STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185333	A. BUILDING ______ B. WING _____	**10/27/2017**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KLONDIKE CENTER	**3802 KLONDIKE LANE LOUISVILLE, KY 40218**

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 0224

Level of harm - Immediate jeopardy

Residents Affected - Few

Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.

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 assessed with [REDACTED].#1.

The facility had assessed Resident #1 to have cognitive impairment and communication problems and independent with most Activities of Daily Living. On [DATE], staff observed Resident #1 in the facility at approximately 3:30 PM. However, the staff did not see or try to locate the resident until 10:30 PM, approximately seven (7) hours later, when staff discovered the resident was not in bed. Interviews with staff revealed the resident was not in his room for dinner at 5:00 PM nor when the tray was discovered untouched at 6:30 PM. In addition, rounds were not conducted by staff during shift change at 6:30 PM, which was facility protocol. At 6:50 PM, staff reported, to the Center Nurse Executive (CNE), a screen was out of one of the windows with the window opened; however, no investigation was conducted. A search was conducted at 10:30 PM after the resident could not be located. The resident could not be found and was reported missing.

Facility video surveillance recorded Resident #1 walking outside of the facility from approximately 4:12 PM to 4:34 PM. The facility's investigation determined the resident probably exited the building through the opened window with the missing screen. The resident was found deceased on [DATE], four (4) days later, approximately 3.5 miles from the facility at an abandoned building. Per the Deputy Coroner's interview, the preliminary findings from the autopsy included the resident's health conditions with minor abrasions/contusions on the extremities. Review of the weather history for [DATE] revealed a high of eighty (80) degrees Fahrenheit (F) and a low of fifty-four (54) degrees F. On [DATE], the high was seventy-three (73) degrees F with a low of fifty-two (52) degrees F. On [DATE], the high was seventy-seven (77) degrees F and the low was fifty-one (51) degrees F.

The facility's failure to ensure residents were free from neglect has caused or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE].

The facility provided an acceptable Allegation of Compliance (A(NAME)) on [DATE], alleging removal of the Immediate Jeopardy on [DATE]; however the State Survey Agency (SSA) verified Immediate Jeopardy was removed on [DATE], prior to exit on [DATE]. Interview and record review revealed rounding protocols and audits were not implemented until [DATE]. Therefore, it was determined the Immediate Jeopardy was not removed until [DATE] versus [DATE] as alleged. 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 Abuse Prohibition Policy, revised [DATE], revealed the facility would prohibit abuse, mistreatment, and neglect. The facility defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Review of the facility's Registered Nurse-Charge Nurse Job Description, revised [DATE], revealed the Charge Nurse was responsible to complete rounds on the unit to observe patients and determine if nursing needs were being met.

Review of the facility's training tool on Nursing Rounds, undated, revealed nursing rounds should be performed by the licensed nurse at least twice per shift.

Observation of the facility's video surveillance cameras, on [DATE], revealed Resident #1 exited the facility on [DATE] at approximately 4:12 PM. The resident walked around the back of the building at approximately 4:13 PM, and the side of the building near the staff smoking area at approximately 4:32 PM. Resident #1 looked around the corner toward the front of the building, and then he/she walked back down the side of the building. The resident was last observed on camera at approximately 4:34 PM.

Review of Resident #1's closed clinical record revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. The record revealed an additional [DIAGNOSES REDACTED].

Review of the annual Minimum Data Set (MDS) for Resident #1, dated [DATE], revealed the facility assessed the resident was severely cognitively impaired and required limited assistance of one (1) staff for dressing, extensive assistance of one (1) staff for hygiene and bathing, and setup help only with eating.

Review of an Elopement Evaluation, dated [DATE], revealed the facility assessed Resident #1 had a history of [REDACTED].

Review of the Care Plan for Resident #1, dated [DATE], revealed the resident exhibited symptoms of decline in cognitive function with interventions to give one direction or ask one question at a time and keep it simple, and re-orient as to day, time of day, and current events if not upsetting to the resident. The facility determined the resident had difficulty making himself/herself understood and had slurred speech with interventions to ask questions that required one or two word answers and/or yes or no answers, if resident became upset then re-approach later, and allow time for resident to process and respond. The resident was at risk for falls due to a shuffling gait, cognition, and lack of safety awareness with interventions to assess for changes in medical status, pain status, mental status, and report to the Physician as indicated.

Interview with Certified Nurse Aide (CNA) #3, via telephone, on [DATE] at 3:08 PM, revealed she worked on [DATE] from 3:00 PM to 11:00 PM on the South Hall (where Resident #1 resided). She stated Resident #1 was assigned to CNA #2, but she remembered seeing the resident in his/her room at approximately 3:30 PM. She verified she delivered the resident's dinner tray to his/her room at approximately 5:00 PM, but Resident #1 was not in the room. She stated it was her normal practice to check the courtyard when the resident was not in the room; however, she was busy and had forgotten to check on him/her.

