

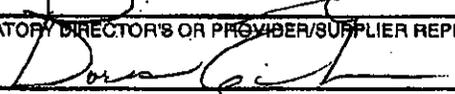
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2011
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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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)	(X6) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated/Partial Extended Survey Investigating KY #00016528, KY #00016688, KY# 00016691, KY #00016690 and KY #00016628. was conducted 06/29/11 through 07/09/11.</p> <p>KY #00016628 was substantiated and Immediate Jeopardy was identified with deficiencies cited at F-281, F-323, F-490 and F-520 at a Scope and Severity (S/S) of a "J" and F-278 at a S/S of a "D". The facility failed to provide adequate supervision for Resident #1 who had a history of leaving the building unsupervised. On 06/10/11 Resident #1 eloped from the facility without staff knowledge and was found off the facility's property, fallen from her/his wheelchair, on the ground, in the dark and pouring rain. The facility's failure to have an effective system in place to accurately assess residents and identify residents at risk for wandering/elopement behaviors and provide supervision to prevent elopement was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/07/11 and was determined to exist on 06/10/11 and is ongoing.</p> <p>KY #00016528 was substantiated with a deficiency at F-246 at a S/S of a "D". KY #00016688 was unsubstantiated with an unrelated deficiency at F-441 at a S/S of a "D". KY #00016691 was unsubstantiated with no deficiencies. KY #00016690 was substantiated with no deficiencies.</p> <p>Deficiencies cited were CFR 483.15 Quality of Life, F-246 at a Scope and Severity of a "D", CFR 483.20 Resident Assessment, F-278 at a S/S of a</p>	F 000	<p>Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <div data-bbox="1061 1336 1380 1522" style="border: 1px solid black; padding: 5px; text-align: center;"> <p>RECEIVED AUG - 5 2011</p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X8) DATE 8/5/2011
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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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F 000	Continued From page 1 "D", F-281 at a S/S of a "J", CFR 483.25 Quality of Care, F-323 at a S/S of a "J", CFR 483.65 Infection Control, F-441 at a S/S of a "D", 483.75 Administration, F-490 at a S/S of a "J", and F-520 at a S/S of a "J". Substandard Quality of Care (SQC) was identified in the area of CFR 483.25 Quality of Care, F-323. The highest Scope and Severity was a "J":	F 000	F 246 The call bell for Resident #12 was placed within her reach. The call bell for Resident #15 was placed within her reach. The call bell for Resident #13 was placed within her reach.	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's State Registered Nursing Aide (SRNA) job description it was determined the facility failed to ensure three (3) of sixteen (16) sampled residents, Residents #12, #15, and #13's needs were accommodated related to the call lights being within reach. Interview with Resident #12's Power of Attorney (POA) revealed Resident #12's call light is often found out of reach for the resident. Observation and interview revealed Resident #15 and #13's call lights were not within reach.</p> <p>The findings include: Review of the facility policy titled " State</p>	F 246	<p>All residents would have the potential to be affected. Rounds of resident rooms were made daily by the Administrator 7/9/2011 - 7/27/2011 to check for call lights within reach of residents. Any concerns identified were addressed as indicated with re-education of the staff as needed by the Administrator. Rounds will continue to be made Monday-Friday by the Administrator and on Saturday & Sunday by the Administrative Weekend Manager to check for call-lights within reach of residents.</p> <p>To prevent the deficiency from re-occurring education was completed on 7/13/2011- 7/15/2011 by the DON/ADON & RN Facility Consultant regarding the accommodation of the needs of residents related to maintaining call bells within the reach of residents at all times. Education was completed 7/23/2011-7/25/2011 by the DON, ADON & SDC Nurse for all applicable staff that reasonable accommodation of individual needs and preferences includes the facility's</p>	

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F 246	<p>Continued From page 2</p> <p>Registered Nurse Aide, SRNA", under the major duties and responsibilities section revealed the SRNAs were to assure that nurses call systems was attached to the bed when residents were bedfast and within reach at all times. It further stated to assure all lights were accessible to residents at all times unless contraindicated by the plan of care.</p> <p>1. Record review revealed the facility admitted Resident #12 on 01/31/07 with diagnoses with included Heart Failure, Hypertension, and Depression. Review of the Quarterly minimum Data Set (MDS) Assessment, dated 05/23/11, revealed the facility assessed the resident as having moderately impaired cognition and as being able to communicate needs and understanding instructions.</p> <p>Interview with Resident #12's POA on 07/09/11 at 12:00 PM revealed she visits Resident #12 at least three (3) or four (4) times per week. She continued to state that at least once a week she finds the call light clipped under the draw sheet, out of the reach of Resident #12. She continued to state, even when Resident #12 is up in the wheel chair the call light is clipped to the bed, out of reach of Resident #12.</p> <p>Interview with SRNA #4 on 07/09/11 at 2:40 PM revealed the call lights for residents were supposed to be clipped within reach at all times.</p> <p>2. Record review revealed the facility admitted Resident #15 on 06/02/08 with diagnoses which included Dementia, Hypertension, and Altered Mental Status. Review of the significant change MDS Assessment, dated 02/28/11 revealed the</p>	F 246	<p>efforts to individualize the resident's physical environment to the extent possible without endangering the health or safety of other residents. Staff was also educated that reasonable accommodation also includes the psychosocial environment in how staff interacts with resident; and to complete a Social Services Referral tool for any concern identified by staff with regard to reasonable accommodation of needs for any resident.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, the DON, ADON, QI nurse, MDS Nurse, and/or Treatment nurse will continue to read the progress notes for all residents, including Resident #12, Resident #13, & Resident #15, daily Monday - Friday, to identify any needs that may need to be addressed by the Social Worker. Daily rounds will continue to be conducted by the Administrator, DON, ADON, Staff Development nurse, QI nurse, and MDS nurses to identify that efforts have been made by staff to individualize resident's physical environment, including that call lights being in reach, and to monitor staff interaction with residents. Any issues will be corrected immediately & reported to the Administrator as indicated.</p>	

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F 246	<p>Continued From page 3</p> <p>facility assessed the resident as having cognitive impairment and as being understood and able to understand.</p> <p>Observation of Resident #15 on 07/09/11 at 10:40 AM revealed the resident was in bed. Further observation revealed the resident's call light was clipped to the pillow above the right shoulder, out of reach to the resident. Observation on 07/09/11 at 4:40 PM revealed Resident #15 was in the bed and the call light was in the chair, three (3) feet away from the resident, out of the resident's reach.</p> <p>Interview with Resident #15 on 07/09/11 at 4:40 PM revealed the resident knew how to use the call bell to call for assistance. She further stated it was often out of reach.</p> <p>3. Record review revealed the facility admitted Resident #13 on 11/26/10 with diagnosis which included a history of Colon Cancer, Chronic Back Pain, and Dementia. Review of the quarterly MDS Assessment, date 05/16/11, revealed the facility assessed the resident as being moderately impaired in cognition and as being understood and able to understand others.</p> <p>Observation of Resident #13 on 07/09/11 at 10:05 AM revealed the resident was in the bed and the call bell was at the head of the bed, under the pillow and out of reach to the resident.</p> <p>Interview with SRNA #2 on 07/09/11 at 10:50 AM revealed she was not sure why the call bell was not within the resident's reach, however all call bells were supposed to be within the residents' reach at all times.</p>	F 246	<p>The results of these audits will be reviewed with the Administrator in the weekly QI Committee meeting, consisting of the Administrator, DON, ADON, QI Nurse, Staff Development Nurse, Treatment Nurse and/or MDS Nurses, where the results of these audits will be compiled and assessed for trends by the Committee & actions taken based on these assessments. Trends & the accompanying action will be reviewed by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, and/or any other persons required to provide information pertinent to the reports being discussed, monthly with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	
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F 246	<p>Continued From page 4</p> <p>Interview with SRNA #1, who was assigned to Resident #13, on 07/09/11 at 3:07 PM revealed she should have made sure the resident's call bell was in reach.</p> <p>Interview with the Charge Nurse/Licensed Practical Nurse (LPN) #1 on 07/09/11 at 2:45 PM revealed the staff was to ensure all call lights were in reach before leaving the room.</p> <p>Interview with Resident #13 on 07/09/11 at 6:40 PM revealed he/she knew how to use the call bell to call for assistance and that often the call bell was out of reach.</p>	F 246		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual</p>	F 278	<p>F 278 A significant correction to the MDS for Resident #1 was completed on 7/25/2011 by the MDS Nurse.</p> <p>All residents have the potential to be affected. The most recent MDS assessment for current in house residents was reviewed on 7/25/11 - 7/26/11 by the MDS nurse, DON, ADON, QI Nurse, Social Worker, Treatment Nurse, and RN Facility Consultant to identify any accuracy related to the residents clarity of speech pattern, ability to understand & ability to be understood. Any discrepancies were addressed as indicated by the MDS Nurses.</p> <p>To prevent the deficiency from re-occurring the MDS Nurses were re-educated on 7/25/2011 by the Facility MDS Consultant on accurately coding the MDS for occurrences during the look back period of the assessment, attesting to the accuracy of the MDS when they sign Section Z of the MDS, if</p>	

