STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185095	A. BUILDING _____ B. WING _____	**03/04/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - HILLCREEK	**3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220**

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 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), it was determined the facility failed to have an effective system in place to ensure resident care plans were revised with appropriate interventions to prevent elopement after attempts of elopement for one (1) of ten (10) sampled residents (Resident #1). Interview with Certified Nursing Assistant (CNA) #2, on 02/18/16 at 1:59 PM, revealed Resident #1 normally wandered all over the facility during the night time hours and it was hard to keep track of the resident when he/she was not on the unit. He stated the resident was found outside in the cold, in the courtyard on the lower level of the facility, several days prior to the resident being found at a local restaurant on 02/16/16. CNA #2 stated he was not given any new nursing interventions after Resident #1 was found outside in the courtyard to prevent the resident from getting out of the facility without staff supervision. On 02/16/16 at 6:20 AM, Registered Nurse (RN) #1 was notified via a phone call from a local restaurant's staff that Resident #1 was at their establishment trying to order food. RN #1 stated she and Certified Nursing Assistant #3, drove to the restaurant, which was located approximately seven (7) tenths of a mile from the facility (across five lanes of traffic and two intersections), and found Resident #1 standing at the entrance door. Resident #1 was returned to the facility at 6:30 AM and assessed with [REDACTED]. The facility's failure to have an effective system in place, to ensure staff revised the care plan to prevent an elopement has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 02/19/16 and determined to exist on 02/16/16. An acceptable Allegation of Compliance (AOC) was received on 02/26/16 which alleged removal of the Immediate Jeopardy on 02/21/16. However, the State Survey Agency determined through validation of the AOC, the Immediate Jeopardy was not removed until 03/04/16. Observation and interview revealed a 300 Unit facility door did not have a functioning alarm. The issue was identified by staff on 02/27/16; however, the door was not repaired until 03/03/16. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Interview with the Director of Nursing, on 02/18/16 at 12:45 PM, revealed the facility followed the Centers for Medicare and Medicaid Resident Assessment Instrument (RAI) manual when developing and revising resident care plans. Review of the facility's photocopied RAI Version 3.0 Manual dated, August 2010, revealed the facility should re-evaluate the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modify the individualized care plan as appropriate and necessary. Following the decision to address a triggered condition on the care plan, key staff or the interdisciplinary team should subsequently review and revise the current plan of care, as needed and communicate with the resident or his/her family regarding the resident care plans, and their wishes. Review of the medical record revealed the facility admitted Resident #1 on 03/18/15, with [DIAGNOSES REDACTED]. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 02/03/16, revealed the facility assessed the resident utilizing the Brief Interview for Mental Status with a score of six (6) meaning the resident was not cognitively intact and determined not interviewable. Review of the Comprehensive Care Plan for Resident #1, revealed the facility developed an updated plan of care on 10/05/15, for the risk of elopement related to the resident attempting to leave the Living Center and wandering with updated goals and target dates for 05/23/16. The goal stated the resident would remain safe during placement at the Living Center through the next review. The interventions listed directed staff to check the Roam Alert (the staff called it the Wander Guard System) for proper placement and functioning; take a photograph of the resident to maintain on file for identification purposes at the receptionist's desk, and provide activities of interest. In addition, the facility developed a plan of care on 03/26/15, related to behaviors due to agitation and attempting to leave the facility, with updated goals and target dates for 05/23/16. The goal stated the resident would remain calm with staff intervention as needed. The interventions listed directed staff to help the resident to avoid situations or people that was upsetting to the resident, offer the resident a preferred diversional activity, and take the resident outside with staff supervision to help the resident calm down. Review of the facility Nursing Assessments, dated 04/20/15 and 09/14/15, revealed Resident #1 was assessed as being cognitively impaired along with impaired decision making skills. In addition, Resident #1 was assessed to be at high risk for elopement due to exit-seeking behaviors, wandering aimlessly about the facility and exhibiting night wandering. On 02/18/16 at 1:59 PM, interview with Certified Nursing Assistant (CNA) #2, revealed Resident #1 normally wandered all over the facility during the night time hours and it was hard to keep track of the resident when he/she was not on the unit. CNA #2 stated the facility provided him a resident care sheet to use as a reference for the care residents were to receive. He stated Resident #1's care sheet stated the resident was an elopement risk, used a wander guard and needed supervision to prevent elopement. He stated the resident was found outside in the cold, in the courtyard on the lower level of the facility, several days prior to the resident's elopement on 02/16/16. CNA #2 stated he was not given any new nursing interventions after Resident #1 was found outside in the courtyard to prevent the resident from getting out of the facility without staff supervision. On 02/19/16 at 2:19 PM, interview with CNA #1, revealed Resident #1 was an elopement risk and wore a wander guard bracelet around the ankle to alert staff if or when he/she tried to leave the building. She stated she could not provide supervision for Resident #1 when he/she was not on the unit. The facility had two floors and Resident #1 would get on the elevator and go downstairs every night. CNA #1 stated Resident #1 wandered the facility throughout the night shift hours looking for someone to take him/her out to smoke. CNA #1 stated Resident #1 had gotten out into the courtyard two days prior to the elopement on 02/16/16. She stated one of the nurses on the 400 Unit called the 100 Unit and said Resident #1 was out in the courtyard and to send someone to get the resident. CNA #1 stated he/she went to the courtyard and found the resident outside in the twelve degree weather without a coat. She stated it was not safe for the resident to be outside unsupervised in the cold. She stated after this incident she was not given any additional interventions regarding how to supervise the resident when he/she was off the unit or to prevent elopement. Interview with the 100 Unit Manager, on 03/01/16 at 11:25 PM, revealed she was responsible for updating resident's plans of care. She stated if she had known Resident #1 had gotten out into the courtyard a few days prior to the elopement on

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