Interview with CNA #2, on [DATE] at 2:30 PM and [DATE] at 2:55 PM, revealed he was assigned to Resident #1 on [DATE] from 3:00 PM through 11:00 PM. He stated he last observed the resident walking to his/her room between 3:00 PM and 3:30 PM. He stated the resident was independent and did not require a lot of care. CNA #2 revealed he was supposed to check on each resident every two (2) hours; however, he was busy caring for other residents. He later attempted to pick up the resident's food tray from his/her room and noticed the resident had not eaten, but did not look for Resident #1 at that time.

Interview with Licensed Practical Nurse (LPN) #6, on [DATE] at 10:12 AM, revealed she was the charge nurse assigned to Resident #1 on [DATE] until 7:00 PM. She recalled observing the resident walking between the dining room and kitchen area between 2:00 PM and 3:00 PM. She gave report on her assigned residents to the CNE shortly before clocking out; however, did not complete a walking round. She revealed she was supposed to complete a walking round with the on-coming nurse, and visualize each resident while giving report.

Interview with the CNE, on [DATE] at 10:45 AM and [DATE] at 12:50 PM, revealed she arrived at the facility on [DATE] between 8:30 AM and 8:45 AM. She revealed she completed her routine walking round that morning when she arrived at work, and she

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 1)
saw Resident #1 at approximately 2:00 PM going toward the kitchen area. She stated a nurse had called in for the night shift and she was required to cover as the Charge Nurse for Resident #1's hall from approximately 6:30 PM to 11:00 PM. She stated it was expected for the on-coming nurse to complete a walking round with the previous nurse, to observe each resident while getting report. The CNE further stated a walking round was not completed and Resident #1 was not observed before she took over the assignment from LPN #6 at approximately 6:30 PM.
Interview with CNA #1, via telephone, on [DATE] at 2:00 PM, revealed she normally worked third shift; however, was called in to work early on [DATE]. She stated she clocked in at approximately 6:50 PM and immediately went to answer a call light in room [ROOM NUMBER] (across the hall from Resident #1's room). She revealed both windows in room [ROOM NUMBER] were open and
the screen was out of the one on the right side and reported her findings to the CNE. She further revealed Resident #1 was not in bed at approximately 10:00 PM and the CNE was made aware and a search was initiated for Resident #1.
Continued interview with the CNE, on [DATE] at 10:45 AM and [DATE] at 12:50 PM, revealed CNA #1 did report a screen was out of the window in room [ROOM NUMBER] (across the hall from Resident #1's room), but she was unsure of the exact report time. She did not investigate the issue, as she stated the windows only opened six (6) inches, and both residents were in the room. She stated at approximately 10:30 PM, CNA #1 reported she could not find Resident #1 in his/her room or bathroom. The CNE stated she went to the resident's room and observed the resident's food tray untouched; therefore, initiated a search for the resident. She expected facility staff to report to her when a resident had not eaten dinner and expected CNAs to complete rounds every two (2) hours on all residents. In a later interview the CNE stated supervision was based on the needs of the resident and Resident #1 did not need to be supervised, as he/she was independent with Activities of Daily Living (ADL's). However, she further revealed she expected staff to ensure the resident's whereabouts at least two (2) times per shift.
Interview with the Center Executive Director (CED), on [DATE] at 12:40 PM, [DATE] at 12:30 PM, and [DATE] at 1:07 PM, revealed she was called and informed about the missing resident at approximately 10:50 PM on [DATE]. She stated it was determined Resident #1 had exited one of the windows in room [ROOM NUMBER]. She stated the facility did not have a policy related to supervision and monitoring of residents, but licensed staff and CNAs supervised residents based on their care needs. She expected licensed staff to make rounds twice per shift (according to the training tool) and more often depending on the needs of each resident. She revealed licensed staff traditionally completed a walking round; however, they were not expected to search for the resident if not in their room. The CED further revealed higher functioning residents did not necessarily need to be observed every two (2) hours and Resident #1 was high functioning regardless of his/her diagnoses; however, she expected staff to verify the resident's whereabouts on [DATE] prior to 10:30 PM.
Interview with Medical Doctor (MD) #1, on [DATE] at 4:10 PM and [DATE] at 9:00 AM, revealed he was the MD for Resident #1 until [DATE]. He revealed it was difficult to measure the resident's intellect due to his/her [DIAGNOSES REDACTED]. He revealed survival on the street with no food or water would be an issue for any resident. He stated Resident #1 had a history of [REDACTED]. He expected the facility standard was to monitor residents every two (2) hours.
Interview with the Police Detective, via telephone, on [DATE] at 9:15 AM, revealed Resident #1 was found deceased early in the morning on [DATE]. He indicated the estimated time of death was the night of [DATE].
Interview with the Deputy Coroner, via telephone, on [DATE] at 10:10 AM, revealed the preliminary findings of the autopsy included Hypertensive and [MEDICAL CONDITION] Cardiovascular Disease, Moderate [MEDICAL CONDITIONS], Cerebral Atrophy, and
