| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 185285 | A. Building<br>B. Wing | 01/03/2025 |

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| Breckinridge Memorial Nursing Facility | 1011 Old Highway 60<br>Hardinsburg, KY 40143 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50442<br><br>Based on interview, record review, and review of facility policies, the facility failed to ensure residents were free from abuse for one of 18 sampled residents (Resident (R)13).<br><br>On 10/10/2024, staff witnessed R1 strike R13 three times on the leg with a rolled-up newspaper.<br><br>The findings include:<br><br>Review of the facility's policy titled, Abuse, Neglect, and Misappropriation in the Nursing Facility, effective date of 09/01/2011, and revised on 06/25/2013, revealed residents had the right to be free from mental, physical, sexual, and verbal abuse, neglect, and misappropriation of property. Per review, it was the policy of the facility to protect residents from real or perceived abuse, neglect, or misappropriation of property from anyone. Further review of the policy revealed it outlined the procedure for the management of suspected abuse/neglect and discussed the requirement for staff education.<br><br>Review of the facility's policy titled, Resident Rights and Responsibilities, with an effective date of 01/01/2000, revealed the resident had the right to a safe and secure environment safeguarded by clinical and non-clinical personnel.<br><br>Review of the facility's Incident Report dated 10/10/2024, revealed on that date at 3:14 PM, R1 was witnessed by Certified Nurse Aide (CNA) 3 self-propelling in her wheelchair over to R13 (her roommate, who was lying on the bed). Per review, CNA 3 observed R1 hit R13 three times across the legs with a rolled-up newspaper. Continued review revealed R13 was immediately moved from R1's room to a different room. Staff were made aware R1 was to be kept under constant supervision and not allowed to enter any other residents' rooms. Review revealed physical examination of R13 was conducted, with no injuries noted. Further review revealed R13 was unable to tell staff if she felt safe or not due to her mental status. Additional review revealed the Assistant Director of Nursing (ADON), Director of Nursing (DON), Administrator (ADM), Medical Director, and families of both residents were notified. Review further revealed changes were made to the Comprehensive Care Plan (CCP) for R1 and changes in R1's medications were made.<br><br>1. Review of the electronic medical record (EMR) for R1 revealed the facility admitted the resident on 08/10/2022, with diabetes type II, aphasia, hemiplegia/hemiparesis, hypertension, hyperlipidemia, and depression.<br><br>(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 |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/24/2024, revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident had been unable to complete the assessment. Per review of the MDS, the facility assessed R1 as not exhibiting any behaviors of wandering. Continued review revealed the facility also assessed R1 to have impairment to both upper and lower extremities on one side and as using a wheelchair. Further review revealed the facility additionally assessed R1 to require assistance to move from sitting to standing and for chair to bed transfers, and was not assessed for the ability to walk.<br><br>Review of R1's Comprehensive Care Plan (CCP), dated 02/14/2024, revealed the facility care planned the resident for a behavior problem related to refusing medications, pocketing medications, throwing fits, and shaking her fist at staff. Per review, the goal was for R1 to have fewer episodes of those behaviors and have no evidence of those behavioral problems by the next review date. Continued review revealed the interventions included: anticipating and meeting R1's needs; assisting her to develop more appropriate methods of coping and interacting with others such as returning to her room when angry or encouraging her to express her feelings appropriately. Further review revealed the interventions also included: caregivers to provide the opportunity for positive interactions and attention by stopping to talk with R1 as they passed by; intervening as necessary to protect the rights and safety of others by approaching and speaking to R1 in a calm manner, diverting her attention, or removing the resident from the situation and taking her to an alternate location if needed. Additionally, review revealed other interventions included: minimizing the potential for R1's disruptive behaviors by offering talks which diverted her attention; monitoring her behavior episodes and attempting to determine the underlying cause by considering location, time of day, persons involved and situations and documenting the behaviors. Review further revealed an update to R1's CCP made on 10/10/2024, related to the behavior of slapping another resident on the leg with a newspaper, with an additional goal added noting the resident would not cause harm or injury to others, with no further interventions added.<br><br>Review of the Progress Note from the Medical Director on 10/15/2024 revealed R1 had expressive aphasia from a stroke and was frustrated that she had issues communicating. Per review, since R1's sister passed away, she had been refusing to take medications or have her labs drawn. Continued review revealed R1 had became increasingly agitated and had even struck her roommate (R13), and he sent the resident to a Geriatric Psychiatry provider who almost immediately sent the resident to the medical floor due to her past atrial fibrillation. Further review revealed the Medical Director noted R1 returned to the facility in no better condition than she left and was still angry and acting out. Review revealed the Medical Director also noted, because R1 refused to take her medications orally, he decided to try Risperdal Consta injections (a long acting antipsychotic medication) for help with her mood issues. In addition, review revealed the Medical Director noted he was trying to find a geriatric psychiatric facility for consultation. Review of the Progress Note dated 10/26/2024 revealed the Medical Director was at the facility checking on R1.<br><br>Observation of R1 on 12/16/2024 at 4:56 PM, revealed the resident sitting up in her wheelchair, rolling herself down the hallway.<br><br>The State Survey Agency (SSA) Surveyor attempted to interview R1 on 12/16/2024 at 4:56 PM, with the resident only answering yes to one of the Surveyor's questions. During the rest of the Surveyor's questions R1 remained silent.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview on 12/17/2024 at 7:08 PM, R1's Family Member (F)3 and POA, stated she had been told of the incident of R1 hitting R13 on the leg with her newspaper immediately after it occurred. F3 stated R1 had gone through emotional issues lately and had been refusing her medications. She stated she thought it might have been from not taking her medications that caused her to act out aggressively towards R13. The Family Member stated she was not sure why R1 had hit R13; however, thought it might be because the resident was not able to communicate well, since her stroke [AGE] years ago. She reported she thought her mother's frustration at not being able to communicate might have contributed to her hitting R13 with the newspaper. F3 said staff were sympathetic to R1 and understood she could not communicate well. She further stated if there were any issues with R1, the facility immediately contacted her or her sister.<br><br>2. Review of the EMR for R13 revealed the facility admitted the resident on 09/21/2021 with diagnoses of Alzheimer's Disease, dysphagia, depression, and gastroesophageal reflux disease (GERD).