STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185069	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45990 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to protect one (1) of seventeen (17) sampled residents (Resident #6), from abuse. Review of the Facility Self-Report form, dated 03/12/2022, revealed Licensed Practical Nurse (LPN) #5 heard residents yelling. Upon entering the residents' room, LPN #5 observed Resident #15 standing over Resident #6, with Resident #15's hands over Resident #6's mouth and nose. Per the report, Resident #15 was also shaking Resident #6. The findings include: Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, dated 05/08/2019, revealed the facility's intention was to prevent the occurrence of abuse through the use of proper identification, reporting, and training. Further review revealed this was accomplished through proper definitions for abuse as well, as prevention methods and timeline to be reported. Continued review of the policy revealed prevention measures would include an admission evaluation as well as periodic evaluations to identify vulnerabilities such as cognitive, physical, psychological, environment, and communication concerns. Review of Resident #15's medical record revealed the facility admitted the resident, on 03/09/2022, with diagnoses that included Posterior Reversible Encephalopathy Syndrome, Gastro-esophageal Reflux Disease, and Muscle Weakness. Review of the Observation Detail List, dated 03/10/2022, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of ten (10) of fifteen (15), which indicated his/her cognition was moderately impaired. Review of Resident #6's medical record revealed the facility admitted the resident, on 02/01/2022, with diagnoses that included Atrial Flutter, Transient Ischemic Attack (TIA), and Generalized Muscle Weakness. Review of Resident #6's Admission Minimum Data Set (MDS) Assessment, dated 02/04/2022, revealed the resident had a BIMS' score of fifteen (15) of fifteen (15), indicating the resident was cognitively intact. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Initial Self-Reported form, dated 03/12/2022, revealed on the evening of 03/12/2022, around 9:00 PM, Resident #6 was drifting off to sleep when Resident #15 stood up out of bed. Resident #6 instructed Resident #15 to sit back down to prevent falling. Per the report, Resident #15 walked over to Resident #6's bed, placed his/her hands on Resident #6's mouth and nose, and starting shaking Resident #6. Resident #6 yelled, Nurse help me. Further review of the report revealed Licensed Practical Nurse (LPN) #5 entered the room, separated the residents, and removed Resident #15 from the room. Resident #15 was placed on one-to-one (1:1) supervision, and both residents were assessed, including skin assessments. Additional review revealed the Physician, families of the residents, the Department for Community Based Services (DCBS/Adult Protective Services), and the Ombudsman were notified of the incident. Review of Resident #6's skin assessment, dated 03/12/2022, no time specified, revealed a scratch to the resident's right cheek area. Requests were made to the Administrator by the State Survey Agency (SSA) Surveyor, to see documentation of Resident #15's skin assessment, but the Administrator did not provide this documentation. Review of Resident #6's Progress Note, dated 03/12/2022 at 11:45 PM, revealed, after the incident, Resident #6 was nervous. Per the note, Registered Nurse (RN) #3 explained to Resident #6 that his/her roommate, Resident #15, would not return. Further notation revealed Resident #6 did not complaint of pain and his/her scratch was cleansed without redness or bleeding. Review of Resident #15's Progress Note, dated 03/12/2022 at 11:39 PM, revealed, after the incident with Resident #6, Resident #15 was placed on one-to-one (1:1) supervision, the Physician was notified, and Physician's Orders were received, which included to send the resident to the emergency room (ER). The Note stated Resident #15's family, the Director of Nursing (DON), and the Administrator were notified as well. Per the note, the ambulance arrived around 9:30 PM, and Resident #15 was taken to the ER. Further review of the Facility's Allegation Report and Investigation, Final Report, dated 03/18/2022, revealed it confirmed the information from the initial report. In addition, the report stated that staff interviewed had not noted any aggression, combative outburst, or verbal outburst from Resident #15, while at facility and prior to the incident with Resident #6. Per the report, the conclusion of the facility's investigation determined resident-to-resident abuse had occurred. It stated Resident #15 was not admitted back to facility after he/she was sent to the ER, on 03/12/2022. It also stated staff had been educated on residents' rights, abuse, and neglect. Interview with Resident #6, on 04/12/2022 at 10:15 AM, revealed, when the incident occurred, he/she was afraid his/her roommate, Resident # 15, was going to fall after standing up from the bed. Resident #6 stated he/she was giving Resident #15 instructions to sit back down to prevent him/her from having a fall. Resident #6 stated he/she still felt safe in the facility, and staff was quick to respond to the incident and removed Resident #15 from the room. Follow-up interview with Resident #6, on 04/15/2022 at 10:30 AM, revealed he/she still felt safe and was eating well and sleeping well. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse (LPN) #5, on 04/13/2022 at 1:00 PM, revealed she was getting ready to go home around 9:00 PM and heard someone yelling and discovered the sound was coming from room [ROOM NUMBER] (the room of Resident #6 and Resident #15), and the door was closed. She stated, upon opening the door, she saw Resident #15 leaning over the bed of Resident #6. LPN #5 stated she immediately separated the two (2) residents, called for help, and other staff responded quickly. At that time, Resident #15 was placed in a wheelchair and removed from the room, with another unidentified staff member sitting with him/her. LPN #5 reported she performed an assessment, including skin, on Resident #6 and discovered a superficial scratch to the resident's right cheek. Per interview, LPN #5 stated the resident's right cheek scratch needed no treatment and was left open to air. LPN # 5 stated Registered Nurse (RN) #3 took over Resident #6's care, and she left the facility. She stated Resident # 15 was in the common area with staff sitting with him/her when she left. Interview with RN #3, on 04/21/2022 at 3:02 PM, revealed she was working the unit where both residents resided, and she heard yelling. She stated she entered room [ROOM NUMBER], Resident #6's and #15's room, and LPN # 5 was already in the room and had the residents separated. After removing Resident #15 from the room and placing him/her on one-to-one (1:1) observation, she immediately reported the incident to the DON and Physician. RN #3 stated she was unsure of the exact time, but thought it was close to 9:00 PM. RN #3 stated both Resident #6 and Resident #15 were assessed, and Resident #6 had a small scratch to the right cheek; Resident #15 had no injuries. Further interview revealed Resident #15 had not exhibited any prior combative or aggressive behavior while at the facility. She stated Resident #15 remained on one-to-one (1:1) observation until he/she was transferred to the ER. Interview with State Registered Nurse Aide (SRNA) #14, on 04/21/2022 at 4:26 PM, revealed she was working that night, on the unit where the altercation happened, but she was not a witness to it. Further interview revealed she provided one-to-one (1:1) supervision with Resident #15 to give another aide a break. She stated Resident #15 had not exhibited any combative or aggressive behavior while at the facility, prior to this incident. Interview with the Social Services Director (SSD), on 04/22/2022 at 10:40 AM, revealed she knew fifteen (15) minute checks were performed on Resident #6, and Resident #15 was placed on one-to-one (1:1) observation. She stated the incident was reported to the Administrator. Interview with the Administrator, on 04/22/2022 at 10:15 AM, revealed the DON had reported the incident to her, and the SSD had followed the process for reporting to the required persons. She stated she knew Resident #15 was placed on one-to-one (1:1) supervision and transferred to a hospital'sER on [DATE], after the incident. Further interview revealed Resident #15 was not readmitted due to behavior issues. The Administrator also stated abuse training was ongoing at that time and would continue until all staff were educated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44396 Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure the Comprehensive Care Plan was revised as determined by the resident's needs for one (1) of seventeen (17) sampled residents (Resident #1). Record review revealed Resident #1 had an exit attempt, on [DATE] at 8:00 AM, during which he/she was able to get his/her feet through the threshold of the facility's door, which triggered the egress door alarm. Record review revealed staff performed an Elopement Risk Evaluation (ERE), on [DATE], and assessed Resident #1 to be at high risk for elopement. Review of the Progress Notes revealed this evaluation was conducted due to increased wandering, as well as exit seeking behavior. On [DATE], a Wander Guard bracelet, (a tracking device designed to prevent persons at risk for wandering from leaving the facility unaccompanied) was placed on the resident. However, there was no documentation the care plan was revised to include the Wander Guard and no documentation the facility monitored the device as per the facility's policy. Staff interviews revealed Resident #1 experienced increased wandering, specifically on [DATE] and on [DATE]. Continued interviews, and review of progress notes, revealed Resident #1 was agitated and exit seeking, pushing on doors to the point of triggering the egress alarms. Additional interviews revealed, on [DATE], Resident #1 was stating he/she needed to go to the store. However, there was no documentation the care plan was revised to include increased supervision. Review of the facility's security camera video recording revealed Resident #1 rolled to the exit door, on [DATE] at 7:56 AM, sat at the door while pushing on it, then exited the building at 7:57 AM, without staff knowledge. Further review revealed the Physical Therapist found Resident #1 in the rear parking lot when coming to work and returned the resident to the facility. The facility's failure to have an effective system in place to ensure each resident's care plan was updated with interventions to reduce or prevent the likelihood of an elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] and was determined to exist on [DATE], in the areas of 42 CFR 483.21 Comprehensive Person-Centered Care Planning, F-657 Care Plan Timing and Revision at a Scope and Severity (S/S) of a J and 42 CFR 483.25 Free of Accidents/Hazards/Supervision, F-689 at a S/S of a J along with Substandard Quality of Care. The facility was notified of the Immediate Jeopardy (IJ) on [DATE]. Licensed Practical Nurse (LPN) #2 The findings include: (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Comprehensive Care Plans, last revised [DATE], revealed person-centered care plans were developed that included measurable objectives to meet medical, nursing, mental, and psychological needs for each resident. Further review of the policy revealed care plans were developed based on a thorough assessment that included, but was not limited to, the Resident Assessment Instrument. Continued review of the policy revealed care plans were designed to incorporate identified problem areas as well as associated risk factors. Additional review revealed care plans identified the professional services that were responsible for each element of care and aided in preventing or reducing declines in the resident's functional status and/or functional levels. Review of the policy also revealed that the MDS was used to assess a resident's condition, cognitive and functional status, and that the Care Area Assessments (CAA) were used in the development of the care plan. Review of the policy further revealed that care plans were ongoing and revised as information about the resident and the resident's condition changed. The continued policy review also revealed that the Nurse/Interdisciplinary Team (IDT) was responsible for the review and updating of care plans, with updating when there had been a significant change in condition, change in goals, and completed at least quarterly. Review of the facility's policy titled, Elopement/Wandering, last reviewed [DATE], revealed that the facility's intent was to maintain resident safety by identifying those who were at risk for wandering/elopement behavior. Further review revealed that any resident displaying significant wandering behavior would be assessed for elopement/wandering risk and care planned appropriately. Review of the facility's policy titled, Care of the Wandering Resident, last reviewed and revised [DATE], revealed that care should be planned to reduce the risk from exit seeking behavior and that the facility should increase supervision as deemed necessary by the IDT. Review of Resident #1's Electronic Medical Record (EMR) revealed the facility admitted the resident, on [DATE], with diagnoses including Non-Hodgkin's Lymphoma, Unspecified, Spleen; Unspecified Dementia with Behavioral Disturbance; Altered Mental Status, Unspecified; and Syncope and Collapse. Upon admission, Resident #1 the facility assessed the resident with a Brief Interview of Mental Status (BIMS) a score of five (5) of fifteen (15), which indicated severe cognitive impairment. An Elopement Risk Evaluation (ERE) was conducted at the same time, which revealed Resident #1 was a low risk for elopement. Review of Resident #1's Comprehensive Care Plan, dated [DATE], revealed a new Problem area for Elopement, with a start date of [DATE], after an ERE completed on [DATE], demonstrated the resident was at risk for elopement. The category was further defined with the statement that the resident was at risk for elopement as evidenced by both wandering and exit seeking behaviors. The approaches, at that time, included: to monitor for tailgating (trying to exit right after another person when the door was open); use cues for redirection; and, to use diversionary activities to prevent elopement. There were no approaches to elopement to increase supervision or to apply a Wander Guard bracelet at that time. Continued review revealed that, after Resident #1's overt exit seeking behaviors on [DATE] and an ERE that assessed the resident as an elopement risk, no nurse or facility staff modified the care plan to reflect the behavior and risk. In addition, the facility failed to add the Wander Guard to the care plan, which had been applied on [DATE]. Additional review revealed that, after subsequent exit seeking behavior on [DATE], the care plan was not updated to reflect any need for increased supervision or other interventions to prevent elopement. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Physician's Orders revealed the addition of orders, Encourage activities twice daily and encourage out of bed daily due to altered mental status on [DATE]. Further review revealed the addition of an order for Psych consult, please ensure has been done. on [DATE]. Review of Progress Notes revealed an entry, dated [DATE], describing receipt of an order for a psychiatric consult for the following Friday, [DATE]. Continued review of Physician's Orders revealed the addition of instructions to Check function of Wander Guard daily and Check placement of Wander Guard every shift as well as Monitor expiration of battery of Wander Guard monthly on [DATE]. These interventions were after the elopement. Review of Resident #1's Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed staff had only documented Wander Guard placement and function checks on each shift beginning [DATE], after the elopement. Review of Resident #1's Progress Notes in his/her EMR revealed aggressive behaviors as of the night of [DATE] and [DATE]. No undue behaviors were noted prior to this date. Review of the second ERE, dated [DATE], reflected that Resident #1 was at risk for elopement, but there was no evidence of such in the Progress Notes. Further review revealed a Progress Note, dated [DATE], when Licensed Practical Nurse (LPN) #8 found Resident #1 going toward an exit door stating that he/she wanted to go home that night. Continued review of Resident #1's Progress Notes revealed an exit attempt on [DATE] at 8:00 PM, during which he/she was able to get his//her feet through the threshold. Resident #1 stated that he/she was looking for his/her children. The resident was returned inside the building, then redirected to his/her room. Additional review revealed the attending nurse reported the event to