| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | N087075 | A. BUILDING: _____ B. WING _____ | 07/11/2017 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a retriaged facility investigation 117862 and complaint investigation #7821 at the above named facility on 7-3-17, 7-5-17, 7-6-17, and 7-11-17. | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-101(f)(1)(B)<br><br>The facility identified a census of 83 residents. The sample included 1 resident. Based on record review, interviews, and observations for 1 (#2) of 1 residents sampled, the administrator failed to ensure no resident shall be subjected to neglect when he/she failed to provide and coordinate necessary services to address resident #2's elopement risk when resident was found wandering outside, confused, and disoriented on 6-23-17. Resident left the facility at an unknown time on 6-27-17, was noted missing at approximately 9:15 p.m. and was found in a wooded area approximately 150 yards from facility sitting on ground at approximately 10:15 p.m. These failures place resident #2 in | S3026 | | |

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

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immediate jeopardy for harm, injury, or death.

Findings included:

- Record review for resident #2 revealed an admit date of 11-30-15 with diagnoses of dementia, depression, hypertension, and atopic dermatitis.

The functional capacity screen dated 12-1-16 (re-admit from hospital) recorded resident required supervision with transfer, walking/mobility, physical assistance with bladder incontinence, experienced poor memory recall, impaired vision/hearing, impaired decision making, and falls/unsteadiness.

The Negotiated Service Agreement/Health Care Plan (NSA/HCP) dated 12-1-16 recorded escort resident to and from meals, remind of meal times, provide redirection to room at times of confusion, occasional verbal cueing and reminders to use walker/cane when ambulating, stand by assistance for mobility, resident has fallen last 90 days, provide stand by assistance for transfer, resident incontinent of bladder, cue or remind resident "frequently, (two hour checks)" and provide stand by assistance. Night time provide stand by assistance with undressing/night time care. Resident is generally oriented but may need occasional cueing to find direction and remember information. Judgment is frequently poor; needs supervision. "N/A for pet management." (Resident has a small dog in room.) 2-19-17 Staff to make sure resident has walker within reach in evenings and at bed time due to fall.

The wellness notes recorded the following:

5-9-17 (no time), "Resident has been sleeping

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more than normal. . . . Resident has difficulty following directions more than normal." Signed licensed nurse A.

6-22-17 at 2:50 p.m. A request faxed to medical care provider for urinalysis with culture and sensitivity due to increased confusion. Signed licensed nurse A.

6-23-17 at 5:00 p.m., "S: 87 year old male/female living in assisted living. O: Resident found wandering outside with a dog. Confused and disoriented! Not aware of where he/she lives, looking for spouse. Resident taken to apartment, made comfortable and reassured. A: Level of decision making has decreased and may become an elopement risk. P: Check hourly." Signed licensed nurse B.

The record lacked documentation that indicated resident #2 was checked hourly. An elopement risk assessment was not conducted at time resident identified as possible elopement risk.

No further documentation until 6-27-17 at 9:15 p.m.

6-27-17 at 9:15 p.m., "Co-workers came to this nurse and asked where was resident as staff was wanting to administer medications and resident was not in room. Called staff and immediate search throughout community conducted, unable to locate resident, staff asked when last seen resident and was unable to recall." Signed licensed nurse C.

6-27-17 at 9:30 p.m. "Care coordinator called and informed of resident unable to be located and searched all rooms, doors, and unable to locate resident." Signed licensed nurse C.

