

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

PRINTED: 08/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/17/2014
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 08/07/14</p> <p>An Abbreviated and Partial Extended Survey was initiated on 07/08/14 and concluded on 07/17/14 to investigate KY21922. The Division of Health Care substantiated the allegation with Immediate Jeopardy and Substandard Quality of Care identified on 07/09/14 and determined to exist on 07/04/14. The facility was notified on 07/09/14 of the Immediate Jeopardy at 42 CFR 483.25 Quality of Care (F323-J) with Substandard Quality of Care in the area of 42 CFR 483.25 Quality of Care (F323).</p> <p>On 07/04/14 at 1:54 PM, Resident #2 was discovered by a housekeeping staff outside the facility approximately one hundred forty (140) feet from a set of propped open exit doors in the rehabilitation gym. The facility staff were unaware the resident was missing. A housekeeping staff found Resident #2 seated in his/her wheelchair in an offset of a parking lot adjacent to the facility between the dumpsters and a cooling unit. Resident #2 was returned to the facility by the housekeeper and assessed by the unit nurse as having no injury.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/15/14 which alleged the Immediate Jeopardy was removed on 07/12/14. The State Survey Agency (SSA) determined Immediate Jeopardy was removed on 07/15/14 versus 07/12/14 as alleged, prior to exit on 07/17/14 with remaining noncompliance at 42 CFR 483.25 Quality of Care (F323) with the Scope and Severity lowered to a "D" while the facility develops and implements a Plan of</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

X Leslie J. Butterfield *X* Administrator *X* 08-10-2014

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.

RESOLVED
AUG 12 2014

If continuation sheet Page 1 of 20
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

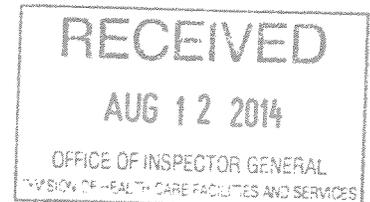
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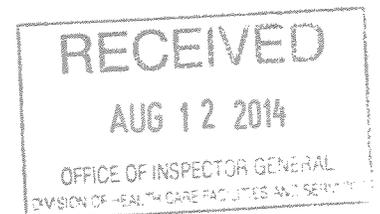
F 000	Continued From page 1 Correction and the facility's Quality Assurance Committee monitors the effectiveness of the systemic changes to achieve and maintain substantial compliance.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's video surveillance, and facility policies, Elopement Prevention and Intervention and Accidents, and review of the facility's Health and Rehab Admission Packet, it was determined the facility failed to have an effective system in place to ensure adequate supervision to prevent elopement for one (1) of eight (8) sampled residents (Resident #2). On 07/04/14 at 1:54 PM, Resident #2 was discovered by staff outside the facility approximately one hundred forty (140) feet. Resident #2 exited the facility by way of a set of propped open exit doors leading from the rehabilitation gym to a patio, enclosed with an iron fence and two gates, of which one was open. The gates led to a paved area off of the parking lot. Resident #2 exited the facility without staff knowledge. Resident #2 was found by a	F 323	1. Resident #2 was not affected negatively. She was assessed on July 04, 2014 by the unit nurse, in charge of her care that day, for any injuries with none noted. She continued to be monitored hourly by all staff for safety times thirty days. Continued monitoring is being completed on hourly monitoring forms which are kept in elopement monitoring sheet binders on each unit. The nurse, on each shift, on the unit is responsible for all checks to be completed and recorded. An order was placed in Matrix for each nurse to monitor and sign the monitoring form for the preceding shift. Holes in the monitoring sheets, if any, would be addressed immediately by the nurse manager on call. On July 04, 2014 our restorative / QA nurse rechecked all of our wander guard doors for proper operation and the administrator check all delayed egress doors for proper operation. All doors and equipment were functioning properly. On August 6, 2014 the resident was re-assessed by our MDS director, the resident's unit nurse manager, our social service director and our staff development director. She remains an elopement risk.	