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 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) 02/16/16 she would have revised the plan of care to include additional interventions to the ensure the resident's safety. Interview with Registered Nurse (RN) #2, on 02/18/16 at 8:12 PM, revealed he had not reviewed Resident #1's plan of care; but did know the resident was an elopement risk due to the wander guard bracelet on the resident's ankle. He stated after the resident had gotten out into the courtyard, prior to eloping 02/16/16, the plan of care should have been updated to reflect additional interventions to promote safety and prevent the resident from eloping. Per interview, he was the house supervisor at night; however, the staff was not used to having someone in this role at night and was still not used to reporting information to him. RN #2 stated Resident #1 routinely wandered about the facility throughout the night time hours. RN #2 revealed he had not shared this information with other leaders because it was Resident #1's nightly behavior. He stated resident safety was a priority and he if he had known Resident #1 had gotten out into the courtyard prior to the elopement on 02/16/16, additional care plan interventions would have been implemented to promote resident safety. Interview, on 02/19/16 with the Director of Nursing Services (DNS) at 3:00 PM revealed any nurse could revise a resident's plan of care; however, the Unit Managers normally revised the care plan when revision was necessary. The DNS stated she had not been made aware of Resident #1's wandering behaviors at night and that the resident had gotten out into the courtyard, she would have instructed the Unit Manager to revise the plan of care. The facility took the following actions to remove the Immediate Jeopardy as follows: 1. On 02/16/16 at approximately 6:20 AM, the facility staff received a call from a local restaurant employee stating Resident #1 was at the restaurant. At this time the facility nurses conducted a head count for all residents on all four units. 2. On 02/16/16 at approximately 6:30 AM, Resident #1 was returned safely to the facility by a nurse and a certified nursing assistant. 3. On 02/16/16 at approximately 6:30 AM, the facility checked Resident #1's wander guard bracelet and determined it was functioning correctly; because the door alarmed when the resident entered the building. The door alarm and mag locks were reset. In addition, the Maintenance Director checked the door alarms and locks and it was determined they all were functioning correctly. 4. On 02/16/16 at approximately 6:40 AM, a facility nurse performed a complete head to toe assessment, including vital signs, on Resident #1. No injuries were noted and vital signs were stable. 5. On 02/16/16 at approximately 6:30 AM, Resident #1 was placed on fifteen (15) minute checks. At approximately 1:00 PM, Resident #1 was placed on one to one (1:1) staff supervision. 6. On 02/16/16, the Maintenance Director contacted a company to check the door locks and wander guard system. It was determined the 400 Hall therapy egress doors were not annunciating at the 400 nurses station. On 02/17/16, the company rewired the panel at the upstairs sunroom door so both would alarm at the nurses station. All tested and worked properly. 7. On 02/16/16 at approximately 9:00 AM, the Nurse Practitioner was notified with no new orders given. At approximately 5:00 PM the Nurse Practitioner was in the facility and assessed Resident #1. New orders to obtain manual blood pressure reading and apical pulse daily for seven days was received. 8. On 02/16/16 at approximately 7:30 AM, the facility nurse notified the responsible party for Resident #1 of the event. 9. On 02/16/16 the Interdisciplinary Team (IDT) reviewed Resident #1's care plans. Care plans were updated by the Reimbursement Nurse Assessment Coordinator (RNAC) to include current event. The IDT included the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), Social Worker, Registered Nursed Assessment Coordinator, Director of Rehabilitation, and the Dietician. 10. On 02/16/16, the DNS and ADNS checked all six (6) elopement binders for accuracy. Resident #1 was located in each of the six binders; along with two other residents. The binders were located at each nursing station along with the Front Office and the Therapy Department. 11. On 02/16/16, the DNS checked the wander guard bracelet of the other two residents deemed to be at risk for elopement. Both bracelets were working correctly. 12. On 02/17/16, the IDT re-assessed all 146 residents at the facility. One additional resident was determined to be at risk for elopement. This resulted in a total of four (4) of our 146 residents to be an elopement risk. The binder was updated on 02/16/16 to add the fourth resident by the ADNS. 13. On 02/19/16, the IDT audited all residents noted at risk for elopement. That was 4 residents of the current 146. The following documentation was reviewed for completion and accuracy: Care Plans, Care Sheets, and bracelets to ensure proper functioning and placement. The IDT would continue to monitor and revised Care Sheets, Care Plans, and Wander Guard Bracelets daily during Clinical Star meeting as needed. The DNS/ADNS or House Supervisor would monitor daily to ensure Care Sheets, Care Plans and Wander Guard Bracelets were revised. The method in which this was completed was by reviewing the elopement risk assessments during clinical start-up meeting (held seven days a week) and updating documentation mentioned above if needed. 14. On 02/19/16, the Area Vice President initiated education with the Executive Director (ED) and the DNS on what, when and how to report to the immediate supervisor or facility management; and this was to include the ED and DNS to ensure that all incident/allegations were properly investigated and all care plans and other pertinent documentation was completed timely and kept up to date. 15. The ED and the DNS initiated the same education with facility staff, including nursing, housekeeping, therapy and dietary. Staff would not be allowed to return to work until they completed the training. New staff would be educated on the elopement guidelines and policy prior to coming to work; this would include anyone that worked in the building. 16. The following management team members were responsible for training new staff: ED DNS, ADNS, Scheduler/HR, Housekeeping Director, Business Office Manager, Director of Rehabilitation, House Supervisor, or Unit Manager. The number of staff in the facility at the time training was initiated during first shift was twenty-six (26) direct care staff and twenty-three (23) department heads, dietary, housekeeping and corporate employees. The number of staff trained to date regarding reporting incidents was one hundred-twenty (120). Agency staff was to be educated by the following managers; the ED, DNS, ADNS, HR Generalist, or House Supervisor. The education was to occur prior to the agency staff working the floor. These managers were trained regarding educating the agency staff on 02/19/16. Staff that was educated was required to sign the company policy regarding reporting incidents to ensure competency and understanding of training. 17. On 02/19/16 training was initiated by the DNS under the guidance of the ED to include the Registered Nurse Assessment Coordinator, ADNS, and Unit Managers with regards to updating care plans timely. The training information was As soon as significant event occurs the care plan should be immediately updated but no longer than 24 hours. Interventions should be appropriately based on event. Follow-up of the care plan updates would be reviewed at the morning clinical start-up meetings at which time competency would be evaluated. 18. On 02/16/16, the Maintenance Director had a mock elopement drill. All staff responded appropriately per Elopement Guidelines. Elopement drills were conducted each day from 02/16/16 through 02/23/16. 19. Elopement drills and door checks would continue to be completed by the Maintenance Director, Department Manager, and/or ED. The logs would be audited by the ED daily Monday through Friday and by the House Supervisor on Saturday and Sunday. The log for the wander guard system included each door in the facility and the magnetic locks to ensure doors were working correctly and if the alarm sounded. 20. On 02/19/16, Door Check training was provided to management staff by the Maintenance Director, under the guidance of the ED, which covered the Activating /Deactivating secondary alarms and how to perform door checks on Maglocks/Wander guard doors. Management trained by title was ED, DNS, ADNS, Admissions Director, Human Resources (HR) Generalist, Business Office Manager, Registered Nurse Assessment Coordinator (RNAC), Social Services Director, Discharge Planner, House Supervisor and Unit Managers. 21. On 02/16/16, an ADHOC Quality meeting was held by the Executive Director with the following in attendance: Medical Director and DNS. 22. All reviews/audits will be taken to the Quality meeting weekly for 4 weeks then monthly for three months than quarterly. The data will be analyzed for trends. If trends are noted appropriate action will be taken, such as system revision and education or what is deemed necessary. These audits/reviews include the elopement drill logs, door check logs, treatment administration record logs, and trends will be tracked by the ED and/or the DNS. 23. Members of the Quality committee team included the ED, DNS, ADNS, Activities Director, Social Services, RNAC, Social Services, Unit Managers and Business Office.

