STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185039	A. BUILDING _____ B. WING _____	**11/11/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS HEALTH AND REHABILITATION CENTER	**1705 STEVENS AVENUE LOUISVILLE, KY 40205**

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) Manual and the facility's policy and procedures, it was determined the facility failed to have an effective system to review and revise care plans to ensure interventions were in place for three (3) of twelve (12) sampled residents, Residents #1, #2, and #3. The facility assessed Resident #1 at risk for elopement and wandering and put interventions in place to ensure the resident's safety. On 10/21/16, Resident #1 eloped from the facility without staff knowledge and was found off the facility's grounds walking down the sidewalk. The facility's investigation determined the resident took the elevator to the lobby where Receptionist #2 keyed in the alarm code to the front door and allowed the resident to exit the building. The resident was returned to the facility uninjured. The facility failed to revise the resident's care plan to mitigate the risk of future elopements. In addition, The facility failed to revise the care plan for Resident #2 to ensure the resident's safety and well-being inside and outside the facility. The facility did not revise the care plan to allow the resident to sit supervised on the facility's front porch. The facility also failed to revise the care plan for Resident #3 after an attempted elopement. The facility's failure to revise the plan of care for residents placed those residents in a situation for risk of serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 11/04/16 and was determined to exist on 10/21/16. The facility was notified of the IJ on 11/04/16. An Acceptable Allegation of Compliance was received on 11/09/16, which alleged removal of the IJ on 11/07/16. The State Survey Agency validated the IJ was removed on 11/07/16, as alleged, and the Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy, Care System Guideline, Elopement, revised 2015, revealed the facility established a process that identified risk and interventions to mitigate the occurrence of elopements. When an elopement occurred, after the facility located and returned the resident to the facility, the facility would complete a thorough evaluation of the resident's physical condition and psychosocial wellbeing. Further review revealed the facility would establish the cause of the elopement and address with an appropriate plan to prevent reoccurrence. In addition, the facility reviewed all other residents identified at risk for elopement to ensure current interventions were in place to prevent elopement. Interview with the Director of Clinical Operations, on 11/11/16 at 2:00 PM, revealed the facility used the Resident Assessment Instrument (RAI) Manual 3.0, as the policy for updating care plans. She stated the RAI manual provided nursing with the only instruction on when to complete various types of resident assessments. Review of the RAI Manual 3.0, revealed the facility reviewed and updated care plans with each quarterly, annual, or other Minimum Data Set (MDS) assessment to ensure the continuance or revision of the existing care plan based on the need of each resident. Additionally, the facility also evaluated the appropriateness of the care plan on an on-going basis, and modified the care plan when appropriate. The RAI Manual stated the facility made changes to the care plan as needed in accordance with professional standards of practice. The facility oriented care plans towards preventing avoidable declines in functioning, managing risk factors, and respecting the resident's right to decline treatment. The facility assessed behavior symptoms in order to determine whether and why behavior was problematic, and to identify underlying causes. The behavior Care Area Assessments (CAA) focuses on potentially problematic behaviors, such as wandering. 1. Review of the clinical record for Resident #1, revealed the facility admitted the resident on 04/22/16 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 05/03/16, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) and determined the resident was not interviewable. Review of Resident #1's Risk of Elopement Review, dated 06/20/16, revealed the facility completed an Admission Elopement Evaluation. The evaluation determined the resident was at risk for elopement due to cognitive impairment, diagnoses, and ability to ambulate independently without a walker or wheelchair. Review of Resident #1's Care Plan for Alzheimer's, dated 08/20/16, revealed the facility placed the resident on the secured unit related to the medical [DIAGNOSES REDACTED]. The interventions included staff to cue the resident for safety and provide supervision. Staff was to observe the resident for exit seeking behavior, and if observed, redirect the resident and notify the supervisor. Review of Resident #1's Care Plan for Elopement, dated 09/09/16, revealed the facility identified the resident was at risk for elopement and wandering. The facility put interventions in place to ensure resident safety that included: placing the resident in areas where frequent observations were possible on the secure unit; placement of a wander guard bracelet on the resident that sounded an alarm when the resident approached an exit door and checking the placement and functioning of the device every shift; alerting staff to the resident's behavior of wandering; and, providing the resident with diversional activities. Further review revealed the care plan stated staff would stay with the resident if he/she wandered away from the unit, and gently persuade the resident to walk back to the designated area with them. Staff was to observe and document the resident's behavior as needed. Review of the facility's investigation, dated 10/21/16, revealed Resident #1 eloped from the facility on 10/21/16. The facility completed an investigation that stated the resident left the secured unit after following a visitor onto the elevator and was then let out of the facility by a Receptionist. The investigation stated the Activities Assistant saw the resident through a window and recognized the resident was out of the facility unsupervised. The Activities Assistant and the Business Office Manager looked for the resident but were unable to locate him/her from the facility's property. The Activities Assistant and Business Office Manager called a Code W and began searching the neighborhood for Resident #1. The staff located the resident and returned with him/her to the facility with no further incident. Interview with Licensed Practical Nurse (LPN) #3, on 11/04/16 at 1:45 PM, revealed he was the nurse working with Resident #1 at the time the resident eloped from the facility. LPN #3 stated after the elopement, staff returned the resident to the unit and the resident was very cheerful and talkative. LPN #3 stated he did not document the elopement or complete any type of assessment on Resident #1 after he/she eloped from the facility. LPN #3 stated he did not update the resident's care plans as the Interdisciplinary Team (IDT) updated care plans in the morning Clinical Start-up Meetings. Interview with Social Services #1, on 11/03/16 at 2:00 PM, revealed Social Services completed resident Elopement Assessments; however, they were not completed quarterly or with any regular frequency. She stated Social Services did not

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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(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	(continued... from page 1) complete a new Elopement Assessment after Resident #1 eloped from the facility nor did they review or revise the resident's care plan. Interview with MDS Coordinator #1, on 11/03/16 at 2:18 PM, revealed the MDS Coordinators updated care plans in the Clinical Start-up Meetings. She stated other departments might also update care plans, such as Social Services or nursing departments. However, MDS Coordinators completed the majority of the care plan updates. She stated the IDT discussed Resident #1's elopement in the Clinical Start-up Meeting on 10/24/16, but she did not update the care plan for Resident #1 after his/her elopement from the facility because the resident already had an elopement care plan in place. However, review of the facility's policy, Care System Guideline, Elopement, revised 2015, revealed the facility would establish the cause of the elopement and address with an appropriate plan to prevent reoccurrence. Interview with the Director of Clinical Operations, on 11/01/16 at 1:30 PM, revealed the facility had not changed any of the current interventions for Resident #1 to prevent a reoccurrence of elopement. Interview with the Director of Nursing Services (DNS), on 11/03/16 at 8:30 AM, revealed the facility discussed the resident's elopement at the next morning meeting on 10/24/16, but she did not ensure the facility updated the care plan. In addition, she stated the facility had not reviewed other residents, assessed at risk for elopement, to ensure interventions were sufficient per the facility's policy. Interview with the Administrator, on 11/03/16 at 3:00 PM, revealed on 10/25/16 he reviewed the Elopement Incident Investigation of Resident #1's 10/21/16 elopement from the facility. However, he did not follow up with the IDT to ensure staff reviewed and revised the care plans during the morning start up meeting and there was no evidence the facility updated the care plans for Resident #1 after he/she eloped from the facility. 2. Review of the clinical record for Resident #2, revealed the facility admitted the resident on 06/22/16 with [DIAGNOSES REDACTED]. Review of the admission MDS assessment, completed 07/01/16, revealed the facility assessed the resident as requiring limited one (1) person physical assistance to walk. The facility assessed the resident as only able to stabilize during transfers and walking with human assistance. During the assessment, the facility conducted a BIMS examination and assessed the resident with a score of ten (10) out of fifteen (15) and determined the resident was interviewable. Review of Resident #2's Physician Orders, dated November 2016, revealed the Physician order [REDACTED]. Review of Resident #2's Risk of Elopement Review, dated 07/13/16, revealed the facility completed an elopement assessment and determined the resident was at risk for elopement and placed a resident monitoring device on the resident. The facility stated the resident was at risk due to cognitive impairment with poor decision-making skills, independent ambulation, [DIAGNOSES REDACTED]. The facility noted the resident wandered the hallway of the unit and frequently discussed wanting to go home. Review of Resident #2's Care Plan pertaining to Exit Seeking Behaviors, dated 07/12/16, revealed interventions for a Wander Guard bracelet that sounded alarms when the resident approached an exit door. Staff was to stay with the resident if he/she wandered away from the unit. Further review of Resident #2's clinical record revealed a document, dated 09/23/16, that Social Services had received permission from Resident #2's health care and financial Power Of Attorney (POA) for the resident to sign himself/herself out and sit on the front porch. Further review of Resident #2's Care Plan revealed no plan that allowed the resident to sign himself/herself out of the facility to sit on the front porch of the facility unsupervised. Review of the Release of Responsibility for Leave of Absence, dated October 2016, revealed Resident #2 signed out of the facility on five (5) occasions. Review of a piece of paper with Sign Out Sheet handwritten at the bottom, undated, revealed Resident #2 signed out of the facility on an additional six (6) occasions. Interview with Social Services #1, on 11/03/16 at 3:00 PM, revealed she had called Resident #2's POA about the resident going out of the facility due to the resident wanting to go outside. She stated that once she received permission from the resident's POA for the resident to sign out of the facility and sit on the front, she had not reviewed the resident's care plan to ensure it contained appropriate interventions for the resident's safety when he/she signed out of the facility. Interview with MDS Coordinator #1, on 11/03/16 at 2:18 PM, revealed MDS Coordinators updated care plans in the Clinical Start-up Meetings. She stated other departments might update care plans, such as Social Services or nursing departments; however, MDS Coordinators completed the majority of the care plan updates. Interview with the DNS, on 11/03/16 at 9:00 AM, revealed she had talked with the Medical Director about residents requesting to go outside and he had advised the facility to obtain a release Against Medical Advice (AMA) form for each of the residents. She stated Resident #2 was one of the residents who requested to go outside. She stated the facility obtained permission from the resident's POA for the resident to go outside and sit on the facility's front porch. The DNS stated the facility had not updated the care plan for Resident #2 to reflect the resident could sign out of the facility. Interview with the Medical Director, on 11/03/16 at 4:57 PM, revealed he had discussed with the Administrator and the DNS, the use of AMA forms for residents who could safely go out of the building unsupervised. However, it was unsafe for Resident #2 to go outside of the facility unattended due to the risk of a [MEDICAL CONDITION] and he was unaware the facility allowed Resident #2 to sign out and leave the facility unsupervised. Interview with the Administrator, on 11/02/16 at 4:45 PM, revealed the facility had Resident #2 sign a Release of Responsibility form and an AMA form so the resident could then sign himself/herself out of the facility; however, the facility had not updated the care plan for Resident #2 to include the plan for the resident to sign himself/herself out or to ensure the resident was safe. 3. Review of the facility's clinical record for Resident #3, revealed the facility admitted the resident on 12/12/13 with [DIAGNOSES REDACTED]. Review of Resident #3's Risk of Elopement Review, dated 09/01/16, revealed the facility conducted an elopement assessment and determined the resident was at risk for elopement due to impaired cognition, [DIAGNOSES REDACTED]. The facility noted the resident frequently remained near the exits stating he/she needed to go home and wandered aimlessly at times. The facility determined to place a Wander Guard bracelet on the resident. Review of Resident #3's printed November 2016 Physician order [REDACTED]. Review of Resident #3's Care Plan for Elopement, dated 12/30/13, revealed the facility developed a care plan to ensure the resident's safety from elopement due to wandering and exit seeking behaviors. The interventions included completing an Elopement Assessment quarterly and as needed. Staff was to escort the resident to activities off his/her unit to ensure the resident got to the correct destinations safely. Review of Resident #3's Significant Change MDS assessment, completed on 09/22/16, revealed the facility assessed the resident as requiring only limited assistance for walking and limited to extensive assistance to complete most ADLs. The facility assessed the resident as having unsteady balance but able to stabilize without staff assistance. During the assessment, the facility conducted a BIMS examination and assessed the resident with a score of eight (8) out of fifteen (15) and determined the resident was interviewable. Review of Resident #3's Nursing Notes, dated 08/03/16 through 11/01/16, revealed the resident had exit seeking behaviors such as pushing and trying to exit doors on 08/29/16, 09/01/16, 09/02/16, 09/06/16, 09/14/16, and 10/12/16. On 10/30/16, the resident ran out of the building behind a family exiting the facility. Staff went out, got the resident, and brought him/her back into the facility. Interview with MDS Coordinator #1, on 11/03/16 at 2:18 PM, revealed she was unaware of Resident #3's elopement attempt on 10/30/16. She stated the facility had not talked about the attempt in the morning Clinical Start-up Meeting on 10/31/16. Further interview revealed the facility did not update the care plan after Resident #3 attempted to elope from the facility. Interview with Social Services #2, on 11/02/16 at 11:15 AM, revealed she had completed Elopement Assessments for Resident #3. Social Services #2 stated Resident #3 had an increase in wandering and exit seeking behaviors and the current interventions for Resident #3 were not effective; however, she did not update the resident's care plan. Interview with the DNS, on 11/03/16 at 8:30 AM, revealed she was aware of Resident #3's attempt to elope from the facility on 10/30/16. She stated the IDT should have updated the Elopement Risk Screen in the morning Clinical Start-up Meeting on 10/31/16 after the elopement attempt. However, she was not present in the meeting on 10/31/16 and had not ensured staff

