STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185455	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALHALLA POST ACUTE	**300 SHELBY STATION DRIVE LOUISVILLE, KY 40245**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Immediate jeopardy **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** Based on interview, record review, and facility policy review it was determined the facility failed to implement the care plan to ensure resident safety and prevent elopement for one (1) of four (4) sampled residents (Resident #1). Resident #1's family member contacted staff on 04/26/2020 and requested to FaceTime with the resident. Staff could not locate the resident inside the facility to conduct the FaceTime (an audio/video phone call) visit. During the search of the building, a rear exit door was found alarming. Staff continued searching and discovered Resident #1 was outside the facility, on the ground crawling up a hill near a heavily traveled roadway. Interview revealed the resident was trying to go home. The facility had assessed the resident as a wanderer, and elopement risk; and, applied a wanderguard bracelet. Interviews with staff revealed on 04/26/2020 the resident was wandering in and out of resident rooms and the nurse's station and redirection was not effective. However, the facility failed to increase the resident's supervision to ensure the resident's safety. Resident #1 exited the facility without knowledge. The facility's failure to ensure care plans were developed to minimize elopement risks has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/15/2020 and determined to exist on 03/11/2020 at 42 CFR 483.25 Quality of Care (F689) and 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656). The facility was notified of the Immediate Jeopardy on 05/15/2020. Substandard Quality of Care was identified at CFR 483.25 Quality of Care (F689). An acceptable Allegation of Compliance was received on 05/20/2020, which alleged removal of Immediate Jeopardy on 05/18/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/18/2020 as alleged, prior to exit on 05/28/2020, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F689) and 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy Care Plans, Comprehensive Person-Centered, undated, revealed the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident. The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy review revealed the comprehensive, person-centered care plan would include measurable objectives and timeframes; describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; incorporate risk factors associated with identified problems; build on the resident's strengths; reflect treatment goals, timetables and objectives in measurable outcomes; identify the professional services that were responsible for each element of care; aid in preventing or reducing decline in the resident's functional status and/or functional levels; and reflect currently recognized standards of practice for problem areas and conditions. Identifying problem areas and their causes, and developing interventions that were targeted and meaningful to the resident, were the endpoint of an interdisciplinary process. Further review of the policy revealed care plan interventions were chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making. When possible, interventions will address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. The policy revealed assessments of residents were ongoing and care plans were revised as information about the resident and the resident's condition changed. Review of the facility's policy, Safety and Supervision of Residents, undated, revealed the facility's individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents. The policy stated the interdisciplinary care team (IDT) would analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. Further review revealed the care team would target interventions to reduce individual risks related to hazards in the environment including adequate supervision and assistive devices. Review of the clinical record revealed the facility admitted Resident #1 on 11/15/19 with [DIAGNOSES REDACTED]. Review of the Nursing - Wandering Risk Observation/Assessment, dated 03/13/2020, revealed the facility assessed the resident as high risk to wander. Review of Resident #1's physician's orders [REDACTED].#1 was at risk for elopement with a goal he/she would not wander out of the facility unattended. Interventions included attempt to divert the resident's attention when he/she became insistent on leaving; check door alarms promptly to ensure safety; placement of an elopement prevention bracelet at all times; and check resident's location frequently. Review of Resident #1's Progress Notes revealed the resident removed the bracelet on 03/10/2020, 03/11/2020, and cut off the bracelet on 03/12/2020, 03/22/2020, 03/31/2020, and 04/18/2020. Interview with CNA #2, on 05/13/2020 at 10:41 AM, revealed on 04/26/2020, Resident #1's family member contacted staff and requested to FaceTime with the resident. Staff could not locate the resident inside the facility to conduct the FaceTime (an audio/video phone call) visit. During the search, staff noted a rear exit door alarming. Resident #1 was outside the facility, on the ground crawling up a hill near a heavily traveled roadway. Interview with the RN House Supervisor, on 04/12/2020 at 4:27 PM, revealed the resident was trying to go home. Interviews with staff revealed on 04/26/2020 the resident was wandering in and out of resident rooms and the nurse's station and redirection was not effective. However, the facility failed to increase the resident's supervision to ensure the resident's safety. On 04/26/2020 at approximately 8:00 PM, Resident #1 eloped from the facility without staff knowledge. Interview with Certified Nursing Assistant (CNA) #3, on 05/13/2020 at 5:30 PM, revealed Resident #1 was adamant about removing the wanderguard bracelet and asked staff to loosen it. CNA #3 stated she was assigned to care for Resident #1, the day he/she eloped. The CNA stated all staff tried to monitor the resident's whereabouts if they were not in the middle of care. However, staff was getting residents ready for bed when Resident #1 eloped. She further stated she did not hear a wanderguard alarm on the English Oaks Garden (EOG) hall. Interview with CNA #4, on 05/13/2020 at 6:19 PM, revealed she was in a resident's room assisting CNA #7 when Resident #1 eloped. She further stated she did not hear a wanderguard alarm on the EOG Hall. Interview with Registered Nurse (RN) #1, on 05/12/2020 at 5:07 PM, revealed Resident #1 was very confused, wandered, and was an elopement risk. RN #1 stated interventions for management of exit-seeking behaviors would include checking for placement of the wanderguard, 15-minute safety checks, and ensuring the resident did not have access to items to remove the wanderguard. She stated all staff was responsible for supervision of residents to ensure their safety; however, Resident #1 was not supervised the evening he/she eloped from the facility. According to RN #1, staff were getting residents ready for bed and she was in the restroom when Resident #1 eloped. Interview with the RN House Supervisor, on 05/12/2020 at 4:27 PM, revealed he was aware of a couple of incidents when Resident #1 exited the building. The RN stated he documented all events on an incident report in the electronic record. The Supervisor stated during further interview, that staff knew to pay more attention to Resident #1 because he/she moved around pretty good. The facility did not provide incident reports for Resident #1. Interview with Licensed Practical Nurse (LPN) #3, on 05/14/2020 at 3:08 PM,

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.

