STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185290	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 50491 Based on observations, interviews and record review it was determined the facility failed to ensure it provided a private space for resident council members to meet. This had the potential to affect 16 of 99 residents who attended resident council meeting on 07/17/2024. The findings include: Record review of the facility's policy, Residents Rights. revised March 2017 revealed the facility informed the resident both orally and in writing of his or her rights as a resident, and the rules and regulations governing the resident's conduct and responsibilities during his or her stay at the facility. During an interview with the Administrator on 07/19/2024 at 3:10 PM, he stated the facility did not have a policy to address a residents' privacy during resident council. He stated his expectations would be that federal and state laws would be followed. Observation of resident council meeting, on 07/17/2024 at 11:00 AM, staff were observed entering and exiting the resident concil meeting area that was held in the dining room of the kitchen. Interviews with members of the resident council stated they asked the Administrator for another place to meet but was denied. During an interview with the [NAME] President of the Resident Council, on 07/17/2024 at 9:54 AM, she stated she had asked for another place to hold the resident council meetings. She stated the Administrator informed her there was no other place the resident's could meet. Interview with the Ombudsman, on 07/17/2024 at 11:20 AM, who also attended the resident council meeting, she stated she had requested a private area for the resident council to meet, by was denied by the Administrator. She stated she, along with the [NAME] President of the Resident Council, informed the council of the denial. During a follow-up interview with the Ombudsman, on 07/18/2024 at 12:00 PM, she stated she attended a meeting on April 5, 2024, with the Administrator, Social Worker, a fell ow Ombudsman, and the Resident [NAME] President, regarding the residents' concerns requesting another place to meet, but the request for a private space for the resident council to meet was denied. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/19/2024 at 3:10 PM, with the Administrator, he stated he met with the Ombudsman regarding having another place to meet for resident council, but felt he did not have a place to provide for the residents to meet privately.

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47567 Based on observation, interview, record review, document review, and facility policy review, it was determined the facility failed to ensure residents' comprehensive care plans were developed and implemented for two of five sampled residents assessed for elopement risk, Resident (R)82 and R259. 1. The facility assessed R259 to be at risk for elopement and R259 was care planned as at risk for elopement due to exhibited exit-seeking behavior. However, the resident exited the facility undetected by staff on 09/08/2022 at approximately 4:10 PM and was outside unsupervised for approximately five minutes. 2. The facility assessed R82 to be at risk for elopement for exhibited exit-seeking behaviors. Tthe facility, however, failed to develop and implement an elopement care plan for the elopement risk until 11/03/2022, seven (7) days after R82 first eloped on 10/27/2022. The resident exited the facility again, without staff's knowledge, on 01/02/2023. Staff failed to follow the resident's interventions and the resident was located unsupervised at a nearby residence approximately ten to 15 minutes later. The facility's failure to ensure residents' care plans were developed and interventions implemented to include ensuring residents received adequate supervision and monitoring to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 07/20/2024 and was determined to exist on 09/08/2022 in the area of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656. The facility was notified of the Immediate Jeopardy on 07/20/2024. An acceptable Immediate Jeopardy (IJ) Removal Plan was received on 07/29/2024, alleging removal of the IJ on 01/30/2023. Specific actions taken to remove the IJ for residents affected include: 1.) On 09/08/2022, Resident 259 remained in the visual sight of a Certified Nursing Assistant (CNA) who was outside the facility when the resident went out until further staff arrived, and she was assisted back in to the facility. Immediately following the event, the unit manager completed a head-to-toe skin assessment and pain evaluation, with no injuiries or pain noted. The wanderguard was noted to be in place at that time. 2.) On 09/08/2022 the maintenance director inspected the wanderguard door system and noted that it was non-functioning due to disconnected wires caused by an accidental contact with the transmitter. The maintenance director immediately repaired the door system. Following the repair, the system was checked for function and determined to be functioning properly. In addition, the maintenance director moved the door sensor to prevent another accidental bumping from a wheelchair. Signage was in place on both entrance doors for notice and education to those entering and exiting the center to be aware of tailgating, (look behind). The vendor acknowledged understanding of notice/education at that time. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) On 10/27/2022, Resident 82 was noted to be outside the facility entrance and was assisted back into the facility and placed on increased monitoring. The wander guard system was fully functioning as designed and intended. Immediately following the event on 10/27/2022, a change in condition was completed, and the resident's guardian and physician were notified, a skin assessment and pain assessment were completed on 10/27/2022; no injuiries or pain were reported. Resident 82 was re-assessed for elopement on 10/27/2022. Based on this assessment, this resident was considered an elopement risk, and a wander guard was placed on the resident immediately following the assessment. 4.) Starting on 10/28/2022 and completed on 11/02/2022, facility staff including agency staff were educated by a licensed nurse or the administrator on resident safety, elopement, care plan developement and updates, and changes in resident behaviors. Any new hires, including agency staf will receive elopement education during onboarding and orientation. 