

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

PRINTED: 09/17/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185468</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>08/31/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER - WEST, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 MAGAZINE STREET LOUISVILLE, KY 40203</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated/partial extended survey investigating KY18936 was initiated on 08/20/12 and concluded on 08/31/12. The Division of Health Care substantiated the allegation with Immediate Jeopardy and Substandard Quality of Care identified on 08/23/12 and determined to exist on 08/15/12.</p> <p>On 08/15/12 at approximately 7:15 PM, Resident #1 eloped from the facility without staff knowledge. Resident #1 had been assessed by the facility to be at risk for elopement, was on every fifteen (15) minute checks, and had a Code Alert bracelet on his/her ankle. Resident #1 was found by the local police at 8:10 PM, ambulating on a city sidewalk in a heavily trafficked, urban area, approximately thirteen (13) blocks from the facility. The local police returned the resident to the facility on 08/15/12 at 8:34:49 PM. Resident #1 was assessed by the facility as having no harm and was discharged to a local Veteran's hospital, later the evening of 08/15/12, upon family request and physician's order.</p> <p>The facility was notified on 08/23/12 of the Immediate Jeopardy at 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490) with Substandard Quality of Care at 42 CFR 483.25 Quality of Care.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/27/12 which alleged the Immediate Jeopardy was removed on 08/25/12. However, the State Survey Agency determined the facility had not trained the agency nursing staff until 08/30/12, therefore Immediate Jeopardy was determined to be removed on 08/31/12 prior</p>	F 000	<p><b>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</b></p>		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

Pg.1

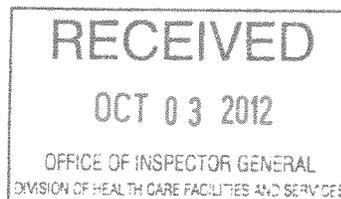
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X Martha Robinson* TITLE *X Administrator* (X6) DATE *X 10-3-12*

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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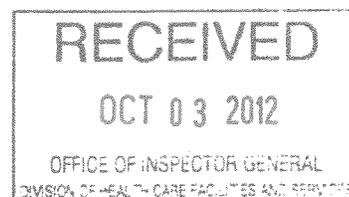
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F 000	Continued From page 1 to exit. The scope and severity for 42 CFR 483.25 Quality of Care (F323), and 42 CFR 483.75 Administration (F490) was lowered to a "D" while the facility develops and implements a plan of correction to achieve substantial compliance with regulation, and while the facility's Quality Assurance program continues to monitor the effectiveness of staff education, effectiveness of resident assessments and care planning, utilization of tools developed, and revisions to policies and procedures.	F 000	<b>F323: Free of accident Hazard/Supervision/Devices</b>	
F 323 SS=J	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, investigation, Observation Flow Sheet, and Code Alert Activities Report, it was determined the facility failed to have an effective system to ensure the resident's environment remained free of accident/hazards for one (1) of seven (7) sampled residents (Resident #1). Resident #1 had been assessed by the facility to be at risk for elopement, was on every fifteen (15) minute checks, and had a Code Alert bracelet on his/her ankle. On 08/15/12 the facility's Code Alert Activities Report (a	F 323	<b>1. Resident #1 - was admitted to the facility on 8/15/12 from St. Catherine Regional Hospital at 3:00p.m. During his hospital stay from 7/30/12 to admission, periods of exit seeking and wandering along with agitation was noted until 8/12/12.</b>  Resident Discharge Summary from St. Catherine Regional Hospital documented: Patient had been cooperative with medication and tolerated medication changes well and behaviors had decreased with less exit seeking and anxiety. No behaviors were noted in last 48 hours. Upon admission the Admission Assessment was completed by a licensed nurse and resident #1 was identified to be at risk for elopement, his interim care plans were started per facility policy & procedure. Resident identification information and a current photograph were placed in the Elopement Risk Binder at the nurses' station and front office by the Director of Nursing and Staff Development Nurse. Pg.2	



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F 323	<p>Continued From page 2</p> <p>computerized report which tracks residents wearing a Code Alert bracelet when the resident comes within five (5) feet of the exit door) indicated Resident #1 was near the following exits at the times listed: Evergreen Court 6:14:56 &amp; 6:15:52 PM, the Dining Room Exit 6:21:03 &amp; 6:21:37 PM, and Maple Boulevard Exit 6:33:06 &amp; 6:33:17 PM. Interviews with facility staff revealed they failed to observe Resident #1 on the unoccupied and unsupervised hallway of Maple Boulevard on that date during the 15 minute checks. On 08/15/12 at approximately 7:15 PM, Resident #1 was discovered missing from the facility. Resident #1 was found by the local police ambulating on a sidewalk approximately thirteen (13) city blocks from the facility in a heavily trafficked urban area and was returned to the facility unharmed at 8:34:49 PM on 08/15/12. Resident #1's Code Alert did not indicate activity on the system from 6:33:17 PM until 8:34:49 PM, when the resident was returned to the facility through the Main Street 1 Exit. In addition, the facility failed to identify an inconsistently alarming exit door which was to assist in the prevention of resident elopement. The facility exit doors were to alarm if a resident, who wore a Code Alert bracelet, attempted to exit the facility. However, the exit door on Maple Boulevard was not alarming inconsistently. Resident #1 was discharged to a local Veteran's hospital, later the evening of 08/15/12, upon family request and physician's order.</p> <p>The facility's failure to supervise residents at risk for elopement and to identify an exit door alarm which was not alarming properly placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or</p>	F 323	<p>A wander alert bracelet was applied to his ankle, his code alert bracelet was entered into the wander management system and 15 minutes supervision checks were initiated due to his assessment findings. This information was relayed to the licensed nurse by the Director of nursing along with the written documentation form to complete these checks. The licensed nurse completing these checks verbalized understanding of the procedure. This information was then placed on the licensed nurse report sheet and the C.N.A. care records. Resident # 1 was not exhibiting any restlessness, agitation or exit seeking behavior at that time.</p> <p>At 7:00p.m resident # 1 was in his room during the 15 minute check by the LN, when this nurse returned to the residents' room at 7:15 to administer medication he was not in his room. The C.N.A. assigned to the hall stated he had been in his room just prior to her going into an adjacent room to provide care. A facility wide search and resident census was taken by the charge nurse and resident # 1 was noted to be missing.</p> <p style="text-align: right;">Pg. 3</p>		