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) revealed Resident #1 was not wearing the physician ordered wanderguard bracelet when he/she went outside unsupervised on or around the day the resident changed rooms on 04/21/2020. However, she did not investigate to determine how the resident removed the bracelet. The LPN revealed she was responsible for documenting the incident and monitoring for further behavior(s). Further review of Resident #1's clinical record revealed LPN #3 failed to document the incident, the circumstances surrounding the event, the removal of the wanderguard bracelet, or the interventions that were implemented to ensure the resident's safety. Interview with LPN #1, on 05/13/2020 at 12:23 PM, revealed she constantly replaced Resident #1's wanderguard bracelet because the resident cut it off. She stated she removed scissors from the resident's room; however, she did not check the room each time the wanderguard was missing. LPN #1 stated the resident's care plan addressed resident's needs and included interventions to meet expected goals; however, she did not implement interventions to address Resident #1's behavior. She revealed the MDS Coordinator was responsible for revising the care plan. Interview with the MDS Coordinator, on 05/14/2020 at 10:01 AM, revealed the goal of the care plan was to identify problems and implement interventions to individualize the care and prevent potential decline. She stated the IDT reviewed physician's orders [REDACTED]. The MDS Coordinator stated interventions for elopement risk could include an activity assessment, frequent safety checks, and/or labs to rule out potential medical issues. She stated it would be important to implement interventions to prevent the resident from removing the wanderguard bracelet and ensure his/her safety. She stated she did not know why the issue with Resident #1's wanderguard was not addressed. The MDS Coordinator further stated all staff were responsible for supervision of residents; however, it was not possible to supervise residents every second. Interview with the Director of Nursing (DON), on 05/14/2020 at 10:41 AM, revealed the care plan was a living, breathing document and should reflect a resident's condition. She stated the IDT reviewed orders, incident reports, and progress notes during the daily clinical meeting and the MDS Coordinator updated care plans as needed. The DON revealed staff supervised Resident #1 and implemented the elopement risk care plan on the day he/she eloped. According to the DON, the facility did not have 1:1 resident supervision. Interview with the Administrator, on 05/28/2020 at 2:47 PM, revealed no concerns were identified during the facility's initial investigation of the incident. The Administrator stated the facility reopened the investigation when Adult Protective Services (APS) contacted them on 05/08/2020 regarding an anonymous complaint. The Administrator revealed staff should be monitoring residents at risk for exit-seeking; however, staff left Resident #1 unattended on the evening he/she eloped. ***The facility implemented the following actions to remove the Immediate Jeopardy effective 05/18/2020: 1. On 05/05/2020 the facility transferred Resident #1 to another facility. 2. On 05/16/2020 and 05/17/2020 the Director of Nursing (DON), Assistant Director of Nursing (ADON), Quality Assurance (QA) Nurse, Advanced Practice Registered Nurse (APRN), Social Services, and Minimum Data Set (MDS) staff reviewed medical records of all residents identified as a wanderer or elopement risk. They also reviewed Care Plans to assure appropriate interventions for supervision were addressed and appropriate. Care plans were updated as needed on 05/17/2020. 3. The facility reviewed all residents' medical records, nurse's notes, progress notes, electronic Medication Administration Record [REDACTED]. They also reviewed care plans to assure appropriate interventions for supervision were addressed. The DON, ADON, QA Nurse, APRN, Social Services, and MDS staff updated care plans as needed on 05/17/2020. The facility reviewed 108 resident records and revised 30 care plans. 4. On 05/17/2020, the Administrator reviewed and revised the facility's Wandering and Elopement Policy to include a secondary risk assessment. The Social Services Director (SSD) will utilize a secondary Wandering/Elopement Risk Assessment when the initial Electronic Health Record (EHR) Wandering Risk Observation/Assessment score indicated the resident was At Risk or High Risk of Wandering/Elopement (risk score of 9 or greater). The interdisciplinary team (IDT) will review 24 hour reports (progress notes, assessments, Medication Administration Record [REDACTED]. Ten (10) residents were added to the Wandering/Elopement risk list by the IDT team. The facility had six (6) residents with wanderguards and added two (2) new residents after the risk assessments were completed. The QA nurse will audit the completion of Wandering Risk Observation/Assessment and the Wandering/Elopement Risk Assessment weekly to ensure the revised policy is implemented and will report the findings to the QA Committee. 