<br><br>Review of R13's Quarterly MDS Assessment, with an ARD of 10/08/2024, revealed the facility had been unable to assess the resident and a BIMS score of 99 was noted. Further MDS review revealed R1 was not assessed as having any behaviors.<br><br>Review of R13's CCP dated 10/10/2024, revealed the facility care planned the resident as at risk of abuse related to R1 hitting her with the newspaper. Per review, the goals were for R13 to be free from any and all harm from other residents or staff and for her not to show any emotional or behavioral changes from the act of abuse she incurred. Further review revealed the interventions included: removing R13 from danger immediately; monitor her behaviors and meal intake; and monitor for any other signs and symptoms that might occur post abuse.<br><br>Review of the Nursing Narrative Note dated 10/10/2024 at 4:30 PM, revealed monitoring of R13 was being completed to ensure her safety and observe for any effects of the incident that occurred earlier that day (when the resident was hit with the newspaper by R13). Per review, there were no signs of emotional distress noted and there were no changes in eating habits or facial grimace noted. Further review All appears within normal limits (WNL).<br><br>Review of the Nursing Narrative Note dated 10/12/2024 at 4:00 PM, revealed R13 was pleasantly confused and had slept on and off throughout the day, as was her usual habit. Further review revealed R13 ate well for breakfast and lunch, and had no signs or symptoms of distress.<br><br>Review of the two Nursing Narrative Notes dated 10/14/2024 at 9:54 AM and at 10:53 PM, revealed R13 remained in a private room at that time, with no signs of distress and no changes in her sleeping or eating habits per the CNAs. Per review, of the second note (timed 10:52 PM) revealed R13 was in good spirits with no signs or symptoms of distress, her appetite remained normal and she slept intermittently as was her pattern.<br><br>Review of the History and Physical (H&P) Report dated 11/09/2024, revealed the Medical Director noted R13 had chronic dementia and profoundly limited insight, and could only respond to simple phrases.<br><br>Observation and an attempted interview with R13 on 12/16/2024 at 5:28 PM, revealed the resident answered the Surveyor's questions with nonsensical answers.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview on 12/17/2024 at 12:04 PM, Family Member (FM) 1, (R13's daughter and POA) stated the resident had not experienced any further issues with R1 since the incident in October. She said the facility immediately changed R13 to another room, away from R1. FM 1 reported the only issue she had was with the resident's room change. She stated R13 was the one who had to be moved even though she had not incited the altercation. She stated she was told the reason for moving R13 to a new room was R1 was wheelchair bound and could move around in her wheelchair in her previous room. The Family Member stated she was also told that it was easier for R1 to access the bathroom in her previous room. She said she had been notified immediately about the incident. FM 1 further stated R13 had not exhibited signs of fear of R1 and there had been no other altercations between the two residents since the one in October.<br><br>In interview on 12/17/2024 at 12:13 PM, FM 2 stated her mother had been notified of the incident between R1 and R13 immediately after it occurred and the facility moved R13 to another room. FM 2 stated she found out about the incident when she went to visit R13 and found that she was no longer in her old room. She said R13 had not voiced any fears of R1 since the incident occurred and was not able to remember the incident.<br><br>In interview with CNA 3 on 12/18/2024 at 9:38 PM, she stated she had been coming out of the dirty supply room when she witnessed R1 roll over to R13's (her roommate's) bed and hit her three times on the leg with a rolled-up newspaper. She stated she separated the residents and placed them in different rooms and reported the incident to Registered Nurse (RN) 2. The CNA said RN 2 notified the ADON, and R13 was moved to a separate room to live.<br><br>In interview with RN 2 on 12/18/2024 at 10:10 AM, she stated she had not seen the incident when R1 hit R13 with the newspaper. She stated CNA 3 witnessed the incident and came and told her about it immediately. RN 2 reported she called the ADON and asked CNA 3 to write down the details of the event she witnessed. She said R1 had been agitated that day and had displayed behaviors such as crying, yelling, and screaming in the hallway. RN 2 stated R1 had been angry because she wasn't getting what she wanted. She explained R1 would often take the blankets off her bed and throw them in the floor if the bed was not made the correct way. The RN reported R1 got angry if she was not the first one to be dressed. Per RN 2 in interview, after the incident she tried to talk with R1 and calm her down, but the resident was so agitated she would not calm down. She said she called R1's family and they came to the facility to calm the resident down. RN 2 stated initially staff moved R1 to another room and left R13 in their old room; however, eventually R13 was moved to a different room. The RN stated R1 had gone through a period where she pocketed the pills under her partial plate and then spit the medications out after the nurse left the room. She said she felt R1 not taking her medications had fueled the incident between her and R13. RN 2 reported after the incident, R1 was sent out to a behavioral health hospital, where they cut down on the medications the resident had been taking. She stated since returning to the facility R1 seemed to be doing better now, and the resident had not had aggressive behaviors after having her medications adjusted. The RN further stated prior to the incident involving R13, R1 had only displayed aggressive behaviors towards staff.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with CNA 4 on 12/18/2024 at 10:26 AM, she stated she had not been at work the day of the incident when R1 hit R13 with the newspaper. She stated R1 had been aggressive towards staff prior to the incident when she did not get what she wanted, but she had never seen the resident be abusive to any other resident before or after that incident. The CNA reported staff must earn R1's trust, meaning that they would come and do things for her when they were done helping another resident. She said if staff were busy, R1 would holler until they came to assist her, and there had been times that she had to walk out of the resident's room due to her aggressive behaviors. CNA 4 stated R1's behavior had been a lot better since her medications had been changed. She further stated R13 was not fearful of R1 after the altercation and her demeanor and behavior had not changed after the incident.<br><br>In interview with the Medical Director on 12/18/2024 at 10:49 AM, he stated R1 had experienced a stroke and had expressive aphasia (difficulty in producing speech or forming words), and acted out because she could not express herself. He said R1 often got frustrated with not being able to communicate her wants and needs. The Medical Director explained R1's behaviors were not dementia related behaviors and he felt like they were frustrated malignant behaviors. He stated R1 had been acting out in the past year, and refusing her medications or pocketing the medications to spit out after the nurse left the room. Per the Medical Director interview, he had treated R1 for many years, even prior to her stroke, and over the years the resident had become angrier and angrier. He said when R1 finally got to the point she refused to take medications by mouth and her behaviors had escalated, he changed her psychiatric medications and ordered R1 Risperdal Consta via an injection. The Medical Director further stated since the medication change R1's behaviors had gotten better. He additionally stated R1 knew what she wanted and what she wanted to do; however, was unable to tell staff and that led to her getting frustrated.