STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185173	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CUMBERLAND NURSING AND REHABILITATION CENTER	**200 NORFLEET DRIVE SOMERSET, KY 42501**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **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** Based on interview, record review, and a review of the facility policy, it was determined the facility failed to ensure one (1) of three (3) sampled residents (Resident #1) received adequate supervision and assistive devices to prevent accidents. In March 2020, the facility front door keypad (used to unlock the door) malfunctioned and was inoperable. The non-functioning keypad was switched with the functioning keypad on the D-Hall exit door on 03/20/2020. Maintenance staff rewired the keypad to the D-Hall exit door and left the wires exposed so that staff could reset the egress alarm if activated. The D-Hall door keypad exposed wires had become disconnected at some point, which deactivated the door lock and alarm on the D-Hall exit door. On 04/26/2020, Resident #1 exited the facility through the D-hall exit door without staff knowledge. The resident was last seen by staff inside the facility between 10:50 AM and 10:55 AM on 04/26/2020. The resident was found outside at approximately 10:58 AM by a facility staff member in the facility parking lot uninjured. The findings include: A review of the facility policy for elopement titled Missing Resident/Elopement Policy and Procedure, undated, revealed the purpose of the policy was to ensure that all necessary steps are taken in the event that a resident wanders away from the facility. According to the policy if a staff member observed a resident attempting to leave the facility the staff member would attempt to prevent such departure. Further review of the policy revealed Maintenance personnel were responsible for seeing that alarms were operational and checked on a routine basis. A review of the medical record for Resident #1 revealed the facility admitted the resident on 12/10/2019 with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was assessed to use a wheelchair for mobility. Further review of the assessment revealed the resident required supervision and setup help with ambulation and had no wandering behaviors. The resident was assessed to be moderately impaired for cognition with a Brief Interview for Mental Status (BIMS) score of ten (10). A review of the plan of care developed for Resident #1 revealed interventions to provide assistance of one staff member for ambulation. Further review of the plan of care revealed the plan of care was revised on 04/26/2020 with interventions for the resident to wear a wanderguard. There was no evidence of any elopement behaviors in the resident's record prior to 04/26/2020. A review of an incident report completed for Resident #1 revealed the resident was found outside in the facility parking lot on 04/26/2020 at 11:58 AM by a facility staff member. According to the report, the resident stated that he/she didn't know why (he/she) went out the door and didn't mean to cause any problems. The resident was returned to the facility and assessed to have no injuries. The resident's vital signs were recorded as: blood pressure of 119/74, heart rate of 79, respirations of 18, and an oxygen saturation of 90%. A review of the facility investigation summary dated 05/01/2020 revealed Resident #1 exited the facility via the D-Hall exit door and walked toward an alternate entrance to the facility. The resident was observed by a staff member and escorted back into the facility without incident. Prior to the incident, the resident was not assessed to be an elopement risk. According to the investigation, the resident was observed in the doorway of his/her room between 11:50 AM and 11:55 AM. A facility housekeeper clocked out at 11:58 PM, exited the building, and observed Resident #1 outside in the parking lot. Per the investigation summary, the resident was escorted back into the building, placed on fifteen (15) minute checks, and a wanderguard was placed on the resident. A review of the investigation revealed the temperature was forty-eight degrees and the resident was dressed in long-sleeve fleece pajamas and high-top slippers with rubber soles. A review of an elopement risk assessment completed for Resident #1 on 04/26/2020 revealed the resident was assessed to not be at risk for elopement, even though the resident had exited the facility the same day. Interview with the Minimum Data Set (MDS) Nurse on 05/06/2020 at 11:23 AM revealed she had completed an MDS assessment for Resident #1. The MDS Nurse stated the resident did not have a history of attempting to exit the building since the resident was admitted and no history of eloping prior to being admitted . According to the MDS nurse, she incorrectly marked the resident's elopement risk assessment in the computer but did consider the resident to be at risk for elopement after the incident on 04/26/2020 and added the wanderguard intervention to the resident's plan of care. An interview with Resident #1 on 05/04/2020 at 10:00 AM revealed the resident had exited the building but the resident could not recall the day. According to the resident, he/she was not hurt and staff assisted the resident back into the building. The resident did not reply when asked where he/she was going or why he/she had exited the building. An interview with Housekeeper (HK) #1 on 05/04/2020 at 12:58 PM revealed the housekeeper was going to lunch on 04/26/2020 and had clocked out at 11:58 AM. HK #1 stated he was walking down the sidewalk toward the parking lot and he observed Resident #1 standing beside his vehicle. HK #1 stated he immediately alerted staff that the resident was outside, a code yellow was called, and staff assisted the resident back into the building. An interview with State Registered Nurse Aide (SRNA) #1 on 05/05/2020 at 10:13 AM revealed the SRNA was alerted by HK #1 on 4/26/2020 that Resident #1 was outside. Per the SRNA, a code yellow was called and SRNA #1 assisted Resident #1 back into the building. According to SRNA #1 the resident had no injuries or was in no distress. SRNA #1 stated Resident #1 told him that the resident wanted to go home. Further interview with SRNA #1 revealed Resident #1 had never attempted to exit the building before. The SRNA stated the resident was placed on 15-minute checks and a wanderguard bracelet was applied to the resident. An interview with the Maintenance Director on 05/06/2020 at 9:23 AM revealed on 04/26/2020 the Maintenance Director came to the facility to check the door after Resident #1 had exited the facility. Further interview with the Maintenance Director revealed he had switched the front door keypad and the D-Hall keypad when the front door keypad became inoperable. The Maintenance Director stated he was instructed by the former Administrator due to budget issues to switch the keypads on the front door and the D-hall door. The Maintenance Director switched the keypads on 03/20/2020, rewired the D-hall keypad, and left the wire exposed so staff could disconnect the wires and reset the door if the alarm was activated. The Maintenance Director also stated he should have placed the wires inside the keypad box to prevent anyone from deactivating the door by disconnecting the wires. The Maintenance Director stated that when the new Administrator became aware of the door keypad being inoperable a new keypad was ordered, obtained, and installed on 05/01/2020. An interview with the Administrator on 05/05/2020 at 10:45 AM revealed the Administrator was not aware of the D-Hall keypad being rewired and not working as intended. According to the Administrator, she was called to the facility on [DATE] after Resident #1 had eloped. The Administrator stated she observed the wires to the keypad were disconnected and reconnected the wires. The Administrator stated she then had the Maintenance Director to install the wires inside the keypad box so the box would have to be taken apart by Maintenance to reset the alarm. The Administrator stated this was done until the box could be replaced. Per the Administrator, a new keypad was ordered, the keypad was installed by a contract company, and the door was checked for function on 05/01/2020.

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

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.