

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

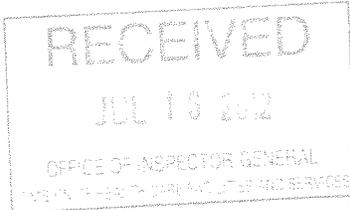
PRINTED: 07/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2012
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NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey KY18538 was initiated on 06/13/12 and concluded on 06/20/12. The allegation was substantiated, with Immediate Jeopardy at 42 CFR 483.20 Resident Assessment (F282) S/S "J" and 42 CFR 483.25 Quality of Care (F323) S/S of "J" and Substandard Quality of Care identified in 42 CFR 483.25 (F323). The Immediate Jeopardy and Substandard Quality of Care was determined to exist on 06/06/12 and the facility was notified on 06/15/12.</p> <p>On 06/06/12 Resident #1 eloped from the facility without staff knowledge, and was found at 6:15 AM in the parking lot adjacent to the facility by a Hospice aide, who was coming to the facility. The facility previously assessed Resident #1, on 04/02/10, at high risk for elopement; however, the physician had ordered the wander guard be discontinued on 11/07/11, after the resident had no further exit seeking behaviors at that time. On 04/06/12, the resident began to have exit seeking behaviors again, with multiple attempts at elopement, and redirection was not effective. From 04/06/12 through 06/06/12, Resident #1 attempted to leave the facility six (6) times. The facility failed to reassess the resident for the wander guard device, which would sound an audible alert to staff when the resident attempted to exit the facility.</p> <p>In addition, the facility had a locking door alarm system in operation at the time of Resident #1's elopement. On 06/06/12, around 1:00 AM, a pharmacy technician exited the building, and nursing staff on the AB Hall reset the front door lock, but failed to reset the alarming sound,</p>	F 000	<p>Plan of Correction</p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p>	
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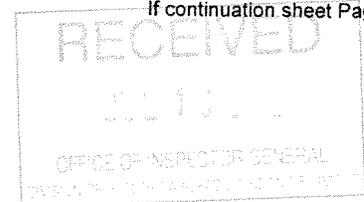
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE X-Administrator	(X6) DATE 7/16/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting 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.

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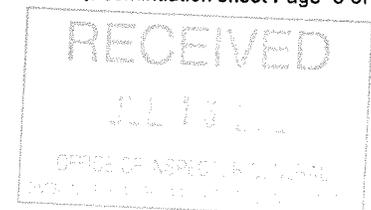
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F 000	Continued From page 1 located at the AB nurse's station, and the alarm continued to sound. With the alarming sound continuing at the AB nurse's station, Resident #1 was able to push on the front door for 15 seconds, causing the emergency exit system to open the doors. The resident was able to exit the front door without staff knowledge on 06/06/12. The facility's failure to provide adequate supervision/monitoring placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 06/15/12 and was found to exist on 06/06/12. An acceptable Allegation of Compliance (AOC) was received, on 06/19/12, alleging Immediate Jeopardy was removed on 06/19/12. The State Agency verified Immediate Jeopardy was removed, on 06/19/12 as alleged, prior to exit of the survey on 06/20/12. The S/S was lowered to a "D" for 42 CFR 483.25 Quality of Care (F323) and CFR 483.20 Resident Assessment (F282), while the facility develops and implements the Plan of Correction to establish and maintain an effective system to ensure residents receive adequate supervision/monitoring to prevent accidents.	F 000	F282 1. Resident #1 was immediately assessed for injury by the Charge Nurse on 06/06/12 and the resident's POA (son) and physician (Dr. Omoruyi) was notified. The assessment for resident #1 did not reveal any injuries. On 06/06/12 the Staff Development Coordinator immediately placed a wander guard on resident #1 and the Unit Manager immediately initiated 15 minute checks which continued through 06/18/12. An order for Trazadone 25mgs was prescribed on 06/06/12 by Dr. Omoruyi, resident physician to help the resident rest. In addition, on 06/06/12, the DNS placed a lavender binder at the receptionist's desk and the nurse's stations equipped with a picture of resident #1 and 8 other residents to serve as a quick reference to inform staff of residents that have been assessed as an elopement risk. 2. All residents were re-assessed for elopement risk by the DON and Unit Managers - initially immediately after elopement on 06/06/2012 - and once again on 06/15/2012 through 06/16/2012 by the DON, Unit Managers, Charge Nurses, and Staff Development Coordinator. The SSD was out of the facility during these assessments. However, when advised of the assessments and the results by the DON on 06/18/12, the SSD agreed with the results of the assessments without recommending changes.		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED 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	F 282			



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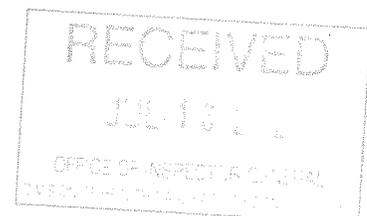
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F 282	Continued From page 2 the facility's policy, it was determined the facility failed to have an effective system to ensure care plan interventions were implemented for one (1) of nine (9) sampled residents (Resident #1) regarding elopement risk. The Comprehensive Care Plan detailed interventions to address the resident's alteration in mood status/behavior related to diagnoses of Depressive Disorder Schizophrenia with mood and behaviors, and wandering, with goals to have a decrease in episodes of exit seeking. Interventions included to observe the resident for changes in mood and behaviors and report these changes to the charge nurse or social services; and, to encourage the resident to remain in the common area due to exit seeking behaviors. However, the facility failed to follow the care plan intervention to report any changes in cognition to the charge nurse or social service when the resident exhibited exit seeking behaviors. Resident #1 was admitted, on 04/02/10, and had a past history of risk for elopement; however, his/her wander guard bracelet had been discontinued by the physician on 11/07/11, due to no further exit seeking behaviors. On 04/06/12, the resident began to have exit seeking behaviors again, with multiple attempts of elopement, and redirection of the resident was not effective. From 04/06/12 through 06/06/12, Resident #1 attempted to leave the facility six (6) times. On 06/06/12, Resident #1 exited the building in a wheelchair and was out of the facility for approximately 20 minutes when a Hospice aide found the resident in the parking lot, adjacent to the building, and brought the resident back into the building with no injury assessed by staff. (Refer to F323).	F 282	2 Continued. On 07/13/12 the SSD initialed all At Risk Elopement Forms to show agreement. The second reassessment was accompanied by a revision of the Elopement Policy and Procedure which was the addition of a form named "At Risk for Elopement Pre-Assessment", in which all nurses have been instructed from 06/18/12 to 07/10/12 to complete when elopement at risk behaviors are noted in any resident, as well as upon admission. The "At Risk for Elopement Pre-Assessment form" is now included in admission paperwork given to charge nurses to complete by Medical Records staff. This initial in-servicing will be upheld for all nurses via monthly in-servicing x 12 months; and then quarterly thereafter by the DON and/or Staff Development Coordinator. All new nurses will receive this in-service upon orientation. The DON and/or Staff Development Coordinator will complete all in-services. In addition, residents exhibiting behavior that places them as risk for elopement will be re-evaluated immediately by their charge nurse. The MDS Coordinators will also evaluate the residents during their quarterly MDS review for significant changes including at risk for elopement behaviors.		