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F 0280 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) reviewed and revised the care plan to reflect appropriate interventions were in place. Continued interview with the DNS, on 11/11/16 at 10:25 AM, revealed she audited charts to ensure staff accurately completed documentation. She stated that after an event, she reviewed the medical record; however, she had not checked documentation to ensure the facility had updated care plans for Resident #1 or Resident #3 after each resident's attempted elopement. She stated she had not reviewed the care plan for Resident #2 to ensure the facility recorded interventions or instructions allowing or disallowing the resident to sign out of the facility and sit on the front porch to ensure the resident's safety. Interview with the Administrator, on 11/03/16 at 3:00 PM, revealed MDS updated care plans during the morning Clinical Start-up Meetings. He stated the facility should have reviewed the care plans for Residents #1, #2, and #3 to ensure interventions were appropriate. The facility implemented the following actions to remove the Immediate Jeopardy: 1. The MDS Coordinator reassessed Resident #1 for elopement risk on 11/05/16. The Elopement Care Plan for Resident #1 was reviewed and updated on 11/06/16 by the MDS Coordinator. 2. The Restorative Nurse, MDS Coordinator, DNS, ADNS, or the Regional Director of Clinical Operations assessed all residents in the facility for elopement risk using the Elopement Evaluation by 11/06/16. 3. Elopement Care Plans were implemented and/or updated by 11/06/16 for the twenty-three (23) residents identified as at risk for elopement by the Restorative Nurse, MDS Coordinator, DNS, ADNS, and the Regional Director of Clinical Operations. 4. An Admission Clinical Health Status was completed, including the Risk for Elopement section, for newly admitted residents and readmitted residents who were admitted to the facility after 11/06/16. The facility admitted on e (1) new resident and readmitted three (3) residents. None of the admitted residents was assessed at risk for elopement. The DNS used the Elopement Tool to discuss all admissions in the IDT morning clinical start up meeting each morning, five (5) days per week. 5. The Elopement Risk Identification book was updated on 11/06/16 by Social Services to include all residents identified at risk for elopement. The books contained each of the twenty-three (23) identified residents' name, face sheet, and picture. Updated Elopement Risk Identification books were placed at the receptionist desk and at each nurses' station on 11/06/16. 6. The code to enter the 1C secured unit via the elevator was changed on 10/21/16 by the Maintenance Director. The task of changing the elevator codes was placed on the maintenance calendar to occur quarterly, with the next code change occurring 01/09/17. 7. Signs were placed on 11/05/16 by the Regional Vice President. Signs were placed on the elevator to the 1C secured unit, on the ground floor at the elevator, and on the first (1st) floor at the elevator. The signs instructed visitors to see an employee for assistance with the elevator code and not to allow residents on the 1C secured unit to enter the elevator without staff assistance. 8. All staff received training on the Wander Guard system, the Elopement Risk Identification book, the Elopement Care System Guidelines, and the security of the elevator and door codes by the Clinical Educator by 11/06/16. The New Hire Pack was updated by the to include education on the current facility Elopement Care System Guidelines, the Wander Guard system, the Elopement Risk Identification book, and the security of the elevator and door codes. All new hires will receive this education by the Clinical Educator or ADNS. 9. Education was provided to the Administrator and the DNS on the Elopement Care System Guidelines, the Wander Guard system, the Elopement Risk Identification book, and the elevator and door codes by the Regional Director of Clinical Services on 11/06/16. 10. Audits were completed by the Administrator, DNS, ADNS, Regional Director of Clinical Operations, or the Regional Vice President using the Elopement QAPI Questionnaire tool with at least five (5) employees, five (5) times per week. The Elopement QAPI Questionnaire tool included the questions: What do you do if you hear a wander guard alarm?; What is the first thing you do if a resident is missing?; What is the code that is announced when a resident is missing?. 11. Elopement drills were conducted weekly by the Administrator, DNS, ADNS, Regional Director of Clinical Operations, or Regional Vice President. All participating staff signed off that they participated in the drills. 12. The facility held a QAPI meeting on 11/06/16 to review the facility actions, the audits, admissions, and newly identified residents at risk for elopement. Findings of audits and actions taken after 11/06/16 will be reviewed at the monthly QAPI meeting by the QAPI team. The QAPI team included the Medical Director, Administrator, DNS, and at least three (3) other departmental leaders. The State Survey Agency validated the facility's actions as follows: 1. Review of the Elopement Care Plan for Resident #1, dated 09/09/16, revealed the facility reviewed and updated the care plan on 11/06/16. Review of the Elopement Evaluation tool for Resident #1, dated 11/05/16, revealed the facility re-assessed Resident #1 for risk for elopement. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility completed Elopement Evaluations and updated the care plan for Resident #1. 2. Review of the Elopement Evaluation, dated November 2016, revealed the facility conducted an elopement assessment with every resident in the facility on 11/05/16 and 11/06/16. The facility assessed twenty-three (23) residents at risk of elopement. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility completed Elopement Evaluations on one hundred percent (100%) of the residents in the facility. 3. Review of the facility's care plans for the twenty-three (23) identified residents at risk for elopement, revealed the facility updated and implemented elopement care plans for each of the identified residents by 11/06/16. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility updated the care plans for each resident assessed as at risk for elopement. 4. Review of the facility's census, 11/09/16, revealed the facility admitted on e new resident and readmitted three (3) additional residents. Review of the Admission Clinical Health Status for each of the new/readmitted residents, dated 11/07/16 and 11/08/16, revealed the facility conducted the Risk for Elopement section in each resident's Admission Clinical Health Status. The facility identified none of the admitted residents were at risk for elopement. Review of the facility's Elopement Tool, dated 11/07/16 and 11/08/16, revealed the facility discussed admissions in the Clinical Start Up Meeting to determine if each admission resident was at risk for elopement. Interview with the DNS, on 11/11/16 at 10:15 AM, revealed she discussed admitted residents in the Clinical Start Up meeting each morning. Meeting attendants discussed the Admission Clinical Health Status to ensure the Risk for Elopement section of the form was complete and accurate. The DNS stated she documented the conversation on the Elopement Tool. 5. Review of the Elopement Risk Identification book, updated 11/06/16, revealed the facility updated the book to include all residents identified at risk for elopement, regardless if the resident wore a Wander Guard. The books contained residents by name, picture, and face sheet. The books were located at the receptionist desk and at each nurses' station. Interview with DNS, on 11/11/16 at 10:15 AM, revealed the facility updated the Elopement Risk Identification book to reflect all residents identified as at risk for elopement. She stated residents, regardless of if they wore a Wander Guard, were represented in the book with a picture and cover sheet. 6. Observation of the code pad on the elevator revealed the facility changed the code to access the 1C secured unit. Review of the maintenance calendar, 2017, revealed the facility placed the task of changing the elevator codes on the calendar to occur quarterly, starting 01/09/17. 7. Observation, on 11/10/16, revealed the facility placed signs on the secured unit at the elevator on the ground floor, and on the 1st floor. The signs gave instruction to not allow residents residing on the memory care unit onto the elevator without staff assistance and instruction for visitors to see an employee for assistance with the elevator code. 8. Review of the facility provided education, posttests, and employee roster, revealed the facility provided education to all staff who had worked pertaining to the facility's Wander Guard system, the Elopement Risk Identification book, the Elopement Care System Guidelines, and elevator and door codes, by the Clinical Educator by 11/06/16. All staff passed all post-tests. Interviews with Receptionist #2, CNA#7, CNA #8, LPN #6, LPN #7, Housekeeping, and Dietary Aide, on 11/11/16, revealed the

