

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

PRINTED: 01/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2010
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NAME OF PROVIDER OR SUPPLIER WESLEY MANOR NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219
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(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
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F 000	INITIAL COMMENTS AMENDED SOD 01/20/11 An abbreviated standard and partial extended survey investigating KY #00015731 and KY #00015573 was initiated on 12/16/10 and concluded on 12/21/10. Immediate Jeopardy was found to exist on 12/17/10 and the facility was notified of Immediate Jeopardy and Substandard Quality of Care on 12/17/10. KY #00015731 and KY #00015573 were substantiated and deficiencies cited were 42CFR 483.25 F323 and 42CFR 483.75 F490. The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/21/10. Immediately Jeopardy was verified to be removed prior to exit on 12/21/10; however, non compliance continues at F323, and F490 at a scope and severity of "E."	F 000		
F 323 SS=K	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 record review, observation, and interview, it was determined the facility failed to provide quality care, treatment, and supervision of	F 323	This plan of correction is not submitted as an admission of guilt related to the deficiencies as stated herein, but rather to comply with the regulatory process. 1. Residents #4 and #5 were both assessed using the <u>Risk Assessment Elopement Decision Tree</u> . Their care plans and nurse aide assignment sheets were updated based on the findings on 12-21-10 (see attached). Identification bracelets were placed on resident #4 and #5 per revised Elopement policy. 2. All residents upon admission and quarterly shall be assessed using the <u>Risk Assessment Elopement Decision Tree</u> . Those residents identified at risk for	1-7-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeremy L. Hodgson</i>	TITLE <i>President/Administrator</i>	(X6) DATE <i>1-28-11</i>
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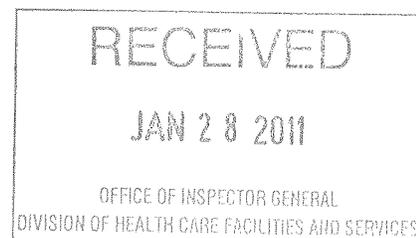
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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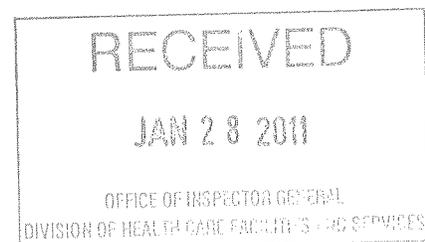
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F 323	<p>Continued From page 1</p> <p>residents identified by the facility as at risk for elopement for two (2) of thirteen (13) sampled residents. The facility failed to ensure policies and procedures were developed which detailed staff responsibilities, and failed to ensure staff was trained to the policies and procedures. The facility failed to ensure alarms were functioning properly and audible to alert staff when the emergency exit door was opened at the end of the corridor/tunnel. On 12/12/10, Resident #4 and Resident #5 who the facility identified as at risk for elopement exited the locked unit and the facility without staff knowledge or supervision. Resident #4 and Resident #5 were found standing outside the facility with minimum temperature of 22 (twenty-two) degrees Fahrenheit in the Louisville area as reported by the National Weather Service on 12/12/10.</p> <p>Immediate Jeopardy was found to exist on 12/17/10 and the facility was notified of Immediate Jeopardy and Substandard Quality of Care on 12/17/10.</p> <p>The findings include:</p> <p>Record review of the Policy and Procedure for Elopement of Residents with revision date of 01/10, revealed the policy was intended to ensure the safety of residents who were at risk for elopement, including procedures for identification of residents at risk for elopement, maintenance of the locked unit, and notification procedures during actual elopement event. The policy stated that the resident care plan and nurse aide assignment sheets would address the elopement risk.</p> <p>Interview with the Vice President of Nursing (VPN) on 12/17/10 at 1:35pm revealed that all</p>	F 323	<p>elopement shall have their care plans and nurse aide assignment sheets updated based on the findings on 12-21-10.</p> <p>3. Multiple systems have been put into place to ensure that the deficient practice will not recur. First, the door at the end of the tunnel was maglocked so that it will only unlock in the event of a fire alarm alert. Second the security system for the Peters Wing (the ambulatory dementia unit) has been upgraded. They key-pad system has been changed to a keyed system. Only a select staff have a key (see attached) to the unit all other staff and visitors shall call for assistance on the intercom and the staff shall key the staff on to the unit. This ensures the staff are monitoring the doors every time someone enters and exits the unit. The Elopement Policy was revised and reviewed with all staff. Finally, Identification bracelets will now be used on all residents identified "at risk" for elopement.</p> <p>4. Multiple audits have been put into place to ensure that solutions are sustained. First, an alarm audit (see attached) shall be performed weekly by the Administrator. An <u>Elopement Drill</u> (see attached) shall be performed at least monthly by the Vice President of Nursing or the Assistant Director of Nursing. An <u>Elopement Policy Compliance</u> audit (see</p>	



