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

PRINTED: 12/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #3	445297	A. BUILDING _____ B. WING _____	C 12/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HEALTH AND REHABILITATION-NORTHHAVEN	3300 BROADWAY NE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #34136, #34279, #34418, and #34690, was completed at Kindred Health and Rehabilitation-Northhaven on November 17 - December 3, 2014. No deficiencies were cited related to complaint investigation #34136 and #34279. A deficiency was cited related to complaint investigation #34418 at F514 at a "D" level. The facility was cited an Immediate Jeopardy at F323 for complaint investigation #34690 with a scope and severity of "J" for failing to ensure the facility provided supervision, a safe environment, and failed to follow a policy related to elopement, for one resident (#7) of six residents reviewed for elopement. The facility's failure to ensure supervision, a safe environment, and failure to follow facility policy, related to elopement was likely to cause serious injury, harm, impairment, or death to Resident #7. A partial extended survey was completed on December 2, 2014. The Administrator, Director of Nursing (DON), and District Director of Clinical Services, were informed of the Immediate Jeopardy on December 2, 2014, at 2:00 p.m., in the Activity Room. Substandard Quality of Care was cited under F323 at a Scope and Severity of "J." The Immediate Jeopardy was effective starting September 5, 2014 through September 9, 2014. The immediacy of the jeopardy was removed on September 10, 2014, and corrective actions were	F 000	Revised 12/31/14	1/6/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy Denham — TITLE: Administrator — (X6) DATE: 12/17/14

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 validated onsite by the surveyor on December 3, 2014. Non-complaince of the Immediate Jeopardy continues at a Scope and Severity of a "D" level for monitoring processes by the Quality Assurance Committee.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
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 review of facility policy, medical record review, review of a Resident Review Report Worksheet (facility investigation), interview, observation, review of Preventative Maintenance Task Sheet, review of in-service sign-in sheets and roster, review of activity calendars, and Performance Improvement form, the facility failed to supervise, provide a safe environment, and follow the facility's elopement policy, for one resident (#7) assessed at a high risk for elopement of six residents identified for elopement risk. The facility's failure placed Resident #7 in Immediate Jeopardy (a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death). The Nursing Home Administrator, Director of	F 323	**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 accident. **Resident affected**: Resident # 7 was discharged from facility on September 17, 2014 to a facility with a locked secure unit. **Residents potentially affected**: Head count was completed on September 5, 2014 with all residents accounted for. Elopement/ Door alarm in-services completed by Director of Nursing, Executive Director and/or Staff Development Coordinator on September 5, 6, 8, 9, 10, 11, 12, and 23rd encompassing 100% of employees including contracted housekeeping staff and Rehabilitation staff. Nurse aide that was on medical leave has since been in serviced. On September 9, 2014, Director of Nursing reviewed all Residents at risk for elopement/ wandering to ensure: wander guards were functioning properly, are checked weekly and documented by Maintenance Director, and	01/02/15

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F 323	Continued From page 2 Nursing (DON), and District Director of Clinical Services, were notified of the Immediate Jeopardy on December 2, 2014, at 2:00 p.m., in the Activity Room. F 323 resulted in Substandard Quality of Care. The findings included: Review of facility policy, Patient Elopement, dated November 11, 2013, revealed "Elopement is when a patient leaves the premises or a safe area without authorization...initiate as soon as the patient is noticed missing the Missing Patient Search Checklist...Conduct searches in an expedient, efficient, calm, and thorough manner...Search areas may include, but are not limited to: Inside Center...Center Grounds..." Resident #7 was admitted to the facility on August 29, 2014, with diagnoses including Malaise, Fatigue, History of Falls, Glaucoma, Coronary Artery Disease, Hypertension, and Dementia. Further review revealed Resident #7 was discharged on September 17, 2014 with son to a facility with a locked secure unit. Medical record review of a Wander/Elopement Risk Evaluation dated August 30, 2014, revealed "...wanders the facility...unable to stay seated or lying down for more than 10 minutes..." Further review revealed interventions for safety included "...personal alarms on bed and wheelchair..." Medical record review of the initial Minimum Data Set (MDS) dated September 5, 2014, revealed the resident was coded 6 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). Further review revealed the	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* elopement/wander risk care plans in place. Director of Nursing found all items in place and functioning properly. Once Resident is assessed and deemed a wander/ elopement risk, care plan is initiated by a licensed nurse and reviewed for completion in Clinical Rounds and updated as needed by Director of Nursing or designee. Care plan will be reviewed quarterly or with significant change of status, and updated if needed during Care Plan meeting by MDS coordinator. When Resident is admitted to facility, photo is taken by Medical Records Clerk or designee and entered into Point Click Care. A copy of the photo is placed on Medication Administration Record, and in business office. If Resident is assessed and deemed a wander /elopement risk, a picture will be placed by Medical Records Clerk, licensed nurse, or designee at each nurses station, and added to wander/elopement list at each nurses station, and on Certified Nursing Assistant care card. Care cards will be reviewed in the care plan meeting by MDS coordinator, and updated as needed. Elopement drills per initial performance improvement plan were completed by Director of Nursing, Executive Director and/or Staff Development Coordinator for the 7 – 3 shift on September 11, 23, 25 and October 4and 16, 2014; 3 – 11 shift on	01/02/15