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F 0280 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 3) facility provided education on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. The education included post tests. Interview with the Director of Clinical Education, on 11/11/16 at 9:30 AM, revealed she provided education on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. She stated she received education on those systems from the Clinical Director of Operations prior to providing education to staff. She stated she provided the education to all staff who worked prior to 11/06/16. Additionally, the Director of Clinical Education stated any employee who had not received the education due to not yet working would not be allowed to work until they first received the education. Review of the New Hire Pack, undated, revealed the facility added education to new hires using current facility elopement guidelines, Elopement Care System Guidelines. The New Hire Pack also included education to new employees pertaining to the facility's Wander Guard system, the Elopement Risk Identification book, and elevator and door codes. 9. Interview with the Clinical Director of Operation, on 11/11/16 at 11:52 AM, revealed she provided education to the Administrator and the DNS on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. Review of the education logs, 11/06/16, revealed the DNS and Administrator also received education with all facility staff. 10. Review of the QAPI Questionnaire Tools, completed between 11/06/16 and 11/09/16, revealed the facility leadership team conducted interviews with at least five (5) employees each day. The questions on the Questionnaire Tool included: What do you do if you hear a wander guard alarm? What is the first thing you do if a resident is missing? What is the code that is announced when a resident is missing? Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed the facility was holding daily QAPI meetings to ensure continued compliance. He stated the Medical Director was either physically present or present via telephone for each of the daily QAPI meetings. The Administrator stated that he and the DSN completed at least five (5) QAPI Questionnaire Tool interviews with staff each day. 11. Review of the Patient/Resident Elopement Drill Worksheets, dated between 11/06/16 and 11/09/16, revealed the facility conducted elopement drills daily and ensured all participating staff signed off on the drills. Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed he conducted daily elopement drills to ensure all staff knew what to do in case of elopement. He stated the facility would ask a resident to participate in the drill and hide the resident. The facility would call a Code W and facility staff conducted searches of the facility and facility grounds with each drill. Interview with LPN #6 and CNA #4, on 11/11/16, revealed the facility conducted elopement drills daily. They each stated the facility called a Code W over the loud speaker and staff begin searching for the missing individual named in the announcement in the facility and on the facility grounds. 12. Review of the Daily Focused QAPI Meeting sheets, dated 11/06/16 through 11/09/16, revealed the facility held QAPI meetings daily. The meetings included the Medical Director and reviewed actions and audits, as well as admissions and newly identified residents at risk for elopement. Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed the Administrator was holding QAPI meetings daily to discuss the elopement plan. He stated the Medical Director had attended every meeting either in person or via telephone. Interview with the DNS, on 11/11/16 ay 10:15 AM, revealed the facility held QAPI meetings each day. She stated she attended the QAPI meetings and the QAPI team discussed the ongoing inservices, drills, admissions, assessments, and other facility elopement initiatives.
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review and review of the Resident Assessment Instrument (RAI) Manual and the facility's policy and procedures, it was determined the facility failed to have an effective system in place to ensure staff implemented the care plan interventions for three (3) of twelve (12) sampled residents, Residents #1, #2, and #3. The facility assessed Resident #1 as a risk for elopement and wandering, put interventions in place to ensure the resident's safety, and applied a Wander Guard on the resident. Interventions included to provide the resident with supervision and redirect the resident if staff observed exit-seeking behavior. On 10/21/16 at 3:00 PM, Licensed Practical Nurse (LPN) #3 observed Resident #1 seated in his/her room, upset, and stating he/she needed to go home. LPN #3 did not provide supervision or redirectional activities per the care plan and walked into the closed medication room leaving the resident unsupervised. Resident #1 eloped from the facility without staff knowledge and was found off the facility's grounds, at approximately 4:00 PM, walking down the sidewalk. The facility's investigation determined the resident took the elevator to the lobby where Receptionist #2 keyed in the alarm code to the front door and allowed the resident to exit the building. The recorded weather conditions on 10/21/16 at 2:31 PM, included a high of sixty-two (62) degrees Fahrenheit with cloudy skies. In addition, the care plan for Resident #2 stated the facility provided supervision when the resident wandered the facility; however, the resident went outside unsupervised. Resident #3 was care planned for staff to accompany the resident when off the unit; however, the resident wandered the facility and near facility exit doors unaccompanied. The facility's failure to follow the plan of care for residents placed those residents in a situation for risk of serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) was identified on 11/04/16 and was determined to exist on 10/21/16. The facility was notified of the IJ on 11/04/16. An Acceptable Allegation of Compliance was received on 11/09/16, which alleged removal of the IJ on 11/07/16. The State Survey Agency validated the IJ was removed on 11/07/16, as alleged, and the scope and severity was lowered to a D while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Interview with the Director of Clinical Operations, on 11/11/16 at 2:00 PM, revealed the facility used the Resident Assessment Instrument (RAI) Manual, Version 3.0, as the policy for updating and following care plans. Review of the RAI Manual, Version 3.0, revealed the purpose of the care plan was to serve as an interdisciplinary communication tool. The care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The services the facility provided or arranged must be consistent with each resident's written plan of care. Review of the facility's policy, Care System Guideline, Elopement, Revised 2015, revealed the facility established a process that identified risk and interventions to mitigate the occurrence of elopements. The facility assessed residents for elopement risk using the tool in the Clinical Health Status upon admission or re-admission to the facility. If the facility determined a risk for elopement, the facility established an individualized plan to mitigate risk. The facility documented interventions on the care plan and initiated the interventions. 1. Review of the facility's clinical record for Resident #1, revealed the facility admitted the resident on 04/22/16 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 05/03/16, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) and determined the resident was not interviewable. Review of Resident #1's Risk of Elopement Review, dated 06/20/16, revealed the facility completed an Admission Elopement Evaluation and determined the resident was at risk for elopement due to cognitive impairment, diagnoses, and the ability to ambulate independently without a walker or wheelchair. Review of Resident #1's Care Plan for Alzheimer's, dated 08/20/16, revealed the facility placed the resident on the secured unit related to a medical [DIAGNOSES REDACTED]. The facility provided interventions that included staff cued the resident for safety and provided the resident with supervision. Staff observed the resident for exit seeking behavior, and if observed, redirected the resident and notified the supervisor. Review of Resident #1's Care Plan for Elopement, dated 09/09/16, revealed the facility put interventions in place to ensure resident safety that included: placing the resident in areas where frequent observation was possible; placement of a Wander Guard bracelet that sounded an alarm when the resident approached an exit door and checking for placement and functioning of the device every shift; alerting staff to the resident's wandering behavior; and providing the resident with diversional

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	185039	A. BUILDING _____ B. WING _____	11/11/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS HEALTH AND REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

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 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) activities. The care plan additionally stated staff would stay with the resident if he/she wandered away from the unit and gently persuade the resident to walk back to the designated area with them. Staff was to observe and document the resident's behavior as needed. Review of the facility's Investigation, dated 10/21/16, revealed Resident #1 eloped from the facility on 10/21/16. The resident followed a visitor onto the elevator and went down to the front lobby. The receptionist opened the door for the resident and the resident exited the building. Interview with Certified Nursing Assistant (CNA) #4, on 11/02/16 at 3:35 PM, revealed she worked on Resident #1's unit when he/she eloped from the facility. She stated she talked with Resident #1 at approximately 3:00 PM and the resident asked her if he/she could go downstairs and go outside. She told the resident she would talk with the nurse, LPN #3, about it and reported it to the nurse and then left the floor to assist another CNA in providing care for another resident. Interview with LPN #3, on 11/04/16 at 1:45 PM, revealed he was Resident #1's nurse when the resident eloped from the facility. He stated the CNA reported to him that Resident #1 was talking about going home. He stated he went and talked with the resident and the resident was calm. He stated he then walked down the hallway and into the medication room. He stated staff was not present in the resident common area or in the hallway of the unit when he went into the medication room. LPN #3 stated the facility did not provide supervision for Resident #1 at the time he/she eloped from the locked unit. Interview with MDS #1, on 11/03/16 at 2:18 PM, revealed MDS reviewed and updated care plans in the Clinical Start-up Meetings. She stated the Interdisciplinary Team (IDT) discussed Resident #1's elopement in the Clinical Start-up Meeting on 10/24/16. She stated the facility did not provide supervision while the resident experienced exit-seeking behaviors, per the care plan. Interview with the Director of Nursing Services (DNS), on 11/03/16 at 8:30 AM, revealed the facility discussed the resident's elopement at the next morning meeting on 10/24/16, but did not review the care plan to ensure the facility had followed all interventions and that all necessary interventions were in place. Interview with the Administrator, on 11/03/16 at 3:00 PM, revealed he reviewed the Elopement Incident Investigation after Resident #1 eloped from the facility on 10/21/16. The Administrator stated he did not follow up with the IDT to ensure staff reviewed the care plan to determine if staff had followed care plan interventions. 2. Review of the facility's clinical record for Resident #2, revealed the facility admitted the resident on 06/22/16 with [DIAGNOSES REDACTED]. Review of the admission MDS assessment, completed 07/01/16, revealed the facility assessed the resident as requiring limited one (1) person physical assistance to walk. The facility assessed the resident as only able to stabilize during transfers and walking with human assistance. During the assessment, the facility conducted a BIMS examination and assessed the resident with a score of ten (10) out of fifteen (15) and determined the resident was interviewable. Review of Resident #2's Care Plan for Exit Seeking Behaviors, dated 07/12/16, revealed an intervention to place a monitoring device on the resident that sounded alarms when the resident left the building. Staff was to stay with the resident if he/she wandered away from the unit and converse with the resident and gently persuade him/her to walk back to designated areas with them. Review of Resident #2's Risk of Elopement Review, dated 07/13/16, revealed the facility completed an elopement assessment and determined the resident was at risk for elopement and placed a monitoring device on the resident. The facility stated the resident was at risk due to cognitive impairment with poor decision-making skills, independent ambulation, and [DIAGNOSES REDACTED]. The facility noted the resident wandered the hallway of the unit and frequently discussed wanting to go home. Further review of Resident #2's medical record revealed a document dated 09/23/16, that stated the POA gave approval for Resident #2 to sign himself/herself out to sit on the facility's front porch. The document was typed on an 8.5" x 11.0" sheet of paper with Social Services #2's name typed at the bottom. Interview with Social Services #1, on 11/03/16 at 3:00 PM, revealed Resident #2 had voiced a desire to go outside. She was unsure why the facility needed permission from the resident's POA to go outside because the resident had a BIMS of a 10, but she called Resident #2's POA and the POA gave permission for the resident to sign himself/herself out of the facility to sit on the front porch. However, review of the resident's care plan for Exit Seeking Behaviors revealed staff was to stay with the resident if he/she wandered from the unit. Review of the Release of Responsibility for Leave of Absence, dated October 2016, revealed Resident #2 signed out of the facility on five (5) occasions. The dates of sign out were 10/04/16 at 11:40 AM, 10/05/16 at 1:30 PM, 10/07/16 at 1:10 PM, and 10/08/16 at 1:30 PM, and one (1) undated and untimed occasion. There were no dates, times, or signature for when the resident returned to the facility. Review of a piece of paper with Sign Out Sheet handwritten at the bottom, undated, revealed Resident #2 signed out of the facility an additional six (6) times. One (1) signature was not dated or timed. Interview with Director of Nursing Services (DNS), on 11/03/16 at 9:00 AM, revealed it was not typical facility practice to allow residents with a Wander Guard to leave the building unaccompanied and she did not believe the facility should allow any resident with a Wander Guard to go out of the facility without supervision. The DNS stated the facility had placed a Wander Guard bracelet on the resident due to exit seeking behaviors, such as pushing on exit doors and talking about wanting to go home. The resident had a history of [REDACTED]. However, she stated the facility obtained permission from the resident's POA for the resident to go outside and sit on the facility's front porch. The DNS further stated the facility could not ensure the resident would stay on the porch when he/she signed out of the facility, as the facility had not provided supervision when the resident signed out per the resident's care plan. 3. Review of the facility's clinical record for Resident #3, revealed the facility admitted the resident on 12/12/13 with [DIAGNOSES REDACTED]. Review of Resident #3's Care Plan for Elopement, initiated on 12/30/13, revealed interventions that included providing supervision. Staff was to escort the Resident #3 to off unit activities and ensure the resident arrived to the correct destinations safely. The facility placed a picture of the resident in the elopement binder. Review of Resident #3's Physician Orders, dated November 2016, revealed on 09/01/16, the physician ordered the facility to place a Wander Guard on the resident's ankle and check placement of the Wander Guard every shift. Review of Resident #3's Significant Change MDS assessment, completed on 09/22/16, revealed the facility assessed the resident as requiring only limited assistance for walking and limited to extensive assistance to complete most ADLs. The facility assessed the resident as having unsteady balance but able to stabilize without staff assistance. During the assessment, the facility conducted a BIMS examination and assessed the resident with a score of eight (8) out of fifteen (15) and determined the resident was interviewable. Review of Resident #3's Nursing Notes, from 08/03/16 through 11/01/16, revealed on 08/29/16, nursing staff heard the wander guard alarm sound and discovered Resident #3 pushing on the door and stating he/she was leaving to live with their family member. On 09/01/16, the resident was walking around inside the facility attempting to find exit doors. On 09/02/16, the resident left the unit and went to the lobby area and attempted to leave the building. On 09/06/16, the facility documented the resident had continued multiple attempts to exit the facility. On 10/30/16, the resident ran out of the building behind a family who was exiting. Staff went out after the resident and was able to redirect him/her back into the facility. Interview with CNA #5, on 11/03/16 at 2:36 PM, revealed CNAs were aware of residents who wore a Wander Guard because it was on the CNA Assignment Sheet. She stated Resident #3 wore a Wander Guard due to wandering behaviors to ensure he/she did not get out of the facility. The Wander Guard bracelet would set off an alarm at the facility exits if the resident tried to go out the door. CNA #5 stated Resident #3 was able to go anywhere in the facility unsupervised. She stated she was unaware of any interventions stating staff was to escort the resident to off unit activities. Interview with MDS Coordinator #1, on 11/03/16 at 2:18 PM, revealed staff did not follow elopement interventions when staff did not escort or redirect the resident when he/she left the unit. Continued interview with the DNS, on 11/11/16 at 10:25 AM, revealed the DNS supervised staff to ensure staff followed care plan interventions for residents by completing rounds. The DNS could not state how often she completed the rounds. Interview with the Administrator, on 11/03/16 at 3:00 PM, revealed the facility had no evidence they reviewed Resident #3's Care Plan after the elopement attempts to ensure staff had followed care plan interventions. The facility implemented the following actions to remove the Immediate Jeopardy:

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

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) 1. The MDS Coordinator reassessed Resident #1 for elopement risk on 11/05/16. The Elopement Care Plan for Resident #1 was reviewed and updated on 11/06/16 by the MDS Coordinator. 2. The Restorative Nurse, MDS Coordinator, DNS, ADNS, or the Regional Director of Clinical Operations assessed all residents in the facility for elopement risk using the Elopement Evaluation by 11/06/16. 3. Elopement Care Plans were implemented and/or updated by 11/06/16 for the twenty-three (23) residents identified as at risk for elopement by the Restorative Nurse, MDS Coordinator, DNS, ADNS, and the Regional Director of Clinical Operations. 4. An Admission Clinical Health Status was completed, including the Risk for Elopement section, for newly admitted residents and readmitted residents who were admitted to the facility after 11/06/16. The facility admitted on e (1) new resident and readmitted three (3) residents. None of the admitted residents was assessed at risk for elopement. The DNS used the Elopement Tool to discuss all admissions in the IDT morning clinical start up meeting each morning, five (5) days per week. 5. The Elopement Risk Identification book was updated on 11/06/16 by Social Services to include all residents identified at risk for elopement. The books contained each of the twenty-three (23) identified residents' name, face sheet, and picture. Updated Elopement Risk Identification books were placed at the receptionist desk and at each nurses' station on 11/06/16. 6. The code to enter the 1C secured unit via the elevator was changed on 10/21/16 by the Maintenance Director. The task of changing the elevator codes was placed on the maintenance calendar to occur quarterly, with the next code change occurring 01/09/17. 7. Signs were placed on 11/05/16 by the Regional Vice President. Signs were placed on the elevator to the 1C secured unit, on the ground floor at the elevator, and on the first (1st) floor at the elevator. The signs instructed visitors to see an employee for assistance with the elevator code and not to allow residents on the 1C secured unit to enter the elevator without staff assistance. 8. All staff received training on the Wander Guard system, the Elopement Risk Identification book, the Elopement Care System Guidelines, and the security of the elevator and door codes by the Clinical Educator by 11/06/16. The New Hire Pack was updated by the to include education on the current facility Elopement Care System Guidelines, the Wander Guard system, the Elopement Risk Identification book, and the security of the elevator and door codes. All new hires will receive this education by the Clinical Educator or ADNS. 9. Education was provided to the Administrator and the DNS on the Elopement Care System Guidelines, the Wander Guard system, the Elopement Risk Identification book, and the elevator and door codes by the Regional Director of Clinical Services on 11/06/16. 10. Audits were completed by the Administrator, DNS, ADNS, Regional Director of Clinical Operations, or the Regional Vice President using the Elopement QAPI Questionnaire tool with at least five (5) employees, five (5) times per week. The Elopement QAPI Questionnaire tool included the questions: What do you do if you hear a wander guard alarm?; What is the first thing you do if a resident is missing?; What is the code that is announced when a resident is missing?. 11. Elopement drills were conducted weekly by the Administrator, DNS, ADNS, Regional Director of Clinical Operations, or Regional Vice President. All participating staff signed off that they participated in the drills. 12. The facility held a QAPI meeting on 11/06/16 to review the facility actions, the audits, admissions, and newly identified residents at risk for elopement. Findings of audits and actions taken after 11/06/16 will be reviewed at the monthly QAPI meeting by the QAPI team. The QAPI team included the Medical Director, Administrator, DNS, and at least three (3) other departmental leaders. The State Survey Agency validated the facility's actions as follows: 1. Review of the Elopement Care Plan for Resident #1, dated 09/09/16, revealed the facility reviewed and updated the care plan on 11/06/16. Review of the Elopement Evaluation tool for Resident #1, dated 11/05/16, revealed the facility re-assessed Resident #1 for risk for elopement. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility completed Elopement Evaluations and updated the care plan for Resident #1. 2. Review of the Elopement Evaluation, dated November 2016, revealed the facility conducted an elopement assessment with every resident in the facility on 11/05/16 and 11/06/16. The facility assessed twenty-three (23) residents at risk of elopement. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility completed Elopement Evaluations on one hundred percent (100%) of the residents in the facility. 3. Review of the facility's care plans for the twenty-three (23) identified residents at risk for elopement, revealed the facility updated and implemented elopement care plans for each of the identified residents by 11/06/16. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility updated the care plans for each resident assessed as at risk for elopement. 4. Review of the facility's census, 11/09/16, revealed the facility admitted on e new resident and readmitted three (3) additional residents. Review of the Admission Clinical Health Status for each of the new/readmitted residents, dated 11/07/16 and 11/08/16, revealed the facility conducted the Risk for Elopement section in each resident's Admission Clinical Health Status. The facility identified none of the admitted residents were at risk for elopement. Review of the facility's Elopement Tool, dated 11/07/16 and 11/08/16, revealed the facility discussed admissions in the Clinical Start Up Meeting to determine if each admission resident was at risk for elopement. Interview with the DNS, on 11/11/16 at 10:15 AM, revealed she discussed admitted residents in the Clinical Start Up meeting each morning. Meeting attendants discussed the Admission Clinical Health Status to ensure the Risk for Elopement section of the form was complete and accurate. The DNS stated she documented the conversation on the Elopement Tool. 5. Review of the Elopement Risk Identification book, updated 11/06/16, revealed the facility updated the book to include all residents identified at risk for elopement, regardless if the resident wore a Wander Guard. The books contained residents by name, picture, and face sheet. The books were located at the receptionist desk and at each nurses' station. Interview with DNS, on 11/11/16 at 10:15 AM, revealed the facility updated the Elopement Risk Identification book to reflect all residents identified as at risk for elopement. She stated residents, regardless of if they wore a Wander Guard, were represented in the book with a picture and cover sheet. 6. Observation of the code pad on the elevator revealed the facility changed the code to access the 1C secured unit. Review of the maintenance calendar, 2017, revealed the facility placed the task of changing the elevator codes on the calendar to occur quarterly, starting 01/09/17. 7. Observation, on 11/10/16, revealed the facility placed signs on the secured unit at the elevator on the ground floor, and on the 1st floor. The signs gave instruction to not allow residents residing on the memory care unit onto the elevator without staff assistance and instruction for visitors to see an employee for assistance with the elevator code. 8. Review of the facility provided education, posttests, and employee roster, revealed the facility provided education to all staff who had worked pertaining to the facility's Wander Guard system, the Elopement Risk Identification book, the Elopement Care System Guidelines, and elevator and door codes, by the Clinical Educator by 11/06/16. All staff passed all post-tests. Interviews with Receptionist #2, CNA#7, CNA #8, LPN #6, LPN #7, Housekeeping, and Dietary Aide, on 11/11/16, revealed the facility provided education on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. The education included post tests. Interview with the Director of Clinical Education, on 11/11/16 at 9:30 AM, revealed she provided education on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. She stated she received education on those systems from the Clinical Director of Operations prior to providing education to staff. She stated she provided the education to all staff who worked prior to 11/06/16. Additionally, the Director of Clinical Education stated any employee who had not received the education due to not yet working would be allowed to work until they first received the education. Review of the New Hire Pack, undated, revealed the facility added education to new hires using current facility elopement guidelines, Elopement Care System Guidelines. The New Hire Pack also included education to new employees pertaining to the facility's Wander Guard system, the Elopement Risk Identification book, and elevator and door codes.