minor abrasions/contusions on extremities.
The facility implemented the following actions to remove the Immediate Jeopardy:
1. The Center Nurse Executive (CNE) and the North Hall Charge Nurse initiated a visual validation of residents that resided in the center on [DATE] at 10:30 PM, to determine fifty-three (53) residents were accounted for, with no concerns.
2. The Clinical Quality Specialist (CQS) educated the CNE and Center Executive Director (CED) on [DATE], over the phone, on the facility's elopement policy with instruction to initiate resident rounds and window checks every two (2) hours.
3. On [DATE], the Maintenance Director arrived at the facility and began a round on the perimeter windows to determine all were secure. He added two (2) additional screws to the window in room [ROOM NUMBER] and three (3) other rooms that had double pane windows. Additionally, he ensured proper functioning of the six (6) exit doors in the facility.
4. A Registered Nurse (RN) reviewed the elopement books for accuracy on [DATE]. The Care Plan and Kardex were also reviewed for one (1) resident identified at risk for elopement in the facility.
5. The Clinical Reimbursement Coordinator (CRC) was trained on the Resident Assessment Instrument (RAI) Process to include Brief Interview for Mental Status (BIMS) assessments per on-line training on [DATE]. The CRC reviewed fifty-three (53) resident's BIMS assessments for accuracy on [DATE].
6. On [DATE], the CNE completed Elopement Risk evaluations, with outcomes reviewed with the CRC, for fifty-two (52) of fifty-three (53) residents, with one (1) resident evaluation completed [DATE].
7. Re-education was initiated by the CNE and CED on [DATE], with completion on [DATE] (with the exception of one (1) PRN (as needed) CNA and one (1) Physical Therapy Assistant (PTA) on medical leave, both would be required to receive the re-education before returning to work). The re-education included center policies on Elopement Prevention and Management, the purpose, and benefits of rounding, rounding during shift change and all three meals, and what to do if a resident was not accounted for during rounds. Each employee completed a post-test to validate the learning.
8. Beginning on the morning shift on [DATE], the CED, CNE, Maintenance Director, Social Service Director, Business Office Manager, RN and/or Licensed Practical Nurse (LPN) would document a head count on the Windows/Visual Account Audit Tool to complete visual observation rounds every two (2) hours (six (6) rounds per shift) and determine all windows were secured for two (2) weeks, including weekends, then four (4) rounds per shift by a Department Manager, RN, or LPN starting [DATE].
9. On [DATE], an ad-Hoc Quality Assurance/Performance Improvement (QAPI) meeting was conducted by the CED and the Physician.
The CED and CNE reviewed the timeline, investigation outlines, immediate action to ensure the issue would not recur, and the plan for ongoing monitoring. It was discussed at that time to change the licensed staff rounding protocol from two (2) times per shift to four (4) times per shift.
10. Starting [DATE], the Maintenance Director rounded weekly on the security of all windows and record on an audit tool. The results would be reported to the CED and/or CNE upon completion of the rounds with corrective action upon discovery. The QAPI Committee would determine if changes to the weekly time frame needed to be adjusted.
11. An elopement drill was conducted [DATE], on all three (3) shifts. The elopement drills would continue monthly on each shift for six (6) months with corrective action and/or re-education provided upon discovery of an issue during the drill.
The SSA validated the facility implemented the following actions:
1. Documentation verified a visual validation was documented for fifty-three (53) residents in the facility on [DATE], by the CNE and LPN #3.
Interview with LPN #3, on [DATE] at 1:40 PM, verified a head count was done immediately after Resident #1 was determined missing.
2. Interview with the CQS, on [DATE] at 2:28 PM, revealed she spoke with the CED and CNE over the phone on [DATE], and educated about the elopement process and their responsibility as supervisors. She stated she instructed them to initiate resident rounds and window security checks every two (2) hours.
Interviews with the CNE, on [DATE] at 2:47 PM, and the CED, on [DATE] at 3:17 PM, revealed they received training by the CQS immediately after the incident on [DATE].
3. Interview with the Maintenance Director, on [DATE] at 10:30 AM, revealed he was called in to the facility after the elopement to check all the windows in the facility. He added two (2) additional screws to secure the window in room [ROOM NUMBER], and enforced windows in four (4) different areas of the facility. He also verified all six (6) exit doors were functioning properly.
4. Review of three (3) elopement books revealed two (2) residents, one (1) of which recently returned from the hospital, at risk for elopement with their picture and information contained in the books.
Interview with RN #4, on [DATE], revealed she reviewed all three (3) elopement books in the facility with no concerns. She also reviewed the Care Plan and Kardex for the one (1) resident identified at risk for elopement.
5. Verified documentation of CRC on-line training for the RAI process on [DATE].
Interview, on [DATE] at 11:20 AM, with the CRC, revealed she reviewed all resident BIMS assessments to validate accuracy on [DATE], with no concerns identified.
6. Documentation verified Elopement Risk Evaluations were completed by the CNE on [DATE], for fifty-two (52) residents and

