STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185127	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Centre for Health & Rehabilitation	642 North Third Street Danville, KY 40422

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** 45113 Based on interview, record review, and facility document and policy review, it was determined the facility failed to ensure the comprehensive care plan for one (Resident (R) 2) of 14 sampled residents was implemented. R2 was assessed upon admission to be at risk for elopement and was care planned with the goal of not leaving the facility without staff supervision. On [DATE], R2 eloped from the facility without staff knowledge when the resident's care planned wander guard (door alarm system used to alert staff of resident's attempts to leave the facility) was not functioning and staff failed to provide additional monitoring, supervision, and/or interventions to prevent the resident from exiting the facility. The facility's failure to ensure the implementation of resident-centered care plans, with interventions to ensure adequate supervision and monitoring to prevent elopement, constituted Immediate Jeopardy (IJ), which is likely to cause serious injury, harm, impairment, or death to a resident. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, effective on [DATE], revised [DATE], and in effect at the time of the [DATE] elopement, 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. Further review of the policy revealed each resident's comprehensive care plan designed to incorporate identified problem areas, risk factors associated with identified problems and the care plan to be revised as necessary with resident changes. Review of the facility's policy, Elopement, effective [DATE], revised [DATE], and in effect at the time of the , d+[DATE] elopement, revealed the policy intended to ensure resident safety and protect their rights and dignity. Staff were required to evaluate residents on admission for elopement risk, displaying exit-seeking behaviors, and preventative interventions were required to be implemented for those residents identified as an elopement risk. These interventions were to be reevaluated as needed. The policy defined Elopement as any situation where a resident left the premises or a safe area without the facility's knowledge and supervision. Per this policy, a care plan would be developed and implemented with interventions for each resident identified as an elopement risk. Routine checks of entrance and exit doors were required to be completed to ensure proper functioning. (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: 185127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
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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	Closed record review of R2's Resident Face Sheet revealed the facility admitted R2 on [DATE], and R2 expired on [DATE]. The resident's diagnoses included vascular dementia with behavioral, psychotic, and mood disturbances, depression, anxiety disorder, loss of cognitive functions and awareness, difficulty in walking, abnormalities of gait and mobility with repeated falls, lack of coordination, muscle wasting and atrophy. Review of an Elopement Risk Evaluation dated [DATE], as well as an Exit-Seeking/Elopement Observation, dated [DATE], revealed the resident was at risk for elopement based on factors including cognitive impairment, poor safety awareness, self-ambulation ability, history of exit-seeking behavior, ability to exit the facility, statements that she was leaving or questioning the need to stay, behaviors that indicated an attempt to leave the facility, and/or body language indicating an elopement may be forthcoming. Review of R2's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed R2 with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE], which indicated severe cognitive impairment. Per the MDS, R2 had wandering behaviors, and required staff supervision with transfers and mobility related to R2 not being steady with balance and during transitions. Review of R2's current physician orders for ,d+[DATE] revealed that the resident had an order, initiated [DATE], for a wander guard (security bracelet) to the left ankle, check placement, and function daily. Review of R2's Comprehensive Care Plan, initiated on [DATE], revealed the facility care planned R2 to be at risk for elopement related to wandering and exit seeking behaviors which included statements of going home at times, and poor safety awareness due to dementia. The goal of the care plan was the resident would not leave the facility and would be monitored as to her whereabouts throughout each shift. Interventions included the physician-ordered wander guard that was placed to R2's left ankle to prevent the resident from leaving the facility without staff supervision. Additional elopement risk interventions were updated on [DATE], for staff to utilize diversional activities when the resident was exhibiting exit seeking behavior to include drinking Pepsi, having snacks, playing cards or poker, and exercising. Review of an undated Elopement Investigation, revealed that