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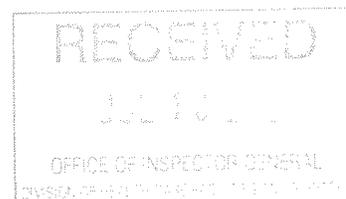
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F 282	Continued From page 3 The facility failed to follow the resident's care plan intervention to report changes and reassess for risk for elopement. The facility's failure to follow the plan of care placed residents at risk for elopement in a situation that is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified, on 06/15/12, and was determined to exist, on 06/06/12. The facility provided a credible Allegation of Compliance (AOC) on 06/19/12, alleging Immediate Jeopardy was removed on 06/19/12. The State Agency verified Immediate Jeopardy was removed, on 06/19/12, prior to exit, on 06/20/12, which lowered the scope and severity to a "D" while the facility's Quality Assurance Committee monitors the effectiveness of implemented action plans to achieve and maintain compliance. The findings include: The facility did not have a specific policy on following the Comprehensive Care Plan; however, interventions were addressed in the facility's Elopement Policy, revised July 2008, regarding sample care plan interventions to develop and follow for residents who attempted elopement after admission and when needed. Those interventions included: 1) account for residents at risk for elopement every 15-30 minutes; 2) provide the resident with a wrist or ankle identification bracelet; 3) mark the resident's clothing with his/her name; 4) photograph the resident on admission and PRN and keep in designated place; 5) require sign-out	F 282	2. Continued Policy and Procedure was developed by DON and members of the Care Plan team (MDS Coordinators, Unit Managers, Social Services Director), Medical Records Director and the Staff Development Coordinator on 06/27/2012 regarding communicating and following new plan of care orders. This new policy details that charge nurses will be responsible for the ongoing supervision, observation, and the driving of individual care concerns and preferences of each resident. If there is a change in condition or change in plan of care – be it addition or discontinuation - the MDS coordinators will update all Nursing and Dietary care plans and communicate this to Social Services to update the cognitive/mood and behaviors section of the care plan including the elopement as risk care plan. The Activity Director will update the Activities care plan. The MDS Coordinator will pass the order on to Medical Records to be input into the computer database. If applicable, the SSD will report changes to the care plan to the behavior committee on a monthly basis to determine if further action is necessary. This new policy also educates charge nurses on how to write a plan of care order and how to discontinue a plan of care order. The Staff Development Coordinator began in-servicing of all nurses on 07/02/2012 and completed in-servicing for all nurses by 07/11/2012.		



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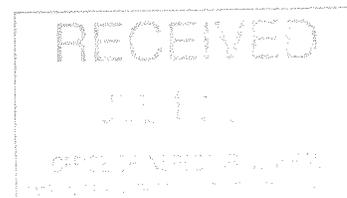
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F 282	<p>Continued From page 4</p> <p>sheets at nurses' station; 6) use door alarms; 7) use of video cameras; 8) use of resident safety alarms; and, 9) provide appropriate activities.</p> <p>Review of the clinical record revealed Resident #1 had an admission date of 04/02/10, with diagnoses of Senile Dementia with Disturbance Mood and Behavior, and Depression with Psychotic Features. The facility initially assessed Resident #1, on 04/02/10, for high risk for elopement based on the resident's impaired cognition and exit seeking behaviors, and placed a wander guard bracelet on the resident at that time. However, on 11/07/11, the physician ordered the wander guard to be discontinued due to no further exit seeking behaviors. Review of the nurse's notes revealed on 04/06/12, the resident began to have exit seeking behaviors again, with multiple attempts at elopement, and redirection was not effective. From 04/06/12 until the time of the elopement on 06/06/12, Resident #1 attempted to leave the facility six (6) times on 04/06/12, 04/24/12, 04/28/12, 05/19/12, 05/21/12, and 05/25/12.</p> <p>Review of Resident #1's last quarterly assessment, dated 04/30/12, revealed the resident had evidence of wandering coded as occurring 1-3 days; however, the facility failed to reassess the resident for the risk of elopement or apply the wander guard device. There was no evidence the resident had been assessed for risk for elopement although multiple nurse's notes indicated exit seeking behavior exhibited by Resident # 1.</p> <p>Review of the Care Plan, dated 05/09/12, for Resident #1, revealed facility interventions to</p>	F 282	<p>3. On 06/06/12 through 07/05/12, the Staff Development Coordinator began in-servicing all nurses on how to properly assess and supervise our residents by utilizing the Elopement Policy and Procedure, Care Plan Policy and Procedure, and Wander Guard Policy and Procedure. The importance of knowing where our residents are and their current status was highlighted in the in services listed above, as monitoring and supervising all residents to keep them safe are our most important responsibility. On 06/06/12 through 07/10/12, the Environmental Services Director (ESD) and Staff Development Coordinator provided education to all staff in regards to properly resetting and recognizing all door alarms and how to respond when exit seeking behavior is exhibited to ensure that all residents are/remain safe. During this in-service, the ESD and the SDC also educated all staff on the importance off knowing where our residents are and their current status in specific regard to resident supervision and what to do if exit seeking behaviors or other concerns are noted that are uncommon to their resident.</p>		



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F 282	Continued From page 5 address the resident's alteration in mood status/ behavior related to diagnoses of Depressive Disorder Schizophrenia with Mood and Behaviors, Anxiety, Delusions, and Wandering, with goals to have a decrease in episodes of exit seeking. However, the resident continued exit seeking behavior on three occasions: 05/19/12; 05/21/12; and 05/25/12. Interventions included to observe for changes in mood and behaviors and report these changes to charge nurse or social services, and to encourage resident to remain in common area due to exit seeking behaviors. In addition, interventions included providing cues and supervision as needed. Interview with the MDS Assessment Nurse, on 06/19/12 at 2:45 PM, revealed the Social Services Director was responsible for completion of the Cognition Section of the Comprehensive Assessment; however, stated she did not always attend the care plan meetings. The MDS Assessment Nurse stated the issue with elopement could have been prevented if the resident had been reassessed, and followed through the care plan process with application of a wander guard. Interview with the Social Services Director, on 06/19/12 at 2:30 PM, revealed she was responsible for completion of the Cognition Section of the Comprehensive Assessment and reviewed residents who were exit seeking or have exhibited behaviors; however, stated she did not consider pacing to be an exit seeking behavior. In addition, the Social Services Director stated there was knowledge that Resident #1 was noted to be wandering in April 2012, prior to the elopement; however, she did not consider this at	F 282	3. Continued The MDS Coordinator was re-educated on the MDS process, resident assessment with change of condition, care planning and behavior interventions by the Good Samaritan Society (GSS) Rehabilitation Skilled Care Consultant on 06/15/12 via conference call. The MDS Coordinator completed GSS learning center courses titled 1. Dementia: Wandering and Elopement and 2. Elopement: Do you know where your resident is on 06/15/12. The Lead MDS Coordinator completed the GSS Learning Center courses on 6/18/12 as she was previously out of the facility on Medical Leave. The Social Worker was re-educated on the following: 1. the need for on going assessment of resident changes in condition 2. When changes in condition are noted, this information needs to be included and/or updated in the resident's care plan 3. If resident's MDS is coded for wandering, this should be assessed and care planned as needed. This training was completed by GSS Rehabilitation Skilled Care Consultant via telephone conference on 06/15/12. The Social Workers completed the GSS Learning Center courses titled 1. Dementia: Wandering and Elopement and 2. Elopement: Do you know where your resident is on 06/17/12 and 06/18/12 respectively.		