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F 323	Continued From page 3 resident required extensive assistance of one for transfer, dressing, and hygiene/bathing. Continued review of the MDS revealed Resident #7 required limited assist of one for ambulation. Medical record review of the Care Plan initiated on September 5, 2014, revealed the resident "...at risk for elopement/wandering as evidenced by decreased safety awareness, impaired communication problems..." Further review of the care plan revealed interventions for elopement risk included "...address wandering behavior by walking with or attempt to redirect from in appropriate area; engage in diversional activity...elopement risk assessment upon admission, quarterly and with significant change in status...photograph of (resident) in wander notebook..." Review of facility, Resident Event Report Worksheet (facility investigation), dated September 5, 2014, at 6:19 p.m., revealed Resident #7 was found out of the building, off premises, and returned to the facility. Medical record review of a Progress Note dated September 5, 2014, at 6:19 p.m., revealed "Resident was observed on the sidewalk in front of the building walking north. CNA (Certified Nursing Assistant) #6 and LPN (Licensed Practical Nurse) #4 brought resident back in without incident. Resident could not tell us (staff) which door (resident) got out of. According to another resident's family member which said heard door alarm on the other end of the building (side 2). Spoke to both nurses and they did not hear the door alarms on. They (nurses) believe it was the door by the time clock."	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* September 9, 19, and October 22, 2014; and on 11 – 7 shift September 19 and 29, and October 28, 2014. Process for Residents that are deemed at risk for elopement was placed at each nurses' station for immediate reference by Executive Director, and will be checked daily for availability by Administrative Assistant or designee. If process instructions not available, will be replaced immediately. **Systemic Changes**: Elopement policy/ education will be discussed at all scheduled monthly General staff, licensed Nursing staff, and Certified Nursing Assistant meetings by Executive Director, Director of Nursing, Staff Development Coordinator, or designee. Director of Nursing, Executive Director, Staff Development Coordinator, or designee will conduct and document elopement drills 2 times a month for 3 months on all shifts, monthly for 6 months on all shifts and then quarterly on all shifts. Head count of Residents will be documented on copy of the census sheet, and employees that participated in elopement drill will sign off as attended. Elopement education will continue to be part of new employee orientation. Residents that are identified as an elopement risk will have a Brief	01/02/15

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F 323	Continued From page 4 Medical record review of a Progress Note dated September 5, 2014, at 6:25 p.m., revealed the resident was brought back in safely after the incident, placed in a wheelchair with a new order written for a wheelchair seat belt. Continued review revealed the resident was monitored to determine whether the seat belt could be released without assistance. Interview with the Administrator on November 17, 2014, at 3:10 p.m., in the Activity Room revealed Resident #7 had exited out the door on the side of the building next to the time clock and the DON's office. Further interview revealed the door alarm sounded and Registered Nurse (RN) #1 responded by going to the door and looking out the two windows in the door. Continued interview revealed upon not seeing anyone outside through the windows, RN #1 reset the door alarm and walked around the inside of the building. Further interview with the Administrator revealed RN #1 did not go outside, did not initiate a head count, and proceeded to return to regular work duties. Continued interview with the Administrator revealed Resident #7 had walked down seven steps, gone around the side of the building through the parking lot toward the front entrance of the facility. Further interview revealed Resident #7 was first observed out a window, facing the front of the facility, by CNA (#6) who was feeding another resident. Continued interview revealed CNA #6 ran out of the resident's room, yelled for LPN #4 and both staff members ran outside to get to the resident. Further interview revealed at the time the staff arrived to the resident to return inside the facility, Resident #7 was on the sidewalk beside a busy four lane highway. Observation on November 17, 2014, at 3:30 p.m.,	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Interview for Mental Status (BIMS) within 24 hours by Social Services or designee. Completion will be monitored in morning meeting by Executive Director or designee. Director of Nursing reviewed all Residents at risk for elopement/ wandering to ensure: wander guards were functioning properly, checked weekly and documented by Maintenance Director, and elopement/wander risk care plans in place. Once Resident is assessed and deemed a wander/ elopement risk, care plan will be initiated by licensed nurse and reviewed for completion in daily Clinical Rounds and updated as needed by Director of Nursing or designee. Care Plan will be reviewed quarterly and with a significant change of status, and updated if needed during the care plan meeting by MDS coordinator. When Resident is admitted to facility, photo is taken by Medical Records Clerk or designee and entered into Point Click Care. A copy is placed on Medication Administration Record, and in business office. If Resident is assessed and deemed a wander /elopement risk, a picture will be placed by Medical Records Clerk, licensed nurse, or designee at each nurses station, and added to wander/elopement list at each nurses station, and on Certified Nursing Assistant care card. Care cards will be reviewed quarterly and	01/02/15