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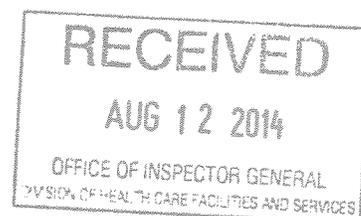
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F 323	<p>Continued From page 2</p> <p>housekeeper seated in his/her wheelchair in an offset of a parking lot adjacent to the facility between the dumpsters and a cooling unit. A Housekeeper assisted the resident back to the facility and a unit nurse assessed the resident as having no injury.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision of residents; and its failure to ensure exit doors in the rehabilitation gym remained closed and locked, and the gates to the parking lot were closed and locked, placed residents of the facility in a situation that caused or is likely to cause, serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/09/14 and was determined to exist on 07/04/14. The facility was notified of the Immediate Jeopardy on 07/09/14.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 07/15/14, alleging the Immediate Jeopardy was removed on 07/12/14. The State Survey Agency (SSA) determined the Immediate Jeopardy was on 07/15/14 versus 07/12/14 as alleged, prior to exit on 07/17/14. The Scope and Severity was lowered to a "D" while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance Committee monitors the effectiveness of the systemic changes to achieve and maintain substantial compliance.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Elopement Prevention and Intervention, dated 12/08/11, revealed all exit doors in the resident halls and main entrance would remain alarmed</p>	F 323	<p>2. All residents that are identified to be at risk for elopement are at risk of being affected by the deficient practice</p> <p>3. On 07-09-14 an emergency meeting was held to review current policy and procedures for assessing for elopement risk. We determined all residents should be reevaluated for potential elopement risks. Education topics were discussed and approved by the team which included the administrator, the MDS nurse, QA nurse, social service director, staff development director and a unit nurse manager.</p> <p>On 07-09-14 all residents were reviewed and re-assessed for potential elopement risk. The reviews were completed by our MDS coordinator, a unit manager, our restorative / QA nurse, social services director and our staff development director. No new residents were assessed as an elopements risk. Our other residents previously identified for elopement risk will continue to be assessed quarterly, annually, upon a significant change or change in behavior and care-plans reviewed for exit seeking behaviors to ensure that appropriate precautions are in place and that care-plans are updated where appropriate. Assesments will be completed and care plans updated by our unit managers. Care plans are reviewed quarterly and annually by our IDT.</p> <p>On July 04, 2014, Resident #2 exited a door from our therapy department. That door had a switch that would disable the alarm which would sound if the door was left open. Upon finding that Resident #2 had left through that door the therapy staff immediately relocked the door.</p>	



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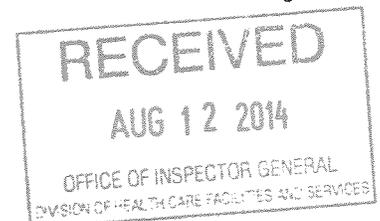
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F 323	Continued From page 3 twenty-four (24) hours a day and those residents who were assessed as cognitively or physically impaired must be accompanied when leaving the facility and must be signed in and out. Review of the facility's policy regarding Accidents, undated, revealed the facility would provide an environment that was free of accidents and/or hazards over which the facility had control and all staff would be involved in observing and identifying potential hazards in the environment. Review of the facility's "Health and Rehab Admission Packet" revealed the facility must protect and promote the rights of each resident to include a safe environment. Review of Resident #2's clinical record revealed the facility admitted the resident on 06/15/11, with diagnoses which included Dementia with Depression, Coronary Artery Disease and Toxic Encephalopathy. Review of the Comprehensive Care Plan, dated 06/12/13, revealed no elopement risk as a concern with interventions. Further record review revealed the facility assessed Resident #2, on 06/09/14, with a Brief Interview of Mental Status (BIMS) score of three (3) which indicated the resident had a severe cognitive loss. Review of the Minimum Data Set, dated 06/09/14, revealed the ambulation assessment stated Resident #2 was wheelchair bound, but was capable of self-propelling the wheelchair with his/her feet independently. Review of an Elopement Risk Assessment, dated 06/09/14, revealed Resident #2 was not an elopement risk. Observation of Resident #2, on 07/08/14 at 11:30 AM, revealed the resident self-propelled his/her	F 323	On July 07, 2014 the maintenance director permanently locked the gate that would not latch as there is a second gate in the patio that functions properly. Re-education of staff including therapy and dietary departments, began immediately on July 04, 2014 and continued daily through July 7, 2014 by our staff development and therapy director, in regard to Missing Resident & Elopement Procedures as well as evaluation and assessment of potential exit seeking residents. Upon reviewing our elopement policies and procedures, we determined that there were some modifications that would make the procedures easier to understand and follow.(Please find our original and revised elopement prevention and intervention policy and procedures being sent with this letter.) Starting on July 09, 2014 all staff including, nursing, administration, maintenance, housekeeping dietary and therapy departments, was inserviced on insuring that all doors and gates are closed and secure at all times and on our changes to our elopement policies and procedures. Staff was also re-educated on environmental safety awareness, focusing on proper notification of Maintenance needs. Training was provided by our staff development nurse and was provided daily on July 9, 10 and completed on 07/11/2014. After July 11, 2014 staff not inserviced were not allowed to work until they had received said training. Springhurst no longer uses temp agencies for nursing. There were 3 temps in housekeeping that were inserviced by the 11th. As of August 8, 2014, all employees have been inserviced.		