<br><br>In interview with the Assistant Director of Nursing (ADON) on 12/19/2024 at 3:41 PM, she stated she had not been at the facility when R1 hit R13 with the newspaper, as she had already left for the day. The ADON stated RN 2 called her and told her CNA 3 witnessed R1 hit R13 on the leg three times with a rolled-up newspaper. She said a staff member was put with R1 to watch her to keep other residents safe after the incident. The ADON explained she was not sure if the staff member stayed with R1 in the room or removed the resident from the room after the incident. Per the ADON in interview, staff had moved R13 to a different room within thirty (30) minutes of the incident.<br><br>In continued interview on 12/19/2024 at 3:41 PM, the ADON stated her expectations of staff witnessing a resident-to-resident altercation was to remove or stay with the residents and notify the nurse immediately. She reported the staffs' priority was to make sure no one was harmed and interventions were placed immediately after the incident. The ADON said one of the interventions put in place after the incident was for staff to keep close supervision of R1, and another intervention had been for R13 to be moved to another room. She reported they had interdisciplinary team (IDT) meetings the next day after any abuse incident and had met the next day after the incident between R1 and R13. The ADON said R1 was also sent out for psychiatric evaluation and medication adjustment following the incident, and R13 had not exhibited any changes in her behaviors after the incident. She stated R13 had been monitored and had not had changes in her eating or sleeping habits. The ADON reported currently R1 and R13 did not acknowledge one another if they passed in the hallway and there had been no other altercations between the residents since the newspaper incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In interview with the Director of Nursing (DON) on 12/19/2024 at 5:12 PM, she stated R1 had not been care planned for potential abuse towards other residents because she had never exhibited that type of behavior before. The DON said they did not care plan for something until it occurred, even if there was a risk for it occurring. She said after the incident of R1 hitting R13 with the newspaper, R1 was removed from the area and staff checked R13 to make sure she had no injuries. Per the DON in interview, someone stayed in the hallway to keep R1 from going into the room where R13 was, or from doing anything to other residents. She reported interventions were placed to prevent further altercations between R1 and R13, which included R13 being moved out of her room to a different room. The DON reported her expectations of staff when they witnessed a resident-to-resident incident was to stop the incident and report via the chain of command immediately. She further stated the most important thing staff should do was make sure both residents were safe.<br><br>In interview with the Administrator on 12/19/2024 at 5:27 PM, she stated she been made aware of the incident between R1 and R13 shortly after it occurred. She said the ADON came to her office and told her about the incident after she returned to the facility and started the investigation. The Administrator reported R13 was moved to a different room and staff were instructed to keep an eye on R1 to protect R13 and other residents. She said the ADON made sure no other residents were abused by R1 or anyone else as part of her investigation. The Administrator stated the ADON put a staff member with R1 to keep a close watch on the resident; however, she did not recall how long the staff member had been placed with the resident for the close supervision.<br><br>In continued interview with the Administrator, on 12/19/2024 at 5:27 PM, she stated she expected staff to report any abuse incident immediately up the chain of command. The Administrator stated R1's mood had changed prior to the incident, and she had stopped taking her medications, with her behaviors worsening because of that. She said R1's aggression towards staff was because they were providing care or wanting her to do something. The Administrator stated R1 had not been aggressive towards other residents prior to that one event, and that was the reason her care plan had been directed to her behaviors toward staff and not to other residents. She further stated they moved R13 because the ADON felt that if they moved R1 she would become more aggressive. |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50442<br><br>Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop and/or implement a Comprehensive Care Plan (CCP) to ensure it met the residents' medical, nursing, mental, and psychosocial needs as identified on his/her comprehensive assessment and other assessments for one (1) of eighteen (18) sampled residents (Resident (R)1).<br><br>On 04/27/2024, R1 exhibited exit seeking behaviors, however, staff failed to care plan the resident for these behaviors. On 04/28/2024, R1 eloped from the skilled nursing facility (SNF) unit, located in a hospital, via the elevator without staff's knowledge and was found in the lobby trying to exit through the doors.<br><br>The facility's failure to have an effective system in place to ensure residents' care plans were developed to address the residents' exit-seeking behaviors is likely to cause serious injury, impairment, or death, if immediate action is not taken.<br><br>Immediate Jeopardy (IJ) was identified on 12/20/2024 and determined to exist on 04/28/2024 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656, at a Scope and Severity (S/S) of a J. The facility was notified of Immediate Jeopardy on 12/20/2024.<br><br>The facility provided an acceptable Immediate Jeopardy Removal Plan, on 12/31/2024, alleging removal of the IJ on 01/01/2025. The State Survey Agency (SSA) validated the IJ was removed on 01/01/2025, prior to the exit on 01/03/2025. Remaining non-compliance continued at a S/S of a D while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.<br><br>Refer to F689<br><br>The findings include:<br><br>Review of the facility's policy titled, Assessments created January 2014, revealed a comprehensive assessment was to be completed within 14 days of a resident's admission, quarterly, and when a significant change in the resident's physical or mental condition occurred that was not normally resolved without further intervention by staff. Per policy review, it included the care area of wandering; however, did not cover elopement.<br><br>During interview on 12/19/2024 at 1:20 PM, the Assistant Director of Nursing (ADON) stated the facility did not have a policy for Elopement or Wandering Assessments.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the facility's policy titled, Care Planning, effective 07/09/2012, revealed the needs of the resident, goals, time frames, required services, and the service setting were critical considerations in determining the resident's plan of care. Continued review of the policy revealed regular reviewing and revising the care plan, treatment, and services was to occur at 90 day intervals or more frequently, based on the resident's clinical condition, care goals, and the plan of treatment, care, and services. Per policy review, revisions were to occur as needed to meet the needs of the resident's changing condition and were to be evaluated through monitoring the effectiveness of care planning and the provision of care, treatment, and services. Review further revealed residents and/or families could be involved in the care planning process.