STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185012	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Nursing and Rehabilitation Center	1500 Pride Avenue Madisonville, KY 42431

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567 Based on observation, interview, record review, document review, and facility policy review, it was determined the facility failed to ensure residents' comprehensive care plans were developed and implemented for three (3) of eight (8) sampled residents assessed for elopement risk (Residents #13, #40, #52, #53). 1. The facility assessed Resident #13 to be at risk for elopement and was care planned as at risk for elopement and exhibited exit-seeking behavior. However, the resident exited the facility undetected by staff on 03/14/2024 at approximately 4:10 PM and was outside unsupervised for approximately five (5) minutes. 2. Resident #40 stated in interview she had carpal tunnel syndrome in both hands. However, review of Resident #40's care plan revealed the facility failed to develop a care plan related to pain or the potential for pain, with necessary interventions for the resident. 3. The facility failed to develop a care plan for Resident #52 for his activity preferences. 4. The facility failed to develop a care plan for Resident #53's psychotropic medication use. The facility's failure to ensure residents' care plans were developed and interventions implemented to include ensuring residents received adequate supervision and monitoring to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 03/29/2024 and was determined to exist on 03/14/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F 689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the Immediate Jeopardy on 03/29/2024. The facility provided an acceptable Immediate Jeopardy Removal Plan on 04/05/2024 alleging removal of the IJ on 03/24/2024. An Extended Survey was initiated on 04/02/2024, and the State Survey Agency (SSA) validated the facility had removed the immediacy of the Jeopardy on 03/24/2024, as alleged. Refer to F689. The findings include: (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Hillside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Pride Avenue Madisonville, KY 42431	

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Care Plans, Comprehensive and Person-Centered, revised 03/01/2022, revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was to be developed and implemented for each resident. The policy also stated assessments of residents were ongoing and care plans were to be revised as information about the resident and the resident's condition changed. Further review revealed when possible, interventions should address the underlying sources of the problem areas not just the symptoms or triggers. 1. Review of the facility's policy titled, Safety and Supervision of Residents, revised 07/01/2017, revealed the facility strived to make the environment as free from accident hazards as possible. Per review of the policy, the care team was to target (residents') interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Review further revealed implementing interventions to reduce accidents and hazards was to include communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions (to appropriate staff); providing training as necessary; and ensuring interventions were implemented, documented, and monitored. Review of the facility's policy titled, Wandering and Elopements, revised 03/01/2019, revealed the facility was to identify residents who were at risk of unsafe wandering and to strive to prevent harm while maintaining the least restrictive environment for residents. Further review revealed if a resident was identified as at risk for wandering, elopement, or other safety issues, the resident's care plan was to include strategies and interventions to maintain the resident's safety. Record review revealed the facility admitted Resident #13 on 04/14/2023, with diagnoses which included dementia, anxiety disorder, and Alzheimer's Disease. Review of Resident #13's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) which indicated he/she was rarely or never understood. The interview was not conducted. Review of Resident #13's Elopement Assessment Risk dated 11/17/2023, revealed the facility assessed him/her as being at risk for elopement related to the resident's ability to self-propel in a wheelchair; agitation, restlessness, impulsiveness, and having a history of elopement and wandering. Review of Resident #13's Treatment Administration Record (TAR), revealed the resident's Wanderguard bracelet was to be checked twice a day; once on day shift and once on night shift. Continued review of the TAR revealed Resident #13's Wanderguard bracelet was last checked for placement on 03/13/2024 by the dayshift nurse, and noted as in place. Review of Resident #13's Comprehensive Care Plan (CCP) revised on 02/01/2024, revealed the facility care planned the resident as at risk for elopement related to Alzheimer's Disease, dementia, psychosis, and exit-seeking behavior. Per review, the interventions included redirecting Resident #13 as appropriate if near an exit or doorways, and diverting him/her by giving alternative objects or activities. Continued review revealed the interventions also included utilizing and monitoring a security bracelet as per facility protocol. Further review revealed no documented evidence the facility care planned Resident #13 for increased supervision (even though