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F 278	<p>Continued From page 5</p> <p>to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument User Manual Version 3.0 it was determined the facility failed to conduct an accurate assessment for one (1) of sixteen (16) sampled residents, (Resident #1) related to speech clarity, and making self understood on the Minimum Data Set (MDS) Assessment dated 03/31/11 and the MDS Assessment dated 06/24/11.</p> <p>The findings include:</p> <p>Review of the Resident Assessment Instrument User Manual Version 3.0 revealed; deficits in the ability to make one's self understood can include reduced voice volume and difficulty in producing sounds, or difficulty finding the right words, or making sentences.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Wernicke's encephalopathy (characterized by a deficit in memory, judgment, decision making) secondary to Alcohol Abuse.</p> <p>Review of the MDS Assessment with an</p>	F 278	<p>medical record documentation does not accurately reflect the resident's abilities and needs, the MDS Nurse must document the actual resident condition, abilities, and needs on the MDS instead of solely depending on the medical record documentation, the need for the MDS nurse to interview staff and observe residents during the look back period to ensure that the resident's actual abilities, needs, cognition, moods, and treatment status are accurately reflected and recorded on the MDS, and that the resident must be accurately assessed for the ability to communicate to staff and others, including family and visitors, and that any individual intervention that staff utilize to communicate must be included on the resident care plan.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, the completed MDS assessments for each week will be reviewed in a weekly QI Committee meeting consisting of the MDS Nurses, DON, ADON, Staff Development Nurse, QI Nurse, and Social Worker to ensure the assessment accurately reflects the resident's status during that assessment reference period. The results of these audits will be reported monthly to the QI Executive Committee, consisting of the Administrator, DON, ADON, Medical</p>	

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F 278	<p>Continued From page 6</p> <p>Assessment Reference Date (ARD) of 03/28/11, revealed the facility assessed the resident as having clear speech with distinct intelligible words as opposed to unclear speech with slurred or mumbled words. In addition, the facility assessed the resident as understood and able to express requests and ideas clearly as opposed to usually understood which would include difficulty communicating some words or finishing thoughts but is able if prompted or given time for Section B.</p> <p>However, review of the Progress Notes from for the seven (7) day look back period revealed the resident's speech was not clear and the resident was not readily understood. Review of the Progress Notes dated 03/24/11 at 3:52 PM revealed the resident made needs known verbally although speech was hard to understand. Review of the Progress Notes dated 03/26/11 at 7:22 AM revealed the resident's speech was often muffled and hard to understand.</p> <p>Interview on 06/30/11 at 2:00 PM with MDS Nurse #1, who completed the MDS Assessment with an ARD date of 03/28/11, revealed she talked to the resident during the look back period, to gather information in addition to a chart review to include reviewing Progress Notes. She agreed the resident did not communicate and speak "completely normal". She stated the resident spoke very softly during interview causing the listener to have to listen closely.</p> <p>Review of the MDS Assessment with an ARD date of 06/20/11, revealed the facility assessed the resident as having clear speech with distinct intelligible words and as understood and able to</p>	F 278	<p>Director, QI Nurse, Treatment Nurse, and/or MDS Nurses with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011.</p>	

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F 278	<p>Continued From page 7 express requests and ideas.</p> <p>However, review of the Progress Notes for the 7 day look back period revealed the resident's speech was not clear and the resident was not readily understood. Review of the Progress Notes dated 06/20/11 at 10:02 AM revealed the resident's speech was hard to understand. Review of the Progress Notes dated 06/20/11 at 11:40 PM revealed the resident was alert and able to understand; however, the resident never communicated with the writer other than head nods.</p> <p>Interview on 07/06/11 at 1:00 PM with MDS Nurse #2 revealed she had completed the MDS with the ARD date of 06/20/11 for Section B. She stated she talked to the resident and family and reviewed Progress Notes for the seven (7) day look back period. She stated she did notice the resident had more trouble "telling you what she/he wanted" during the assessment period.</p> <p>Interview, on 07/07/11 at 2:05 PM, with the Speech Therapist revealed the resident spoke slow and in a low volume, which was difficult for her to hear unless she was in a quiet setting. She further stated the resident could express basic needs and wants; however, the listener needed to give the resident time to answer. She further stated the resident would not have a conversation, but would make a statement or a comment.</p>	F 278		
F 281 SS-J	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation it was determined the facility failed to ensure services provided met professional standards of quality related to Physician's Orders being followed for residents who had a history of leaving the building unsupervised for one (1) of sixteen (16) sampled residents (Resident #1). Resident #1 had a Physician's Order for a wander guard; however, on 03/29/11 the facility assessed Resident #1 as not being at risk for wandering and removed the resident's wander guard bracelet. There was no documented evidence the Physician was consulted nor a Physician's Order obtained to discontinue the wander guard bracelet.</p> <p>On 06/10/11 Resident #1 exited the facility without staff knowledge and was found off the premises in the parking lot of the building beside the facility. Resident #1 was last seen inside the building at 9:15 PM, could not be located at 9:30 PM, and was found approximately fifteen (15) minutes later at 9:45 PM per staff interview. The resident had fallen out of the wheelchair and was on the ground in the dark and pouring rain. Interviews with staff revealed the resident was soaking wet when found. The facility investigation revealed the resident went out the South Hall exit by the beauty shop which had a door that was activated to alarm by a wander guard. However, the resident was not wearing a wander guard when she/he eloped.</p> <p>The facility's failure to provide services to meet</p>	F 281	<p>F 281 A wander guard alarm was applied to Resident # 1 on 6/10/2011.</p> <p>All residents have the potential to be affected. A review of the nurse's progress notes and physician's orders for the last 30 days on all residents was completed on 7/11/11 by the Facility Registered Nurse Consultants and Administrative Nursing Team consisting of the DON, ADON, MSD Nurses, SDC, QI Nurse and Treatment Nurse to identify that all care needs have been met using professional standards of quality that include appropriate recognition and intervention of an emergency situation including documentation of vital signs, notification of the MD as appropriate, and following physician's orders. Any issues identified as a result of the audit have been reported to the physician for new orders as appropriate.</p> <p>Re-education began on 7/09/11 & completed 7/13/11. Licensed Nurses and Certified Medication Aides were re-educated by the Director of Nursing (DON) on following physician orders. All Licensed Nurses were re-educated by the Assistant Director of Nursing (ADON) regarding obtaining and documenting vital signs as a part of the post-assessment after any resident</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2011
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY, 40311
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F 281	<p>Continued From page 9</p> <p>professional standards of quality related to following Physician's Orders for residents at risk for wandering/elopement behaviors was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/07/11 and was determined to exist on 06/10/11 and is ongoing.</p> <p>The findings include:</p> <p>Review of the Clinical Record revealed Resident #1 was admitted to the facility on 09/13/07 with diagnoses which included Wernicke's encephalopathy (an inflammatory hemorrhagic degenerative condition of the brain, characterized by decreased mental function which may be mild or severe) secondary to Alcohol Abuse, Unspecified Psychosis, and Depressive Disorder. Review of the Long Term Care (LTC) Progress Notes revealed the resident had a history of leaving the building unsupervised. Review of the monthly Physician's Orders from 10/2007 through 06/2011 revealed orders for a wander guard for wandering.</p> <p>Review of the Comprehensive Plan of Care initiated 01/18/11 by MDS Nurse #1 revealed the resident had cognitive loss related to Wernicke's encephalopathy which was characterized by deficit in memory, judgement, decision making and a history of getting lost. The goal stated the resident would find her/his way around the unit without getting lost, with an intervention for a wander guard.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/31/11, and the Annual MDS Assessment, dated 06/24/11,</p>	F 281	<p>incident, fall, and/or change in condition as indicated. Re-education was completed by the DON/ADON/SDC Nurse/Facility Consultants on 7/14/2011 for licensed nurses and certified medication aides that if there is a question regarding an order, then the physician must be notified for clarification. Any new licensed nursing staff and certified medication aides will receive this education during their orientation process from the Staff Development Coordinator Nurse. To monitor facility performance to ensure solutions are sustained through the QI process the progress notes and pink copies of all physician's orders of current residents, including Resident #1, will continue to be read daily, Monday thru Friday, by the DON, ADON, QI Nurse, Staff Development Coordinator, Treatment Nurse, and/or MDS Nurses to identify that any new physician's orders for residents are being followed. Any discrepancies will be addressed immediately as indicated up to & including a reassessment of the resident and/or MD notification if needed. The results of these audits will be reviewed with the Administrator in the weekly QI Committee Meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, and/or MDS Nurse. Trends & any accompanying actions will be reviewed monthly by the QI Executive QI</p>	