<br><br>1. Review of the electronic medical record (EMR) for R1 revealed the facility admitted her on 08/10/2022 with diabetes that included: aphasia (loss of ability to express or understand speech), hemiplegia/hemiparesis, type II diabetes, and depression.<br><br>Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/24/2024, revealed the facility assessed R1 with a Brief Interview for Mental Status (BIMS) score of ninety-nine (99), which indicated she had been unable to complete the assessment. Per review of the MDS, the facility assessed R1 as not exhibiting any behaviors of wandering. Review of the MDS revealed R1 had impairment to both her upper and lower extremities on one side of her body and she used a wheelchair for mobility. Further review revealed the facility also assessed R1 as needing assistance for transferring from the wheelchair to bed and for moving from sitting to standing.<br><br>Review of R1's CCP dated 02/14/2024, revealed the facility had not care planned the resident for wandering or exit seeking behaviors. Per review of R1's CCP dated 04/28/2024, revealed the facility had care planned R1 for elopement risk and as a wanderer after she eloped from the facility.<br><br>Review of the EMR revealed Wandering Risk Assessments for R1 dated 08/10/2022 (her admitted ), 05/04/2023, and on 04/13/2024. Review of the Wandering Risk assessment dated [DATE], revealed the facility assessed R1 as not being independently mobile; not exhibiting wandering behaviors; not having exit seeking behaviors; and not having the ability to exit the facility. Review of the Wandering Risk assessment dated [DATE] for R1, revealed the facility assessed the resident as the same as on her admission (08/10/2022). Review of the Elopement Risk assessment dated [DATE] (fifteen days prior to her elopement) revealed the facility assessed R1 as having no elopement attempts, no wandering behaviors, and as independently mobile.<br><br>Review of the Nursing Narrative Note for R1 dated 04/28/2024, electronically signed by Registered Nurse (RN) 4 at 5:49 PM, revealed an unidentified Certified Nurse Aide (CNA) told the RN that R1 had been found by housekeeping staff in an elevator on the first floor. Review revealed the housekeeper brought R1 back up to the SNF unit, and Medical Director (MD) was notified, and an order received for a wander guard device which was placed on the resident's left ankle. Continued review revealed the MDS RN, (who was currently the ADON) had been covering for the DON, who was on vacation. Per review, the MDS RN (current ADON) notified R1's family, and the resident was educated on the purpose of the wander guard device.<br><br>(continued on next page) |

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| | 185285 | A. Building<br>B. Wing | 01/03/2025 |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation on 12/16/2024 at 4:56 PM, of R1 revealed the resident seated in her wheelchair and rolling herself about the unit's hallway. The State Survey Agency (SSA) Surveyor attempted to interview R1 (who had a diagnosis of expressive aphasia), at the time of observation; however, the resident only responded with yes to the Surveyor's questioning of her name. All other questions were met with silence.<br><br>In interview on 12/17/2024 at 3:58 PM, Registered Nurse (RN) 1 stated she worked in acute care for the hospital the SNF unit was located in and was the person who found R1 in the first-floor lobby (on 04/28/2024). She said R1 had been in a wheelchair and was pushing on the lobby door trying to get out the door which led to the parking lot. RN 1 stated R1 had a coke and some snacks with her and when she approached R1 to ask what she was doing, R1 told her she was trying to leave. She reported she had a cafeteria staff member call the SNF unit to let them know R1 was in the lobby. RN 1 said she stayed with R1 until a staff member from the SNF unit came to take her back to the unit. She explained she thought the elopement occurred around 4:00 PM to 5:00 PM, that day and there had been no one in the business office which was located near the lobby. RN 1 further stated she had never seen any other SNF unit residents in the lobby unless they were with staff or family, and had not seen R1 back in the lobby area since.<br><br>In interview on 12/19/2024 at 10:56 AM, CNA 7 stated she had been going on break (on 04/28/2024) and was on her way to the elevator when she saw R1 rolling down the hallway towards the nurses' station. She said she had not thought anything about the resident rolling towards the nurses' station and also the elevators, so she left for lunch. CNA 7 stated she left to sit in her car during her break and when she returned she had not seen R1 in the hallway, and asked CNA 5 if the resident had gone to her room. She reported while looking for R1 in her room, housekeeping called the SNF unit and alerted CNA 5 that R1 was downstairs in the lobby. CNA 7 stated she had not seen R1 when she entered the facility's lobby after returning from her lunch break. She said she did not remember any issues occurring with R1 the day she eloped (04/28/2024); however, stated R1 had been having a tough week that week and had been hitting staff and having exit seeking behaviors. CNA 7 reported she had been told in report (on 04/28/2024) that R1 had tried to get out off the unit, the day before (on 04/27/2024). She stated she could not recall the CNA who gave her that information in report and did not know if that CNA notified the RN of R1's exit seeking behaviors.<br><br>In interview on 12/19/2024 at 11:27 AM, CNA 8 stated she remembered R1 having a lot of exit seeking behaviors in the month prior to her elopement. CNA 8 stated she had been physically assaulted by R1 when she stopped R1 from trying to get on the elevator and leave the unit. She reported telling RN 4 and the former DON (RN 6) and said management (present ADON and the former DON) had been aware of R1's exit seeking behaviors prior to her elopement. The CNA said staff had been told they had to watch R1 closely to prevent her from leaving the unit. She stated in the month of April, R1 tried to get off the unit three to four times, but staff had been able to retrieve her most of the times. CNA 8 reported however, twice R1 had gotten in the elevator (one of which was the day she eloped). She said the day of the week or time of day when R1 attempted to get off the SNF unit was not a factor, as the resident had tried on different shifts and on different days. CNA 8 further stated if R1 thought she had an opportunity to get off the unit she would try and leave.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In interview on 12/19/2024 at 1:20 PM, the ADON/MDS Coordinator, she stated she had been the MDS Coordinator at the time of R1's elopement (on 04/28/2024). She stated she had been notified of R1's elopement as she had been the manager on call, and was covering for the DON, who was on vocation at the time. The ADON said that when she arrived to the facility on the day of the elopement, staff had already brought R1 upstairs and talked to the Medical Director who ordered a wander guard device for the resident. Per the interview, the ADON stated she did not care plan the resident for her exit-seeking behavior prior to the resident's elopement because staff did not inform her of the resident's exit-seeking behaviors.<br><br>In interview on 12/19/2024 at 1:41 PM, the DON stated she had been the DON since 06/30/2024. She said she expected her staff to keep residents safe by redirecting the resident when they were exhibiting exit seeking behaviors. She reported she also expected staff to notify the nurse, ADON, DON, Administrator, Medical Director, and resident's family of those behaviors. The DON explained if a resident got out of the facility, she expected staff to also alert the police, and implement constant supervision of the resident and place a wander guard monitor on him/her immediately.