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) 24. The Area Vice President and/or Field Services Clinical Director would monitor Quality minutes and audit findings weekly for 4 weeks, then monthly for three months and then quarterly for compliance. The State Survey Agency validated the removal of the Immediate Jeopardy as follows: 1. Interview with Registered Nurse #1, on 02/19/16 at 11:55 AM, revealed the facility was notified, on 02/16/16 at 6:20 AM, via a phone call from the restaurant staff that Resident #1 was at their establishment trying to order food. 2. Interview with Registered Nurse (RN) #1, on 02/19/16 at 11:55 AM, revealed she and Certified Nursing Assistant (CNA) #3 drove to the restaurant and found Resident #1 standing at the entrance to the establishment. RN #1 stated she drove the resident back to the facility. 3. Interview with Registered Nurse (RN) #1, on 02/19/16 at 11:55 AM, revealed as they entered the facility with Resident #1 the wander guard system alarmed. She stated she reset the door locks and the alarm system. 4. Review of the Nursing Documentation, dated 02/16/16, revealed Registered Nurse #1 documented a head to toe assessment, including a skin assessment was completed at 6:40 AM. The resident's skin was intact with no new issues or open areas noted. There were no apparent injuries or complaints of pain at that time. The resident was alert with confusion, lungs were clear to auscultation, respirations even and unlabored, pulse strong, positive bowel sounds in all four quadrants, and the abdomen was soft and non-tender. No acute distress was noted. Vitals signs were temperature 97.6 degrees Fahrenheit, Pulse 76 beats per minute, respirations 20, blood pressure 119/88 and oxygen saturation on room air was 99%. Interview with Registered Nurse #1, on 02/18/16 at 8:12 PM, revealed she had conducted a head to toe assessment, made notifications to the family and physician. Registered Nurse #1 stated Resident #1 did not have injuries and was not in any distress upon return to the facility. 5. Review of the Nursing Documentation, dated 02/16/16, revealed at approximately 6:30 AM, Resident #1 was placed on fifteen (15) minute checks and at approximately 1:00 PM, Resident #1 was placed on one to one (1:1) staff supervision. Interview with Registered Nurse #1, on 02/18/16 at 8:12 PM, revealed the resident was placed on fifteen minute checks upon return to the facility. 6. Interview with the Maintenance Director, on 03/02/16 at 8:25 AM, revealed on 02/16/16, the Maintenance Director contacted a company to check the door locks and wander guard system. It was determined the 400 Hall therapy egress doors were not annunciating at the 400 nurses station. On 02/17/16, the company rewired the panel at the upstairs sunroom door so both would alarm at the nurses station. All doors were tested and worked properly. Review of invoice, dated 02/16/16, revealed the panel was rewired. Further interview revealed the door on the 300 Unit was identified on 02/27/16 to have a malfunctioning alarm. Observations on 03/01/02 and 03/02/16 revealed the alarm would go off without the presence of a wander guard to set it off. The door was repaired on 03/03/16. 7. Review of the Nursing Documentation, dated 02/16/16, revealed the Nurse Practitioner was notified with no new orders given. At approximately 5:00 PM the Nurse Practitioner was in the facility and assessed Resident #1. New orders to obtain manual blood pressure reading and apical pulse daily for seven days was received. Interview with the Medical Director, on 03/03/16 at 1:15 PM, revealed he was notified by his Nurse Practitioner regarding the elopement and no new orders were given. He stated the Nurse Practitioner assessed the resident later that evening and ordered blood pressure checks. 8. Review of Nursing Documentation, dated 02/16/16, revealed at approximately 7:30 AM, the facility nurse notified the responsible party for Resident #1 of the event. 9. Review of Resident #1's plan of care revealed it was reviewed and updated by the IDT on 02/16/16. Resident #1's care plans were updated by the Reimbursement Nurse Assessment Coordinator (RNAC) to include current event. Interview, on 03/02/16 at 1:25 PM, with the Executive Director (ED) revealed the IDT consisted of the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), Social Worker, Registered Nursed Assessment Coordinator, Director of Rehabilitation, and the Dietician. Interview with the Dietitian, the Director of Rehabilitation, and the ADNS, on 03/02/16 at 9:00 AM, revealed they were all on the IDT. 10. Review of the facility's Elopement binder review documentation, dated 02/16/16, revealed the DNS and ADNS checked all six (6) elopement binders for accuracy. Resident #1 was located in each of the six binders; along with two other residents. Observations made, on 03/01/16 at 2:00 PM, 2:05 PM, 2:10 PM, 2:15 PM and 2:20 PM, revealed the Elopement binders were located at each nursing station along with the Front Office and the Therapy Department. Interview with Receptionist, on 03/02/16 at 9:18 AM, revealed one of the elopement binders was kept at the front desk. Interview with 100 Unit Manager, on 03/01/16 at 11:25 PM, revealed there were elopement binders kept at each nursing station in the facility and one in the Therapy Department. 11. Review of the facility's Audit documentation, dated 02/16/16, revealed the DNS checked the wander guard bracelet of the other two residents deemed to be at risk for elopement. Both bracelets were working correctly. Interview, on 03/02/16 at 1:25 PM, with the DNS revealed she had checked the wander guard bracelets of the other two residents and they were deemed to be working properly. 12. Review of the facility's Audit documentation, dated 02/17/16, revealed the IDT re-assessed all 146 residents at the facility. One additional resident was determined to be at risk for elopement. This resulted in a total of four (4) of the 146 residents to be an elopement risk. The binder was updated on 02/16/16 to add the fourth resident by the ADNS. Interview, on 03/02/16 at 1:25 PM, with the ADNS, revealed she had updated the elopement binder with the fourth resident identified as at risk. 13. Review of the facility's Audit documentation, dated 02/19/16, revealed the IDT audited all residents noted at risk for elopement; that was 4 residents of the current 146. The audit documentation revealed the facility reviewed the following documentation for completion and accuracy: Care Plans, Care Sheets, and bracelets to ensure proper functioning and placement. Observation, on 03/02/16 at 9:00 AM, of the IDT meeting revealed they continued to monitor and revise Care Sheets, Care Plans, and Wander Guard Bracelets during the meeting. Interview with the DNS and ADNS during the meeting, revealed they were monitoring daily to ensure Care Sheets, Care Plans and Wander Guard Bracelets were revised. They each stated the method in which this was completed was by reviewing the elopement risk assessments during clinical start-up meeting (held seven days a week) and updating documentation mentioned above if needed. 14. Interview, on 03/02/16 at 2:10 PM, with the Area Vice President, revealed he initiated education with the Executive Director (ED) and the DNS on what, when, and how to report to the immediate supervisor or facility management. This was to include the ED and DNS to ensure that all incident/allegations were properly investigated and all care plans and other pertinent documentation was completed timely and kept up to date. Interview, on 03/02/16 at 1:25 PM, with the DNS and the ED revealed they received training from the Area Vice President regarding reporting, documentation and investigation of events. 