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| S3026 | Continued From page 3<br><br>6-27-17 at 9:45 p.m., "All staff in community prompted to search hallways and court yard again and do thorough search of community inside and outside parameters." Signed licensed nurse C.<br><br>6-27-17 at 10:00 p.m., "Call placed to family member, message left urgent call to please return call." Signed licensed nurse C.<br><br>6-27-17 at approximately 10:30 p.m., "This nurse received a call from team leader (licensed nurse C) that the staff were unable to locate resident #2 in facility at this time. I instructed the team leader to have staff check the outside walking path, the day care across the street to the south of us and check at the (independent living) located to the east of the facility. Licensed nurse C stated that staff had been sent out to check these areas. This nurse advised the team leader he/she was on way to the facility. This nurse then notified the sales director, executive chef, life enrichment director to come to community to assist. Executive director also notified of situation, upon arrival to the community this nurse observed two staff member crossing the street to the east to go check at the independent living again. This nurse then gave directions to the other team members to pair up and gave then directions to start looking. This nurse and sales director went north of the independent living to the pond and the open field and to the north of independent living in the open field. This nurse was walking north towards a pasture that has horses in it, calling out the residents name and the resident's dog's name. As this nurse was walking north and to the east the flashlight caught something shiny, as this nurse approached the object it was the resident's dog and the resident sitting on the ground. At 10:15 p.m., the resident was alert and was asking | S3026 | | |

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who's there? Who are you? This nurse explained to resident who I was. The resident was very happy to see this nurse and stated, 'I know you', resident was sitting on the ground on a slight embankment with dog on his/her lap. When asked if he/she was hurt resident replied, 'no just stiff from sitting here.' Resident was able to move all extremities without pain or difficulty. No physical injuries noted at this time. Resident assisted up off ground with assistance two staff. Resident able to bear weight without pain or difficulty. Resident stated, 'I'm not hurt but my pants are wet.' (Incontinent of urine). Resident was assisted to the car that was brought over to where he/she was. Resident's gait was steady but the ground was very uneven. Resident was talking with staff members and in pleasant mood. Resident was taken back to facility at approximately 10:30 p.m. and assisted to room to restroom and clothing changed for bed. No injuries were noted on skin assessment. Buttocks was red, no bruising or open areas noted. Vital signs: blood pressure 138/80, temperature 98.8, pulse 90, respirations 20, oxygen saturation 97% on room air. Resident stated he/she was tired and glad to be home. Resident was assisted to get a glass of water and a sandwich, drank all water and ate 75% sandwich. Resident was offered more water. Resident's dog was given food and water. Resident to be on 15 minute checks until family can provide one on one companion/sitter. Will continue to monitor for any changes related to this incident." Signed licensed nurse A.

6-27-17 at 11:42 p.m., Durable Power of Attorney (DPOA) returned call to this nurse. This nurse explained the situation of the incident that occurred. Told DPOA that resident would be on 15 minute checks until they were able to come sit

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with resident or until they arranged for resident to have a one on one companion. This nurse also informed DPOA that resident would be next to move to memory care. DPOA agreed and stated that they would get in contact with a company to provide the one on one care until resident is able to move to memory care for his/her safety. Signed licensed nurse A.

6-28-17 at 2:30 a.m. "at approximately 9:30 p.m. came in to work and was informed by staff that resident #2 was unable to be located. . . Received a messaged over walkie resident was found north of the independent living facility where the pasture and horses are. This nurse drove up to help bring resident to car. Resident was assessed and during night continued every 15 minute checks as we are to be one on one for him/her. Will follow up and push fluids during the night. Signed licensed nurse D.

The record lacked further documentation since incident on 6-27-17.

Review of incident investigation #7821 reported to the department on 6-29-17 at 1:35 p.m. recorded "medication aide went to dispense medication at 9:15 p.m. in resident's room and noted lights out, resident and dog not in room. Licensed nurse C was unable to identify when resident was last seen and had all staff look for resident in facility, called licensed nurse A who then called all department heads to come to facility to look for resident. At approximately 10:15 p.m. resident was located in an open field north east and behind independent living facility next to a horse ranch and fenced wooded area. Resident was sitting in the corner of fenced wooded area and fenced horse ranch sitting on bottom with dog sitting on lap. Resident taken back to facility and