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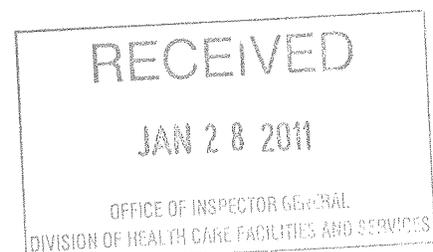
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F 323	<p>Continued From page 2</p> <p>residents on the West Hall locked unit were at risk for elopement since all residents had some cognitive impairment. The VPN stated that the residents who exhibited exit-seeking behaviors were identified as elopement risks on the Nursing Assistant Assignment Sheets.</p> <p>1. Record review revealed the facility admitted Resident #4 on 09/10/10 with a diagnosis of mental disorder. The Minimum Data Set Assessment dated 09/16/10 revealed the facility assessed Resident #4 as having severely impaired cognitive skills with memory problems. Record review of Nursing Assistant Assignment Sheets for 12/11/10, revealed the facility identified Resident #4 as an elopement risk.</p> <p>Record review of Nurse's Notes, on 12/12/10 at 5:00pm documented by LPN #1 revealed the Hall Nurse identified Resident #4 could not be found on the unit and a search was conducted. The resident was found outside the facility near the emergency door. LPN #1 documented in the Nurse's Notes on 12/12/10 at 5:30pm that Resident #4 was assessed after the elopement and determined there was no injury to Resident #4.</p> <p>Interview with CNA #5, on 12/17/10 at 3:05pm, revealed they were told Resident #4 left the unit with another resident on 12/12/10 during the time they were monitoring residents in the common area of the West Hall. CNA #5 did not observe Resident #4 leave the unit.</p> <p>Interview with LPN #1, on 12/17/10 at 3:55pm, revealed that during medication pass on 12/12/10 at 5:00pm, a family member stated they were unable to locate Resident #5. LPN #1</p>	F 323	<p>attached) shall be performed at least monthly by the Vice President of Nursing or the Assistant Director of Nursing. The Staff Development Coordinator has added to the orientation of all new employees the review of the Elopement Policy and Enunciator Panel review. The findings will be reported monthly to the Performance Improvement (PIC) and quarterly to the Quality Assessment and Assurance Committee (QAAC) for their review and recommendations; if any. Members of PIC include: The Administrator, Vice President of Nursing and Client Services, Assistant Director of Nursing (Chairman of the Committee), Director of RAI, Medical Records, Director of Social Services, Staff Development Coordinator, Director of Activities, Director of Dietary, Housekeeping Supervisor, Maintenance and Chaplain.</p> <p>Members of QAAC include: The Medical Director, Chairman of the Board, 2 members of the board (Resident Care Policies Committee), Administrator, Vice President of Nursing and Client Services, Assistant Director of Nursing (Chairman of the Committee) Director of Social Services, Director of Activities, Pharmacist, Staff Development Coordinator, Director of RAI.</p> <p>5. <u>To prevent the recurrence of the deficient practice, and to ensure that compliance is maintained,</u> the</p>



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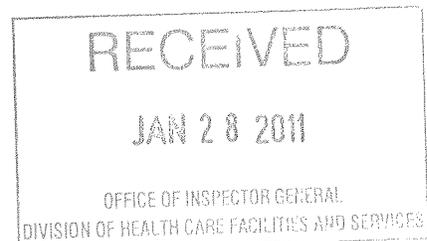
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F 323	<p>Continued From page 3</p> <p>remembered seeing Resident #4 and Resident #5 near the door as an Assisted Living Resident left the unit on a scooter, and wondered if the two residents may have followed the Assisted Living Resident off of the unit. LPN #1 stated Resident #4 was missing during a busy time on the West Hall as CNA #5 was monitoring residents in the common area where chair alarms were sounding from residents who needed assistance to stand. LPN #1 stated CNA #3 was off the unit when Resident #4 was missing. Resident #4 was found holding hands with Resident #5 outside the exit door. LPN #1 stated she did not consider Resident #4 to be an elopement risk because Resident #4 was a follower as Resident #4 was often seen holding hands while walking with other residents. LPN #1 did not know how long Resident #4 was locked outside but did not think it could have been longer than thirty (30) minutes.</p> <p>Interview with LPN #2, on 12/17/10 at 4:20pm, revealed he was in charge during the time Resident #4 was reported missing. LPN #2 was called to the West Hall and was advised Resident #4 was missing from the unit. LPN #2 reported seeing Resident #4 with Resident #5, five (5) minutes before both residents were reported missing. LPN #2 led the search for the residents, and stated Resident #4 was found with Resident #5 outside the facility near the emergency exit door. LPN #2 did not think the residents were outside longer than five (5) minutes.</p> <p>2. Record review revealed the facility admitted Resident #5 on 05/20/10 with medical diagnoses of Alzheimer's disease, vascular dementia, hallucinations, and anxiety. Review of a Discharge Summary from a local psychiatric facility, dated 05/20/10, revealed Resident #5 was</p>	F 323	<p><u>administrator has-</u> 1) Coordinated repairs, enhancements of the door security/alarm system, 2) Personally conducted weekly alarm audits/checks and prescribed appropriate measures/repairs to ensure acceptable operation, 3) Participated in any policy and procedure revisions and had final approval for all such revisions, 4) Personally observed (on a daily basis) security status on the locked wing to ensure proper compliance with policies and procedures, 5) Attended regularly scheduled meetings of the Performance Improvement and Quality Assurance Committees.</p>	