5. On 05/17/2020, the facility re-educated all nurses regarding the Wandering and Elopement Policy, Care Planning - Interdisciplinary Team, Care Plans, Care Plan Revision, and Safety and Supervision of Residents. The Administrator, Director of Nursing (DON), and Director of Staff Development conducted the training. The education included a pre- and post-test derived from Valhalla Post-Acute policy and procedures. The facility reeducated all nurses except for five (5) regular staff and, as needed staff or those on leave. As needed staff or staff on leave have been flagged on the schedule as unable to return to work until education is completed. The education is also included in the nursing section for new-hire orientation. 6. The Interdisciplinary Plan of Care (IPOC) Team will review 24-hour reports (to include 24-hour summary, Progress Notes, Incidents, eMAR notes, User Defined Assessments (UDA), Admissions/Discharges, Order Recap Report, and Assessment report) Monday through Friday and revise the care plan as needed for behavior and supervision interventions. The weekend RN House Supervisor will review the reports and revise care plans as needed on weekends. The DON will report findings of the audits to the QA Committee. 7. The DON and Administrator will review incident/accident reports, new resident behavior(s), care plan intervention(s), investigation findings, and all reportable events, for thoroughness of investigation and appropriateness of care planning/supervision interventions. The reviews will be conducted weekly and the DON will report identified areas of concern to the QA Committee. 8. On 05/12/2020, the Administrator created an Action Plan and presented the plan to the QA committee on 05/13/2020 during an Ad Hoc meeting. Members of the committee include: the Medical Director, Administrator, DON, QA Nurse, Infection Control Nurse/Director of Staff Development, Social Services, Dietary Manager, Pharmacy, Admissions and Therapy Director. 9. The Action Plan included inservicing all staff on the facility's policy and procedure for Wandering and Elopement, and Behavioral Assessment, Intervention and Monitoring; reviewing all wandering/elopement assessments to ensure assessments were current; reviewing care plans of residents at risk for wandering/elopement to ensure interventions were appropriate; updating all 'Valhalla Voyager elopement binders; checking wanderguard alert check points and exit doors; and verifying physician's orders [REDACTED]. 10. On 05/17/2020, the Administrator conducted an Ad Hoc QA meeting to notify the Medical Director of events and the Action Plan. Committee members attending included: the Medical Director, Administrator, DON, QA Nurse, ADON, and the Regional Director of Operations. 11. The QA Committee is meeting weekly until the IJ is removed and monthly thereafter. The committee will discuss current AOC measures and will evaluate the effectiveness of the AOC for on-going compliance with Accidents and Supervision and Care Planning. *** The State Survey Agency verified the facility implemented the following actions to remove the Immediate Jeopardy on 05/18/2020. 1. Record review on 05/27/2020 revealed the facility transferred Resident #1 to a behavioral health facility on 05/05/2020. Notifications were made according to policy. 2. Interviews with the DON, ADON, QA Nurse, APRN, Director of Social Services (SSD), and MDS Coordinator revealed the facility reviewed clinical records of all residents assessed as a wandering or elopement risk to identify unknown behaviors and revised care plans as needed. Record review revealed the facility revised Residents #2, #3, and #5's care plan for elopement on 05/17/2020. 3. Interviews with the DON, ADON, QA Nurse, APRN, Director of Social Services (SSD), and MDS Coordinator revealed the facility reviewed all resident clinical records to identify any unknown behaviors for the previous 60 days and reviewed care plans to ensure interventions were in place to address supervision. Record review revealed the facility revised thirty (30) care plans on 05/17/2020. 4. Interview with the Administrator, on 05/28/2020 at 2:47 PM, revealed she revised the Wandering and Elopement Policy on 05/17/2020 and implemented a secondary Wandering/Elopement Risk Assessment form to be completed when a resident triggered at risk or high risk for elopement. Interview with the QA Nurse, on 05/27/2020 at 2:01 PM, revealed she reviewed wandering/elopement risk assessments during the daily Interdisciplinary Plan of Care (IPOC) meeting to ensure secondary assessments were completed according to the revised policy. She revealed the DON recorded the findings on the IPOC meeting form and new residents identified at risk or high risk were included in the weekly QA meeting report. Record review revealed the SSD conducted secondary assessments on 05/17/2020 for thirteen (13) residents identified as at risk or high risk for wandering/elopement. Review of the clinical records for Residents #2, #3, and #5 revealed the facility conducted a secondary assessment and revised the care plan on 05/17/2020. Review of the clinical record for Resident #6, revealed the facility identified new wandering behaviors, conducted a secondary risk assessment, revised the care plan and implemented new interventions to address elopement risk on 05/23/2020. Review of the 'Valhalla Voyager' elopement binder revealed seventeen (17) residents were at risk for wandering and/or elopement; nine (9) residents at risk for elopement and eight (8) residents with wanderguards. 