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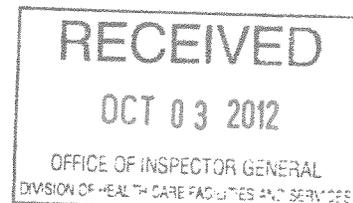
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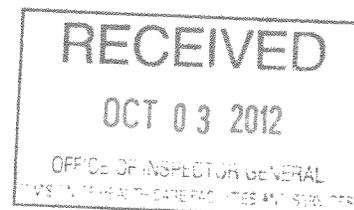
F 323	<p>Continued From page 3</p> <p>death. The facility was notified on 08/23/12 of the Immediate Jeopardy and Substandard Quality of Care at 42 CFR 483.25 Quality of Care (F323).</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/27/12 which alleged the Immediate Jeopardy was removed on 08/25/12. However, the State Survey Agency determined the facility had not trained the agency nursing staff until 08/30/12, therefore Immediate Jeopardy was determined to be removed on 08/31/12 prior to exit. The scope and severity for Substandard Quality of Care at 42 CFR 483.25 Quality of Care F323 Accidents and Supervision was lowered to a "D" while the facility develops and implements a plan of correction to achieve substantial compliance with regulation, and while the facility's Quality Assurance program continues to monitor the effectiveness of staff education, effectiveness of resident assessments and care planning, utilization of tools developed, and revisions to policies and procedures.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Procedure for Code Alert Alarms (undated) revealed when the resident approached an exit door, the alarm would sound and the door would lock. The procedure also revealed staff would check exits and server computer to identify the resident and the exit door. Staff was to proceed to the identified exit and redirect the resident. If the resident was not seen, staff was to check the area and outside to assure the resident had not exited.</p> <p>Review of Code Alert Activities Report for</p>	F 323	<p>Staff members were immediately sent out in cars and on foot to search the area, the DON, Administrator, police and family were notified.</p> <p>The police arrived at the facility obtained identifying information with current photograph and information was dispatched. The Administrator, DON and additional staff arrived at the facility to assist and oversee the process for location of the resident. His daughter arrived at facility and provided information on sites the resident might have gone.</p> <p>At approximately 8:20pm the police reported the resident had been found by an officer, was unharmed and was being escorted back to facility. The code alert bracelet was intact and sounded when resident reentered the building. This bracelet was removed, tested on all exits by the Maintenance Supervisor and found to be in working order. A head to toe assessment was completed by the licensed nurse. The physician was notified and orders were received to discharge resident to VA medical center and family was in agreement.</p>	
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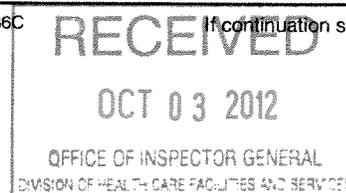
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F 323	<p>Continued From page 4</p> <p>08/15/12 indicated Resident #1 near the following exits at the times listed: Evergreen Court 6:14:56 &amp; 6:15:52 PM, the Dining Room Exit 6:21:03 &amp; 6:21:37 PM, and Maple Boulevard Exit 6:33:06 &amp; 6:33:17 PM. Resident #1's Code Alert did not indicate activity on the system again until 8:34:49 PM at the Main Street 1 Exit.</p> <p>Record review revealed Resident #1 was initially admitted to the facility on 07/10/12 and the facility assessed the resident as having a cognition score of ten (10) on the Minimum Data Set (MDS) indicating a moderate impairment of cognition. Review of the nursing notes, dated 07/30/12, revealed Resident #1 attempted to elope from the facility on 07/30/12 and was discharged to a psychiatric hospital on 07/30/12 for an evaluation. Review of a discharge summary from the psychiatric hospital dated 08/15/12 revealed Resident #1 had no exit seeking behavior for the previous forty-eight (48) hours. The resident was re-admitted to the facility on 08/15/12 at 3:00 PM.</p> <p>Review of the nursing admission elopement assessment, dated 08/15/12 and timed 3:00 PM, revealed Resident #1 triggered as an elopement risk due to his/her being ambulatory, having a history of wandering and having a diagnosis of Dementia. Review of the interim nursing plan of care revealed a problem for Resident #1 was a risk for elopement, the goal listed was to decrease the risk for elopement and one intervention for the prevention of elopement was to apply a Code Alert bracelet. Review of an every fifteen (15) minute observation document revealed Resident #1 was not located in the facility at 7:15 PM.</p>	F 323	<p>Resident#1 was under 1:1 supervision with Social Service Director until transfer by ambulance.</p> <p><b>2. All residents identified at potential risk-</b> On 8/15/2012 the following occurred : Code alert bracelets were checked for placement and functioning by the Charge Nurse for the seven Residents assessed to be at risk for elopement. All were found to be in place and functioning properly. The Director of Nursing checked the Elopement at Risk binders to assure all resident at risk had identifying information and a current photograph present. The Director of Nursing interviewed all staff present to determine their activity, and the activity of Resident #1, when last observed including the licensed staff assigned to complete every 15 minute supervision observation checks as determined by the interdisciplinary team prior to his arrival to the facility. The Administrator and the Director of Clinical Support reviewed the elopement assessments and care plans of these residents. Assessments and care plans were determined to be accurate. Pg. 5</p>		



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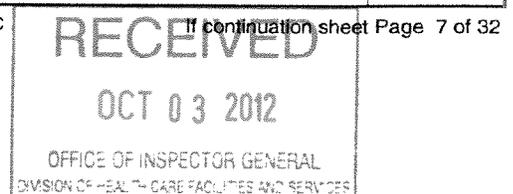
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F 323	<p>Continued From page 5</p> <p>Review of the facility's investigation, dated 08/15/12, revealed a check of the Maple Boulevard exit door by the Director of Clinical Services (DCS) on 08/15/12 prior to Resident #1's return indicated inconsistent alarming of the Maple Boulevard exit door. The facility investigation included an interview with Resident #1, upon return to the facility, during which Resident #1 stated he/she left the facility out a back door. Further review of the facility's investigation revealed Resident #1 was wearing a Code Alert bracelet upon return to the facility and the Code Alert bracelet did cause the exit doors to alarm when checked by the Maintenance Supervisor.</p> <p>Review of the Maintenance Supervisor's maintenance log sheet revealed all of the exit door alarms had been functional when checked on 08/10/12. Review of the door alarm company's representative's report on 08/16/12 revealed the exit door on Maple Boulevard did not shut completely and needed repair; however, if shut completely the door did lock properly and all functions were working for the Code Alert system.</p> <p>Interview with the Maintenance Supervisor, on 08/20/12 at 3:50 PM, revealed he was called to the facility on 08/15/12 at approximately 8:30 PM after Resident #1's elopement from the facility. He stated his initial assessment of the eleven (11) alarmed exit doors revealed they were all working correctly. However, another assessment of the eleven (11) alarmed exit doors revealed the exit door on Maple Boulevard was alarming inconsistently. He stated he discovered the exit door on Maple Boulevard was not shutting properly and he thought this might have</p>	F 323	<p>On 8/15/12 at approximately 8:50pm, IT support checked the code alert computer program for documented system function and activity of resident.</p> <p>On 8/15/12 the Maintenance Supervisor, IT Support, DON and Director of Clinical Support checked all exit doors. On 8/15/12 the DCS and DON noted the door on Maple Blvd. opened without alarming with code alert in hand, all other exits wander management and perimeter alarms were found to be functioning properly. These inconsistencies were determined to be the root cause of the residents exit from the building. The Director of Clinical support, DON, Maintenance and IT remained at the door until the security guard was assigned and a chair was place by the door on 8/15/12. He was relieved on 8/16/12 at 7 am by a housekeeper who remained at the door until the service representative had tested doors/system, repaired, and deemed to be functioning appropriately on 8/16/12. Routine facility supervision rounds were continued by on duty staff to ensure resident safety. 6</p>		