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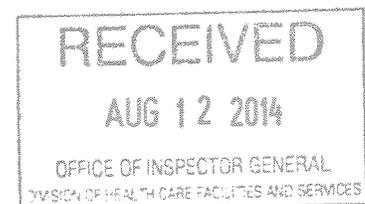
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F 323	<p>Continued From page 4</p> <p>wheelchair down the South Hall from the resident's room to the dining room and entered the dining room for lunch. Observations of Resident #2, on 07/09/14 at 3:00 PM; on 07/15/14 at 10:00 AM; and on 07/16/14 at 4:00 PM, revealed the resident self-propelled his/her wheelchair up and down the South Hall.</p> <p>Review of the facility's investigation, dated 07/05/14, revealed a housekeeper saw Resident #2 outside the facility seated in his/her wheelchair at approximately 1:54 PM on 07/04/14. The housekeeper immediately brought the resident into the facility. Resident #2 was assessed by the unit nurse as being unharmed and an investigation was initiated. Review of the facility's investigation revealed on 07/04/14, the exit doors from the rehabilitation gym onto the patio were unlocked and propped open from 10:00 AM until 2:00 PM. At 2:00 PM, the doors were closed and locked upon staff's knowledge of Resident #2's elopement. In addition, all other facility locked exit doors were checked for proper working order on 07/04/14 after Resident #2's elopement from the facility. The facility determined the causal factor for Resident #2's elopement was determined to be the propped open exit doors from the rehab gym onto the patio and an open gate in the wrought iron fence at the perimeter of the patio. The facility notified the appropriate State agencies and Resident #2's family and physician.</p> <p>Review, of the 07/04/14 video surveillance tape, on 07/10/14 at 2:40 PM, revealed Resident #2 self-propelled his/her wheelchair onto the patio directly in front of the rehab gym exit doors at 1:37 PM. The rehab gym exit doors were in deep shadow on the video surveillance at 1:37 PM and</p>	F 323	<p>All new staff will receive all of the above training during orientation; prior to them providing any direct care.</p> <p>We utilize a wander guard system for our residents identified as an elopement risk. All doors equipped with the wander guard system will continue to be checked daily by restorative aides. All of our delayed egress doors will continue to be checked weekly by our maintenance department. The administrator will, weekly, check documentation of the wander guard door checks. Documentation sheets used by restorative and maintenance departments will be provided upon request.</p> <p>4. Ongoing an elopement committee, composed of the administrator, the D.O.N., the social service director, the maintenance director and our staff development director, will meet weekly until our QA committee meeting in October 2014. The QA committee in October will determine the frequency of future elopement meetings. At this time, we will commit that we will not meet less than once a month for the next year. The first elopement committee was held on July 14, 2014. Our first scheduled QA committee meeting was on July 21, 2014. The QA committee was updated on our progress and actions taken to make our residents safe from elopement. The administrator will present the elopement committee's actions and findings at each QA committee meeting.</p>	8-09-2014	



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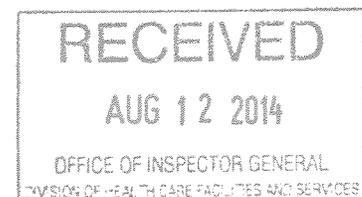
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F 323	Continued From page 5 Resident #2 could not be observed going over the threshold and through the exit doors of the rehab gym. Continued review of the video surveillance revealed Resident #2 turned left and self-propelled his/her wheelchair to a closed gate in a wrought iron fence at the perimeter of the patio. The resident then turned right and self-propelled along two (2) gardening boxes to a second open gate in the fence at the perimeter of the patio. Resident #2 proceeded to self-propel through the open gate at 1:40 PM onto a sidewalk ending at a facility parking lot. Video surveillance ended at 1:42 PM at the end of the sidewalk and patio. Interview, on 07/09/14 at 11:30 AM, with the Housekeeper revealed she discovered Resident #2 self-propelling his/her wheelchair toward the facility dumpsters which were located on a parking lot inset between two (2) buildings at the facility, on 07/04/14 at 1:54 PM. The Housekeeper indicated she immediately called for help and took the resident into the facility and to the nurse on the resident's living unit, the South Hall. She stated the resident was dressed in street clothing appropriate to the dry, warm weather with tennis shoes on and was smiling when she spoke to him/her. Observation of the rehab gym, on 07/08/14 at 11:00 AM, revealed a room measured by the Maintenance Director to be thirty-six (36) feet North to South and thirty-two (32) feet East to West. The rehab gym was one room with an offset approximately ten (10) by ten (10) feet with computers and chairs for the staff's use. The open room held multiple forms of therapy equipment, with open spaces allowing wheelchairs to be maneuvered throughout the	F 323			