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F 281	<p>Continued From page 10</p> <p>revealed the facility assessed the resident to have moderate impairment in cognitive skills for decision making and to require extensive assistance with transfers and ambulation.</p> <p>Review of the Progress Notes, from 03/24/11 through 03/27/11 revealed the resident could only voice simple needs, had short term memory loss, decisions were made by staff and Power of Attorney (POA), and the resident had muffled speech. The resident was also showing confusion as evidenced by thinking she/he was going horse back riding.</p> <p>However, review of the facility "Wandering Risk Assessment" dated 03/29/11 and completed by MDS Nurse #1, revealed the Diagnosis Section was marked to indicate the resident having mild cognitive loss, and the Decision Making/Memory Section was marked to indicate the resident was independent in decision making. The Communication Section was marked indicating the resident was expressive, and had understandable communication with others. The resident's Wandering Risk score was a four (4). According to the Assessment if the resident's score was greater than a five (5) the resident would be at risk for wandering. Review of the resident's Care Plan revealed the intervention for the wander guard was discontinued on 03/29/11.</p> <p>Interview with MDS Nurse #1 on 06/30/11 at 2:00 PM, revealed she and Licensed Practical Nurse (LPN) #3 made the decision to discontinue the wander guard bracelet because the "Wandering Risk Assessment" completed on 03/29/11 indicated the resident was not at risk to wander</p>	F 281	<p>Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, &/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p> <p>Completion Date: 07/28/2011</p>	

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F 281	<p>Continued From page 11</p> <p>and the wander guard bracelet was removed on 03/29/11. Further interview revealed they did not consult with the administrative nurses or consult with the interdisciplinary team, or the Physician about the decision. She further stated she assumed LPN #3 had called the Physician to obtain an order to discontinue the wander guard.</p> <p>Interview on 07/05/11 at 3:30 PM with LPN #3 revealed she did not remember the resident ever trying to exit the doors. She stated, she and MDS Nurse #1 made the decision to remove the wander guard bracelet after the "Wandering Risk Assessment" was completed on 03/29/11. She further stated she did not review the resident's record before making the decision; however, felt she knew the resident well from being assigned to her/him several times a week. Continued interview revealed she could not remember if she had obtained a Physician's Order to remove the wander guard bracelet; however, if she did, she would have written the order as well as written a notation in the Progress Notes. However, there was no documented evidence the Physician was notified related to discontinuing the wander guard.</p> <p>Review of the Progress Notes dated 06/11/11 at 10:13 PM completed by Registered Nurse (RN) #2 revealed staff found the resident off the premises sitting on the ground. According to the Note, the resident expressed she/he was looking for her/his parents. A wander guard was applied to the right ankle per order.</p> <p>Interview on 07/05/11 at 1:00 PM with RN #2 revealed she was assigned to the resident on 06/10/11 and was unaware the resident no longer wore a wander guard bracelet. Per interview,</p>	F 281		

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F 281	<p>Continued From page 12</p> <p>after notifying the Interim Director of Nursing (DON) of the incident, she was instructed to place a wander guard on the resident.</p> <p>Interview on 06/30/11 at 3:30 PM and 07/07/11 at 9:00 AM with the Attending Physician revealed the resident's diagnosis of Wernicke's encephalopathy was a type of Dementia and detailed the resident had very little speech and chronic confusion. The Physician stated the resident had significant cognitive loss, and "major brain damage" and was unaware of her/his location. The Physician stated she was not notified of the facility's decision to remove the wander guard, and was not asked for a Physician's Order to remove the wander guard. Per interview, she had only been the resident's Physician for about a year and she was unaware the resident had left the building unsupervised in the past. Continued interview revealed after learning of the prior history of events related to the resident leaving the building unsupervised she felt the resident needed a wander guard.</p> <p>Interview with the Interim DON on 07/07/11 at 2:30 PM revealed the Care Plan team should have met before a decision was made to remove the wander guard bracelet on 03/29/11. She further stated a Physician's Order should have been obtained prior to removing the wander guard bracelet.</p> <p>Interview on 07/07/11 at 3:00 PM with the Registered Nurse (RN) Consultant/ Quality Improvement (QI) Nurse, revealed the facility did not identify there was a Physician's Order for the wander guard during the Facility Investigation, and it was not identified until 06/17/11 through the</p>	F 281		
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F 281	Continued From page 13 Quality Improvement audits. Interview on 07/09/11 at 12:20 PM with the Administrator revealed since there was a Physician's Order for the wander guard, there should have been consultation with the Physician prior to removing the wander guard. Continued interview revealed there should have been a meeting with the Care Plan team to discuss removing the wander guard prior to staff removing the wander guard 03/29/11.	F 281		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility's investigation review, and review of the facility's policies it was determined the facility failed to provide adequate supervision and monitoring to prevent accidents for residents with a known risk for elopement and a history of leaving the building unsupervised. The facility failed to have an effective system to ensure staff was knowledgeable on how to accurately assess residents to identify risk factors related to wandering behaviors in order to implement interventions to prevent elopement for	F 323	F 323 Resident # 1 was returned to the building immediately on 6/10/2011, assessed by nursing, and physician and family notified. A new wander guard alarm was applied to resident on 6/10/2011 per protocol. On 6/10/2011, resident was placed on one-on-one monitoring while out of bed. A wandering risk assessment was completed for Resident #1 on 6/11/2011. Resident was moved to Room 105A in the South Unit within the wander guard system on 6/13/2011. One-on-one monitoring was discontinued with move into the wander guard system. 6/21/2011 at 20:30, Resident #1 made statements that she would leave the building, physician was notified, family was notified and resident #1 was placed on one-on-one monitoring and a second wander guard alarm was applied to resident #1's wheelchair. Resident #1 was moved into Room 121 in the secure unit on 6/22/2011. One-on-one monitoring was discontinued at the time of this move. Physician and family	