5.) On 01/02/2023, Resident 82 was assisted back into the facility and was immediately placed on one-to-one monitoring. Immediately following the event on 01/02/2023, a skin assessment and pain assessment were completed, with no injuries or pain noted. Resident 82's wander guard was noted to be in place and functioning at that time. Also on 01/02/2023 a change in condition was completed by a licensed nurse, and the resident's physician and guardian were notified on 01/02/2023 of the event. 6.) Starting on 01/02/2023 and completed on 01/23/2023, facility staff including agency staff were educated by a licensed nurse or the administrator on resident safety, elopement, care plan developement, and updates, and changes in resident behaviors. Any new hires including agency staff will recieve elopement education during onboarding and orientation. No further incidents of elopements have occurred since 01/02/2023 and the education and training provided during that time. 7.) All Residents at risk for elopement and those with change in condition were reviewed in the daily clinical meetings by the interdisciplinary care plan teams for events, orders, progress notes, behaviors, labs, clinical, and any additional needs identifed were addressed and care plans developed and implemented, and Kardex uodated as necessary. 8.) Starting 01/06/2023, the Minimum Data Set (MDS) Coordinators and or Regional MDS Consultant reviewed residents, new admissions care plans for developement and updates to ensure residents at risk for elopement have a care plan developed and implemented for staff to follow. The Comprehensive Care Plan will ensure each resident identified, medical, nursing, mental, and psychosocial needs are met if elopement triggers. This will continue weekly for two weeks, then decrease monthly for two months. Audits will be reviewed in the Quality and Perfomance Improvement (QAPI) meetings. An Extended Survey was initiated on 07/30/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 08/02/2024, and determined the removal of jeopardy by the facility on 01/30/2023. Therefore, the IJ was determined to be Past IJ. Cross Reference F689. The findings include: Review of the facility's policy titled, Care Plans, Comprehensive and Person-Centered, revised 03/01/2022, revealed a comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was to be developed and implemented for each resident. Further review of the policy revealed when possible, interventions should address the underlying sources of the problem areas and not just the symptoms or triggers. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Safety and Supervision of Residents, revised 07/01/2017, revealed the care team was to target (residents') interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Review further revealed implementing interventions to reduce accidents and hazards was to include communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions (to appropriate staff); providing training as necessary; and ensuring interventions were implemented, documented, and monitored. Review of the facility's policy titled, Wandering and Elopements, revised 03/01/2019, revealed the facility was to identify residents who were at risk of unsafe wandering and to strive to prevent harm while maintaining the least restrictive environment for residents. Further review revealed if a resident was identified as at risk for wandering, elopement, or other safety issues, the resident's care plan was to include strategies and interventions to maintain the resident's safety. 1.) Closed record review of an Admission Sheet revealed the facility admitted R259 on 07/18/2022, with diagnoses to include depression, anxiety disorder, bipolar disorder, unspecified dementia, alcohol abuse, aphasia (communication disorder), and dysarthria (difficulty speaking). Review of R259's Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R259 to have a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated severe cognitive impairment. Further review of the MDS Assessment revealed the facility assessed R259 to require a wheelchair for mobility. Review of R259's Care Plan, initiated on 07/18/2022, revealed the resident was Care Planned to be at risk for elopement related to one or more attempts to leave the facility. The goal of the Care Plan was the resident would not leave the facility without an escort,with interventions to include a wander guard to left ankle, and to utilize and monitor security bracelet per protocol. The facility failed to ensure the resident's care plan was implemented as the resident exited the facility unescorted and her wander guard failed to alarm staff when she exited the facility. Review of R259's Elopement Assessment Risk dated 08/15/2022 at 10:39 AM, revealed the facility assessed the resident as being at risk for elopement based on her ability to self-propel in a wheelchair independently; history of hovering near exits and pushing on front doors. Record review of the facility's investigation, dated 09/08/2022 at approximatley 10:30AM, revealed R259 exited the front entrance with a vendor. The vendor thought she was a visitor. R259 was redirected back into the facility without injury. An investigation was initiated, and the root cause found wass the loose wiring on the left side of the exit door that failed to trigger the wanderguard alarm. Skin and pain assessment initated on R259 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	In a telephonic interview on 07/25/2024 at 9:50 AM, with CNA14, she stated she worked for an agency and was contracted to work for the facility when R259's elopement occurred in 2022. CNA14 stated she was sitting in her truck in the parking lot at work around 10:40 AM. She could not remember the exact date but remembered she had signed a statement regarding the incident, which was signed and dated on 09/08/2022. During the interview, CNA14 stated she was looking down on her phone while she ate her lunch and when she looked up, she witnessed R259 going up through the parking lot in her wheelchair. She stated she jumped out of her truck and ran to R259 , who had rolled herself in her wheelchair all the way up the road and was about three houses from the main road. She stated