5. Review of the Nursing In-Service, dated 05/17/2020, revealed the facility re-educated nurses regarding the Wandering and Elopement Policy, Care Planning - Interdisciplinary Team, Care Plans, Care Plan Revision, and Safety and Supervision of Residents. Thirty-two (32) staff members were educated. Four (4) nurses that worked as needed schedules or were on leave remained untrained on 05/28/2020. Interview with the Director of Staff Development, on 05/27/2020 at 3:36 PM,

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F 0656 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) revealed all staff would be educated on the Wandering and Elopement, Care Plans, Care Plan Revision, and Safety and Supervision policy and procedure during new-hire orientation. The Director of Staff Development revealed she reviews the staffing schedule daily and communicates with the scheduler to ensure agency staff are trained prior to providing direct resident care. 6. Interview with the IPOC Team revealed they reviewed 24-hour reports daily and revised care plans as needed for behavior and supervision interventions. Interview with the weekend RN House Supervisor, on 05/27/2020 at 11:47 AM, revealed he reviewed 24-hour reports on weekends, documented revisions in the clinical record, and reported audit findings in the weekend report submitted to the DON, Minimum Data Set (MDS) Coordinator, and Administrator. Interview with the DON, on 05/28/2020 at 2:01 PM, revealed she recorded findings of the IPOC record reviews on the daily IPOC notes/follow-up and reported findings of the reviews to the QA Committee. Review of the clinical record for Resident #6, revealed the facility identified new wandering behaviors, conducted a secondary risk assessment, revised the care plan and implemented new interventions to address elopement risk on 05/23/2020. 7. Review of the audit for Behaviors, Incident/Accident Reports, Reportable Event, dated 05/22/2020, revealed the DON and Administrator conducted an initial audit of twenty (20) records. 8. Review of the QA Meeting minutes, dated 05/13/2020, revealed the Administrator conducted an Ad Hoc QA meeting on 05/13/2020 and presented an action plan to committee members. Members attending the QA meeting included the Medical Director, DON, Assistant Director of Nursing (ADON), QA Nurse, Director of Staff Development/Infection Control Nurse, SSD, Therapy Director, and the Activities Director. Interview with the Administrator, on 05/28/2020 at 2:47 PM, revealed the facility conducted an Ad Hoc QA Meeting on 05/13/2020 to notify the Medical Director of the elopement and discuss the facility's action plan. Interview with the Medical Director, on 05/28/2020 at 11:17 AM, revealed he attended an Ad Hoc QA meeting by phone on 05/13/2020 to review the facility's action plan. 9. Review of the Ad Hoc QA minutes, dated 05/13/2020, revealed the facility's Action Plan included inservicing all staff on the facility's policy and procedure for Wandering and Elopement, and Behavioral Assessment, Intervention and Monitoring; reviewing all wandering/elopement assessments to ensure assessments were current; reviewing care plans of residents at risk for wandering/elopement to ensure interventions were appropriate; updating all 'Valhalla Voyager elopement binders; checking wanderguard alert check points and exit doors; and verifying physician orders [REDACTED]. Interviews with QA Committee members revealed they attended the Ad Hoc QA meeting on 05/13/2020 to discuss Resident #1's elopement and review the facility's Action Plan with the Medical Director. 10. Review of the QA meeting minutes, dated 05/17/2020, revealed the QA Committee reviewed elopement reassessments, care plans and revisions, education of staff, checks of wanderguard checkpoints, activation of eMAR notes report, and IPOC process. Interview with the Administrator, on 05/28/2020 at 2:47 PM revealed she conducted an Ad Hoc QA meeting on 05/17/2020 to review the audits, findings, and actions taken by the clinical team. Interview with the Medical Director, on 05/28/2020 at 11:17 AM, revealed he attended Ad Hoc QA meetings to follow up and discuss progress of the facility's Action Plan. 11. Review of QA Meeting minutes revealed the facility conducted a weekly Ad Hoc QA meeting on 05/13/2020, 05/17/2020, 05/19/2020, and 05/25/2020. Interview with the Administrator, on 05/28/2020 at 2:47 PM, revealed the facility held a weekly Ad Hoc QA meeting to ensure the Medical Director was kept informed regarding the facility's actions and identified concerns.