the facility assessed the resident to be at risk for elopement on 11/17/2023). (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's investigation documentation dated 03/19/2024 revealed at approximately 4:10 PM on 03/14/2024, Resident #13 eloped from the facility through the exit door on the 400 Hall without staff's knowledge. Review further revealed Resident #13 was located outside near the exit door on the 100 Hall and brought back into the facility by two (2) staff members. In an interview on 04/02/2024 at 11:26 AM, LPN #3 stated she worked day shift on 03/13/2024, Resident #13 had a Wanderguard bracelet in place to his/her left ankle and to the best of her knowledge it had not came off during the time she was working her shift. She stated she checked Resident #13's Wanderguard for placement that day, which she documented. Review of Resident #13's TAR revealed LPN #3 documented the Wanderguard was in place to Resident #13's left ankle as per interview. She further stated if a resident was found not to be wearing a Wanderguard bracelet as they were care planned for, she would replace the bracelet immediately, and check it's function. In an interview on 04/03/2024 at 3:10 PM, LPN # 4 stated he worked the night of 03/13/2024 on the 400 Hall; however, he could not recall if Resident #13 had a Wanderguard bracelet in place or not. He stated he also could not recall what he documented on Resident #13's TAR that day regarding his/her Wanderguard placement. The LPN stated he was not sure who was responsible for updating a resident's care plan. LPN #4 stated he had not thought Resident #13 would elope. He further stated if he found a resident without a Wanderguard bracelet in place as per their care plan, he would immediately notify the Director of Nursing (DON) and place a new Wanderguard bracelet on the resident. In an interview on 04/05/2024 at 11:55 AM, LPN #1 stated she had not received report that Resident #13 did not have a Wanderguard bracelet on from the nightshift nurse in report on the morning of 03/14/2024. She stated when Resident #13 was found after eloping and brought back to the unit he/she was noted to not have a Wanderguard device in place as care planned. LPN #1 stated someone put a Wanderguard bracelet on Resident #13 after the elopement; however, she could not recall who that person had been. She further stated day shift checked the placement of the Wanderguard devices and she could not recall if she had checked Resident #13 for Wanderguard placement before he/she eloped that day. In an additional interview on 04/05/2024 at 5:40 PM, LPN #1 stated she had provided increased supervision of Resident #13 on 03/14/2024, because of the resident's potential risk for falls, not due to the elopement. She stated she received no education in regards to developing residents' care plans with additional interventions which might be necessary. LPN #1 stated the MDS Nurse updated residents' care plans; however, she knew how to update them in the residents' electronic medical record (EMR). In an interview on 04/05/2024 at 6:36 PM, the Assistant Director of Nursing (ADON) stated she expected staff to follow each resident's care plan and if they saw something a resident needed, all they had to do was just add the necessary interventions. The ADON further stated that was something any licensed nurse at the facility could do, as the MDS Nurse worked remotely and was only at the facility two (2) days a week. She stated Resident #13 never gave any indication she would actually elope so she had not felt the need to update the resident's care plan with interventions that included increased supervision. The ADON stated there was no reason for nightshift not to have checked the function and placement of a resident's Wanderguard bracelet unless the resident was not physically in the building. She further stated the potential for harm for a resident was that they would get out of the building if their Wanderguard bracelet was not working properly or was not in place. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/05/2024 at 7:30 PM, the DON stated there was no logical explanation as to why staff would not follow a resident's care plan and check the placement and function of the Wanderguard bracelet as required. In an interview on 04/05/2024 at 8:15 PM, the Administrator stated she expected residents' care plans to be updated and interventions followed according to the facility's policy. She further stated staff should follow residents' care plans as written and she expected the MDS Nurse to code the residents' MDS assessments correctly because that was what drives the care plans. 44370 2. Review of the Admission Record for Resident #40 revealed the facility admitted the resident on 12/15/2023, with the following diagnoses: spina bifida, carpal tunnel syndrome bilateral upper limbs, and type 2 diabetes mellitus. Review of the Admission MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS' score of fifteen (15) out of fifteen (15) indicating no cognitive impairment. Review of Resident #40's Comprehensive Care Plan revealed no documented evidence the facility developed a focus problem related to pain or the potential for pain, with necessary interventions. In an interview on 04/03/2024 at 11:21 AM, Resident #40 stated she had been at the facility since December (2023). The resident stated she had been admitted to the facility from another long term care facility. She stated she wore splints when her hands hurt. Resident #40 stated she had pain medication ordered but had not used any since being at the facility. During interview on 04/05/2024 at 7:34 PM, the DON stated she expected the MDS Nurse to catch if a baseline care plan was not initiated on admission and make the necessary changes. She stated she expected all residents to have a care plan initiated for potential for pain even if they had no current issues with pain. The DON further stated her expectation was for the MDS Nurse to complete residents' comprehensive care plans in order to prevent potential problems from occurring. 