<br><br>In interview on 12/19/2024 at 1:50 PM, the Administrator stated R1's elopement occurred on a weekend, and the ADON called her to let her know the resident had gone downstairs where she had been found by a staff member from another department. She stated she was unaware of R1's wandering and exit seeking behaviors prior to her elopement. The Administrator stated her expectations for staff, for residents exhibiting exit seeking behaviors, was for them to report up the facility's chain of command to the ADON. She said interventions she expected to be put in place to prevent further elopements, was to closely supervise the resident and place a wander guard on the resident after an elopement. The Administrator reported if R1 was out of her room staff should keep an eye on her regularly and should bring her to where they were providing other residents' care so they could observe her more often. She further stated R1's behaviors were never voiced to her by nursing staff. The Administrator stated R1 was care planned for elopement and exit seeking behaviors after R1's elopement. She stated staff did not make management aware of the resident's exit seeking behaviors.<br><br>The facility provided an acceptable IJ Removal Plan on 12/31/2024:<br><br>Resident affected by the IJ:<br><br>The facility took immediate action on 4/28/2024, to remove the IJ. Immediately following the elopement of R1 that occurred on 4/28/2024, the resident was returned to the facility without any injury/harm sustained, as determined by an assessment performed by the RN on duty. Per MD order, a wander guard was placed on R1's person to ensure staff would be alerted if she tried to enter the elevator/exit the 2nd floor facility again. Her family was notified, and they agreed with the plan in place. R1 was able to continue to self-propel in her wheelchair throughout the facility while she worked on her crossword puzzles, as she normally did. Staff continued to complete a weekly elopement risk assessment, per the facility's assessments policy. As documentation shows, R1 was not previously identified as an elopement risk, with no documentation of wandering or exit-seeking behaviors. Policy was followed and continues to be followed. Additional policy has been created to ensure a consistent plan following an elopement.<br><br>Other residents affected:<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | All residents are assessed weekly per assessments policy. No other residents were considered to be an elopement risk.<br><br>Training:<br><br>Upon receiving the IJ, education on wandering and exit-seeking behavior was provided to all staff of the nursing facility by the ADON. Education began on 12/23/2024 and was completed on 12/30/2024 for all actively working staff.<br><br>The education was added to the orientation check list for new hires of the facility as of 12/23/2024 by the ADON. The training was an in-person verbal educational format in which employees received a copy of the material presented. It described wandering and exit-seeking behaviors, and the steps that were to be taken should those behaviors occur within the facility.<br><br>Monitoring:<br><br>The MDS Coordinator completed audits to ensure the wander guard transmitter was in place for R1 and elopement assessments were completed on the resident as per policy. Audits were done 04/28/2024 through 06/29/2024, with 100% compliance.<br><br>The ADON will conduct random interviews with staff to ensure understanding of the education provided. A minimum of 2 interviews will be conducted at least once weekly for six months. If staff give any indication they were unclear of education provided, they will be reeducated immediately. Interviews began on 12/30/2024 and will continue until 100% compliance is maintained for 90 days.<br><br>The ADON will monitor resident charts weekly to ensure completion of elopement risk assessment. The audit began on 12/30/2024 and will continue until 100% compliance is maintained for 90 days. Information from all audits and interviews will be taken to quarterly QAPI meetings.<br><br>Action:<br><br>Assessments policy was revised to change the wording from wander risk assessment to Elopement Risk Assessment by ADON on 12/23/2024.<br><br>Policy named assessments was already in place for assessing residents for elopement and wandering.<br><br>A new policy titled, Elopement was created on 12/30/2024, to address steps to be completed upon an elopement occurring. Input for the policy was provided by QAPI members: CEO, DON, ADON, Safety Office, and Quality Officer. The new policy was provided to all Nurses on 12/30/2024.<br><br>Per policy, care plans are updated immediately following a change in care by the nurse on duty. R1's care plan was updated on 4/28/2024, after her elopement by the RN on duty. It was not updated prior because the facility was not aware of any wandering/exit-seeking behaviors by the resident. All staff received education (see prior training section) on reporting behaviors. Care plans continue to be updated immediately by the nurse on duty and reviewed quarterly by the MDS Coordinator.<br><br>IJ removal date: 01/01/2025<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Attached you will find:<br><br>1. Education sign in sheet<br><br>2. Assessments Policy<br><br>3. Elopement Policy<br><br>(The attachments referenced above are on file with the State Survey Agency.) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50442<br><br>Based on interview, record review, and review of the facility's investigation documentation and policies, the facility failed to have an effective system in place to ensure resident safety for 1 of 18 sampled residents, (Resident (R)1).<br><br>On 04/27/2024, R1 exhibited exit-seeking behaviors, however, the facility failed to ensure the resident was provided increased supervision. On 04/28/2024, R1 eloped from the facility (a skilled nursing facility [SNF] unit) without staff knowledge and was found on the first-floor lobby (of the acute care hospital the facility was located in) trying to exit the building [facility].<br><br>The facility's failure to have an effective system in place to ensure residents' safety is likely to cause serious injury, impairment, or death, if immediate action is not taken.<br><br>Immediate Jeopardy (IJ) was identified on 12/20/2024 and determined to exist on 04/28/2024 in the area of 42 CFR 483.25 Quality of Care, F689, and Substandard Quality of Care (SQC) at 42 CFR 483.25.<br><br>The facility provided an acceptable Immediate Jeopardy Removal Plan, on 12/31/2024, alleging removal of the IJ on 01/01/2025. The State Survey Agency (SSA) validated the IJ was removed on 01/01/2025, prior to exit on 01/03/2025. Remaining non-compliance continued at a S/S of a D while the facility develops and implements a Plan of Correction (PoC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.<br><br>Refer to F656<br><br>The findings include:<br><br>Review of the facility's policy titled, Assessments, created January 2014, revealed a comprehensive assessment was to be completed within 14 days of a resident's admission. Per review, the comprehensive assessment was also to be completed quarterly, and when there was a significant change in a resident's physical or mental condition that was not normally resolved without further intervention by staff or by starting standard disease related clinical interventions. Continued review revealed the policy addressed the care area of wandering; however, not elopement.<br><br>In interview on 12/19/2024 at 1:20 PM, the Assistant Director of Nursing (ADON) stated the facility did not have a policy for Elopement or Wandering Assessments.