15. Interview with the ED and the DNS, on 03/02/16 at 1:25 PM, revealed they initiated the same education with facility staff, including nursing, housekeeping, therapy and dietary. They both stated staff would not be allowed to return to work until they completed the training. In addition, all new staff would be educated on the elopement guidelines and policy prior to coming to work; this would include anyone that worked in the building. 16. Interview with the ED and the DNS, on 03/02/16 at 1:25 PM, revealed the following management team members were responsible for training new staff: ED, DNS, ADNS, Scheduler/HR, Housekeeping Director, Business Office Manager, Director of Rehabilitation, House Supervisor, or Unit Manager. They stated the number of staff in the facility at the time training was initiated during first shift was twenty-six direct care staff and twenty-three department heads, dietary, housekeeping and corporate employees. They stated the number of staff trained to date regarding reporting incidents was 120. The ED stated agency staff would be educated by the following managers; the DNS, ADNS, HR Generalist, or House Supervisor. The education was to occur prior to the agency staff working the floor. The ED stated the managers were trained regarding educating the agency staff on 02/19/16. The ED also stated the staff that was educated was required to sign the company policy regarding reporting incidents to ensure competency and understanding of training. Interview with Licensed Practical Nurse #4, on 03/02/16 at 11:10 AM, revealed she had received training regarding the policy and procedure for reporting and elopement. Interviews with Certified Nursing Assistant #8, on 03/03/16 at 9:42 AM, Registered Nurse #3, on 03/03/16 at 2:40 PM, and LPN #3, on 03/03/16 at 2:45 PM, revealed they had received training regarding the policy and procedure for reporting and elopement. 17. Review of the facility's training records, dated 02/19/16, revealed training was initiated by the DNS under the guidance

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) of the ED to include the Registered Nurse Assessment Coordinator, ADNS, and Unit Managers with regards to updating care plans timely. The training information stated as soon as a significant event occurs the care plan should be immediately updated, but no longer than 24 hours. Interventions should be appropriately based on the event. In addition, the training information directed management staff to perform a follow-up on the updates made to residents care plan and the information would be reviewed at the morning clinical start-up meetings at which time competency would be evaluated. Interview with the Minimum Data Set Nurse (MDS/RNAC), on 03/02/16 at 12:35 PM, revealed she received training on updating care plans timely. Interview with the 100 Unit Manager, on 03/01/16 at 3:05 PM, revealed she had received training on updating care plans timely after events had occurred. 18. Observation, on 03/01/16 at 1:46 PM, revealed an Elopement drill was enacted by the Maintenance Director. Staff were observed to do a head count, search for missing resident and report back to the leader of the drill. Review of Elopement drill documentation, dated 02/16/16, revealed the Maintenance Director had a mock elopement drill on 02/16/16. The Maintenance Director documented all staff responded appropriately per Elopement Guidelines. Continued review of Elopement drill documentation revealed drills were conducted from 02/16/16 through 02/23/16. Interview with Receptionist, on 03/02/16 at 9:18 AM, revealed she participated in the Elopement drills by going out the front door and looking in the parking lot. Interview with Certified Nursing Assistant (CNA) #10, on 03/01/16 at 2:40 PM, and CNA #3 at 3:00 PM, revealed they had participated in the elopement drills and their responsibility was to look for the missing resident until found. 19. Interview with the Maintenance Director, on 03/02/16 at 8:25 AM, revealed he would continue to conduct Elopement drills and door checks and if he was unable then a Department Manager, and/or ED would complete them. He stated the logs would be audited by the ED daily Monday through Friday and by the House Supervisor on Saturday and Sunday. He stated he documented in the log each time the wander guard system was checked along with each door in the facility. He stated the magnetic locks were also checked to ensure they were working correctly and if the alarm sounded. He stated these checks were also documented on the logs. Review of Elopement Drill and door check logs revealed drills and locks were being completed and checked daily. Interview with the Business Manager, on 03/03/16 at 8:41 AM, and the 100 Unit Manager, on 03/01/16 at 3:05 PM, revealed they were trained to do door checks and documenting the findings in the log. 20. Interview with the Maintenance Director, on 03/02/16 at 8:25 AM, revealed he provided the Door Check training to the management staff, under the guidance of the ED, which covered the Activation /Deactivation of the secondary alarms and how to perform door checks on Maglocks/Wander guard doors. He stated the management trained by title was ED, DNS, ADNS, Admissions Director, Human Resources (HR) Generalist, Business Office Manager, Registered Nurse Assessment Coordinator (RNAC), Social Services Director, Discharge Planner, House Supervisor and Unit Managers. Interview with the MDS/RNAC, on 03/02/16 at 12:35 PM, revealed she had received training from the Maintenance Director regarding how to perform door checks. Interview with the MDS/RNAC, on 03/02/16 at 12:35 PM, the ED at 1:25 PM, and the DNS at 1:41 PM, revealed they had received training from the Maintenance Director regarding how to perform door checks. 21. Review of the Quality Assurance Committee meeting sign in sheet, dated 02/16/16, revealed the ADHOC Quality meeting was held by the Executive Director with the following in attendance: Medical Director and DNS. 22. Interview with the Medical Director, on 03/03/16 at 1:15 PM, revealed the Quality Assessment Committee will analyze all reviews and audits related to the Elopement action plan on a weekly basis, for 4 weeks then monthly for three months than quarterly. He stated the data will be analyzed for trends, and if trends are noted, appropriate action will be taken, such as system revision and education or what is deemed necessary. The Medical Director stated the committee reviewed audits on 02/25/16 and found no trends for an action plan to be developed. 23. Interview with the Medical Director, on 03/03/16 at 1:15 PM, revealed the members of the Quality committee team included the ED, DNS, ADNS, Activities Director, Social Services, RNAC, Social Services, Unit Managers and Business Office. 24. Interview, on 03/02/16 at 2:10 PM, with the Area Vice President, revealed he or the Field Services Clinical Director would monitor the Quality Assurance minutes and audit findings weekly for 4 weeks, then monthly for three