the Unit Manager (UM). Further review review revealed the following day she conducted the third ERE, which confirmed that Resident #1 was a high risk for elopement; a Wander Guard ankle bracelet was applied. Continued review of the Progress Notes revealed exit seeking behavior with redirection on [DATE]; and, again on [DATE] when he/she was able to trigger door alarms. Review of the facility's security camera video recording, viewed on [DATE] at 1:51 PM, revealed Resident #1 advanced in a wheelchair to the Northeast door, by the residents' library, on [DATE] at 7:56:54 AM. He/she was at the door, alternating pushing on the door and looking back down the hall, for forty (40) seconds before exiting through the door. The next image revealed Resident #1 returning through the door with Physical Therapist (PT) #1 pushing his/her wheelchair at 7:59:56 AM. Interview with Resident #1, on [DATE] at 1:40 PM, while resting in bed revealed that he/she did not remember leaving the building nor recalled any reason he/she might have attempted to leave. The resident stated he/she felt safe in the facility. Observation at this time revealed the resident had a one-to-one (1:1) staff member assigned. Interview with Certified Nursing Assistant (CNA) #3, on [DATE] at 3:52 PM, revealed Resident #1 had dementia and that he/she should be on a dementia unit as he/she is constantly wandering, always. She stated that she had worked night shift prior to Resident #1's ([DATE]) exit incident. The CNA stated that the resident had been wandering during the night. She further stated that Resident #1 was at the door over and over, but did not push on it long enough to trigger the alarm. CNA #3 stated the resident was very persistent on pursuing the door, having stated that he/she had to get up and go to work at the store. She stated that Resident #1 was determined to get out the door, but finally got tired, was helped to bed, and then slept the remainder of the night. Further interview revealed she did not report the behavior to the nurse on duty, LPN (Licensed Practical Nurse) #2. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA #6, on [DATE] at 1:29 PM, revealed the day before the elopement, on [DATE], Resident #1 was antsy, stating he/she wanted to leave and was looking for the door. She stated she was on light duty, so she was walking around with Resident #1, trying to redirect and occupy the resident's time. CNA #6 further stated that while wandering, Resident #1 was sitting by the Northwest door, pushed on the door, and the alarm sounded. She stated she and CNA #7 responded to the door alarm, redirected Resident #1 to the dining area, and settled him/her for dinner. She stated she reported this to the Director of Nursing (DON), who asked her to stay with the resident until the end of the shift for the resident's safety. CNA #6 further stated Resident #1 had been anxious about his/her glasses being broken and was calmed when the DON was able to repair them. She stated she gave report to the oncoming staff about Resident #1's wandering. After dinner, CNA #6 stated Resident #1 roamed the dining room after dinner and was reading instructions on the door about egress and the fifteen (15) second wait when doors opened, but was not close enough to trigger the Wander Guard door alarm. Interview with Licensed Practical Nurse (LPN) #1, on [DATE] at 4:05 PM, revealed, on Monday night, [DATE], Resident #1 had gone to the middle door, but was redirected to the nurses' station. Interview with LPN #2, on [DATE] at 8:20 PM, revealed Resident #1 had been exit seeking before the elopement, pushing the doors, and setting off alarms. She stated Resident #1 was exit seeking last week, on [DATE], and that she had redirected the resident, put the code in to cancel the alarm, and called maintenance for assistance, as well as documented the behavior in the EMR. Further interview revealed LPN #2 had not updated Resident #1's care plan. Interview with the Unit Manager, on [DATE] at 11:24 AM, revealed that elopement care plans and CNA Point of Care (POC) plans for residents, who were elopement risks started with the nurse, then received subsequent oversight from the Director of Nursing (DON) and the Administrator. Interview with the Minimum Data Set (MDS) Coordinator, on [DATE] at 9:00 AM, revealed care planning was the responsibility of many across the whole staff, with the MDS Coordinator adding problems and approaches related to what the resident's assessments revealed. Continued interview revealed that nursing staff was expected to add to care plans in response to new events or Physician's Orders. Additional interview revealed the Social Services Director (SSD) might add problems such as behavior management goals or approaches. Further interview revealed nurses were responsible for noting an event then adding an intervention in the care plan, while the facility's Interdisciplinary Team (IDT) might meet the next day to add more details, also using the Progress Notes and 24 Hour Report (a document that detailed significant events that have occurred in the past twenty-four (24) hours on a given unit) to review and revise the care plan. She stated the IDT included the MDS Coordinator, SSD, Activities Director, DON, UM, and Medical Records Director. Continued interview revealed revising the care plan was a collaborative effort, and no single person was responsible for all residents' care plans. The MDS Coordinator stated that her phone number was available in the communication book so nurses could call for guidance on adding to care plans if she was not in the facility. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Assistant Director of Nursing (ADON) #2, on [DATE] at 1:29 PM, revealed the [DATE] ERE occurred after Resident #1 had exhibited behaviors changes. She further reported that the [DATE] occurred in response to overt exit seeking, to include getting feet over the threshold of a door and that a Wander Guard was applied because of this event. Further interview revealed that she was able to make the decision to apply the Wander Guard and then take it to the IDT for review. Continued interview revealed that she did not necessarily need a doctor's order, though the staff would notify the Physician with the change of condition anyway. ADON #2 stated that in response to any resident who was exit seeking, the nurse was expected to notify the Director of Nursing (DON), who would in turn inform the Unit Manager (UM). She stated the DON could also give the instruction to apply the Wander Guard, start every fifteen (15) minute supervisory checks or whatever was necessary for the situation. ADON #2 stated the expectation was that staff observing exit seeking behavior would notify leaders, keep a closer observation of the resident or provide interventions to prevent elopement, and revise the care plan, if a nurse. Interview with the DON, on [DATE] at 3:42 PM, revealed she had been in her position since [DATE]. Further interview revealed that she had observed Resident #1 wandering with glasses in his/her/hand during the late afternoon, before dinner, on [DATE]. She stated she repaired Resident #1's glasses. Since CNA #6 was on light duty she asked her to keep an eye on Resident #1, due to agitation. The DON stated the instructions, to the CNA, were to stay with him/her, keep him/her company, and help the resident avoid exit doors. Continued interview revealed that she made no assignment of one-to-one (1:1) supervision for the night because the resident was wandering but did not exhibit exit seeking at the time. Additional interview revealed she was not aware of Resident #1's prior exit seeking behavior, and if that had happened, the nurse should have notified her or placed the resident on the 24 Hour Report. The DON also stated she expected observations of exit seeking behaviors from residents would be carried forward in report from shift to shift, and the residents' care plans should be revised to reflect the interventions undertaken to prevent elopement. Interview with the Administrator, on [DATE] at 2:12 PM, revealed she was aware of Resident #1's increased exit seeking, but had personally observed that he/she was able to be redirected easily prior to this incident. She stated she had not been aware of the details of changes in behaviors due to time of day or any specific precipitator. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on [DATE] that alleged removal of the IJ on [DATE]. Review of the IJ Removal Plan revealed the facility implemented the following: 1. On [DATE] Resident #1 was placed on one-to-one (1:1) supervision immediately upon being brought back into the facility. One on one was provided by the Unit Manager (UM) and then she was replaced by a Certified Nurse Assistant (CNA). Resident #1 was assisted to his/her room and received a head-to-toe assessment by UM LPN. No new concerns. Vital signs were obtained by UM: BP ,d+[DATE], HR 74, RR 20, Temp 97.4 O2 saturation 98%. No concerns noted. A pain Assessment was completed, the Wander Guard was tested , and the Physician and family were notified by the UM. No noted concerns. 2. On [DATE], prior Residents reviewed that had been identified to be an elopement risk and validation was completed that their Wander Guard was working, not expired, was monitored for function and placement, elopement binder up to date, elopement assessment and care plan up to date by Social Worker (SSD) Director of Nursing (DON), Plant Director, and Minimum Data Set (MDS) Nurse. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Elopement risk evaluation were completed on 100% of residents on [DATE] by the DON, UM, ADON and Regional Nurse. All residents had been assessed correctly. 4. An audit was completed on [DATE] of the care plans of current residents who were at risk for exit seeking/elopement behavior and the care plans and CNA point of care plans were revised by the DON, UM, ADON and Regional Nurse. No other elopement issues were identified that were not on the care plans. 5. On [DATE] Maintenance checked all doors and alarms and changed door codes. The door in question was malfunctioning and alarm was not sounding when release bar held for 15 seconds. The Plant Operations Director (DOP) was placed at this door and rotated out with both plant operations assistants until it could be repaired. Maintenance immediately requested servicing from Pads and Mags Doors to come and inspect the malfunctioning alarm. Delayed egress controller was found to have an internal faulty wire which caused door to not alarm, per the technician with Pads and Mags Doors. Administrator reviewed the past 30-day door checks completed by Plant Director and found no concerns. All facility doors with and without Wander Guards will be checked Monday-Friday by facility maintenance and the same checks done on Saturday and Sunday by the facility Manager on Duty. 6. Signature Care Consultant educated Administrator, Staff Development Coordinator (SDC), DON, UM's and MDS nurse on [DATE] on the following Elopement/missing person policy, care of a wandering resident policy, comprehensive care plan update related to elopement risk residents and changes in behaviors. 7. Re-education started on [DATE] and was completed by [DATE] on Elopement/Missing Resident, Elopement/Wandering Residents, Care of Wandering Resident, and Revision of the Comprehensive Care Plans by the SDC for all staff (Elopement) and nurses for comprehensive care plans, and what to include, door alarms and door codes, use of entrances and exits, behavior management of residents at risk for elopement and wandering, and the wander guard test box system. All stakeholders working [DATE] were educated on that day and all stakeholders were educated from then on, before they worked. As of midnight, on [DATE], 36 of 75 stakeholders had been educated. Agency staff were educated before they worked per the schedule by the Staff Development Coordinator. Stakeholders who have not received the re-education by start of shift [DATE] will be expected to complete the education prior to the next shift they work given by the Administrator, DON and SDC. This education will also be included in orientation for all new staff. Any elopement concerns by nursing will be placed on the 24-hour shift report. 8. Elopement drills were conducted daily starting on [DATE] and going through [DATE]. Elopement drills were completed by Plant Operations. Following the elopement drills for five (5) days, then elopement drills will be conducted three (3) times per week on different shifts for thirty (30) days and two (2) times per week for the next thirty (30) days and one (1) time per week for the next thirty (30) days. Any issues identified will be immediately corrected, re-education provided, up to and including disciplinary action as deemed necessary by the Director of Nursing and Administrator. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. All residents' progress notes will be read during the daily clinical meeting for monitoring of any exit seeking behavior by the Interdisciplinary Team (IDT), (the team includes DON, UM, ADON, SSD, Activities Director and Therapy) seven (7) days per week for thirty (30) days at stand-up meeting and on Saturday and Sunday the progress notes will be read by the DON and Administrator starting on [DATE] and continuing for next thirty (30) days. Any resident identified will have elopement assessment completed and if determined to be at risk will have an intervention put in place, appropriate care plans updated, and the elopement binders updated. 10. All exit doors in the facility, both with and without the Wander Guard system, will have monitoring seven days per week, Monday through Friday by the facility Maintenance and Saturday and Sunday by the facility Manager on Duty. 11. A Quality Assurance Meeting was conducted on [DATE] and again on [DATE], reviewing all proposed education and action plan with Medical Director, DON, SDC, UM and Regional Nurse. On [DATE] the Quality Assurance Committee, consisting of Administrator, DON, ADON, UM, Regional Nurse, SDC, and SSD met to review all interventions put in to place thus far and the plan moving forward. It was determined that the SDC or DON would educate all stakeholder who had not yet worked before they worked from [DATE] forward. 12. Regional oversight has been in place daily for this plan since [DATE]. Regional oversight has occurred on site or by phone from the Signature Care Consultant, the Regional [NAME] President, or a member of the Regional Team. This will continue until immediate jeopardy is abated. The State Survey Agency validated the implementation of the facility's IJ Removal Plan as follows: 1. Review of Resident #1's EMR revealed a progress note and care plan additions for 1:1 supervision as of [DATE]. Interview with the UM on [DATE] at 11:24 AM revealed she provided initial 1:1 supervision after Resident #1 was returned to his/her room, until that supervision was scheduled with aides for each shift. The UM stated she assisted Resident #1 to his/her room after being returned inside the facility from the parking lot, she performed a measure of vital signs and all were within normally defined limits, she assessed Resident #1's pain, Resident #1's Wander Guard was tested and shown to be in working order after return to his/her room and found no concerns. Review of staffing schedules for the shifts subsequent to the elopement demonstrated CNA assignments for Resident #1's supervision. Review of Medication Administration Record/Treatment Administration Record (MAR/TAR) revealed placement and function testing was completed on [DATE]. Review of the Event Report post incident revealed a pain assessment was completed. Interviews with LPN #6 on [DATE] at 09:29 PM, and the DON on [DATE] at 11:26 AM revealed that the physician and Resident #1's son were notified on the date of the event and review of the Event Report documented notification at [DATE] by 12:17 PM. Review of the Resident #1's progress notes revealed that his/her son arrived shortly after 09:15 AM on [DATE], post incident. Interview with POA revealed they had been notified that morning, and Resident #1's son went to the facility right away. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Interview with the SSD on [DATE] at 11:40 AM revealed she had completed all Wander Guard reviews, ensuring all were in place, working and not expired. Continued interview revealed she then reviewed and revised care plans, including Wander Guard interventions, in conjunction with the MDS nurse, the DON and Administrator as well as reviewed and confirmed entries in the Elopement Binder to be accurate, and that Wander Guard interventions were in those care plans. Observation revealed appropriate testing of Wander Guard placement and function with no concerns noted. 3. Interview with the DON on [DATE] at 11:56 AM revealed she had completed Elopement Risk Assessments on each resident in the facility on [DATE], in conjunction with ADON, UM and Regional Nurse. Review of residents' EMRs revealed Elopement Risk Assessments were documented for each resident on [DATE]. 