she asked R259 where she was going, and the resident told her she was going home. CNA14 stated she assisted the resident back to the facility without her getting upset. The CNA14 stated she could not recall if R259 was care planned for elopement. In a telephonic interview, on 07/24/2024 at 11:40 AM, with the former MDS Coordinator, she stated she thought R259 wore a wander guard. She stated she remembered being in the common area speaking with the Director of Orthopedic Rehabilitation (DOR) when R259 exited through the front doors. In an interview with the former Director of Nursing (DON), on 07/25/2024 at 5:50 PM, she stated that at the time she was employed with the facility, there were between two to five residents who wandered and wore wanderguards. She stated R259 was required to have a sitter because she was care planned to be at risk for elopement, but there was no care plan for a one on one sitter. The former DON stated the CNAs were asked to look in on R259 if they had any spare time. Further, she stated the need for the resident's increased supervision to include the need for a sitter should have been care planned. In a telephonic interview on 07/26/2024 at 9:49AM, with the facility's former Telehealth Nurse Practitioner, she stated she was contracted by the facility from March 2023 to June 2023. She stated she assessed the residents upon admission and identieid the residents who were at risk for elopement. She stated that if the residents were at risk, then a care plan should have been in place for the resident. She further stated care plans were important, so that the staff would know how to provide quality care to the residents. In an interview with the Director of Nursing Services (DONS), on 08/02/2024 at 2:41 PM, she stated the effort of preventing elopements was going to effectively identify barriers on admission and any history of elopements at the beginning of the admission process, development of appropriate care plans, in following the elopement policy, and follow-up with those individuals accordingly. In an interview with the Administrator on 08/02/2024 at 2:51 PM, he stated his expectation was for staff to follow the facility's policies and procedures. 2.) Record review of R82's Facesheet revealed the facility admitted R82 on 04/17/2022 with diagnoses to include, anoxic brain damage, dementia in other diseases classified elsewhere, and impulse disorder. Review of R82's Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) assessement date of 04/23/2022 revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R82's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated the resident had severe cognitive impairment. Review of R82's Comprehensive Care Plan, dated 10/28/2022, revealed the facility initiated a care plan for wandering that stated R82 wanders through resident care areas with a goal that R82 would remain safe in the facility when exhibiting exit seeking behaviors. Interventions included: identification information placed in the Elopement Binder, increased supervision, a wander guard placed to the left lower extremity to decrease the risk of attempting to leave the facility unsupervised and to check the placement and function of the wander gaurd every shiift. Review of R82's Comprehensive Care Plan, dated 11/03/2022, revealed an elopement care plan for the resident related to the resident had made one or more attempts to leave the facility during her stay or previous stays in other facilities. The care plan further stated the facility spoke with the resident's state guardian and R82 was not to leave the facility with anyone and to call the guardian. Goals included: R82 would not attempt to leave the facility without an escort by next review. Call State Guardian before allowing resident a leave of absence. Interventions included: allow time for expressions of feelings: provide empathy, encouragement, and reassurance. Redirect from exits by sitting down, comforting, and conversing. Listen to R82 and try to calm resident. On 01/02/2023, the facility failed to implement the care plan in order to prevent R82 from exiting the facility a second time by not providing increased supervision when the resident was noted to have exit seeking behaviors. Review of the facility's investigation dated 11/02/2022, revealed on 10/27/2022 at approximately 7:58 PM, a gentleman showed up at the front entrance of the facility and stated he thought one of the facility's residents was at his home. Continued review of the facility's investigation revealed R82 was seen on video exiting the facility around 7:47 PM, and two staff members (Licensed Practial Nurse [LPN2] and unknown staff) went to the gentleman's home to retrieve the resident and brought the resident back to the facility without incident or injury. In an interview with the Minimum Data Set (MDS) Coordinator 1on 07/19/2024 at 04:09 PM, she stated if the elopement assessment did not indicate a risk they would not have developed a care plan to address elopement in but based on that elopement assessment and the residents actions when they come in, if they weren't considered a risk they would not put in an elopement care plan. During an interview with the Unit Manager, on 07/19/2024 at 9:23 AM, he stated residents should have an initial elopement risk assessment upon admission and be care planned when appropriate. He stated the nursing staff were responsible for updating the resident's care plans and MDS staff would go over them. Further, he stated the care plans were discussed in morning meetings. The Unit Manager stated R82's unit did not have a unit manager during the time of her elopements, so he was not certain if the resident had a care plan developed to address elopements. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with Licensed Practical Nurse (LPN) 2 on 07/19/2024 at 9:27 AM, she stated R82 was an elopement risk and should have been care planned for elopement. LPN2 stated she was watching the resident the day she eloped. She stated the resident displayed exit seeking behaviors, would wander the facility, and talked about leaving the facility frequently. Further, she stated the resident constantly talked about someone coming to pick her up. She stated she did not know why no one care planned the resident's exit seeking behaviors. In an interview with the Former MDS Coordinator on 07/20/2024 at 2:05 PM, she stated that when residents were first admitted , each department was supposed to complete assessments on the residents within 24-48 hours. Further, she stated a care plan would then be initiated. She stated if a resident was assessed to be at risk for elopement, then a care plan for elopement would be initiated. She stated the nurse that admitted the resident should have initiated one for the resident, if not, another nurse should have caught it and care planned the resident to be at risk for elopement. In an interview with the former Director of Nursing Services (DONS) on 07/25/2024 at 1:38 PM, she stated R82 should have had an elopement care plan completed because she was the biggest elopement risk the facility had at that time and her not having one was a complete oversight on the facility's behalf. Further, she stated the consequences of the resident not having an elopement care plan was that staff would not know what to do for the resident to try and prevent an elopement, ultimately resulting in the resident getting out. 50491

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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, facility document and policy review, it was determined the facility failed to provide effective monitoring and supervision to prevent elopement and to prevent residents from becoming missing for two of five sampled residents assessed for elopement risk, (Resident (R)82 and R259) out of the total resident sample of twenty-three (23). R259 on 09/08/2022, and R82 on 10/27/2022, eloped from the facility unescorted, unsupervised, and without staff knowledge. The facility's failure to have an effective system in place to ensure each resident received adequate supervision and monitoring to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 07/20/2024 and was determined to exist on 09/08/2022 in the areas of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656; and 42 CFR 483.25 Quality of Care, F 689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. On 07/30/2024, the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified that the failure to ensure residents were provided supervision and protected from further elopement is likely to cause serious injury, impairment, or death and constituted IJ at 42 CFR 483.25 F689. The IJ at F689 also constituted Substandard Quality of Care (SQC) at 42 CFR 483.25. The IJ was determined to exist on 09/08/2022 when the facility discovered R259 had eloped from the building. The facility provided an acceptable plan for the removal of the IJ on 07/29/2024. This plan alleged the IJ was removed, and the deficient practice was corrected on 01/30/2023, prior to the initiation of the investigation. The plan provided by the facility alleged the following: 1. On 09/08/2022, R259 remained in the visual site of a CNA who was outside the facility when the resident went out until further staff arrived, and she was assisted back into the facility. Immediately following the elopement event, the Unit Manager completed a head-to-toe skin assessment, and pain evaluation, with no injuries or pain noted. The wander guard was noted to be in place at that time. Resident 259's Physician and family/Responsible party were notified of the event. In addition, on 09/08/2022, the Maintenance Director inspected the wander guard door system and noted that it was non-functioning due to disconnected wires caused by accidental contact with the transmitter. The Maintenance Director immediately repaired the door system. Following the repair, the system was checked for function and determined to be functioning properly. Additionally, on 09/08/2022, the Maintenance Director moved the door sensor to prevent another accidental bumping from a wheelchair. Signage was in place on both entrance doors for notice and education to those entering and exiting the center to be aware of tailgating (look behind). On 09/08/2022, the Vendor acknowledged understanding of notice/education at that time. A prior inspection of the wander guard door system had been completed on 09/07/2022, and the system was noted to be functioning. Following the events on 09/08/2022, a one-time reassessment was completed on residents assessed at risk for elopement and change in condition, and no new residents were noted to be 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	2. On 10/27/2022, R82 was noted to be outside the facility entrance and was assisted back into the facility and placed on increased monitoring. The wander guard system was fully functioning as designed and intended. Immediately following the event of R82's elopement on 10/27/2022, a change in condition was completed, and the resident's guardian and physician were notified. In addition, a skin assessment and a pain assessment were completed on 10/27/2022; no injuries or pain noted. Additionally, R82 was reassessed for elopement on 10/27/2022 and based on this assessment, the resident was an elopement risk, and a wander guard was placed on the resident immediately following the assessment. Following the events on 10/27/2022, a one-time reassessment was completed on residents assessed at risk for elopement and change in condition, and no new residents were noted to be at risk for elopement. The Maintenance Director inspected the wander guard system on 10/27/2022 and found the system fully functional and operating properly as intended. 3. On 01/02/2023, R82 was assisted back into the facility and was immediately placed on one-to-one monitoring. Immediately, following the events on 01/02/2023, a skin assessment and pain assessment were completed, with no injuries or pain noted. R82's wander guard was noted to be in place and functioning at that time. Also, on 01/02/2023, a one-time assessment was completed on residents assessed at risk for elopement and change in condition, and no new residents were noted to be at risk for elopement by a licensed nurse. The resident's guardian and physician were notified on 01/02/2023 of the elopement event. In addition, on 01/02/2023, the Maintenance Director checked the wander guard system's functioning, and it was determined to be functioning properly as intended and designed. Additionally, on 01/03/2023, R82 was re-assessed for elopement, and her care plan was reviewed, developed, implemented, and updated to reflect increased supervision. On 01/05/2023, a technologies Healthcare system inspected the wander guard system on all doors and noted that they were functioning properly; adjustments were made at that time to increase sensor range for maximum potential. Residents at risk for elopement and those with changes in condition were reviewed in the daily clinical meetings by the interdisciplinary care plan teams for events, orders, progress notes, behaviors, labs, clinical and any additional needs identified were addressed, and care plans were developed and implemented, and Kardex were updated as necessary. 