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HIGHLANDS HEALTH AND REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) 9. Interview with the Clinical Director of Operation, on 11/11/16 at 11:52 AM, revealed she provided education to the Administrator and the DNS on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. Review of the education logs, 11/06/16, revealed the DNS and Administrator also received education with all facility staff. 10. Review of the QAPI Questionnaire Tools, completed between 11/06/16 and 11/09/16, revealed the facility leadership team conducted interviews with at least five (5) employees each day. The questions on the Questionnaire Tool included: What do you do if you hear a wander guard alarm? What is the first thing you do if a resident is missing? What is the code that is announced when a resident is missing? Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed the facility was holding daily QAPI meetings to ensure continued compliance. He stated the Medical Director was either physically present or present via telephone for each of the daily QAPI meetings. The Administrator stated that he and the DSN completed at least five (5) QAPI Questionnaire Tool interviews with staff each day. 11. Review of the Patient/Resident Elopement Drill Worksheets, dated between 11/06/16 and 11/09/16, revealed the facility conducted elopement drills daily and ensured all participating staff signed off on the drills. Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed he conducted daily elopement drills to ensure all staff knew what to do in case of elopement. He stated the facility would ask a resident to participate in the drill and hide the resident. The facility would call a Code W and facility staff conducted searches of the facility and facility grounds with each drill. Interview with LPN #6 and CNA #4, on 11/11/16, revealed the facility conducted elopement drills daily. They each stated the facility called a Code W over the loud speaker and staff begin searching for the missing individual named in the announcement in the facility and on the facility grounds. 12. Review of the Daily Focused QAPI Meeting sheets, dated 11/06/16 through 11/09/16, revealed the facility held QAPI meetings daily. The meetings included the Medical Director and reviewed actions and audits, as well as admissions and newly identified residents at risk for elopement. Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed the Administrator was holding QAPI meetings daily to discuss the elopement plan. He stated the Medical Director had attended every meeting either in person or via telephone. Interview with the DNS, on 11/11/16 ay 10:15 AM, revealed the facility held QAPI meetings each day. She stated she attended the QAPI meetings and the QAPI team discussed the ongoing inservices, drills, admissions, assessments, and other facility elopement initiatives.
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 an incident of elopement for three (3) of twelve (12) sampled residents, Residents #1, #2, and #3. On 10/21/16, Resident #1 eloped from the facility without staff knowledge. The resident was found, at approximately 4:00 PM, off the facility's grounds walking down the sidewalk. At 3:00 PM, Licensed Practical Nurse (LPN) #3 observed Resident #1 seated in his/her room, upset, and stating he/she needed to go home. LPN #3 did not provide supervision or redirectional activities per the care plan and walked into the closed medication room. No other staff was available on the unit at the time. The facility's investigation determined the resident took the elevator to the lobby where Receptionist #2 keyed in the alarm code to the front door and allowed the resident to exit the building. The recorded weather conditions on 10/21/16 at 2:31 PM, included a high of sixty-two (62) degrees Fahrenheit with cloudy skies. The resident was returned to the facility uninjured. Additionally, the facility failed to provide supervision to mitigate the risk of elopement for Residents #2 and #3. The facility assessed Resident #2 as at risk for elopement; however, allowed the resident to sign himself/herself out of the facility and sit on the front porch unsupervised on eleven (11) occasions. Resident #3 was care planned for supervision when he/she went off the unit; however, the facility allowed the resident to wander the building unsupervised and he/she attempted to elope from the facility on 10/30/16. The facility's failure to have an effective system in place to ensure staff provided adequate supervision of residents has placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy (IJ) with Substandard Quality of Care was identified on 11/04/16 and was determined to exist on 10/21/16. The facility was notified of the IJ on 11/04/16. An Acceptable Allegation of Compliance (AOC) was received on 11/09/16, which alleged removal of the IJ on 11/07/16. The State Survey Agency validated the IJ was removed on 11/07/16, as alleged, and the scope and severity was lowered to an D while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy, Care System Guideline, Elopement, revised 2015, revealed the facility established a process that identified risk and interventions to mitigate the occurrence of elopements. The facility assessed residents for elopement risk using the Clinical Health Status upon admission or re-admission to the facility. If the facility determined a resident was at risk for elopement, the facility established an individualized care plan and documented interventions to prevent elopement. The facility placed elopement interventions on the Direct Care Giver Card and initiated the interventions. The facility maintained a central binder system and placed a photograph and information about each resident assessed as at risk of elopement. If the facility chose to place a Wander Guard bracelet alarm on a resident, the facility established a plan for monitoring the function of the bracelet alarm. When an elopement occurred, the facility alerted all staff to search the building and grounds as soon as the facility discovered a resident was missing. If the resident was not quickly located in the building or on the grounds, the facility designated a point person to notify the Administrator and Director of Nursing Services (DNS), to notify the guardian or family member, and to notify the police. After locating the resident, the facility completed a thorough evaluation of the resident's physical condition and psychosocial wellbeing. The facility notified the family and physician of the return. The facility established the cause of the elopement and addressed the cause with an appropriate plan to prevent reoccurrence. The facility documented the resident's condition, notifications, and times of actions. The facility reviewed all other residents identified at risk for elopement to ensure current interventions were in place to prevent elopement. The facility's Quality Assurance reviewed patterns or trends in elopements or elopement risks. Review of the facility's New Hire Pack, undated, revealed the facility provided training to new employees pertaining to elopement using the policy, Elopement from Designated Area of Facility, dated 08/01/12. The policy did not discuss prevention, assessment prior to or after an elopement, or quality improvement measures. The New Hire Pack did not contain the elopement policy, Care System Guideline, Elopement, revised 2015. Interview with the Director of Clinical Operations, on 11/11/16 at 2:00 PM, revealed the facility did not use the policy titled, Elopement from Designated Area of Facility, as the policy followed for elopement. However, this was included in new employee orientation. Further interview revealed the facility used the policy, Care System Guideline, Elopement, revised 2015, to provide guidance on managing elopement. She stated she did not know why the facility educated new employees using an outdated policy. Review of the facility's Elopement Risk Identification book, updated 10/27/16, revealed the facility identified and placed pictures and information pertaining to seven (7) residents in the book. The book contained documentation stating each resident wore a Wander Guard. The binder contained a photograph of each resident, the face sheet, a list of diagnoses, and a Risk of Elopement Review for each of the seven (7) residents. 1. Observation of Resident #1, on 11/01/16 at 10:10 AM, revealed the resident ambulated independently. The resident appeared neat and clean and his/her affect was appropriate. The resident talked about needing to leave the facility to go home. Resident #1 stated he/she thought he/she was at the racetrack. The resident stated he/she left the facility the other day to go for a walk to visit his/her mother. Resident #1 stated he/she walked to his/her mother's home nearly every morning.

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	185039	A. BUILDING _____ B. WING _____	11/11/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS HEALTH AND REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