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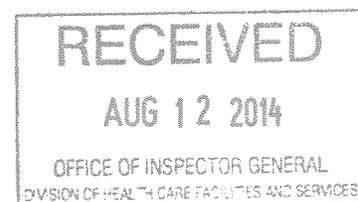
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F 323	Continued From page 6 room. The door to the rehab gym was located on the West side of the room at the end of the North Hall and the exit doors onto the patio were located on the South side of the room. The rehab gym exit doors onto the patio were closed and locked with signs on the doors to keep them locked, alarmed and never propped open. Interview with the Administrator, on 07/08/14 at 9:45 AM, revealed he was unaware the Therapy Staff was in the habit of unlocking and propping the exit doors from the therapy gym onto the patio, but he should have known. He stated the exit doors were closed and locked immediately by the Therapy Staff when they were informed of Resident #2's elopement from the facility and all of the therapy staff had been inserviced on 07/04/14 and 07/05/14 regarding keeping the rehab gym exit doors closed and locked and never propping them open. Interview, on 07/08/14 at 11:31 AM, with Physical Therapist (PT) #1 revealed she had worked on 07/04/14 and she had unlocked and propped open the double exit doors from the therapy gym to the patio around 10:00 AM for the residents to enjoy the weather. She stated Resident #2 had visited in the therapy gym on 07/04/14 in the morning and she had assisted the resident over the threshold of the double exit doors to go onto the patio. She revealed she told the resident to stay on the patio and after the resident had self-propelled around the patio, PT #1 assisted him/her back into the therapy gym. PT #1 indicated Resident #2 returned to the therapy gym on 07/04/14 in the afternoon around 1:30 PM. She stated she and another Physical Therapist were in the gym the entire afternoon. However, she did not see Resident #2 exit the	F 323			



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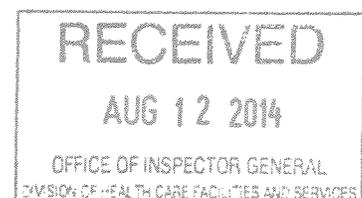
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F 323	Continued From page 7 double doors onto the patio in the afternoon and she did not know how the resident maneuvered the wheelchair over the exit doors' threshold unassisted. Interview, on 07/09/14 at 2:35 PM, with PT #2 revealed she worked on 07/04/14 until about 3:00 PM and she was in the Therapy Gym the entire afternoon. However, she revealed she did not see Resident #2 exit the propped open exit doors onto the patio in the afternoon. She was busy at the fax machine with her back turned away from the doors. PT #2 indicated PT #1 was also in the Therapy Gym in the afternoon, but she was working with another resident who was seated in front of her and PT #1's view of the exit double doors was possibly obstructed by the other resident. She further indicated she did not think Resident #2 could self-propel over the double exit door threshold independently and did not know how the resident exited the therapy gym. Interview with the Rehabilitation Director, on 07/08/14 at 1:47 PM, revealed she was aware the exit double doors from the Therapy Gym onto the patio were sometimes unlocked and propped open when residents were receiving occupational therapy on the patio. She stated the staff knew to close and lock the doors if they were not in the Therapy Gym. She further stated she had never recognized the doors being unlocked and propped open was a concern to be reported to the Administrator. Interview, on 07/08/14 at 1:35 PM, with Certified Nursing Assistant (CNA) #6, who was assigned to Resident #2 on day shift, on 07/04/14, revealed she had taken Resident #2 into the sun room for a music program around 1:00 PM on 07/04/14.	F 323			



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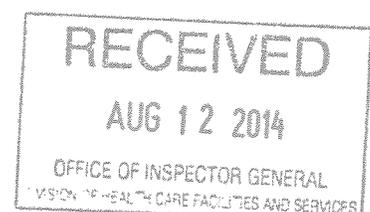
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F 323	<p>Continued From page 8</p> <p>CNA #6 further stated she had seen Resident #2 self-propel into the therapy gym at the end of the North Hall around 1:40 PM on 07/04/14. CNA #6 stated she then left the North Hall to attend to her other assigned residents. She indicated Resident #2 was known to go to the therapy gym to visit with the staff.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/08/14 at 1:13 PM, revealed he was Resident #2's nurse on 07/04/14, at the time of the resident's elopement and he did the head to toe assessment of Resident #2 when the resident was returned to the South Hall. LPN #1 stated he did not find Resident #2 to have been injured and informed the Nursing Supervisor on duty at that time. LPN #1 further stated he had seen Resident #2 at about 1:00 PM on 07/04/14 as the resident was leaving the dining room.</p> <p>Interview with the Quality Assurance (QA) Nurse, on 07/08/14 at 1:20 PM, revealed she was the Nursing Supervisor on duty on day shift on 07/04/14. She stated when she was made aware of Resident #2's elopement she immediately checked all of the Wander Guard door alarms and bracelets worn by elopement risk residents to ensure they were in proper working order. She also stated she was informed by LPN #1 of Resident #2's head to toe assessment which revealed no injury to the resident. The QA Nurse indicated she made calls to the Administrator, Social Services Director, Staff Development Nurse, appropriate State agencies, the resident's family and physician and started the facility's investigation into Resident #2's elopement. Further interview with the QA Nurse, on 07/17/14 at 8:59 AM, revealed a Wander Guard bracelet was placed on Resident #2 on 07/04/14 after the</p>	F 323			



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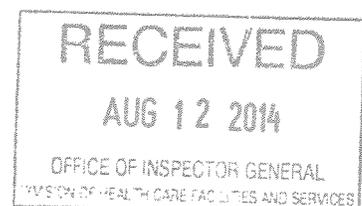
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/17/2014
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F 323	Continued From page 9 resident's head to toe assessment as the resident was now considered an elopement risk. She indicated the resident's picture and demographic face sheet were placed in an elopement binder at each nursing station and the resident's comprehensive care plan was updated to include the concern of elopement risk. Interview with the Maintenance Director, on 07/09/14 at 9:30 AM, revealed the exit double doors from the Therapy Gym to the patio were alarmed and should have remained closed. He stated there was a switch on the doors and when the switch was turned, it would deactivate the alarm on the doors and allow them to be propped open without sounding. He further stated he had never seen the exit doors in the Therapy Gym propped open. The Maintenance Director revealed, on 07/05/14 he removed the switch on the Therapy Gym doors which allowed the alarm to be deactivated. Further interview revealed the alarm company came to the facility to ensure the proper working order of all locked doors on 07/11/14. Telephone interview with the Director of Nursing (DON) on 07/09/14 at 1:40 PM, revealed she had never seen the exit double doors from the Therapy Gym onto the patio unlocked and propped open, but she was aware Resident #2 would sometimes self-propel into the Therapy Gym to visit with staff. The DON stated the Medical Director had been informed of Resident #2's elopement on 07/05/14. Further interview with the Administrator, on 07/17/14 at 3:37 PM, revealed he had been informed by the QA Nurse right after Resident #2 was returned to the facility. He stated he	F 323			



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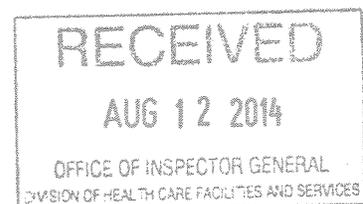
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F 323	<p>Continued From page 10</p> <p>immediately became involved in the investigation of the elopement and wished he had known the therapy staff had disengaged the alarm and unlocked and propped open the exit doors from the Therapy Gym onto the patio on 07/04/14 to prevent this occurrence. He stated the Rehab Director reported to him; however, the exit doors being unlocked and propped open had never been reported as a recognized concern. The Administrator indicated the facility had a Safety Committee in the past, but the leader of the Committee stepped down and he could not find any meeting minutes, and he did not know the date of the last meeting and could not remember if there had been any previous concerns with unlocked doors. The Administrator further indicated staff was trained on resident safety on hire and had been retrained since Resident #2's elopement. He further indicated there would be a QA meeting on 07/21/14 and all actions taken would be discussed at that time with planning for future actions.</p> <p>The facility provided an Allegation of Compliance (AOC) on 07/15/14 alleging the Immediate Jeopardy was removed on 07/12/14; the facility took the following steps to remove the Immediate Jeopardy.</p> <ol style="list-style-type: none"> 1. Resident #1 was immediately returned to the facility on 07/04/14 at 1:54 PM by the housekeeper who found him/her. 2. The exit double doors from the therapy gym to the patio were immediately locked by PT #1. 3. LPN #1 completed a head to toe assessment on Resident #2, on 07/04/14 at 2:20 PM, following his/her return to the facility and no injuries were 	F 323		



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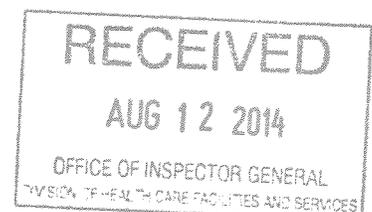
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F 323	<p>Continued From page 11 found.</p> <p>4. An investigation was initiated on 07/04/14 by the Quality Assurance (QA) Nurse.</p> <p>5. A Wander Guard bracelet was placed on Resident #2 on 07/04/14, his/her picture and demographic face sheet were placed in the elopement binder at each nursing station and the resident's Comprehensive Care Plan was updated to include the concern of elopement risk by the QA Nurse.</p> <p>6. Resident #2 was placed on hourly monitoring to be completed by the floor staff for thirty (30) days to begin on 07/09/14 by the Administrator, Staff Development, QA Nurse, Social Services, MDS Coordinator and the LPN Unit Manager.</p> <p>7. On 07/09/14, a decision was made during the emergency meeting to place a directive in the Matrix (computer) of each of the six (6) residents at risk for elopement to be signed each shift by the nurse indicating the hourly check sheets for those six (6) residents were completed.</p> <p>8. It was determined during the emergency meeting on 07/09/14 that Resident #2 would be reassessed for elopement risk and continued need for hourly checks in thirty (30) days (08/04/14).</p> <p>9. On 07/09/14, during the emergency meeting it was determined the current Elopement policy and procedures for assessing resident's for elopement risk would be reviewed by the Administrator, Social Services, MDS Coordinator, QA Nurse and the LPN Unit Manager. The review resulted in a revision to the policy that exit door</p>	F 323		



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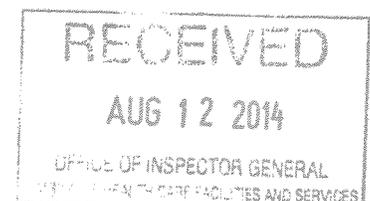
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F 323	<p>Continued From page 12</p> <p>alarms would be monitored daily on the evening shift and night shift to ensure locks and alarms were intact and functioning. The locations of the elopement binders were increased to include the dietary office, therapy gym and personal care home front desk. In addition, the Charge Nurse will assume the role of coordinating the search effort for the missing resident. Any staff on break would be called back to assist with the search. An elopement checklist would be completed during the search and a safety round would be completed on all exits and doorways to investigate and identify possible routes of elopement.</p> <p>10. It was determined on 07/09/14 by the Administrator and the other attendees at the emergency meeting that all residents would be re-evaluated for potential elopement risks.</p> <p>11. Staff education topics of Elopement, Resident Safety, Door alarms, the new Elopement policy and hourly checks were discussed and approved by the attendees at the emergency meeting held on 07/09/14.</p> <p>12. All residents (census of {81} eighty-one) were reviewed and reassessed for potential elopement risk on 07/09/14 by the QA Nurse, MDS Coordinator and Staff Development Coordinator.</p> <p>13. The six (6) residents (including Resident #2) that were already identified as being at risk for elopement would continue to be monitored hourly by staff and their Comprehensive Care Plans would continue to be reviewed and updated as appropriate by the nursing staff.</p> <p>14. All staff was retrained on Elopement,</p>	F 323		



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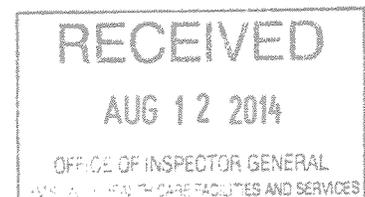
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F 323	<p>Continued From page 13</p> <p>Resident Safety, Door Alarms, the new Elopement policy and Hourly Checks. This was completed by midnight on 07/11/14, by the Staff Development Coordinator.</p> <p>15. All Wander Guard door alarms were checked by the QA Nurse for proper operation, all Wander Guard bracelets in place on residents were checked for proper working order and all locked doors were checked for proper working order by 3:00 PM on 07/04/14.</p> <p>16. A newly formed Elopement Committee met on 07/14/14 and will meet weekly until the next QA meeting on 07/21/14 when it will be decided how often to have the Elopement Committee meetings.</p> <p>Through observation, interview and record review the State Survey Agency validated the Allegation of Compliance with removal of Immediate Jeopardy on 07/16/14 through 07/17/14 prior to exit as follows:</p> <p>1. Review of the facility's investigation and Nursing Notes, dated 07/04/14 at 2:20 PM, revealed Resident #2 was returned to the facility at 1:54 PM on 07/04/14.</p> <p>2. Interview with the Administrator, on 07/08/14 at 9:45 AM, revealed the exit doors were closed and locked immediately by the therapy staff when they were informed of Resident #2's elopement from the facility. Interview with PT #1, on 07/08/14 at 11:31 AM, revealed the exit doors from the therapy gym to the patio were immediately locked upon being informed of Resident #2's elopement from the facility at approximately 2:00 PM.</p>	F 323		