4. Education: Starting on 09/09/2022 and ending on 09/20/2022, the Regional clinical market team lead educated the Administrator and Director of Nursing on Elopement policy and procedure, talking points and posttest. Starting on 09/09/2022 and ending on 09/20/2022, a Licensed Nurse or the Administrator, educated facility staff, including Agency staff on elopement education, exit-seeking behavior, care plan revision, developments and updates, elopement assessments, status changes, and notifications for condition changes. Any new staff, including Agency staff would receive an education during on boarding and orientation. In addition, starting on 10/28/2022 and completed on 11/02/2022, facility staff including Agency staff were educated by a Licensed Nurse or the Administrator on resident safety, elopement, care plan development, and updates, and changes in resident behaviors. Any new hires, including Agency staff would receive elopement education during on boarding and orientation. Additionally, starting on 01/02/2023 and completed on 01/23/2023, facility staff including Agency staff were also educated by a Licensed Nurse or the Administrator on resident safety, elopement, care plan development and updates, and changes in resident behaviors. Any new hires including Agency staff would receive elopement education during on boarding and orientation. No further incidents of elopement had occurred since 01/02/2023, and the education and training were provided during that time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Nursing and Rehabilitation Center	1550 Raydale Drive Louisville, KY 40219

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Audits: Starting on 01/03/2023 through 01/26/2023, daily elopement drills were completed on various shifts by a License Nurse or Maintenance Director/Assistant. This continued weekly for two (2) more weeks, then decreased to monthly for two (2) months and ongoing. Audits would be reviewed in Quality Assurance Performance Improvement (QAPI) meetings. Then, starting on 02/08/2023, elopement drills were decreased monthly. In addition, starting 01/27/2023, the Maintenance Director or Assistant completed the testing of doors, locks, and alarms four (4) times monthly. This would continue weekly for two (2) more weeks, then decrease to monthly for two (2) months and ongoing. Audits would continue to be reviewed in QAPI meetings. 4. QAPI: On 01/03/2023 an ad-hoc QAPI meeting was held with the Administrator, DON, Nurse Educator, Infection Preventionist, and Medical Director, who participated by phone. The Administrator presented information regarding the elopement incidents and the created plan. The Medical Director had no further recommendations. An additional QAPI meeting was held on 01/20/2023, the QAPI committee members, and the Administrator presented the information at the meeting. The Medical Director had no further recommendations. Starting on 01/20/2023, the QAPI meeting would be held Monthly/Quarterly thereafter. The Administrator/Director of Nursing would present the information at the QAPI meetings. The QAPI committee would increase the frequency of meetings as needed. The Administrator/Director of Nursing would be responsible for ensuring the plan was carried out. In addition, as part of the ongoing QAPI process of systems the following review was completed when ownership changed last fall (2022) by new ownership/clinical team. Therefore, on 11/08/2023, a review of facility elopement events from prior ownership was initiated. Residents at risk for elopement or those that had a change in condition, or as needed in the facility were to be reassessed for elopement. Five previously identified residents were noted to remain at risk for elopement, and no additional residents were determined to be at risk. On 11/08/2023, residents identified as at risk for elopement were noted to have their picture in the elopement book and to have an order in place for wander guard device monitoring for placement and function. Also, on 11/08/2023, residents noted at risk for elopement had a one-time review of their care plan addressing development, elopement risk, including interventions and updated/updates made as necessary. Additionally, on 11/15/2023, the Maintenance Director and/or Maintenance Assistant assessed all doors for proper functioning and safeguards. Further, the volume of the door alarm annunciator was adjusted. An Extended Survey and IJ Removal validation was conducted 07/30/2024 - 08/02/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 08/02/2024. The SSA validated the immediacy of the IJ had been removed on 01/30/2023, as alleged. The findings include: Review of the facility's policy, Safety and Supervision of Residents, revised 07/01/2017, revealed the facility was to strive to make the (residents') environment as free from accident hazards as possible which was a facility-wide priority. Continued review revealed the safety risks and environmental hazards were identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Further review revealed the safety risks and environmental hazards were also identified on an ongoing basis through the Quality Assurance and Performance Improvement (QAPI) reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Continued review of the policy, revised 07/01/2017, revealed individualized, resident-centered care was a core component of the facility's systems approach to safety, and the type and frequency of resident supervision was determined by each resident's assessed individualized needs. The Interdisciplinary Care Team analyzed information obtained from assessments and observations to identify any specific risks for individual residents and shall target interventions to reduce related hazards in the environment, including adequate supervision. Further, review revealed the 