47798 3. Review of Resident #52's Admission Record revealed the facility admitted the resident on 08/21/2023, with diagnoses to include: myelodysplastic syndrome, major depressive disorder, recurrent, severe with psychotic symptoms, and chronic obstructive pulmonary disease (COPD). Review of the Quarterly MDS Assessment, dated 02/13/2024, revealed the facility assessed Resident #52 to have a BIMS' score of a fifteen (15) out of fifteen (15) indicating the resident was cognitively intact and interviewable. Continued record review revealed no documented evidence the facility developed Resident #52's care plan to include activities or the resident's preferences. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Resident #52 on 04/03/2024 at 10:27 AM, he stated he did activities in his room most of the time. Resident #52 stated staff did not permit him to go outside and sit in the sun; however, he did not know why. He stated they did not let anyone go outside, which made him feel non-human and like he was just a piece of livestock. During an interview with State Registered Nurse Aide (SRNA) #3 on 04/05/2024 at 4:13 PM, she stated Resident #52 had asked to go outside before; however, had been stopped from doing so by the former Administrator. She stated she had never observed Resident #52 outside the facility. During an interview on 04/05/2024 at 10:03 AM, the Activities Director (AD) stated she was responsible for developing residents' activities/preferences care plans. The AD stated she was not sure why she had not developed Resident #52's care plan to include the resident's preferences related to activities. During an interview on 04/05/2024 at 7:30 PM, the DON stated she expected Activities to follow up with residents to find out what type of activities they enjoyed and to develop the residents' activities/preferences care plan. The DON stated if a care plan was not developed, staff would not know what a resident's activity preferences were unless they asked the resident. 4. Review of the Admission Record for Resident #53 revealed the facility admitted the resident on 01/10/2024, with diagnoses to include: acute or chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD), and respiratory disorders. Review of the Significant Change MDS Assessment, dated 02/13/2024, revealed the facility assessed Resident #53 to have a BIMS' score of seven (7) out of fifteen (15) indicating the resident was severely cognitively impaired. Continued record review revealed no documented evidence Resident #53's care plan was developed and initiated regarding the resident's psychotropic medications. Review of Resident #53's Physician's Orders revealed the resident was on Clonazepam (a sedative medication) 1 milligram (mg) 3 times a day. During an interview with LPN #1 on 04/05/2024 at 5:39 PM, she stated the admitting nurse should have initiated Resident #53's baseline care plan to include use of a psychotropic medication. LPN #1 further stated the purpose of a resident's care plan was for staff to know how to provide the care a resident needed. During an interview with LPN #7 on 04/05/2024 at 5:56 PM, she stated a baseline care plan was to be initiated upon admission by any nurse. LPN #7 stated she would discuss comprehensive care plans development with the DON. She stated if the care plan was not developed, staff would not know how to provide the proper care for a resident. During an interview with the Assistant Director of Nursing (ADON) on 04/05/2024 at 6:36 PM, she stated staff were expected to follow resident's care plans and if they saw that a necessary care plan was not in place, they should correct the problem. The ADON stated any licensed nurse could initiate a care plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During continued interview on 04/05/2024 at 7:30 PM, the DON (who had previously been an MDS Nurse) stated if a necessary care plan was not initiated during a resident's comprehensive assessment (MDS Assessment) she expected the MDS Nurse to catch that and make the necessary changes. The DON stated the admitting nurse was to initiate a baseline care plan for new residents and the MDS Nurse should initiate the Comprehensive Care Plan based on the MDS Assessment findings. She stated she expected the MDS Nurse to complete residents' comprehensive care plans to prevent potential problems from occurring. She stated her expectations were for her staff to follow residents' care plans and carry out the interventions because that was what the care plans were for, to provide direction of care of the resident. During an interview with the Administrator on 04/05/2024 at 8:16 PM, she stated if a care plan was not developed, staff would not know what a resident's care needs were. The Administrator stated she expected staff to develop residents' care plan based on their assessed needs.