<br><br>Review of the facility's policy titled, Code [NAME] (Missing Patient/Resident), last revised 09/2023, revealed the policy described the procedure for staff to follow when a resident went missing from their department.<br><br>Review of the facility's policy titled, Resident Rights and Responsibilities, with an effective date of 01/01/2000, revealed the resident had the right to a safe and secure environment safeguarded by clinical and non-clinical personnel.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Adult Transmitter manual (for the resident monitoring devices) revealed it contained information regarding the use of the device, transmitter testing, and how to place the device on a resident.<br><br>Review of the electronic medical record (EMR) for R1 revealed the facility admitted the resident on 08/10/2022 with diagnoses that included: diabetes type II, aphasia, hemiplegia/hemiparesis, hypertension, hyperlipidemia, and depression.<br><br>Continued review of R1's EMR revealed Wandering Risk Assessments dated 08/10/2022 and 05/04/2023. Review of the Wandering Risk assessment dated [DATE], revealed the facility assessed R1 as not independently mobile, not having exit seeking behaviors, not exhibiting wandering behaviors, and not having the ability to exit the facility. Review of the Wandering Risk assessment dated [DATE], revealed the facility again assessed R1 as not being independently mobile, not demonstrating exit seeking behaviors, not having wandering behaviors, not having a history of elopement. Continued review of the 05/04/2023, Wandering Risk Assessment for R1 revealed the resident had the ability to exit the facility. Further review of R1's EMR revealed an additional Elopement Risk assessment dated [DATE], which noted R1 as having no elopement attempts, no wandering behaviors, and as being independently mobile.<br><br>Review of the Activities of Daily Living (ADLs) documentation charted by the Certified Nurse Aides (CNA's) on 04/28/2024, revealed R1 had ADL care performed at 9:02 AM and 7:59 PM on 04/28/2024.<br><br>In interview on 12/19/2024 at 1:20 PM, the ADON stated the CNAs did not have an area to chart resident checks on their flowsheets.<br><br>Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 02/24/2024, revealed the facility assessed R1 as having a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident had been unable to complete the assessment. Per review of the MDS, the facility assessed R1 as not exhibiting any behaviors of wandering. Continued review revealed the facility assessed R1 as having impairment to both the upper and lower extremities on one side and to use a wheelchair. Further review revealed the facility also assessed R1 as needing assistance for chair to bed transfers, and for moving from sitting to standing. In addition, review revealed the facility assessed R1 as not having the ability to walk.<br><br>Review of R1's Comprehensive Care Plan (CCP) dated 02/14/2024, revealed the facility had not care planned the resident for wandering or exit seeking behaviors. Continued review of R1's CCP revealed the facility care planned the resident on 04/28/2024 (the date of her elopement from the facility), for being an elopement risk and wanderer.<br><br>Review of the Nursing Narrative Note for R1 dated 04/28/2024 at 5:49 PM, electronically signed by Registered Nurse (RN) 4, revealed the Certified Nurse Aide (CNA, no specific aide identified) came to get Registered Nurse (RN) 4 to tell her the resident had been found by housekeeping in an elevator on the first floor, of the hospital in which the SNF was located. Per review, the housekeeper brought R1 back up to the unit (facility). Continued review revealed the Medical Director was notified, and a wander guard (monitoring device) was placed on R1's left ankle, and the resident's family also notified. Further review revealed R1 was educated on the purpose of the wander guard.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Facility's Incident Report dated 04/28/2924 at 4:22 PM, revealed RN 1, from the acute care on the first floor, found R1 in her wheelchair in the lobby of the building. Per review, CNA 5 went to the lobby and brought R1 back to the unit (facility). Review revealed the ADON, resident's Family Member (FM) 3, and Medical Director were notified and an order received for a wander guard (monitoring device) According to review of the Report, the investigation noted the facility's security cameras were reviewed, and showed R1 leaving the unit (facility) at 3:58 PM via the elevator. Continued review revealed R1 was observed on the video exiting the elevator at 3:59 PM where she propelled herself into the lobby and down the hallway toward Radiology. Continued review revealed at 4:22 PM a nurse (RN 1) from the acute care floor was seen with R1. Review revealed CNA 5 was notified and was seen on the video attending to R1 at 4:24 PM and returning her to the facility on the second floor. Per continued review, interviews with staff revealed R1 had been self-propelling in the hallway as she normally did, and a CNA (not identified by name) reported after she returned from her lunch break, she had not seen R1 in the hallway and checked the resident's room, but had not found R1 there either. Further review revealed the CNA also reported while she was walking to ask the other CNA where R1 was, they received the call notifying them that the resident was downstairs (in the lobby). Additionally, review revealed R1 was assessed and found to have no injuries, and had been assessed as not wandering aimlessly nor being considered an elopement risk. Review further revealed R1, was interviewed; however, due to her expressive aphasia, when asked about leaving the facility she shook her head back and forth as if to indicate no.<br><br>Observation of R1 on 12/16/2024 at 4:56 PM, revealed the resident was seated in her wheelchair in the hallways and was rolling herself about the unit (facility).<br><br>The State Survey Agency (SSA) Surveyor attempted to interview R1 on 12/16/2024 at 4:56 PM; however, the resident only answered yes to the Surveyor's question regarding her name. All the other questions the SSA Surveyor asked were met with silence.<br><br>In interview with RN 1 on 12/17/2024 at 3:58 PM, she stated she worked in acute care in the hospital where the SNF unit was located. RN 1 stated she found R1 in the first-floor lobby, pushing on the exit door trying to get out the door which led to the parking lot. She said R1 was in a wheelchair when she found her, and had a coke and snacks with her. RN 1 reported she approached R1 and asked what the resident what she was doing and what unit she was from. She stated R1 told her she was trying to leave. RN 1 said she had a cafeteria staff member call the SNF unit (where R1 resided) to let them know R1 was in the lobby. She said she stayed with R1 until a staff member from the SNF unit came to take her back to the unit. RN 1 stated she thought the elopement occurred around 4:00 to 5:00 PM, and no one was in the business office located near the lobby. She further stated she had never seen any other residents in the lobby unless they were with staff or family and had never seen R1 back in the lobby since.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In interview with FM 3 (R1's POA) on 12/17/2024 at 7:03 PM, she stated she had been notified the resident got off the unit; however, could not remember how long it took them to tell her after the incident occurred. She stated she did not think there was a lapse of time between when her mother (R1) got off the unit and when the facility notified her. FM 3 said R1 rolled up and down the hallways (of the facility) in her wheelchair, but she had never got off the unit before that incident. She reported R1 had been virtually non-verbal since her stroke [AGE] years prior. The Family Member stated family frequently took R1 outside for fresh air, so the resident knew the way out of the building prior to her elopement. She said since the incident however, they had not taken R1 out of the facility. FM 3 reported after R1 got off the unit, staff kept a close eye on her and the resident now had a wander guard in place to prevent her from getting off the unit again.