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure residents received adequate supervision to prevent accidents for one (1) of five (5) sampled residents (Resident #1). On 02/16/16 at 6:20 AM, Registered Nurse #1 was notified via a phone call from a local restaurant's staff that Resident #1 was at their establishment trying to order food. Registered Nurse #1 and Certified Nursing Assistant #3, drove to the restaurant, which was located approximately seven (7) tenths of a mile from the facility (across five lanes of traffic and two intersections), and found Resident #1 standing at the entrance door of the restaurant. She stated Resident #1 was wearing sweat pants, a t-shirt and sweat shirt/hoodie type jacket when she picked him/her up at the restaurant. RN #1 stated she returned to the facility at 6:30 AM and her assessment revealed the resident had not sustained any injuries. The recorded weather conditions on 02/16/16 at 5:53 AM, was noted as over cast skies and thirty-three (33) degrees Fahrenheit with a wind chill of twenty-six (26) degrees Fahrenheit. The facility's failure to have an effective system in place, to ensure staff provided adequate supervision to prevent an elopement has caused or is likely to cause serious injury, harm, impairment or death. Immediate Jeopardy was identified on 02/19/16 and determined to exist on 02/16/16. An Acceptable Allegation of Compliance (AOC) was received on 02/26/16 which alleged removal of the Immediate Jeopardy on 02/22/16. However, the State Survey Agency determined through validation of the AOC, the Immediate Jeopardy was not removed until 03/04/16. Observation and interview revealed a 300 Unit facility door did not have a functioning alarm. The issue was identified by staff on 02/27/16; however, the door was not repaired until 03/03/16. The scope and severity was lowered to a D while the facility monitors the implementation of the Plan of Correction and the facility's Quality Assurance monitors the effectiveness of the systemic changes. The findings include: Review of the undated facility's Elopement Policy revealed an Elopement was defined as a situation in which a resident with impaired decision-making ability, who was oblivious to his/her own safety and was at risk for injury outside of the confines of the Living Center, left the facility without knowledge of the staff. In addition, an Elopement would also occur when a resident left the premises or a safe area without authorization and/or necessary supervision to do so. The policy also stated the Living Center would implement interventions to minimize elopement risks and hazards as appropriate. Review of the medical record revealed the facility admitted Resident #1 on 03/18/15, with [DIAGNOSES REDACTED]. Review of Resident #1's Annual Minimum Data Set (MDS) assessment, completed on 02/03/16, revealed the facility assessed the resident utilizing the Brief Interview for Mental Status with a score of six (6) meaning the resident was not cognitively intact and determined to be not interviewable. Review of the facility Nursing Assessments, dated 04/20/15 and 09/14/15, revealed Resident #1 was assessed as being cognitively impaired with impaired decision making skills. In addition, Resident #1 was assessed to be at high risk for elopement due to exit-seeking behaviors, wandering aimlessly about the facility and exhibiting night wandering. Review of History and Physical, dated 10/15/15, revealed Resident #1 had decreased judgement and insight due to Dementia. Review of the Physician's Physical Assessment, dated 02/16/16, revealed Resident #1 was noted to be impulsive, non-verbal, a poor historian, had memory loss, and an unsteady gait. Review of Resident #1's Comprehensive Care Plan, revealed the facility developed an updated plan of care on 10/05/15, for the risk of elopement related to the resident attempting to leave the Living Center and wandering with updated goals and target dates for 05/23/16 . The goal stated the resident would remain safe during placement at the Living Center through the next review. The interventions listed directed staff to check the Roam alert (Wander Guard System) for proper placement and functioning; take a photograph of the resident to maintain on file for identification purposes at the receptionist's desk, and provide activities of interest. In addition, the facility developed a plan of care on 03/26/15, related to behaviors due to agitation and attempting to leave the facility, with updated goals and target dates for 05/23/16. The goal stated the resident would remain calm with staff intervention as needed. The interventions listed directed staff to help the resident to avoid situations or people

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	185095	A. BUILDING _____ B. WING _____	03/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - HILLCREEK	3116 BRECKINRIDGE LANE LOUISVILLE, KY 40220

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) that was upsetting to the resident, offer the resident a preferred diversional activity, and take the resident outside with staff supervision to help the resident calm down. Interview with Registered Nurse #1, on 02/19/16 at 11:55 AM, revealed the resident was aphasic, usually mumbled and was very hard to understand. RN #1 stated the facility was notified, on 02/16/16 at 6:20 AM via a phone call from the restaurant's staff, Resident #1 was at their establishment trying to order food. RN #1 revealed she and Certified Nursing Assistant (CNA) #3 drove to the restaurant, which was located approximately seven (7) tenths of a mile from the facility, and found Resident #1 standing at the entrance door of the restaurant. She stated Resident #1 was wearing sweat pants, a t-shirt and sweat shirt/hoodie type jacket when she picked him/her up at restaurant. She returned the resident to the facility at 6:30 AM and her assessment revealed the resident had not sustained any injuries. RN #1 stated when she returned and escorted the resident to his/her room she noticed the resident's wheelchair was missing. She stated around 6:40 AM, she told the resident to stay seated on his/her bed and she left the resident unattended in his/her room. She stated she walked down the hall, went into the bathroom to wash her hands and when she came back out, the resident was standing way down the hall at the elevator door. Per interview, by the time she got down to the elevator, the door had already closed and the resident was going down to the lower level. She stated she pushed the button for the elevator to return and when it did, the resident was on the elevator sitting in his/her wheelchair. She stated the resident was taken back to their room and sometime after 7:00 AM was put on 1:1 supervision by the Director of Nursing Services. Interview with Certified Nursing Assistant (CNA) #3, on 02/18/16 at 12:20 PM, revealed she worked first shift and had just arrived to the facility when she was asked to to ride to the restaurant down the road, with RN #1 to pick up Resident #1. She stated it was very cold outside when they found the resident standing outside the restaurant's entrance. She stated once they returned to the building, she did see the resident roaming around the building with another staff member during the day shift. She stated she had not been told how the resident had gotten out of the facility and did not know if he had been put on any kind of special checks. Interview with CNA #1, on 02/19/16 at 2:19 PM, revealed the facility had two floors and Resident #1 would get on the elevator and go downstairs every night. CNA #1 stated Resident #1 wandered the facility throughout the night shift hours looking for someone to take him/her out to smoke. CNA #1 stated Resident #1 would get upset and combative if staff did not agree to take him/her out to smoke. CNA #1 revealed it was very difficult to monitor Resident #1's whereabouts when he/she was taking care of other residents' needs. Per interview, Resident #1 had gotten out into the courtyard two days prior to being found at the restaurant down the road. She stated one of the nurses on the 400 Unit called the 100 Unit and said Resident #1 was out in the courtyard and to send someone to get the resident. CNA #1 went to the courtyard and found the resident outside in the twelve degree weather without a coat. She stated after this incident she was not given any additional interventions regarding how to supervise or prevent Resident #1 from exiting the building unless escorted by staff. She stated on 02/16/16, Resident #1 was wandering around the facility in his/her wheelchair and the last time she had seen the