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F 323	Continued From page 5 of the exit door next to the therapy department, revealed two staff members responded by reporting to the site of the door alarm sounding within a 30 second timeframe. Observation outside the facility with the Administrator on November 17, 2014, at 3:45 p.m., revealed Resident #7 had gone out the door in between the DON's office and the Dietary Department entrance, down seven steps, around the corner of the facility in the paved parking lot, to the front of the building where the resident was first seen by a staff member, and then was on the sidewalk (next to a transformer) beside the busy four lane highway when the staff arrived. Observation with the Administrator on November 18, 2014, beginning at 10:55 a.m., of the nine exit door alarms, revealed all door alarms sounded properly with timely staff response. Interview with the DON on November 18, 2014, at 2:00 p.m., in the Activity Room revealed during the facility's investigation it was determined Resident #7 was seen at approximately 6:05 p.m. on September 5, 2014, talking with another resident's family. Further review revealed the door alarm sounded at approximately 6:10 p.m. and the resident was returned at 6:19 p.m. Continued interview revealed the facility's process when a door alarm sounds is "go to the door immediately, look for a resident, go outside if necessary and look...search the premises, and if not found to return inside, report to the nurse, and initiate a head count." Further interview with the DON confirmed RN #1 did not follow the facility's policy and did not go outside to search for the resident but turned the door alarm off after looking out the glass window of the door.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* with a significant change in status in the care plan meeting by MDS coordinator, and updated as needed. Elopement drills per initial performance improvement plan were completed by Director of Nursing, Executive Director, Director of Nursing, Staff Development Coordinator and/or designee for the 7 -3 shift on September 11, 23, 25, and October 4and 16, 2014; for the 3 – 11 shift on September 9, 19 and October 22, 2014; and for the 11 – 7 shift on September 19 and 29 and October 28, 2014. Drills have been conducted for 7 – 3 shift on December18 and 26, 2014; for the 3 – 11 shift on December 2 and 29, 2014; and for the 11 – 7 shift on December 27 and 30, 2014. Process for Residents that are deemed at risk for elopement has been placed at nurses' station for immediate reference by Executive Director, and will be checked daily for availability by Administrative Assistant or designee. If not available, will be replaced immediately. Clinical Management team, which consists of the, Director of Nursing, Case Manager, Unit Managers, MDS Coordinator, and Staff Development Coordinator, will discuss Residents in Clinical Rounds done Monday through Friday to include weekends with review of: Progress notes, dashboard and alerts in Point Click Care (EMR system) to	01/02/15

