" and 2. Resident #1 to reside on the 'secured unit' (locked). Nursing documentation revealed Resident #1 displayed exit-seeking behaviors on 03/24/11, 03/25/11, 03/28/11, 03/31/11, 04/03/11 and 08/20/11. Review of the facility investigation on 11/08/11 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 those doors approximately two (2) hours later revealed some of the 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. After the assessment on 11/02/11, the facility suspended direct supervision of the exit doors. The facility investigation also revealed the alarm company was to increase visits to ensure operation of locked/alarmed exit doors to monthly during the construction and the nursing staff was to monitor an electrical relay box to ensure there were no power disruptions to the door alarms. However, further review of the facility's investigation revealed the facility did not identify all causal factors of the elopement. There was no documented evidence that the facility had identified that staff had not provided supervision,	F 520	elopement risk was given. 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 where identified as at risk for elopement. Those residents who were identified as at risk previously to this review were reassessed, and their 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	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 41 knowing the whereabouts of Resident #1 at all times everyday, per the comprehensive care plan. Additionally, the investigation did not identify that staff was not knowledgeable of the care plan intervention for supervision or that staff had not been trained on the care plan intervention. In addition, the facility could provide no evidence of the implementation of interventions related to ensuring adequate supervision to prevent the recurrence of elopements for Resident #1 or other residents of the facility who had been identified as an elopement risk, per the care plan 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. 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. Further interview with the DON, on 11/10/11 at 9:00 AM and 5:00 PM, revealed 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"	F 520	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 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 Managers to add hourly checks during internal construction. General Alarm company (GAC) notified of door safety concerns. Safety watches implemented the night of 11/2/11. All alarming exit doors were reviewed by GAC on 11/3/11 and remained on direct supervision until review and clearance of	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 42 for Resident #1 could have contributed to the resident's elopement. 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 and had a safety committee meeting weekly but this did not prevent an elopement. She stated the facility had not recognized staff was unaware of care plan interventions and this concern was not discussed in the Quality Assurance Committee. She also stated she understood that lack of supervision and lack of implementation of the comprehensive care plan could have contributed to the elopement of Resident #1. Interview with the Medical Director, on 11/16/11 at 10:45 AM, revealed she attended the QAA Committee meetings at least quarterly and she attended care plan meetings almost every week. She stated she did not realize implementation of the comprehensive plans of care was a concern in regards to the residents at high risk for elopement. 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: 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.	F 520	each door was given by GAC on 11/3/11. Investigation by the QAA committee indicated a unanticipated power fluctuation to the relay box caused a door failure several hours after construction vibrations ceased as root cause for the failure. Director of Nursing via interview on 11/2/11 and 11/3/11, evaluated staff understanding of Elopement policy, Elopement Logs, code yellow, care plans and their extensions, IAP and special needs of the residents on the secured unit. No overall deficit of knowledge was identified , however the QAA committee gave direction to provide additional education for the Highlands staff. This was to include all departments, and cover understanding of Elopement policy, Elopement Logs, code yellow, care plans and their extensions, IAP and special needs of the residents on the secured unit. Due to the nature of the failure QAA determined it was unavoidable, and while	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 43 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. 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. 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. 7. Every one hour checks were initiated 11/15/11 by licensed nursing staff on all residents identified	F 520	unlikely to occur again as construction was complected on that HVAC renovation phase, relay box monitoring on the 1B unit was initiated on 11/3/11. Nursing staff on 1B would check the relay box control panels for any lights that would indicate power failure to the box, and consequently to the exit doors. On 11/15/11 this monitoring 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. Additional 1C Hall Monitoring 11/15/11. The monitoring will occur on the East	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1705 STEVENS AVENUE
LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 44 as high risk for elopement for the remainder of internal construction of the roof top HVA vent placement. 8. All high risk for elopement residents are in the Elopement Log 11/09/11 which was located at each nurses station and at the receptionist's desk. 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. 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. 11. All non-high risk for elopement residents had every shift checks initiated 11/15/11. 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. 13. The gray relay box which indicated power disruption to the exit doors will remain on continual surveillance as through out the hours of construction as well as one hour after with	F 520	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. 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. On 11/2/11 The processes for construction safety was reviewed by the Administrator, Director of Nursing and Director of Maintenance and modifications were made. The modifications included -all exterior doors will be checked a minimum twice daily	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1706 STEVENS AVENUE
LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 45 documentation of checks to begin on 11/14/11. 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 verified all had been completed as alleged. Observations of the residents on the secured unit, on 11/16/11 10:00 AM, wanderguards were in place, staff were visible on the units interacting with the residents in activities or in the hallway. The residents were dressed appropriately for the season. 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. The staff was knowledgeable regarding the addition of a second hall monitor to the 'secure unit', the position description, and how to identify and respond to a missing resident and the revisions to policies/procedures related to this identified concern. Immediate Jeopardy was verified removed on 11/17/11 which lowered the scope and severity to a "E" at 42 CFR 483.75 Administration (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 tools developed,	F 520	by Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Second Shift Supervisor, Weekend Supervisor, or Maintenance Assistant starting 11/2/11. 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. 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, beginning 11/3/11 to 11/17/11. Director of Nursing reviewed policy POC, and eduction with Medical Director on 11/16/11. No changes were made.	

RECEIVED
JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND PROVIDERS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS NURSING & REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 46 and revisions to policies and procedures.	F 520	4). Auditing 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 further monitoring to ensure problem is resolved. The Director of Nursing is responsible for validating that additional hall monitoring is completed on unit 1C throughout the internal construction. The Director of Nursing will complete routine audits to validate that residents identified as at risk for elopement are visualized hourly, residents not identified as at risk for elopement are visualized	

JAN 0 3 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1705 STEVENS AVENUE
LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 46 and revisions to policies and procedures.	F 520	every shift as part of the construction safety program, and that staff adhere to the hall monitoring program. This audit will occur 5 x week for the duration of the internal construction. The audit consist of reviewing the documentation for accuracy. Issues or discrepancy's found during the audits will be reported to QAA for direction which may include investigation, education and further monitoring to ensure problem is resolved. The Director of Maintenance is responsible for monitoring that exterior doors are checked at a minimum twice daily by Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Second Shift Supervisor, Weekend Supervisor, or Maintenance Assistant. The Director of Maintenance will audit the documentation for the additional door checks 5 x week for the duration of interior construction. Issues or discrepancy's found during the audits will be reported to QAA for direction which	

RECEIV
JAN 0 3 2
OFFICE OF INSPECT
DIVISION OF HEALTH CARE FAC

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185039		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1705 STEVENS AVENUE
LOUISVILLE, KY 40205

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 46 and revisions to policies and procedures.	F 520	may include investigation, education and further monitoring to ensure problem is resolved. The results of these audits will be presented to the QA&A team on December 29th, 2011 in formal QA. the QAA team, which consist of at least the 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. 5) Facility alleges compliance on ~~January 2, 2012.~~ 12-29-11 per Karole Hamilton, Adm. by PB 1-4-12	

pg. 49

JAN 03 2012
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES