

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

PRINTED: 12/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220		
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated/partial extended survey (KY #19384) was conducted on 11/20/12 through 11/21/12 to determine the facility's compliance with Federal requirements. KY #19384 was substantiated with deficiencies cited. Immediate Jeopardy was identified on 11/21/12 and determined to exist on 11/18/12 at CFR 483.13 Resident Behavior and Facility Practices, F-224, CFR 483.20 Resident Assessment, F-282 and CFR 483.25 Quality of Care, F-323 at a scope and severity of a "J". Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and CFR 483.25 Quality of Care.</p> <p>Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide adequate supervision for one resident (#1), in the selected sample of six (6) residents. The facility assessed Resident #1 as an elopement risk requiring supervision to include a care trak assistive device; as the resident had a history of elopement prior to admission. The facility failed to follow their policy and procedures related to providing supervision to prevent elopement and failed to implement the care plan related to redirecting the resident when needed. On 11/18/12, Resident #1 was able to exit the front doors of the facility in his/her wheelchair, cross a two lane road with a speed limit of 35 miles per hour, and propel up an inclined driveway to a patio without the staff's knowledge. The facility failed to redirect the resident to an area where staff could provide supervision when Resident #1 was seen in an area of the building that was close to the entrance doors and where there was no staff. In addition,</p>	F 000	Past noncompliance: no plan of correction required.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 a Personal Care Medication Aide (PCMA) was leaving work when she saw Resident #1 on the neighbor's driveway across the street from the facility. The PCMA approached the resident to escort the resident back to the facility. The resident became combative and the PCMA neglected the resident by leaving the resident unsupervised while she returned to the facility for assistance. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/21/12, determined to exist on 11/18/12, and determined corrected 11/20/12. The State Agency validated that the facility implemented all corrective action prior to the State Agency's investigation on 11/21/12; thus, it was determined to be past non-compliance at the level of Past Jeopardy. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F224 and F323)	F 000			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of	F 224			
			Past noncompliance: no plan of		

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F 224	<p>Continued From page 2</p> <p>the facility's policy and procedure, it was determined staff failed to implement policies and procedure that prohibited neglect for one resident (#1), in the selected sample of six (6) residents. The facility assessed Resident #1 as an elopement risk requiring supervision to include a care trak assistive device; as the resident had a history of elopement prior to admission. On 11/18/12, Resident #1 was able to exit the front doors of the facility in his/her wheelchair, cross a two lane road with a speed limit of 35 miles per hour, and propel up an inclined driveway to a patio. An employee leaving work saw the resident on the neighbor's driveway, approached the resident and attempted to escort the resident back to the facility. The resident became combative and the employee neglected the resident by leaving the resident unsupervised to return to the facility for assistance.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/21/12, determined to exist on 11/18/12, and determined corrected 11/20/12. The State Agency validated that the facility implemented all corrective action prior to the State Agency's investigation on 11/21/12; thus, it was determined to be past non-compliance at the level of Past Jeopardy. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F282 and F323)</p> <p>Findings include:</p> <p>A review of the facility's Abuse and Neglect policy and procedure, dated 10/29/12, revealed</p>	F 224	correction required.		

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F 224	<p>Continued From page 3</p> <p>"Neglect" is defined as a failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. A review of the facility's Elopement policy and procedure, last revised 05/25/11, revealed the definition of "elopement" is the ability of a resident - who is not capable of protecting him/her self from harm - was able to successfully leave the nursing facility unsupervised and unnoticed and enter into harms way.</p> <p>A record review revealed the facility admitted Resident #1 on 12/05/11 with diagnoses to include Dementia and Behavioral Changes. A review of the Elopement Risk Assessment, dated 12/05/11, revealed the facility assessed Resident #1 as an Elopement Risk due to the resident's history of elopement. A review of the Comprehensive Care Plan for Elopement/Wandering, dated 12/05/11, revealed interventions to apply a Care Trak bracelet to the right forearm and redirect the resident's attention, as needed.</p> <p>Interview with the Personal Care Medication Aide (PCMA), on 11/20/12 at 3:30 PM, revealed she clocked out and went to her car on 11/18/12 around 7:00 AM. She warmed up her car, then proceeded to drive out the driveway of the facility. She stated when she stopped before turning on to the road in front of the facility, she noted someone in a wheelchair going to the top of the driveway across the street. She stated at first she thought it was someone who lived there, but then thought she should check and make sure. She drove up the road, pulled over into the other driveway of the facility, exited the car and could see it was Resident #1 in his/her wheelchair. She</p>	F 224			

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F 224	<p>Continued From page 4</p> <p>stated she tried to get the resident to come back to the facility with her but the resident became combative and was trying to hit her with the wheelchair. She stated she did not have a cell phone, so she left the resident unsupervised, went back to her car, drove back up to the facility, went into the PC side of the facility, told staff that Resident #1 was across the street and staff called over to the other side of the facility to make staff aware. She stated she went back outside and there were 5 or 6 staff outside assisting the resident back to the facility.</p> <p>A review of a nurse's note, dated 11/18/12 at 7:10 AM, revealed the nurse received a phone call from the Personal Care Unit informing her that Resident #1 was across the street at the brick house on the patio. The nurse notified staff about the elopement and three staff members and the nurse went across the street to retrieve the resident. The resident was combative but staff was able to encourage the resident to come back to the building so he/she could call his/her spouse. Staff noted when they escorted the resident through the entrance door of the facility the alarm did not sound. When staff looked at the resident's wrist they noted the care trak bracelet was not in place. The Care Trak bracelet was found in the drawer of the resident's bedside table.</p> <p>Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed the staff member should not have left Resident #1 outside alone while she came back to the facility to get assistance. She stated the staff member neglected Resident #1 and placed the resident in danger when she left the resident without supervision while she came</p>	F 224			

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F 224	<p>Continued From page 5 back to the facility to get help.</p> <p>The State Agency verified the facility implemented the following corrective actions which were completed on 11/20/12. Thus verifying the facility was in compliance on 11/20/12.</p> <p>The facility implemented the following actions to correct the deficiency on 11/18/12:</p> <p>*PCMA #4 received a written warning related to not leaving a resident outside without supervision and making sure the resident was always in arms' length.</p> <p>*Nursing Facility Elopement policy was updated by the Administrator. Revisions made to the policy included: Clarifying staff must be within arms' length of the resident until resident was brought back into the facility.</p> <p>*Facility Nursing, Housekeeping, Laundry, Dietary, and Supportive Staff/Department Heads were in-serviced under the supervision of the Director of Nursing regarding the revised policy and intervention of the NF Elopement policy. Staff not in the facility on 11/18/12 were inserviced over the phone if possible. A sign was placed at the time clock, to instruct staff who were not in-serviced over the telephone to immediately receive in-service education prior to their next working shift.</p> <p>* Quality Assurance Meeting was held with Medical Director regarding problems identified and new policies and procedures were put in place on 11/18/12 and 11/19/12.</p>	F 224			

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F 224	<p>Continued From page 6</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>A review of PCMA's personnel record revealed there was a written warning related to her leaving the resident outside without supervision. The PCMA was made aware if it happened again, she would be terminated. Interview with the PCMA, on 11/20/12 at 11:50 AM, revealed she received written counseling that a resident should always be in arms' length and never left outside without supervision.</p> <p>A review of the NF Elopement policy, dated 11/18/12, revealed the Administrator revised the policy to include staff must be within arms' length of the resident until the resident was brought back into the facility.</p> <p>A review of the inservice sign-in sheet and what the inservice entailed, dated 11/18/12, revealed facility Nursing, Housekeeping, Laundry, Dietary, and Supportive Staff/Department Heads were in-serviced under the supervision of the Director of Nursing (DON) regarding the revised policy and intervention related to the NF Elopement policy and staff never being more than arms' length from a resident outside. Any staff not in the building were contacted by phone and inserviced. Those not inserviced over the phone were instructed to contact the facility and receive inservice education prior to their next working shift. Observation, on 11/21/12, revealed a sign above the time clock that instructed staff who was not in-serviced over the telephone to immediately receive in-service education prior to the next working shift. Interview with Licensed Practical Nurse (LPN) #1, LPN #2, LPN #3, LPN #4,</p>	F 224			

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F 224	Continued From page 7 Certified Medication Aide (CMA) #1, PCMA #4, Certified Nurse (CNA) #1, CNA #2, CNA #4, Housekeeper #2, Housekeeper #3, on 11/20/12 at 11:10 AM, 1:25 PM, 1:30 PM, 1:45 PM, 1:50 PM, 3:25 PM, 3:45 PM, 3:50 PM, 4:15 PM, 5:00 PM, and on 11/21/12 at 9:00 AM, revealed they were inserviced, on 11/18/12, when a resident was outside, the resident should never be more than arms' length away from the staff. Interview with the DON, on 11/21/12 at 10:30 AM, revealed he was notified about the elopement on 11/18/12. He stated all staff in the facility was inserviced on 11/18/12 and phone calls were conducted with other staff with inservicing completed on phone. The Assistant Director of Nursing (ADON) completed the inservicing on 11/19/12, except for five staff who have not worked in a while. The five (PRN) staff will be inserviced before they work the floor again. He stated he was trying to contact them now to ensure they still want to remain as PRN staff since they have not worked in a while. Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed a QA Meeting was held, on 11/18/12 and 11/19/12, with the Medical Director regarding the problem identified and the revised new policy and procedure put in place. She stated the facility addressed the staff neglecting the resident by reinforcing a resident should never be more than arms' length away from staff when outside. Based on the above validated actions completed by this facility the IJ was removed and deficient practice was determined corrected on 11/20/12.	F 224			
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282			

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F 282 SS=J	Continued From page 8 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to implement the care plan related to providing adequate supervision for one resident (#1), in the selected sample of six (6) residents. The facility assessed Resident #1 as an elopement risk requiring supervision to include a care trak assistive device; as the resident had a history of elopement prior to admission. The facility failed to follow their Elopement policy and procedure and the care plan related to providing adequate supervision to minimize the potential for elopement. On 11/18/12, Resident #1 was able to exit the front doors of the facility in his/her wheelchair, cross a two lane road with a speed limit of 35 miles per hour, and propel up an inclined driveway to a patio without the staff's knowledge. Licensed Practical Nurse (LPN) #3 failed to implement the resident's care plan when she failed to redirect the resident to an area where staff could provide supervision when she saw Resident #1 in an area that was close to the entrance doors and where there was no staff. In addition, the Personal Care Medication Aide (PCMA), failed to implement the resident's care	F 282	Past noncompliance: no plan of correction required.		

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F 282	<p>Continued From page 9</p> <p>plan related to supervision when she left the resident across the street without supervision while she returned to the facility to get assistance.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/21/12, determined to exist on 11/18/12, and determined corrected 11/20/12. The State Agency validated that the facility implemented all corrective action prior to the State Agency's investigation on 11/21/12; thus, it was determined to be past non-compliance at the level of Past Jeopardy. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices and 483.25 Quality of Care. (Refer to F224 and F323)</p> <p>Findings include:</p> <p>A review of the facility's Elopement policy and procedure, last revised 05/25/11, revealed the facility should provide adequate supervision to minimize the potential of elopement. The definition of "elopement" is the ability of a resident - who is not capable of protecting him/her self from harm - was able to successfully leave the nursing facility unsupervised and unnoticed and enter into harms way.</p> <p>A record review revealed the facility admitted Resident #1 on 12/05/11 with diagnoses to include Dementia and Behavioral Changes.</p> <p>A review of the Elopement Risk Assessment, dated 12/05/11, revealed the facility assessed Resident #1 as an Elopement Risk. Interview with Resident #1's spouse, on 11/20/12 at 1:05</p>	F 282			

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F 282	<p>Continued From page 10</p> <p>PM, revealed Resident #1 had a history of walking off at home and everyone having to search for him/her. She revealed Resident #1 had eloped from this facility when he/she was a Personal Care (PC) home resident and the facility placed the Care Trak bracelet on the resident.</p> <p>A review of the Comprehensive Care Plan for Elopement/Wandering, dated 12/05/11, revealed interventions to apply a Care Trak bracelet to the right forearm, verify Care Trak in place and functioning every shift, change Care Trak battery every month, divert resident's attention when the resident became insistent on leaving the facility, check promptly when the alarm system sounded, and redirect the resident's attention, as needed.</p> <p>A review of the Minimum Data Set (MDS) assessment and Elopement Risk Assessment, dated 09/13/12, revealed the facility assessed the resident as having wandering behavior and as an elopement risk. In addition, the Wandering/Elopement care plan was still in effect.</p> <p>A review of the Nursing Assistant Care Plan, dated 11/2012, revealed an intervention for a care trak bracelet on at all times.</p> <p>Interview with LPN #2, on 11/20/12 at 3:45 PM, revealed when she came to work at 7:00 AM, Resident #1 was sitting in his/her wheelchair by the Administrative door just inside the lobby. She stated no other staff was around and she did not follow Resident #1's the care plan and redirect the resident back to where staff was available to provide supervision.</p>	F 282			

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F 282	<p>Continued From page 11</p> <p>Interview with the PCMA, on 11/20/12 at 3:30 PM, revealed she clocked out and went to her car on 11/18/12 around 7:00 AM. She warmed up her car, then proceeded to drive out the driveway of the facility. She stated when she stopped before turning on to the road in front of the facility, she noted someone in a wheelchair going to the top of the driveway across the street. She stated at first she thought it was someone who lived there, but then thought she should check and make sure. She drove up the road, pulled over into the other driveway of the facility, exited the car and could see it was Resident #1 in his/her wheelchair. She stated she tried to get the resident to come back to the facility with her, but the resident became combative and was trying to hit her with the wheelchair. She stated she did not have a cell phone, so she left the resident unsupervised, went back to her car, drove back up to the facility, went into the PC side of the facility, told the staff Resident #1 was across the street and staff called over to the other side to make the staff aware. She stated she went back outside and there were 5 or 6 staff outside assisting the resident back to the facility. The PCMA stated she knew the resident was care planned for the need of supervision but because he/she was an elopement risk but she panicked and when the resident would not come back to the facility she immediately went to get help.</p> <p>A review of a nurse's note, dated 11/18/12 at 7:10 AM, and interview with LPN #4, on 11/21/12 at 9:00 AM, revealed she received a phone call from the Personal Care Unit informing her that Resident #1 was across the street at the brick house on the patio. The nurse notified staff regarding the elopement and three staff members</p>	F 282			

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F 282	<p>Continued From page 12</p> <p>and the nurse went across the street to retrieve the resident. The resident was combative but staff was able to encourage the resident to come back to the building so he/she could call his/her spouse. Staff noted when they escorted the resident through the entrance door of the facility, the alarm did not sound. When staff looked at the resident's wrist they noted the care trak bracelet was not in place. The Care Trak bracelet was found in the drawer of the resident's bedside table.</p> <p>Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed staff should have implemented the care plan and redirected Resident #1 attention away from the front door area at that time of day because it was before the Administrative staff arrived and there was not always someone there to provide supervision. In addition, the staff member was not following the care plan when she left Resident #1 outside alone while she came back to the facility to get assistance. This placed the resident in danger with no supervision in the lobby area and no supervision while staff came back to the facility to get help.</p> <p>The State Agency verified the facility implemented the following corrective actions which were completed on 11/20/12. Thus verifying the facility was in compliance on 11/20/12.</p> <p>The facility implemented the following actions to correct the deficiency on 11/18/12:</p> <p>* A head to toe skin assessment was conducted on Resident #1 with no injuries identified. A new Care Trak bracelet was placed on Resident #1's</p>	F 282			

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F 282	<p>Continued From page 13</p> <p>right ankle. Resident #1 was placed on one to one supervision. The guardian was made aware of the elopement. An Elopement assessment was conducted on Resident #1 and he/she was still identified at risk for elopement. Resident #1's physician was notified (facility's Medical Director) and an order was received to place a Care Trak bracelet on the cross bars of the wheelchair. The Comprehensive Care Plan was updated to include a Care Trak bracelet on the right ankle and crossbars of the wheelchair. Resident #1 was changed to every 15 minute monitoring. Appropriate State Agencies were made aware of the elopement. The Care Trak door alarms were verified by laundry personnel and Director of Environmental Services to be in proper working condition.</p> <p>* An audit was conducted on Nursing Facility residents medical records with Care Trak application. The audit consisted of ensuring there were wander/elopement care plans in place for all residents with care Trak in place. This audit was conducted under the supervision of the Director of Nursing (DON).</p> <p>* The Nursing Facility (NF) Care Trak policy and procedure was updated by the Administrator. Revisions made to the policy included: NF and PC policies were separated clearly defining the increased supervision for NF residents and G-tube Nurse was responsible for ensuring the Care Trak transmitter was in place, had not been tampered with, and for proper function every two hours, and documented on the Treatment Administrative Record.</p> <p>*The NF Elopement policy was updated by the</p>	F 282		

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F 282	<p>Continued From page 14</p> <p>Administrator. Revisions made to the policy included: Clarifying staff must be within arms' length of a resident until resident was brought back into the facility.</p> <p>*Facility Nursing, Housekeeping, Laundry, Dietary, and Supportive Staff/Department Heads were in-serviced under the supervision of the Director of Nursing regarding the revised policies and interventions: NF Elopement policy, NF Care Track Policy, NF Elopement Risk Assessment, Checklist, NF Elopement/Wandering Care Plan, NF Elopement Tool Kit, CQI Tool, two alarms now placed on Resident #1 and on his/her wheelchair, redirecting and escorting the resident to the NF part of building from PC and not leaving any resident unsupervised outside . Any staff not in the building were contacted by phone and inserviced. Those not inserviced over the phone were instructed to contact the facility and receive inservice education prior to the next working shift. A sign was placed at the time clock, to instruct staff who were not in-serviced over the telephone to immediately receive in-service education prior to the next working shift.</p> <p>* The Care Plans were updated to include the changes in the policies related to supervision for all residents identified as an elopement risk.</p> <p>* A Quality Assurance (QA) Meeting was held with the Medical Director regarding problems identified and new policies and procedures were put in place, to include audits conducted.</p> <p>*CQI Tool N-24 was updated and completed by the Administrator. Audit Tool revisions included: TAR initiated and completed to determine</p>	F 282			

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F 282	<p>Continued From page 15</p> <p>transmitter was in place, had not been tampered with, and for proper function every two hours, and an appropriate intervention put in place on the care plan post elopement.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>Observation, on 11/20/12, revealed Resident #1 was sitting in a wheelchair. There was a Care Trak bracelet on the resident's right arm, right lower leg and crossbars of the wheelchair. Staff were conducting 15 minute checks of the resident. Observations of Resident #2, #3, #4, #5, and #6 revealed their Care Trak bracelets were in place per physicians' orders.</p> <p>A record review for Resident #1 revealed a body audit was conducted upon return to the facility and 15 minute checks were documented from the time the Resident returned to the facility to the present. Record reviews for Resident #2, #3, #4, #5 and #6 revealed all physician's orders, nurse's notes, Treatment Administration Record (TARS), Elopement assessments and Care Plans were updated and included checking care trak bracelets for placement, function and evidence of tampering every two hours. The TARs were initialed every two hours by staff.</p> <p>A review of the Nursing Facility Care Trak policy and procedure, dated 11/18/12, revealed the Administrator revised the policy to include: NF and PC policies were separated clearly defining the increased supervision for NF residents and G-tube Nurse was responsible for ensuring the Care Trak transmitter was in place, was not tampered with, and for proper function every two</p>	F 282			

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F 282	<p>Continued From page 16 hours and the check was documented on the TAR.</p> <p>A review of the NF Elopement policy, dated 11/18/12, revealed the Administrator revised the policy to include staff must be within arms' length of a resident until the resident was brought back into the facility.</p> <p>A review of the inservice sign in sheet and what the inservice entailed, dated 11/18/12, revealed facility Nursing, Housekeeping, Laundry, Dietary, and Supportive Staff/Department Heads were in-serviced under the supervision of the Director of Nursing regarding the revised policies and interventions: NF Elopement policy, NF Care Track Policy, NF Elopement/Wandering Care Plan, NF Elopement Tool Kit, Comprehensive Quality Improvement Tool, two alarms now placed on Resident #1 and his/her wheelchair, redirecting and escorting at risk resident to NF part of building from PC and following the care plan related to the assessed needs of supervision for each resident. Any staff not in the building were contacted by phone and inserviced. Those not inserviced over the phone were instructed to contact the facility and receive inservice education prior to the next working shift. Observation, on 11/21/12, revealed a sign above the time clock that instructed the staff who was not in-serviced over the telephone to immediately receive in-service education prior to the next working shift. Interview with LPN #1, LPN #2, LPN #3, LPN #4, Certified Medication Aide (CMA) #1, CMA #2, CNA #1, CNA #2, CNA #4, Housekeeper #2, Housekeeper #3, on 11/20/12 at 11:10 AM, 1:25 PM, 1:30 PM, 1:45 PM, 1:50 PM, 3:25 PM, 3:45 PM, 3:50 PM, 4:15 PM, 5:00</p>	F 282			

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F 282	<p>Continued From page 17</p> <p>PM, and on 11/21/12 at 9:00 AM, revealed they were inserviced, on 11/18/12, that the nurse checked to make sure the Care Trak bracelets were in place, functioning and not tampered with every two hours. Staff should follow care plans related to if staff see a resident who is considered at risk for elopement in an area where there was no staff to provide supervision, the resident should be escorted back to the NF part of the building and when a resident was outside, the resident should never be more than arms' length away from the staff. In addition, they were told that Resident #2 was care planned for a Care Trak bracelet on his/her right arm and leg and on the crossbars of the wheelchair.</p> <p>Interview with the DON, on 11/21/12 at 10:30 AM, revealed he was called, on 11/18/12, and notified about the elopement. He stated he came to the facility and worked on the new orders for all residents, changed the bracelet checks to every 2 hours, inserviced all staff who was at work Sunday and made phone calls to the staff who could be reached. He revealed he updated the TARS for all residents with new orders, and updated the care plans. They assessed all residents with bracelets and made sure the bracelets fit well, were the right bracelets, were functioning, and were not tampered with. He stated the Assistant Director of Nursing (ADON) completed the inservicing, on 11/19/12, except for five staff who have not worked in a while. The five (PRN) staff will be inserviced before they work the floor again. He stated he was trying to contact them now to ensure they still want to remain as PRN staff since they have not worked in a while.</p>	F 282			

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F 282	Continued From page 18 Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed a Quality Assurance Meeting was held, on 11/18/12 and 11/19/12, with the Medical Director regarding problems identified and new policies and procedures put in place, to include audits conducted. A review of the CQI Tool N-24 , dated 11/18/12, revealed the Audit Tool included: TAR was initiated and completed to determine transmitter was in place, was not tampered with, and was functioning properly every two hours, interventions were on care plans and an appropriate intervention was put in place post elopement.	F 282			
F 323 SS=J	Based on the above validated actions completed by this facility the IJ was removed and deficient practice was determined corrected on 11/20/12. 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 interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to provide adequate supervision for one resident (#1), in the selected	F 323	Past noncompliance: no plan of correction required.		

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F 323	<p>Continued From page 19</p> <p>sample of six (6) residents. The facility assessed Resident #1 as an elopement risk requiring supervision to include a care trak assistive device; as the resident had a history of elopement prior to admission. The facility failed to follow their Elopement policy and procedure to provide adequate supervision to minimize the potential for elopement and failed to follow the care plan and redirect the resident when needed. On 11/18/12, Resident #1 was able to exit the front doors of the facility in his/her wheelchair, cross a two lane road with a speed limit of 35 miles per hour, and propel up an inclined driveway to a patio without the staff's knowledge. Licensed Practical Nurse (LPN) #3 failed to redirect the resident to an area where staff could provide supervision, at approximately 7:05 AM, when she saw Resident #1 in an area that was close to the entrance doors and where there was no staff. In addition, the Personal Care Medication Aide (PCMA) was leaving work, at approximately 7:10 AM, when she saw the resident on the neighbor's driveway and attempted to escort the resident back to the facility. The resident became combative and the employee left the resident unsupervised and returned to the facility for assistance.</p> <p>This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 11/21/12, determined to exist on 11/18/12, and determined corrected 11/20/12. The State Agency validated that the facility implemented all corrective action prior to the State Agency's investigation on 11/21/12; thus, it was determined to be past non-compliance at the level of Past Jeopardy. Substandard Quality of Care was identified at 483.13 Resident Behavior and Facility Practices</p>	F 323			

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F 323	<p>Continued From page 20 and 483.25 Quality of Care. (Refer to F224 and F282)</p> <p>Findings include:</p> <p>A review of the facility's Elopement policy and procedure, last revised 05/25/11, revealed the facility should provide adequate supervision to minimize the potential of elopement. The definition of "elopement" is the ability of a resident - who is not capable of protecting him/her self from harm - was able to successfully leave the nursing facility unsupervised and unnoticed and enter into harms way.</p> <p>A record review revealed the facility admitted Resident #1 on 12/05/11 with diagnoses to include Dementia and Behavioral Changes. A review of the Elopement Risk Assessment, dated 12/05/11, revealed the facility assessed Resident #1 as an Elopement Risk. A review of the Comprehensive Care Plan for Elopement/Wandering, dated 12/05/11, revealed interventions to apply a Care Trak bracelet to the right forearm, verify Care Trak in place and functioning every shift, change Care Trak battery every month, divert resident's attention when the resident became insistent on leaving the facility, check promptly when the alarm system sounded, and redirect the resident's attention, as needed.</p> <p>A review of the Minimum Data Set (MDS) assessment and Elopement Risk Assessment, dated 09/13/12, revealed the facility assessed the resident as having wandering behavior and as an elopement risk. In addition, the Wandering/Elopement care plan was still in effect.</p>	F 323			

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F 323	Continued From page 21 A review of the Nursing Assistant Care Plan, dated 11/2012, revealed an intervention for a care trak bracelet on at all times. Interview with Resident #1's spouse, on 11/20/12 at 1:05 PM, revealed Resident #1 had a history of walking off at home and everyone having to search for him/her. She revealed Resident #1 had eloped from this facility when he/she was a Personal Care (PC) home resident and the facility placed the Care Trak bracelet on the resident. Interview with Certified Nurse Aide (CNA) #1, on 11/20/12 at 11:10 AM, revealed she assisted the resident on 11/18/12 at 5:00 AM to get dressed. The resident requested a warm pair of pants and long sleeve shirt. She stated the sleeve caught on the Care Trak bracelet on the resident's wrist when putting the resident's shirt on. The resident stayed in his/her room most of the morning with his/her door closed. She stated every time she checked on the resident he/she was watching television. She revealed around 6:45 AM, LPN #3 assisted the resident to the bathroom. Interview with CNA #2, on 11/20/12 at 1:25 PM, revealed she last saw the resident that morning coming up the hallway in his/her wheelchair on 200 hall when she was administering medications around 6:00 AM. Interview with the PCMA, on 11/20/12 at 3:30 PM, revealed the last time she saw Resident #1 prior to the incident was around 6:00 AM- 6:30 AM when she was doing accu-checks and the resident was propelling down the front hallway in his/her wheelchair.	F 323			

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F 323	<p>Continued From page 22</p> <p>Interview with Housekeeper #3, on 11/20/12 at 1:45 PM. revealed the last time she saw Resident #1, prior to the elopement, was between 6:30 AM and 7:00 AM on the hall by his/her bedroom.</p> <p>Interview with LPN #3, on 11/20/12 at 4:15 PM, revealed Resident #1 stayed in his/her room throughout the night on 11/18/12. At around 6:45 AM, she heard Resident #1's chair alarm going off. When she entered the resident's room, he/she was trying to get up to use the bathroom. She assisted the resident to the bathroom and back to his/her wheelchair.</p> <p>Interview with LPN #2, on 11/20/12 at 3:45 PM, revealed when she came to work at 7:00 AM, Resident #1 was sitting in his/her wheelchair by the Administrative door just inside the lobby. She stated no other staff was around and she did not redirect the resident back to where staff was available to provide supervision.</p> <p>Interview with the PCMA, on 11/20/12 at 3:30 PM, revealed she clocked out and went to her car on 11/18/12 around 7:00 AM. She warmed up her car, then proceeded to drive out the driveway of the facility. She stated when she stopped before turning on to the road in front of the facility, she noted someone in a wheelchair going to the top of the driveway across the street. She stated at first she thought it was someone who lived there, but then thought she should check and make sure. She drove up the road, pulled over into the other driveway of the facility, exited the car and could see it was Resident #1 in his/her wheelchair. She stated she tried to get the resident to come back to the facility with her, but the resident became combative and was trying to</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/21/2012
NAME OF PROVIDER OR SUPPLIER HEARTHSTONE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 506 ALLENSVILLE ROAD ELKTON, KY 42220		
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F 323	<p>Continued From page 23</p> <p>hit her with the wheelchair. She stated she did not have a cell phone, so she left the resident unsupervised, went back to her car, drove back up to the facility, went into the PC side of the facility, told the staff Resident #1 was across the street and staff called over to the other side to make the staff aware. She stated she went back outside and there were 5 or 6 staff outside assisting the resident back to the facility.</p> <p>Interview with CNA #2, on 11/20/12 at 1:25 PM, revealed she was working the medication cart that morning around 7:15 AM when the neighbor across the street from the facility called and said Resident #1 was in her driveway. She stated the neighbor then said staff had just arrived.</p> <p>A review of a nurse's note, dated 11/18/12 at 7:10 AM, and interview with LPN #4, on 11/21/12 at 9:00 AM, revealed she received a phone call from the Personal Care Unit informing her that Resident #1 was across the street at the brick house on the patio. The nurse notified staff regarding the elopement and three staff members and the nurse went across the street to retrieve the resident. The resident was combative but staff was able to encourage the resident to come back to the building so he/she could call his/her spouse. Staff noted when they escorted the resident through the entrance door of the facility, the alarm did not sound. When staff looked at the resident's wrist they noted the care trak bracelet was not in place. The Care Trak bracelet was found in the drawer of the resident's bedside table.</p> <p>Interview with LPN #2, on 11/20/12 at 3:45 PM, revealed after arriving at work she counted</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>narcotics with LPN #3 and received report. She stated a couple of minutes later, staff came up and said Resident #1 was across the street. She stated her and other staff went across the street and brought the resident back to the facility. The resident did not have his/her Care Trak bracelet on and staff found it in the second drawer of the bed side table.</p> <p>Interview with Housekeeper #3, on 11/20/12 at 1:45 PM. revealed she heard staff say the resident was across the street. She stated she stood at the front door and watched staff bring him/her back across street. When they brought him/her through the doors, the alarm did not sound. Staff checked the resident and the care trak bracelet was not on his/her right arm. She stated she went to search in the resident's room and found the bracelet in the second drawer of the bedside table.</p> <p>Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed staff should have redirected Resident #1 away from the front door area at that time of day because it was before Administrative staff arrived and there was not always someone there to provide supervision. In addition, the staff member should not have left Resident #1 outside alone while she came back to the facility to get assistance. This placed the resident in danger of elopement with no supervision in the lobby area and no supervision while staff came back to facility to get help.</p> <p>The State Agency verified the facility implemented the following corrective actions which were completed on 11/20/12. Thus verifying the facility was in compliance on 11/20/12.</p>	F 323			

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F 323	Continued From page 25 The facility implemented the following actions to correct the deficiency on 11/18/12: * A head to toe skin assessment was conducted on Resident #1 with no injuries identified. A new Care Trak bracelet was placed on Resident #1's right ankle. Resident #1 was placed on one to one supervision. The guardian was made aware of the elopement. An Elopement assessment was conducted on Resident #1 and he/she was still identified at risk for elopement. Resident #1's physician was notified (facility's Medical Director) and an order was received to place a Care Trak bracelet on the cross bars of the wheelchair. The Comprehensive Care Plan was updated to include a Care Trak bracelet on the right ankle and crossbars of the wheelchair. Resident #1 was changed to every 15 minute monitoring. Appropriate State Agencies were made aware of the elopement. * The Care Trak door alarms were verified by laundry personnel and Director of Environmental Services to be in proper working condition. * An audit was conducted on Nursing Facility residents medical records with Care Trak application. The audit consisted of physician's orders, wander/elopement care plans, face sheet, pictorial list of residents with Care Trak orders, and actual Care Trak placement, function, and assessment for evidence of tampering. This audit was conducted under the supervision of the Director of Nursing (DON). * The Nursing Facility (NF) Care Trak policy and procedure was updated by the Administrator.	F 323			

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F 323	<p>Continued From page 26</p> <p>Revisions made to the policy included: NF and PC policies were separated clearly defining the increased supervision for NF residents and G-tube Nurse was responsible for ensuring the Care Trak transmitter was in place, had not been tampered with, and for proper function every two hours, and documented on the Treatment Administrative Record.</p> <p>*The NF Elopement policy was updated by the Administrator. Revisions made to the policy included: Clarifying staff must be within arms' length of a resident until resident was brought back into the facility.</p> <p>*Facility Nursing, Housekeeping, Laundry, Dietary, and Supportive Staff/Department Heads were in-serviced under the supervision of the Director of Nursing regarding the revised policies and interventions: NF Elopement policy, NF Care Track Policy, NF Elopement Risk Assessment, Checklist, NF Elopement/Wandering Care Plan, NF Elopement Tool Kit, CQI Tool, two alarms now placed on Resident #1 and on his/her wheelchair and redirecting and escorting the resident to the NF part of building from PC. Any staff not in the building were contacted by phone and inserviced. Those not inserviced over the phone were instructed to contact the facility and receive inservice education prior to the next working shift. A sign was placed at the time clock, to instruct staff who were not in-serviced over the telephone to immediately receive in-service education prior to the next working shift.</p> <p>* The physician's orders were clarified to reflect the policy change along with the corresponding Care Plans, TARs and nurse's notes for all</p>	F 323			

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F 323	<p>Continued From page 27 residents identified as elopement risk.</p> <p>* A Quality Assurance (QA) Meeting was held with the Medical Director regarding problems identified and new policies and procedures were put in place, to include audits conducted.</p> <p>*CQI Tool N-24 was updated and completed by the Administrator. Audit Tool revisions included: TAR initiated and completed to determine transmitter was in place, had not been tampered with, and for proper function every two hours, and an appropriate intervention put in place post elopement.</p> <p>* On 11/19/12, the Administrator called the care trak system manufacturer and tried to determine how the resident could have removed the bracelet and what actions they could take to try to prevent it from happening again. The manufacturer recommended the facility also keep a bracelet on Resident #1's arm. The physician was called and orders were received to place a care trak bracelet on the resident's right arm.</p> <p>The surveyor validated the corrective action taken by the facility as follows:</p> <p>Observation, on 11/20/12, revealed Resident #1 was sitting in a wheelchair. There was a Care Trak bracelet on the resident's right arm, right lower leg and crossbars of the wheelchair. Staff were conducting 15 minute checks of the resident. Observations of Resident #2, #3, #4, #5, and #6 revealed their Care Trak bracelets were in place per physicians' orders.</p> <p>A record review for Resident #1 revealed a body</p>	F 323			