F 0689 **Level of harm -** Immediate jeopardy **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 observation, interview, record review, and facility policy review it was determined the facility failed to supervise residents to ensure safety and prevent accidents for one (1) of four (4) sampled residents, Resident #1. Resident #1's family member contacted staff on the evening of 04/26/2020 and requested to FaceTime with the resident. Staff could not locate the resident inside the facility to conduct the FaceTime visit. During the search of the building a rear exit door was found alarming. Staff continued searching and discovered Resident #1 outside the facility, on the ground crawling up a hill near a heavily traveled roadway. Interview revealed the resident was trying to go home. The facility's failure to ensure residents were supervised to prevent accidents has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/15/2020 and determined to exist on 03/11/2020 at 42 CFR 483.25 Quality of Care (F689) and 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656). The facility was notified of the Immediate Jeopardy on 05/15/2020. Substandard Quality of Care was identified at CFR 483.25 Quality of Care (F689). An acceptable Allegation of Compliance was received on 05/20/2020, which alleged removal of Immediate Jeopardy on 05/18/2020. The State Survey Agency determined the Immediate Jeopardy was removed on 05/18/2020 as alleged, prior to exit on 05/28/2020, which lowered the scope and severity to D at 42 CFR 483.25 Quality of Care (F689) and 42 CFR 483.21 Comprehensive Resident Centered Care Plans (F656), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy Safety and Supervision of Residents, undated, revealed the facility's individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents. The policy revealed the interdisciplinary care team (IDT) would analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. Further review revealed the care team would target interventions to reduce individual risks related to hazards in the environment to include adequate supervision and assistive devices. The policy revealed resident supervision was the core component of the system's approach to safety. The type and frequency of resident supervision was determined by the individual resident's assessed needs and identified hazards in the environment; and may vary among residents and over time for the same resident. Review of the facility's policy Wandering and Elopements, undated, revealed the facility would identify residents who were at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The policy stated if identified at risk for wandering, elopement, or other safety issues, the resident's care plan would include strategies and interventions to maintain the resident's safety. If an employee observed or was alerted that a resident was attempting to leave the premises, he/she should: Attempt to prevent the resident from leaving in a courteous manner; get help from other staff members in the immediate vicinity, if necessary; and instruct another staff member to inform the Charge Nurse or Director of Nursing (DON) that a resident was attempting to leave or had left the premises. Further review of the policy revealed when the resident returned to the facility, the Director of Nursing Services (DON) or Charge Nurse would examine the resident for injuries; contact the Attending Physician and report findings and conditions of the resident; notify the resident's legal representative (sponsor); notify search teams that the resident had been located (if applicable); complete and file an incident report; and document relevant information in the resident's medical record. Review of the policy's Emergency Procedure - Missing Resident, undated, revealed residents at risk for wandering and/or elopement would be monitored and staff would take necessary precautions to ensure their safety. Review of the section Emergency Job Tasks - Missing Resident revealed nursing staff would ensure the incident and events were documented objectively in the resident's record, including: circumstances and precipitating factors; interventions utilized to return resident to the unit; the resident's response to the interventions; results of reassessment upon the resident's return and the condition of the resident; care rendered; notification of police, family, and physician; physician orders [REDACTED]. Review of the facility's policy Maintenance Service, undated, revealed the Maintenance Department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel included, but were not limited to maintaining the building in good repair and free from hazards; and providing routinely scheduled maintenance service to all areas including monthly checks of all facility door alarms and wander guard alarms/systems. The Maintenance Director was responsible for maintaining the monthly log of door alarm/wander guard checks. Review of the clinical record revealed the facility admitted Resident #1 on 11/15/19 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of four (4) and determined he/she was not interviewable. Review of the Nursing - Wandering Risk Observation/Assessment, dated 03/13/2020, revealed the facility assessed the resident as high risk to wander. Review of Resident #1's Physician Orders, dated 02/21/2020, revealed an order for [REDACTED]. Review of Resident #1's Progress Notes revealed the resident removed the bracelet on 03/10/2020, 03/11/2020, and cut off the bracelet on 03/12/2020, 03/22/2020, 03/31/2020, and 04/18/2020. However, the facility failed to implement interventions to manage this behavior. Further review of the Progress Notes, dated 04/26/2020 at 5:51 PM, revealed Resident #1 wandered throughout the unit, entered other residents' rooms, attempted to exit the building to the courtyard, and went behind the nurses' station while staff worked the floor. Further review revealed staff blocked the entrance to the nurses' station with medication carts. However, the