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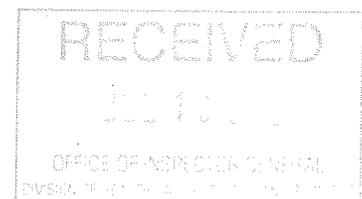
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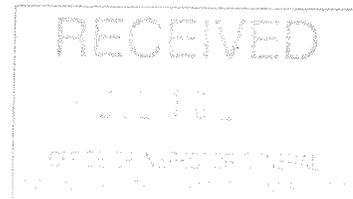
F 282	<p>Continued From page 6</p> <p>the time. Interview revealed the care plan intervention of observing and reassessing the resident's behavior had not been followed.</p> <p>Interview with the Unit Manager on the A/B Hall, on 06/14/12 at 5:15 PM, revealed the floor nurses were responsible to ensure that care plans were followed, and were responsible for identifying the need for reassessment and updating the plan of care.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 06/15/12 at 1:30 PM, revealed any residents exhibiting behaviors should be re-assessed, and the care plan and CNA care plan should be updated. Per interview, nurses were responsible to ensure care plans were being followed.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 06/15/12 at 11:00 PM, revealed Resident #1 had been wandering and combative with redirection most of the night on 06/06/12 (11-7 shift). The CNA stated she was responsible for Resident #1 and stated the resident had rolled him/herself around the facility. CNA #4 also stated when she started her rounds that evening, she had to make sure the resident was still on the unit each time she came out of a resident's room. CNA #4 revealed Resident #1 tried to get out of the facility all the time, and this had been reported to the floor nurse. The CNA stated the resident needed a wander guard, but did not know why he/she did not have one. CNA #4 revealed the resident had behaviors listed on the CNA care plan and to report to the nurse any behaviors.</p> <p>Interview with the Director of Nursing (DON), on 06/14/12 at 12:30 PM, revealed Resident #1's</p>	F 282	<p>3. Continued</p> <p>The Environmental Services Director or Housekeeping Supervisor will provide education to all newly hired staff during orientation in regards to properly resetting and recognizing all door alarms and how to respond to ensure that all residents are/remain safe. The Environmental Services Director will have 50% of newly hired employees to conduct return demonstrations on how to properly reset alarms. Door alarm systems were checked on 06/06/2012 for proficiency by Environmental Services Director that ensured safe response of security measures. Alarm manufacturer was contacted on 06/07/2012 in order to discuss and prepare for added intervention and addition to alarm system. It was determined that the addition would be the implementation of a voice activated alarm system, which will clearly denote by which doorway a resident is located threatening potential elopement.</p> <p>This measure will be completed by 07/11/12. All staff understands how to reset the new alarm as it was discussed during the training which was provided to all staff and completed on 07/10/12. Resetting the new alarm follows the same steps of the last system with the exception of the last step. The last step requires staff to lift up and replace the receiver of the nurse call system on the AB Unit. All staff were informed during the training which was completed on 07/10/12 that the last step would no longer be required to set the alarm.</p>	
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F 282	<p>Continued From page 7</p> <p>care plan interventions for cognitive deficit should have been followed by reporting the wandering behaviors, and the resident should have been reassessed for elopement risk after exhibiting exit seeking behaviors beginning on 04/06/12. Interview further revealed if the resident had been reassessed and received a wander guard device, prior to 06/06/12, the elopement could have been prevented, because there would have been a different sounding alarm from the door alarm.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility took the following actions:</p> <ol style="list-style-type: none"> 1. Upon return to the facility on 06/06/12, Resident #1 was assessed and found to have no injuries. A wander guard bracelet was applied. Resident #1 was reassessed for wandering/elopement behavior. Fifteen minute checks were initiated on 06/06/12, and monitored. The facility initiated an investigation on 06/06/12. 2. All elopement risk assessments which included the resident census of eighty-five (85) were completed on 06/06/12 with care plans and Certified Nurse Aide plans of care updated. All residents were re-assessed for wandering behaviors and wander guards applied for resident safety, by 6/16/12, by Unit Managers, Weekend Supervisor, or Staff development nurse. The facility determined nine (9) residents to be at risk for elopement. 3. The Staff Development Nurse re-trained all nursing staff on 06/06/12, to include Policies on "How to properly assess and supervise the resident at risk for elopement", " Elopement Policy and Procedure", " Care Plan Policy and 	F 282	<p>3. Continued</p> <p>However, the ESD and SDC will continue to rein-service all staff as they report for duty and randomly select employees to conduct return demonstrations to ensure understanding. In addition, written correspondence was developed by the Administrator on 7/11/12 on the changes to the alarm system and how to reset the new system to be given to all staff during the next pay period. From 06/06/2012 forward, the Environmental Services Director, Weekend Supervisor, and/or Charge Nurse will keep a written log of daily security measure checks and a written log that proves that mechanism malfunction will be accounted for. Digital photography detailing the likeness of each at risk for Elopement Residents was placed at front lobby receptionist entrance, as well as at each nurse's station in dark lavender binders labeled QUICK REFERENCE BINDER on 06/06/2012 by the DNS. Written correspondence dictated by Environmental Services Director as how to reset alarms and trouble shooting for door alarms was placed at receptionist desk, and at each nurse's station on 06/06/2012 by the DNS. All residents were re-assessed for elopement risk by the DON and Unit Managers - initially immediately after elopement on 06/06/2012 - and once again on 06/15/2012 through 06/16/2012 by the DON, Unit Managers, Charge Nurses, and Staff Development Coordinator. The SSD was out of the facility during these assessments.</p>		



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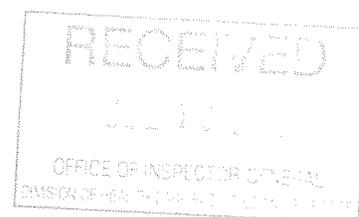
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2012
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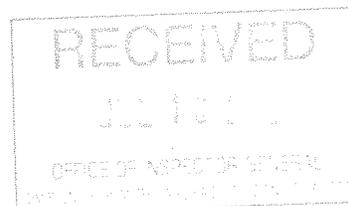
F 282	<p>Continued From page 8 procedure", "Wander Guard Policy and Procedure." The Wander Guard Policy was revised on 06/06/12 by the Director of Nursing.</p> <p>4. A new Quick Reference Binder was developed, on 06/06/12, to identify all residents assessed at risk for elopement. The binder will identify each resident assessed for elopement with a digital photo of the resident and will also contain policies for Elopement, Wander Guard, and the Door Alarm Systems.</p> <p>5. A revision was completed for the Resident at Risk for Elopement Policy on 06/15/12 by the Director Nursing Services, with the new Pre-Assessment Form initiated. All (PRN) 'as needed' staff have been called and notified that they will not be able to work until they receive the in-services.</p> <p>6. All resident care plans were revised and all care plans updated and ensured that all residents at risk were identified. Through this process the Unit Managers and floor nurses will ensure implementation of the care plan interventions. All resident care plans will be audited for proficiency and effectiveness by 6/18/12 by Medical record Staff.</p> <p>7. The Rehabilitation/Skilled Care Consultant re-educated the MDS Assessment Nurse, on 06/15/12 via conference call, regarding reassessment with change of condition, care planning and behavior interventions. The MDS Assessment Nurse will also complete the Good Samaritan Society's Learning Center courses titled: 1) Dementia: Wandering and Elopement; and 2) Elopement: Do you Know Where Your</p>	F 282	<p>3. Continued</p> <p>However, when advised of the assessments and the results by the DON on 06/18/12, the SSD agreed with the results of the assessments without recommending changes. On 07/13/12 the SSD initialed all At Risk Elopement Forms to show agreement. The second reassessment was accompanied by a revision of the Elopement Policy and Procedure which was the addition of a form named "At Risk for Elopement Pre-Assessment", in which all nurses have been instructed from 06/18/12 to 07/10/12 to complete when elopement at risk behaviors are noted in any resident, as well as upon admission.</p> <p>The "At Risk for Elopement Pre-Assessment form" is now included in admission paperwork given to charge nurses to complete by Medical Records staff. This initial in-servicing will be upheld for all nurses via monthly in-servicing x 12 months; and then quarterly thereafter. All new nurses will receive this in-service upon orientation. The DNS and/or Staff Development Coordinator will complete all in-services. In addition, residents exhibiting behavior that places them as risk for elopement will be re-evaluated immediately by their charge nurse. The MDS Coordinators will also evaluate the residents during their quarterly MDS review for significant changes including at risk for elopement behaviors.</p>	
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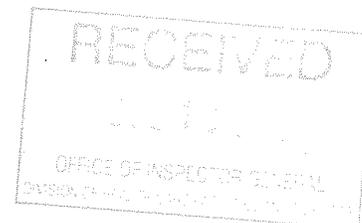
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F 282	Continued From page 9 Resident Is? This was completed on 6/15/12. The Alternate MDS Assessment Nurse was educated on 06/18/12 utilizing the above course titles. 8. The Social Worker Consultant, via telephone conference on 06/15/12, re-educated the Social Services Director regarding need for on-going assessment of resident changes in condition, updating changes in condition on the resident's care plan, and assessment and care planning if the comprehensive assessments are coded for wandering. The Social Services Director will complete the Learning Center courses for: 1) Dementia: Wandering and Elopement; and 2) Elopement: Do you Know Where Your Resident Is? (completed on 06/15/12). The part time Social Services worker was educated on 06/18/12. 9. QA measures were put into place, on 06/06/12 by the Administrator, DON, Social Services Director, Environmental Services Director, along with consultation of the Medical Director, and the Rehabilitation/Skilled Care Consultant. These QA measures included all residents to be reassessed for elopement after the incident, all care plans to be updated, all staff to be trained on the elopement policy, door alarm system, and updating and following care plans. The informal Continuous Quality Improvement (CQI) meeting discussed and devised a plan to ensure the safety of each resident in the facility. This had been discussed on a daily basis since the elopement occurred on 06/06/12. The Director of Nursing, Unit Managers, Weekend Supervisor, or Staff Development nurse will complete chart audits for all residents exhibiting wandering	F 282	4. The DON, Unit Managers, Weekend Supervisor and/or Staff Development will complete chart audits for 100% of residents exhibiting wandering behavior weekly x 4, then monthly x 2 to ensure assessments are completed, safety devices are in place and care plans are updated. The HR Director will complete a weekly review of newly hired staff's orientation records to ensure that all newly hired staff is trained during orientation on how to properly reset and recognize all door alarms, and to ensure that 50% of newly hired employees are conducting return demonstrations of how to properly reset an alarm. The Unit Manager will ensure that the Quick reference binders which contains information on residents that are at risk for elopement and are located at the receptionist desk and the nurse's stations are updated as needed but no less than weekly x 12 and will continue to update them on an as needed basis but no less than weekly thereafter. The Administrator will conduct random review of the Quick reference binders located at the receptionist desk and the nurse's station to ensure that it is being updated as needed but no less than weekly to ensure compliance. The results of the audits will be reported to QA Committee. If non compliance with is determined re-education and/or corrective action up to and including termination will occur as well as continued monitoring will be recommended in a timeframe of no less than monthly by the QA committee. 5. All corrective measures will be completed by 07/13/12.		