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F 0224

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 2)
one (1) resident on [DATE].
Interview with the CNE, on [DATE] at 10:45 AM, revealed all elopement evaluations were updated as of [DATE].
Interview with the CRC, on [DATE] at 11:20 AM, revealed Elopement Risk evaluations were completed by the CNE on [DATE].
7. Record review revealed elopement education post-tests and rounding education post-tests completed by all staff by [DATE].
A detailed two (2) page agenda on rounding was in the re-education binder with instruction for rounding at least every two (2) hours.
Interviews with the CNE, on [DATE] at 2:47 PM and the CED, on [DATE] at 3:17 PM, verified staff was re-educated to complete resident rounds every two (2) hours by [DATE].
Interview with LPN #2, on [DATE], revealed she was asked by the CNE, after the elopement, to fill out two (2) tests, one (1) on elopement and the other about rounding.
Interview with LPN #3, on [DATE], revealed re-education included the CNE and CED giving her a handout with information, including every two (2) hour rounds, and she was required to take a test.
Interview with CNA #9, on [DATE], revealed staff must search for the resident if not in their room when meal trays were passed, make a walking-round at the beginning of the shift, and round based on the needs of the resident.
8. Documentation verified a Window/Visual Account Audit Tool was used to complete rounds every two (2) hours (six (6) times per shift) from [DATE] through [DATE]. Documentation verified the Window/Visual Account Audit Tool was changed from every two (2) hour rounds to four (4) times per shift.
Interview with the CNE, on [DATE] at 2:47 PM, and the CED, on [DATE] at 3:17 PM, revealed documentation of the two (2) hour rounds (to visualize each resident and check to ensure window security) was initiated immediately after the elopement.
Interview with the Maintenance Director, on [DATE] at 10:30 AM, revealed he checked the security of windows daily.
Interview with RN #3, on [DATE] at 1:15 PM, revealed licensed staff were to round four (4) times per shift looking at window and residents.
9. Interview with the CED, on [DATE] at 3:05 PM, revealed she spoke with the Physician via telephone and reviewed the immediate action taken and the Physician had no concerns.
Interview with the CNE and the CED on [DATE], revealed they had discussed changing the licensed staff rounding protocol to four (4) times per shift on [DATE].
However, interview with LPN #2, on [DATE] at 8:12 AM, and LPN #6, on [DATE] at 8:45 AM revealed they were not instructed to document rounds four (4) times per shift until [DATE].
10. Documentation verified window audits signed by the Maintenance Director on [DATE], [DATE], [DATE], and [DATE].
Interview with the Maintenance Director, on [DATE] at 10:30 AM, revealed he had been checking the security of the windows daily but he did not document the results. He revealed he was not instructed until [DATE], by the CED to complete the audit tool; however, per the A(NAME), beginning [DATE], the Maintenance Director would round weekly and record on an audit tool.
Interview with the CED, on [DATE] at 3:17 PM, revealed the audit tool was not initiated on [DATE]; however, per the A(NAME), the Maintenance Director would round weekly and record on an audit tool beginning [DATE].
11. Documentation verified Elopement Drills began on [DATE] for each shift.
Interview with the CNE, on [DATE] at 2:47 PM, revealed she, or the Maintenance Director, would continue monthly drills on each shift for six (6) months with re-education provided immediately with issues. She revealed results would be discussed in monthly QAPI meetings.