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F 323	<p>Continued From page 14 one (1) of sixteen (16) sampled residents (Resident #1).</p> <p>Resident #1 had a history of elopement in the past and had made statements she/he was going home per record review. On 03/29/11, the facility assessed Resident #1 as not being at risk for wandering and removed the resident's wander guard bracelet, even though there was a Physician's Order for a wander guard bracelet for wandering. Record review revealed the facility failed to assess Resident #1 accurately for wandering risk prior to the wander guard bracelet being removed, and failed to consult with the resident's Physician and obtain a Physician's Order to discontinue the wander guard bracelet.</p> <p>On 06/10/11 Resident #1 eloped from the facility without staff knowledge. Resident #1 was found off the premises in a parking lot of the building beside the facility. The resident was found at approximately 9:45 PM per staff interviews on the ground in front of her/his wheelchair in the dark, and pouring rain. Interviews with staff revealed on the evening of 06/10/11 the resident was seen going down the hall with a bag towards the beauty shop which was next to an exit door; however, the staff failed to monitor the resident for wandering behavior. The facility investigation revealed the resident went out the South Hall exit by the beauty shop which had a door that was activated to alarm by a wander guard. However, the resident was not wearing a wander guard when she/he eloped.</p> <p>The facility's failure to have an effective system in place to ensure adequate supervision and monitoring for residents who exhibited</p>	F 323	<p>were notified. Resident was seen by the psychiatrist on 6/25/2011.</p> <p>All residents have the potential to be at risk. A review of wandering risk assessments for all residents was completed by the DON 6/11/2011 - 6/13/2011. No additional residents were identified as being at risk for wandering through this review. A second review of wandering risk assessments for all residents was completed by the Director of Nursing, MDS Nurse and Facility Nurse Consultant 6/29/2011 - 7/2/2011. Three additional residents were identified as being at high risk for wandering, with the first being identified on 6/30/2011, the second identified on 7/1/2011, and the third resident identified on 7/2/2011. Those additional residents identified as being at risk for wandering had wander guard alarms applied, moved into the South unit and identified on the facility wandering board. In addition, the care plan and care guide for these residents were updated to reflect the resident at risk for wandering.</p> <p>A visual round was conducted by the Administrator, DON, Maintenance Director & Environmental Services on 7/14/11 - 7/15/11 to identify hazards or risks in the resident's environment</p>	

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NAME OF PROVIDER OR SUPPLIER

JOHNSON MATHERS NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

2323 CONCRETE ROAD
CARLISLE, KY 40311

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F 323	<p>Continued From page 15</p> <p>wandering/elopement behaviors and failure to accurately assess residents to identify residents at risk for wandering/elopement was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/07/11 and was determined to exist on 06/10/11 and is ongoing.</p> <p>The findings include:</p> <p>Review of the facility's "Wandering Risk Potential Protocol", dated 05/2007, revealed the purpose of the protocol was to implement guidelines to identify a resident's risk for inappropriate wandering within or outside the facility, and to ensure a resident's safety in regards to the identified behaviors. Further review revealed, to identify this behavior and to ensure a resident's safety, utilization of the Wandering Risk Potential Protocol should occur as indicated. The Risk Assessment should be completed on admission, and/or re-entry to the facility. If the resident's score was greater than five (5), the following guidelines should be instituted. The Care Plan should include measurable goals and interventions to ensure the resident's safety, and a Risk Assessment should be reviewed for a significant change in a resident's condition. For residents identified at risk, the assessment would be completed quarterly. Any change in behavior/wandering or a one time attempt to leave the facility unsupervised should trigger a new risk assessment.</p> <p>Record review revealed Resident #1 was admitted to the facility on 09/13/07 with diagnoses which included Wernicke's encephalopathy (characterized by a deficit in memory, judgement,</p>	F 323	<p>and to implement interventions to reduce any hazards or risks identified.</p> <p>On 7/8/2011, the wandering risk assessment form was reviewed by the RN Nurse Consultant and updated to include instructions consistent with MDS 3.0 as guidance to nursing staff when completing a wandering risk assessment for residents. A copy of the updated wander risk assessment form was provided to the Medical Director on 07/08/2011 by the Administrator. The Administrator and Administrative Nursing Team consisting of the DON, ADON, MSD Nurses, SDC Nurse, QI Nurse and Treatment Nurse were educated on the 7/8/2011 by the RN Nurse Consultant on the definition of wandering based on the RAI definition, completion of the At Risk for Wandering Assessment using the new instructions for completion and Wandering Risk Protocol. On 7/8/2011, the Administrative Nursing Team completed At Risk for Wandering Assessments on all residents who had not previously been identified as at risk for wandering. All residents identified as being at risk for wandering had a wander guard alarm applied and were identified on the facility wandering board; their care plans and care guides were updated to reflect at risk for wandering.</p>	

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F 323	<p>Continued From page 16</p> <p>decision making) secondary to Alcohol Abuse, Unspecified Psychosis, and Depressive Disorder. Review of the Long Term Care (LTC) Progress Notes revealed the resident had a history of leaving the building unsupervised stating she/he was going home.</p> <p>Observation and interview with Resident #1 on 06/30/11 at 10:15 AM revealed the resident was in the bed watching television. When asked how long the resident had been at the facility, she/he stated for three (3) or four (4) days. Further interview revealed the resident was unaware of the name or location of the facility. When asked if she/he enjoyed socializing with the residents, she/he stated she/he had not met them yet.</p> <p>Review of the Minimum Data Set Assessment (MDS) dated 10/11/10 revealed the facility assessed the resident as having severe impairment in cognitive skills for daily decision making. Review of the Comprehensive Plan of Care dated 10/18/10 revealed the resident had behaviors and cognitive loss with a history of wandering at times. The goal stated the resident would have no episodes of wandering from the facility. The interventions included a wander alert bracelet.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/31/11 and the Annual MDS Assessment dated 06/24/11 revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making. Review of the Comprehensive Plan of Care, dated 01/18/11, revealed the resident had cognitive loss related to Wernicke's encephalopathy characterized by deficit in</p>	F 323	<p>In-service by the RN consultants of licensed nursing staff with regard to completion of the At Risk for Wandering Assessment using the new Instructions for completion, wandering risk potential protocol, events that trigger completion of a new at risk for wandering assessment including potential behaviors such as packing bags, comments of wanting to leave the facility, increased pacing, etc., immediate response to all alert system alarms and the redirection of residents was done 7/8/2011 - 7/13/11. This education will be provided to all new employees during their orientation by the Staff Development Nurse.</p> <p>To identify any new or increased behaviors that could potentially indicate an increased risk for wandering in all residents, including those not currently identified as at risk for wandering, the DON, ADON, MDS Nurses, QI Nurse, SDC Nurse and/or Facility Registered Nurse Consultant will read nurse's notes, talk to direct care staff and observe residents during rounds, & review 24 hour nursing reports daily, Monday - Friday. Also, to ensure that for any resident(s) newly identified as being at risk for wandering, the at risk for wandering assessment has been completed properly and the wandering protocol followed. In addition, DON, ADON,</p>	