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 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) The resident had a Wander Guard bracelet on his/her ankle. Review of the facility's clinical record for Resident #1, revealed the facility admitted the resident on 04/22/16 with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment, dated 05/03/16, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of four (4) out of fifteen (15) and determined the resident was not interviewable. Review of Resident #1's Risk of Elopement Review, dated 06/20/16, revealed the facility completed an Admission elopement evaluation on 06/20/16. The facility determined the resident was at risk for elopement due to cognitive impairment, diagnosis, and ability to ambulate independently without a walker or wheelchair. The facility stated the resident had a history of [REDACTED]. The facility stated the resident verbally expressed the desire to go home and frequently sat near the exits. Based on the findings of the assessment, the facility initiated elopement interventions including placing an updated evaluation in the Elopement Risk Identification books and placing a Wander Guard bracelet on the resident. The facility also documented having informed staff of the resident's wander risk. Review of the Physician orders [REDACTED]. The facility was to check the placement of the Wander Guard every shift, two (2) times per day. Review of Resident #1's Care Plan for Alzheimer's, with a Problem Onset date of 08/20/16, revealed the facility placed the resident on the secured unit related to a medical [DIAGNOSES REDACTED]. Interventions included staff cued the resident for safety and provided the resident with supervision. Staff observed the resident for exit seeking behavior, and if observed, redirected the resident and notified the supervisor. Review of Resident #1's Care Plan for Elopement, with a Problem Onset date of 09/09/16, revealed the facility identified the resident was at risk for elopement and wandering. The facility put interventions in place to ensure the resident's safety. The interventions included: placing the resident in areas where frequent observations were possible on the secure unit; placement of a Wander Guard bracelet on the resident that sounded an alarm when the resident approached an exit door, and checking the placement and functioning of the device every shift; alerting staff to the resident's wandering behavior; and providing the resident with diversional activities. The care plan additionally stated staff would stay with the resident if he/she wandered away from the unit, and gently persuade the resident to walk back to the designated area with them. Staff was to observe and document the resident's behavior as needed. Review of the Direct Caregiver Card for Resident #1, undated, revealed the resident's card stated Wander Guard on the care sheet under the section titled Other Special Needs. No other care planned interventions or instructions pertaining to elopement risk were present on the card. Review of the facility's investigation, dated 10/21/16, revealed on 10/21/16, the Activities Assistant reported Resident #1 was outside the facility at approximately 4:00 PM. Resident #1 was described as ambulating independently but not interviewable and did not have the capacity to make informed decisions. Resident #1 followed a visitor onto the elevator and off the secured unit. The report stated the resident dressed nicely and looked like a visitor to the new Receptionist. The Receptionist observed Resident #1 walking on the facility grounds until the Activities Assistant entered the lobby asking about the resident. The Receptionist pointed the resident out to the Activities Assistant. The facility called a Code W and the Activities Assistant and the Business Office Manager approached the resident and easily redirected him/her back to the facility. The investigation summary stated staff members kept the resident within vision for the entire incident. However, review of the portion of the employees' written statements of the investigation revealed the facility did not have visual contact with the resident throughout the incident. Review of the written statements of the Activities Assistant and the Business Office Manager stated they ran out the door after Resident #1, but when they arrived at the intersection at the corner of the facility, they looked in every direction and could not locate the resident. At that point, the Business Office Manager returned to the facility and called the Code W while the Activities Assistant ran to the right of the facility. Then, both staff members ran straight down the street on which the facility was located. Approximately one (1) block from the facility, they observed the resident walking approximately one (1) block farther down the road. When staff caught up with the resident, the resident stated he/she was walking home. They returned to the facility with no further incident. Continued observation of Resident #1, on 11/01/16 at 10:10 AM, revealed the resident resided on the first floor, above the ground floor of the facility, on the secure unit, 1C. The secure unit had two (2) exits, an elevator and a doorway. The elevator was across the hallway from the door and was located next to the common area. Each of the unit exits had a keypad that required a code to open. Observations of the facility and facility grounds with the Activities Assistant, on 11/02/16 at 9:20 AM, revealed the layout of the facility and the route Resident #1 took after he/she eloped from the facility on 10/21/16. On the ground floor, the elevator was located behind and around the corner from the reception area. To exit the reception area, there was one set of double doors. The doors could be opened either with a code keyed into the keypad at the door, or if an employee pressed a door release button located at the reception desk. The facility was located on the corner of a two (2)-way busy street and a one (1)-way street. Interview with the Maintenance Director, on 11/02/16 at 3:00 PM, revealed the alarms on the exit doors in the facility were Wander Guard alarms. Doors did not alarm when held open too long or when pressed on. He stated all the doors stayed locked and facility staff could only open the doors using a badge or key code. He stated the doors did not open after any amount of delay; they would remain locked. Interview with Receptionist #2, on 11/01/16 at 3:40 PM, revealed he unknowingly let Resident #1 out of the facility's front door. Receptionist #2 stated he had worked for the facility for a few weeks at the time of the incident. He stated he attended a one (1) day orientation and an additional few days of shadowing the lead Receptionist, Receptionist #1. During the orientation, Receptionist #2 received training on the Wander Guard system and elopement book; however, he did not remember much of the training pertaining to wandering residents due to having received a large amount of information at one time during the orientation. Receptionist #2 stated Resident #1 approached the lobby and said, Have a good day and Receptionist #2 pushed the button to release the front door. When the resident got close to the front door, an alarm sounded. The receptionist stated he got up and keyed in the code to turn off the alarm and unlock the door. He stated he thought the alarm had gone off for a different reason because the week prior the alarm had gone off when residents and families were entering and exiting the building. Once the resident exited the building, the Activities Assistant came to the lobby and asked if he had let Resident #1 out of the facility. The receptionist told the Activities assistant that he had let the resident out and pointed the direction Resident #1 took to the Activity Assistant and Business Office Manager. A few minutes later, staff returned to the facility with the resident. Interview with the Activities Assistant, on 11/02/16 at 9:20 AM, revealed he observed Resident #1 through a window and the resident was out of the facility unsupervised. He stated he was in the smoking room on the ground floor of the facility located across the dining room, hallway, and through two (2) locked doors. He stated he was letting a resident out of the smoking room doors and happened to look across the hallway, across the dining room, and out a window in time to see a person wearing a hat he thought looked like Resident #1's hat. He stated he ran to the dining room and had to stand on a chair to see out an adjacent window, when he identified that Resident #1 was out of the facility. He called another staff to stay with residents in the smoking room and ran to the reception area where he confirmed with the Receptionist that Resident #1 was out of the facility unsupervised. He stated he called the resident's unit, but staff did not answer the phone so he ran down the hallway to look for the Administrator. The Administrator's door and the door to Social Services offices were closed. He then ran back to the reception area, and the Business Office Manager met him there. He stated they both ran out to the location the Activities Assistant observed the resident, looked in every direction, and did not see the resident. He instructed the Business Office Manager to go back in the building to call a Code W. The Activities Assistant then ran to the right, down one of the streets in search of the resident. He stated he did not find the resident and returned to the last point of observation outside of the facility. The Business Office Manager met him at that location and they ran straight down the street away from the facility. Approximately one (1) block from the facility, he observed the resident, identifiable by his/her hat, turning a corner approximately one (1) block further up the street. He stated he began shouting the resident's name and the resident came back around the corner and waved at them. The employees reached the resident and the resident told them he/she was looking for a pay phone to call home. He further stated it was cold that day and he told the resident it was too cold to walk that far. The resident agreed with him and returned to the facility