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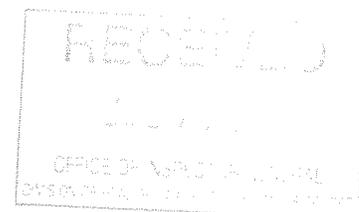
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F 282	Continued From page 10 behavior weekly x4, then monthly x 2 to ensure assessments are completed, safety devices are in place. and care plans are updated. An audit tool (unnamed) was developed and will be submitted to Continuous Quality Improvement (CQI)committee for further recommendations. The State Agency validated the AOC as follows: 1. The State Agency validated, through record review, the assessment of Resident #1, dated 06/06/12, was documented in the nurses notes. The State Agency validated through record review, evidence of 15 minute checks completed for Resident #1, on 06/06/12. Observations of Resident #1, on 06/13/12 at 10:25 AM, and 10:40 AM, and on 06/14/12 at 11:30 AM, revealed the resident sitting in the common area fully dressed sitting in a wheelchair at the table. The resident had his/her head on the table and appeared to be sleeping. A wander guard, and tab alarm was being utilized by the resident. 2. The State Agency validated through record review, and observation that the nine (9) residents (#1, 2, 3, 7, 8, 9, 10, 11, 12) found to be at risk for elopement on 06/06/12, were reassessed, and care plans developed. This included the complete resident census of eighty-five (85) residents. This was verified on 06/19/12, with updated care plans for all nine resident determined by the facility to be at risk for elopement. 3. The State Agency validated through record review evidence of education provided to staff which included policies for: Elopement Policy, Assessment and Intervention for residents at risk	F 282			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 11 for elopement, Care Plan Updating, and Supervision of care. Training was completed on 06/06/12, 06/15/12, 06/16/12, and 06/18/12. The facility staff roster indicted one-hundred and thirty-two (132) of the one-hundred and sixty one (161) total staff had been educated by 06/18/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remaining thirty-two (32) prior to the date of their return to work. In addition, the State Agency verified through record review and interview, the revision of the Wander Guard Policy revised on 06/06/12 by the DON. This was verified on 06/19/12 during interviews with LPN #1 and LPN #10 at 2:00 PM, LPN #6 at 2:45 PM, LPN #8 at 3:20 PM, LPN #9 at 3:40 PM and LPN #7 at 4:35. The State Agency validated through interview with the staff and record review that the revision of the Elopement Policies and Wander Guard Policies were completed and provided to the staff by 06/18/12. This was verified on 06/19/12 by CNA #2 at 10:35 PM, CNA # 3 at 11:05 PM, CNA #4 at 11:00 PM, and CNA # 5 at 10:30 PM. 4. The State Agency validated through record review and interviews with the Receptionist on 06/19/12 at 2:30 PM, and interviews with LPN #1 at 2:00 PM, LPN #6 at 2:45 PM, LPN #7 at 4:35, LPN #8 at 3:20 PM, LPN #9 at 3:40 PM, and LPN #10 at 2:00 PM, that a Dark Lavender Quick Reference Binder was located at the front entrance and at both nurse's station. All binders contained photos of all nine residents identified at risk for elopement with policies and procedures regarding elopement procedures, and wander guard policy. 5. The State Agency validated through record	F 282			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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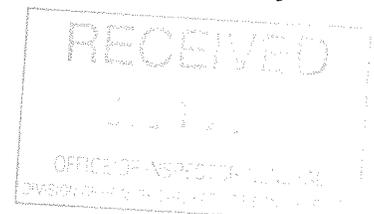
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F 282	Continued From page 12 review, and interview, on 06/19/12 at 11:45 AM, with the Staff Development Nurse, the revised policy for residents at risk for elopement, revised on 06/15/12 by the DON, with the new Pre-Assessment Form initiated. Review of the 9 residents assessed at risk for elopement verified the new Pre-Assessment Form had been completed for each resident. Documentation reviewed and interview with the Staff Development Coordinator, on 06/19/12 at 11:45 AM, regarding notification of all 'as needed staff' revealed that they would not be able to work until they received the in-services. 6. The State Agency validated through record review that all resident care plans were audited for proficiency and effectiveness by 6/18/12 by Medical Records staff. This was verified on 06/19/12. 7. The State Agency validated through record review and interview with the MDS Assessment Nurse, on 06/19/12 at 2:30 PM, the education was received, on 06/15/12, via conference call with the Rehabilitation/Skilled Care Consultant and the Education Courses, were completed on 6/15/12. Review of training shows the Alternate MDS Assessment Nurse received education on 06/18/12. 8. The State Agency validated re-education of the Social Services Director by the Social Worker Consultant via telephone conference, on 06/15/12, regarding need for on-going assessment of resident changes in condition, updating changes in condition on the resident's care plan, and assessment and care planning if Comprehensive Assessments are coded for	F 282			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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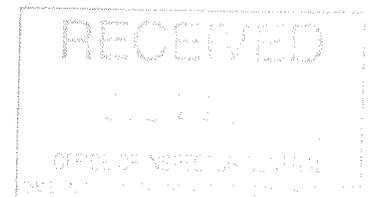
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F 282	Continued From page 13 wandering. Training Courses were verified, on 06/19/12, and was completed by Social Services Director, on 06/15/12, and the part time Social Services worker was educated on 06/18/12. 9. The State Agency validated through interview with the Administrator, on 06/19/12 at 2:30 PM, and interview with the Director of Nursing, on 06/19/12 at 12:30 PM, and record review revealed the QA measures were put into place, on 06/06/12, by the Administrator, DON, Social Services Director, Environmental Services Director, and Rehabilitation/Skilled Care Consultant. The State Agency verified through interview, on 06/19/12 at 1:00 PM, and record review that the Medical Director was consulted on 06/06/12 via telephone conference. The informal Continuous Quality Improvement (CQI) meeting was verified on 06/19/12, to have occurred on 06/06/12. QA measures included Interventions to reassess all residents, identify residents at risk, train all staff on following and updating care plans, were put into place on 06/06/12. The State Agency validated through record review the facility completed an investigation on 06/11/12. The Director of Nursing, Unit Managers, Weekend Supervisor, or Staff Development nurse will complete chart audits for all residents exhibiting wandering behavior weekly x4, then monthly x 2 to ensure assessments are completed and safety devices are in place. The audit tool to be used (unnamed) was reviewed and will be submitted to Continuous Quality Improvement (CQI) committee for further recommendations.	F 282	F323 1. Resident #1 was immediately assessed for injury by the Charge Nurse on 06/06/12 and the resident's POA (son) and physician (Dr. Omoruyi) was notified. The assessment for resident #1 did not reveal any injuries. On 06/06/12 the Staff Development Coordinator immediately placed a wander guard on resident #1 and the Unit Manager immediately initiated 15 minute checks which continued through 06/18/12. An order for Trazadone 25mgs was prescribed on 06/06/12 by Dr. Omoruyi, resident physician to help the resident rest. In addition, on 06/06/12, the DNS placed a lavender binder at the receptionist's desk and the nurse's stations equipped with a picture of resident #1 and 8 other residents to serve as a quick reference to inform staff of residents that have been assessed as an elopement risk. 2. All residents were re-assessed for elopement risk by the DON and Unit Managers - initially immediately after elopement on 06/06/2012 - and once again on 06/15/2012 through 06/16/2012 by the DON, Unit Managers, Charge Nurses, and Staff Development Coordinator. The SSD was out of the facility during these assessments. However, when advised of the assessments and the results by the DON on 06/18/12, the SSD agreed with the results of the assessments without recommending changes.		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			