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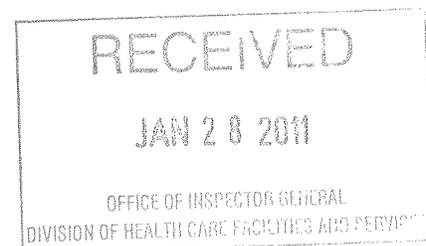
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F 323	<p>Continued From page 4</p> <p>admitted due to paranoid behavior, had attempted to leave the home, and the family could not safely manage the resident at home. The Minimum Data Set Assessment dated 11/02/10 revealed the facility assessed Resident #5 as having moderately impaired cognitive skills, required supervision with memory problems, and detailed no wandering behaviors. Record of Nursing Assistant Assignment Sheet dated 12/11/10, revealed the facility identified Resident #5 as an elopement risk.</p> <p>Record review of Nurse's Notes dated 12/12/10 at 5:00pm revealed Resident #5 could not be found on the West Hall and a search was conducted. Resident #5 was found standing outside the facility by the emergency exit door. Nurse's notes dated 12/12/10 at 5:30pm revealed Resident #5 was assessed after the elopement with no signs of physical injury documented.</p> <p>Interview with CNA #5, on 12/17/10 at 3:05pm, revealed she was told Resident #5 left the West Hall while she was monitoring residents with chair alarms in the common area on 12/12/10. CNA #5 said she assisted in the search for Resident #5 who was found outside the facility near the emergency exit door.</p> <p>Interview with LPN #1 on 12/17/10 at 3:55pm, revealed she was notified Resident #5 was not on the West Hall unit by the resident's husband during the medication pass on 12/12/10 at 5:00pm. LPN #1 reported seeing Resident #5 with Resident #4 at the locked door as an Assisted Living Resident on a scooter went through the door and wondered if the residents may have followed the Assisted Living Resident off of the West Hall. LPN #1 said the elopement</p>	F 323		



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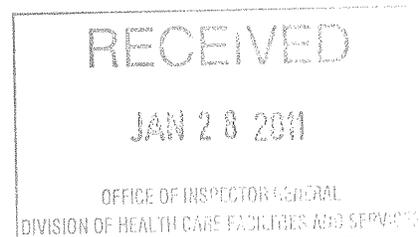
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F 323	<p>Continued From page 5</p> <p>occurred during a busy time on the unit because CNA #5 was watching residents in the common area where chair alarms sounded, and CNA #3 was off the unit on a break. After conducting a search, LPN #1 said Resident #5 was found standing outside of the facility near the emergency exit door with Resident #4, and did not know how long the residents were outside but did not think it was longer than thirty (30) minutes.</p> <p>Interview with CNA #3, on 12/17/10 at 4:15pm, revealed he was off the unit from 4:30pm until 5:00pm on dinner break. When CNA #3 returned to the unit, they were told Resident #5 could not be found on the unit. CNA #3 assisted in the search and said Resident #5 was found outside the facility with Resident #4.</p> <p>Interview with LPN #2, on 12/17/10 at 4:20pm, revealed he was the charge nurse on 12/12/10 when the elopement of Resident #5 was reported. LPN #2 saw Resident #5 with Resident #4 near the locked door of the West Hall before being told both residents were missing. LPN#2 began the search on the West Hall and said Resident #5 was found with Resident #4 outside the facility near the emergency exit door, and stated both residents were outside no longer than five (5) minutes.</p> <p>Record review of the facility investigation regarding the elopement of Resident #4 and Resident #5 revealed that all staff working on the West Hall were interviewed, but no written documentation was completed of the investigation.</p> <p>Interview with LPN #1 on 12/17/10 at 3:55pm revealed she could not recall hearing the</p>	F 323		