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) without further incident. The Activities Assistant stated the resident had decreased safety awareness and was not oriented to place. He stated the resident was at risk of serious injury or death. He stated the resident could have tried to enter another home or could have been hit by a car. He stated the resident was out of sight of any facility employee for a few minutes. The Activities Assistant stated he did not have the resident in sight at the time of elopement. The Activities Assistant reviewed the Incident Investigation and stated the summary of his statement was not accurate in that the summary left out the part of the search when staff lost the resident. The Activities Assistant stated the DNS asked him in front of everyone in the lobby if he maintained a visual on the resident the whole time and he told her No, I lost him. Interview with the Business Office Manager, on 11/01/16 at 4:00 PM, revealed she took part in the search for Resident #1. She stated she heard the Code Alarm on the front door sound. She stated one (1) to two (2) minutes after the door alarm sounded, she observed the Activities Assistant running down the hallway, then ran back. She stated the Activities Assistant told her the facility had a Code W and that he had observed a resident outside of the facility. She stated she went outside with him to the corner of the street, looked in all four (4) directions, and did not see the resident. The Business Office Manager came back into the facility and announced a Code W over the intercom system. She stated she then went back to the corner of the facility and met the Activities Assistant. They ran together down the street one (1) block and saw the resident's hat. They yelled the resident's name and the resident turned around and waved at them. When they reached the resident, the resident was calm and walked back to the facility without incident. Upon return to the facility, the nurse and the DNS were in the lobby. The nurse escorted the resident back to his/her unit. The DNS asked specifically if the resident had always been in sight of the staff and she stated she answered no. She stated the resident was at risk of being hit by a car as the cars on the street do not have to stop at the intersection, often drove fast on the neighborhood street, and the resident had a decrease in safety awareness. She stated the resident was out of the building for approximately four (4) to five (5) minutes. The Business Office Manager reviewed the facility's investigation summary of the statement she gave to the DNS and stated it was not accurate. She stated the facility's investigation omitted the fact that the resident was not in sight during the entire incident. She stated the resident was out of sight and facility staff did not know where he/she was. Interview with CNA #4, on 11/02/16 at 3:35 PM, revealed she worked on Resident #1's unit when he/she eloped from the facility on 10/21/16. She stated she talked with Resident #1 at approximately 3:00 PM and the resident asked her if he/she could go downstairs and go outside. She told the resident she would talk with the nurse, LPN #3, about it and she reported it to the nurse. Interview with LPN #3, on 11/04/16 at 1:45 PM, revealed he was Resident #1's nurse at the time the resident eloped from the facility. He stated the CNA reported to him that Resident #1 was talking about going home. He stated he went and talked with the resident and the resident was calm. LPN #3 then walked down the hallway and into the medication room. He stated no staff was present in the resident common area or in the hallway of the unit when he went into the medication room. Interview with CNA #2, on 11/01/16 at 11:00 AM, revealed she worked Resident #1's unit and she had previously observed visitors on the unit use the code to get on the elevator or to go through the door into or off the locked unit. Continued interview with the Maintenance Director, on 11/02/16 at 3:00 PM, revealed the facility had no set schedule to change the codes to the elevator, secure unit door, or stairwells. He stated he worked for the facility for ten (10) months and had not changed the codes to the stairwell because the facility had not had a problem with the stairwell. Interview with Social Services #1, on 11/03/16 at 2:00 PM, revealed Social Services completed elopement assessments on residents. Upon admission, if the intake referral or first twenty-four (24) hours of behavior indicated, then Social Service completed an elopement assessment. Social Services did not complete elopement assessments quarterly or with any regular frequency. She stated the facility did not complete elopement assessments after a resident eloped from the facility. She stated Social Services completed a new elopement assessment if, through observation of the resident and talking with staff, it was determined the resident had a new elopement risk. She stated the purpose of the elopement risk assessment was to determine what, if any, signs or symptoms of elopement risk existed. Interview with the DNS, on 11/03/16 at 8:30 AM, revealed she was in charge of the investigation into Resident #1's elopement from the facility on 10/21/16. When staff returned to the facility with the resident, she initiated the investigation. She stated she had talked with Resident #1 who stated he/she followed a person onto the elevator and rode down to the ground floor. The DNS stated the facility should have completed a new elopement risk screening in the morning start up meeting, however, she stated she was unsure if the facility completed a new elopement assessment after Resident #1 eloped from the facility. She also stated she was unsure if the facility updated the care plan after the elopement. She stated the facility did not review other residents assessed at risk for elopement to ensure interventions were sufficient. She stated Resident #1 was at risk of injury from elopement from the facility. The DNS further revealed she did not substantiate the elopement because the resident was out of the building for less than fifteen (15) minutes and had gone only a couple of blocks. She stated although staff did lose the resident for a couple of moments, she believed staff would have been able to see the resident from the facility property, and therefore she considered the resident in sight. Interview with the Administrator, on 11/03/16 at 3:00 PM, revealed he reviewed the Elopement Incident Investigation form for Resident #1's 10/21/16 elopement on 10/25/16. He stated he did not read all of the staff statements or review the clinical record for Resident #1. He stated Social Services should have completed elopement assessments quarterly, but had not instructed them to do so. The Administrator stated the Director of Clinical Operations trained the DNS on how to complete incident investigations. Interview with the Director of Clinical Operation, on 11/03/16 at 4:10 PM, revealed there was not a policy stating how often the facility completed elopement assessments; however, the facility should complete them after an elopement attempt per reference to the elopement policy. She stated she provided the facility guidance with how to complete an incident investigation. Additionally, the investigation tool guided the facility staff on each step in completing an investigation. She stated the DNS called her for guidance the day after Resident #1 eloped from the facility. 2. Review of the facility's clinical record for Resident #2, revealed the facility admitted the resident on 06/22/16 with [DIAGNOSES REDACTED]. Review of the Kentucky Power of Attorney (POA) form, dated 06/30/16, revealed Resident #2 appointed his/her relative to act on his/her behalf in financial and healthcare decisions. Review of the admission MDS assessment, completed 07/01/16, revealed the facility assessed the resident as requiring limited one (1) person physical assistance to walk. The facility assessed the resident as only able to stabilize during transfers and walking with human assistance. During the assessment, the facility conducted a BIMS examination and assessed the resident with a score of ten (10) out of fifteen (15) and determined the resident was interviewable. Review of Resident #2's printed November 2016 Physician order [REDACTED]. On 07/11/16, the physician also ordered the facility to check the function and placement of the Wander Guard each shift. Review of Resident #2's Care Plan pertaining to Exit Seeking Behaviors, dated 07/12/16, revealed the facility had developed interventions to place a monitoring device on the resident that sounded alarms when the resident left the building. The facility also had interventions to instruct staff to stay with the resident if he/she wandered away from the unit. Staff was to converse with the resident and gently persuade him/her to walk back to designated areas with them. Review of Resident #2's Risk of Elopement Review, dated 07/13/16, revealed the facility completed an elopement assessment and determined the resident was at risk for elopement and placed a Wander Guard bracelet on the resident. The facility stated the resident was at risk due to cognitive impairment with poor decision-making skills, independent ambulation, and a [DIAGNOSES REDACTED]. The facility noted the resident wandered the hallway of the unit and frequently discussed wanting to go home. However, further review of Resident #2's medical record revealed a document dated 09/23/16, that stated the resident's Power of Attorney (POA) gave approval for Resident #2 to sign himself/herself out to sit on the facility's front porch. The document was typed on an 8.5" x 11.0" sheet of paper with Social Services #2's name typed at the bottom. Further review of Resident #2's Care Plan revealed no plan for allowing the resident to sign himself/herself out of the facility to sit on the front porch of the facility unsupervised. Review of the Release of Responsibility for Leave of Absence, dated October 2016, revealed Resident #2 signed out of the facility on five (5) occasions. The dates of sign out were 10/04/16 at 11:40 AM, 10/05/16 at 1:30 PM, 10/07/16 at 1:10 PM, 10/08/16 at 1:30 PM, and one (1) undated and untimed occasion. The document contained no dates, times, or signature for when the resident returned to the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) Review of a piece of paper with Sign Out Sheet handwritten at the bottom, undated, revealed Resident #2 signed out of the facility an additional six (6) times. Review of Resident #2's Nursing Notes, dated 06/23/16 through 10/18/16, revealed nursing had not documented any instances of wandering or exit seeking behaviors. The facility did report one (1) instance where the resident signed out of the facility against medical advice on 10/07/16. The note stated the resident would return later the same evening. No other notes indicated the resident left the facility. Interview with LPN #4, on 11/02/16 at 3:50 PM, revealed the resident had wandered on all floors of the facility since admission. The resident wore a Wander Guard and was allowed to sign him/herself out of the facility to sit on the front porch of the facility. The LPN stated the resident's POA gave permission for the resident to go out of the facility. Interview with Social Services #1, on 11/03/16 at 3:00 PM, revealed she called Resident #2's POA about the resident going out of the facility due to the resident wanting to go outside. The resident had a BIMS of 10 and the facility assessed the resident to have decisional capacity so she was unsure why she had to obtain permission from the resident's POA. She stated she did not review the resident's care plan to ensure it contained appropriate interventions for the resident's safety when he/she signed out of the facility. She stated Social Services completed the elopement assessment on Resident #2 and determined the resident was at risk for elopement due to exit seeking behaviors such as talking about wanting to leave the facility and pressing on exit doors. Interview with the DNS, on 11/03/16 at 8:30 AM, revealed it was facility practice not to let residents, with a Wander Guard, out of the building unaccompanied. The facility placed a Wander Guard on Resident #2 because he/she was exhibiting exit seeking behaviors, including pushing on exit doors and trying to go outside; however, the facility allowed Resident #2 to sign self out of the facility. She stated she expressed a concern with the Medical Director because some residents wanted to go outside. The DNS stated the Medical Director reviewed a list of residents who wanted to go outside but who were medically contraindicated to go out of the facility unsupervised and Resident #2 was on that list. She stated the resident had a history of [REDACTED]. Continued interview with the DNS, on 11/03/16 at 4:40 PM, revealed she was aware Resident #2 would sign out of the facility and sit on the porch unaccompanied. She stated the resident wanted to go outside and the nurse called the resident's POA. At first, the POA said no but later agreed to allow Resident #2 to sign out of the facility to sit on the front porch only. The DNS stated the facility could not ensure the resident would stay on the porch, as he/she was not accompanied. Interview with the Medical Director, on 11/03/16 at 4:57 PM, revealed he had discussed with the Administrator and the DNS, the use of AMA forms for residents who could safely go out of the building unsupervised; however, it was unsafe for Resident #2 to go outside of the facility unattended due to the risk of a seizure. The Medical Director stated he was unaware the facility allowed Resident #2 to sign out of the facility. Interview with the Administrator, on 11/02/16 at 4:45 PM, revealed the facility had an increased number of residents making requests to go outside in the last six (6) months. The Administrator stated Resident #2 suffered from seizures and had a history of [REDACTED]. Therefore, he stated the facility had Resident #2 sign a Release of Responsibility form and an AMA form. The resident could then sign him/herself out of the facility; however, the facility had not updated the care plan for Resident #2 to include the plan for the resident to sign him/herself out of the facility. Additionally, the Administrator stated the purpose of the AMA and the Release of Responsibility forms was to protect the facility if the resident did not return. 3. Review of Resident #3's clinic
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on interview, record review, review of the Administrator's job description, and review of the facility's policy, it was determined the facility's Administration failed to have an effective system in place to ensure resources, including care plans, were used effectively and efficiently to maintain the highest practicable well-being of one (1) of twelve (12) sampled residents, Resident #1. (Refer to F280, F282 and F323) On 10/21/16, Resident #1 eloped from the facility without staff's knowledge. The resident followed a visitor onto the elevator and off the secured unit. The resident went to the lobby where Receptionist #2 keyed in the code to the front door and allowed Resident #1 to exit the building. The Administration's failure to ensure facility policies/procedures related to elopement were followed and care plan interventions were implemented caused, or was likely to cause, serious injury, harm, impairment, or death to residents at the facility. Immediate Jeopardy (IJ) and Substandard Quality of Care was identified on 11/04/16 and determined to exist on 10/21/16. The facility was notified of the IJ on 11/04/16. An Acceptable Allegation of Compliance was received on 11/09/16, which alleged removal of the IJ on 11/07/16. The State Survey Agency validated the IJ was removed on 11/07/16, as alleged, and the scope and severity was lowered to a D while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility's Position Description for the position title Administrator, dated August 2015, revealed the facility Administrator was responsible for ensuring residents were at the center of every decision made, and was to ensure compliance with State and Federal Regulations. The Administrator ensured the quality of care and services provided to all residents met the satisfaction of the residents, family, and other service partners. The Administrator led an effective Quality Assurance and Process Improvement (QAPI) Program. Review of the facility's policy, Care System Guideline, Elopement, Revised 2015, revealed the facility established a process that identified risk and interventions to mitigate the occurrence of elopements. The facility assessed residents for elopement risk using the tool in the Clinical Health Status upon admission or re-admission to the facility. If the facility determined a risk for elopement, the facility established an individualized plan to mitigate risk. The facility documented interventions on the care plan, on the direct caregiver's care card, and initiated the interventions. The facility placed a photograph in the central system where information regarding all those identified at risk was located. If a bracelet alarm was chosen as an intervention, the facility established a plan for monitoring of the function of the bracelet alarm. When an elopement occurred, the facility alerted all staff to search the building and grounds as soon as there was an awareness of the resident missing. If the resident was not quickly located in the building or on the grounds, the facility designated a point person to notify the Administrator and Director of Nursing Services (DNS), notify the guardian or family member, and notify the police. After the facility located the resident, the facility completed a thorough evaluation of the resident's physical condition and psychosocial wellbeing. The facility notified the family and physician of the return. The facility established the cause of the elopement and addressed the cause with an appropriate plan to prevent reoccurrence. The facility documented the resident's condition, notifications, and times of actions. The facility reviewed all other residents identified at risk for elopement to ensure current interventions were in place to prevent elopement. The facility's Quality Assurance reviewed patterns or trends in elopements or elopement risks. Interview and record review revealed the facility assessed Resident #1 at risk for elopement, care planned the resident for elopement, and applied a Wander Guard to the resident. Record review revealed on 10/21/16, Resident #1 left the facility without staff knowledge. Review of the facility's investigation, dated 10/21/16, revealed Resident #1 eloped from the facility on 10/21/16. The facility completed an investigation that stated the resident left the secured unit after following a visitor onto the elevator and was then let out of the facility by a Receptionist. The investigation stated the Activities Assistant saw the resident through a window and recognized the resident was out of the facility unsupervised. The Activities Assistant and the Business Office Manager looked for the resident but were unable to locate the resident on the facility property. The Activities Assistant and Business Office Manager called a Code W and began searching the neighborhood for Resident #1. Staff located the resident and returned with him/her to the facility with no further incident. Further review of the facility's investigation, dated 10/21/16, revealed staff members kept the resident within vision for the entire incident; however, review of the portion of the employees' written statements of the investigation revealed the facility did not have visual contact with the resident throughout the incident. Interview with the Activities Assistant and the Business Office Manager and review of their written statements revealed they ran out the door after Resident #1, but when they arrived at the intersection at the corner of the facility, they looked in every direction and could not locate the resident.

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	185039	A. BUILDING _____ B. WING _____	11/11/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS HEALTH AND REHABILITATION CENTER	1705 STEVENS AVENUE LOUISVILLE, KY 40205