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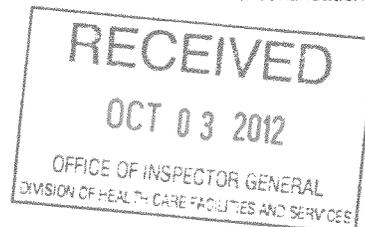
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F 323	<p>Continued From page 6</p> <p>contributed to the inconsistent alarming of that door. He further stated administrative staff took turns manning the Maple Boulevard exit door until a security guard came to work at 11:00 PM to man the door to ensure the safety of all residents. The Maintenance Supervisor indicated he checked the alarming exit doors bi-monthly prior to Resident #1's elopement from the facility; however, he was now checking the doors daily to ensure their functionality. He stated it was his understanding the alarms on the doors would sound when a resident wearing a Code Alert bracelet attempted to exit one of the doors. He stated there was no manufacturer's recommendation or facility policy as to how often to check the alarms on exit doors and he checked them as they were checked at another company's facility. Record review of the manufacture's recommendation revealed no recommendations to the frequency of door alarm checks.</p> <p>Interview with CNA (Certified Nursing Assistant) #4, on 08/21/12 at 11:45 AM, revealed she was assigned to Resident #1 on the evening shift of 08/15/12 and LPN #5 was assigned to observe Resident #1 every fifteen (15) minutes and document the same. She stated she saw Resident #1 at about 6:30 PM on 08/15/12 in his/her room and further stated she had not seen the resident ambulating on Maple Boulevard prior to his/her elopement. CNA #4 stated she had not heard any exit door alarms in the facility the evening of 08/15/12. CNA #4 stated she had been trained on the Code Alert door alarm system on hire and her understanding was the exit doors would alarm when a resident wearing a Code Alert bracelet attempted to go out an exit door. She stated the computer at the nurses station</p>	F 323	<p>Per Standard of Practice and facility procedures rounds were made a minimum of every two hours by CNAs' and nurses to ensure Resident safety and comfort.</p> <p>All residents' Admission assessments, care plans, C.N.A. care records, assignments sheets, elopement, fall and smoking at risk assessments were reviewed and revised as indicated by licensed nurses Administrator and the DCSS beginning on 8/15/12 and Administrator and the DCSS. The treatment administration sheets for all residents identified as elopement risk were reviewed for documentation of placement &amp; function and revised as indicated on 8/16/12 by a licensed nurse.</p> <p>All windows were checked by maintenance and housekeeping supervisors to assure only an approximate 4" allowed opening on 8/15/12 &amp; 8/16/12. All windows are at an approximate allowed opening of 4". pg7</p>	



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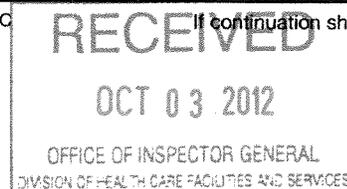
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F 323	<p>Continued From page 7</p> <p>had a facility diagram on the screen which would show a blinking light at the exit door which was alarming. CNA #4 indicated the Code Alert door alarms would help the staff know if a resident wearing a Code Alert bracelet attempted to go out an exit door.</p> <p>Interview with LPN (Licensed Practical Nurse) #5, on 08/21/12 at 11:00 AM, revealed she had been assigned to do the every fifteen (15) minute observations of Resident #1 and she stated she had seen the resident at 6:30 PM, 6:45 PM and 7:00 PM. However, she stated Resident #1 was not in his/her room at 7:15 PM and could not be located in the facility. She stated she did not hear an exit door alarm during the evening shift of 08/15/12 until the Maintenance Supervisor and administrative staff arrived and began checking the exit door alarms. She also stated no alarms or indicators went off on the computer schematic diagram of the facility to indicate any alarming exit door. LPN #5 indicated she had been trained on the Code Alert alarm system on hire and she understood the exit doors would alarm if a resident actually attempted to exit an alarmed door and that alarm would help the staff keep the residents safe. Interview with LPN #5, on 08/23/12 at 4:00 PM, revealed she had not seen Resident #1 on Maple Boulevard on 08/15/12; however, the Code Alert log had placed the resident on the unoccupied wing at approximately 6:33 PM. Review of the resident's Observation Flow Sheet revealed documentation that Resident #1 was seen at the nurse's station at 6:30 PM and 6:45 PM, and in his/her room at 7:00 PM.</p> <p>Interview with LPN #6, on 08/21/12 at 3:15 PM,</p>	F 323	<p><b>3. Systematic changes –</b></p> <p>The Elopement and Missing Person policy and procedure was reviewed by the Administrator and Director of Nursing on 8/17/12, and determined no revisions were required.</p> <p>All current staff was re-in serviced by the Staff Development Nurse beginning on 8/15/12 and completing on 8/17/12 regarding: Policies on Elopement risk/assessment, interventions and steps taken during an incident and Missing Resident that included a post-test to ensure competency.</p> <p>Any staff on vacation, PRN or on a leave of absence will be re-in serviced prior to giving care.</p> <p>All new employees will receive training on Elopement risk/assessment, interventions and steps taken during an incident and Missing Resident that included a post-test to ensure competency during orientation. Any temporary staff will be in serviced prior to working. <span style="float: right;">pg. 8</span></p>	



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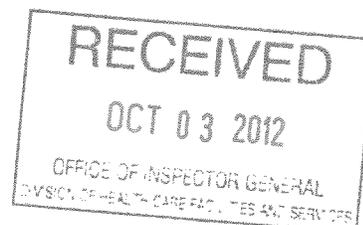
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F 323	<p>Continued From page 8</p> <p>revealed she was the admitting nurse for Resident #1 on 08/15/12 but she was working on another hall that evening. She stated she was aware Resident #1 was placed on every fifteen (15) minute observations which were to be done by LPN #5. She stated she did not hear any exit door alarms that evening, she had been trained on the Code Alert door alarm system on hire, and she was aware the computer at the nurses station would indicate which exit door was alarming. LPN #6 indicated it was her understanding the exit doors would alarm if a resident with a Code Alert bracelet got 'near' an exit door, and it was also her understanding the Code Alert alarms on the exit doors would help the staff keep the residents safe.</p> <p>Interview with the Director of Nursing (DON), on 8/21/12 at 11:30 AM, revealed she was present in the facility on 08/15/12 and had made the determination to place Resident #1 on every fifteen (15) minute observations by LPN #5. She stated she made this determination based on the documentation from the psychiatric hospital which stated Resident #1 had not had exit-seeking behaviors there for forty-eight (48) hours prior to discharge. She stated the nursing staff had no responsibility to check exit doors for alarming function or monitoring of the computer screen at the nurses station except when an alarm was sounding. The DON stated she thought Resident #1 eloped from the facility through an exit door which was not alarming properly although the purpose of the alarms on the exit doors was to assist the staff in keeping the residents safe.</p> <p>Interview with the Administrator, on 08/22/12 at 3:45 PM, revealed there was no policy on how</p>	F 323	<p>All code alert bracelets will be assessed for placement every shift and function daily by charge nurse and documented on the Treatment Administration Records.</p> <p>The Maintenance Director received education on proper care and inspection of all door locks and controllers from the manufacturer and suggestions taken regarding the monitoring of the Code alert system on 8/16/12.</p> <p>The Preventive maintenance form for checking door and code alert function was revised to <b>include specific areas to check (code alert lock down, code alert at door, and code alert light activity at both sensors &amp; 15 minute emergency egress). Update form reviewed</b> with the Maintenance Supervisor to ensure competence to complete the checks in accordance with the education given by the service representative on 8/16/12 by the Administrator.</p> <p><b>Pg. 9</b></p>		