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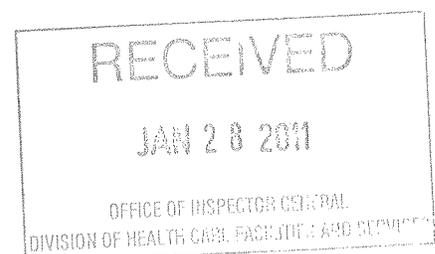
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F 323	<p>Continued From page 6</p> <p>emergency exit door alarm on the West Hall that during the elopement of Resident #4 and Resident #5.</p> <p>Interview with CNA #3 on 12/17/10 at 4:15pm revealed he could not recall hearing an audible alarm at the time of the elopement of Resident #4 and Resident #5.</p> <p>Interview with LPN #2 on 12/17/10 at 4:20pm revealed he did not recall hearing an audible alarm at the time of the elopements and said, "Sometimes the alarm is low and can be hard to hear."</p> <p>Interview with the VPN, on 12/17/10 at 5:35pm, revealed the alarm failed to alert staff to the elopement of Resident #4 and Resident #5 and that a service call was performed on 12/13/10 to ensure the alarm was functioning properly.</p> <p>Telephone interview with the Director of Maintenance, on 12/17/10 at 6:15pm, revealed that he was aware of the service repair work completed on 12/13/10 and stated he did not test the alarm system or visualize a demonstration of the alarm system after the repair. The Director of Maintenance stated he didn't see any reason to check the alarm because, "I took their word for it."</p> <p>Observation on 12/17/10 at 12:45pm with the Administrator and Vice President of Nursing revealed the exit door at the end of the tunnel/corridor which led outside was equipped with an alarm system. However, when the Administrator opened the exit door, no audible alarm sounded in the tunnel. The Administrator explained the alarm did not sound in the tunnel; the alarm sounded near the nursing station to</p>	F 323		



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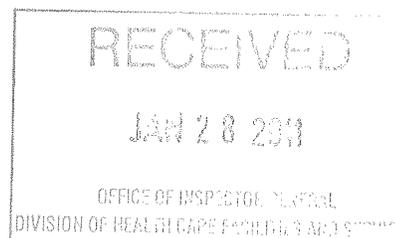
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F 323	<p>Continued From page 7</p> <p>alert staff on the unit that the exit door had been opened. The Administrator explained the annunciator box was located in a common area across from the nursing station and sounded when the tunnel/corridor exit door was opened.</p> <p>Further observation, on 12/17/10 at 4:45pm, revealed the alarm was not audible on the West Hall Unit or the nursing station.</p> <p>Further observation revealed CNA #6, LPNA #1, LPN #3, LPN #2, and the VPN stated the alarm was not audible on the West Hall locked unit, halfway down the West Hall, at the Nurse's Station, halfway down the South Hall, or in the resident rooms. The VPN stated, the alarm was not tested after the repair because it was assumed the work on the alarm had been completed. The VPN stated, "I was surprised when I heard it. It is not fixed, it doesn't make enough sound to alert anyone (of the exit door opening)." The Administrator stated, "I would agree that we need a louder alarm."</p> <p>Observation with the Administrator on 12/17/10 at 4:45pm during a test of the alarm on the emergency exit door revealed staff members had difficulty hearing the alarm on the West Hall. CNA #6, with three (3) years of service at the facility, said the VPN told her the alarm meant a resident had left the West Hall, and was not sure what to do to locate the resident and did not know what the alarm meant.</p> <p>While the facility had identified both Residents #4 and #5 as at risk for elopement and noted this on the Nurse Aide Care Plan, there was no evidence that the facility ensured the security of the locked unit after the occurrence of the two elopements</p>	F 323		