F 0281

Level of harm - Immediate jeopardy

Residents Affected - Few

Make sure services provided by the nursing facility meet professional standards of quality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on interview, record review, review of the facility's training tool on Nursing Rounds, and review of Standards of Practice for Nursing Assistants, it was determined the facility failed to have an effective system to ensure services provided met professional standards of care related to the failure to round (visual checks of residents' whereabouts) on residents identified with cognitive impairment and communication deficits for one (1) of seven (7) sampled residents, Resident #1.
The facility had assessed Resident #1 to have cognitive impairment and communication problems and independent with most Activities of Daily Living. On [DATE], staff observed Resident #1 in the facility at approximately 3:30 PM. However, the staff did not see or try to locate the resident until 10:30 PM, approximately seven (7) hours later, when staff discovered the resident was not in bed. Interviews with staff revealed the resident was not in his room for dinner at 5:00 PM nor when the tray was discovered untouched at 6:30 PM. In addition, rounds were not conducted by staff during shift change at 6:30 PM, which was facility protocol. At 6:50 PM, staff reported, to the Center Nurse Executive (CNE), a screen was out of one of the windows with the window opened; however, no investigation was conducted. A search was conducted at 10:30 PM after the resident could not be located. The resident could not be found and was reported missing.
Facility video surveillance recorded Resident #1 walking outside of the facility from approximately 4:12 PM to 4:34 PM. The facility's investigation determined the resident probably exited the building through the opened window with the missing screen. The resident was found deceased on [DATE], four (4) days later, approximately 3.5 miles from the facility at an abandoned building. Per the Deputy Coroner's interview, the preliminary findings from the autopsy included the resident's health conditions with minor abrasions/contusions on the extremities.
The facility's failure to ensure services provided met professional standards of quality has caused or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE].
The facility provided an acceptable Allegation of Compliance (A(NAME)) on [DATE], alleging removal of the Immediate Jeopardy on [DATE]; however the State Survey Agency (SSA) verified Immediate Jeopardy was removed on [DATE], prior to exit on [DATE]. Interview and record review revealed rounding protocols and audits were not implemented until [DATE]. Therefore, it was determined the Immediate Jeopardy was not removed until [DATE] versus [DATE] as alleged. 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 Mosby's Textbook for Long-Term Care Nursing Assistants, sixth (6th) edition, dated 2011, revealed Nursing Assistant standards included assisting the nurse with observing residents and identifying their needs.
Review of the facility's Registered Nurse-Charge Nurse Job Description, revised [DATE], revealed the Charge Nurse was responsible to complete rounds on the unit to observe patients and determine if nursing needs were being met.
Review of the facility's training tool on Nursing Rounds, undated, revealed nursing rounds should be performed by the licensed nurse at least twice per shift.
Review of the closed clinical record for Resident #1 revealed the facility admitted the resident on [DATE], with [DIAGNOSES REDACTED]. The record revealed an additional [DIAGNOSES REDACTED].
Review of the annual Minimum Data Set (MDS) for Resident #1, dated [DATE], revealed the facility assessed the resident was severely cognitively impaired and required limited assistance of one (1) staff for dressing, extensive assistance of one (1) staff for hygiene and bathing, and setup help only with eating.
Review of an Elopement Evaluation, dated [DATE], revealed the facility assessed Resident #1 had a history of [REDACTED].
Review of Resident #1's Care Plan, dated [DATE], revealed the resident exhibited symptoms of decline in cognitive function with interventions to give one direction or ask one question at a time and keep it simple, and re-orient as to day, time of day, and current events if not upsetting to the resident. The facility determined the resident had difficulty making himself/herself understood and had slurred speech with interventions to ask questions that required one or two word answers and/or yes or no answers, if resident became upset then re-approach later, and allow time for resident to process and respond. The resident was at risk for falls due to a shuffling gait, cognition, and lack of safety awareness with interventions to assess for changes in medical status, pain status, mental status, and report to the Physician as indicated.
Interview with Certified Nurse Aide (CNA) #3, via telephone, on [DATE] at 3:08 PM, revealed she worked on [DATE] from 3:00 PM to 11:00 PM on the South Hall (where Resident #1 resided). She stated she delivered the resident's dinner tray to