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567 Based on observation, interview, record review, facility document and policy review, it was determined the facility failed to provide effective monitoring and supervision to prevent elopement for one (1) of eight (8) sampled residents assessed for elopement risk (Resident #13), out of the total resident sample of twenty-five (25). The facility assessed Resident #13 as at risk for elopement and care planned him/her for the elopement risk, Interventions included utilizing and monitoring a security bracelet for Resident #13 as per protocol. However, on 03/14/2024, facility staff failed to follow the resident's interventions, and allowed Resident #13, whose mobility was per wheelchair, to exit the facility without staffs' knowledge at approximately 4:10 PM. Resident #13 was located unsupervised outside the facility approximately five (5) minutes later. The facility's failure to have an effective system in place to ensure each resident received adequate supervision and monitoring to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 03/29/2024 and was determined to exist on 03/14/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F 689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the Immediate Jeopardy on 03/29/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 04/05/2024, alleging removal of the IJ on 03/24/2024. An Extended Survey was initiated on 04/05/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 04/05/2024. The SSA valiadted the immediacy of the IJ had been removed on 03/24/2024, as alleged. The findings include: Review of the facility's policy titled, Safety and Supervision of Residents, revised 07/01/2017, revealed the facility was to strive to make the (residents') environment as free from accident hazards as possible which was a facility-wide priority. Continued review revealed the safety risks and environmental hazards were to be identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Further review revealed the safety risks and environmental hazards were also to be identified on an ongoing basis through the Quality Assurance and Performance Improvement (QAPI) reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization. Continued review revealed resident supervision was a core component of the facility's systems approach to safety, and the type and frequency of resident supervision was determined by each resident's assessed needs and was to be increased when there were temporary hazards in the environment, (i.e.,construction) or, if there was a change in the resident's condition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, Wandering and Elopements, revised 03/01/2019, revealed the facility was to identify residents who were at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for those residents. Continued review revealed if a resident was identified as at risk for wandering, elopement, or other safety issues, the resident's care plan was to include strategies and interventions to maintain the resident's safety. The policy also noted if a resident was missing, the facility was to initiate the elopement/missing resident emergency procedure and upon returning to the facility, the resident was to be examined for injuries by the Director of Nursing Services (DNS) or charge nurse. Staff were to notify the attending physician and report the findings and condition of the resident; notify the resident's legal representative; notify search teams that the resident had been located; complete and file an incident report; and document relevant information in the resident's medical record. Review of the facility's policy titled, Accidents and Incidents-Investigating and Reporting, revised 07/01/2017, revealed all accidents and/or incidents involving residents .occurring on facility premises were to be investigated and reported to the Administrator. Further review of the policy revealed incident and accident reports were to be reviewed by the facility's safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. Review of the facility's Elopement Binder revealed eight (8) residents listed who were noted to be at risk for elopement. 1. Record review revealed the facility admitted Resident #13 on 04/14/2023, with diagnoses to include Alzheimer's Disease, Unspecified Dementia, and Anxiety Disorder. Review of Resident #13's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed Resident #13 to have a Brief Interview for Mental Status (BIMS) score of ninety-nine (99) indicating the interview was not conducted as she was rarely or never understood. Further review of the MDS Assessment revealed the facility assessed Resident #13 to require a wheelchair for mobility. Review of Resident #13's Elopement Assessment Risk dated 11/17/2023, revealed the facility assessed the resident as being at risk for elopement based on her ability to self-propel in a wheelchair; restlessness and agitation, impulsiveness; and history of elopement and wandering. Review of the facility's investigation dated 03/19/2024, revealed on 03/14/2024 at approximately 4:10 PM, Resident #13 eloped out the facility from the exit door on the 400 Hall. Continued review revealed Resident #13 was located near the exit door on the 100 Hall and brought back in by two (2) staff members. Review of the Internet weather history for 03/14/2024 at 4:10 PM for the facility's location, revealed it had been cloudy and the temperature was 77 degrees Fahrenheit (F). 