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) resident was confused and repeatedly attempted to take items from the nurses' station and the medication carts. The note stated redirection from wandering was effective for only a short period of time, usually less than 10 minutes. Interview with Certified Nursing Assistant (CNA) #2, on 05/13/2020 at 10:41 AM, revealed Resident #1's daughter text her on 04/26/2020 around 7:40 PM and asked to FaceTime (audio/video phone call) with the resident. The CNA stated she left her assigned hall and went to the English Oak Garden (EOG) Hall, and looked for the resident in his/her room. CNA #2 stated the resident was not in his/her room, so she asked CNA #3, CNA #4, CNA #7, and the Certified Medication Technician (CMT) if they knew where to find Resident #1. However, none of the staff knew the resident's whereabouts. She stated she started a search of resident rooms, and when she reached the end of the hall, she heard a real faint alarm. The CNA stated she walked in the direction of the back door, and discovered it was alarming. She stated she text CNA #3 to notify her of the alarm. CNA #2 stated she exited the building, searched around the maintenance garage, and returned to the back door, when she saw a Physical Therapy Assistant (PTA) coming out the door; she told the PTA that Resident #1 was missing. According to CNA #2, the wanderguard system should have alarmed when the resident passed the sensor at the end of the EOG Hall; however, there was no audible wanderguard alarm on the EOG Hall. Further interview with CNA #2 revealed she walked up the driveway to the front entrance, saw the Nurse Supervisor, and notified him that Resident #1 was missing. CNA #2 stated when she turned her head she noticed something that looked like a person crawling up the grass hill near the road. The CNA stated she ran towards the resident and yelled his/her name, but the resident would not stop. Further interview with CNA #2 revealed once she reached the resident she stayed with him/her until RN #1 and the Nurse Supervisor arrived. CNA #2 stated all staff were responsible for supervision of residents to ensure their safety. She stated a resident could potentially elope and get hit by a car or drown in the lake. Interview with the PTA, on 05/14/2020 at 9:26 AM, revealed she went downstairs around 8:15 - 8:30 PM to take some paperwork to a unit when she heard a wanderguard and back door alarm. She stated she went out the back door and saw CNA #2 in the parking lot. The PTA stated CNA #2 told her Resident #1 was missing and she began a search of the lake and courtyard area. She stated she returned to the building, searched resident rooms on the EOG Unit, and then went upstairs to find out if anyone found the resident. The PTA revealed the RN House Supervisor was in the lobby area and told her they found the resident. Interview with CNA #3, on 05/13/2020 at 5:30 PM, revealed she last saw Resident #1 when she redirected him/her from a resident's room. She stated she was in a room providing care when CNA #2 asked where she could find Resident #1 to FaceTime. She stated she searched the resident's room, bathroom, and other residents' rooms because Resident #1 was a wanderer. The CNA stated she asked RN #1, CNA #4 and CNA #7 if they knew where to find the resident, but they did not know the resident's location. She stated she returned to the nurses' station to notify another unit of the missing resident when she received a text from CNA #2 stating the back exit door was alarming. According to the CNA, the wanderguard system should trigger when a resident got near a sensor; however, she never heard a wanderguard alarm on the EOG Unit. She further revealed staff could not hear the wanderguard alarm if they were in a resident's room near the back of the hall. Further interview with CNA #3 revealed she left the EOG Unit to search for the resident. She stated she went out the back door, walked up the driveway towards the front of the building, and saw CNA #3 run across the parking lot. She stated once she reached the front of the building she observed CNA #2 walking Resident #1 down a hill near the road. CNA #3 stated she went back to the building to get a wheelchair and returned to assist Resident #1 back inside the facility. Further interview with CNA #3 revealed Resident #1 was a wanderer and an elopement risk. She stated she checked on the resident every hour or so when the resident was in his/her room. The CNA further stated the resident asked staff to loosen the wanderguard and was adamant about removing the bracelet. She stated all staff tried to monitor the resident's whereabouts if they were not in the middle of care; however, staff were getting residents ready for bed the evening Resident #1 eloped. CNA #3 stated staff were not aware the resident was missing until CNA #2 tried to find him/her to FaceTime. Interview with CNA #4, on 05/13/2020 at 6:19 PM, revealed she was assisting CNA #7 with resident care when another aide asked the whereabouts of Resident #1. The CNA stated she did not know where the resident was and started a search of resident rooms, closets, and the courtyard. CNA #4 stated she never heard a wanderguard alarm on the EOG Unit. The State Survey Agency (Surveyor) attempted to interview CNA #7 on 05/12/2020 at 2:55 PM, on 05/12/2020 at 4:25 PM, and 05/13/2020 at 10:03 AM. Interview with Registered Nurse (RN) #1, on 05/12/2020 at 5:07 PM, revealed Resident #1 was very confused and could not be redirected by staff. The RN stated she last observed Resident #1 standing at the nurses' station around 8:00 PM. The nurse stated she went to the restroom, and when she returned about five (5) minutes later, an aide asked where she could find Resident #1. The RN stated she did not know the resident's whereabouts. Further interview revealed she and CNA #3 followed the sound of a regular door alarm to the back doors and went outside to search. She stated as she walked towards the front of the building she saw CNA #2 run across the parking lot, and when she reached the top of the hill, she saw the CNA holding on to Resident #1 at the tree line near the road. RN #1 stated all staff was responsible for supervising residents to ensure their safety; however, Resident #1 left the building unsupervised and without staff knowledge. She further stated she was not sure the wanderguard system alarmed on the EOG Unit the evening the resident eloped. Further interview with RN #1 revealed she assessed the resident for injuries, documented the findings in the progress notes, and notified the nurse practitioner (NP) and family of the incident. According to RN #1, the nursing assessment included verifying placement of the wanderguard post incident. Review of Resident #1's Progress Note, dated 04/26/2020 at 8:46 PM, revealed RN #1 notified the Advanced Practice Registered Nurse (APRN) and received orders for 15-minute safety checks and labs (laboratory tests). The Progress Note revealed the resident had no visible injuries; however, the nurse failed to collect vital signs, perform a head-to-toe assessment, or assess neurological status for the unwitnessed fall. Further review revealed RN #1 failed to notify the resident's family/responsible party of the elopement or the resident's condition. Further review of the physician's orders [REDACTED]. Review of Resident #1's Medication Administration Record (MAR), dated April 2020, revealed staff administered [MEDICATION NAME] 0.5 mg on 04/26/2020 at bedtime and a one-time dose