on [DATE], R2, who resided on a locked unit, eloped from the facility without staff knowledge. (Refer to F689.) Although the resident's wander guard was in place per the care plan, the alarm system was shut down/not functioning while a sprinkler company was in the facility for yearly testing. Staff were unaware/not monitoring the whereabouts of R2 from approximately 3:00 PM, when she was last seen by Kentucky Medication Aide (KMA) 1, until R2 was found by a person driving by the facility, who saw the resident trip and fall along the grassy area in front of the parking lot, called 911 at 3:33 PM, and got out of their vehicle to check on the resident. At that time, another resident's family member (FM1) alerted staff that R2 was in front of the facility. After preliminary assessment R2 was transferred to the emergency room (ER) for evaluation and returned from the hospital with no injuries noted. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the investigation found that when R2 exited the locked unit without supervision, she traveled approximately 120 feet from the exit door before she tripped and fell in the grassy area. The investigation determined that R2 exited the facility during an annual inspection of the sprinkler system when the fire monitoring system was interrupted and unlocked the exit doors on the gated community (locked unit). The investigation found that staff did not realize the exit doors would not alarm/were silenced when the sprinkler system was tested , and as a result, the resident could exit the facility without staff knowledge. In an interview with the Plant Operations Director (POD) on [DATE] at 10:49 AM, he stated that once he and the other staff realized R2 had exited the door on the locked unit, they knew immediately that no one had been monitoring or watching that door during the time that the wander guard system was not functioning during the inspection of the sprinkler system. Interview with KMA7 on [DATE] at 10:29 AM, revealed R2 was mobile and assessed as a wanderer with exit-seeking behaviors, so R2 was placed on the locked unit with a wander guard alarm system to prevent elopement. KMA7 stated that she worked on the locked-down unit the day R2 eloped from the facility, and that while Certified Nursing Assistant (CNA) 8 was at lunch, she was the only direct care staff on the unit. KMA7 related that she and the rest of the facility staff were unaware that R2 wandered out of the building unsupervised and got to the main roadway until after the resident was found. KMA7 stated that at the time of elopement, she was responsible for the safety and supervision of up to 18 residents and while working by herself, she had tried to gather all the mobile residents and those already up in their wheelchairs into the dayroom to monitor and supervise them. KMA7 stated she was unaware that the care plan called for diversional activities when R2 was exhibiting exit-seeking behaviors. KMA7 stated that she felt the elopement of R2 could have been prevented if the facility had prepared and planned to ensure adequate staff coverage to monitor all doors and units during the alarm shutdown. During an interview on [DATE], at 3:02 PM, Registered Nurse (RN) 1 stated there was supposed to be two staff members monitoring and supervising in the hallways to watch and make sure the residents could not get to the doors since the alarm system was not working. RN1 stated the elopement could have been prevented if staff had monitored R2 closer. Interview with MDS1 on [DATE] at 10:53 AM, revealed that R2's behaviors included walking up and down the halls of the locked-down unit, going room-to-room with signs of confusion/forgetfulness and statements of wanting to go home. MDS1 stated that it was crucial to ensure care plans were implemented for the wellbeing of the residents and their overall safety. MDS1 added that direct care staff needed to know the resident-specific interventions for each of the residents in the locked dementia unit where R2 resided, due to the challenges of their behaviors. In an interview on [DATE] at 12:00 PM, the current Director of Nursing (DON) and Administrator stated they both would expect staff to implement the care plan interventions as per policy and stated the facility has not encountered any resident elopements since R2's in 2023. The facility provided an acceptable plan for the removal of the IJ on [DATE]. This plan alleged the IJ was removed, and the deficient practice was corrected on [DATE], prior to the initiation of the investigation. The plan provided by the facility alleged the following: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.a) On [DATE], R2 was assessed for injury at the time of the incident (elopement) and assisted back into the facility with a wheelchair by the DON. Immediately following the elopement event, the DON completed a head-to-toe skin assessment for injury and harm evaluation, with old bruises noted from a previous fall to the left flank and to the back of left thigh, but no new injuries noted. The Administrator initiated a Code Green, the code for a missing resident, and a head count was performed per the Unit Managers on each