resident was around 4:30 AM. Interview with CNA #2, on 02/18/16 at 1:59 PM, revealed Resident #1 normally wandered all over the facility during the night time hours and it was hard to keep track of the resident when he/she was not on the unit. He stated the resident was found outside in the cold, in the courtyard on the lower level of the facility, several days prior to the resident being found at the restaurant on 02/16/16. CNA #2 stated he was not given any new nursing interventions after Resident #1 was found outside in the courtyard to prevent the resident from getting out of the facility without staff supervision. CNA #2 stated he had last seen Resident #1 around 4:00 AM on 02/16/16, asking a nurse from the 200 unit to take him/her out to smoke; he stated he overheard the nurse telling the resident she would not take the resident out to smoke. CNA #2 stated he seen Resident #1 later getting on the elevator to go to the lower level of the facility around 4:30 AM in his/her wheelchair. Continued interview with RN #2, on 02/18/16 at 8:12 PM, revealed when he was notified about Resident #1 being at the restaurant down the road, he went to each door on the lower level of the facility and found the door alarm to the door in the Therapy Department sounded but was very faint. Interview with the Maintenance Director, on 02/19/16 at 10:30 AM, revealed he checked the wander guard system daily by taking a wander guard transmitter (the part that each resident wears on their ankle) to each door and no problems with the alarm system were found. However, after Resident #1's elopement on 02/16/16 it was determined that the alarm did not sound at the 400 Unit nurses station when the Therapy Department exit doors were tested . He stated a company was called and made repairs to the system to ensure it would alarm at the nurses station. Interview with the Director of Nursing Services (DNS), on 02/18/16 at 11:58 AM, revealed the facility had determined Resident #1 had exited through the Therapy Department exit doors since the alarm was not audible at the nurse's station. Staff had reported not hearing an alarm the morning the resident left the facility. Continued interview on 02/19/16 with the DNS at 3:00 PM revealed Resident #1 was smart, observant and quick when trying to get out. She stated the resident needed to be checked on more frequently then every two (2) hours due to his/her exit seeking behavior; however this was hard to do. She was not aware the resident had gotten into the courtyard previously. She stated the courtyard was not a secure area even though there was a locked gate. She revealed the resident could get over the gate if he/she wanted to. Per interview, staff should have reported the incident so additional interventions could have been implemented to prevent future elopements. Interview on 02/19/16 at 3:45 PM with the Executive Director at 3:45 PM, revealed Resident #1 wandered about the facility continuously exit seeking and the facility utilized the wander-guard system as a means of supervision for Resident #1. The Executive Director was not aware that the wander guard alarm system on the Therapy Department doors did not sound at the 400 Unit nurses station until after the resident eloped. Observation of Resident #1, on 02/18/16 at 11:40 AM, revealed he/she was seated in a wheelchair in his/her room with 1:1 supervision by CNA #6. The facility implemented the following actions to remove the Immediate Jeopardy: 1. On 02/16/16 at approximately 6:20 AM, the facility staff received a call from a local restaurant employee stating Resident #1 was at the restaurant. At this time the facility nurses conducted a head count for all residents on all four units. 2. On 02/16/16 at approximately 6:30 AM, Resident #1 was returned safely to the facility by a nurse and a certified nursing assistant. 3. On 02/16/16 at approximately 6:30 AM, the facility checked Resident #1's wander guard bracelet and determined it was functioning correctly; because the door alarmed when the resident entered the building. The door alarm and mag locks were reset. In addition, the Maintenance Director checked the door alarms and locks and it was determined they all were functioning correctly. 4. On 02/16/16 at approximately 6:40 AM, a facility nurse performed a complete head to toe assessment, including vital signs, on Resident #1. No injuries were noted and vital signs were stable. 5. On 02/16/16 at approximately 6:30 AM, Resident #1 was placed on fifteen (15) minute checks. At approximately 1:00 PM, Resident #1 was placed on one to one (1:1) staff supervision. 6. On 02/16/16, the Maintenance Director contacted a company to check the door locks and wander guard system. It was determined the 400 Hall therapy egress doors were not annunciating at the 400 nurses station. On 02/17/16, the company rewired the panel at the upstairs sunroom door so both would alarm at the nurses station. All tested and worked properly. 7. On 02/16/16 at approximately 9:00 AM, the Nurse Practitioner was notified with no new orders given. At approximately 5:00 PM the Nurse Practitioner was in the facility and assessed Resident #1. New orders to obtain manual blood pressure reading and apical pulse daily for seven days was received. 8. On 02/16/16 at approximately 7:30 AM, the facility nurse notified the responsible party for Resident #1 of the event. 9. On 02/16/16 the Interdisciplinary Team (IDT) reviewed Resident #1's care plans. Care plans were updated by the Reimbursement Nurse Assessment Coordinator (RNAC) to include current event. The IDT included the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), Social Worker, Registered Nursed Assessment Coordinator, Director of Rehabilitation, and the Dietician. 10. On 02/16/16, the DNS and ADNS checked all six (6) elopement binders for accuracy. Resident #1 was located in each of the six binders; along with two other residents. The binders were located at each nursing station along with the Front Office and the Therapy Department. 11. On 02/16/16, the DNS checked the wander guard bracelet of the other two residents deemed to be at risk for elopement.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) Both bracelets were working correctly. 12. On 02/17/16, the IDT re-assessed all 146 residents at the facility. One additional resident was determined to be at risk for elopement. This resulted in a total of four (4) of our 146 residents to be an elopement risk. The binder was updated on 02/16/16 to add the fourth resident by the ADNS. 13. On 02/19/16, the IDT audited all residents noted at risk for elopement. That was 4 residents of the current 146. The following documentation was reviewed for completion and accuracy: Care Plans, Care Sheets, and bracelets to ensure proper functioning and placement. The IDT would continue to monitor and revised Care Sheets, Care Plans, and Wander Guard Bracelets daily during Clinical Star meeting as needed. The DNS/ADNS or House Supervisor would monitor daily to ensure Care Sheets, Care Plans and Wander Guard Bracelets were revised. The method in which this was completed was by reviewing the elopement risk assessments during clinical start-up meeting (held seven days a week) and updating documentation mentioned above if needed. 14. On 02/19/16, the Area Vice President initiated education with the Executive Director (ED) and the DNS on what, when and how to report to the immediate supervisor or facility management; and this was to include the ED and DNS to ensure that all incident/allegations were properly investigated and all care plans and other pertinent documentation was completed timely and kept up to date. 15. The ED and the DNS initiated the same education with facility staff, including nursing, housekeeping, therapy and dietary. Staff would not be allowed to return to work until they completed the training. New staff would be educated on the elopement guidelines and policy prior to coming to work; this would include anyone that worked in the building. 