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 are implemented and documenting and monitoring the effectiveness of the interventions. Review of the facility's policy, Wandering and Elopements, revised 03/01/2019, revealed the facility identified residents who were at risk of unsafe wandering and strove to prevent harm while maintaining the least restrictive environment for those residents. Continued review revealed if a resident was identified as at risk for wandering, elopement, or other safety issues, the resident's care plan was to include strategies and interventions to maintain the resident's safety. The policy also noted if a resident was missing, the facility was to initiate the elopement/missing resident emergency procedure and upon returning to the facility, the resident was to be examined for injuries by the Director of Nursing Services (DNS) or charge nurse. Staff were to notify the attending physician and report the findings and condition of the resident; notify the resident's legal representative; notify search teams that the resident had been located; complete and file an incident report; and document relevant information in the resident's medical record. Review of the facility's operations policies and procedures manual titled Elopement of Patient dated 2022, revealed residents would be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the clinical assessment process. Those residents determined to be at risk received appropriate interventions to reduce risk and minimize injury. The procedures manual defined Elopement as any situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary. Review of the facility's Elopement Binder revealed four (4) residents listed who were noted to be at risk for elopement. Resident 259 no longer resided at the facility. 1.Closed record review of an Admission Sheet revealed the facility admitted R259 on 07/18/2022, with diagnoses to include depression, anxiety disorder, bipolar disorder, unspecified dementia, alcohol abuse, aphasia (communication disorder), and dysarthria (difficulty speaking). Review of R259's Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R259 to have a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated severe cognitive impairment. Further review of the MDS Assessment revealed the facility assessed R259 to require a wheelchair for mobility. Review of R259's Elopement Assessment Risk dated 08/15/2022 at 10:39 AM, revealed the facility assessed the resident as being at risk for elopement based on her ability to self-propel in a wheelchair independently; history of hovering near exits and pushing on front doors. Review of R259's Order Summary dated 08/15/2022 at 11:29 AM, revealed a written physician order for a wander guard (security bracelet) to left ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's investigation dated 09/13/2022, revealed on 09/08/2022 at approximately 10:30 AM, Resident 259 exited the facility with a vendor, as he thought resident was a visitor. The vendor stated he observed resident propelling fast in her wheelchair towards the left side of the facility parking lot. Approximately two to three minutes later, after putting his equipment inside the van, the vendor then went to alert staff of his suspicion that he let a resident out of the facility. Per the facility's investigation, R259 wore a security bracelet (wander guard) to her ankle; however, the security alarm (wander guard) did not sound when the resident exited the facility. Upon the Maintenance Director's investigation, it was revealed the sensor on the left side of the entrance/exit door was not connected. Continued review of the facility's investigation revealed after R259 went missing and was later located in the facility's parking lot unsupervised, she was redirected back into the facility per staff assistance. Further review of the facility's investigation revealed due to R259's difficult time communicating related to her aphasia, the facility conducted another Brief Interview for Mental Status (BIMS) score of the resident on 09/08/2022, at which time resident scored an 11 out of 15, which indicated the resident had moderate cognitive impairment. However, review of R259's Admission MDS assessment dated [DATE], revealed the facility assessed resident to have a BIMS score of two out of 15, which indicated severe cognitive impairment. In addition, review of R259's Quarterly MDS assessment dated [DATE], three (3) months after the resident went missing revealed the facility assessed resident to have a BIMS score of five out of 15, which also indicated severe cognitive impairment. Review of the internet weather history for 09/08/2022 at 10:30 AM for the facility's location, revealed it had been sunny with passing clouds and the temperature was 74 degrees Fahrenheit (F). In an interview with the Maintenance Director on 07/20/2024 at 9:00 AM , he stated the security (wander guard) alarm system would sound an alarm when the entrance/exit door handles were pressed on, of which had a slow beep sound and once it recognized the wander guard alarm the beeping would speed up, and if the door handle continued to be pressed on, the fire egress system would initiate and the door would automatically unlock and open in 15 seconds as long as the door handle itself was still being pressed on. He stated maintenance performed mandatory tests on the exit doors twice a week on Mondays and Fridays and may perform an additional test during the week as needed. The Maintenance Director further stated the facility had eight (8) doors that had the security (wander guard) alarm system. He stated with the elopement that occurred in September of 2022, his investigation revealed the antennas on the door sensor were knocked loose and he repaired that immediately. He stated he also had the alarm company come out and check the system as well to ensure that it was functioning properly. In addition, the facility also put in strobe lights and loud decibel alarms to get staff's attention and improve staff's response to the alarm. He further stated he did not recall any other resident making it outside of the building besides R82. He stated she was the only resident to cross the threshold, others got close but to his knowledge, residents never made it out of the building and the only door the facility ever had issues with was the front door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Vendor