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

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 10) Interview with the Activities Assistant, on 11/02/16 at 9:20 AM, and the Business Office Manager, on 11/01/16 at 4:00 PM, revealed they stated the summary of their statements in the Incident Investigation was not accurate in that the summary left out the part of the search that staff had lost the resident. Review of the investigation summary, dated 10/21/16, revealed the form did not have a place for the person conducting the investigation to sign the form and that no one signed the form. The investigation form did contain a section to include summaries of interviews. Each Summary of Interview section contained a place for a signature acknowledging the accuracy of the summary. Review of the form revealed the DNS conducted three staff interviews with the Activities Assistant, the Business Office Manager, and Receptionist #2. None of the interview summaries were signed to acknowledge the accuracy of the summary. The investigation summary was not signed by any facility staff. Interview with the DNS, on 11/03/16 at 8:30 AM, revealed she was in charge of the investigation into Resident #1's elopement from the facility on 10/21/16. She stated that since the resident was not missing for more than fifteen (15) minutes, they did not substantiate the elopement. The DNS further revealed although staff did lose the resident for a couple of moments, she believed staff would have been able to see the resident from the facility property, and therefore she considered the resident in sight. Interview with the Administrator, on 11/03/16 at 3:00 PM, revealed he reviewed the investigation for Resident #1's elopement on 10/25/16 when he returned to the facility. However, he did not read all of the staff statements or review the clinical record for Resident #1 to ensure the investigation was complete and accurate. Interview revealed he was under the impression the resident was in sight of staff the whole time and therefore he did not consider the incident to be an actual elopement and did not take the incident to the Quality Assurance Committee. However, interview and record review revealed the resident exited the facility without staff knowledge. Continued interview with the Administrator revealed he did not provide training or instruction to the DNS pertaining to how to complete an incident investigation. Instead, he stated the DNS contacted the Director of Clinical Operations for instruction on how to complete the incident investigation for Resident #1's elopement. However, the Administrator did state he was responsible for providing supervision and oversight to the DNS. Further interview with the Administrator, on 11/11/16 at 11:05 AM, revealed he read the entire elopement incident investigation including staff statements after the initiation of the abbreviated survey. The Administrator stated he was concerned with the investigation into Resident #1's elopement due to discrepancies between the information in the facility's investigation and the information on the staff statements. The facility implemented the following actions to remove the Immediate Jeopardy: 1. The MDS Coordinator reassessed Resident #1 for elopement risk on 11/05/16. The Elopement Care Plan for Resident #1 was reviewed and updated on 11/06/16 by the MDS Coordinator. 2. The Restorative Nurse, MDS Coordinator, DNS, ADNS, or the Regional Director of Clinical Operations assessed all residents in the facility for elopement risk using the Elopement Evaluation by 11/06/16. 3. Elopement Care Plans were implemented and/or updated by 11/06/16 for the twenty-three (23) residents identified as at risk for elopement by the Restorative Nurse, MDS Coordinator, DNS, ADNS, and the Regional Director of Clinical Operations. 4. An Admission Clinical Health Status was completed, including the Risk for Elopement section, for newly admitted residents and readmitted residents who were admitted to the facility after 11/06/16. The facility admitted on e (1) new resident and readmitted three (3) residents. None of the admitted residents was assessed at risk for elopement. The DNS used the Elopement Tool to discuss all admissions in the IDT morning clinical start up meeting each morning, five (5) days per week. 5. The Elopement Risk Identification book was updated on 11/06/16 by Social Services to include all residents identified at risk for elopement. The books contained each of the twenty-three (23) identified residents' name, face sheet, and picture. Updated Elopement Risk Identification books were placed at the receptionist desk and at each nurses' station on 11/06/16. 6. The code to enter the 1C secured unit via the elevator was changed on 10/21/16 by the Maintenance Director. The task of changing the elevator codes was placed on the maintenance calendar to occur quarterly, with the next code change occurring 01/09/17. 7. Signs were placed on 11/05/16 by the Regional Vice President. Signs were placed on the elevator to the 1C secured unit, on the ground floor at the elevator, and on the first (1st) floor at the elevator. The signs instructed visitors to see an employee for assistance with the elevator code and not to allow residents on the 1C secured unit to enter the elevator without staff assistance. 8. All staff received training on the Wander Guard system, the Elopement Risk Identification book, the Elopement Care System Guidelines, and the security of the elevator and door codes by the Clinical Educator by 11/06/16. The New Hire Pack was updated by the to include education on the current facility Elopement Care System Guidelines, the Wander Guard system, the Elopement Risk Identification book, and the security of the elevator and door codes. All new hires will receive this education by the Clinical Educator or ADNS. 9. Education was provided to the Administrator and the DNS on the Elopement Care System Guidelines, the Wander Guard system, the Elopement Risk Identification book, and the elevator and door codes by the Regional Director of Clinical Services on 11/06/16. 10. Audits were completed by the Administrator, DNS, ADNS, Regional Director of Clinical Operations, or the Regional Vice President using the Elopement QAPI Questionnaire tool with at least five (5) employees, five (5) times per week. The Elopement QAPI Questionnaire tool included the questions: What do you do if you hear a wander guard alarm?; What is the first thing you do if a resident is missing?; What is the code that is announced when a resident is missing?. 11. Elopement drills were conducted weekly by the Administrator, DNS, ADNS, Regional Director of Clinical Operations, or Regional Vice President. All participating staff signed off that they participated in the drills. 12. The facility held a QAPI meeting on 11/06/16 to review the facility actions, the audits, admissions, and newly identified residents at risk for elopement. Findings of audits and actions taken after 11/06/16 will be reviewed at the monthly QAPI meeting by the QAPI team. The QAPI team included the Medical Director, Administrator, DNS, and at least three (3) other departmental leaders. The State Survey Agency validated the facility's actions as follows: 1. Review of the Elopement Care Plan for Resident #1, dated 09/09/16, revealed the facility reviewed and updated the care plan on 11/06/16. Review of the Elopement Evaluation tool for Resident #1, dated 11/05/16, revealed the facility re-assessed Resident #1 for risk for elopement. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility completed Elopement Evaluations and updated the care plan for Resident #1. 2. Review of the Elopement Evaluation, dated November 2016, revealed the facility conducted an elopement assessment with every resident in the facility on 11/05/16 and 11/06/16. The facility assessed twenty-three (23) residents at risk of elopement. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility completed Elopement Evaluations on one hundred percent (100%) of the residents in the facility. 3. Review of the facility's care plans for the twenty-three (23) identified residents at risk for elopement, revealed the facility updated and implemented elopement care plans for each of the identified residents by 11/06/16. Interview with MDS #1, on 11/11/16 at 9:00 AM, revealed the facility updated the care plans for each resident assessed as at risk for elopement. 4. Review of the facility's census, 11/09/16, revealed the facility admitted on e new resident and readmitted three (3) additional residents. Review of the Admission Clinical Health Status for each of the new/readmitted residents, dated 11/07/16 and 11/08/16, revealed the facility conducted the Risk for Elopement section in each resident's Admission Clinical Health Status. The facility identified none of the admitted residents were at risk for elopement. Review of the facility's Elopement Tool, dated 11/07/16 and 11/08/16, revealed the facility discussed admissions in the Clinical Start Up Meeting to determine if each admission resident was at risk for elopement. Interview with the DNS, on 11/11/16 at 10:15 AM, revealed she discussed admitted residents in the Clinical Start Up meeting each morning. Meeting attendants discussed the Admission Clinical Health Status to ensure the Risk for Elopement section of

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	185039	A. BUILDING _____ B. WING _____	**11/11/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS HEALTH AND REHABILITATION CENTER	**1705 STEVENS AVENUE LOUISVILLE, KY 40205**

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

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) the form was complete and accurate. The DNS stated she documented the conversation on the Elopement Tool. 5. Review of the Elopement Risk Identification book, updated 11/06/16, revealed the facility updated the book to include all residents identified at risk for elopement, regardless if the resident wore a Wander Guard. The books contained residents by name, picture, and face sheet. The books were located at the receptionist desk and at each nurses' station. Interview with DNS, on 11/11/16 at 10:15 AM, revealed the facility updated the Elopement Risk Identification book to reflect all residents identified as at risk for elopement. She stated residents, regardless of if they wore a Wander Guard, were represented in the book with a picture and cover sheet. 6. Observation of the code pad on the elevator revealed the facility changed the code to access the 1C secured unit. Review of the maintenance calendar, 2017, revealed the facility placed the task of changing the elevator codes on the calendar to occur quarterly, starting 01/09/17. 7. Observation, on 11/10/16, revealed the facility placed signs on the secured unit at the elevator on the ground floor, and on the 1st floor. The signs gave instruction to not allow residents residing on the memory care unit onto the elevator without staff assistance and instruction for visitors to see an employee for assistance with the elevator code. 8. Review of the facility provided education, posttests, and employee roster, revealed the facility provided education to all staff who had worked pertaining to the facility's Wander Guard system, the Elopement Risk Identification book, the Elopement Care System Guidelines, and elevator and door codes, by the Clinical Educator by 11/06/16. All staff passed all post-tests. Interviews with Receptionist #2, CNA#7, CNA #8, LPN #6, LPN #7, Housekeeping, and Dietary Aide, on 11/11/16, revealed the facility provided education on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. The education included post tests. Interview with the Director of Clinical Education, on 11/11/16 at 9:30 AM, revealed she provided education on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. She stated she received education on those systems from the Clinical Director of Operations prior to providing education to staff. She stated she provided the education to all staff who worked prior to 11/06/16. Additionally, the Director of Clinical Education stated any employee who had not received the education due to not yet working would be allowed to work until they first received the education. Review of the New Hire Pack, undated, revealed the facility added education to new hires using current facility elopement guidelines, Elopement Care System Guidelines. The New Hire Pack also included education to new employees pertaining to the facility's Wander Guard system, the Elopement Risk Identification book, and elevator and door codes. 9. Interview with the Clinical Director of Operation, on 11/11/16 at 11:52 AM, revealed she provided education to the Administrator and the DNS on the Wander Guard system, the Elopement Risk Identification book, The Elopement Care System Guidelines, and elevator and door codes by the Clinical Educator. Review of the education logs, 11/06/16, revealed the DNS and Administrator also received education with all facility staff. 10. Review of the QAPI Questionnaire Tools, completed between 11/06/16 and 11/09/16, revealed the facility leadership team conducted interviews with at least five (5) employees each day. The questions on the Questionnaire Tool included: What do you do if you hear a wander guard alarm? What is the first thing you do if a resident is missing? What is the code that is announced when a resident is missing? Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed the facility was holding daily QAPI meetings to ensure continued compliance. He stated the Medical Director was either physically present or present via telephone for each of the daily QAPI meetings. The Administrator stated that he and the DSN completed at least five (5) QAPI Questionnaire Tool interviews with staff each day. 11. Review of the Patient/Resident Elopement Drill Worksheets, dated between 11/06/16 and 11/09/16, revealed the facility conducted elopement drills daily and ensured all participating staff signed off on the drills. Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed he conducted daily elopement drills to ensure all staff knew what to do in case of elopement. He stated the facility would ask a resident to participate in the drill and hide the resident. The facility would call a Code W and facility staff conducted searches of the facility and facility grounds with each drill. Interview with LPN #6 and CNA #4, on 11/11/16, revealed the facility conducted elopement drills daily. They each stated the facility called a Code W over the loud speaker and staff begin searching for the missing individual named in the announcement in the facility and on the facility grounds. 12. Review of the Daily Focused QAPI Meeting sheets, dated 11/06/16 through 11/09/16, revealed the facility held QAPI meetings daily. The meetings included the Medical Director and reviewed actions and audits, as well as admissions and newly identified residents at risk for elopement. Interview with the Administrator, on 11/11/16 at 11:04 AM, revealed the Administrator was holding QAPI meetings daily to discuss the elopement plan. He stated the Medical Director had attended every meeting either in person or via telephone. Interview with the DNS, on 11/11/16 ay 10:15 AM, revealed the facility held QAPI meetings each day. She stated she attended the QAPI meetings and the QAPI team discussed the ongoing inservices, drills, admissions, assessments, and other facility elopement initiatives.