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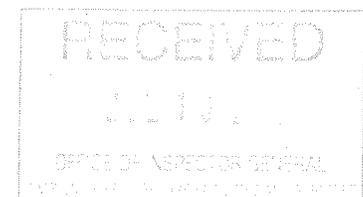
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F 323	Continued From page 14 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and investigative report, it was determined the facility failed to have an effective system to provide adequate assessment, supervision, and monitoring for one (1) of nine (9) sampled residents. (Resident #1) The facility's policy regarding Elopement, was to maintain a system which clearly defined the mechanisms and procedures for monitoring and managing residents at risk for elopement by identifying hazards and resident risks; evaluating/analyzing hazards and risks; implementing interventions; and monitoring/modifying interventions as needed. This included assessment of all residents to be assessed for risk of elopement through the pre-admission and/or admission process and as needed. On 06/06/12, Resident #1 eloped from the facility without staff knowledge, and was found in the parking lot at 6:15 AM, adjacent to the facility by a Hospice aide, who was coming to the facility. The facility previously assessed Resident #1, on 04/02/10, at high risk for elopement; however, the physician had ordered the wander guard be discontinued on 11/07/11,	F 323	2 Continued. On 07/13/12 the SSD initialed all At Risk Elopement Forms to show agreement. The second reassessment was accompanied by a revision of the Elopement Policy and Procedure which was the addition of a form named "At Risk for Elopement Pre-Assessment", in which all nurses have been instructed from 06/18/12 to 07/10/12 to complete when elopement at risk behaviors are noted in any resident, as well as upon admission. The "At Risk for Elopement Pre-Assessment form" is now included in admission paperwork given to charge nurses to complete by Medical Records staff. This initial in-servicing will be upheld for all nurses via monthly in-servicing x 12 months; and then quarterly thereafter by the DON and/or Staff Development Coordinator. All new nurses will receive this in-service upon orientation. The DON and/or Staff Development Coordinator will complete all in-services. In addition, residents exhibiting behavior that places them as risk for elopement will be re-evaluated immediately by their charge nurse. The MDS Coordinators will also evaluate the residents during their quarterly MDS review for significant changes including at risk for elopement behaviors.		



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F 323	<p>Continued From page 15</p> <p>after the resident had no further exit seeking behaviors at that time. On 04/06/12, the resident began exhibiting exit seeking behaviors, with multiple attempts at elopement, and redirection was not effective. From 04/06/12 through 06/06/12, Resident #1 attempted to leave the facility six (6) times on 04/06/12, 04/24/12, 04/28/12, 05/19/12, 05/21/12, and 05/25/12. The facility failed to reassess the resident for elopement risk and the wander guard device, which would sound an audible alert to staff when the resident attempted to exit the facility.</p> <p>In addition, the facility had a locking door alarm system in operation at the time of Resident #1's elopement. On 06/06/12, around 1:00 AM, a pharmacy technician exited the building, and nursing staff on the AB Hall reset the front door lock, but failed to reset the alarming sound, located at the AB nurse's station, and the alarm continued to sound. With the alarming sound continuing at the AB nurse's station, Resident #1 was able to push on the front door for 15 seconds, causing the emergency exit system to open the doors. The resident was able to exit the front door without staff knowledge on 06/06/12. The facility's failure to provide adequate supervision/monitoring placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 06/15/12 and was determined to exist on 06/06/12.</p> <p>The facility provided a credible Allegation of Compliance (AOC) on 06/19/12 alleging Immediate Jeopardy was removed on 06/19/12. The State Agency verified Immediate Jeopardy was removed on 06/19/12 prior to exit on</p>	F 323	<p>2. Continued</p> <p>Policy and Procedure was developed by DON and members of the Care Plan team (MDS Coordinators, Unit Managers, Social Services Director), Medical Records Director and the Staff Development Coordinator on 06/27/2012 regarding communicating and following new plan of care orders. This new policy details that charge nurses will be responsible for the ongoing supervision, observation, and the driving of individual care concerns and preferences of each resident. If there is a change in condition or change in plan of care – be it addition or discontinuation - the MDS coordinators will update all Nursing and Dietary care plans and communicate this to Social Services to update the cognitive/mood and behaviors section of the care plan including the elopement as risk care plan. The Activity Director will update the Activities care plan. The MDS Coordinator will pass the order on to Medical Records to be input into the computer database. If applicable, the SSD will report changes to the care plan to the behavior committee on a monthly basis to determine if further action is necessary.</p> <p>This new policy also educates charge nurses on how to write a plan of care order and how to discontinue a plan of care order. The Staff Development Coordinator began in-servicing of all nurses on 07/02/2012 and completed in-servicing for all nurses by 07/11/2012.</p>	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 16</p> <p>06/20/12, which lowered the scope and severity to a "D", while the facility develops and implements the Plan of Correction to establish and maintain an effective system to ensure residents receive adequate supervision/monitoring to prevent accidents.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Elopement, revised July 2008, revealed all residents would be assessed for risk of elopement through the pre-admission and/or admission process and as needed...8. a resident who was assessed to not be at risk for elopement during the pre-admission process, but begins to exhibit wandering behaviors or attempts to elope would be assessed and monitored in the following way: 1) Any significant changes in the resident's status will be documented in the IDT notes.</p> <p>Review of the facility's investigation dated 06/06/12, revealed Resident #1 exited the facility without staff knowledge. Review of the facility's investigation, dated 06/06/12, revealed Resident #1 exited the building in a wheelchair and was out of the facility for approximately 20 minutes when a Hospice aide found him/her in the parking lot, adjacent to the building, and brought the resident back into the building. The resident was assessed by nursing staff and no injuries were found. No medical interventions were required. Nursing staff initiated 15 minute checks on Resident #1 at that time. The investigation also revealed the resident had episodes of confusion and had short term and long term memory loss, with psychiatric services was following on an as needed basis. The resident could not remember the incident.</p>	F 323	<p>3. On 06/06/12 through 07/05/12, the Staff Development Coordinator began in-servicing all nurses on how to properly assess and supervise our residents by utilizing the Elopement Policy and Procedure, Care Plan Policy and Procedure, and Wander Guard Policy and Procedure. The importance of knowing where our residents are and their current status was highlighted in the in services listed above, as monitoring and supervising all residents to keep them safe are our most important responsibility. On 06/06/12 through 07/10/12, the Environmental Services Director (ESD) and Staff Development Coordinator provided education to all staff in regards to properly resetting and recognizing all door alarms and how to respond when exit seeking behavior is exhibited to ensure that all residents are/remain safe. During this in-service, the ESD and the SDC also educated all staff on the importance off knowing where our residents are and their current status in specific regard to resident supervision and what to do if exit seeking behaviors or other concerns are noted that are uncommon to their resident.</p>		



