Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101385	A. BUILDING: _____ B. WING _____	R-C 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF HOPKINSVILLE	1595 MARIE DRIVE HOPKINSVILLE, KY 42240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{P 000}	Initial Comments An On-site Revisit Survey was initiated and completed on 05/09/2024. Based on the Plan of Correction (PoC), the facility had achieved substantial compliance on 05/07/2024.	{P 000}		

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

Office of Insoector General
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA

PRINTED: 04/30/2024
FORM APPROVED

	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	101385	A. BUILDING: _____ B. WING _____	C 04/17/2024

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P 000	Initial Comments A Complaint Survey investigating KY42090, KY42188, and KY41903 was initiated on 04/10/2024 and concluded on 04/17/2024. There was no deficient practice identified with KY42090 and KY41903. Deficient practice was identifed with KY42188 and a deficiency was cited. On 04/05/2024 at 8:35 AM, Registered Nurse (RN) #1 could not locate Resident #7 during her morning medication pass. When Resident #7 was not found in the dining room, the charge nurse and care staff began looking inside the facility, when the housekeeper stated she had seen Resident #7 out in the parking lot. Resident #7 was found in the rear parking lot of a grocery store across the street. Resident #7 was secured by staff and an employee drove across the street to return the resident to the facility. Based on the above findings, it was determined the facility's failure to monitor Resident #7, presented an imminent danger and created substantial risk that death or serious physical harm to a resident would occur. A Type "A" Citation was issued on 04/19/2024.	P000		
P 185	902 KAR 20:036 4(1)(a)1-4 Section 4. Provision of Services (1) Basic health and health related services. (a) A PCH or SPCH shall provide basic health and health related services, including: 1. Supervision and monitoring of the resident to assure that the resident's health care needs are met;	P 185		

RECEIVED
MAY - 8 2024
CHFS Office of Inspector General
Division of Health Care - WB
Received by

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keri Garrett

TITLE: Executive Director

(X6) DATE: 05/07/24

Office of Insoector General

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P 185	Continued From page 1 2. Supervision of self-administration of medications; 3. Storage and control of medications; and 4. Arranging for therapeutic services ordered by the resident's health care practitioner, if the services are not available in the facility. This requirement is not met as evidenced by: Based on observation, interview, record review and review of facility policy, it was determined the facility failed to provide supervision to prevent elopement for one (1) of fourteen sampled residents (Resident #7). On 04/05/2024 at 8:35 AM, Registered Nurse (RN) #1 could not locate Resident #7 during her morning medication pass. When Resident #7 was not found in the dining room, the charge nurse and care staff began looking inside the facility, when the housekeeper stated she had seen Resident #7 outside in the parking lot. Resident #7 was found in the rear parking lot of a grocery store across the street from the facility. Resident #7 was secured by staff and an employee returned the resident to the facility. Based on the above findings, it was determined the facility's failure to monitor Resident #7, presented an imminent danger and created	P 185	1. Resident # 7 was located in the Kroger parking lot adjacent to Charter Senior Living and driven back to the community. Resident#7 was immediately assessed for any injury or medical distress by Charter Senior Living staff. Resident #7 was sent to the ER for further assessment. Resident #7 was cleared medically and sent from JSMC ER to Murray Calloway Co Hospital Behavioral Health for assessment secondary to changes in cognitive status. Resident #7 was admitted to behavioral health on 04/05/24 and returned to Charter Senior Living on 04/22/24.	

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P 185	Continued From page 2 substantial risk that death or serious physical harm to a resident would occur. A Type "A" Citation was issued on 04/19/2024. The findings include: Review of the facility's policy titled, "Elopement/Unsupervised Absence-(Personal Care Home), revised 12/2021, revealed the purpose of the policy and procedure was to provide an overview of the process for an elopement or unsupervised absence and to establish guidelines to safeguard residents who were at risk for elopement. Elopement occurs when a resident has the potential for or may experience a serious injury, needs supervision due to increased confusion or cognitive impairment. Elopement also occurs when the resident does not have permission to leave a secured area unaccompanied or is identified as a risk. The Procedure outlining when a wandering and elopement risk review would be performed on all residents at the following intervals: Upon move-in, Quarterly and if there was a change of condition, when there were changes in the physical or cognitive status that may lead to elopement and possible serious injury. Record review revealed Resident #7 was admitted to the facility on 03/04/2024 with the diagnoses which included Dementia. Review of the Facility Investigation dated 04/05/2024, revealed that at 8:50 AM, Resident #7 was observed ambulating with a cane in the parking lot behind the local grocery store which was adjacent to the facility. When staff secured the resident he was assessed and no injuries, medical distress or harm were noted. Resident #7 was confused and looking for his truck.	P 185	2. Resident #7 returned to Charter Senior Living on 04/22/24 from Behavioral Health. Resident #7 was admitted to the secured Memory Care Unit upon return. Resident #7 was formally residing on the Personal Care side before the elopement incident. Resident #7 was placed on 15 min checks for 24 hours following return, then 30 min checks for 24 hours, and one hour checks for 24 hours to allow staff to monitor behaviors and ensure resident was adjusting well. An individualized care plan was developed. A door chime was placed on resident #7 door to alert staff of resident entering and exiting the room. A behavioral huddle was completed with the interdisciplinary care team to implement purposeful activity and engagement opportunities for resident #7 to help with transition and adjustment to the Memory Care Unit. 3. All residents receive an elopement assessment and MMSE at admission to Charter Senior Living and quarterly thereafter. Elopement education including policy and procedure is completed with all staff at hire as well as annually.	