2. Record review revealed the facility admitted Resident #1 on 06/07/2023, with diagnoses to include COVID-19, Cognitive Communication Deficit, and Open Wound to Right Lower Leg. Review of Resident #1's Quarterly MDS assessment dated [DATE], revealed the facility assessed Resident #1 to have a BIMS score of fifteen (15) out of fifteen (15), indicating no cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Resident #1 on 03/27/2024 at 5:32 PM, the resident stated she had been sitting in her wheelchair at the 100 Hall Nurse's Station on 03/14/2024, and just happened to turn around and saw Resident #13 standing outside through the exit door on 100 Hall. Resident #1 stated Resident #13 was not standing on the porch but had been out in the parking lot very close to the porch. The resident stated she said out loud, Hey that looks like Resident #13 outside, and someone said, no it could not be Resident #13. Resident #1 stated she replied, Yes that is Resident #13 I know him/her. Resident #1 further stated State Registered Nurse Aide (SRNA) #6 went outside at that time and brought Resident #13 back inside the facility. In addition, Resident #1 stated she asked Resident #13 later if she had gotten outside, and all Resident #13 said to her was Yep. In an interview on 04/05/2024 at 12:15 PM, Resident #13's Family Member (FM) stated he was notified of the resident's elopement that day (03/14/2024) by a facility nurse. The FM stated when Resident #13 lived at home with him the resident would frequently elope and on occasion had been found by the neighbors, walking down the street. The neighbors brought her back home. Resident #13's FM further he guessed the resident must have wanted to get outside and get some fresh air the day she eloped. In an interview with Licensed Practical Nurse (LPN) #1 on 03/27/2024 at 11:48 AM, she stated she had only been employed at the facility for approximately thirty (30) days and had been the nurse responsible for Resident #13 on the day she eloped from the facility (03/14/2024). LPN #1 stated she had been providing increased supervision of Resident #13 for her safety because she had been up and down out of her wheelchair all day that day. The LPN stated she had to frequently stop and redirect her back into her wheelchair because she kept standing up. She stated Resident #13 had to be given cues constantly and her behavior could be difficult to manage as she was often non-compliant with taking her medications. In continued interview on 03/27/2024 at 11:48 AM, LPN #1 stated the last time she saw Resident #13 on 03/14/2024, had been around 3:40 PM-3:45 PM, when she had been trying to walk holding onto the nurse's station desk. The LPN stated she immediately engaged Resident #13 at that time and had her sit back down into her wheelchair. She said Resident #13 was sitting right in front of her at the nurse's desk at that time. LPN #1 stated around that time she got a new admission and had been finishing up the paperwork and medications for that resident, when she heard someone say, Where is (Resident #13)? She stated she looked up and saw that Resident #13 was no longer sitting in her wheelchair in front of the desk. She had staff start doing room to room searches and conducted a head count on all residents on the 400 Hall. LPN #1 stated she heard someone state that Resident #13 had been found, (she thought it was SRNA's from the 100 Hall) as they brought the resident back to the unit. She stated Resident #13 was placed on increased supervision at that time, and given a snack to distract her. LPN #1 stated she did not recall the exit door alarm going off and could not recall if Resident #13 was actually wearing her wanderguard bracelet (a device to alert staff when a resident was near an exit door) or not. She stated when a resident eloped they called a Code Golden and the elopement binders were located at each nurse's station and at the receptionist desk for staff to review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Nursing and Rehabilitation Center	1500 Pride Avenue Madisonville, KY 42431

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with SRNA #5 on 03/27/2024 at 2:32 PM, she stated she had been in a room on 03/14/2024 providing resident care when SRNA #6 came and asked her to help get a resident back inside the facility. She stated as she exited the room, she looked down the hallway and saw Resident #13 standing outside the facility on the patio by the 100 Hall holding the hand of Resident #33's family. SRNA #5 stated Resident #13 had not said anything, and did not appear to be in any distress, and was at her baseline behavior when located. She stated the weather had been warm outside that day. She stated Resident #13 had been wearing a new pants and top outfit she had received for her birthday. SRNA #5 stated she did not think Resident #13's wanderguard bracelet had been working at the time she got out. She stated she did not recall it alarming when she brought the resident back into the facility. The SRNA stated she notified the Director of Nursing (DON) and Administrator that Resident #13 had eloped and she left shortly after that as it was the end of her shift. She stated she wrote a witness statement and had performed a head count of residents on the 100, 200, and 300 Halls before she left the facility that day. She stated they had an all staff meeting the next day, did inservices and took a post test with the DON and Administrator. In an interview with SRNA #6 on 03/27/2024 at 3:05 PM, she stated around 3:30 PM-4:00 PM on 03/14/2024 she had been walking down the 100 