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F 323	<p>Continued From page 17</p> <p>memory, judgement, decision making and a history of getting lost. The goal stated the resident would find her/his way around the unit without getting lost and there was an intervention for the wander guard.</p> <p>However, review of the facility's "Wandering Risk Assessment" dated 03/29/11 and completed by MDS Nurse #1 revealed the Diagnosis Section was marked as the resident having mild cognitive loss, and the Decision Making/Memory Section was marked as independent in decision making. The Communication Section was marked as expressive, understandable communication with others. The resident's Wandering Risk score was a four (4). According to the Assessment if the resident's score was greater than five (5), the resident would be at risk for wandering. Record review revealed the wander guard was discontinued on the resident's Care Plan on 03/29/11.</p> <p>Interview with MDS Nurse #1 on 06/30/11 at 2:00 PM revealed when completing the "Wandering Risk Assessment", she marked mild cognitive loss instead of Dementia with moderate cognitive loss because she could not find a diagnosis of Dementia in the clinical record and was not aware the resident's diagnosis of Wernicke's was a type of Dementia. Further interview revealed she marked independence in decision making as opposed to occasional episodes of confusion and modified decision making because she was unsure if the resident was confused or just had short term memory loss. She felt the resident could express basic needs and understand simple messages, so she marked expressive,</p>	F 323	<p>MDS Nurses, QI Nurse, SDC Nurse and/or Facility Registered Nurse Consultant will read nurse's notes, talk to direct care staff and observe residents during rounds, & review 24 hour nursing reports daily, Monday - Friday, to ensure that interventions have been put into place for any residents identified with wandering, socially inappropriate and/or disruptive behaviors and that such interventions remain effective at reducing the risk of danger to self and others. The Administrator will be made aware of any potential concerns immediately by the nurse reviewer and appropriate actions will be taken as deemed necessary. Re-educated was provided on 7/8/11 for licensed nursing staff by the DON/ADON/Facility Consultant regarding the need for the Administrator to be notified immediately in person or by phone of any wandering, socially inappropriate and/or disruptive behaviors to ensure immediate action could be taken as indicated. If the Administrator is unavailable staff has been instructed to contact the DON. The Administrator or DON will notify the Facility Registered Nurse Consultant of any reported wandering, socially inappropriate and/or disruptive behaviors posing a potential risk to others. Any new staff will receive this</p>	

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F 323	<p>Continued From page 18</p> <p>understandable communication with others instead of usually understands and is understood. She stated she did not review the MDS dated 03/31/11 when completing the "Wandering Risk Assessment" because it had not been completed.</p> <p>Continued Interview with MDS Nurse #1 on 06/30/11 at 2:00 PM revealed she had spoken with LPN #3 on 03/29/11 and the decision was made to remove the resident's wander guard bracelet due to the "Wandering Risk Assessment" completed on 03/29/11 indicating the resident was not at risk to wander. She further stated she assumed LPN #3 had called the Physician to obtain an order to discontinue the wander guard. She stated staff did not need a Physician's Order to apply or discontinue a wander guard; however, if there was a Physician's Order for a wander guard, an order would need to be obtained to discontinue the wander guard and she thought LPN #3 had obtained the order.</p> <p>Interview on 07/05/11 at 3:30 PM with LPN #3 revealed the resident made no attempts to leave in over a year and she did not remember the resident ever trying to exit the doors. She stated the decision was made to remove the wander guard bracelet by she and MDS Nurse #1. She further stated she did not review the resident's record before making the decision; however, knew the resident well from being assigned to her/him several times a week. Continued interview revealed she did not remember if she had obtained a Physician's Order to remove the wander guard bracelet; however, if she did, she would have written the order as well as written a notation in the Progress Notes.</p>	F 323	<p>information during the orientation process.</p> <p>To monitor facility performance to ensure that solutions are sustained through the QI process, the progress notes and 24 hour reports for all residents, including Resident #2, will continue to be read by the DON, ADON, QI nurse, Treatment nurse, and/or MDS nurse daily, Monday - Friday to ensure that interventions implemented for a resident identified with behaviors remain effective at reducing the risk of danger to others. The results of these audits will be reviewed with the Administrator in the weekly QI Committee Meeting, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, and/or MDS Nurse. Trends & any accompanying actions from these audits in additions to reports from the Falls, Wandering Residents, Restraints, Safety, Event & Incident, and the Physical Plant Quality Improvement Committees will be reviewed monthly by the QI Executive Committee, consisting of the Administrator, DON, ADON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, &/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented as directed by the committee.</p>	

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY. 40311
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F 323	<p>Continued From page 19</p> <p>Continued interview with MDS Nurse #1 on 07/01/11 at 10:40 AM revealed if she had marked the resident as having a diagnosis of Dementia with moderate cognitive loss, and occasional episodes of confusion with modified independence in decision making and memory, the score would have been a six (6) on the "Wandering Risk Assessment" which would have placed the resident as a wandering risk.</p> <p>Review of the Progress Notes dated 06/10/11 at 10:13 PM completed by Registered Nurse (RN) #2 revealed the resident was found off the premises sitting on the ground. The Note stated there were no injuries noted; however, the resident stated her/his "bottom hurts". Further review revealed a wander guard was applied to the right ankle per order. The Note further stated the resident expressed she/he was looking for her parents.</p> <p>Interview on 07/05/11 at 1:00 PM with RN #2, who was assigned to the resident on 06/10/11, revealed she had seen the resident looking out the exit door at the end of the corridor near the beauty shop on the South Unit at 9:15 PM. Further interview revealed she started searching for the resident about 9:30 PM to administer medications; however, could not locate the resident. She stated the staff on the North and South units were instructed to search for the resident, and the resident was found about fifteen (15) minutes after the search started by Certified Nursing Assistant (CNA) #6. She stated she was unaware the resident no longer wore a wander guard bracelet. Further interview revealed she notified the interim Director of Nursing (DON) who instructed her to place a wander guard on</p>	F 323	Completion Date: 07/28/2011	