<br><br>In a follow up interview on 12/19/2024 at 11:54 AM with FM 3, she stated no one had been to visit R1 on 04/28/2024, the day the resident eloped. She stated she could not remember if anyone had taken R1 out of the facility (either outside, to eat or to shop) in the month preceding her elopement either.<br><br>In interview with CNA 2 on 12/18/2024 at 9:18 AM, she stated she had worked part time at the facility for two to three years, and in that time had never seen R1 exhibit exit seeking behaviors. She stated however, in the past when R1's daughters or sister came for a visit the resident seemed like she wanted to leave with them because she would become more unsettled after their visits.<br><br>In interview with CNA 8 on 12/19/2024 at 11:27 AM, she stated she remembered R1 having a lot of exit seeking behaviors in the month prior to her elopement. CNA 8 reported she had been physically assaulted by R1 when the resident was trying to get off the unit and she (the CNA) tried to stop R1 from getting on the elevator. She stated she told nursing staff, RN 4 and the former DON/RN 6, and management (the present ADON and former DON) had been aware of R1's exit seeking behaviors prior to her elopement. The CNA said staff were told they had to watch R1 closely to prevent her from leaving the unit. She reported in the month (April) R1 tried to get off the unit at least three to four times, but staff had been able to retrieve her most of the times. CNA 8 stated however, twice R1 had gotten on the elevator, one being the day she eloped. She explained the day of the week or time of day that R1 attempted to get out was not a factor because she had tried to leave on different shifts and on different days. CNA 8 further stated she thought if R1 had an opportunity to get off the unit she would try and leave now.<br><br>(continued on next page) |

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|---|---|---|---|
| | 185285 | A. Building<br>B. Wing | 01/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Breckinridge Memorial Nursing Facility | 1011 Old Highway 60<br>Hardinsburg, KY 40143 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In interview with CNA 7 on 12/19/2024 at 10:56 AM, she stated on the day of R1's elopement, she had been going on break when she saw R1 rolling down the hallway towards the nurses' station. CNA 7 said she had not thought anything about R1 rolling down the hallway towards the nurses' station and consequently the elevators, so she left for lunch. She reported when she returned from lunch she did not see R1 in the hallway and asked CNA 5 if R1 had gone to her room, then went to the resident's room to look for her. The CNA stated housekeeping called and spoke with CNA 5, and told her R1 was downstairs in the lobby. She reported she had not seen R1 when she exited the building for lunch or upon her return from lunch. CNA 7 said she did not recall what time she went to lunch but remembered CNA 6 (who was scheduled to work until 2:00 PM) had left already for the day. She stated her lunch break had lasted 30 minutes on the day R1 eloped. The CNA explained she did not recall any issues with R1 occurring on 04/28/2024; however, did remember the resident had been having a tough week that week. She said R1 had been hitting staff and having exit seeking behaviors. CNA 7 stated she had been told in report on 04/28/2024, that the resident had tried to get out of the unit, the day before (04/27/2024). She could not recall the CNA who gave her that report though and did not know whether that CNA notified the RN of R1's exit seeking behaviors (on 04/27/2024). CNA 7 further stated R1 was not able to walk and could only move about the unit/facility in her wheelchair.<br><br>In interview with RN 5 on 12/19/2024 at 11:37 AM, she stated R1 had no exit seeking behaviors before the elopement that she had witnessed or had been told about. RN 5 stated R1 went up and down the hallway in her wheelchair, but did not try to get on the elevator. She said she and her CNAs watched R1 just like they did all the other residents, making sure they were safe and accounted for. RN 5 explained she did not recall anything occurring around the time R1 eloped which might have upset her. She reported R1 liked to exert control and would often throw a fit if she did not get her needs met in the way she wanted. RN 5 stated R1 had not tried to get out since the elopement, and she had never seen R1 hanging out by the elevators.<br><br>In interview with the [NAME] Clerk (WC) on 12/18/2024 at 9:54 AM, she said she sat at the desk at the entrance to the unit and R1 would have had to have gone past her to get to the elevators (when she eloped). She stated she also took care of residents' laundry and so, was sometimes away from the desk. The WC explained she only worked Monday through Friday 7:00 AM to 3:00 PM, and had not been at work when R1 eloped, as the incident occurred on a Sunday afternoon. She said she was the only WC for the unit and there was not a WC on nights and weekends. She further stated after R1's elopement she had observed the resident at the elevator trying to get on it and then being removed from the elevator area by CNAs and taken back to her room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 12/19/2024 at 10:42 AM, the Safety and Compliance Director (SCD) stated he had been the person viewing the camera video footage of R1's elopement with the ADON. He said however, the facility no longer had that video footage because it got taped over after about a month. The SCD stated on the video, R1 rolled down the hallway towards Radiology on the first floor of the building, but had not tried to access any doors along the way. Per the SCD in interview, R1 was then observed to turn around and roll back the way she came from, towards the exit doors. He stated he could not recall which door in the lobby R1 had been trying to exit through. The SDC stated all the doors on the left side of the building's main corridor and the right side of the main corridor, except the main cafeteria door were locked on nights and weekends. He reported the Radiology Department, which R1 passed by, had two doors located on the main hallway, one of which was always locked. The SCD said the other door to Radiology was always closed, but might not be locked if staff were working in Radiology. He stated radiology staff ensured both doors were locked if they had to go to the Emergency Department (ED). The SCD said he was not sure if staff had been in the Radiology Department at the time the event occurred (on 04/28/2024).<br><br>In interview with the ADON on 12/19/2024 at 1:20 PM, she stated she had been the MDS Coordinator at the time of R1's elopement and the SNF unit had not had a ADON at the time of R1's elopement. The ADON stated R1 had not had exit seeking behaviors prior to that elopement. She said R1 wheeled up and down the hallway only, and never tried to get on the elevator. The ADON reported she had never been made aware of R1 exhibiting exit seeking behaviors by any staff member prior to the elopement. She stated nor had she been informed of anything that went on during that day (04/28/2024) that might have upset R1. Per the ADON in interview, she had been the on call for the former DON (RN 6), who was on vacation at the time of R1's elopement. She said the former DON now worked full time in the hospital's Medical Surgical Unit; however, still worked Pro Re Nata (PRN) for the SNF unit. The ADON stated when she arrived at the facility on the day of R1's elopement, staff had already brought R1 back upstairs and talked to the Medical Director, who ordered the wander guard device.