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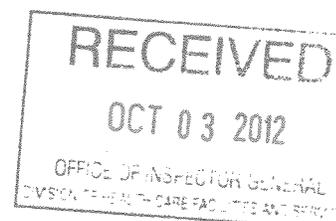
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F 323	<p>Continued From page 9</p> <p>often the door alarm system should be checked and no policy regarding utilization of the Code Alert computer information. The Administrator stated the purpose of the Code Alert alarm system on the exit doors was to assist in keeping the residents safe. She further stated it was ultimately her responsibility to ensure adequate assistance devices (door alarms) to ensure the safety of the residents in the facility.</p> <p>Review of the acceptable AOC revealed the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. A facility wide search and resident census was taken by the charge nurse immediately to determine if Resident #1 was missing and all other residents were present. The Administrator, DON, police, physician and family of Resident #1 were all notified by telephone.</li> <li>2. All exit doors were checked for functionality by the Maintenance Supervisor at approximately 8:40 PM on 08/15/12 with the exit door on Maple Boulevard alarming inconsistently. Administrative staff monitored the exit door on Maple Boulevard until 11:00 PM when the security guard came on duty.</li> <li>3. After Resident #1's return to the facility at 8:34:49 PM by the local police, the resident was placed on one-to-one (1:1) supervision by the Social Services Director to ensure his/her safety until Resident #1's transfer out of the facility to the local veteran's hospital.</li> <li>4. On 08/15/12, after Resident #1's elopement from the facility, LPN #6 checked all seven (7)</li> </ol>	F 323	<p><b>4. Monitoring for sustained solutions:</b></p> <p>Treatment Administration records of all residents with a Code Alert bracelet will be audited by Nursing management ( DON, Unit Manager and Staff Development Coordinator ) 5 times weekly for two weeks, then 2 times weekly for two weeks, then weekly or as recommended by the Quality Assurance Committee. Any discrepancies will be corrected immediately by licensed nurse identified or manager if applicable. Re-education will be completed as indicated. The DON will review audits with the administrator weekly, who will then present findings during the Quality Assurance Meeting that will be conducted weekly for two weeks, then bi weekly times two weeks then monthly. A review of POC for implementation and/or changes will be conducted at QA meeting on 9/18/12.</p> <p>All exit door alarms and locking mechanisms were checked daily until 8/27/2012.</p> <p>Pg. 10</p>	



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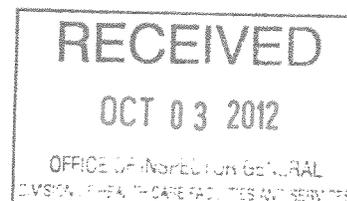
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F 323	Continued From page 10 residents (remaining in the facility) who had been assessed as being at risk for elopement with Code Alert bracelets to ensure the bracelets' placement and functionality.  5. On 08/15/12, the DON checked the Elopement at Risk binder at the nursing station to ensure all identifying information and a current photo was in the binder for the eight (8) residents (to include Resident #1) who had been assessed as being at risk for elopement.  6. The DON initiated the facility's investigation into Resident #1's elopement from the facility, on 08/15/12 at 9:00 PM, with interviews of the staff on duty.  7. The Administrator and the Director of Clinical Services (DCS) reviewed the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement on 08/15/12 at 10:00 PM and determined those assessments and documents were correct. The Administrator and the DCS also reviewed all residents' admission assessments, care plans, CNA care records, assignment sheets, elopement, fall and smoking at risk assessments beginning on 08/15/12 and completed on 08/16/12 with revisions as indicated.  8. A minimum of every two hours facility supervision rounds were continued by on duty staff to ensure resident safety.  9. On 08/20/12, all current staff were re-in-serviced on elopement risk/assessment, interventions and steps taken during an incident	F 323	As of 8/27/2012 All exit door alarms and locking mechanisms will be checked 5 times weekly for two weeks, then two times weekly for two weeks, then weekly or as recommended by the Quality Assurance Committee by the maintenance supervisor, any discrepancies will be corrected immediately and reported to the Administrator. The Maintenance Supervisor will review audits with the administrator weekly, who will then present findings during the Quality Assurance Meeting.  Findings of the Audits and results of the Quality Assurance meetings will be reviewed by the Administrator with VP of Older Adults Communities.  5. Date of Compliance <b>9/5/2012</b>  <b>Pg. 11</b>		



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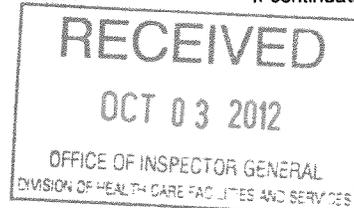
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F 323	Continued From page 11 and missing residents which included a post test to ensure competency. The in-services was conducted by the Director of Nurses.  10. All interdisciplinary team members and licensed nurses were to be re-in-serviced on the facility's policy regarding Care Plans beginning on 08/23/12, by the Staff Development Nurse. All interdisciplinary team members and licensed nurses were to be re-in-serviced on that policy prior to beginning their next shift or giving care with the date of compliance of 08/25/12. Review of in-service training sheets and interview revealed all nurses were not trained by 08/25/12 with seven (7) agency nurses having worked 08/23/12 through 08/29/12 prior to re-in-service on the Care Plan policy. All nursing staff were re-in-serviced by 08/30/12 on the policy: Care Plan which changed the facility date of compliance to 08/30/12.  11. On 08/24/12 regulatory guidelines and facility policies were reviewed with the Administrator by the Vice President of Older Adults Communities to ensure resident care was provided in accordance with accurate comprehensive care plans and safety through supervision. On 08/24/12 the Administrator reviewed and re-signed her job description to assure ongoing knowledge and acceptance of duties and responsibilities.  The State Survey Agency validated the Immediate Jeopardy was removed as follows:  1. The State Survey Agency validated through record review and interview with the Administrator, on 08/20/12 at 3:15 PM, she was	F 323	<b>F490: Effective Administration/Resident Well-Being</b>  1.Administration: On 8/15/12 after Notification of Residents' #1 elopement and receiving update on policy implementation by staff, the administrator returned to the facility immediately. While en route she notified her immediate supervisor, the VP of Older Adults Communities. The Administrator and the Director of Clinical Support reviewed the elopement assessments and care plans of these residents. Assessments and care plans were determined to be accurate.  An update on progress in place for locating resident #1 was received from police officer on site. Additional management staff was notified to return to the facility to assist. The Administrator directed the continuation of the Policy implementation. Resident # 1 was returned to the Building by police officers at approximately 8:20 pm unharmed.  Pg. 12		



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F 323	<p>Continued From page 12</p> <p>notified by LPN #5 at approximately 7:30 PM by telephone on 08/15/12 of the elopement of Resident #1 after a facility wide search and determination Resident #1 was missing from the facility and immediate grounds. Interview with the DON, on 08/20/12 at 4:15 PM, revealed she was notified by LPN #5 by telephone at approximately 7:35 PM on 08/15/12 of the elopement of Resident #1. Review of documents provided labeled, Exhibit #5 Evergreen nurse report sheet and Exhibit #7 Lakeview nurse report sheet, revealed a resident head count had been conducted by the charge nurses on each of those halls on 08/15/12 at 7:30 PM.</p> <p>2. The State Survey Agency validated through record review and interview with the Director of Clinical Services, on 08/21/12 at 5:35 PM, she monitored the exit door on Maple Boulevard from 8:40 PM until 10:00 PM on 08/15/12. Interview with the DON, on 08/21/12 at 11:30 AM, revealed she monitored the Maple Boulevard exit door from 10:00 PM until 11:00 PM on 08/15/12. Interview with the security guard, on 08/23/12 at 6:00 AM, revealed he was assigned to monitor the Maple Boulevard exit door on 08/15/12 from 11:00 PM until 6:45 AM. Interview with Housekeeper #1, on 08/22/12 at 2:10 PM, revealed he was assigned to monitor the Maple Boulevard exit door on 08/16/12 at 6:45 AM until the Code Alert company representative arrived to check the exit doors Code Alert alarm system at approximately 12:00 Noon.</p> <p>3. The State Survey Agency validated through record review and interview with the Social Services Director, on 08/20/12 at 4:30 PM, she did provide 1:1 supervision to Resident #1 from</p>	F 323	<p>The administrator directed the Director of Social Services to remain with Resident #1 to provide 1:1 supervision until his transfer to the VA Hospital.</p> <p>2. All actions taken to remove the immediate risk to residents and changes made to prevent a recurring incident were directed by the Administrator in collaboration with the DON, DCSS and VP of Older Adults Communities. These actions Included:</p> <p>On 8/15/2012 the following occurred: Code alert bracelets were checked for placement and functioning by the Charge Nurse for the seven Residents assessed to be at risk for elopement. All were found to be in place and functioning properly. The Director of Nursing checked the Elopement at Risk binders to assure all resident at risk had identifying information and a current photograph present.</p> <p>Pg. 13</p>	