unit. Resident 2's Physician and Family/Responsible Party were notified of the event per the DON and Administrator; R2 was sent to the Emergency Department (ED) for evaluation to rule out any injuries or change in condition on [DATE] and returned on [DATE] with no injuries, no change in condition, and no new orders. Upon return from the hospital, R2 had a complete head-to-toe skin assessment per the Regional Care Consultant and the DON with no new areas of concern. Following R2's return from the hospital on [DATE], she received 1:1 (one-to-one) supervision from facility staff for the next 72 hours. In addition, on [DATE], facility staff were assigned to monitor unlocked doors by the Administrator until the fire system and door locks resumed normal function. The care plan for R2 was also reviewed and updated by the Social Services Director (SSD) and MDS1 on [DATE]. Per the IJ validation, R2 had an elopement risk assessment on [DATE] and was at risk for elopement. An elopement risk assessment was repeated for R2 by the Unit Manager on [DATE] and R2 was noted at risk for elopement. 1.b.) Continued review and validation of the IJ revealed an elopement risk assessment was performed by a licensed nurse on [DATE], [DATE], [DATE], and [DATE] and R2 remained at risk for elopement until she expired on [DATE]. Continued review of the IJ validation revealed the facility had a census of 74 on [DATE], all residents had an elopement risk assessment completed by the Unit Manager and Medical Records Nurse; 16 residents were identified to be at risk for elopement. Additionally, the profile for R2 in the elopement binder was reviewed by the Social Services Director (SSD) and R2's Activity assessment was updated by the Activities Director (AD) on [DATE]. Following the events on [DATE], continued review of the facility's corrective actions taken for the identified resident (R2), that was affected by the facility's deficient practice revealed and validated that on [DATE], the SSD completed a BIMS assessment for R2 with a score of , d+[DATE] and a Patient Health Questionnaire-9 assessment, with both scores indicating severe cognitive impairment. Further validation revealed on [DATE], the [NAME] President of Operations (VPO) completed a root cause analysis via Fishbone Diagram, and a care plan meeting was held for R2 with the resident's family. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review and validation of the facility's IJ Removal plan revealed on [DATE], all residents had an elopement risk assessment completed by the Unit Manager and Medical Records Nurse; 16 residents were identified to be at risk for elopement and those residents had orders and their care plans reviewed by the DON, Signature Care Consultant (SCC) and/or SSD. On [DATE], upon system restoration, all doors were checked to ensure locks were functioning by the Plant Operations Assistant (POA). All residents in the gated community (locked unit) had a secure unit observation and residents with a wander guard bracelet had orders reviewed, placement of wander guard checked, and care plans were reviewed by the DON on [DATE]. In addition, all exit door codes were changed by the POD on [DATE], and Activity assessments were also updated for all residents on the Reflections Unit by the Activities Director on [DATE]. Following the events on [DATE], all elopement books were reviewed by the SSD on [DATE] to ensure resident profiles and pictures were updated and accurate and included all residents at risk for elopement. In addition, validation revealed that beginning [DATE] until [DATE], elopement drills and door checks were completed each shift by the POD, Unit Managers, Staff Development Coordinator (SDC), DON, Medical Records Nurse, MDS Coordinator, and Administrator. Continued validation revealed on [DATE], the POD and VPO reviewed all electronic life safety system elopement drills and door checks to validate compliance for a 90 day look back period. Additionally, starting [DATE], door checks were performed weekly ongoing, and elopement drills were performed weekly for four weeks and then monthly ongoing. 3. Education: Review and validation of the facility's IJ Removal plan revealed on [DATE], additional door alarms not tied to the fire alarm system were placed on the two (2) exterior exit doors on the Reflections Unit. In addition, vinyl window frosting was also placed on the two (2) exterior exit doors on the Reflections Unit to camouflage the doors and minimize exit seeking behaviors. Also, on [DATE], a Hasp lock (a flat metal plate with a hoop through which the lock goes in) and a key padlock was placed on one (1) door of the nurse's station for resident safety. In addition, on [DATE], the facility initiated that prior to the POD or POA allowing any work to be performed that could possibly affect any safety systems, the Administrator and DON must be notified to ensure staff were assigned to doors for monitoring. Beginning [DATE] and completed on [DATE], the VPO educated the Administrator, DON, POD, and POA that anytime life safety or a utility system was to be turned off, the DON and/or Administrator should be notified to allow for staff