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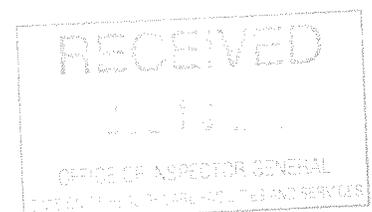
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F 323	Continued From page 17 Record review revealed Resident #1 was admitted, on 04/02/10, with multiple diagnoses that included Senile Dementia with Disturbance Mood and Behavior, and Depression with Psychotic Features. The facility initially assessed Resident #1, on 04/02/10, as high risk for elopement based on the resident's impaired cognition and exit seeking behaviors, and placed a wander guard bracelet on the resident at that time. However, on 11/07/11, the physician ordered the wander guard to be discontinued due to no further exit seeking behaviors. On 04/06/12, the resident began to have exit seeking behaviors again, with multiple attempts at elopement, and redirection was not effective. Review of the Nurses notes from 04/06/12 until the time of the elopement, on 06/06/12, revealed Resident #1 attempted to leave the facility six (6) times on 04/06/12, 04/24/12, 04/28/12, 05/19/12, 05/21/12, and 05/25/12. Continued record review revealed a Nurse's note, dated 04/06/12, that stated multiple attempts of elopement with redirection were not effective. Nurse's note, dated 04/24/12, revealed at 3:00 AM, the resident was fretful and exit seeking; stated "I'm going home", and unable to redirect. Nurse's note, dated 04/28/12, revealed a statement from the resident, "Get me out of here". Review of Resident #1's last quarterly assessment, dated 04/30/12, revealed the resident had evidence of wandering coded as occurring 1-3 days; however, the facility failed to reassess the resident for the risk of elopement or apply the wander guard device, which would	F 323	3. Continued The MDS Coordinator was re-educated on the MDS process, resident assessment with change of condition, care planning and behavior interventions by the Good Samaritan Society (GSS) Rehabilitation Skilled Care Consultant on 06/15/12 via conference call. The MDS Coordinator completed GSS learning center courses titled 1. Dementia: Wandering and Elopement and 2. Elopement: Do you know where your resident is on 06/15/12. The Lead MDS Coordinator completed the GSS Learning Center courses on 6/18/12 as she was previously out of the facility on Medical Leave. The Social Worker was re-educated on the following: 1. the need for on going assessment of resident changes in condition 2. When changes in condition are noted, this information needs to be included and/or updated in the resident's care plan 3. If resident's MDS is coded for wandering, this should be assessed and care planned as needed. This training was completed by GSS Rehabilitation Skilled Care Consultant via telephone conference on 06/15/12. The Social Workers completed the GSS Learning Center courses titled 1. Dementia: Wandering and Elopement and 2. Elopement: Do you know where your resident is on 06/17/12 and 06/18/12 respectively.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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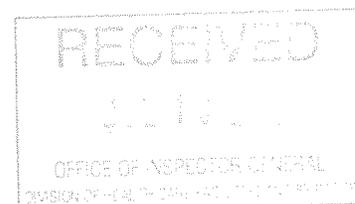
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F 323	<p>Continued From page 18</p> <p>sound an audible alert to staff when the resident attempted to exit the facility. Review of the Behavior care plan, updated on 05/09/12, revealed the resident had wandering behaviors with interventions to observe for changes in mood and behaviors, and report to the nurse or social services.</p> <p>Further review of a Nurse's note, dated 05/19/12, revealed the resident tried to leave through the front doors and the receptionist tried to bring the resident back inside. The resident became combative with staff, hitting and pulling at them. The Nurse's note, dated 05/21/12, revealed the resident had increased behaviors with exit seeking behavior. A Urinalysis was obtained at that time, and the results were negative. The Nurse's note, dated 05/25/12, revealed the resident tried to leave the facility several times.</p> <p>Interview with the MDS Assessment Nurse, on 06/19/12 at 2:45 PM, revealed the Social Services Director was responsible for completion of the Cognition Section of the Comprehensive Assessment; however, stated she did not always attend the care plan meetings. The MDS Assessment Nurse stated the issue with elopement could have been prevented if the resident had been reassessed, and followed through the care plan process with application of a wander guard.</p> <p>Interview with the Social Services Director, on 06/19/12 at 2:30 PM, revealed she was responsible for completion of the Cognition Section of the MDS Assessment, and reviewed for residents who were exit seeking or exhibited behaviors. The Social Services Director stated</p>	F 323	<p>3. Continued</p> <p>The Environmental Services Director or Housekeeping Supervisor will provide education to all newly hired staff during orientation in regards to properly resetting and recognizing all door alarms and how to respond to ensure that all residents are/remain safe. The Environmental Services Director will have 50% of newly hired employees to conduct return demonstrations on how to properly reset alarms. Door alarm systems were checked on 06/06/2012 for proficiency by Environmental Services Director that ensured safe response of security measures. Alarm manufacturer was contacted on 06/07/2012 in order to discuss and prepare for added intervention and addition to alarm system. It was determined that the addition would be the implementation of a voice activated alarm system, which will clearly denote by which doorway a resident is located threatening potential elopement.</p> <p>This measure will be completed by 07/11/12. All staff understands how to reset the new alarm as it was discussed during the training which was provided to all staff and completed on 07/10/12. Resetting the new alarm follows the same steps of the last system with the exception of the last step. The last step requires staff to lift up and replace the receiver of the nurse call system on the AB Unit. All staff were informed during the training which was completed on 07/10/12 that the last step would no longer be required to set the alarm.</p>		



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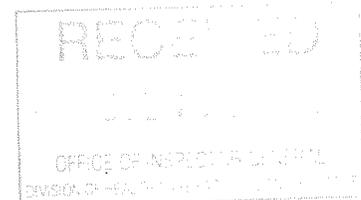
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F 323	Continued From page 19 she previously did not consider pacing to be an exit seeking behavior; however, she had been trained since the elopement, and would consider this behavior in the future. In addition, the Social Services Director stated Resident #1 was noted to be wandering around in April 2012, prior to the elopement, and did not consider this as a risk at that time. The Social Service Director was aware of the policy regarding elopement; however, had not followed the policy related to wandering. Interview with CNA #4, on 06/15/12 at 11:00 PM, revealed she was responsible for Resident #1 on 06/06/12 (11-7 shift) and stated the resident was up all night in the wheelchair, rolling around the facility, and tried to get out on several other nights she worked. CNA #4 stated the resident had to be watched very closely, especially at night. The CNA stated the resident needed a wander guard, but did not know why he/she did not have one. The CNA revealed she last saw the resident around 5:00 AM, because she had to start her rounds, and tried to come out of each room and look for Resident #1. However, at 6:20 AM, the CNA noticed Resident #1 was not on the unit and started to search all units and went to the front lobby, when a Hospice aide was noted returning the resident through the front door. CNA #4 also revealed the front door alarm sounded around 2:00 AM, and she went to reset the front door. She stated she did not hear the door alarm again, because it sounds similar to the call lights, and didn't notice if it was the door alarm or the call light. Interview with Certified Nurse Aide (CNA) #5, on 06/15/12 at 10:30 PM, revealed she had been asked to go to the front door and reset the alarm	F 323	3. Continued However, the ESD and SDC will continue to rein-service all staff as they report for duty and randomly select employees to conduct return demonstrations to ensure understanding. In addition, written correspondence was developed by the Administrator on 7/11/12 on the changes to the alarm system and how to reset the new system to be given to all staff during the next pay period. From 06/06/2012 forward, the Environmental Services Director, Weekend Supervisor, and/or Charge Nurse will keep a written log of daily security measure checks and a written log that proves that mechanism malfunction will be accounted for. Digital photography detailing the likeness of each at risk for Elopement Residents was placed at front lobby receptionist entrance, as well as at each nurse's station in dark lavender binders labeled QUICK REFERENCE BINDER on 06/06/2012 by the DNS. Written correspondence dictated by Environmental Services Director as how to reset alarms and trouble shooting for door alarms was placed at receptionist desk, and at each nurse's station on 06/06/2012 by the DNS. All residents were re-assessed for elopement risk by the DON and Unit Managers - initially immediately after elopement on 06/06/2012 - and once again on 06/15/2012 through 06/16/2012 by the DON, Unit Managers, Charge Nurses, and Staff Development Coordinator. The SSD was out of the facility during these assessments.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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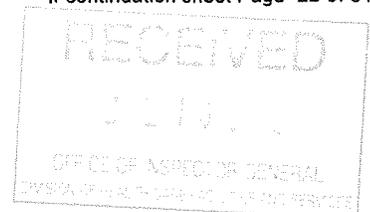
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F 323	<p>Continued From page 20 around 1-2 AM, and did not hear an alarm after that. The CNA stated that all the alarms sound the same.</p> <p>Interview with Licensed Practical Nurse #3, on 06/14/12 at 9:15 PM, revealed she remembered hearing the alarm sound around 2:00 AM; however, stated that alarms sound all night long. She stated she knew how to reset the alarms, and received training on how to reset; however, the alarm sounded again around 4:00 AM, and she was unable to turn off the alarm mechanism at the nurses station. LPN #3 revealed she spoke with the nurse on the C/D Hall, who told her to put a book over the alarm mechanism to muffle the sound; however, stated she did not do this. LPN #3 stated when the Unit Manager came in at 6:00 AM, she also could not get the alarm to turn off, and then called the Maintenance Director. Attempts were made to contact the C/D Nurse, with messages left to call; however, she did not return the call. LPN #3 revealed she should have called the physician and updated the care plan for elopement risk that night, however she did not do it. Both LPN #3 and the C/D Nurse were terminated from employment at the facility.</p> <p>Review of the investigation and interview with Unit Manager #1, on 06/14/12 at 5:15 PM, revealed she received a call from the C/D nurse on 06/06/12, around 6:00 AM, who stated they could see Resident #1 on the cameras, between the glass doors out front. The Unit Manager stated alarms were sounding, but did not distinguish the type of alarm at the time, since the alarms that ring for the call bells sound similar. The Unit Manager stated she did not see any problems</p>	F 323	<p>3. Continued However, when advised of the assessments and the results by the DON on 06/18/12, the SSD agreed with the results of the assessments without recommending changes. On 07/13/12 the SSD initialed all At Risk Elopement Forms to show agreement. The second reassessment was accompanied by a revision of the Elopement Policy and Procedure which was the addition of a form named "At Risk for Elopement Pre-Assessment", in which all nurses have been instructed from 06/18/12 to 07/10/12 to complete when elopement at risk behaviors are noted in any resident, as well as upon admission.</p> <p>The "At Risk for Elopement Pre-Assessment form" is now included in admission paperwork given to charge nurses to complete by Medical Records staff. This initial in-servicing will be upheld for all nurses via monthly in-servicing x 12 months; and then quarterly thereafter. All new nurses will receive this in-service upon orientation. The DNS and/or Staff Development Coordinator will complete all in-services. In addition, residents exhibiting behavior that places them as risk for elopement will be re-evaluated immediately by their charge nurse. The MDS Coordinators will also evaluate the residents during their quarterly MDS review for significant changes including at risk for elopement behaviors.</p>		