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P 185	Continued From page 3 Registered Nurse (RN) #1 had been looking for the resident during her morning medication pass and realized she could not the resident. A housekeeper told RN #1 she had seen the resident earlier in the parking lot. Staff headed out the door to walk around the building. A member of the therapy department revealed she had seen the resident in the parking lot earlier. When Resident #7 was located by facility staff, he was driven back the facility with a staff member. The residents daughter was called and she wanted the resident sent to the local hospital for evaluation. The physician was notified as was Emergency Medical Services (EMS) to transport the resident to the hospital. EMS arrived to the facility at 9:15 AM and transported the resident to a local Emergency Room. Resident #7's daughter agreed to have the resident sent to a Behavioral Unit where he was admitted for a Psychiatric Evaluation. A review of the Elopement Risk Assessment, dated 03/04/2024, revealed the resident received a score of six (6) on the assessment. In an interview with Caregiver #1, on 04/13/2024 at 12:13 PM, she stated Resident #7 was sitting at breakfast having a cup of coffee at 8:30 AM on the morning he eloped. She did not note the resident being anxious or acting like he was wanting to leave. Caregiver #1 stated Resident #7 used a cane and stated he coutd be confused at times. She stated that around 8:40 AM, RN #1 asked her if she had seen Resident #7 and at this time all staff were looking for him. Everyone in the area then started looking for the resident. Caregiver #1 stated a staff member had noticed the resident across the road in the grocery store parking lot. The caregiver went back inside when someone was with the resident.	P 185	3. continued Elopement drills are conducted per policy and as warranted. A collaborative care meeting was held with Dr. E Toms on 04/30/24 to implement an improved communication process with Charter Senior Living facility regarding resident concerns, changes in condition, and any other pertinent medical information needed to provide care in a was sent to all current residents and families requesting medical records following appointments, changes in medications, and notification of any procedures/test performed to ensure all changes in condition are being monitored as warranted. Any resident who is diagnosed with dementia or newly admitted with a dementia diagnosis to the PC side will have increased monitoring put in place per HWD direction including but not limited to an assessment for the Memory Care Unit. Any resident with a history of wandering or new development of wandering/exit seeking behaviors will be assessed for the Memory Care Unit as warranted following medical clearance.	

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P 185	Continued From page 4 In an interview with the Health and Wellness Director, on 04/16/2024 at 11:01 AM, she stated when Resident #7 was admitted, he arrived via private vehicle with family. On admission the resident was alert, oriented. She stated the day before the resident eloped he was confused, and did not plan to stay at the facility long term. The Health and Wellness Director stated when the resident returned to the facility he would be placed on the memory care unit. She stated that residents on the personal care unit have the ability to come and go as they please after signing out at the concierge desk. In an interview with the Executive Director (ED), on 04/15/2024 at 3:24 PM, she stated that residents on the personal care unit come and go out of the facility as they please. Residents were supposed to sign out at the concierge desk before leaving and when returning. She further stated an Elopement Risk Assessment was completed for all new admissions. In an interview with Resident #1's daughter, on 04/17/2024 at 9:52 AM, she stated the resident had been diagnosed with mild cognitive impairment and Dementia in 2022. She stated the resident would be out driving and get lost. On 02/11/2024, the resident left home enroute to church and went the wrong way and ended up in a neighboring town. Resident #1's daughter revealed the resident had called her phone forty-six (46) times in one day but she was at work and couldn't answer all of the cans. She stated she thought the resident should have been on the memory care unit and getting medications. In an interview with the facility Physician, on 04/17/2024 at 11:41 AM, she stated she last saw	P 185	Continued- All of the above interventions were fully implemented and in place by date submission of POC on 05-07-24.	

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P 185	Continued From page 5 Resident #7 on 04/02/2024 at the facility. She stated she knew he had Dementia and wanted to go home. While she was there seeing residents, Resident #7 was seen pushing on a door to exit the building. The Physician stated a staff member was nearby and redirected the resident to a safe area. She further stated she had talked with the resident's daughter about her concerns and the consideration of placing the resident on the memory care unit.	P 185		