of [MEDICATION NAME] 0.5 mg at 9:15 PM. Review of the Treatment Administration Record, dated April 2020, revealed RN #1 checked placement and function of the wanderguard bracelet on 04/26/2020 at 8:52 PM, after the resident was returned to the facility. Interview with LPN #2, on 05/14/2020 at 9:35 AM, revealed the nurse was responsible for performing a head-to-toe assessment and documenting findings in the clinical record following an elopement. The LPN stated the assessment would include vital signs, neurological, skin, respiratory, and pain status to ensure there was nothing abnormal from baseline. He stated it would be important to assess a resident if he/she was found on the ground to ensure there were no injuries, especially if the resident had a memory problem. Further interview with LPN #2 revealed the nurse was responsible for notifying the family/responsible party to inform them of the resident's status following an elopement. He stated the nurse should attempt to call everyone on the list of contacts until a family member/responsible party was notified of the incident. The LPN stated it was especially important during this time of Covid-19 because the residents' families were not able to visit residents at the facility. Interview with the RN House Supervisor, on 05/12/2020 at 4:27 PM, revealed he was leaving work around 8:00 PM or 8:30 PM when CNA #2 approached him outside and reported Resident #1 was missing. He stated he turned his head and saw the resident crawling in the grass near the entrance to the parking lot. The Supervisor stated CNA #2 ran to the resident and he, RN #1, and CNA #3 followed. He stated RN #1 assessed the resident and reported he/she was fine. He stated CNA #3 went to get a wheelchair and staff brought the resident back inside the building. According to the House Supervisor, the resident stated he/she was going home. Continued interview with the RN House Supervisor, on 05/12/2020 at 4:27 PM, revealed he was aware of a couple of incidents when Resident #1 exited the building and recalled a recent incident when the resident exited to the courtyard. The RN stated he documented all events on an incident report in the electronic record. Further interview with the RN House Supervisor revealed the wanderguard sensor located at the end of the EOG Unit should alarm when a resident wearing a wanderguard bracelet was nearby. He further revealed the back doors were alarmed and opened only when someone held the handle down for 15 seconds. Observation of the back door, on 05/11/2020 at 3:05 PM, revealed two (2) delayed 15-second egress doors; however, the right side door opened immediately when the handle was pushed. The facility did not provide incident reports for Resident #1. Interview with Licensed Practical Nurse (LPN) #3, on 05/14/2020 at 3:08 PM, revealed Resident #1 was extremely confused, walked around a lot, wandered in resident rooms, collected things, and required frequent redirection. According to LPN #3, if the resident saw a door he/she pushed the handle until it opened. LPN #3 revealed she gave the resident a magazine or newspaper to occupy time whenever she noticed him/her going towards a door. LPN #3 stated she tried to keep staff around the nurses' station to monitor the dining room exits. Further interview with LPN #3 revealed Resident #1 exited the building to the courtyard on or around 04/21/2020, when the resident first transferred to the EOG Unit. According to LPN #3, staff saw the resident outside and brought him/her back in the building; however, the resident was not wearing the prescribed wanderguard bracelet. The LPN revealed staff should document whenever a resident removed the wanderguard in order to monitor the

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	185455	A. BUILDING _____ B. WING _____	**05/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALHALLA POST ACUTE	**300 SHELBY STATION DRIVE LOUISVILLE, KY 40245**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) behavior(s). LPN #3 stated she was not sure if she documented anything. She further revealed she did not question the resident or check the room to determine how the resident removed the bracelet. Further review of Resident #1's clinical record revealed the nurse failed to document the resident exited the building on 04/21/2020, the circumstances surrounding the event, the missing wanderguard bracelet, interventions implemented to ensure the resident's safety, or notifications to the physician and family. Interview with LPN #1, on 05/13/2020 at 12:23 PM, revealed Resident #1 was very confused and exhibited behaviors. She stated the resident wandered in to resident rooms, removed items from resident mailboxes, and tried to use the call light phone at the nurses' station. The LPN revealed the facility assessed the resident as an elopement risk and the physician prescribed a wanderguard bracelet for monitoring; however, the resident would cut the wanderguard off and she constantly had to replace it. She stated the resident told her that he/she cut the bracelet off and showed the LPN a pair scissors in a drawer. The nurse stated she removed the scissors from the room; however, she did not check the room each time she discovered the wanderguard missing. Further interview with LPN #1 revealed staff obtained new wanderguard bracelets from the Unit Manager (UM), Assistant Director of Nursing (ADON), or Director of Nursing (DON) and believed they were aware of the issues with Resident #1 removing the bracelet. She revealed she reported the wandering in rooms to the Social Services Director (SSD) because she was concerned about the resident's safety and stated the facility moved the resident to the EOG Unit. Interview with the Maintenance Director, on 05/12/2020 at 3:17 PM, revealed he checked doors and alarms monthly to ensure they were functioning. Further interview with the Director, on 05/13/2020 at 2:48 PM, revealed the back doors should have a 15 second delay; however, he was not aware there was no delay on one of the doors. Review of the TELS (electronic maintenance management program) Logbook Documentation for Door Alarm checks revealed maintenance last checked the back door on 04/17/2020 Interview with the DON, on 05/14/2020 at 10:41 AM, revealed the RN House Supervisor called her on the evening of 04/26/2020 and notified her that Resident #1 eloped from the building. She stated the Supervisor reported the resident was exit seeking and wandered in and out of rooms all day. The DON stated she directed RN #1 to notify the physician and family, and to start 15-minute safety checks immediately. The DON revealed she and the Administrator initiated an investigation, took verbal statements from the House Supervisor and RN #1, and notified the SSD to have