assignments to be made to ensure resident safety. Additionally, beginning [DATE] and completed on [DATE], current staff received education by the SDC on the following policies: Abuse, Neglect, Misappropriation of Property; Comprehensive Care Plans, Resident Rights: Missing Resident; Accident and Incident Investigation Reporting; Safety and Supervision. A post-test was completed by all current staff with the requirement of achieving 100% passing score to validate understanding. Validation revealed beginning [DATE], all staff that had not received education, all new hires, and agency staff were educated and received a post-test until a score of 100% was achieved prior to working their shifts. Continued review of the IJ Removal plan revealed on [DATE], the facility initiated individual resident activity boxes to be located on the Memory Care (locked unit) and a report was created for monitoring doors when the system was down. Beginning [DATE], the DON, Unit Managers (UM), SDC, Medical Records Nurse (MRN) or Manager on Duty (MoD) were required to assist the Reflections Unit (locked unit) during staff breaks to provide additional support. On [DATE] a new fence with a keypad was installed outside of the Reflections Unit (locked unit). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4.a.) Quality Assurance and Performance Improvement (QAPI): Starting [DATE], the Administrator or Activities Director audited documentation of activities and care plans for three random residents at risk for elopement to ensure documentation was complete and care plans were appropriate, weekly for four weeks, and then monthly for two months. Results of the audits were presented to the QAPI committee for review and recommendation. Once the committee determined the problem no longer existed the audits were conducted on a random basis. On [DATE], an Ad Hoc Quality Assurance (QA) meeting was held to review the investigation and the current plan of corrective action. Members present were the VPO, Administrator, the POD, DON, SSD, SCC, and the Medical Director attended via phone. The Medical Director reviewed the entirety of the plan and made no further suggestions. The Medical Director validated the plan was appropriate and will be effective. 4.b.) In addition to QAPI, starting on [DATE], a post-education test was provided by the Administrator, DON, and/or SDC to 10 random staff on shifts weekly for four weeks, and then monthly for two weeks. Results of the audits were presented to the QAPI committee for review and recommendation. Once the committee determined the problem no longer existed the audits were conducted on a random basis. Starting on [DATE], QA meetings were held daily for five days and weekly for four weeks, then monthly for recommendations and further follow-up regarding the above-stated plan of IJ removal. Initial audits were reviewed during the meeting to ensure 100% compliance was achieved. At that time, based on evaluation, the QA committee determined what frequency ongoing audits needed to continue. The Administrator, Medical Director, DON, Assistant Director of Nursing (ADON), POD, SSD, Activity Director, Therapy Director, and MDS Coordinator were expected to be present unless unable to attend. The Quality QAPI Committee determined at what frequency any ongoing audits needed to continue. Additionally, the Administrator was responsible for the implementation of this plan.

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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** 45113 Based on observation, interview, record review, and facility document and policy review, it was determined the facility failed to provide adequate monitoring and supervision to prevent elopements for one (Resident (R) 2) of four sampled residents reviewed for elopement risk out of a total sample of 14 residents. On [DATE], R2 exited the facility without staff knowledge during a time period in which the facility's wander guard system (door alarm system used to alert staff of a resident's attempts to leave the facility) was not functioning. The facility's failure to have an effective system to ensure each resident received adequate supervision and monitoring to prevent elopements caused or is likely to cause serious injury, harm, impairment, or death to a resident. The findings include: Review of the facility's policy, Safety and Supervision of Residents, dated [DATE], revised [DATE], and in effect at the time of the [DATE] elopement, revealed the facility was to ensure the safety and well-being of the residents and that the environment was as free from accident hazards as possible, which was a facility-wide priority. The policy review revealed that resident safety risks and environmental hazards would be identified through employee training, monitoring, and reporting processes. In addition, the policy stated that safety risks and environmental hazards would also be identified continuously through the Quality Assurance (QA) reviews of safety and incident/accident data and a facility-wide commitment to safety at all levels of the organization. Continued review of the policy revealed individualized, resident-appropriate care was a core