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F 323	Continued From page 6 Interview with LPN #4 on November 18, 2014, at 3:10 p.m., in the Activity Room, revealed LPN #4 was at the medication cart outside the 100 hall nurses station when CNA #6 yelled a resident was outside the facility. Continued interview with LPN #4 revealed Resident #7 was next to the transformer on the sidewalk next to the four lane highway. Further interview revealed the resident was wearing sweat pants and a tee shirt at the time of the elopement. Continued interview revealed the resident stated "I'm going home." Further interview with LPN #4 revealed the LPN last saw Resident #7 approximately "six minutes" prior to finding the resident outside. Interview with CNA #6 on November 18, 2014, at 3:25 p.m., in the Activity Room revealed on September 5, 2014, CNA #6 was feeding another resident and looked out of the window at which time the CNA saw Resident #7. Continued interview revealed CNA #6 ran to the hallway and yelled at LPN #4 the resident was outside the facility. Further interview revealed when CNA #6 first saw Resident #7, the resident was in the front parking lot in front of the entrance to the facility. Continued interview with CNA #6 revealed CNA #6 and LPN #4 ran outside the facility and when they arrived at Resident #7's side, the resident was on the sidewalk next to the busy four lane highway. Interview with RN #1 on November 19, 2014, at 3:40 p.m., in the Activity Room, revealed RN #1 was on duty September 5, 2014, and did not remember which door Resident #7 had gone out. Continued interview revealed RN #1 did remember signing a Performance Improvement Form related to the elopement incident with	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* identify Residents that may have potential for change in behavior/wandering/elopement risk. Director of Nursing or designee will keep a log of daily checks, new Residents and/or those that are deemed a new wander/elopement risk, a wander/elopement assessment will be completed by licensed nurses and reviewed in Clinical Rounds Monday through Friday to include weekends by Director of Nursing or designee. **Monitoring Measures:** Clinical Management team, which consists of the Director of Nursing, Case Manager, Unit Managers, MDS Coordinator, and Staff Development Coordinator, will discuss Residents in Clinical Rounds Monday through Friday to include weekends with review of: Progress notes, dashboard and alerts in Point Click Care (EMR system) to identify Residents that may have potential for change in behavior/wandering/elopement risk. Director of Nursing or designee will keep a log of daily checks, new residents and/or those that are deemed a new wander/elopement risk, will have a wander/elopement assessment completed by licensed nurses and reviewed in clinical rounds Monday through Friday to include	01/02/15

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F 323	Continued From page 7 Resident #7 but was unsure of the door the resident had gone out. Further interview revealed when the door alarm sounded, RN #1 went to the door next to the time clock, but RN #1 "couldn't tell which alarm was going off." Continued interview revealed RN #1 did not remember resetting the alarm but remembered pushing on the door in the dining room and the door was locked. Further interview revealed RN #1 went around the building on the inside and by the time the RN had gone around the building, someone had seen Resident #7. Continued interview with RN #1 revealed, "Probably should have gone outside." Interview with the Maintenance Director on November 19, 2014, at 5:00 p.m., in the Activity Room revealed on September 5, 2014, Resident #7 had walked approximately 284 feet outside from the exit door, down seven steps, and to the front entrance where CNA #6 first observed the resident. Further interview revealed the resident walked approximately another 100 feet from the time first observed by CNA #6 to the time CNA #6 and LPN #4 got to the resident standing on the sidewalk next to the busy four lane highway. Review of facility, Resident Event Report Worksheet, dated September 5, 2014, at 6:19 p.m., revealed new interventions for Resident #7 included self-release seat belt and wanderguard. The Immediate Jeopardy was effective from September 5, 2014, through September 9, 2014. The immediacy of the jeopardy was removed on September 10, 2014, and corrective actions were validated onsite by the surveyor through review of documents, staff interviews, and observations on December 3, 2014. The surveyor verified	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* weekends by Director of Nursing or designee. Director of Nursing or designee will assure that Resident has wander guard in place and functioning, photo at nurses stations, and name on wander/elopement risk list at nurses stations, care plan updated, care card updated, and will notify Social Services to complete Brief Interview for Mental Status. Resident's name will be added to the Maintenance Director log for weekly wander guard function testing. Elopement drills will be completed and documented 2 times a month on all shifts for 3 months, monthly x 6 months on all shifts, then quarterly on all shifts by Director of Nursing, Executive Director, Staff Development Coordinator and/or designee. Elopement/drills will be an agenda item and discussed in the monthly Performance Improvement meeting, as needed, and/or monthly. The Performance Committee consisting of the, Executive Director, Director of Nursing, Unit Managers, Dietary Services Manager, Activities Director, Social Services, Staff Development Coordinator, Maintenance, and Medical Director, will review findings for at least 9 months, and continue until deemed no longer necessary.	01/02/15