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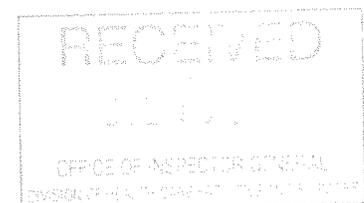
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F 323	<p>Continued From page 21</p> <p>with the alarm system at that time. She stated Resident #1 was brought back to his/her room, was assessed, and had no injury.</p> <p>Interview with the Director of Nursing (DON), on 06/14/12 at 12:30 PM, revealed Resident #1 should have been reassessed for elopement after exhibiting exit seeking behaviors beginning on 04/06/12. Further interview revealed both nurses on duty, on 06/06/12, should have called the Maintenance Director, Administrator, or Director of Nursing when the alarm would not silence. Interview further revealed if the resident had been wearing a wander guard device, on 06/06/12, the elopement could have been prevented, because there would have been a different sounding alarm from the door alarm. Per interview, the DON revealed, according to interview with CNA #4, she was with Resident #1 all night long, because of the exit seeking, and did not leave Resident #1 until approximately 5:00 AM to do her rounds.</p> <p>Interview with the Administrator, on 06/14/12 at 2:30 PM, and review of the facility's investigation, revealed the facility utilized the Wander Guard Alert System and the Locking Door Alarm system to provide safety for residents who were evaluated to be at risk for elopement. Per interview and review of the facility's investigation, nursing staff did not hear the door alarm on the AB Hall, on 06/06/12, when Resident #1 exited the facility, because the alarm was already sounding. Further interview revealed the facility's investigation determined the front doors had been reset by staff, after the pharmacy technician exited the building around 1-2 AM; however, staff failed to go back to the AB nurses station, pick up the phone on the alarm system, and replace the</p>	F 323	<p>4. The DON, Unit Managers, Weekend Supervisor and/or Staff Development will complete chart audits for 100% of residents exhibiting wandering behavior weekly x 4, then monthly x 2 to ensure assessments are completed, safety devices are in place and care plans are updated. The HR Director will complete a weekly review of newly hired staff's orientation records to ensure that all newly hired staff is trained during orientation on how to properly reset and recognize all door alarms, and to ensure that 50% of newly hired employees are conducting return demonstrations of how to properly reset an alarm.</p> <p>The Unit Manager will ensure that the Quick reference binders which contains information on residents that are at risk for elopement and are located at the receptionist desk and the nurse's stations are updated as needed but no less than weekly x 12 and will continue to update them on an as needed basis but no less than weekly thereafter. The Administrator will conduct random review of the Quick reference binders located at the receptionist desk and the nurse's station to ensure that it is being updated as needed but no less than weekly to ensure compliance. The results of the audits will be reported to QA Committee. If non compliance with is determined re-education and/or corrective action up to and including termination will occur as well as continued monitoring will be recommended in a timeframe of no less than monthly by the QA committee.</p> <p>5. All corrective measures will be completed by 07/13/12.</p>		



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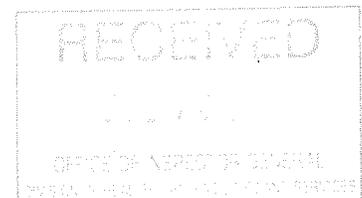
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F 323	<p>Continued From page 22</p> <p>receiver in order to shut off the alarming sound, thus allowing the alarm to sound continuously. Interview also revealed both 11-7 nurses were terminated for failure to follow policy, and failure to notify the physician of Resident #1's exit seeking behavior.</p> <p>The facility was not able to provide evidence that the front door alarm system was functional at the time Resident #1 eloped, based on interviews with LPN #3, Unit Manager AB Hall, and CNA #4 and #5 on 06/14/12. Per interview, the night shift nurses were not aware of how to turn off the front door alarm at the AB Nurse's desk, and were waiting for the Maintenance Director to arrive the next morning and reset the alarm.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility took the following actions:</p> <ol style="list-style-type: none"> 1. Upon return to the facility on 06/06/12, Resident #1 was assessed and found to have no injuries. A wander guard bracelet was applied. Resident #1 was reassessed for wandering/elopement behavior. Fifteen minute checks were initiated on 06/06/12, and monitored. The facility initiated an investigation on 06/06/12. 2. All elopement risk assessments which included the resident census of eighty-five (85) were completed on 06/06/12 with care plans and Certified Nurse Aide plans of care updated. All residents were re-assessed for wandering behaviors and wander guards applied for resident safety, by 6/16/12, by Unit Managers, Weekend Supervisor, or Staff development nurse. The facility determined nine (9) residents to be at risk for elopement. 	F 323			



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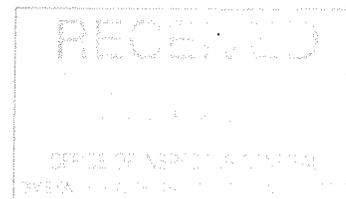
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/20/2012
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F 323	Continued From page 23 3. The Staff Development Nurse re-trained all nursing staff on 06/06/23, to include Policies on "How to properly assess and supervise the resident at risk for elopement" , " Elopement Policy and Procedure", " Care Plan Policy and procedure", "Wander Guard Policy and Procedure." The Wander Guard Policy was revised on 06/06/12 by the Director of Nursing. 4. Environmental Services Director provided education to all staff on properly resetting and recognizing all door alarms on 06/06/12. An explanation of security measures (i.e. what do door alarms sound like, look like, and proper code) and when and who to notify (Environmental Services Director, DON, or ADM). All door alarm systems were checked, on 06/06/12, by Environmental Services Director to ensure safe response of security measures. The Alarm manufacturer was contacted, on 06/07/12, to discuss and add a voice activated door alarm to the current alarm system. A log of the daily security checks will be documented as evidence of a malfunction, if it should occur. 5. A new Quick Reference Binder was developed, on 06/06/12, to identify all residents assessed at risk for elopement. The binder will identify each resident assessed for elopement with a digital photo of the resident and will also contain policies for Elopement, Wander Guard, and the Door Alarm Systems. 6 . A revision was completed for the Resident at Risk for Elopement Policy on 06/15/12 by the Director Nursing Services, with the new Pre-Assessment Form initiated. All (PRN) 'as	F 323			



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

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

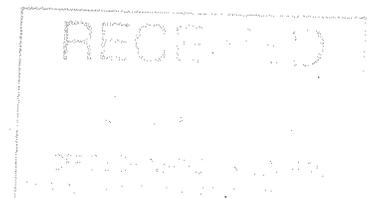
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F 323	<p>Continued From page 24</p> <p>needed' staff have been called and notified that they will not be able to work until they receive the in-services.</p> <p>7. All resident care plans were revised and all care plans updated and ensured that all residents at risk were identified. Through this process Unit Managers and floor nurses will ensure implementation of the care plan interventions. All resident care plans will be audited for proficiency and effectiveness by 6/18/12 by Medical record Staff.</p> <p>8. The Rehabilitation/Skilled Care Consultant re-educated the MDS Assessment Nurse, on 06/15/12 via conference call, regarding reassessment with change of condition, care planning and behavior interventions. The MDS Assessment Nurse will also complete the Good Samaritan Society's Learning Center courses titled: 1) Dementia: Wandering and Elopement; and 2) Elopement: Do you Know Where Your Resident Is? This was completed on 6/15/12. The Alternate MDS Assessment Nurse was educated on 06/18/12 utilizing the above course titles.</p> <p>9. The Social Worker Consultant, via telephone conference on 06/15/12, re-educated the Social Services Director regarding need for on-going assessment of resident changes in condition, updating changes in condition on the resident's care plan, and assessment and care planning if the comprehensive assessments are coded for wandering. The Social Services Director will complete the Learning Center courses for: 1) Dementia: Wandering and Elopement; and 2) Elopement: Do you Know Where Your Resident</p>	F 323		