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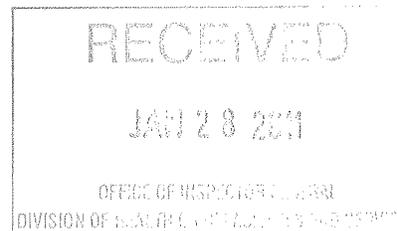
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F 323	<p>Continued From page 8</p> <p>on 12/12/10. Interviews with staff revealed the facility was aware that the door alarms did not sound at the time of the elopement; however on 12/17/10, the facility's door alarm system continued to fail as the alarms were not audible throughout the facility despite having contractors attempt to repair the door alarms on 12/13/10. Furthermore, the facility did not ensure all staff was knowledgeable regarding the alarms as evidenced by CNA #3 being unaware of what the alarms meant and what to do.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/21/10. The facility AOC detailed the facility implemented a plan to provide around the clock observation of the West Hall doors by positioning a CNA not involved in resident care to monitor the West Hall doors. The CNA would continue to monitor the doors until a new entry/lock system was installed to be accessed by key only. The alarm would be upgraded to an audible level to alert staff on the West Hall and adjoining units that the emergency exit door had been opened. On the spot inservices were planned to educate staff of the risk of elopement and promote strategies to prevent elopement on the West Hall. The Elopement Policy and Procedure would be updated to include staff responsibilities in the event of an elopement, and in-services and elopement drills were implemented. A monthly audit of the facility's alarm system was implemented. The Vice President of Nursing provided the Assisted Living Residents with a letter outlining preventive actions to avoid elopement, and held a meeting to discuss the risk of elopement on the West Hall.</p> <p>Record review of Elopement Inservices provided</p>	F 323		



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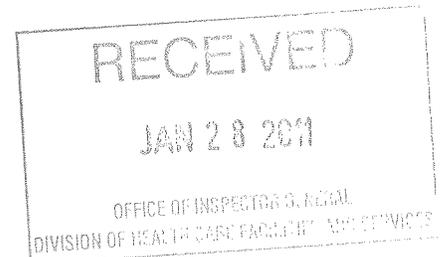
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2010
NAME OF PROVIDER OR SUPPLIER WESLEY MANOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5012 EAST MANSLICK RD LOUISVILLE, KY 40219	
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F 323	Continued From page 9 by the VPN revealed one-hundred (100%) compliance and completed attendance sheets of staff in attendance. The VPN also provided an updated Elopement Policy and Procedure which detailed staff responsibilities during an elopement with attendance sheets, and documentation of an Elopement Drill conducted on 12/20/10. Record review revealed the facility's alarm system audit was completed 12/20/10. Verified the completion of the meeting with the Assisted Living Residents regarding the notice given to ensure elopement prevention. On 12/20/10 and 12/21/10, observation revealed a CNA was stationed continuously monitoring the West Hall door to prevent elopement. Interview with the CNA confirmed that her job duty was strictly to monitor the door and was not to be used for direct care. Further observation on 12/20/10 revealed a service contractor at the facility installing/upgrading an alarm on the emergency exit door. Immediately Jeopardy was verified to be removed prior to exit on 12/21/10; however, non compliance continues at 42 CFR 483.25, F323, at a scope and severity of "E" based on the facility's need to evaluate the effectiveness of the interventions implemented related to supervision to prevent elopement and continued monitoring of the facility's elopement prevention systems.	F 323		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	1. Residents #4 and #5 were both assessed using the <u>Risk Assessment Elopement Decision Tree</u> . Their care plans and nurse aide assignment sheets were updated based on the findings on 12-21-10 (see attached). Identification bracelets were placed on resident #4 and #5 per revised Elopement policy.	1-7-11



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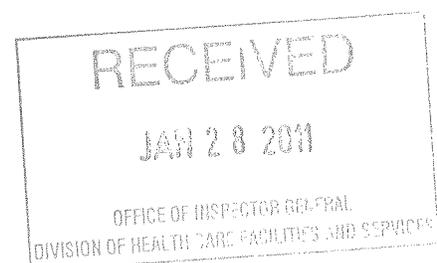
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F 490	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to provide administrative support and management which demonstrated effective use of resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Substandard Quality of Care and Immediate Jeopardy were identified to exist in CFR 483.25 (F323, and F490). The facility failed to ensure adequate supervision to prevent accidents for two (2) residents out of a sample of thirteen (13), Resident #4 and Resident #5 who the facility identified as elopement risks. The facility Administration failed to implement effective interventions to prevent the recurrence of the elopement. The facility failed to ensure staff was knowledgeable and trained to the elopement procedures and door alarms. The facility failed to ensure the door alarms were audible throughout the facility. On 12/12/10, Residents #4 and #5 exited the facility, without staff knowledge and supervision. Both residents were found locked outside of the facility for an undetermined period of time. The National Weather Service detailed as the minimum temperature in the Louisville, Kentucky area on 12/12/10 was twenty-two (22) degrees Fahrenheit. The facility identified ten (10) of sixty-seven (67) residents as being at risk for elopement or wandering. Immediate Jeopardy was found to exist on 12/17/10 when the facility failed to ensure adequate supervision for residents #4 and #5 to prevent elopement which was likely to cause serious injury, harm, impairment or death to a	F 490	2. All residents upon admission and quarterly shall be assessed using the <u>Risk Assessment Elopement Decision Tree</u> . Those residents identified at risk for elopement shall have their care plans and nurse aide assignment sheets updated based on the findings on 12-21-10. 3. Multiple systems have been put into place to ensure that the deficient practice will not recur. First, the door at the end of the tunnel was mag locked so that it will only unlock in the event of a fire alarm alert. Second the security system for the Peters Wing (the ambulatory dementia unit) has been upgraded. They key-pad system has been changed to a keyed system. Only a select staff have a key (see attached) to the unit all other staff and visitors shall call for assistance on the intercom and the staff shall key the staff on to the unit. This ensures the staff are monitoring the doors every time someone enters and exits the unit. The Elopement Policy was revised and reviewed with all staff. A new policy was implemented for the maintenance and checking of the alarms for the facility (see attached). Finally, Identification bracelets will now be used on all residents identified "at risk" for elopement.	