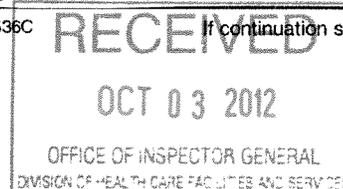


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F 323	Continued From page 13 8:35 PM on 08/15/12 until his/her discharge from the facility at 10:15 PM. Review of the nursing notes in the record, dated 08/15/12 at 8:30 PM, revealed Resident #1 was placed on 1:1 supervision upon return to the facility until discharge at 10:15 PM.  4. The State Survey Agency validated through record review and interview with LPN #6, on 08/22/12 at 1:50 PM, she checked the seven (7) remaining residents with Code Alert bracelets to ensure the bracelets' placement and functionality on 08/15/12 at approximately 9:00 PM. Review of a twenty-four (24) hour nursing document for 08/15/12 evening shift on 08/29/12 revealed LPN #6 documented the checking of the remaining seven (7) residents with Code Alert bracelets to ensure the Code Alert bracelets' placement and functionality.  5. The State Survey Agency validated through record review and interview with the DON, on 08/20/12 at 4:15 PM, she checked the elopement at risk binder at the nursing station, on 08/15/12 at approximately 8:45 PM, to ensure all identifying information and a current photo was in the binder for the eight (8) residents (to include Resident #1) who had been assessed at being at risk for elopement. Review of the facility's elopement binder on 08/29/12 revealed all residents' at risk for elopement identifying information was in the binder.  6. The State Survey Agency validated through record review and interview with the DON, on 08/20/12 at 4:15 PM, she started the facility investigation of the elopement at 9:00 PM on 08/15/12 with staff interviews (who were on duty	F 323	The Director of Nursing interviewed all staff present to determine their activity, and the activity of Resident #1, when last observed including the licensed staff assigned to complete every 15 minute supervision observation checks as determined by the interdisciplinary team prior to his arrival to the facility.  On 8/15/12 at approximately 8:50pm, IT support checked the code alert computer program for documented system function and activity of resident #1. The Maintenance Supervisor, IT Support, DON and Director of Clinical Support checked all exit doors on 8/15/12. The DCS and DON noted the door on Maple Blvd. opened without alarming with code alert in hand, all other exits wander management and perimeter alarms were found to be functioning properly.  These inconsistencies were determined to be the root cause of the residents exit from the building.		

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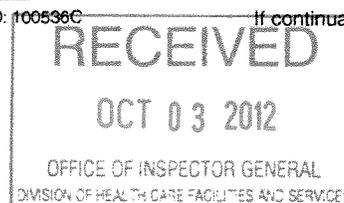


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F 323	Continued From page 14 at the time of Resident #1's elopement). Interview with CNA #4 on 08/31/12 at 10:10 AM (assigned to Resident #1 at the time of the resident's elopement) revealed she was interviewed regarding Resident #1's elopement from the facility. Review of the facility's investigation into Resident #1's elopement on 08/29/12 revealed staff interviews were done timely.  7. The State Survey Agency validated through record review and interview with the Administrator, on 08/20/12 at 3:15 PM, she had reviewed, on 08/15/12 at 10:00 PM, the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. She also indicated revisions were made to the other documents reviewed as necessary. Interview with the Director of Clinical Services (DCS), on 08/21/12 at 5:35 PM, revealed she had assisted the Administrator, on 08/15/12 at 10:00 PM, in reviewing the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. She further stated the other residents' documents were reviewed with the Administrator and revisions were made as necessary. Review of the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement on 08/30/12 revealed signatures/dates of review and revision by the DCS and the Administrator.  8. The State Survey Agency validated through	F 323	The Director of Clinical support, DON, Maintenance and IT remained at the door until the security guard was assigned and a chair was place by the door. He was relieved on 8/16/12 at 7 am by a housekeeper who remained at the door until the service representative had tested doors/system, repaired, and deemed to be functioning appropriately on 8/16/12. Routine facility supervision rounds were continued by on duty staff to ensure resident safety. Per Standard of Practice and facility procedures rounds were made a minimum of every two hours by CNAs' and nurses to ensure Resident safety and comfort.  All residents' Admission assessments, care plans, C.N.A. care records, assignments sheets, elopement, fall and smoking at risk assessments were reviewed and revised as indicated by licensed nurses Administrator and the DCSS beginning on 8/15/12 and Administrator and the DCSS.		

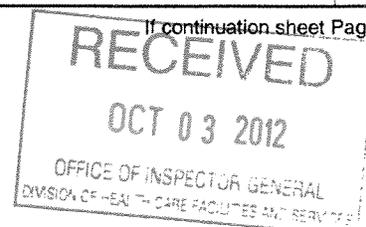
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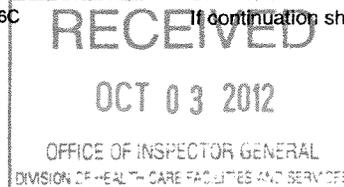
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F 323	Continued From page 15 record review and interview with CNA #3, on 08/21/12 at 3:15 PM, she checked on her assigned residents at least every two (2) hours and it was her understanding this was the facility's practice. Interview with CNA #4, on 08/21/12 at 11:45 AM, revealed the facility's practice was to check on her assigned residents at a minimum of every two hours and she continued to do so after Resident #1's elopement from the facility on 08/15/12. Interview with the DON, on 08/20/12 at 4:15 PM, revealed it was the facility's practice to check on all residents at least every two (2) hours and that was also standard practice. The DON stated the nursing staff had access to up-to-date nursing standards of practice via the computers at the nursing station and a review of that standard of practice was done in nursing orientation. Review of a nursing orientation worksheet on 08/30/12 revealed every two (2) hour checking on residents was discussed in the orientation.  9. The State Survey Agency validated through record review and interview with the Staff Development nurse, on 08/30/12 at 9:15 AM, she had provided the in-services regarding elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test to ensure staff competency. Interview with CNA #4, on 08/21/12 at 11:45 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test on 08/16/12. Interview with CNA #3, on 08/21/12 at 3:15 PM, revealed he received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an	F 323	The TAR's for all residents identified as elopement risk were reviewed for documentation of placement & function and revised as indicated on 8/16/12 by a licensed nurse.  All windows were checked by maintenance and housekeeping supervisors to assure only an approximate 4" allowed opening on 8/15/12 & 8/16/12. All windows are at an approximate allowed opening of 4".  . Systemic Changes: Upon arrival on site on 8/15/12, the Administrator received an update on search activity, resident's status and testing of monitoring systems for supervision and safety from the charge nurse. The census count and code alert function and placement documentation was reviewed by the Administrator and found to be in compliance.  On 8/15/12 the Administrator and the Director of Clinical Support reviewed the elopement assessments and care plans of these residents. Assessments and care plans were determined to be accurate.  Pg.16	