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further assessed, fluids encourage, and ate 75% of a sandwich. Temperature at time of incident was 80 degree Fahrenheit (F). The investigation report further recorded management staff E recalled seeing resident at approximately 3:30 p.m. in the lobby with dog."
Interventions implemented after resident returned to facility per investigation report included:
1. Resident assessed immediately
2. Physician notified
3. Message left with DPOA
4. Resident placed on 15 minute visual checks
5. Resident to continue treatment for UTI
6. Resident will have one on one companion from 6:00 p.m. to 6:00 a.m. starting 6-27-17 until Wednesday 7-5-17 with 15 minute visual checks to continue while the one on one is not here. Motion sensor to be set on apartment door from 6:00 a.m. to 6:00 p.m. On 7-5-17 will reassess resident since resident will have completed antibiotic for UTI and move the one on one to 5:00 p.m. to 9:00 p.m. An agency was chosen by DPOA for companion care. Visual checks will continue when one on one is not here. Motion sensor on apartment door will be se from 7:00 p.m. to 6:00 a.m. starting 7-5-17.
7. Resident is the next to transition to memory care.

The NSA/HCS plan lacked documentation of these interventions for staff to follow and provide care and services to resident after elopement incident.

Written statement dated 7-5-17 at 12:30 p.m. from management staff C recorded, "I seen resident at approximately 4:45 p.m. out front lobby. Resident was visiting with him/her about name tag different from other staff name tags and

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then management staff left and did not see where resident #2 went. Resident did not go out front door when he/she left."

Written statement dated 6-27-17 by staff L recorded ". . . . At 9:15 p.m. went to give night time pill and noticed resident was not in room."

The following staff were involved in assisting and looking for resident: Staff A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, and P.

Interview on 7-3-17 at 5:00 p.m. with licensed nurse A stated and confirmed the record lacked documentation to indicate hourly checks implemented as identified in wellness care notes on 6-23-17 and further confirmed every fifteen minutes checks implement on 6-27-17 lacked documentation to indicate resident was checked from 6:00 a.m. through 4:00 p.m. on 7-3-17.

On 7-3-17 at 3:00 p.m. licensed nurse A and surveyor walked out front door to location resident was found. Observed a walking path in front of facility with an added cement path to walk around a body of water (pond) and to walk across street to an independent living facility that also has a body of water (pond) in front of it. The ponds do not have a means of security. Licensed nurse A and surveyor walked across street and down walking path next to independent living. Observed the independent living had an open covered parking in back of facility and large open area of land. The land had uneven ground with inclines and declines from small raised areas covered with waist high weeds/brush. The area where licensed nurse A stated he/she found resident was approximately 150 yards from facility and approximately 50 yards from the nearest paved surface. Resident was found in a

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| S3026 | Continued From page 8<br>corner on down-hill slant. One fenced side of corner lot was large brush wooded area and other corner fenced area was an area that contained horses. There were no outdoor lights in the area.<br><br>Wunderground.com documented the temperature on 6-27-17 at 6 p.m. as 89 degrees Fahrenheit (F) and at 81 degrees F at 10 p.m.<br><br>For resident #2, the administrator failed to ensure the resident was not subjected to neglect when he/she failed to provide and coordinate necessary services to address resident #2's elopement risk when resident was found wandering outside, confused, and disoriented on 6-23-17. Resident left the facility at an unknown time on 6-27-17, was noted missing at approximately 9:15 p.m. and was found in a wooded area approximately 150 yards from facility sitting on ground at approximately 10:15 p.m. These failures place resident #2 in immediate jeopardy for harm, injury, or death.<br><br>The immediate jeopardy was removed at midnight 12:00 on 6-28-17 when fifteen minute visual checks were implemented, a one on one companion was provided from 6:00 p.m. to 6:00 a.m., and motion sensor was placed on apartment door from 6:00 a.m. to 6:00 p.m. to alert staff the resident had left her room. | S3026 | | |