on 07/24/2024 at 4:33 PM, he stated he was making a routine delivery to replace oxygen tanks at the facility on 09/08/2022 and commented, you must be buzzed in and out of the facility. He stated at about 10:30 AM, late morning, in the middle of his rounds he noticed a lady in a wheelchair (R259), going room to room and up and down the halls. The Vendor stated shortly after 10:30 AM, as he finished up all his rounds and went back to the entrance, he asked to be buzzed out and a maintenance man came and asked if he was ready to go out. The vendor stated R259 was behind him the whole time, and when he was permitted to exit, R259 followed and came out too. He further stated, as he walked to his truck, he observed R259 propel towards the left side of the parking lot, rolling fast. However, the Vendor stated he noticed R259 was headed quickly towards the exit area of the parking lot and; therefore, he thought something might be wrong and went back in the facility to alert staff. He added this was all within an approximate three to five minute time frame. In an interview with the facility's Scheduler on 07/25/2024 at 4:20 PM, she stated she started as a central supply staff member in November 2021 and then in May 2022, moved into the scheduler position and worked that position until April 2024. The Scheduler stated she remembered the elopement incident of R259 on 09/08/2022, as R259 followed a vendor out the entrance door. The scheduler stated a staff member, Certified Nursing Assistant (CNA14), was sitting in their car, and a woman's voice called the front desk and asked if R259 was supposed to be outside alone. Shortly after, she remembered someone rolled R259 back into the facility. The scheduler recalled the Administrator, and the DON were present in the front area when this occurred. She further stated there was an elopement binder kept at the front desk and at each nurse's stations that list residents at risk of elopement with a picture of the residents at risk of wandering. However, the scheduler did not know if R259 had been care planned for wandering and elopement but she knew R259 wore a security alarm (wander guard) for monitoring. In an interview with CNA13 on 07/20/2024 at 12:10 PM, she stated a wandering resident would have a wander guard in place, and staff must supervise and monitor those residents because if you do not watch them, on any given moment they could be exit seeking. CNA13 further stated, there were elopement binders at each nurse's station and at the front desk with the receptionist, that included those residents' identity, photo, and elopement risk information. In an interview with CNA14 on 07/25/2024 at 9:50 AM, she stated when the elopement occurred in September 2022 with R259, she was sitting in her truck in the parking lot at work, eating her lunch and looking on her phone at approximately 10:40 AM. She happened to look up as R259 was going through the parking lot in her wheelchair. CNA14 stated she then called the Scheduler and asked if R259 was to be outside and the Scheduler told her No. Therefore, CNA14 jumped out of her truck and ran to R259, who had rolled herself all the way down the road and was about three houses from the main road. She stated she asked R259 where she was going, and the resident told her she was going home. At that time, CNA14 stated she rolled resident back into the facility in her wheelchair. Further, she observed the Administrator and the Maintenance Director checking the wander guard sensor wires on the front entrance doors. In an interview with CNA15 on 07/23/2024 at 4:00 PM, she stated she remembered R259 being in a wheelchair, and moving up and down the halls a lot in her wheelchair. CNA15 stated R259 would sit up front around the entrance and was considered a risk for elopement. CNA15 stated R259 did not ever elope while she was working that she was aware; however, resident was a wanderer and noted to be exit seeking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the former Minimum Data Set (MDS) Coordinator on 07/24/2024 at 11:40 AM, she stated she recalled R259's placement of a security bracelet (wander guard) and the facility care planned R259 for elopement risk. MDS Coordinator remembered R259, and the resident did not recall nor communicate a lot during the interview, indicating a low BIMS score. In an interview with the former Director of Nursing (DON) on 07/25/2024 at 1:38 PM, she stated she recalled R259 exitting the facility with the oxygen vendor as the vendor let her go out with him. She stated after this incident she did a lot of education with staff and vendors on elopement and educated them on which residents were at risk for eloping. She stated she remembered R259 was a younger resident who could easily be mistaken as a visitor. She stated she made sure her education focused on that concern and making sure someone was at the front desk and that they stayed well informed of who came and went out of the building. She stated she believed before R259's incident they knew about her exit seeking behavior, but it was not until after the resident had eloped that they placed her as a one-on-one (1:1) with staff. She stated R259 used to be very easy to redirect, up until the elopement then afterwards she was always 1:1 supervision because she continued to attempt to elope. The former DON, on 07/25/2024 at 1:38 PM, also stated she tried to stress to staff the importance of responding to the door alarm as soon as it sounded; however, she learned during the re-education process that some of the staff were not aware of the process of what to do when the alarm went off, some of the CNAs stated to her that they did not realize they were to respond, but thought other staff members were responsible for checking the doors. The former DON further stated at the time that the elopement incident occurred, she felt it had to do with how the staff responded because one of the incidents occurred during shift change. Since the elopement, former DON stated the facility tried to ensure someone was always up front watching the front entrance by having the Administrator's office up front, extending the receptionist hours at the desk, and to have another staff member cover the desk if she had to go to the restroom or on break. She stated the goal was to always have somebody up front watching the front entrance. In