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F 323	Continued From page 8 compliance by: 1. Corrective actions validated for Resident #7 included: a. Review of the facility's documentation of every 15 minute checks for Resident #7, revealed every 15 minute checks were initiated September 5, 2014, at 6:20 p.m., and continued until discharge on September 17, 2014 at 4:00 p.m. b. Review of Resident #7's activity calendar from September 5, 2014, through September 17, 2014, revealed Resident #7 attended at least one group activity daily. c. Medical record review of a Progress Note for Resident #7 dated September 11, 2014, revealed "...one on one has stopped at this time, every 15 minute checks continue..." d. Interview with the Activity Director on December 2, 2014, at 8:40 a.m., in the Activity Room, revealed Resident #7 attended group activities daily. Further interview revealed the resident was also kept in small group or 1 on 1 activities such as walking with the Activity Director or Assistant Activity Director. Continued interview revealed the Activity Assistant also works weekends and would walk with the resident on weekends. Further interview with the Activity Director revealed volunteers were also utilized to do one on one with Resident #7. e. Interview with the Administrative Assistant on December 2, 2014, at 9:20 a.m., in the Activity Room revealed extra staff had been scheduled to stay with Resident #7 one on one. Further	F 323		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	445297	A. BUILDING _____ B. WING _____	C 12/03/2014

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F 323	Continued From page 9 interview revealed "Someone knew where (resident) was at all times...we stuck to (resident) like glue..." f. Review of a Performance Improvement Form, dated September 8, 2014, revealed RN #1 received a written warning related to "Employee did not follow procedure related to patient elopement. Door alarm was sounding and employee went to the door, closed the door and alarm was reset. Employee did not check the parking lot and surrounding area for a patient and employee did not immediately put the patient head count into effect to ensure all patients were accounted for." Further review revealed RN #1 signed the form on September 8, 2014. 2. Corrective actions validated for residents at risk for elopement included: a. Review of the Preventative Maintenance Task Sheet revealed on September 5, 2014, the wandering resident bracelet testing was performed on the wanderguards of five current residents including a spare bracelet. b. Observation of the signs on each exit door on December 2, 2014, at 11:20 a.m., revealed each door had at least three signs stating "Please: Speak with our staff members before letting anyone out of this door. This will ensure our residents remain safe...Emergency Exit Alarm will Sound. Please use front door...Push Until Alarm Sounds - Door can be opened in 15 seconds..." c. Interview with the Admissions Coordinator on December 2, 2014, at 11:00 a.m., in the Activity Room revealed on admission the family or the responsible party are in-serviced on the door	F 323		

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F 323	Continued From page 10 alarms, the entrance and exit door, and to observe for any resident following the family to a door. 3. Review of the facility's in-service records related to the door alarms, random elopement drills, and interviews with employees, family members, and a volunteer revealed: a. Review of the facility's in-service sign in sheets related to the door alarms, revealed in-service regarding when a door alarm sounds, go to the alarm, look at the surroundings, look outside, walk around the building, and if a resident is not found return to the inside of the building to initiate a head count. Continued review of the facility in-service sign-in sheets revealed drills were initiated during the 3-11 p.m. shift on September 5, 2014, and continued for all shifts on September 6, 8, 9, 10, 2014, with 100% of employees in-serviced including contract housekeeping staff. Further review of the in-service records revealed the wanderguard system was also discussed during the in-services. b. Review of the facility's in-service attendance roster related to random elopement drills, revealed the drills were conducted on September 9, 11, 19, 23, 29, 2014, and October 4, 16, 22, 28, 2014. c. Interviews were conducted on December 2-3, 2014, with five family members and one volunteer related to the door alarms, exit doors, and wanderers. Each family member was aware of the door alarms, exit doors, and aware to watch for residents upon exit. Further interview with the volunteer revealed the Activity Director, who is	F 323		

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F 323	Continued From page 11 responsible for the volunteer program, gave the volunteer a copy of the elopement policy and procedure and discussed the policy prior to working with the residents. d. Interviews were conducted on December 2-3, 2014, with ten employees, including housekeeping (contract services), Occupational Therapy Assistant, Activities Assistant, and licensed and non-licensed staff on the 7-3 and 3-11 shifts. The staff members were asked if they attended an in-service on the elopement policy including the door alarms and procedure to follow if a door alarm sounded. Interviews revealed each staff member had attended one or more of the in-services and drills, and could repeat the process to follow once a door alarm sounded or a head count was initiated. 3. Monitoring and Quality Assurance: a. Review of a plan for correction developed during an ad hoc Performance Improvement Meeting dated September 9, 2014, revealed an agenda topic related to Elopement. Continued review revealed the interventions included "...In-services...review of policy and procedures for all staff...audit of resident pictures...Residents who are assessed to be an elopement risk to have BIMS completed within 24 hours of assessment...alert to be placed to state new admit or residents assessed to be a new elopement risk...two photos to be available...elopement policy and procedure to be reviewed in new employee orientation and at least annually...elopement drill...Resident continues on 15 minute checks..." b. Interview with the DON on December 2,	F 323		