Hall when she saw Resident #13 standing by the door outside. She stated she yelled for SRNA #5 to come and help her get Resident #13 back into the facility. SRNA #6 stated when they got outside, Resident #13 was standing outside with some of Resident #33's family, and she had SRNA #5 stay with the resident while she went back inside and grabbed a wheelchair for the resident. She stated she and SRNA #5 assisted Resident #13 to sit in the wheelchair and took the resident to the 400 Hall, and told LPN #1 the resident had been found outside. SRNA #6 further stated Resident #13 did not have a wanderguard bracelet on at the time she eloped, and the door alarm did not go off when they brought the resident back in. She additionally stated she received education and inservices on elopement from the DON after that, and had taken a post test. In an interview with the Maintenance Director on 03/26/2024 at 3:19 PM, he stated the exit door on the 400 Hall was either partially open or had not closed all the way on the day of Resident #13's elopement (03/14/2024). He stated he had been notified by staff that day, and had made repairs to the door immediately. He stated he checked the door alarms on the days that he worked and did not check the alarms on the weekends unless he got called in to fix something else. The Maintenance Director stated the door checks were logged after being completed. However, review of the door check logs revealed there were days with no documented evidence the checks were completed. He stated he was not sure who all had access to the door codes prior to Resident #13's elopement. The Maintenance Director further stated that since the elopement he had been checking the doors daily and logging the checks in the log book. He stated the security codes on the door were changed monthly and the code was only given to facility staff members. He stated a stop alarm was placed at the 400 Hall exit door, after the resident's elopement, to ensure the alarm was heard clearly by all staff in case they were not in close proximity to the door. In an interview with the Regional Director of Operations on 03/29/2024 at 1:30 PM, she stated the door alarms were checked everyday including on weekends. She stated if maintenance was not at the facility on weekends they were checked by the manager on duty for that weekend. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Assistant Director of Nursing (ADON) on 04/05/2024 at 6:36 PM, she stated she left the facility and came back later that night to relieve the DON because they were covering a call-in on the 400 Hall. She stated Resident #13 never gave them any indication she would attempt to elope from the facility, so there was no need to increase her supervision. The ADON stated she had not been aware that the exit door on the 400 Hall was having issues. The ADON further stated before Resident #13's elopement she would take each resident who had a wanderguard bracelet in place close to the exit door and see if it would alarm. She stated she checked wanderguard bracelets on residents, during her shift after Resident #13's elopement, for placement and function, and received education and took a post test from the DON as well. In an interview with the DON on 04/05/2024 at 7:30 PM, she stated she had been informed of Resident #13's elopement by SRNA #5. She stated she immediately went to the 400 Hall and assessed the resident to have no injuries. The DON stated she had not been aware of any issues with the 400 Hall exit door prior to the resident's elopement, and was not aware of any malfunction of the door the day the resident eloped. She stated she suspected someone went out the exit door on the 400 Hall and the door had not closed back all the way, and Resident #13 slipped out the door behind them. The DON stated the door was locked back after Resident #13's elopement, and maintenance put up a stop alarm at that exit. She stated Resident #13 was placed on 1:1 observation after the elopement because she had been the nurse who provided the supervision until the ADON came in and took over the shift from her. She stated night shift nursing staff were to check the wanderguards for placement and function daily. (However, review of the door checks documentation revealed some daily checks had been missed which included the night before and day of Resident #13's elopement). The DON stated she participated in head counts of residents, provided education to staff and gave post tests, attended Ad Hoc meetings after the incident, placed signs at all the exit doors, and also educated the agency staff as well. In an interview with the Administrator on 04/05/2024 at 8:15 PM, she stated she was notified of Resident #13's elopement on 03/14/2024 at approximately 4:22 PM, by facility staff. She stated she initiated an investigation at that time, and notified the facility's Medical Director of the event. The Administrator stated she had not been aware of any issues with the exit door on the 400 Hall. She stated her expectations were for staff to ensure residents were safe and accounted for. She stated nightshift was responsible for ensuring the wanderguard bracelets were checked to ensure they were in place and working. The Administrator stated the exit doors were being checked daily by maintenance prior to Resident #13's elopement. She further stated the first Ad Hoc Meeting had been held on 03/21/2024, during which the elopement incident was discussed along with other triggers of the facility.