16. The following management team members were responsible for training new staff: ED DNS, ADNS, Scheduler/HR, Housekeeping Director, Business Office Manager, Director of Rehabilitation, House Supervisor, or Unit Manager. The number of staff in the facility at the time training was initiated during first shift was twenty-six (26) direct care staff and twenty-three (23) department heads, dietary, housekeeping and corporate employees. The number of staff trained to date regarding reporting incidents was one hundred-twenty (120). Agency staff was to be educated by the following managers; the ED, DNS, ADNS, HR Generalist, or House Supervisor. The education was to occur prior to the agency staff working the floor. These managers were trained regarding educating the agency staff on 02/19/16. Staff that was educated was required to sign the company policy regarding reporting incidents to ensure competency and understanding of training. 17. On 02/19/16 training was initiated by the DNS under the guidance of the ED to include the Registered Nurse Assessment Coordinator, ADNS, and Unit Managers with regards to updating care plans timely. The training information was As soon as significant event occurs the care plan should be immediately updated but no longer than 24 hours. Interventions should be appropriately based on event. Follow-up of the care plan updates would be reviewed at the morning clinical start-up meetings at which time competency would be evaluated. 18. On 02/16/16, the Maintenance Director had a mock elopement drill. All staff responded appropriately per Elopement Guidelines. Elopement drills were conducted each day from 02/16/16 through 02/23/16. 19. Elopement drills and door checks would continue to be completed by the Maintenance Director, Department Manager, and/or ED. The logs would be audited by the ED daily Monday through Friday and by the House Supervisor on Saturday and Sunday. The log for the wander guard system included each door in the facility and the magnetic locks to ensure doors were working correctly and if the alarm sounded. 20. On 02/19/16, Door Check training was provided to management staff by the Maintenance Director, under the guidance of the ED, which covered the Activating /Deactivating secondary alarms and how to perform door checks on Maglocks/Wander guard doors. Management trained by title was ED, DNS, ADNS, Admissions Director, Human Resources (HR) Generalist, Business Office Manager, Registered Nurse Assessment Coordinator (RNAC), Social Services Director, Discharge Planner, House Supervisor and Unit Managers. 21. On 02/16/16, an ADHOC Quality meeting was held by the Executive Director with the following in attendance: Medical Director and DNS. 22. All reviews/audits will be taken to the Quality meeting weekly for 4 weeks then monthly for three months than quarterly. The data will be analyzed for trends. If trends are noted appropriate action will be taken, such as system revision and education or what is deemed necessary. These audits/reviews include the elopement drill logs, door check logs, treatment administration record logs, and trends will be tracked by the ED and/or the DNS. 23. Members of the Quality committee team included the ED, DNS, ADNS, Activities Director, Social Services, RNAC, Social Services, Unit Managers and Business Office. 24. The Area Vice President and/or Field Services Clinical Director would monitor Quality minutes and audit findings weekly for 4 weeks, then monthly for three months and then quarterly for compliance. The State Survey Agency validated the removal of the Immediate Jeopardy as follows: 1. Interview with Registered Nurse #1, on 02/19/16 at 11:55 AM, revealed the facility was notified, on 02/16/16 at 6:20 AM, via a phone call from the restaurant staff that Resident #1 was at their establishment trying to order food. 2. Interview with Registered Nurse (RN) #1, on 02/19/16 at 11:55 AM, revealed she and Certified Nursing Assistant (CNA) #3 drove to the restaurant and found Resident #1 standing at the entrance to the establishment. RN #1 stated she drove the resident back to the facility. 3. Interview with Registered Nurse (RN) #1, on 02/19/16 at 11:55 AM, revealed as they entered the facility with Resident #1 the wander guard system alarmed. She stated she reset the door locks and the alarm system. 4. Review of the Nursing Documentation, dated 02/16/16, revealed Registered Nurse #1 documented a head to toe assessment, including a skin assessment was completed at 6:40 AM. The resident's skin was intact with no new issues or open areas noted. There were no apparent injuries or complaints of pain at that time. The resident was alert with confusion, lungs were clear to auscultation, respirations even and unlabored, pulse strong, positive bowel sounds in all four quadrants, and the abdomen was soft and non-tender. No acute distress was noted. Vitals signs were temperature 97.6 degrees Fahrenheit, Pulse 76 beats per minute, respirations 20, blood pressure 119/88 and oxygen saturation on room air was 99%. Interview with Registered Nurse #1, on 02/18/16 at 8:12 PM, revealed she had conducted a head to toe assessment, made notifications to the family and physician. Registered Nurse #1 stated Resident #1 did not have injuries and was not in any distress upon return to the facility. 5. Review of the Nursing Documentation, dated 02/16/16, revealed at approximately 6:30 AM, Resident #1 was placed on fifteen (15) minute checks and at approximately 1:00 PM, Resident #1 was placed on one to one (1:1) staff supervision. Interview with Registered Nurse #1, on 02/18/16 at 8:12 PM, revealed the resident was placed on fifteen minute checks upon return to the facility. 6. Interview with the Maintenance Director, on 03/02/16 at 8:25 AM, revealed on 02/16/16, the Maintenance Director contacted a company to check the door locks and wander guard system. It was determined the 400 Hall therapy egress doors were not annunciating at the 400 nurses station. On 02/17/16, the company rewired the panel at the upstairs sunroom door so both would alarm at the nurses station. All doors were tested and worked properly. Review of invoice, dated 02/16/16, revealed the panel was rewired. Further interview revealed the door on the 300 Unit was identified on 02/27/16 to have a malfunctioning alarm. Observations on 03/01/02 and 03/02/16 revealed the alarm would go off without the presence of a wander guard to set it off. The door was repaired on 03/03/16. 7. Review of the Nursing Documentation, dated 02/16/16, revealed the Nurse Practitioner was notified with no new orders given. At approximately 5:00 PM the Nurse Practitioner was in the facility and assessed Resident #1. New orders to obtain manual blood pressure reading and apical pulse daily for seven days was received. Interview with the Medical Director, on 03/03/16 at 1:15 PM, revealed he was notified by his Nurse Practitioner regarding the elopement and no new orders were given. He stated the Nurse Practitioner assessed the resident later that evening and ordered blood pressure checks. 8. Review of Nursing Documentation, dated 02/16/16, revealed at approximately 7:30 AM, the facility nurse notified the responsible party for Resident #1 of the event. 9. Review of Resident #1's plan of care revealed it was reviewed and updated by the IDT on 02/16/16. Resident #1's care plans were updated by the Reimbursement Nurse Assessment Coordinator (RNAC) to include current event. Interview, on 03/02/16 at 1:25 PM, with the Executive Director (ED) revealed the IDT consisted of the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS), Social Worker, Registered Nursed Assessment Coordinator, Director of Rehabilitation, and the Dietician. Interview with the Dietitian, the Director of Rehabilitation, and the ADNS, on 03/02/16 at 9:00 AM, revealed they were all on the IDT.