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F 0281

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 3)
his/her room at approximately 5:00 PM, but Resident #1 was not in the room and she was busy and forgot to check on the resident.
Interview with CNA #2, on [DATE] at 2:30 PM and [DATE] at 2:55 PM, revealed he was assigned to Resident #1 on [DATE] from 3:00 PM through 11:00 PM. Per interview, he was supposed to check on each resident every two (2) hours; however, he was busy caring for other residents. He later went to pick-up the resident's food tray from his/her room and noticed the resident had not eaten; however, he did not look for Resident #1 at that time.
Interview with Licensed Practical Nurse (LPN) #6, on [DATE] at 10:12 AM, revealed she was the charge nurse assigned to Resident #1 on [DATE] until 7:00 PM. She stated she gave report on her assigned residents to the CNE shortly before clocking out; however, they did not complete a walking round. She revealed she was supposed to complete a walking round with the on-coming nurse to round on each resident while giving report; however, failed to do so that evening.
Interview with the CNE, on [DATE] at 10:45 AM and [DATE] at 12:50 PM, revealed a nurse had called in for the night shift and she was required to cover as the Charge Nurse for Resident #1's hall from approximately 6:30 PM to 11:00 PM. She stated it was expected for the on-coming nurse to complete a walking round with the previous nurse and to observe each resident while getting report. However, per interview, she did not do a walking round when she took over care for Resident #1 from LPN #6 at approximately 6:30 PM. She stated at approximately 10:30 PM, CNA #1 reported she could not find Resident #1 in his/her room or bathroom and the CNE went to the resident's room and observed the resident's food tray untouched and initiated a search for the resident. She stated she expected CNAs to complete rounds every two (2) hours on all residents; however, supervision was based on the needs of the resident. She further revealed she expected staff to ensure a resident's whereabouts at least two (2) times per shift and when residents needed assistance.
Interview with the Center Executive Director (CED), on [DATE] at 12:40 PM, [DATE] at 12:30 PM, and [DATE] at 1:07 PM, revealed she was called and informed about the missing resident at approximately 10:50 PM on [DATE]. She stated she expected licensed staff to make rounds twice per shift (according to the training tool) and more often depending on the needs of each resident. She revealed licensed staff traditionally completed a walking round; however, they were not expected to search for the resident if the resident was not in their room. The CED further revealed higher functioning residents did not necessarily need to be observed every two (2) hours and Resident #1 was high functioning regardless of his/her diagnoses; however, she expected staff to verify the resident's whereabouts on [DATE] prior to 10:30 PM.
Interview with Medical Doctor (MD) #1, on [DATE] at 4:10 PM and [DATE] at 9:00 AM, revealed he was the MD for Resident #1 until [DATE]. He revealed it was difficult to measure the resident's intellect due to his/her [DIAGNOSES REDACTED]. He expected the facility standard was to monitor residents every two (2) hours.
The facility implemented the following actions to remove the Immediate Jeopardy:
1. The Center Nurse Executive (CNE) and the North Hall Charge Nurse initiated a visual validation of residents that resided in the center on [DATE] at 10:30 PM, to determine fifty-three (53) residents were accounted for, with no concerns.
2. The Clinical Quality Specialist (CQS) educated the CNE and Center Executive Director (CED) on [DATE], over the phone, on the facility's elopement policy with instruction to initiate resident rounds and window checks every two (2) hours.
3. On [DATE], the Maintenance Director arrived at the facility and began a round on the perimeter windows to determine all were secure. He added two (2) additional screws to the window in room [ROOM NUMBER] and three (3) other rooms that had double pane windows. Additionally, he ensured proper functioning of the six (6) exit doors in the facility.
4. A Registered Nurse (RN) reviewed the elopement books for accuracy on [DATE]. The Care Plan and Kardex were also reviewed for one (1) resident identified at risk for elopement in the facility.
5. The Clinical Reimbursement Coordinator (CRC) was trained on the Resident Assessment Instrument (RAI) Process to include Brief Interview for Mental Status (BIMS) assessments per on-line training on [DATE]. The CRC reviewed fifty-three (53) resident's BIMS assessments for accuracy on [DATE].
6. On [DATE], the CNE completed Elopement Risk evaluations, with outcomes reviewed with the CRC, for fifty-two (52) of fifty-three (53) residents, with one (1) resident evaluation completed [DATE].