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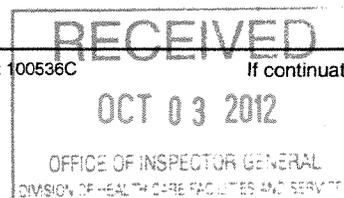
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185468</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/31/2012</b>
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F 323	<p>Continued From page 16</p> <p>incident of a missing resident which included a post test on 08/15/12. Interview with LPN #1, on 08/21/12 at 11:00 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test to ensure competency on 08/17/12. Interview with LPN #5, on 08/21/12 at 11:00 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test to ensure competency on 08/15/12. All in-service training content and staff sign-in sheets were reviewed on 08/30/12 to ensure all nursing staff had been re-trained per the AOC.</p> <p>10. The State Survey Agency validated through record review and interview with LPN #2, on 08/29/12 at 4:30 PM, she had not been re-in-serviced on the Care Plan policy prior to starting her shift and giving resident care at 2:30 PM. Interview with LPN #1, on 08/30/12 at 8:00 AM, revealed he had worked two (2) shifts prior to having a re-in-service on the policy, Care Plans which he received via telephone on 08/29/12. Interview with the DON, on 08/30/12 at 8:30 AM, revealed she placed an in-service binder at the nurses station for the agency nurses to read and sign for the re-in-service on the Care Plan policy. However, she stated that was a new procedure for the facility and the agency nurses were not told to read/sign the in-service prior to starting their shifts. The DON stated it was an oversight and the agency was notified on 08/27/12 to have the agency nurses read/sign the in-service binder which was two (2) days after the alleged date of compliance. Review of all in-service content and</p>	F 323	<p><b>On 8/15/12 the Administrator instructed the Staff Development Coordinator to initiate staff education on supervision of residents identified at risk for elopement to include: Risk/assessment, individual resident interventions and steps taken during an incident for a missing resident. Administrator reviewed information reeducation was started for all staff on duty and was ongoing to assure all staff received.</b></p> <p>On 8/24/12 Administrator reviewed and resigned job description to assure ongoing knowledge and acceptance of duties and responsibilities.</p> <p>The Administrator will review with the Director of Nursing and the Maintenance Supervisor audits of the TAR's for Code Alert bracelet placement and functioning and all exit door alarms and locking mechanisms. These audits as well as any changes needed to the process will be presented to the Quality Assurance Committee at the Monthly meeting.</p> <p><b>Pg. 17</b></p>		



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F 323	Continued From page 17 agency nurse re-training sign-in sheets were reviewed on 08/30/12 to ensure compliance with the AOC.  11. The State Survey Agency validated through record review and interview with the Administrator, on 08/29/12 at 4:00 PM, she did have a job performance review with the Vice President of Older Adults Communities on 08/24/12 and she did re-sign her job description indicating understanding of same. Interview with the Vice President of Older Adults Communities, on 08/30/12 at 5:00 PM, revealed the Administrator was re-educated on her job duties.	F 323	<p><b>4. Monitoring to sustain solution:</b> The administrator will provide a report on the Quality Assurance findings to the VP of Older Adults Communities. The VP of Older Adults Communities will conduct a monthly on site update meeting and advise the Administrator if needed.</p> <p><b>The Medical Director reviews the development and revisions of all facility policies and procedures. The Administrator reviewed the POC and discussed staff educational needs on 9/4/12 with the Medical Director. Review and updates are ongoing.</b></p> <p>5. Date of Compliance: <b>9/5/2012</b> <b>Pg. 18</b></p>	
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility's policies, investigation, and Code Alert system, it was determined the facility failed to have an effective system to ensure its resources were used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of seven (7) sampled residents, Resident #1. The facility failed to ensure policies were developed and/or implemented related to the Code Alert system. The facility failed to utilize a computerized program, which would detect when residents with	F 490		



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F 490	<p>Continued From page 18</p> <p>Code Alert bracelets were within five (5) feet of an exit door, and failed to identify an inconsistently alarming exit door. On 08/15/12 Resident #1 eloped from the facility without staff knowledge and was discovered missing from the facility at 7:15 PM. Resident #1 was found by the local police ambulating on a sidewalk approximately thirteen (13) city blocks from the facility in a heavily trafficked urban area and was returned to the facility unharmed at 8:34:49 PM on 08/15/12. The facility's failures to be administered effectively and efficiently placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death. The facility was notified on 08/23/12 of the Immediate Jeopardy in 42 CFR 483.75 Administration (F490).</p> <p>The facility's failure to supervise residents at risk for elopement and to identify an exit door alarm which was not alarming properly placed residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death. The facility was notified on 08/23/12 of the Immediate Jeopardy at 42 CFR 483.75 Administration (F490).</p> <p>An acceptable Allegation of Compliance (AOC) was received on 08/27/12 which alleged the Immediate Jeopardy was removed on 08/25/12. However, the State Survey Agency determined the facility had not trained the agency nursing staff until 08/30/12, therefore Immediate Jeopardy was determined to be removed on 08/31/12 prior to exit. The scope and severity at 42 CFR 483.75 Administration (F490) was lowered to a "D" while the facility develops and implements a plan of correction to achieve</p>	F 490			

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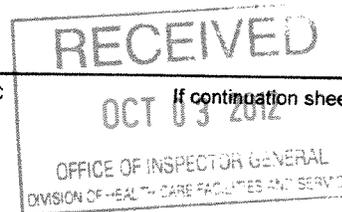
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F 490	<p>Continued From page 19</p> <p>substantial compliance with regulation, and while the facility's Quality Assurance program continues to monitor the effectiveness of staff education, effectiveness of resident assessments and care planning, utilization of tools developed, and revisions to policies and procedures.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Procedure for Code Alert Alarms (undated) revealed when the resident approaches an exit door, an alarm will sound and the door will lock. The procedure also revealed staff will check exits and the server computer to identify the resident and the exit door. Staff are to proceed to the identified exit, redirect the resident, if the resident is not seen, check the area and outside to assure the resident has not exited.</p> <p>Review of Code Alert activities report for 08/15/12 indicated Resident #1 near the following exits at the times listed: Evergreen Court 6:14:56 &amp; 6:15:52 PM, the Dining Room Exit 6:21:03 &amp; 6:21:37 PM, and Maple Boulevard Exit 6:33:06 &amp; 6:33:17 PM. Resident #1's Code Alert did not indicate activity on the system again until 8:34:49 PM at the Main Street 1 Exit.</p> <p>Review of the facility's investigation, dated 08/15/12, revealed a check of the Maple Boulevard exit door by the Director of Clinical Services (DCS) on 08/15/12, prior to Resident #1's return, which indicated inconsistent alarming of the Maple Boulevard exit door. The facility's investigation included an interview with Resident #1, upon return to the facility, during which</p>	F 490		

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F 490	<p>Continued From page 20</p> <p>Resident #1 stated he/she left the facility out a back door. Further review of the facility's investigation revealed Resident #1 was wearing a Code Alert bracelet upon return to the facility and the Code Alert bracelet did cause the exit doors to alarm when checked by the Maintenance Supervisor. Review of the facility's investigation also revealed print-out logs of documentation for the date/time/location of exit doors/Code Alert bracelet number which indicated if a staff had exited an alarmed door, if a resident with a Code Alert bracelet had exited an alarmed door, or if a resident with a Code Alert bracelet had been 'near' an alarmed exit door.</p> <p>Review of the computer print-out logs revealed Resident #1 had been 'near' the Maple Boulevard exit door at 6:33:06 &amp; 6:33:17 PM on 08/15/12. Review of the report revealed Resident #1's Code Alert was not logged again until 8:34:49 PM, when the resident was returned to the facility through the Main Street 1 Exit.</p> <p>Review of the Maintenance Supervisor's maintenance log sheets for July 2012 and August 2012 revealed all of the exit door alarms had been functional bi-monthly in July and on 08/10/12. Review of the door alarm company's representative's report on 08/16/12 revealed the exit door on Maple Boulevard did not shut completely and needed repair.</p> <p>Interview with the Maintenance Supervisor, on 08/20/12 at 3:50 PM, revealed he was called to the facility on 08/15/12 at approximately 8:30 PM he discovered the exit door on Maple Boulevard was alarming inconsistently. He stated he discovered the exit door on Maple Boulevard was</p>	F 490		