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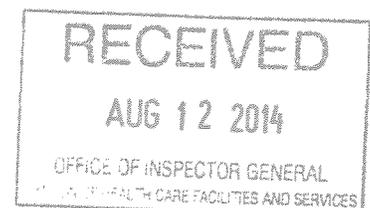
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F 323	Continued From page 14 3. Interview with Licensed Practical Nurse (LPN) #1, on 07/08/14 at 1:13 PM, revealed he was Resident #2's nurse on 07/04/14 at the time of the resident's elopement and he did the head to toe assessment of Resident #2 when the resident was returned to the South Hall. LPN #1 stated he did not find Resident #2 to have been injured and informed the Nursing Supervisor on duty at the facility at that time. Review of the head to toe assessment by LPN #1 revealed a completion date of 07/04/14 with no injury identified. 4. Interview with the Quality Assurance (QA) Nurse, on 07/08/14 at 1:20 PM, revealed she started the facility's investigation into Resident #2's elopement. This was confirmed through review of the investigation initiated on 07/04/14. 5. Interview with the QA Nurse, on 07/17/14 at 8:59 AM, revealed a Wander Guard bracelet was placed on Resident #2 on 07/04/14 after the resident's head to toe assessment, the resident's picture and demographic face sheet were placed in an elopement binder at each nursing station and the resident's Comprehensive Care Plan was updated to include the concern of elopement risk. Review of the elopement binder revealed six (6) residents' pictures and a face sheet were in the binder and the locations were confirmed through observation on 07/15/14. 6. Interview with the Staff Development Director, on 07/16/14 at 4:20 PM, revealed the facility had initiated every fifteen (15) minute checks on Resident #2 following the resident's elopement from the facility for two (2) days and then had reverted to every two (2) hour checks. However, an emergency meeting was held on 07/09/14 at	F 323		



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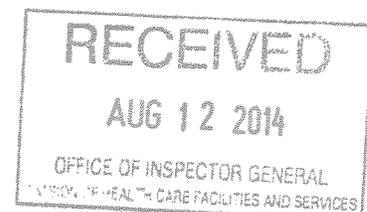
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F 323	<p>Continued From page 15</p> <p>which time it was decided to start hourly monitoring of the six (6) residents assessed to be at elopement risk (to include Resident #2) and these hourly checks would continue for thirty (30) days (until 08/04/14). Review of all monitoring sheets revealed two (2) days of every fifteen (15) minute checks of Resident #2 through 07/06/14; every two (2) hour monitoring of Resident #2 from 07/06/14 at 2:00 PM through 07/09/14 at 2:00 PM; and, every hour checks of Resident #2 and five (5) other elopement risk residents from 2:00 PM on 07/09/14 through 3:00 PM on 07/16/14, and is ongoing.</p> <p>7. Review of the Medication Administration Records for Resident #1, #2, #6, #7 and #8 revealed an order had been placed in the Matrix to be signed at the end of each shift by the Unit Nurse indicating the hourly check sheets had been completed and signed. Interview with the Staff Development Director, on 07/17/14 at 3:00 PM, revealed it was decided in the emergency meeting to place an order in the Matrix for all of the elopement risk residents which would be signed each shift by the Unit Nurse indicating the hourly check sheets had been completed.</p> <p>8. Interview with the DON, on 07/16/14 at 3:10 PM, revealed it was also determined in the emergency meeting that Resident #2 would be reassessed for elopement risk and continued need for hourly checks in thirty (30) days (08/04/14).</p> <p>9. Review of the emergency meeting notes of 07/09/14 revealed the meeting was called to review current policy and procedure for assessing (residents) for elopement risk and the attendees were the Administrator, the Social Services</p>	F 323			



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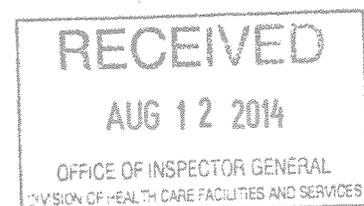
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F 323	<p>Continued From page 16</p> <p>Director, the Staff Development Director, the Minimum Data Set (MDS) nurse, the QA Nurse and a LPN Unit Manager.</p> <p>10. Interview with the Social Service Director, on 07/16/14 at 3:10 PM, revealed she attended the meeting on 07/09/14 which was called to review current policy and procedure for assessing (residents) for elopement risk and it was determined all residents would be re-evaluated for potential elopement risks. Interview with the Minimum Data Set (MDS) Nurse, on 07/17/14 at 9:20 AM, revealed she attended the meeting of 07/09/14 which was called to review current policy and procedure for assessing (residents) for elopement risk and it was determined all residents would be re-evaluated for potential elopement risks.</p> <p>11. Interview with the Staff Development Director, on 07/16/14 at 3:40 PM, revealed she attended the emergency meeting held on 07/09/14 and participated in discussion and approval of education topics for staff retraining of Elopement, Resident Safety, Door Alarms, the new Elopement Policy and Hourly Checks. Interview with the Minimum Data Set (MDS) nurse, on 07/17/14 at 9:20 AM, revealed she attended the emergency meeting held on 07/09/14 and participated in discussion and approval of education topics for staff retraining.</p> <p>12. Interview with the Staff Development Director, on 07/16/14 at 3:40 PM, revealed she participated in reassessing some of the facility's residents for elopement risk. Interview with the Minimum Data Set (MDS) Nurse, on 07/17/14 at 9:20 AM, revealed she participated in reassessing some of the facility residents for</p>	F 323		