4. Interview with DON on [DATE] at 11:56 AM revealed that she, the UM, ADON and Regional Nurse audited, and revised resident care plans as needed by [DATE], for exit seeking/elopement based on latest ERE. Further interview revealed no elopement issues identified that were not on the care plans. Review of resident care plans, identified to be at risk of elopement revealed that those had been reviewed as reported. 5. Interview with DPO on [DATE] at 11:49 AM revealed the door alarms were all checked and passed on [DATE]. On the following day, [DATE], the door had not been yet checked at the time of elopement incident. Further interview revealed, post incident, the northeast door alarm was found to have failed. Additional interview revealed staff was posted on each door until all were checked and that he supervised the northeast door, then rotated with assistants in his department until the door was repaired, as well as changed the door codes. Review of the facility's door alarm logs confirmed pass checks, including on the northeast door, which was checked and passed after repair. Review of the supervision log confirmed that the northeast door was covered throughout the day until the alarm was repaired. Review of documentation from Enterprise Technical Solutions LLC revealed the repairs were completed on [DATE]. Observation of door alarm checks and Wander Guard checks revealed all were currently in working order, while review of the logs revealed continued checks on a daily basis. 6. Interviews on [DATE] with the Administrator at 12:14 PM, the DON at 11:56 PM, the UM at 11:24 AM and the MDS nurse at 09:00 AM revealed the Signature Care Consultant provided education to the Administrator, Staff Development Coordinator (SDC), DON, UM's and MDS nurse on [DATE] on the Elopement/missing person policy, care of a wandering resident policy, and comprehensive care plan update related to elopement risk residents and behavior changes. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Interview with the DON on [DATE] at 11:56 PM revealed that she and the SDC provided re-education to all staff beginning on [DATE] for Elopement/Missing Resident, Elopement/Wandering Resident, Care of Wandering Residents, and care plans. Continued interview with DON and with the UM on [DATE] at 11:24 AM revealed that specific re-education also began on Comprehensive Care plans for nurses, detailing what to include, door alarms, door codes, use of entrances and exits, behavior management of residents at risk for elopement and the Wander Guard test box system and the necessity to place elopement concerns on the 24-hour report. Additional interview revealed that all staff working on [DATE] and [DATE] were educated on those days, and the remainder were educated before they next worked. Interview with the Administrator and DON revealed that this training will be included in orientation training for all new staff. Interviews with CNA #5 at [DATE] at 12:35 PM, LPN #1 on [DATE] at 8:45 PM, LPN #7 on [DATE] at 8:57 PM, CNA #11 on [DATE] at 1:59 PM, Hospitality Aide (HA) #1 on [DATE] at 2:11 PM, HA #2 on [DATE] at 2:31 PM, RN #3 on [DATE] at 3:17 PM, HA #3 on [DATE] at 3:31 PM, CNA #1 on [DATE] at 3:54 PM, CNA #13 on [DATE] at 4:21 PM, CNA #2 on [DATE] at 4:48 PM, CNA #2 on [DATE] at 4:48 PM, LPN #4 on [DATE] at 8:45 PM, LPN #9 on [DATE] at 10:40 PM, Environmental Services (EVS) #1 on [DATE] at 9:00 AM, Physical Therapist (PT) #1 on [DATE] at 9:43 AM, Occupational Therapist (OT) #1 on [DATE] at 09:45 AM, Dietary Manager (DM) on [DATE] at 10:00 AM and Cook #1 on [DATE] at 10:15 PM all revealed they had received such education and were able to define the content of education. Interview with the SSD on [DATE] at 11:40 AM revealed that care plan responsibility falls across disciplines and that her contact information is available at the nurse stations in the event of needing assistance with adding to a care plan after hours. Review of in-service documents confirmed delivery of education by content and dates. Review of Resident #1's care plan revealed that it had been updated to reflect more specific interventions for elopement prevention and review of MAR/TAR revealed that it reflected completed tasks for placement and function checks each day. Review of care plans for the residents in the Elopement Book revealed appropriate interventions for prevention and completed tasks in the MAR/TAR. 8. Interviews with the Administrator on [DATE] at 12:14 PM and the DON on [DATE] at 11:56 AM revealed drills were being conducted and they were monitoring the drills. Interview with the DPO on [DATE] at 11:49 AM revealed he was responsible for conducting the drills. Interviews with CNA #5 at [DATE] at 12:35 PM, LPN #1 on [DATE] at 8:45 PM, LPN #7 on [DATE] at 8:57 PM, CNA #11 on [DATE] at 1:59 PM, HA #1 on [DATE] at 2:11 PM, HA #2 on [DATE] at 2:31 PM, RN #3 on [DATE] at 3:17 PM, HA #3 on [DATE] at 3:31 PM, CNA #1 on [DATE] at 3:54 PM, CNA #13 on [DATE] at 4:21 PM, CNA #2 on [DATE] at 4:48 PM, CNA #2 on [DATE] at 4:48 PM, LPN #4 on [DATE] at 8:45 PM, LPN #9 on [DATE] at 10:40 PM, Environmental Services (EVS) #1 on [DATE] at 9:00 AM, PT #1 on [DATE] at 9:43 AM, OT #1 on [DATE] at 9:45 AM, DM on [DATE] at 10:00 AM and Cook #1 on [DATE] at 10:15 PM revealed the DPO had conducted many elopement drills since [DATE], on both shifts and at varying times. Observation of an elopement drill on [DATE] at 11:15 AM revealed process consistent with interviews and revealed successful location of a resident who was hiding in a small office within minutes. Review of documentation on [DATE], confirmed such, with completed [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44396 Based on observation, interview, record review, review of manufacturer's user guides, review of the facility's policies, and review of the facility's investigation, it was determined the facility failed to have an effective system to ensure each resident received adequate supervision and monitoring to prevent elopement for one (1) of seventeen (17) sampled residents (Resident #1). Resident #1's Admission Elopement Risk Evaluation (ERE), dated [DATE], the day of admission, revealed he/she was at low risk for elopement. However, after Resident #1's new onset of exit seeking behaviors, on [DATE], a repeat ERE assessed him/her to be at high risk for elopement. Resident #1's care plan was revised for this risk, with the addition of the interventions of monitoring for tailgating (following an individual exiting the facility to try and exit as well) and using redirection and diversionary activities. On the evening of [DATE], Resident #1 was in a wheelchair and pushed the northwest door open, with his/her feet through the doorway before staff returned him/her inside and redirected the resident. On [DATE], a follow-up ERE confirmed Resident #1 was at risk of elopement. Another intervention done was to apply a Wander Guard bracelet, a tracking device designed to prevent persons at risk for wandering from leaving the facility unaccompanied. The Wander Guard bracelet would sound an alarm when the resident went through a doorway with a Wander Guard receiver in place. There was no documented evidence the facility otherwise increased Resident #1's level of supervision. Subsequently, on [DATE], Resident #1 exited the building without staff knowledge. The delayed egress door alarm failed, and no Wander Guard receiver was in place on that door. Resident #1 exited the northeast door of the facility at 7:57 AM, and was found by Physical Therapist (PT) #1, who happened to be arriving to work, in the rear parking lot, and was returned to the building at 7:59 AM. The exit door was found to have loose wiring on the delayed egress controller. The facility's failure to have an effective system in place to ensure each resident received adequate supervision to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] and was determined to exist on [DATE], in the areas of 42 CFR 483.21 Comprehensive Person-Centered Care Planning, F-657, Care Plan Timing and Revision at a Scope and Severity (S/S) of a J and 42 CFR 483.25 Free of Accidents/Hazards/Supervision, F-689 at a S/S of a J along with Substandard Quality of Care. The facility was notified of the Immediate Jeopardy (IJ) on [DATE]. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on [DATE], alleging removal of the IJ on [DATE]. The State Survey Agency (SSA) validated removal of the IJ, on [DATE], as alleged, prior to exit on [DATE]. The findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Elopement/Wandering, last reviewed [DATE], revealed an elopement/wandering assessment would be completed upon admission and quarterly thereafter. Continued review revealed that any resident displaying significant wandering behaviors would be assessed for elopement/wandering risk and care planned appropriately. Additional review revealed that care plans and individual behavior plans would address wandering as a specific problem, with approaches formulated, patterns identified if any, and the causes determined. Further review revealed that a wandering/elopement notebook containing pictures and pertinent demographic information would be maintained by social services and kept at nurses' stations and the receptionist desk with quarterly updates. Review of the facility's policy titled, Elopement/Missing Resident, effective date [DATE], revealed elopement drills were conducted a minimum of twice per year and documented accordingly. Further review revealed that staff should remain alert and follow re-direction techniques if a wandering resident gained access to any exit areas. Continued review revealed that staff shall request help if a wandering resident could not be redirected easily and that staff would be routinely alerted by the Director of Nursing (DON) of residents identified to be at risk. Additional review revealed service plans would reflect interventions for resident safety, that routine safety checks would be made by staff and that, in the event a resident continued to unsafely wander or exit seek, more appropriate placement might be required. Review of The Equipment Lifecycle System (TELS) instructions for magnetic lock and exit doors revealed these doors should be checked daily. Further review revealed detailed instructions for checking the operation of the magnetic door locks and the delayed egress operation. The instructions detailed that checking magnetic door locks required inspecting the door lock mounting and the operation and panic hardware on egress doors. Per the instructions, this inspection included verifying the resident transmitter to make sure the door stayed locked and the alarm sounded if a resident with a transmitter device attempted to exit the door. The instructions also described checking the delayed egress operation by pushing the door release hard for a fraction of a second, which should not allow the door to open, and the alarm should not sound. The instructions stated to then apply pressure to the door release for the pre-determined nuisance period setting of one (1) to three (3) seconds, then the door should go into an irreversible unlocking sequence that sounded the alarm and opened the door in less than fifteen (15) seconds. The instructions further stated to close the door and reset the alarm. Continued review of the instructions revealed the facility must ensure that signs were placed on doors adjacent to the release device that read, Keep pushing. Door will unlock after 15 seconds. The instructions concluded by stating, after the doors and hardware were tested for proper operation and condition, the results should be documented in a logbook. Review of the Secure Care 430 KHz Advantage Series Non-ID Resident Transmitter with Strap User Guide (for the Wander Guard device) revealed that the resident transmitter must be applied to an unelevated ankle. Further review of the guide revealed that the aide responsible for the care of the resident utilizing the Secure Care System must ensure that the transmitter was in place at each shift change. Additional review revealed that each transmitter should be tested daily to ensure it was working properly, and a documented test of each transmitter at the facility must be made each day. Review of TELS logs, on [DATE], revealed each exit door locked and both doors with Wander Guard capability had passed testing on a daily basis for the past thirty (30) days, from [DATE] to [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Electronic Medical Record (EMR) revealed the facility admitted the resident, on [DATE], with diagnoses that included Non-Hodgkin's Lymphoma, Unspecified, Spleen; Unspecified Dementia with Behavioral Disturbance; Altered Mental Status, Unspecified; and Syncope and Collapse. Review of Resident #1's Brief Interview for Mental Status (BIMS), on [DATE], revealed a score of five (5) of fifteen (15), indicating severely impaired cognition. Subsequently, in the Admission Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident's BIMS' score was fifteen (15) of fifteen (15), indicating intact cognitive ability. Review of Resident #1's additional BIMS assessments, done by the Social Services Director (SSD) revealed, on [DATE], a score of fourteen (14); on [DATE], a score of thirteen (13); and on [DATE], a score of fifteen (15); all of these indicated intact cognition. The SSD also documented a BIMS assessment, after Resident #1's elopement, on [DATE] at 12:32 PM, which revealed a score of eleven (11), indicating moderate cognitive impairment. However, review of Resident #1's Progress Note, on [DATE], by the Speech Therapist, revealed she also conducted a BIMS assessment for Resident #1 at 1:15 PM, with a score of three (3), which indicated severe cognitive impairment. Review of Resident #1's care plan, dated [DATE], revealed the addition of the new problem of Elopement, on [DATE], with interventions of adding the resident to the Elopement Book, to monitor Resident #1 for tailgating, and using diversionary activities as well as cues for redirection. Further review revealed no additions or revisions until [DATE], [DATE], and then [DATE], when new orders to check placement and function of the Wander Guard were added. Review of Resident #1's initial ERE, dated [DATE], revealed he/she was at low risk for elopement. In addition, the initial ERE indicated Resident #1 was not cognitively impaired and was not independently mobile. However, Resident #1's Admission Note, dated [DATE] and written by Registered Nurse (RN) #3 reflected he/she was forgetful and had a short-term memory problem. Review of the second ERE, dated [DATE], reflected Resident #1 was at risk for elopement, but there was no evidence of such in Resident #1's Progress Notes. Review of Resident #1's Progress Notes (PN), in the EMR, revealed the resident first exhibited aggressive behaviors the nights of [DATE] and [DATE]. Further review revealed, on [DATE], Licensed Practical Nurse (LPN) #8 found Resident #1 going toward an exit door stating that he/she wanted to go home that night. The SSD note, on [DATE] at 3:03 PM, reflected no exit seeking behavior. Continued review of Resident #1's PN's revealed an exit attempt, on [DATE] at 8:00 PM, during which he/she was able to get his/her feet through the threshold. At that time, the resident stated he/she was looking for his/her children. Per the notes, the resident was moved inside the building and redirected to his/her room. Additional review revealed the Attending Nurse reported the event to Unit Manager (UM) #2, and the following day UM #2 conducted the third ERE, which confirmed that Resident #1 was a high risk for elopement. Per the notes, UM #2 applied a Wander Guard resident transmitter to Resident #1's ankle. Continued review of the PN's revealed Resident #1 exhibited exit seeking behavior with redirection given, on [DATE], and again, on [DATE], when he/she was able to trigger the door alarms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Physician's Orders revealed new orders, on [DATE], for laboratory tests, a psychiatric consult, and to encourage Resident #1 to be out of bed and engaged in activity. These orders were given subsequent to verbal altercations with Resident #1's roommate, which occurred on [DATE] and [DATE]. Additional review revealed an order, dated [DATE], for Macrobid (an antibiotic used for urinary tract infections) daily for seven (7) days and Depakote (an anti-convulsant which could be used to treat certain psychiatric disorders) twice daily, with no end date, added on [DATE]. Further review revealed no order for the Wander Guard, for placement and function checks, until [DATE]. Review of Resident #1's Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed staff had only documented Wander Guard placement and function checks on each shift beginning [DATE]. Review of the facility's security camera video recording, viewed on [DATE] at 1:51 PM, revealed Resident #1 advanced in a wheelchair to the