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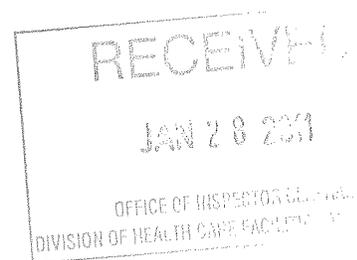
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F 490	Continued From page 11 resident. The facility was notified of Immediate Jeopardy and Substandard Quality of Care on 12/17/10. The findings include: Review of the facility's "Elopement of Residents" policy and procedure, revised 01/10, revealed the facility was to ensure the safety of residents who are at risk for elopement. The procedures included: staff would consider any resident who attempted to leave the facility or who had a known history of exit seeking at risk for elopement; the care plan and nurse aide assignment sheet will address the elopement risk; staff observing resident(s) attempts to leave shall intervene, using distraction, redirection or other means to prevent the resident from leaving; hall nurse shall document any attempts of resident elopement in the nurses notes; staff will supervise residents who insist on leaving the facility by taking them outside and staff will obtain a walkie-talkie in the event of an emergency; all doors are code or key locked to prevent elopement without staff knowledge; if a resident at risk for elopement learns the code to the door locks, maintenance staff will be notified immediately and the codes on all the doors will be changed; in the event of an elopement the Shift Supervisor will call 911 and report the incident, assign staff to specific areas on the property to begin the search and will notify the family, Physician, Administrator, Vice President of Nursing (VPN), and Client Services immediately; staff will conduct a physical exam of the resident, complete an incident report, document in the medical record and turn dial to green to indicate follow-up charting is required; and the Nurse Program Manager/ADON or VPN will discuss with the physician and family the	F 490	In addition, Dr. Brown was notified by the Administrative Assistant during the survey. The Vice President of Nursing spoke directly to him during the extended survey and followed up with him after to discuss the changes that we being made in the facility. Dr. Brown reviewed the revisions in the Elopement policy and made no further recommendations (see attached). 4. Multiple audits have been put into place to ensure that solutions are sustained. First, an alarm audit (see attached) shall be performed weekly by the Administrator. An <u>Elopement Drill</u> (see attached) shall be performed at least monthly by the Vice President of Nursing or the Assistant Director of Nursing. An <u>Elopement Policy Compliance</u> audit (see attached) shall be performed at least monthly by the Vice President of Nursing or the Assistant Director of Nursing. The Staff Development Coordinator has added to the orientation of all new employees the review of the Elopement Policy and Enunciator Panel review. The findings will be reported monthly to the Performance Improvement (PIC) and quarterly to the Quality Assessment and Assurance Committee (QAAC) for their review and recommendations; if any. Members of PIC include: The Administrator, Vice President of Nursing and Client Services, Assistant Director of	