7. Re-education was initiated by the CNE and CED on [DATE], with completion on [DATE] (with the exception of one (1) PRN (as needed) CNA and one (1) Physical Therapy Assistant (PTA) on medical leave, both would be required to receive the re-education before returning to work). The re-education included center policies on Elopement Prevention and Management, the purpose, and benefits of rounding, rounding during shift change and all three meals, and what to do if a resident was not accounted for during rounds. Each employee completed a post-test to validate the learning.
8. Beginning on the morning shift on [DATE], the CED, CNE, Maintenance Director, Social Service Director, Business Office Manager, RN and/or Licensed Practical Nurse (LPN) would document a head count on the Windows/Visual Account Audit Tool to complete visual observation rounds every two (2) hours (six (6) rounds per shift) and determine all windows were secured for two (2) weeks, including weekends, then four (4) rounds per shift by a Department Manager, RN, or LPN starting [DATE].
9. On [DATE], an ad-Hoc Quality Assurance/Performance Improvement (QAPI) meeting was conducted by the CED and the Physician.
The CED and CNE reviewed the timeline, investigation outlines, immediate action to ensure the issue would not recur, and the plan for ongoing monitoring. It was discussed at that time to change the licensed staff rounding protocol from two (2) times per shift to four (4) times per shift.
10. Starting [DATE], the Maintenance Director rounded weekly on the security of all windows and record on an audit tool. The results would be reported to the CED and/or CNE upon completion of the rounds with corrective action upon discovery. The QAPI Committee would determine if changes to the weekly time frame needed to be adjusted.
11. An elopement drill was conducted [DATE], on all three (3) shifts. The elopement drills would continue monthly on each shift for six (6) months with corrective action and/or re-education provided upon discovery of an issue during the drill.
The SSA validated the facility implemented the following actions:
1. Documentation verified a visual validation was documented for fifty-three (53) residents in the facility on [DATE], by the CNE and LPN #3.
Interview with LPN #3, on [DATE] at 1:40 PM, verified a head count was done immediately after Resident #1 was determined missing.
2. Interview with the CQS, on [DATE] at 2:28 PM, revealed she spoke with the CED and CNE over the phone on [DATE], and educated about the elopement process and their responsibility as supervisors. She stated she instructed them to initiate resident rounds and window security checks every two (2) hours.
Interviews with the CNE, on [DATE] at 2:47 PM, and the CED, on [DATE] at 3:17 PM, revealed they received training by the CQS immediately after the incident on [DATE].
3. Interview with the Maintenance Director, on [DATE] at 10:30 AM, revealed he was called in to the facility after the elopement to check all the windows in the facility. He added two (2) additional screws to secure the window in room [ROOM NUMBER], and enforced windows in four (4) different areas of the facility. He also verified all six (6) exit doors were functioning properly.
4. Review of three (3) elopement books revealed two (2) residents, one (1) of which recently returned from the hospital, at risk for elopement with their picture and information contained in the books.
Interview with RN #4, on [DATE], revealed she reviewed all three (3) elopement books in the facility with no concerns. She also reviewed the Care Plan and Kardex for the one (1) resident identified at risk for elopement.
5. Verified documentation of CRC on-line training for the RAI process on [DATE].
Interview, on [DATE] at 11:20 AM, with the CRC, revealed she reviewed all resident BIMS assessments to validate accuracy on [DATE], with no concerns identified.
6. Documentation verified Elopement Risk Evaluations were completed by the CNE on [DATE], for fifty-two (52) residents and one (1) resident on [DATE].
Interview with the CNE, on [DATE] at 10:45 AM, revealed all elopement evaluations were updated as of [DATE].
Interview with the CRC, on [DATE] at 11:20 AM, revealed Elopement Risk evaluations were completed by the CNE on [DATE].
7. Record review revealed elopement education post-tests and rounding education post-tests completed by all staff by [DATE].
A detailed two (2) page agenda on rounding was in the re-education binder with instruction for rounding at least every two (2) hours.
Interviews with the CNE, on [DATE] at 2:47 PM and the CED, on [DATE] at 3:17 PM, verified staff was re-educated to complete resident rounds every two (2) hours by [DATE].
Interview with LPN #2, on [DATE], revealed she was asked by the CNE, after the elopement, to fill out two (2) tests, one (1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **185333**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/27/2017**
NAME OF PROVIDER OF SUPPLIER **KLONDIKE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **3802 KLONDIKE LANE LOUISVILLE, KY 40218**	