component of the facility's systems approach to safety, and each resident's assessed individualized needs determined the type and frequency of resident supervision. The Interdisciplinary Care Team analyzed information from assessments and observations to identify specific risks for individual residents and target interventions to reduce related environmental hazards, including adequate supervision. Further, individualized, resident-centered approach to safety included implementing interventions to reduce accident risks and hazards that included communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, ensuring interventions were implemented, and documenting and monitoring the effectiveness of the interventions. A review of the facility's policy, Elopement, dated [DATE], revised [DATE], and in effect at the time of the [DATE] elopement, revealed the policy intended to ensure resident safety and protect their rights and dignity. The policy defined Elopement as any situation where a resident leaves the premises or a safe area without the facility's knowledge and supervision. Per the policy, residents would be evaluated for elopement risk upon admission, displaying exit-seeking behaviors, and preventative interventions implemented for those identified as an elopement risk and reevaluated as needed. In addition, the facility would ensure an elopement risk binder was kept at a secure location known to stakeholders and routine checks of entrance and exit doors were completed to ensure proper functioning. Review of the facility's Elopement Binder, last updated [DATE], revealed 22 current residents were at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Closed record review of a Resident Face Sheet revealed the facility admitted R2 on [DATE] and the resident expired on [DATE]. R2's diagnoses included vascular dementia with behavioral, psychotic, and mood disturbances, depression, anxiety disorder, loss of cognitive functions and awareness, difficulty in walking, abnormalities of gait and mobility with repeated falls, lack of coordination, muscle wasting and atrophy (gradual decline in effectiveness). Review of R2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed R2 with a Brief Interview for Mental Status (BIMS) score of ,d+[DATE], which indicated severe cognitive impairment. Further review of the MDS Assessment revealed the R2 displayed wandering behaviors, required staff supervision with transfers and supervision to include contact-guard/touch assistance with mobility for the resident to walk 50 feet or greater, and was not steady with balance and during transitions. Review of R2's Elopement Risk Evaluation, dated [DATE], revealed that the facility assessed the resident to be at risk for elopement based on her cognitive impairment of poor safety awareness, self-ambulation ability, history of exit-seeking behavior, and ability to exit the facility. An Exit-Seeking/Elopement Observation, dated [DATE], also revealed the facility assessed the resident to be at risk for elopement based on ambulatory status, history of wandering into unsafe areas, statements that she was leaving or questioning the need to stay, displaying behaviors that indicate an attempt to leave the facility, and body language indicating an elopement may be forthcoming. A review of R2's Order Summary dated [DATE] revealed a written physician order for a wander guard (security bracelet) to the left ankle, check placement, and function daily. Review of current physician orders for ,d+[DATE] revealed that the order for a wander guard was still in effect. Review of an undated Elopement Investigation revealed that on [DATE], at approximately 2:59 PM, the Plant Director had the receptionist announce over the speakers to ignore the fire alarm, it is a test. Per the investigation report, the sprinkler company was in the facility for yearly testing, resulting in the door alarm system being silenced/shut down. R2, who resided in the locked unit, was last seen by Kentucky Medication Aide (KMA) 1 at approximately 3:00 PM. The facility was unaware that the resident had eloped until a person driving by the facility saw R2 trip and fall along the grassy area in front of the parking lot, called 911 at 3:33 PM, and got out of their vehicle to check on the resident, and a family member of another resident (FM1) alerted staff of the resident in front of the facility. Continued review of the investigation report revealed the Director of Nursing (DON) assessed R2 and assisted her back into the facility for transfer to the emergency room (ER) for evaluation. R2 returned from the hospital with no injuries noted and was immediately placed on additional supervision/monitoring. The investigation found that R2 exited the facility during the sprinkler system's annual inspection when the fire monitoring system was interrupted, which unlocked the exit doors on the gated community (locked unit). Staff did not realize the exit doors would not alarm/were silenced, and a resident could exit the facility. Per the investigation, R2 exited the locked unit and traveled approximately 120 feet from the exit door toward the main road when she tripped and fell in the