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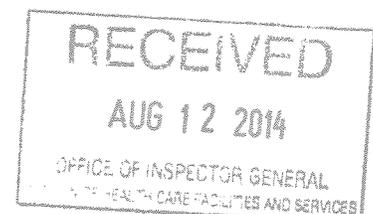
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F 323	Continued From page 17 elopement risk. Interview with the QA Nurse, on 07/17/14 at 8:59 AM, revealed she participated in reassessing some of the facility's residents for elopement risk and all of the residents were reassessed for elopement risk on 07/09/14. Review of eighty-one (81) elopement risk assessments for all the residents was completed on 07/09/14. This revealed all were done with no new at risk residents identified, excluding Resident #2. 13. Review of all monitoring sheets revealed two (2) days of every fifteen (15) minute checks of Resident #2 through 07/06/14; every two (2) hour monitoring of Resident #2 from 07/06/14 at 2:00 PM through 07/09/14 at 2:00 PM; and every one (1) hour checks of Resident #2 and five (5) other elopement risk residents from 2:00 PM on 07/09/14 through 3:00 PM on 07/16/14 and continuing. Observations on the North Hall, on 07/16/14 at 10:00 AM and 11:00 AM revealed two staff (CNA and LPN) completed the hourly checks on Residents #6, #7 and #8. Interview with the Staff Development Director, on 07/17/14 at 3:25 PM revealed the six (6) residents identified as elopement risk would continue to be monitored hourly for thirty (30) days (08/04/14) and Comprehensive Care Plans would continue to be reviewed and updated as appropriate by nursing staff. 14. Review of staff sign in sheets for retraining/education on Elopement, Resident Safety, Door Alarms, the new Elopement Policy and Hourly Checks revealed all staff was re-trained by midnight on 07/11/14. Interview with the Staff Development Director, on 07/09/14 at 2:25 PM, revealed she had been retrained on elopement, resident safety, door alarms, the new	F 323			



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F 323	Continued From page 18 Elopement Policy and hourly checks on 07/05/14. Telephone interview with LPN #5, on 07/12/14 at 10:55 PM, revealed she had retraining on elopement, resident safety, door alarms, the new Elopement Policy and hourly checks prior to her shift on 07/08/14. Interview with CNA #8, on 07/15/14 at 4:35 PM, revealed he had retraining on elopement, resident safety, door alarms, the new Elopement Policy and hourly checks prior to his shift on 07/09/14. Interview with LPN #3, on 07/16/14 at 11:44 AM, revealed she had retraining on elopement, resident safety, door alarms, the new Elopement Policy and hourly checks prior to her shift on 07/09/14. Interview with CNA #4, on 07/17/14 at 9:31 AM, revealed she had retraining on elopement, resident safety, door alarms, the new Elopement Policy and hourly checks prior to her shift on 07/09/14 and again on 07/10/14. One hundred and seventy-three (173) total employees received the training with twelve (12) to be trained when they return to work and before starting their shift. 15. Interview with the Quality Assurance (QA) Nurse, on 07/08/14 at 1:20 PM, revealed she was the Nursing Supervisor on duty on day shift on 07/04/14. When she was made aware of Resident #2's elopement she immediately checked all of the Wander Guard door alarms and bracelets worn by elopement risk residents to ensure they were in proper working order. She also indicated all locked doors were checked for proper working order by 3:00 PM on 07/04/14. 16. Interview with the Staff Development Director, on 07/17/14 at 3:25 PM, revealed she attended the newly formed Elopement Committee on 07/14/14 and it was decided the committee would meet weekly until the next QA meeting on	F 323			



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/17/2014
NAME OF PROVIDER OR SUPPLIER SPRINGHURST HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3001 N. HURSTBOURNE PKWY. LOUISVILLE, KY 40241		
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F 323	Continued From page 19 07/21/14 when it would be decided how often to have the Elopement Committee meetings. Interview with the Administrator, on 07/17/14 at 3:37 PM, revealed he was at the Elopement Committee meeting on 07/14/14 and it was decided the committee would meet weekly until the next QA meeting on 07/21/14. He stated it would be decided at the 07/21/14 QA meeting how often the Elopement Committee would continue to meet.	F 323			