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) 10. Review of the facility's Elopement binder review documentation, dated 02/16/16, revealed the DNS and ADNS checked all six (6) elopement binders for accuracy. Resident #1 was located in each of the six binders; along with two other residents. Observations made, on 03/01/16 at 2:00 PM, 2:05 PM, 2:10 PM, 2:15 PM and 2:20 PM, revealed the Elopement binders were located at each nursing station along with the Front Office and the Therapy Department. Interview with Receptionist, on 03/02/16 at 9:18 AM, revealed one of the elopement binders was kept at the front desk. Interview with 100 Unit Manager, on 03/01/16 at 11:25 PM, revealed there were elopement binders kept at each nursing station in the facility and one in the Therapy Department. 11. Review of the facility's Audit documentation, dated 02/16/16, revealed the DNS checked the wander guard bracelet of the other two residents deemed to be at risk for elopement. Both bracelets were working correctly. Interview, on 03/02/16 at 1:25 PM, with the DNS revealed she had checked the wander guard bracelets of the other two residents and they were deemed to be working properly. 12. Review of the facility's Audit documentation, dated 02/17/16, revealed the IDT re-assessed all 146 residents at the facility. One additional resident was determined to be at risk for elopement. This resulted in a total of four (4) of the 146 residents to be an elopement risk. The binder was updated on 02/16/16 to add the fourth resident by the ADNS. Interview, on 03/02/16 at 1:25 PM, with the ADNS, revealed she had updated the elopement binder with the fourth resident identified as at risk. 13. Review of the facility's Audit documentation, dated 02/19/16, revealed the IDT audited all residents noted at risk for elopement; that was 4 residents of the current 146. The audit documentation revealed the facility reviewed the following documentation for completion and accuracy: Care Plans, Care Sheets, and bracelets to ensure proper functioning and placement. Observation, on 03/02/16 at 9:00 AM, of the IDT meeting revealed they continued to monitor and revise Care Sheets, Care Plans, and Wander Guard Bracelets during the meeting. Interview with the DNS and ADNS during the meeting, revealed they were monitoring daily to ensure Care Sheets, Care Plans and Wander Guard Bracelets were revised. They each stated the method in which this was completed was by reviewing the elopement risk assessments during clinical start-up meeting (held seven days a week) and updating documentation mentioned above if needed. 14. Interview, on 03/02/16 at 2:10 PM, with the Area Vice President, revealed he initiated education with the Executive Director (ED) and the DNS on what, when, and how to report to the immediate supervisor or facility management. This was to include the ED and DNS to ensure that all incident/allegations were properly investigated and all care plans and other pertinent documentation was completed timely and kept up to date. Interview, on 03/02/16 at 1:25 PM, with the DNS and the ED revealed they received training from the Area Vice President regarding reporting, documentation and investigation of events. 15. Interview with the ED and the DNS, on 03/02/16 at 1:25 PM, revealed they initiated the same education with facility staff, including nursing, housekeeping, therapy and dietary. They both stated staff would not be allowed to return to work until they completed the training. In addition, all new staff would be educated on the elopement guidelines and policy prior to coming to work; this would include anyone that worked in the building. 16. Interview with the ED and the DNS, on 03/02/16 at 1:25 PM, revealed the following management team members were responsible for training new staff: ED, DNS, ADNS, Scheduler/HR, Housekeeping Director, Business Office Manager, Director of Rehabilitation, House Supervisor, or Unit Manager. They stated the number of staff in the facility at the time training was initiated during first shift was twenty-six direct care staff and twenty-three department heads, dietary, housekeeping and corporate employees. They stated the number of staff trained to date regarding reporting incidents was 120. The ED stated agency staff would be educated by the following managers; the DNS, ADNS, HR Generalist, or House Supervisor. The education was to occur prior to the agency staff working the floor. The ED stated the managers were trained regarding educating the agency staff on 02/19/16. The ED also stated the staff that was educated was required to sign the company policy regarding reporting incidents to ensure competency and understanding of training. Interview with Licensed Practical Nurse #4, on 03/02/16 at 11:10 AM, revealed she had received training regarding the policy and procedure for reporting and elopement. Interviews with Certified Nursing Assistant #8, on 03/03/16 at 9:42 AM, Registered Nurse #3, on 03/03/16 at 2:40 PM, and LPN #3, on 03/03/16 at 2:45 PM, revealed they had received training regarding the policy and procedure for reporting and elopement. 17. Review of the facility's training records, dated 02/19/16, revealed training was initiated by the DNS under the guidance of the ED to include the Registered Nurse Assessment Coordinator, ADNS, and Unit Managers with regards to updating care plans timely. The training information stated as soon as a significant event occurs the care plan should be immediately updated, but no longer than 24 hours. Interventions should be appropriately based on the event. In addition, the training information directed management staff to perform a follow-up on the updates made to residents care plan and the information would be reviewed at the morning clinical start-up meetings at which time competency would be evaluated. Interview with the Minimum Data Set Nurse (MDS/RNAC), on 03/02/16 at 12:35 PM, revealed she received training on updating care plans timely. Interview with the 100 Unit Manager, on 03/01/16 at 3:05 PM, revealed she had received training on updating care plans timely after events had occurred. 18. Observation, on 03/01/16 at 1:46 PM, revealed an Elopement drill was enacted by the Maintenance Director. Staff were observed to do a head count, search for missing resident and report back to the leader of the drill. Review of Elopement drill documentation, dated 02/16/16, revealed the Maintenance Director had a mock elopement drill on 02/16/16. The Maintenance Director documented all staff responded appropriately per Elopement Guidelines. Continued review of Elopement drill documentation revealed drills were conducted from 02/16/16 through 02/23/16. Interview with Receptionist, on 03/02/16 at 9:18 AM, revealed she participated in the Elopement drills by going out the front door and looking in the parking lot. Interview with Certified Nursing Assistant (CNA) #10, on 03/01/16 at 2:40 PM, and CNA #3 at 3:00 PM, revealed they had participated in the elopement drills and their responsibility was to look for the missing resident until found. 19. Interview with the Maintenance Director, on 03/02/16 at 8:25 AM, revealed he would continue to conduct Elopement drills and door checks and if he was unable then a Department Manager, and/or ED would complete them. He stated the logs would be audited by the ED daily Monday through Friday and by the House Supervisor on Saturday and Sunday. He stated he documented in the log each time the wander guard system was checked along with each door in the facility. He sta