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F 323	<p>Continued From page 20 the resident.</p> <p>Interview on 06/30/11 at 2:15 PM with CNA #6, revealed she was assigned to the resident the evening the resident eloped. She stated the resident was "talking off the wall" which was not normal for the resident. Continued interview revealed the resident packed her/his belongings in a blue bag which was the size of a reusable grocery bag when she/he was in a confused state. She stated on the evening of 06/10/11 she saw the resident going towards the south nursing station between 9:00 PM and 9:30 PM with the blue bag in tow. Further interview revealed when RN #2 asked her where the resident was, she told the nurse she saw the resident going down the South Hall towards the beauty shop which was at the end of the hall with her/his bags. Continued interview revealed she went outside looking for the resident and heard the resident's wheelchair pressure alarm ringing. She found the resident sitting on the ground in front of the wheelchair. She stated it was raining and the resident was "soaked". She was unsure of the time the resident was brought back into the facility; however, stated it was 9:30 PM or after. Continued interview revealed when the resident was brought back to her/his room, the resident's bed was full of belongings including shoe boxes, shopping bags, and a cosmetic bag. She further stated the resident had the blue bag with her when she/he was found which was full of clothes and miscellaneous items. She stated she did not tell the nurse when she saw the resident packing belongings and going towards the South Unit exit door with the bag because it was normal for this resident. Continued interview revealed she never thought the resident would try to leave.</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>Interview on 06/29/11 at 2:30 PM with Certified Nursing Assistant (CNA)#8 revealed she had seen the resident sitting next to the exit door on the South hall while doing rounds on 06/10/10 in the evening; however, was unsure of the exact time. She stated she spoke to the resident who was noted to have a packed reusable bag and a cup. She further stated RN #2 later asked if she had seen the resident, and she helped search and drove outside around the facility in the rain. Continued interview revealed she saw the resident who was off the premises and noted two girls were picking the resident up off the ground and assisting her/him to the wheelchair.</p> <p>Interview on 06/30/11 at 9:50 PM with CNA #7 revealed the North staff had informed her the resident was missing and she and CNA #6 found the resident outside, off the premises on the ground sitting in front of the wheelchair. She stated it was pouring rain and the resident had a blue bag and a cup with her. She was unsure of the exact time the resident was found.</p> <p>Interview on 06/30/11 at 3:30 PM and 07/07/11 at 9:00 AM with the Attending Physician revealed the resident's diagnosis of Wernicke's encephalopathy was a type of Dementia and the resident had very little speech and chronic confusion. She stated the resident had significant cognitive loss, "major brain damage" and was unaware of her/his location. She further stated the resident's parents made decisions for the resident. Continued interview revealed she was not notified of the facility's decision to remove the wander guard, and was not asked for a Physician's Order to remove the wander guard.</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>She stated she was unaware the resident had a history of leaving the building unsupervised. She further stated after learning of the prior events related to the resident leaving the building unsupervised she felt the resident would have needed a wander guard.</p> <p>Interview was conducted with the Interim DON on 07/07/11 at 2:30 PM, and she was asked if the "Wandering Risk Assessment" dated 03/29/11 was done accurately. She stated she may have done it differently because the resident was not independent with decision making due to her/his poor short term memory and the resident was difficult to understand at times due to mumbling. She stated the "Wandering Risk Assessment" was a "snapshot" in time which was based on the nurses assessment at the time. She further stated the "Wander Risk Assessments" could be interpreted differently by different nurses and therefore the wandering risk scores could vary. Further interview revealed the Care Plan team should have met before a decision was made to remove the wander guard bracelet on 03/29/11. In addition, she stated a Physician's Order should have been obtained prior to removing the wander guard bracelet.</p> <p>Interview on 07/07/11 at 3:00 PM with the RN Nurse Consultant revealed she was the Quality Assurance Nurse for the building and the facility had not identified a problem with the "Wandering Risk Assessment" and there had been no retraining on how to complete them. She stated she trained the MDS Nurses on the "Wandering Risk Assessment"; however, it was not formal training and she did not have the nurses sign any inservice sheet and was unaware if they had</p>	F 323		

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F 323	<p>Continued From page 23</p> <p>previous training. She stated the "Wander Risk Assessment" was self explanatory and there was no protocol or instruction sheet to refer to when completing the Assessment. Continued interview revealed the "Wandering Risk Assessments " were not being reviewed for accuracy.</p> <p>Interview on 07/09/11 at 12:20 PM with the Administrator revealed the Quality Improvement (QI) Committee was reviewing residents with wandering behaviors; especially ensuring the residents at risk had alarm bracelets, the wander guard bracelets were checked nightly to ensure they were working, and the door alarms were checked. However, they had not reviewed Resident #1 as a wanderer until the elopement on 06/10/11 because she/he was not considered a wandering risk per the "Wandering Risk Assessment". She stated she did not remember the resident leaving the building unsupervised in the past until recent chart review. Further interview revealed the wander guard, which was in place until 03/29/11, would not have been very effective due to the resident's room being on the North Unit, and the wander guard system was on the South Unit.</p> <p>However, the facility investigation revealed the resident had gone out the South exit near the beauty shop which would have alarmed had the resident been wearing a wander guard. She stated the resident should have been assessed for the need for a wander guard when the resident was moved from South to North; however, she was unsure if this was done because it was years ago. Further interview revealed there should have been a meeting with the Care Plan team to discuss removing the</p>	F 323		

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F 323 F 441 SS=D	<p>Continued From page 24 wander guard prior to staff removing the wander guard 03/29/11.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of</p>	F 323 F 441	<p>F441 Resident #13's perineal area was assessed by the Licensed Nurse on 7/9/2011, to include application of treatment per physician's order. SRNA #1 was re-educated by the DON on 7/11/2011 to provide perineal care to residents after each incontinent episode in the appropriate manner following infection control standards.</p> <p>All residents have the potential to be affected. Licensed and unlicensed nursing staff were re-educated by the DON/ADON/SDC Nurse/Facility RN Consultant on July 14, 2011, with regard to maintaining an infection control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. This program includes hand washing practices consistent with accepted standards of practice and properly handling linens to minimize cross-contamination.</p> <p>Adherence to the Infection Control Program including proper hand washing, perineal care and handling of</p>	

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F 441	<p>Continued From page 25 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy, and review of the facility's job description for State Registered Nurse Aides (SRNA) it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of sixteen (16) sampled residents, Resident #13.</p> <p>The findings include:</p> <p>Observation of perineal care, on 07/09/11 at 10:10 AM, performed by State Registered Nurse Aide (SRNA) #1 revealed she failed to gather needed supplies before beginning perineal care, failed to wash hands before perineal care, and put the wet brief and pants on Resident #13's bed instead of bagging the items. Further observation revealed SRNA #1 did not use wipes or soap and water to cleanse Resident #13 during the perineal care.</p> <p>Interview with SRNA #1, on 07/09/11 at 3:07 PM, revealed she was aware she should have washed her hands and gathered her supplies before beginning perineal care. She further stated she should have bagged the wet brief and pants and put them in the appropriate containers instead of putting them on the resident's bed. Further</p>	F 441	<p>linens will be monitored during daily rounds by the Administrator & Administrative Nurses. To monitor facility performance to ensure that solutions are sustained through the QI process, The Infection Control Committee will meet monthly to review and analyze facility statistics related to infection occurrences and control issues and assist in determining corrective action to maintain a safe, clean and comfortable environment for residents and staff. This committee will report on the effectiveness of the Infection Control Program monthly to the QI Executive Committee, consisting of the Administrator, DON, ADDON, QI Nurse, Treatment Nurse, MDS Nurse, Medical Director, &/or any other persons required to provide information pertinent to the reports being discussed, with further retraining or other such interventions implemented.</p> <p>Completion Date: 07/28/2011</p>	

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F 441	<p>Continued From page 26</p> <p>interview revealed she was aware it was an infection control issue to place soiled items on a resident's bed. Continued interview revealed she should have used wipes for perineal care.</p> <p>Interview with Licensed Practical Nurse (LPN)#1, who was the charge nurse, on 07/09/11 at 2:45 PM, revealed staff should have the supplies needed for perineal care before beginning perineal care and should not place wet, soiled items on a resident's bed.</p> <p>Review of the job description for SRNA's (revised 04/19/07) revealed SRNA's are supposed to (#37)-wash hands per recognized standards of infection control and (#38)-follow infection control procedures as established by the facility using standard precautions.</p> <p>Further review of a document titled "INCONTINENCE CARE", nursing policy manual (version 04/2007) revealed perineal care will be given after each incontinent episode.</p>	F 441		
F 490 SS=J	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, and review of the facility's investigation, it was determined the facility's Administration failed</p>	F 490	<p>F490</p> <p>The Regional Vice President of Operations reviewed with the Administrator on 7/11/11 facility oversight and ensuring implementation and monitoring effectiveness of this credible allegation of compliance. Daily communication will be conducted by the Administrator with the Regional Vice President of Operations until compliance is maintained to ensure that established policies are implemented related to the management and daily operation of the facility to maintain compliance with minimum State and Federal requirements by providing a safe environment for each resident. The DON will be held responsible by the Administrator to coordinate the care each resident receives and to assist in communicating with the Administrator and Medical Director when changes occur that may affect the care and services each resident receives to ensure care is carried out daily by the direct care staff according to each</p>	