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F 323	<p>Continued From page 28</p> <p>audit was conducted upon return to the facility and 15 minute checks were documented from the time the Resident returned to the facility to the present. Record reviews for Resident #2, #3, #4, #5 and #6 revealed all physician's orders, nurse's notes, Treatment Administration Record (TARS), Elopement assessments and Care Plans were updated and included checking care trak bracelets for placement, function and evidence of tampering every two hours. The TARs were initialed every two hours by staff.</p> <p>Observation of the Care Trak door alarms revealed they were in working order. Interview with the Environmental Services Supervisor, on 11/20/12 at 4:10 PM, revealed she was notified about the elopement on 11/18/12 and went to the facility and checked all the Care Trak door alarms. She stated they were in working order.</p> <p>A review of the pictorial list of residents revealed it was updated, on 11/18/12, and included two additional residents.</p> <p>A review of the Nursing Facility Care Trak policy and procedure, dated 11/18/12, revealed the Administrator revised the policy to include: NF and PC policies were separated clearly defining the increased supervision for NF residents and G-tube Nurse was responsible for ensuring the Care Trak transmitter was in place, was not tampered with, and for proper function every two hours and the check was documented on the TAR.</p> <p>A review of the NF Elopement policy, dated 11/18/12, revealed the Administrator revised the policy to include staff must be within arms' length</p>	F 323			

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F 323	Continued From page 29 of a resident until the resident was brought back into the facility. A review of the inservice sign in sheet and what the inservice entailed, dated 11/18/12, revealed facility Nursing, Housekeeping, Laundry, Dietary, and Supportive Staff/Department Heads were in-serviced under the supervision of the Director of Nursing regarding the revised policies and interventions: NF Elopement policy, NF Care Track Policy, NF Elopement Risk Assessment, Checklist, NF Elopement/Wandering Care Plan, NF Elopement Tool Kit, Comprehensive Quality Improvement Tool, two alarms now placed on Resident #1 and his/her wheelchair, redirecting and escorting at risk resident to NF part of building from PC. Any staff not in the building were contacted by phone and inserviced. Those not inserviced over the phone were instructed to contact the facility and receive inservice education prior to the next working shift. Observation, on 11/21/12, revealed a sign above the time clock that instructed the staff who was not in-service over the telephone to immediately receive in-service education prior to the next working shift. Interview with LPN #1, LPN #2, LPN #3, LPN #4, Certified Medication Aide (CMA) #1, CMA #2, CNA #1, CNA #2, CNA #4, Housekeeper #2, Housekeeper #3, on 11/20/12 at 11:10 AM, 1:25 PM, 1:30 PM, 1:45 PM, 1:50 PM, 3:25 PM, 3:45 PM, 3:50 PM, 4:15 PM, 5:00 PM, and on 11/21/12 at 9:00 AM, revealed they were inserviced, on 11/18/12, that the nurse checked to make sure the Care Trak bracelets were in place, functioning and not tampered with every two hours. If staff saw a resident who was considered at risk for elopement in an area where there was no staff to provide supervision, the	F 323			

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F 323	<p>Continued From page 30</p> <p>resident should be escorted back to the NF part of the building. When a resident was outside, the resident should never be more than arms' length away from the staff. In addition, they were told that Resident #2 now had a Care Trak bracelet on his/her right arm and leg and on the crossbars of the wheelchair.</p> <p>Interview with the DON, on 11/21/12 at 10:30 AM, revealed he was called, on 11/18/12, and notified about the elopement. He stated he came to the facility and worked on the new orders for all residents, changed the bracelet checks to every 2 hours, inserviced all staff who was at work Sunday and made phone calls to the staff who could be reached. He revealed he updated the TARS for all residents with new orders, and updated the care plans. They assessed all residents with bracelets and made sure the bracelets fit well, were the right bracelets, were functioning, and were not tampered with. He stated the Assistant Director of Nursing (ADON) completed the inservicing, on 11/19/12, except for five staff who have not worked in a while. The five (PRN) staff will be inserviced before they work the floor again. He stated he was trying to contact them now to ensure they still want to remain as PRN staff since they have not worked in a while.</p> <p>Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed a Quality Assurance Meeting was held, on 11/18/12 and 11/19/12, with the Medical Director regarding problems identified and new policies and procedures put in place, to include audits conducted.</p> <p>A review of the CQI Tool N-24 , dated 11/18/12,</p>	F 323			

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F 323	<p>Continued From page 31</p> <p>revealed the Audit Tool included: TAR was initiated and completed to determine transmitter was in place, was not tampered with, and was functioning properly every two hours, and was an appropriate intervention put in place post elopement.</p> <p>Interview with the Administrator, on 11/21/12 at 11:50 AM, revealed the Administrator called the care trak system manufacturer, on 11/19/12, and tried to determine how the resident could have removed the bracelet and what, if any actions, they could take to try to prevent this from happening again. The manufacturer recommended the facility also keep a bracelet on Resident #1's arm. The physician was notified and orders were received to place a care trak bracelet on the resident's right arm. The care trak bracelet was then placed on Resident #1's right arm.</p> <p>Based on the above validated actions completed by this facility the IJ was removed and deficient practice was determined corrected on 11/20/12.</p>	F 323			