northeast door, by the resident library, on [DATE] at 7:56:54 AM. He/she was at the door, alternating pushing on the door and looking back down the hall, for forty (40) seconds before exiting through the door. The next image revealed Resident #1 returning through the door with Physical Therapist (PT) #1 pushing his/her wheelchair at 7:59:56 AM. Interview with the Director of Plant Operations (DPO), on [DATE] at 1:51 PM, revealed the security camera was triggered by a motion sensor, so it recorded when there was motion in range of the camera. The security camera recorded no images between Resident #1's exit and his/her return. Further, the DPO stated he tested the northeast door immediately after the elopement, and the alarm was not functional, in spite of passing the test the previous day. Additionally, he stated he examined the control box and realized the repair was beyond what the facility could complete independently and, in turn, called the regional DPO who provided instruction for the source of the repair service. The DPO further stated he and his assistants rotated supervision on the door until the repairers came around 2:30 PM, on [DATE]. Observation of the elopement route, on [DATE] at 1:10 PM, with the State Survey Agency (SSA) Surveyor and the DPO, revealed the measurement of the elopement route was seventy (70) feet. Per the observation, the area leading from the northeast exit to the rear parking lot began with a small flat stoop and then continued with a sloping sidewalk to the asphalt parking lot. Also measured, at this time, was the distance from the location in the parking lot where PT #1 met Resident #1 to the street, which was one-hundred eighteen and seven-tenths (118.7) feet. Further observation of the facility revealed five (5) of seven (7) doors were not outfitted with the sensor for Wander Guard and the northeast door where Resident #1 exited did not have the Wander Guard sensor. Interview with Resident #1, on [DATE] at 1:40 PM, revealed the resident was resting in bed and he/she did not remember leaving the building, nor did the resident recall any reason he/she might have attempted to leave. Per the interview, the resident stated he/she felt safe at the facility. Observation at this time revealed the resident had a one-to-one (1:1) staff member assigned. Additional interview with Resident #1, on [DATE] at 3:15 PM, revealed again that he/she had no recollection of exiting the facility, nor a plan to leave. Also, the resident could not state the date, day of week, month, or year. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with PT #1, on [DATE] at 2:14 PM, revealed she was in the rear parking lot, on [DATE] around 8:00 AM, having arrived for the workday. She stated she observed Resident #1 rolling down the ramp to the parking lot from the northeast door. PT #1 stated the resident got as far as the fourth parked car, where she met the resident. PT #1 stated the resident asked PT #1 if she was going to take him/her home. PT #1 also stated Resident #1 did not appear to be upset at going back in the building. She stated she was aware Resident #1 was typically confused. Interview with Certified Nursing Assistant (CNA) #8, on [DATE] at 3:11 PM, revealed she had arrived at the facility, on [DATE] around 8:00 AM, and parked in the rear parking lot where she did not notice anyone else out in the area. Further interview revealed she entered the facility, stowed her belongings, and then went to the north side desk. She stated she then observed PT #1 pushing Resident #1, saying she found him/her outside, and the alarm was not sounding. Per the interview, CNA #8 stated she asked Resident #1 where he/she was going, with his/her response, Oh, I was just going home. CNA #8 stated she reminded Resident #1 that he/she lived here now, to which the resident responded that he/she did not. She stated the resident was calmed after learning that his/her son was coming to visit. Interview with CNA #6, on [DATE] at 1:29 PM, revealed the day before the elopement, on [DATE], Resident #1 was antsy, stating he/she wanted to leave and was looking for the door. She stated she was on light duty, so she was walking around with Resident #1, trying to redirect and occupy the resident's time. CNA #6 further stated that while wandering, Resident #1 was sitting by the northwest door, pushed on the door, and the alarm sounded. She stated she and CNA #7 responded to the door alarm, redirected Resident #1 to the dining area, and settled him/her for dinner. She stated she reported this to the Director of Nursing (DON), who asked her to stay with the resident until the end of the shift for the resident's safety. CNA #6 further stated Resident #1 had been anxious about his/her glasses being broken and was calmed when the DON was able to repair them. She stated she gave report to the oncoming staff about Resident #1's wandering. After dinner, CNA #6 stated Resident #1 roamed the dining room after dinner and was reading instructions on the door about egress and the fifteen (15) second wait when doors opened, but was not close enough to trigger the Wander Guard door alarm. CNA #6 stated she had never observed Resident #1 to be exit seeking prior to [DATE]. Additional interview with CNA #6, on [DATE] at 4:07 PM, clarified her instructions to the oncoming shift, on [DATE], related to Resident #1, were to keep an eye on him/her, and specifically, stay with the resident and divert him/her from exit doors. (continued on next page)

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	185069	A. Building B. Wing	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Manor	3300 Tates Creek Road Lexington, KY 40502

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA #7, on [DATE] at 2:49 PM, revealed after morning shift change, on [DATE], LPN #6 had asked her to check on Resident #1 due to a concern for falling. She further stated she found Resident #1 sitting up on the side of the bed, demanding to be taken to the kitchen. When reminded that he/she did not have his/her own kitchen, Resident #1 wanted to make a grocery list, and in turn, CNA #7 placed the overbed table in front of him/her and offered a word search book with a suggestion to find what was needed for the list there. CNA #7 also stated Resident #1 was content and occupied, so she went to deliver breakfast trays, returning after a few minutes to check on him/her. When finding Resident #1 still occupied with the word search, CNA #7 stated she returned to delivering trays. She stated the next thing she knew, PT #1 was pushing Resident #1 up the hall, saying he/she had been in the parking lot. Further interview revealed she then learned that Licensed Practical Nurse (LPN) #6 had transferred him/her to the chair and then positioned him/her in the sitting area by the nurses' station. She stated staff was either administering medications or delivering trays at the time of exit, and the door alarm never sounded. She stated she had received elopement training via the online training system, and the facility had a door alarm drill, but not until after this elopement event. CNA #7 stated she had not observed exit seeking behaviors prior to the incident and had no report of exit seeking during shift report for Resident #1. Interview with LPN #6, on [DATE] at 9:29 PM, revealed she was new to the building, and she did not recall from whom she received report on [DATE]. She further revealed she could not be sure, but she did not recall receiving information that Resident #1 had exit seeking behavior. LPN #6 stated she just knew that Resident #1 was sitting on the edge of the bed, and she was afraid the resident might try to get up by himself/herself and fall. She further stated Resident #1 was somewhat unsteady on her feet, and since she was caring for another resident, she asked CNA #7 to check on Resident #1. She stated she transferred Resident #1 to a wheelchair about 7:30 AM and moved him/her to the sitting area across from the North Wing nurses' station so that someone would have eyes on him/her all the time. Per the interview, she stated Resident #1 could propel himself/herself pretty well. LPN #6 stated she did not see Resident #1 rolling down the hall and nobody reported to her that they had seen the resident going down the hall either. She also stated that the door alarm did not sound when Resident #1 pushed the door open and exited the building. Interview with CNA #1, on [DATE] at 3:10 PM, revealed she had been working today and yesterday providing one-to-one (1:1) supervision for Resident #1. She stated the resident had been confused but pleasant and cooperative, which appeared to be the resident's baseline demeanor. She stated when she was with Resident #1 yesterday, the resident wandered the facility but did not exhibit exit seeking behavior, but acknowledged the resident asked if doors were used to go out. Interview with CNA #3, on [DATE] at 3:52 PM, revealed Resident #1 had dementia and that he/she should be on a dementia unit as he/she is constantly wandering, always. She stated that she had worked the night shift prior to Resident #1's elopement incident, and he/she had been wandering during the night. She further stated that Resident #1 was at the door over and over but did not push on it long enough to trigger the alarm. CNA #3 stated the resident was very persistent on pursuing getting to the door, having stated that he/she had to get up and go to work at the store. She stated that Resident #1 was determined to get out the door, but finally got tired, was helped to bed, and then slept the remainder of the night. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #2, on [DATE] at 8:20 PM, revealed when she first met Resident #1, he/she was able to make needs known, could ambulate to the bathroom, knew his/her name, and knew he/she was in a nursing home. LPN #2 stated Resident #1 became more confused and agitated after a room change due to issues with the roommate. LPN #2 stated Resident #1 had been exit seeking before, pushing the doors, and setting off alarms. She stated, when that happened, she redirected the resident, put the code in to cancel the alarm, and then called maintenance for assistance. She stated that happened within the last week. Additional interview with Resident #1, on [DATE] at 3:16 PM, revealed the resident could not recall the date, day of week, month, or year. Further interview revealed Resident #1 had five (5) children; and could only call one (1) child by name. The resident stated he/she had been in the facility for two (2) weeks and was going home today. However, Resident #1 could not state why or how he/she was getting home, but just stated he/she wanted to go home. Interview with CNA #1, on [DATE] at 11:05 AM, revealed Resident #1 was sleeping, and had slept until 11:45 AM, and then got up for lunch. She stated Resident #1 was wandering and agitated yesterday about her touching the resident's chair or following the resident. CNA #1 stated Resident #1 was often more oriented earlier in the day after awakening; then his/her orientation declined around 4:00 PM and continued the rest of the day. Interview with CNA #5, on [DATE] at 12:35 PM, revealed she observed no wandering or exit seeking behavior with Resident #1 until he/she was moved to the North Wing after difficulty with his/her roommate, after which she noticed increased wandering by Resident #1. CNA #5 stated Resident #1 might be in a good mood one day, then not so much on another day; but she never observed exit seeking until the resident was placed on the South Wing after the elopement. CNA #5 stated, since the elopement, Resident #1 had continued to seek doors/exits and talked frequently of going home. Interview with the Assistant Director of Nursing (ADON) #2, on [DATE] at 1:29 PM, revealed Resident #1 had been infected with the COVID-19 virus, as evidenced by a positive test on [DATE]. ADON stated the Interdisciplinary Team (IDT, which included the DON, the Unit Manager (UM), the ADON, the SSD, the Activities Director (AD) and Therapy had considered whether this could have been a precipitating factor to his/her behavior changes, including exit seeking. She further reported that the ERE in [DATE] occurred in response to overt exit seeking, to include getting feet over the door threshold, and that a Wander Guard bracelet was applied in response to this event. Further interview revealed that she was able to make the decision to apply the Wander Guard bracelet and then take it to IDT for review. She explained she did not necessarily need a Physician's Order, though the staff would notify the Physician with the change of condition anyway. ADON #2 stated that in response to any resident who was exit seeking, the nurse was expected to notify the DON, who would in turn inform the UM. She stated the DON could also give the instructions to apply the Wander Guard bracelet, start fifteen (15) minute checks, or whatever was necessary for the situation. ADON #2 stated that her expectation was that staff observing exit seeking behavior would notify leaders, would keep closer observation on the resident, and would give report to the receiving nurse/CNA upon transfer of care or at shift change. She stated that shift change was a high risk time, which made shift report all the more important as well as rounding with purpose. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON (Director of Nursing), on [DATE] at 3:42 PM, revealed she had been in the position since [DATE]. Further interview revealed that she had observed Resident #1 wandering with glasses in hand during the late afternoon, before dinner on [DATE], and that she fixed the glasses for him/her. Since CNA #6 was on light duty, she stated she asked her to keep an eye on Resident #1 due to agitation. She stated the instructions given to CNA #6 were to stay with the resident, keep him/her company, and help the resident avoid exit doors. Continued interview revealed that the DON made no assignment of one-to-one (1:1) supervision for the night because even though the resident was wandering, exit seeking behavior was not observed. Continued interview with the DON, on [DATE] at 3:42 PM, revealed she was not aware of exit seeking behavior prior to the elopement, and if that had happened, the nurse should have notified the DON or placed Resident #1 on the 24 Hour Report, a document that detailed significant events that have occurred in the past twenty-four (24) hours on a given unit. The DON also stated her expectation was that this would also be carried forward in report from shift to shift. The DON stated the placement of Wander Guard door alarms on only the central doors was a decision made before she came to the facility. She stated she suspected this was because the central doors were in eyesight of the administrative staff during the day, but less so during the night. She also stated the distant doors were under the eyesight of direct care staff at any given time. The DON explained, at the time of elopement, the staff would have been delivering breakfast trays, assisting with feeding, or for nurses, administering morning medications. She stated, because of these tasks, staff was moving up and down the hall a lot at that time. Interview with the Administrator, on [DATE] at 2:12 PM and on [DATE] at 4:11 PM, revealed she had been in her position for almost a year. She stated the Wander Guard sensors were on two (2) doors only, and the decision was made at the corporate level before she was hired. Continued interview revealed her belief that it might be because the staff do not really use the other doors. She stated it had been discussed among the facility's leadership whether to add the Wander Guard sensor to all doors or to remove them altogether. She stated she was aware of Resident #1's increased exit seeking but had personally observed that he/she was able to be redirected easily prior to this incident. She stated she had not been aware of the details of changes in Resident #1's behaviors due to the time of day or any specific precipitating factor. She also stated her expectation was that any staff member's observation of exit seeking by a resident would be reported to leadership. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on [DATE] that alleged removal of the IJ on [DATE]. Review of the IJ Removal Plan revealed the facility implemented the following: 1. On [DATE], Resident #1 was placed on one-to-one (1:1) supervision immediately upon being brought back into the facility. One on one was provided by the Unit Manager (UM) and then she was replaced by a Certified Nurse Assistant (CNA). Resident #1 was assisted to his/her room and received a head-to-toe assessment by UM LPN. No new concerns. Vital signs were obtained by UM: BP ,d+[DATE], HR 74, RR 20, Temp 97.4, O2 saturation was 98%. No concerns noted. A pain Assessment was completed, the Wander Guard was tested , and the Physician and family were notified by the UM. No concerns were noted. (continued on next page)

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