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F 490	<p>Continued From page 27</p> <p>to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.</p> <p>The facility failed to have an effective system to ensure supervision to prevent accidents related to residents who were at risk for elopement/wandering. The facility failed to have an effective system to ensure staff accurately assessed residents regarding elopement/wandering risk. The facility failed to have an effective system to ensure Physician's Orders were followed related to orders for wander guards for residents with a known risk for elopement and a history of leaving the facility unsupervised. The facility failed to ensure the Quality Assessment and Assurance Committee (QA) was effective in identifying and correcting quality issues with the potential for negatively affecting residents. (Refer to F-281, F-323, and F-520).</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/07/11 and was determined to exist on 06/10/11, and is ongoing.</p> <p>The findings include:</p> <p>Review of the facility's investigation dated 06/10/11 revealed Resident #1 left the facility and</p>	F 490	<p>residents individualized assessment and plan of care.</p> <ul style="list-style-type: none"> Audits have been completed by the DON, ADON, MDS Nurses, SDC Nurse, QI Nurse, Treatment nurse and/or Facility Registered Nurse Consultants and will continue daily, Monday - Friday, to ensure all care areas and/or needs have been addressed. Concerns will be addressed immediately and corrected as indicated with oversight from the DON. Staff education has been conducted on the issues identified in this allegation of compliance to include completion of wandering risk assessments, identification of behaviors that indicate potential wandering, immediate response to all alert system alarms and the redirection of residents, and is ongoing as any other concerns are identified through the audits being conducted by the DON, ADON, MDS Nurses, QI Nurse, SDC Nurse and/or Facility Consultant. QI meetings will continue to be conducted weekly to continue to monitor effectiveness of this credible allegation of compliance. 	

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F 490	<p>Continued From page 28</p> <p>was found sitting on the ground off the premises and complained of having a "sore bottom". The interventions taken to prevent reoccurrence included an alarm system bracelet and a room change to a secure care system.</p> <p>Review of the facility's "Wandering Risk Potential Protocol", dated 05/2007, revealed the purpose of the protocol was to implement guidelines to identify a resident's risk for inappropriate wandering within or outside the facility, and to ensure a resident's safety in regards to the identified behaviors.</p> <p>Interview and record review revealed Resident #1 had a known risk for elopement and a history of leaving the building unsupervised. While the facility had previously assessed Resident #1 to be at risk for unsupervised exits, on 03/29/11 the facility assessed Resident #1 as not being at risk for wandering per the "Wandering Risk Assessment" and removed the resident's wander guard bracelet. This was despite the resident's cognitive status, history of elopement, medical diagnoses, and Physician's Order for a wander guard bracelet. On 06/10/11 Resident #1 eloped from the facility without staff knowledge. At approximately 9:30 PM, facility identified the resident was not in the building. Resident #1 was found off the facility's property, lying on the ground where he/she had fallen from the wheelchair, in the dark and pouring rain.</p> <p>Interview on 07/07/11 at 3:00 PM with the RN Nurse Consultant revealed she was the Quality Assurance Nurse for the building and the facility had not identified any problems with the "Wandering Risk Assessment". Interview</p>	F 490	<ul style="list-style-type: none"> On 7/08/2011 and again on 07/12/2011, the Medical Director was made aware of the results of the audits that have been completed and the education that has been provided to the staff and will continue to be made aware weekly of any observations and investigations conducted by the Administrator through a weekly written report. Rounds by the Facility Administrator utilizing the Administrative Staff/Department Head Rounds Sheet and Rounds by the DON utilizing the Administrative Nurse Rounds Tool are ongoing daily, Monday - Friday, to ensure that each resident receives the care and services to attain or maintain the highest practicable physical, mental, and psychological well being and safety of each resident. Rounds by Administrative Nurses including ADON, MDS Nurses, SDC Nurse, and QI Nurse are ongoing daily, Monday - Friday, utilizing the Administrative Nurse Rounds Tool. Any issues identified by the Administrative Nursing Rounds involving risk to 	

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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F 490	<p>Continued From page 29</p> <p>revealed the facility had provided training to the MDS Nurses, on how to complete the "Wander Risk Assessment". She was unaware of the MDS Nurses having formal training; however, stated she had provided on the job training. However, no documented evidence of the training was provided. Continued interview revealed the "Wandering Risk Assessment" was self explanatory and there was no protocol or instruction sheet in which to refer when completing the Assessment. She stated the "Wandering Risk Assessments" were not reviewed for accuracy by the Administrative Nurses after they were completed by the MDS Nurses.</p> <p>Interview on 07/09/11 at 12:20 PM with the Administrator revealed the Quality Improvement (QI) Committee was reviewing residents with wandering behaviors; to ensure the residents at risk had alarm bracelets, the wander guard bracelets were checked nightly to ensure they were working, and the door alarms were checked. Continued interview revealed they had not reviewed Resident #1 as a wanderer until the elopement on 06/10/11 because she/he was not considered a wandering risk per the "Wandering Risk Assessment" dated 03/29/11. She did not remember the resident leaving the building unsupervised in the past until recent chart review. The Administrator stated the wander guard, which was in place until 03/29/11, would not have been very effective due to the resident's room being on the North Unit, and the wander guard system being on the South Unit because there was an exit door on the North Unit which did not have a wander guard alarm. However, she stated the facility investigation revealed the resident had</p>	F 490	<p>resident safety will be immediately corrected as indicated and communicated to the Administrator.</p> <ul style="list-style-type: none"> Department head meetings between the Administrator, DON, ADON, Housekeeping Supervisor, Social Worker, Activities Director, Dietary Manager, and Rehab Manager will continue to be held daily, Monday thru Friday, to communicate any areas of concern and any items related to resident care, services or safety to the Administrator as indicated. <p>Weekly visits will continue to be made by the Regional Vice President of Operations and/or Facility Registered Nurse Consultant to provide additional oversight and guidance in ensuring implementation and effectiveness of this credible allegation of compliance. An Executive QI committee, including the Administrator, DON, ADON, QI Nurse, Medical Director and other interdisciplinary team members as directed by the Administrator, will meet at least monthly to ensure continued compliance and oversight of this credible allegation of compliance.</p> <p>Completion Date July 28, 2011</p>	

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F 490	Continued From page 30 gone out the South exit near the beauty shop which would have alarmed, had the resident been wearing a wander guard. Continued interview with the Administrator on 07/09/11 at 12:20 PM revealed Resident #1 was the only resident on the North Unit with a wander guard bracelet and was placed there years ago after a conflict with another resident. She stated the resident should have been assessed for the need for a wander guard when the resident was moved; however, she was unsure if this was done. Continued interview revealed there should have been discussion with the Care Plan team related to removing the wander guard prior to staff removing the wander guard 03/29/11. Further interview revealed the wander guard should not have been removed on 03/29/11 without a Physician's Order, since there was an order for the wander guard.	F 490		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	F520 The Facility Registered Nurse Consultants reviewed with the Administrator, DON, ADON, and QI Nurse the components of the facility QI program to identify quality deficiencies and develop and implement plans of action to correct those deficiencies including monitoring the effectiveness of the implemented changes and making needed revisions to the action plans on 7/11/2011. Weekly QI meeting will be held with the DON, ADON, Administrator, MDS Nurses, QI Nurse and other Interdisciplinary team members as directed by the Administrator. Any identified areas of concern will be immediately addressed and corrected. QI areas to review include: <ul style="list-style-type: none">• Weekly QI review of problems identified and the actions taken as a result of audits of nurse's	