<br><br>In continued interview on 12/19/2024 at 1:20 PM, the ADON stated she observed the camera video footage of the elopement with the SCD, R1 had not tried to access any doors in the downstairs hallways. Per the ADON in interview, on the video R1 had rolled down the hallway towards Radiology, then turned around and came back to the lobby prior to where she pushed on the exit door, trying to get out. The ADON said the lobby had two exit doors, but she did not remember which door in the lobby R1 had been pushing on to try and exit the building. She stated R1 could read and did word puzzles, and it was thought she read signs and that was why she had not tried opening other doors in the hallways. The ADON reported R1 was the only resident who wandered and had tried to elope.<br><br>In interview with the DON on 12/19/2024 at 1:41 PM, she stated she had only been the DON since 06/30/2024, and had worked in the acute care unit of the hospital prior to that. The DON stated her expectations of her staff regarding residents who wandered was for staff to keep those residents safe by redirecting the resident when they were exhibiting exit seeking behaviors. She said she also expected staff to notify the nurse, ADON, DON, Administrator, Medical Director, and resident's family of those types of behaviors. According to the DON in interview, if a resident got out of the facility, she expected staff to also alert the police. She reported interventions to prevent further elopement were expected to be implemented, providing constant supervision. The DON further stated she would want someone constantly with the individual one on one (1:1) for the first few days after the elopement. She additionally said she expected staff to make sure they knew where to find all residents on an hourly basis.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In interview with the Administrator on 12/19/2024 at 1:50 PM, she stated the elopement of R1 occurred on a weekend. The ADON called her to let her know that R1 went downstairs where she was found by a staff member from another department and had not sustained any injuries. She said the ADON told her staff had brought R1 upstairs to the unit and assessed her and placed a wander guard device on her. Per the Administrator in interview, the ADON said she would make a report about the incident to the proper authorities and start the investigation. She stated her expectations of facility staff, regarding a resident exhibiting exit seeking behaviors, was that they would report such information up the chain of command to the ADON. The Administrator said she also expected staff to report the incident to the resident's family and the Medical Director. She said the ADON would alert her and the DON. The Administrator reported interventions staff should put in place to prevent further elopements were to put the resident on closer supervision, and it would depend on the resident's mobility and condition that would dictate how often the resident should have eyes laid on them. The Administrator stated staff should keep the at risk resident in line of sight at all times after an elopement, and place a wander guard device on resident. She stated immobile residents should be seen by staff hourly and mobile residents more frequently. The Administrator further stated if R1 was out of her room, staff should keep an eye on her regularly and should take her to where they were providing care for other residents care in order to observe her more often.<br><br>The facility provided an acceptable IJ Removal Plan on 12/31/2024:<br><br>Resident affected by the IJ:<br><br>The facility took immediate action on 4/28/2024, to remove the IJ. Immediately following the elopement of R1 that occurred on 4/28/2024, the resident was returned to the facility without any injury/harm sustained, as determined by an assessment performed by the RN on duty. Per MD order, a wander guard was placed on R1's person to ensure staff would be alerted if she tried to enter the elevator/exit the 2nd floor facility again. Her family was notified, and they agreed with the plan in place. R1 was able to continue to self-propel in her wheelchair throughout the facility while she worked on her crossword puzzles, as she normally did. Staff continued to complete a weekly elopement risk assessment, per the facility's assessments policy. As documentation shows, R1 was not previously identified as an elopement risk, with no documentation of wandering or exit-seeking behaviors. Policy was followed and continues to be followed. Additional policy has been created to ensure a consistent plan following an elopement.<br><br>Other residents affected:<br><br>All residents are assessed weekly per assessments policy. No other residents were considered to be an elopement risk.<br><br>Training:<br><br>Upon receiving the IJ, education on wandering and exit-seeking behavior was provided to all staff of the nursing facility by the ADON. Education began on 12/23/2024 and was completed on 12/30/2024 for all actively working staff.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The education was added to the orientation check list for new hires of the facility as of 12/23/2024 by the ADON. The training was an in-person verbal educational format in which employees received a copy of the material presented. It described wandering and exit-seeking behaviors, and the steps that were to be taken should those behaviors occur within the facility.<br><br>Monitoring:<br><br>The MDS Coordinator completed audits to ensure the wander guard transmitter was in place for R1 and elopement assessments were completed on the resident as per policy. Audits were done 04/28/2024 through 06/29/2024, with 100% compliance.<br><br>The ADON will conduct random interviews with staff to ensure understanding of the education provided. A minimum of 2 interviews will be conducted at least once weekly for six months. If staff give any indication they were unclear of education provided, they will be reeducated immediately. Interviews began on 12/30/2024 and will continue until 100% compliance is maintained for 90 days.<br><br>The ADON will monitor resident charts weekly to ensure completion of elopement risk assessment. The audit began on 12/30/2024 and will continue until 100% compliance is maintained for 90 days. Information from all audits and interviews will be taken to quarterly QAPI meetings.<br><br>Action:<br><br>Assessments policy was revised to change the wording from wander risk assessment to Elopement Risk Assessment by ADON on 12/23/2024.<br><br>Policy named assessments was already in place for assessing residents for elopement and wandering.<br><br>A new policy titled, Elopement was created on 12/30/2024, to address steps to be completed upon an elopement occurring. Input for the policy was provided by QAPI members: CEO, DON, ADON, Safety Office, and Quality Officer. The new policy was provided to all Nurses on 12/30/2024.<br><br>Per policy, care plans are updated immediately following a change in care by the nurse on duty. R1's care plan was updated on 4/28/2024, after her elopement by the RN on duty. It was not updated prior because the facility was not aware of any wandering/exit-seeking behaviors by the resident. All staff received education (see prior training section) on reporting behaviors. Care plans continue to be updated immediately by the nurse on duty and reviewed quarterly by the MDS Coordinator.<br><br>IJ removal date: 01/01/2025<br><br>Attached you will find:<br><br>1. Education sign in sheet<br><br>2. Assessments Policy<br><br>3. Elopement Policy<br><br>(The attachments referenced above are on file with the State Survey Agency.) |