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

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/20/2012
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F 323	Continued From page 25 Is? (completed on 06/15/12). The part time Social Services worker was educated on 06/18/12. 10. QA measures were put into place, on 06/06/12 by the Administrator, DON, Social Services Director, Environmental Services Director, along with consultation of the Medical Director, and the Rehabilitation/Skilled Care Consultant. These QA measures included all residents to be reassessed for elopement after the incident, all care plans to be updated, all staff to be trained on the elopement policy, door alarm system, and updating and following care plans. The informal Continuous Quality Improvement (CQI) meeting discussed and devised a plan to ensure the safety of each resident in the facility. This had been discussed on a daily basis since the elopement occurred on 06/06/12. The Director of Nursing, Unit Managers, Weekend Supervisor, or Staff Development nurse will complete chart audits for all residents exhibiting wandering behavior weekly x4, then monthly x 2 to ensure assessments are completed, safety devices are in place. and care plans are updated. An audit tool (unnamed) was developed and will be submitted to Continuous Quality Improvement (CQI)committee for further recommendations. The State Agency validated the AOC as follows: 1. The State Agency validated, through record review, the assessment of Resident #1, dated 06/06/12, was documented in the nurses notes. Observation, on 06/13/12, revealed Resident #1 with a wander guard bracelet attached to the left ankle. The State Agency validated through record review, evidence of 15 minute checks completed	F 323			



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

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 26</p> <p>for Resident #1, on 06/06/12. Observations of the Resident #1, on 06/13/12 at 10:25 AM, and 10:40 AM, and on 06/14/12 at 11:30 AM, revealed the resident sitting in the common area fully dressed sitting in a wheelchair at the table. The resident had his/her head on the table and appeared to be sleeping. A wander guard, and tab alarm was being utilized by the resident.</p> <p>2. The State Agency validated through record review, and observation that the nine (9) residents (#1, 2, 3, 7, 8, 9, 10, 11, 12) found to be at risk for elopement on 06/06/12, were reassessed, and care plans developed. This was verified on 06/19/12, with updated care plans for all nine resident determined by the facility to be at risk for elopement.</p> <p>3. The State Agency validated through record review evidence of education provided to staff which included policies for: Elopement Policy, Assessment and Intervention for residents at risk for elopement, Care Plan Updating, and Supervision of Care. Training was completed on 06/06/12, 06/15/12, 06/16/12, and 06/18/12. The facility staff roster indicted one-hundred and thirty-two (132) of the one-hundred and sixty one (161) total staff had been educated by 06/18/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remaining thirty-two (32) prior to the date of their return to work. In addition, the State Agency verified through record review and interview, the revision of the Wander Guard Policy revised on 06/06/12 by the DON. This was verified on 06/19/12 during interviews with LPN #1 at 2:00 PM, LPN #6 at 2:45 PM, LPN #7 at 4:35, LPN #8 at 3:20 PM, LPN #9 at 3:40 PM and LPN #10 at</p>	F 323		



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

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 27 2:00 PM. The State Agency validated through interview with the staff and record review that the revision of the Elopement Policies, Wander Guard Policies, and Door Alarm System Policies were completed and provided to the staff by 06/18/12. This was verified on 06/14/12 by CNA #2 at 10:35 PM, CNA # 3 at 11:05 PM, CNA #4 at 11:00 PM, and CNA # 5 at 10:30 PM. 4. The State Agency validated through record review, that education was provided to all staff on 06/06/12 regarding properly resetting and recognizing all door alarms. Interview with LPN #1 on 06/19/12 at 2:00 PM, LPN #6 at 2:45 PM, LPN #7 at 4:35, LPN #8 at 3:20 PM, LPN #9 at 3:40 PM and LPN #10 at 2:00 PM and interview, on 06/19/12 by CNA #2 at 10:35 PM, CNA # 3 at 11:05 PM, CNA #4 at 11:00 PM, and CNA # 5 at 10:30, verified they had been trained on properly resetting the doors. Review of the daily logs verified daily monitoring of all doors to ensure properly working doors. Interview on 06/19/12, with CNA #2 at 10:35 PM, CNA # 3 at 11:05 PM, CNA #4 at 11:00 PM, and CNA # 5 at 10:30 PM, revealed they had been required to complete a return demonstration regarding resetting of doors. 5. The State Agency validated through record review and interviews with the Receptionist on 06/19/12 at 2:30 PM, and interviews on 06/19/12 with LPN #1 at 2:00 PM, LPN #6 at 2:45 PM, LPN #7 at 4:35, LPN #8 at 3:20 PM, LPN #9 at 3:40 PM, and LPN #10 at 2:00 PM, that a Dark Lavender Quick Reference Binder was located at the front entrance and at both nurse's station. All binders contained photos of all nine residents identified at risk for elopement with policies and procedures regarding elopement procedures,	F 323			



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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 28</p> <p>wander guard policy, and operation of the door alarm system, with troubleshooting information.</p> <p>6. The State Agency validated through record review, and interview on 06/19/12 at 11:45 AM, with the Staff Development Nurse, the revised policy for residents at risk for elopement, revised on 06/15/12 by the DON, with the new Pre-Assessment Form initiated. Review of the 9 residents assessed at risk for elopement verified the new Pre-Assessment Form had been completed for each resident. Documentation reviewed, and interview with the Staff Development Coordinator on 06/19/12 at 11:45 AM, regarding notification of all 'as needed staff' revealed that they would not be able to work until they received the in-services.</p> <p>7. The State Agency validated through record review that all resident care plans were audited for proficiency and effectiveness by 6/18/12 by Medical Records staff. This was verified on 06/19/12.</p> <p>8. The State Agency validated through record review and interview with the MDS Assessment Nurse, on 06/19/12 at 2:30 PM, the education was received, on 06/15/12, via conference call with the Rehabilitation/Skilled Care Consultant and the Education Courses, were completed on 6/15/12. Review of training shows the Alternate MDS Assessment Nurse received education on 06/18/12.</p> <p>9. The State Agency validated re-education of the Social Services Director by the Social Worker Consultant via telephone conference, on 06/15/12, regarding need for on-going assessment of resident changes in condition,</p>	F 323		



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

PRINTED: 07/02/2012
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OMB NO. 0938-0391

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F 323	Continued From page 29 updating changes in condition on the resident's care plan, and assessment and care planning if Comprehensive Assessments were coded for wandering. Training Courses were verified, on 06/19/12, and was completed by Social Services Director, on 06/15/12, and the part time Social Services worker was educated on 06/18/12. 10. The State Agency validated through interview with the Administrator, on 06/19/12 at 2:30 PM, and interview with the Director of Nursing, on 06/19/12 at 12:30 PM, and record review revealed the QA measures were put into place, on 06/06/12, by the Administrator, DON, Social Services Director, Environmental Services Director, and Rehabilitation/Skilled Care Consultant. The State Agency verified through interview, on 06/19/12 at 1:00 PM, and record review that the Medical Director was consulted on 06/06/12 via telephone conference. The informal Continuous Quality Improvement (CQI) meeting was verified on 06/19/12, to have occurred on 06/06/12. QA measures included interventions to reassess all residents, identify residents at risk, train all staff on following and updating care plans, were put into place on 06/06/12. The State Agency validated through record review the facility completed an investigation on 06/11/12. The Director of Nursing, Unit Managers, Weekend Supervisor, or Staff Development nurse will complete chart audits for all residents exhibiting wandering behavior weekly x4, then monthly x 2 to ensure assessments are completed and safety devices are in place. The audit tool to be used (unnamed) was reviewed and will be submitted to Continuous Quality Improvement (CQI) committee for further recommendations.	F 323			



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

PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

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