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F 520	<p>Continued From page 31</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective Quality Assurance (QA) Committee that was structured to identify quality issues with the potential for negatively affecting the residents, and failed to implement plans of action to correct identified deficient practices. In addition, there was no evidence the Committee implemented an effective action plan to ensure that the corrective actions related to deficiencies cited during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 and the onsite Revisit Survey concluded on 05/26/11 were resolved, thus resulting in continued non-compliance in the areas of CFR 483.20 Resident Assessment, F-281 and CFR 483.25 Quality of Care, F-323; although the facility deemed compliance on 05/12/11 for these deficiencies.</p> <p>The facility failed to have an effective system for ensuring services provided met professional standards of care related to ensuring staff were knowledgeable on how to accurately assess residents regarding elopement/wandering risk and Physician's Orders were followed related to</p>	F 520	<p>notes, review of pink carbon copies of physician's orders and audit of the medication administration records to identify if any care needs were potentially not met related to F281.</p> <ul style="list-style-type: none"> Weekly QI review of problems identified and the actions taken as a result of audits of nurses' notes and 24-hour nursing reports and review of daily rounds tools to identify if residents at risk for wandering have been properly assessed and appropriate interventions have been put in place to reduce the risk of potential hazards related to F323. Effectiveness of the facility's At Risk for Wandering protocol and residents identified as being at risk for wandering will be reviewed weekly by the Quality Improvement Committee consisting of the Administrator, DON, ADON, QI Nurse and MDS Nurse. <p>The Quality Improvement Executive Committee consisting of the Administrator, DON, ADON, QI Nurse, Medical Director, and other persons required to provide information pertinent to the reports being discussed at the Executive Committee</p>	

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F 520	<p>Continued From page 32</p> <p>orders for wander guards for residents with a known risk for elopement and a history of leaving the facility unsupervised.</p> <p>The facility failed to identify quality issues related to supervision to prevent accidents related to residents who were at risk for elopement/wandering. On 06/10/11 Resident #1 eloped from the facility without staff knowledge between 9:15 PM and 9:45 PM. Resident #1 was found off the premises in a parking lot of the building beside the facility, had fallen from her/his wheelchair, and was lying on the ground in the dark and pouring rain.</p> <p>The facility's failure to have an effective system in place to identify quality issues related to ensuring nursing care was provided in accordance with accepted standards of care and supervision to prevent accidents was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/07/11 and was determined to exist on 06/10/11, and is ongoing.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Based on interview and record review, it was determined the facility failed to have an effective system to ensure nursing care was provided in accordance with professional standards of care. This was a repeat deficiency which was cited on the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 for CFR 483.20 Resident Assessment F-281 at a S/S of a "J". Immediate Jeopardy identified during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11, was removed on the onsite Revisit Survey concluded on 05/26/11; 	F 520	<p>meeting will meet monthly. This committee has been charged with the implementation of the objectives of the Quality Improvement program. The role of the committee was clarified by the Administrator with guidance from the Regional Vice President and Facility Registered Nurse Consultant on 7/11/11. The job of the committee includes establishment, maintaining and documenting evidence of an ongoing Quality Improvement Program that includes systems for monitoring and evaluating resident care and for obtaining an appropriate response to findings. Trends & the accompanying action from the above listed action teams will be reviewed by this Executive Qi Committee monthly with further retraining or other such interventions implemented as necessary.</p> <p>Completion Date July 28, 2011</p>	

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F 520	<p>Continued From page 33 however, the deficiency was recited and lowered to a S/S of a "D".</p> <p>Review of the facility's acceptable Plan of Correction with a compliance date of 05/12/11 revealed the DON, ADON, RN Supervisor and/or Facility RN Consultant would review the carbon copies of Physician's Orders, and would read Nurse's Notes daily to ensure Physician's Orders were followed.</p> <p>However, the facility failed to have an effective system to ensure Physician's Orders were followed related to orders for wander guards. On 03/29/11 the facility removed the resident's wander guard bracelet although the resident had a Physician's Order for a wander guard bracelet. Resident #1 eloped from the facility without staff knowledge on 06/10/11 and was found and fifteen (15) to thirty (30) minutes later off the facility's property, lying on the ground where he/she had fallen from the wheelchair, in the dark and pouring rain. The facility investigation identified the resident eloped through the South Unit exit door next to the beauty shop which had a wander guard alarm system.</p> <p>Interview with the RN Consultant/Quality Assurance Nurse on 07/07/11 at 3:00 PM revealed the facility continued to review Physician's Orders and Nurse's Notes daily to ensure Physician's Orders were followed. However, she stated it was not identified until 06/17/11 through the Quality Improvement audits, that there was a Physician's Order for the wander guard after the resident eloped on 06/10/11.</p> <p>2. Based on interview and record review, it was</p>	F 520		

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F 520	<p>Continued From page 34</p> <p>determined the facility failed to have an effective system to ensure supervision to prevent accidents. This was a repeat deficiency which was cited on the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 for CFR 483.25 Quality of Care at a S/S of a "K". Immediate Jeopardy identified during the Abbreviated Survey and Partial Extended Survey concluded on 05/05/11 had been removed on the onsite Revisit Survey concluded on 05/26/11; however, the deficiency was recited and lowered to a S/S of a "E" as the facility had not completed the development and implementation of the Plan of Correction (POC) to ensure each resident received adequate supervision to prevent accidents.</p> <p>Review of the facility's acceptable Plan of Correction with a compliance date of 05/12/11 revealed the DON, Assistant DON, Quality Improvement (QI) Nurse, Minimum Data Set (MDS) Nurse, Treatment Nurse and/or Facility Consultant Nurses were to read Progress Notes and review the twenty-four (24) Hour Report daily to ensure the interventions implemented for a resident identified with behaviors remained effective at reducing the risk of danger to others. The facility further alleged the results of the audits would be reviewed weekly in the QI Meeting and reported monthly to the QI Executive Committee Meeting which consisted of the Medical Director and other staff as attended the weekly QI Committee.</p> <p>However, the facility failed to have an effective system to ensure residents were accurately assessed for being at risk for wandering/elopement. The facility failed to have</p>	F 520		

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F 520	Continued From page 35 an effective system to ensure staff was knowledgeable on how to accurately assess residents regarding elopement/wandering risk. Although the facility had previously assessed Resident #1 to be at risk for unsupervised exits, on 03/29/11 the resident was inaccurately assessed to not be at risk for wandering despite the resident's cognitive status, diagnoses, and history of leaving the facility unsupervised. Interview on 06/29/11 at 5:00 PM with the RN Nurse Consultant/Quality Assurance Nurse revealed the facility had not identified a problem with the "Wandering Risk Assessment" not being completed accurately. She stated there had been no retraining on how to complete them since Resident #1 eloped on 06/10/10. She further stated she had trained the Minimum Data Set (MDS) Nurses on the "Wandering Risk Assessment" in the past; however, it was not a formal training and no documented evidence was provided of the training. Continued interview revealed the "Wandering Risk Assessment" was self explanatory and there was no protocol or instruction sheet related to the Assessment. She further stated the "Wandering Risk Assessments" were not reviewed by the administrative nurses for accuracy, after they were completed by the MDS Nurses. Interview on 07/09/11 at 12:20 PM with the Administrator revealed the Quality Improvement (QI) Committee met weekly and the Executive QI Committee met monthly which included all staff who attended the weekly meeting and the Medical Director. She stated they continued to review residents with wandering behaviors; to ensure the residents at risk for wandering had	F 520		

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F 520	Continued From page 36 alarm bracelets, and that the wander guard bracelets were checked nightly to ensure they were working properly. She stated they also ensured audits were completed to check the door alarms. Further interview revealed they were not reviewing the "Wander Risk Assessments" for accuracy and was unaware there was a problem with the Assessments. She stated the committee had not reviewed Resident #1 as a wanderer until the elopement on 06/10/11, because she/he was not considered a wandering risk per the "Wandering Risk Assessment" dated 03/29/11. Continued interview revealed there should have been discussion with the resident's Physician prior to removing the wander guard since there was a Physician's Order for the wander guard. In addition, she stated the interdisciplinary staff and the Care Plan team should have discussed removing the wander guard prior to staff removing the wander guard 03/29/11.	F 520		