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F 490	<p>Continued From page 21</p> <p>not shutting properly and he thought this might have contributed to the inconsistent alarming of that door. The Maintenance Supervisor stated he was aware the Code Alert computer system could monitor and log an exit from all alarmed doors and could also monitor and log the presence of a resident with a Code Alert bracelet when that resident was 'near' an alarmed exit door. However, he stated this information was not being utilized to his knowledge. He stated 'near' meant within five (5) feet of an exit door. The Maintenance Supervisor stated there was no facility policy regarding how often to check the alarms on the exit doors. He stated it was his understanding the alarms on the doors would sound when a resident wearing a Code Alert bracelet attempted to exit one of the doors.</p> <p>Interview with LPN (Licensed Practical Nurse) #5, on 08/21/12 at 11:00 AM, revealed during the evening shift of 08/15/12 no alarms or indicators went off on the computer schematic diagram of the facility to indicate any alarming exit door. Further interview with LPN #5, on 08/23/12 at 4:00 PM, revealed she had not seen Resident #1 on Maple Boulevard on 08/15/12; however, the Code Alert log had placed the resident on the unoccupied wing at approximately 6:33 PM.</p> <p>Interview with LPN #6, on 08/21/12 at 3:15 PM, revealed she did not hear any exit door alarms the evening of 08/15/12. LPN #6 indicated it was her understanding the exit doors would alarm if a resident with a Code Alert bracelet got 'near' an exit door and it was also her understanding the Code Alert alarms on the exit doors would help the staff keep the residents safe.</p>	F 490		

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F 490	<p>Continued From page 22</p> <p>Interview with the Director of Nursing (DON), on 08/21/12 at 11:30 AM, revealed the nursing staff had no responsibility to check exit doors for alarming function or monitoring of the computer screen at the nurses station except when an alarm was sounding. The DON stated she thought Resident #1 eloped from the facility through an exit door which was not alarming properly although the purpose of the alarms on the exit doors was to assist staff in keeping the residents safe. The DON further stated she was aware the computer system for the Code Alert could monitor and log each of the alarmed exit doors for exit and the presence of a resident with a Code Alert bracelet when that resident was 'near' an alarmed exit door. She stated the logs of that information were not monitored or used for resident safety to her knowledge.</p> <p>Interview with the Administrator, on 08/22/12 at 3:45 PM, revealed there was no policy on how often the door alarm system should be checked and no policy regarding utilization of the Code Alert computer information. The Administrator stated she was aware the Code Alert computer system could monitor and log by date and time which facility doors were exited, if staff or a resident with a Code Alert bracelet (assigned by code to individual residents) exited an alarmed door, or if a resident with a Code Alert bracelet was 'near' an exit door. She stated the purpose of the Code Alert alarm system on the exit doors was to assist in keeping residents safe. She further stated the computer system logs had not been used previously to assist in keeping residents safe; however, it was ultimately her responsibility to ensure adequate assistance devices (door alarms or computer systems) were</p>	F 490		
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F 490	<p>Continued From page 23</p> <p>utilized to ensure the safety of the residents in the facility.</p> <p>Review of the acceptable AOC revealed the facility took the following actions to remove the Immediate Jeopardy:</p> <ol style="list-style-type: none"> <li>1. A facility wide search and resident census was taken by the charge nurse immediately to determine if Resident #1 was missing and all other residents were present. The Administrator, DON, police, physician and family of Resident #1 were all notified by telephone.</li> <li>2. All exit doors were checked for functionality by the Maintenance Supervisor at approximately 8:40 PM on 08/15/12 with the exit door on Maple Boulevard alarming inconsistently. Administrative staff monitored the exit door on Maple Boulevard until 11:00 PM when the security guard came on duty.</li> <li>3. After Resident #1's return to the facility at 8:34:49 PM by the local police, the resident was placed on one-to-one (1:1) supervision by the Social Services Director to ensure his/her safety until Resident #1's transfer out of the facility to the local veteran's hospital.</li> <li>4. On 08/15/12, after Resident #1's elopement from the facility, LPN #6 checked all seven (7) residents (remaining in the facility) who had been assessed as being at risk for elopement with Code Alert bracelets to ensure the bracelets' placement and functionality.</li> <li>5. On 08/15/12, the DON checked the</li> </ol>	F 490			

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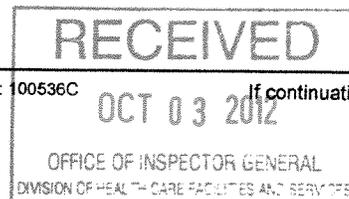
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F 490	<p>Continued From page 24</p> <p>Elopement at Risk binder at the nursing station to ensure all identifying information and a current photo was in the binder for the eight (8) residents (to include Resident #1) who had been assessed as being at risk for elopement.</p> <p>6. The DON initiated the facility's investigation into Resident #1's elopement from the facility, on 08/15/12 at 9:00 PM, with interviews of the staff on duty.</p> <p>7. The Administrator and the Director of Clinical Services (DCS) reviewed the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement on 08/15/12 at 10:00 PM and determined those assessments and documents were correct. The Administrator and the DCS also reviewed all residents' admission assessments, care plans, CNA care records, assignment sheets, elopement, fall and smoking at risk assessments beginning on 08/15/12 and completed on 08/16/12 with revisions as indicated.</p> <p>8. A minimum of every two hours facility supervision rounds were continued by on duty staff to ensure resident safety.</p> <p>9. On 08/20/12, all current staff were re-in-serviced on elopement risk/assessment, interventions and steps taken during an incident and missing residents which included a post test to ensure competency. The in-services was conducted by the Director of Nurses.</p> <p>10. All interdisciplinary team members and licensed nurses were to be re-in-serviced on the</p>	F 490		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185468</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/31/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEALTH CENTER - WEST, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 MAGAZINE STREET LOUISVILLE, KY 40203</b>
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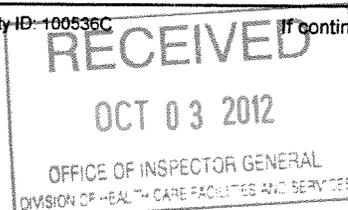
F 490	<p>Continued From page 25</p> <p>facility's policy regarding Care Plans beginning on 08/23/12, by the Staff Development Nurse. All interdisciplinary team members and licensed nurses were to be re-in-serviced on that policy prior to beginning their next shift or giving care with the date of compliance of 08/25/12. Review of in-service training sheets and interview revealed all nurses were not trained by 08/25/12 with seven (7) agency nurses having worked 08/23/12 through 08/29/12 prior to re-in-service on the Care Plan policy. All nursing staff were re-in-serviced by 08/30/12 on the policy: Care Plan which changed the facility date of compliance to 08/30/12.</p> <p>11. On 08/24/12 regulatory guidelines and facility policies were reviewed with the Administrator by the Vice President of Older Adults Communities to ensure resident care was provided in accordance with accurate comprehensive care plans and safety through supervision. On 08/24/12 the Administrator reviewed and re-signed her job description to assure ongoing knowledge and acceptance of duties and responsibilities.</p> <p>The State Survey Agency validated the Immediate Jeopardy was removed as follows:</p> <p>1. The State Survey Agency validated through record review and interview with the Administrator, on 08/20/12 at 3:15 PM, she was notified by LPN #5 at approximately 7:30 PM by telephone on 08/15/12 of the elopement of Resident #1 after a facility wide search and determination Resident #1 was missing from the facility and immediate grounds. Interview with the DON, on 08/20/12 at 4:15 PM, revealed she was</p>	F 490		
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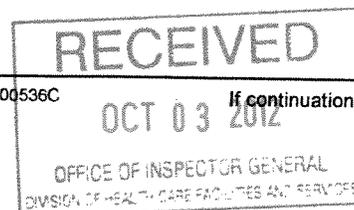
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F 490	<p>Continued From page 26</p> <p>notified by LPN #5 by telephone at approximately 7:35 PM on 08/15/12 of the elopement of Resident #1. Review of documents provided labeled, Exhibit #5 Evergreen nurse report sheet and Exhibit #7 Lakeview nurse report sheet, revealed a resident head count had been conducted by the charge nurses on each of those halls on 08/15/12 at 7:30 PM.</p> <p>2. The State Survey Agency validated through record review and interview with the Director of Clinical Services, on 08/21/12 at 5:35 PM, she monitored the exit door on Maple Boulevard from 8:40 PM until 10:00 PM on 08/15/12. Interview with the DON, on 08/21/12 at 11:30 AM, revealed she monitored the Maple Boulevard exit door from 10:00 PM until 11:00 PM on 08/15/12. Interview with the security guard, on 08/23/12 at 6:00 AM, revealed he was assigned to monitor the Maple Boulevard exit door on 08/15/12 from 11:00 PM until 6:45 AM. Interview with Housekeeper #1, on 08/22/12 at 2:10 PM, revealed he was assigned to monitor the Maple Boulevard exit door on 08/16/12 at 6:45 AM until the Code Alert company representative arrived to check the exit doors Code Alert alarm system at approximately 12:00 Noon.</p> <p>3. The State Survey Agency validated through record review and interview with the Social Services Director, on 08/20/12 at 4:30 PM, she did provide 1:1 supervision to Resident #1 from 8:35 PM on 08/15/12 until his/her discharge from the facility at 10:15 PM. Review of the nursing notes in the record, dated 08/15/12 at 8:30 PM, revealed Resident #1 was placed on 1:1 supervision upon return to the facility until discharge at 10:15 PM.</p>	F 490	