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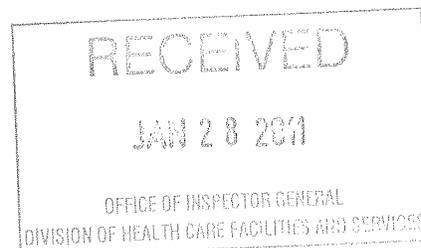
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F 490	Continued From page 12 behavior that was noted at the time of the elopement, causal factors, and interventions to be put into place to eliminate the risk, having the new interventions added to the nurse aide assignment sheets and care plans. Interview with the Vice President of Nursing (VPN), on 12/17/10 at 1:35pm, revealed all residents on the West Hall locked unit were considered to be at risk for elopement since all residents had some cognitive impairment. The VPN stated that the residents who were identified as elopement risks on the Nursing Assistant Assignment Sheets demonstrated exit-seeking behaviors on the unit. Record review of the nurse's notes for both resident #5 and #4 revealed on 12/12/10 both residents were found outside the locked unit and outside the facility at approximately 5:00 pm. Review of the medical records for both residents #5 and #4 revealed the facility had identified them as at risk for elopement and the nurse aide assignment sheets detailed this risk dated 12/11/10. Interview with LPN #1, on 12/17/10 at 3:55pm, and review of Resident #5's medical record revealed the facility had not identified either resident missing until Resident #5's spouse reported being unable to find Resident #5. The facility initiated a search and found Resident #5 and #4 standing outside an exit door of the facility. Interviews with LPN #1, CNA #5 (on 12/17/10 at 3:05pm), CNA #3 (on 12/17/10 at 4:15pm) and LPN #2 (on 12/17/10 at 4:20pm) revealed none of these staff was knowledgeable of either resident leaving the facility nor had they heard an audible door alarm that would signify a resident had exited the building. Continued interview with LPN #1 revealed she remembered	F 490	Nursing (Chairman of the Committee), Director of RAI, Medical Records, Director of Social Services, Staff Development Coordinator, Director of Activities, Director of Dietary, Housekeeping Supervisor, Maintenance and Chaplain. Members of QAAC include: The Medical Director, Chairman of the Board, 2 members of the board (Resident Care Policies Committee), Administrator, Vice President of Nursing and Client Services, Assistant Director of Nursing (Chairman of the Committee) Director of Social Services, Director of Activities, Pharmacist, Staff Development Coordinator, Director of RAI. <u>To ensure that the deficient practice does not recur, and to ensure that compliance is maintained, the administrator -</u> 1) Coordinated repairs/enhancements of the door security/alarm system, 2) Personally conducted weekly alarm audits/checks and prescribed appropriate measures/repairs to ensure acceptable operation, 3) Participated in any policy and procedure revisions and had final approval for all such revisions, 4) Personally observed (on a daily basis) security status on the locked wing to ensure proper compliance with policies and procedures, 5) Attended regularly scheduled meetings of the Performance Improvement and Quality Assurance Committees.		



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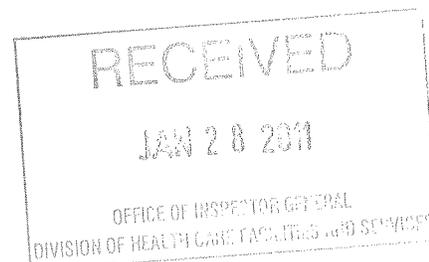
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F 490	Continued From page 13 seeing resident #4 and #5 near the door as an Assisted Living resident exited the unit on a scooter. Interview with the VPN on 12/17/10 at 5:35pm revealed that the alarm failed to alert staff to the elopement of Resident #4 and Resident #5 and that a service call was performed on 12/13/10 to ensure the alarm was functioning properly. While the facility identified the door alarms weren't functioning properly and had a contractor work on the doors on 12/13/10, observation on 12/17/10 at 12:45pm with the Administrator and Vice President of Nursing found the exit door at the end of the tunnel/corridor which led outside was equipped with an alarm system. When the Administrator opened the exit door, no audible alarm sounded in the tunnel. The Administrator explained the alarm did not sound in the tunnel; the alarm sounded near the nursing station to alert staff on the unit that the exit door was opened. The Administrator explained the annunciator box was located in a common area across from the nursing station and sounded when the tunnel/corridor exit door was opened. The alarm was not audible at the nursing station, or behind closed and locked doors of the West Hall Locked Unit. Further observation, on 12/17/10 at 4:45pm with the Administrator and Vice President of Nursing, CNA #6, LPNA #1, LPN #2 revealed during a demonstration of the door alarms, the alarm was not audible on the West Hall Locked Unit, the South Hall, the nursing station, or in the residents' rooms. The VPN stated the alarm was not tested after the repair was completed because it was assumed the work on the alarm had been completed. The VPN stated, "I was surprised when I heard it. It is not fixed; it doesn't make enough sound to alert	F 490		