grassy area. Observation on [DATE] at 11:05 AM revealed the main road near where the resident was found was a traffic congested, two-lane highway. (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 on [DATE] at 9:30 AM, FM1 stated that on the day of the event, the temperature was warm outside as she had been visiting with her mother. FM1 noted that upon leaving the facility's front entrance, she looked down the hill on the main highway. FM1 recalled two vehicles stopped in the middle of the road, checking on a little lady sitting in the ditch right next to the highway. At that time, FM1 stated she knew a resident from the facility had got out without anybody knowing. Therefore, she returned to the facility and made them aware that someone had escaped, and the staff ran out the door and down the hill toward the resident. In an interview with the Plant Operations Director (POD) on [DATE] at 10:49 AM, he stated that once he and the other staff realized R2 had exited the door on the locked unit, they knew immediately that no one had been monitoring or watching that door while the door alarm system was not working. The POD stated prior to the elopement in 2023, the facility did not have a procedure in place that included monitoring responsibilities, manned stations at all exit-doors, and leadership involvement/notification to ensure resident supervision and safety when the door alarms were not functioning. He added that, at present, before any procedure is to be initiated that would affect the alarm system, all exit doors must be manned (monitored), the DON and Administrator must be notified, and a system was in place to ensure all units were covered, doors were checked/monitored, and each unit had adequate staff coverage for resident supervision and safety. In an interview with KMA7 on [DATE] at 10:29 AM, she stated she worked on the locked-down unit the day R2 eloped from the facility. KMA7 stated that R2 was mobile and assessed as a wanderer with exit-seeking behaviors, so R2 was placed in the locked unit with a wander guard alarm system to prevent elopement. KMA7 added that the resident would roam the halls and walk to the exit doors with statements of going home. KMA7 stated that during the elopement, the resident wandered out of the building unsupervised and traveled from the facility to the main roadway before staff were aware of her whereabouts. KMA7 recalled it was sometime after lunch, approximately 2:00 PM when she must have heard an announcement about a routine fire drill; however, she did not hear any information given that the facility's wander guard system was not currently functioning or that additional monitoring/supervision of wandering residents was needed. KMA 7 added that at that time, she was responsible for the safety and supervision of up to 18 residents by herself due to CNA 8 being on lunch break. KMA7 stated she had to try to gather all the mobile residents and those already up in their wheelchairs into the dayroom to monitor and supervise the residents while CNA8 was at lunch and was unaware that R2 had eloped through the unalarmed door until she was found outside the facility. KMA7 stated during the interview that she felt the elopement of R2 could have been prevented if the facility had prepared and planned to ensure adequate staff coverage to monitor all doors and units during an alarm shutdown. An attempt was made to interview CNA8 via telephone from [DATE] through [DATE]; however, it was unsuccessful, and CNA8 was no longer employed at the facility. However, a review of CNA8's Witness Statement undated, revealed she worked the locked down unit the day R2 eloped, on [DATE]. CNA8's statement noted at approximately 1:00 PM, R2 was awake and walking in the hall behind the nurse's station. At 2:35 PM, CNA8 stated she went to lunch and informed KMA7 that she would be off the unit, and there was no notation of staff coverage for CNA8 to assist KMA7 in monitoring and supervising the safety of the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185127	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Danville Centre for Health & Rehabilitation	642 North Third Street Danville, KY 40422

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Registered Nurse (RN)1 on [DATE] at 3:02 PM, RN1 stated that R2 was located down an embankment in front of the facility, sitting in a ditch beside the main roadway. RN1 stated there were supposed to be two staff members monitoring and supervising in the hallways to watch and make sure the residents could not get to the doors since the alarm was not working. RN1 stated the elopement could have been prevented if R2 had been monitored closer. RN1 stated that due to the elopement incident, the facility had initiated and implemented a new system to ensure all areas of resident safety would be covered. In an interview with the former Regional Nurse Consultant (RNC) on [DATE] at 10:25 AM, she stated that during R2's elopement, the facility did not have a system in place to ensure adequate staff coverage on all units or that all exit doors were covered, assigned, and monitored when the alarm was silenced and/or shut down. The RNC stated the DON (who was in place at the time of elopement) made her aware of the incident, and she was directly involved in the plan of correction to prevent reoccurrence. Multiple attempts were made to interview the former DON and Administrator from [DATE] to [DATE]; however, all attempts were unsuccessful. In an interview on [DATE] at 12:00 PM, the current DON and Administrator stated that since taking over leadership positions beginning in ,d+[DATE], the facility has not encountered any elopements since R2's in 2023. The Administrator stated that everything now was based on policy and procedure; staff are aware and understand the policies and their responsibilities, including management and leadership roles. The facility provided an acceptable plan for the removal of the IJ on [DATE]. This plan alleged the IJ was removed, and the deficient practice was corrected on [DATE], prior to the initiation of the investigation. The plan provided by the facility alleged the following: 1.a) On [DATE], R2 was assessed for injury at the time of the incident (elopement) and assisted back into the facility via wheelchair by the DON. Immediately following the elopement event, the DON completed a head-to-toe skin assessment for injury with no new injuries noted. The Administrator initiated a Code Green, the code for a missing resident, and a head count was performed per the Unit Managers on each unit. R2's Physician and Family/Responsible Party were notified of the event per the DON and Administrator; R2 was sent to the ED for evaluation to rule out any injuries or change in condition on [DATE] and returned to the facility on [DATE] with no injuries, no change in condition, and no new orders. Following R2's return from the hospital on [DATE], R2 received 1:1 (one-to-one) supervision from facility staff for the next 72 hours. In addition, on [DATE], facility staff were assigned to monitor unlocked doors by the Administrator until the fire system and door locks resumed normal function. The care plan for R2 was also reviewed and updated by the Social Services Director (SSD) and MDS Coordinator 1 on [DATE]. An elopement risk assessment was completed for R2 on [DATE] and [DATE] and the resident was assessed to be at risk for elopement. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Danville Centre for Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 642 North Third Street Danville, KY 40422	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1.b.) Review and validation of the IJ Removal plan revealed an elopement risk assessment was performed by a licensed nurse on [DATE], [DATE], [DATE], and [DATE] and R2 remained at risk for elopement until she expired on [DATE]. Continued review of the IJ Removal Plan revealed the facility had a census of 74 on [DATE], all residents had an elopement risk assessment completed by the Unit Manager and Medical Records Nurse and 16 residents were identified to be at risk for elopement. Additionally, the profile for R2 in the elopement binder was reviewed by the SSD and R2's Activity assessment was updated by the Activities Director (AD) on [DATE]. Following the events on [DATE] the SSD completed a BIMS for R2 with a score of , d+[DATE], and a Patient Health Questionare-9 assessment, with both scores indicating R2 suffered from severe cognitive impairment. Further validation revealed on [DATE], the [NAME] President of Operations (VPO) completed a root cause analysis, and a care plan meeting was held for R2 with the resident's family. 2. Review and validation of the facility's IJ Removal plan revealed on [DATE], the 16 residents who were identified to be at risk for elopement had orders and their care plans reviewed by the DON, Signature Care Consultant (SCC), and/or SSD. On [DATE], upon system restoration, all doors were checked to ensure locks were functioning by the Plant Operations Assistant (POA). All residents in the gated community (locked unit) had a secure unit observation and residents with a wander guard bracelet had orders reviewed, placement of wander guard checked, and care plans were reviewed by the SCC and DON on [DATE]. In addition, all exit door codes were changed by the POD on [DATE], and Activity assessments were also updated for all residents in the Reflections unit by the Activities Director on [DATE]. Following the events on [DATE], all elopement books were reviewed by the SSD on [DATE] to ensure resident profiles and pictures were updated and accurate and included all residents at risk for elopement. In addition, validation revealed that beginning [DATE] until [DATE], elopement drills and door checks were completed each shift by the POD, Unit Managers, Staff Development Coordinator (SDC), DON, Medical Records Nurse, MDS Coordinator, and Administrator. Continued validation revealed on [DATE], the POD and VPO reviewed all electronic life safety system elopement drills and door checks to validate compliance for a 90 day look back period. Additionally, starting [DATE], door checks were performed weekly ongoing, and elopement drills were performed weekly for four weeks and then monthly ongoing. (continued on next page)

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