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 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) on elopement and the other about rounding. Interview with LPN #3, on [DATE], revealed re-education included the CNE and CED giving her a handout with information, including every two (2) hour rounds, and she was required to take a test. Interview with CNA #9, on [DATE], revealed staff must search for the resident if not in their room when meal trays were passed, make a walking-round at the beginning of the shift, and round based on the needs of the resident. 8. Documentation verified a Window/Visual Account Audit Tool was used to complete rounds every two (2) hours (six (6) times per shift) from [DATE] through [DATE]. Documentation verified the Window/Visual Account Audit Tool was changed from every two (2) hour rounds to four (4) times per shift. Interview with the CNE, on [DATE] at 2:47 PM, and the CED, on [DATE] at 3:17 PM, revealed documentation of the two (2) hour rounds (to visualize each resident and check to ensure window security) was initiated immediately after the elopement. Interview with the Maintenance Director, on [DATE] at 10:30 AM, revealed he checked the security of windows daily. Interview with RN #3, on [DATE] at 1:15 PM, revealed licensed staff were to round four (4) times per shift looking at window and residents. 9. Interview with the CED, on [DATE] at 3:05 PM, revealed she spoke with the Physician via telephone and reviewed the immediate action taken and the Physician had no concerns. Interview with the CNE and the CED on [DATE], revealed they had discussed changing the licensed staff rounding protocol to four (4) times per shift on [DATE]. However, interview with LPN #2, on [DATE] at 8:12 AM, and LPN #6, on [DATE] at 8:45 AM revealed they were not instructed to document rounds four (4) times per shift until [DATE]. 10. Documentation verified window audits signed by the Maintenance Director on [DATE], [DATE], [DATE], and [DATE]. Interview with the Maintenance Director, on [DATE] at 10:30 AM, revealed he had been checking the security of the windows daily but he did not document the results. He revealed he was not instructed until [DATE], by the CED to complete the audit tool; however, per the A(NAME), beginning [DATE], the Maintenance Director would round weekly and record on an audit tool. Interview with the CED, on [DATE] at 3:17 PM, revealed the audit tool was not initiated on [DATE]; however, per the A(NAME), the Maintenance Director would round weekly and record on an audit tool beginning [DATE]. 11. Documentation verified Elopement Drills began on [DATE] for each shift. Interview with the CNE, on [DATE] at 2:47 PM, revealed she, or the Maintenance Director, would continue monthly drills on each shift for six (6) months with re-education provided immediately with issues. She revealed results would be discussed in monthly QAPI meetings.
F 0387 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that doctors visit residents regularly, as required.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's Standards and Procedures for All Licensed Independent Practitioners, it was determined the facility failed to ensure each resident was routinely visited by a Physician every thirty (30) days for the first ninety (90) days after admission for one (1) of seven (7) sampled residents, Resident #7. The findings include: Review of the Standards and Procedures for All Licensed Independent Practitioners, revised 07/27/17, revealed the attending physician would make required routine visits to residents thirty (30), sixty (60), and ninety (90) days after admission. Review of Resident #7's clinical record revealed the facility admitted the resident on 07/07/17, with [DIAGNOSES REDACTED]. Review of the initial Minimum Data Set (MDS), dated [DATE], revealed the facility determined Resident #7 was severely cognitively impaired. Review of Resident #7's History and Physical (H&P) revealed the Physician assessed the resident on 07/12/17. Review of a Progress Note for Resident #7, dated 08/29/17, revealed an assessment of the resident by an Advanced Practice Registered Nurse (forty-eight (48) days after the initial H&P). There was no documentation a ninety (90) day assessment was completed by the Physician for Resident #7. Interview with the Health Information Management, on 10/26/17 at 1:48 PM, revealed the Physician was required to visit all residents thirty (30), sixty (60), and (90) days after admission. She stated a new Medical Director started September 2017. The previous Medical Director had his own system of ensuring each resident received his/her required visits; therefore, she did not have to keep up with it herself. She revealed random audits were completed about every three (3) months with no issues identified prior to Resident #7. However, per interview she did not document the audits. Interview with the Center Nurse Executive (CNE), on 10/26/17 at 2:00 PM, revealed the previous Medical Director initiated a system to ensure required physician visits for all residents, which was explained to the new Medical Director's staff during the transition period in September 2017. She revealed the facility did not keep up with physician visits. Interview with the Center Executive Director (CED), on 10/26/17 at 2:25 PM, revealed the previous Medical Director had his own tracking system for required physician visits and Health Information Management was responsible to complete monthly audits. She stated the facility had not identified any issues. However, there was no documented evidence audits were completed. Per interview, she expected physician visits completed within guidelines, if not more often, depending on the resident's clinical condition.
F 0494 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that all full-time nurse aids employed for more than 4 months are fully trained and competent to provide nursing and nursing-related services, as defined by Federal requirements.** Based on interview, record review, and review of the Non-Certified Nursing Aide Job Description, it was determined the facility failed to ensure individuals working in the facility as a nurse aide for more than four (4) months had completed a competency evaluation program for one (1) of one (1) uncertified nurse aides currently employed by the facility. The findings include: Review of the Non-Certified Nursing Aide Job Description, revised 06/27/17, revealed the Non-Certified Nurse Aide was required to obtain certification from a state approved certified nursing assistant program within four (4) months of hire. Review of the In-service Record for Nurse Aide (NA) #1 revealed a hire date of 03/06/17. Review of NA #1's Timecard, dated 02/01/17 through 10/26/17, revealed she started the Certified Nursing Assistant Program on 03/06/17 and ended the program 05/12/17. The Timecard revealed NA #1 clocked in to work sixteen (16) days in June 2017 (starting 06/01/17), twenty-two (22) days in July 2017, twenty-two (22) days in August 2017, ten (10) days in September 2017, and twelve (12) days in October 2017 (last clock-in date was 10/22/17). Review of the Nurse Aide Testing list, dated 06/15/17, revealed NA #1 did not pass the written test on 06/15/17. NA #1 re-tested in October 2017; however, the facility was unable to obtain a copy of the results. Interview with NA #1, on 10/26/17 at 1:30 PM, revealed she attended the certified nursing assistant program from March 2017 to May 2017, and then started working as a NA at the facility in June 2017. She stated she failed her certification test in June 2017, but continued working as a NA. She stated she re-tested in October 2017; however, she failed the test again. She stated the facility allowed her to work a couple more days after the second failed attempt. She revealed her last day working as a NA was 10/22/17. Interview with the Center Nurse Executive (CNE), on 10/26/17 at 2:05 PM, revealed the staff responsible for teaching the certified nursing assistant program scheduled the classes and testing for NA #1; therefore, she assumed they would also track how long the employee could work as a NA. She indicated she was not familiar with how long NAs could work prior to certification. Interview with the Center Executive Director (CED), on 10/26/17 at 2:15 PM, revealed she assumed the staff teaching the program would keep track of how long NA #1 could work prior to receiving her certification; however, it was ultimately her responsibility. She revealed NA #1 attempted the certification test twice (June 2017, October 2017), but failed both times. She stated the facility did not follow through.

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NAME OF PROVIDER OF SUPPLIER **KLONDIKE CENTER**	STREET ADDRESS, CITY, STATE, ZIP **3802 KLONDIKE LANE LOUISVILLE, KY 40218**

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 0494 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5)