addition, the former DON stated she provided an extensive amount of education and the facility had only three of their own staff members at the time of R259's elopement and all the rest were agency. The DON added the facility increased the length of orientation to one full week and dedicated one-half day of orientation to customer satisfaction education and the other half of the day to customer escalation techniques. Futher, the former DON stated she ultimately had to follow up with the staff that was refusing to participate in the elopement drills by enforcing the discipline process, giving verbal warnings to staff that she knew she had already educated but were not being active in participation because she felt any elopement was important and must be addressed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the former Administrator on 07/20/2024 at 2:00 PM, she stated she was the former Administrator during R259's elopement on 09/08/2022. She stated she remembered, R259 and stated the resident was admitted to the facility due to a stroke; therefore, required a wheelchair and was assessed as difficulties with communication. The Former Administrator further stated that on the day R259's exited the facility unsupervised, she was in her office when she and the Maintenance Director heard the alarm. She stated she observed the vendor coming back in the front entrance as the agency CNA (CNA14) was coming back inside the facility with R259 without any injuries or concerns and resident was placed on one-on-one supervision at that time. The former Administrator stated all the doors were checked and ensured R259's wander guard bracelet was on properly and activated. She stated she was informed that after the Maintenance Director's inspection, he revealed the sensor was knocked to the side and was not working properly; therefore, the sensors were repaired immediately. In addition, the Maintenance Director preformed checks on all the doors daily and R259 was listed in the binder as an elopement risk. The former Administrator could not recall if the receptionist was at the front entrance or not during the incident. She stated R259 experienced no injuries, nor psychosocial issues. Additionally, facility wide drills, door checks, staff re-education and trainings were initiated and implemented immediately. 2 a). Review of the facility's investigation dated 11/02/2022, revealed on 10/27/2022 at approximately 7:58 PM, a gentleman showed up at the facility front entrance and stated he thought one the facility's residents was at his home. Continued review of the facility's investigation revealed R82 was observed on video exiting the facility around 7:47 PM, and two staff members went to the gentleman's home to retrieve the resident and brought the resident back to the facility without incident or injury. Record review revealed R82 was admitted on [DATE] with diagnoses to include, anoxic brain damage, dementia in other diseases classified elsewhere, and impulse disorder. Review of R82's Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of seven out of fifteen, which indicated the resident had severe cognitive impairment. The State Survey Agency (SSA) surveyor attempted an interview with Certified Nursing Assistant (CNA) 7 on 07/17/2024 at 6:40 PM. The SSA surveyor left a voicemail message; however, did not receive a return phone call and the staff member was no longer employed at the facility. The SSA surveyor attempted an interview with CNA8 on 07/17/2024 at 6:42 PM and a voicemail was left; however, the SSA surveyor did not receive a return phone call and the staff member. The staff member was no longer employed at the facility. In an interview with R82's State Guardian on 07/18/2024 at 10:00 AM, she stated she was notified by the facility regarding R82's elopement incidents. She stated she was made aware that R82 would be placed on one-on-one monitoring. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50671 Based on observation, interview, and facility policy review it was determined the facility failed to store, prepare, distribute and/or serve food in accordance with professional standards for food service safety. Observations revealed food items were opened with no dates and/or uncovered. This had the potential to affect 95 of 99 residents with five residents receiving tube feedings The findings include: Review of facility policy, dated 03/2023, revealed all opened food items should be dated with the date opened and covered. Additionally, all food items will be checked to ensure consumption before their use-by date, or frozen, or discarded. During the initial kitchen tour on 07/16/2024 at 5:30 AM, observation revealed in the reach-in refrigerator a package of strawberry yogurt. In the walk-in refrigerator a bag of carrots, cabbage in a shredded cheese box, one package of bacon not covered, a bag of potato tots, all of which was opened and not dated. Additionally, observation revealed a pork roast lying on a top shelf in the freezer, not in correct box, or dated when it was placed on shelf. During an interview with the Dietary Aide/Cook 1, on 07/16/2024 at 5:30 AM, she stated she cooks in the morning and helps as a dietary aide on evening shift when needed. She stated it was everyone's responsibility to date and label all opened items. She further stated undated items placed in the refrigerator, unlabeled, could cause residents to become ill, as staff would not have an idea how old the items were. During an interview with the Dietary Manager 1, on 07/16/2024 at 9:30 AM, she stated everyone working in the kitchen was responsible to label and date all items placed in the refrigerator and to place items back in the correct box. She further stated by not doing so, staff would have no way of knowing how old a food item was; therefore, the food item would have to dispose of it because serving it to the resident could cause stomach issues. The Dietary manager stated her expectation was for all dietary staff to follow the facility's policy and procedure. During an interview with the Corporate Dietary Manager on 07/18/2024 at 12:30 PM, she stated it was the responsibility of all dietary employees working in the kitchen to ensure all items were covered, labeled, and checked for expiration dates. She then stated her expectation was for the Dietary Manager to enforce the policy and to retrain staff as needed.