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F 490	Continued From page 14 anyone (of the exit door opening)." Interview by telephone with the Director of Maintenance on 12/17/10 at 6:15pm revealed that he was aware of the service repair work completed on 12/13/10 and stated that he did not test the alarm system or visualize a demonstration of the alarm system after the repair. The Director of Maintenance stated he didn't see any reason to check the alarm because, "I took their word for it." Continued interview with the Administrator revealed that the alarm needed to be louder. Furthermore, there was no evidence that the administration increased supervision of the ten residents identified as elopement risk to prevent elopement recurrence while being aware of the door alarm failure. During the demonstration of the alarm with the Administrator, on 12/17/10 at 4:45pm, CNA #6, with three (3) years of service at the facility, was observed asking the Administrator what she should do to locate the resident and that she didn't know what the alarm meant. Review of the Elopement Policy and Procedure revealed there was no documented procedure detailing the use of the alarms or what staff was to do in the event of the alarm. The policy and procedure also did not detail any information about the maintenance of the door alarm system used to identify if a resident had left the unit or the facility. Therefore, the administration did not ensure the Elopement policy and procedure included the use of the door alarms and their maintenance. The administration did not ensure all staff was knowledgeable to the elopement prevention systems the facility had implemented as evidenced by CNA #6's lack of knowledge to what actions should be taken or what the alarms meant.	F 490			



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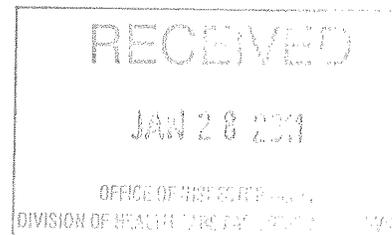
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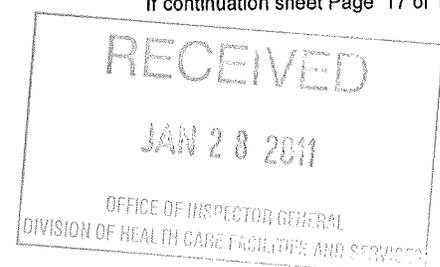
F 490	<p>Continued From page 15</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/21/10. The facility AOC detailed the facility implemented a plan to provide around the clock observation of the West Hall doors by positioning a CNA not involved in resident care to monitor the West Hall doors. The CNA would continue to monitor the doors until a new entry/lock system was installed to be accessed by key only. The alarm would be upgraded to an audible level to alert staff on the West Hall and adjoining units that the emergency exit door had been opened. On the spot in-services were planned to educate staff of the risk of elopement and promote strategies to prevent elopement on the West Hall. The Elopement Policy and Procedure would be updated to include staff responsibilities in the event of an elopement, and in-services and elopement drills were implemented. A monthly audit of the facility's alarm system was implemented. The Vice President of Nursing provided the Assisted Living Residents with a letter outlining preventive actions to avoid elopement, and held a meeting to discuss the risk of elopement on the West Hall.</p> <p>Record review of Elopement In-services provided by the VPN revealed one-hundred (100%) compliance and completed attendance sheets of staff in attendance. The VPN also provided an updated Elopement Policy and Procedure which detailed staff responsibilities during an elopement with attendance sheets, and documentation of an Elopement Drill conducted on 12/20/10. Record review revealed the facility's alarm system audit was completed 12/20/10. The completion of the meeting with the Assisted Living Residents regarding the notice given to ensure elopement</p>	F 490		
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F 490	<p>Continued From page 16 prevention was verified.</p> <p>On 12/20/10 and 12/21/10, observation revealed a CNA was stationed continuously monitoring the West Hall door to prevent elopement. Interview with the CNA confirmed that her job duty was strictly to monitor the door and was not to be used for direct care. Further observation on 12/20/10 revealed a service contractor at the facility installing/upgrading an alarm on the emergency exit door.</p> <p>Interview with the VPN on 12/17/10 at 5:35pm regarding administrative efforts to remove Immediate Jeopardy related to potential elopements revealed a Quality Assurance meeting was scheduled for 12/21/10 to discuss elopement issues. The VPN also stated the Elopement Policy was determined to be inadequate because the policy did not include actions to be taken in case of actual elopement. The VPN reported that the Administrative group met on 12/20/10 to discuss options to further secure the West Hall. The VPN did not know if the Medical Director had been advised of the Immediate Jeopardy which resulted from the elopement of Resident #4 and Resident #5.</p> <p>Interview with the Administrator on 12/20/10 at 3:30pm revealed that the Administrative Group met on 12/20/10 to discuss the Immediate Jeopardy and options to secure the West Hall. The Administrator stated that the Medical Director was not in attendance and did not know if the Medical Director was aware of the Immediate Jeopardy which resulted from the elopement of Resident #4 and Resident #5.</p> <p>The facility provided an acceptable credible</p>	F 490			



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F 490	Continued From page 17 Allegation of Compliance (AOC) on 12/21/10. Immediately Jeopardy was verified to be removed prior to exit on 12/21/10; however, non compliance continues at 42 CFR 483.75 Administration, F490, at a scope and severity of "E."	F 490			