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F 323	Continued From page 12 2014, at 12:45 p.m., in the Activity Room, revealed the QA (Quality Assurance) related to elopement continues monthly even if no elopements have occurred. Further interview with the DON revealed elopements are discussed each day during the morning meeting. Review of the facility's Corrective Action Timeline following the elopement on September 5, 2014, revealed systemic changes that will be included "Elopement Policy/Procedure will be discussed at General, Nursing, and CNA monthly meetings...drills will be completed on a monthly basis...elopement has always been discussed in orientation; it will be added to check list for confirmation...weekend activities assistant to take newly admitted Residents who are admitted Friday night and thru the weekend." C/O #34690	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete: accurately documented; readily accessible; and systematically organized. **Resident affected:** Resident # 8 had narcotic cards and sheets counted. Medication Administration Record compared to Narcotic sign out sheet. Licensed nurses were re-educated by Director of Nursing and Staff Development Coordinator on proper documentation procedure.	01/02/15

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F 514	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a complete and accurate clinical record for one resident (#8) of four records reviewed. The findings included: Medical record review of the Narcotic Sign Out Sheet for Resident #8 dated July 4, 2014 through July 14, 2014, revealed thirty-two (32) doses of Oxycodone-Acetaminophen 5 mg (milligrams)-325 mg tablets were documented as administered. Medical record review of the Medication Record for Resident #8 from July 4, 2014 through July 14, 2014, revealed thirteen (13) doses of Oxycodone-Acetaminophen 5 mg-325 mg tablets were documented as administered. Medical record review of the Nurse's Medication Notes for Resident #8 from July 4, 2014 through July 14, 2014, revealed seventeen (17) doses of Oxycodone-Acetaminophen 5 mg-325 mg tablets were documented as administered. Interview with the Director of Nursing on November 20, 2014, at 2:30 p.m., in the Activity Room confirmed the Narcotic Sign Out Sheet, Medication Record, and Nurse's Medication Notes for Resident #8 from July 4, 2014 through July 14, 2014, did not match and were incomplete. C/O #34418	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Residents potentially affected:** Director of Nursing and Staff Development Coordinator re-educated 100% of Licensed Nurses' on November 19, 21, and 25th regarding documentation on the Medication Administration Record (MAR), Narcotic sign out sheet, and Nurses' medication notes on back of Medication Administration Record. All residents in house had narcotic cards and sheets counted and compared to the Narcotic sign out sheet on 11/20/14 by the Director of Nursing and District Director of Clinical Operations. **Systemic changes:** Director of Nursing, Staff Development Coordinator or designee to educate all nursing staff on Medication Administration Record (MAR) (62002) and Shift to Shift Narcotic Sheet (62011-05) policies quarterly. Audits will be completed on medication card and narcotic sheet count, PRN pain medication documentation Monday through Friday to include weekends x 4 weeks, then weekly x3 months, and then quarterly by Director of Nursing and/or designee.	01/02/15

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

01/02/15

Monitoring Measures:

Director of Nursing, Staff Development Coordinator and/or designee will conduct audits of medication cards and narcotic sheet count Monday through Friday to include weekends x 4 weeks, weekly x 3months, then quarterly. Audits will be documented on audit tool A. Director of Nursing, Staff Development Coordinator and/or designee will complete audit of PRN documentation on MAR, and nursing notes on back of MAR Monday through Friday to include weekends x 4 weeks, weekly x 3 months, then quarterly, documented on audit tool B, with disciplinary action as needed by Director of Nursing or Executive Director. Staff Development Coordinator or designee will educate newly hired licensed nurses regarding appropriate documentation on Medication Administration Record, Narcotic Count sheet, PRN medications and documentation on back of Medication Administration Record. Results of audits will be documented and discussed in the Performance Improvement monthly meeting and/or as needed, for at least six months and continue until deemed no longer necessary by the Performance Improvement committee. Performance Improvement committee consist of the, Executive Director, Director of Nursing, Unit Managers, Dietary Services Manager, Activities director, Social Services, Staff Development Coordinator, Maintenance, and Medical Director.