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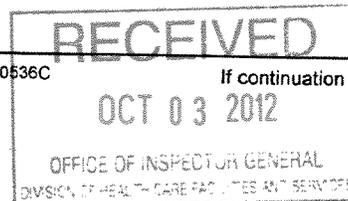
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F 490	Continued From page 27  4. The State Survey Agency validated through record review and interview with LPN #6, on 08/22/12 at 1:50 PM, she checked the seven (7) remaining residents with Code Alert bracelets to ensure the bracelets' placement and functionality on 08/15/12 at approximately 9:00 PM. Review of a twenty-four (24) hour nursing document for 08/15/12 evening shift on 08/29/12 revealed LPN #6 documented the checking of the remaining seven (7) residents with Code Alert bracelets to ensure the Code Alert bracelets' placement and functionality.  5. The State Survey Agency validated through record review and interview with the DON, on 08/20/12 at 4:15 PM, she checked the elopement at risk binder at the nursing station, on 08/15/12 at approximately 8:45 PM, to ensure all identifying information and a current photo was in the binder for the eight (8) residents (to include Resident #1) who had been assessed at being at risk for elopement. Review of the facility's elopement binder on 08/29/12 revealed all residents' at risk for elopement identifying information was in the binder.  6. The State Survey Agency validated through record review and interview with the DON, on 08/20/12 at 4:15 PM, she started the facility investigation of the elopement at 9:00 PM on 08/15/12 with staff interviews (who were on duty at the time of Resident #1's elopement). Interview with CNA #4 on 08/31/12 at 10:10 AM (assigned to Resident #1 at the time of the resident's elopement) revealed she was interviewed regarding Resident #1's elopement from the facility. Review of the facility's	F 490			



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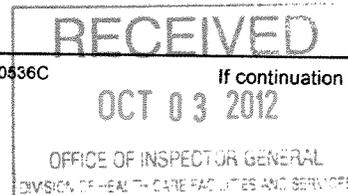
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F 490	Continued From page 28 investigation into Resident #1's elopement on 08/29/12 revealed staff interviews were done timely.  7. The State Survey Agency validated through record review and interview with the Administrator, on 08/20/12 at 3:15 PM, she had reviewed, on 08/15/12 at 10:00 PM, the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. She also indicated revisions were made to the other documents reviewed as necessary. Interview with the Director of Clinical Services (DCS), on 08/21/12 at 5:35 PM, revealed she had assisted the Administrator, on 08/15/12 at 10:00 PM, in reviewing the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement and determined those assessments and documents were correct. She further stated the other residents' documents were reviewed with the Administrator and revisions were made as necessary. Review of the elopement assessments and care plans of the eight (8) residents the facility had assessed as being at risk for elopement on 08/30/12 revealed signatures/dates of review and revision by the DCS and the Administrator.  8. The State Survey Agency validated through record review and interview with CNA #3, on 08/21/12 at 3:15 PM, she checked on her assigned residents at least every two (2) hours and it was her understanding this was the facility's practice. Interview with CNA #4, on 08/21/12 at 11:45 AM, revealed the facility's	F 490			



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F 490	Continued From page 29 practice was to check on her assigned residents at a minimum of every two hours and she continued to do so after Resident #1's elopement from the facility on 08/15/12. Interview with the DON, on 08/20/12 at 4:15 PM, revealed it was the facility's practice to check on all residents at least every two (2) hours and that was also standard practice. The DON stated the nursing staff had access to up-to-date nursing standards of practice via the computers at the nursing station and a review of that standard of practice was done in nursing orientation. Review of a nursing orientation worksheet on 08/30/12 revealed every two (2) hour checking on residents was discussed in the orientation.  9. The State Survey Agency validated through record review and interview with the Staff Development nurse, on 08/30/12 at 9:15 AM, she had provided the in-services regarding elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test to ensure staff competency. Interview with CNA #4, on 08/21/12 at 11:45 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test on 08/16/12. Interview with CNA #3, on 08/21/12 at 3:15 PM, revealed he received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test on 08/15/12. Interview with LPN #1, on 08/21/12 at 11:00 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a	F 490			



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F 490	<p>Continued From page 30</p> <p>post test to ensure competency on 08/17/12. Interview with LPN #5, on 08/21/12 at 11:00 AM, revealed she received the facility in-service on elopement risk/assessment, interventions and steps to be taken during an incident of a missing resident which included a post test to ensure competency on 08/15/12. All in-service training content and staff sign-in sheets were reviewed on 08/30/12 to ensure all nursing staff had been re-trained per the AOC.</p> <p>10. The State Survey Agency validated through record review and interview with LPN #2, on 08/29/12 at 4:30 PM, she had not been re-in-serviced on the Care Plan policy prior to starting her shift and giving resident care at 2:30 PM. Interview with LPN #1, on 08/30/12 at 8:00 AM, revealed he had worked two (2) shifts prior to having a re-in-service on the policy, Care Plans which he received via telephone on 08/29/12. Interview with the DON, on 08/30/12 at 8:30 AM, revealed she placed an in-service binder at the nurses station for the agency nurses to read and sign for the re-in-service on the Care Plan policy. However, she stated that was a new procedure for the facility and the agency nurses were not told to read/sign the in-service prior to starting their shifts. The DON stated it was an oversight and the agency was notified on 08/27/12 to have the agency nurses read/sign the in-service binder which was two (2) days after the alleged date of compliance. Review of all in-service content and agency nurse re-training sign-in sheets were reviewed on 08/30/12 to ensure compliance with the AOC.</p> <p>11. The State Survey Agency validated through record review and interview with the</p>	F 490			

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F 490	Continued From page 31 Administrator, on 08/29/12 at 4:00 PM, she did have a job performance review with the Vice President of Older Adults Communities on 08/24/12 and she did re-sign her job description indicating understanding of same. Interview with the Vice President of Older Adults Communities, on 08/30/12 at 5:00 PM, revealed the Administrator was re-educated on her job duties.	F 490		
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