the resident transferred. The DON stated staff supervised the resident, followed alarms, and actively pursued the resident. She stated the facility did not have 1:1 supervision and the resident was not on 1:1 supervision at the time of the elopement. The facility trained staff on the wandering, elopement, and missing resident procedure on 04/13/2020; however, they did not reeducate staff following Resident #1's elopement. The Director stated the facility worked tirelessly to get Resident #1 transferred and stated he/she was eventually transferred to a behavioral health facility on 05/05/2020 to adjust medications in a controlled environment. According to the DON, the facility determined the root cause of the elopement was the resident's decline in cognitive status. She stated the facility concluded the investigation on 05/05/2020 and no concerns were identified. Interview with the Administrator, on 05/28/2020 at 2:47 PM, revealed the RN House Supervisor notified her of Resident #1's attempted elopement. She stated interviews with the House Supervisor and RN #1 indicated staff responded to a door alarm, found the resident in a green space between the facility and an adjacent building, and returned him/her safely to the facility. The Administrator revealed the facility reopened the investigation when Adult Protective Services (APS) contacted them regarding an allegation the resident eloped two (2) blocks away. Further interview with the Administrator revealed she was not aware Resident #1 removed his/her wanderguard bracelet(s) and stated staff were responsible for monitoring residents at risk for exit seeking. She revealed the facility investigation identified concerns with staff supervision. According to the Administrator, Resident #1 exhibited increased wandering the day of the elopement and RN #1 left the resident unsupervised. She stated the nurse was responsible for documenting assessment findings and notifications in the clinical record; however, she had not reviewed the nursing progress notes and was not aware of concerns. The Administrator revealed she monitored maintenance logs to ensure doors and alarms were functional and had not identified any concerns. The facility implemented the following actions to remove the Immediate Jeopardy on 05/18/2020: 1. On 05/05/2020, the facility transferred Resident #1 to a behavioral health facility. 2. The facility reviewed Elopement Assessments on 05/12/2020 for all residents identified as at risk to ensure they were accurate, updated the 'Valhalla Voyager' elopement binders with face sheets and pictures for all residents at risk, and checked to ensure physician's orders [REDACTED]. 3. The Administrator reviewed and revised the facility's Wandering and Elopement Policy on 05/17/2020 to include a secondary risk assessment. The Social Services Director (SSD) will utilize a secondary Wandering/Elopement Risk Assessment when the initial Electronic Health Record (EHR) Wandering Risk Observation/Assessment score indicated the resident was At Risk or High Risk of Wandering/Elopement (risk score of 9 or greater). The interdisciplinary team (IDT) reviews 24 hour reports (progress notes, assessments, medication administration record (MAR), incidents, admissions, and discharges) daily to identify new behaviors and the Quality Assurance (QA) Registered Nurse (RN) audits to ensure the Wandering/Elopement Risk Assessment(s) are implemented according to the revised policy. 4. On 05/27/2020, the ADON audited the 'Valhalla Voyager' elopement binders to ensure the information in the binders was current to include facesheet and picture. Wanderguards were listed on the residents' eMAR to check function every shift and were care planned. On 05/17/2020, the ADON audited to ensure the wanderguards and function checks were on the eMAR and the wanderguards were on the care plan. The facility trained all staff on policy and procedure for Abuse Investigating and Reporting, Behavioral Assessment, Intervention and Monitoring, Emergency Procedure - Missing Resident, and Wandering and Elopement. The education included a pre- and post-test derived from Valhalla Post-Acute policy and procedures. The Administrator, DON, ADON, QA Nurse, Director of Staff Development, and Therapy Director educated facility staff by 05/17/2020. The facility trained all employees except for staff that work as needed and staff on leave. The facility removed the employees from the schedule until education has been completed. The facility will educate all staff on the policy and procedure during new-hire orientation. 5. The Interdisciplinary Plan of Care (IPOC) Team will review 24-hour reports (to include 24-hour summary, Progress Notes, Incidents, eMAR notes, User Defined Assessments (UDA), Admissions/Discharges, Order Recap Report, and Assessment report) Monday through Friday and revise the care plan as needed for behavior and supervision interventions. The weekend RN House Supervisor will review the reports on weekends and revise care plans as needed on weekends. The DON will report findings of the audits to the QA Committee. 6. On 05/13/2020, the Administrator conducted an Ad Hoc QA meeting and presented an action plan to committee members. Members attending the QA meeting included the Medical Director, DON, Assistant Director of Nursing (ADON), QA Nurse, Director of Staff Development/Infection Control Nurse, SSD, Therapy Director, and the Activities Director. 7. The Action Plan included inservicing all staff on the facility's policy and procedure for Wandering and Elopement, and Behavioral Assessment, Intervention and Monitoring; reviewing all wandering/elopement assessments to ensure assessments were current; reviewing care plans of residents at risk for wandering/elopement to ensure interventions were appropriate; updating all 'Valhalla Voyager elopement binders; checking wanderguard alert check points and exit doors; and verifying physician orders [REDACTED]. 8. The facility trained all staff on policy and procedure for Abuse Investigating and Reporting, Behavioral Assessment, Intervention and Monitoring, Emergency Procedure - Missing Resident, and Wandering and Elopement. The education included a pre- and post-test derived from Valhalla Post-Acute policy and procedures. The Administrator, DON, ADON, QA Nurse, Director of Staff Development, and Therapy Director educated facility staff by 05/17/2020. The facility has trained all employees except for staff that work as needed and staff on Leave. The facility removed the employees from the schedule until education has been completed. The facility will educate all staff on the policy and procedure during new-hire orientation. 9. On 05/17/2020, the DON and Director of Staff Development reviewed the new-hire orientation program to ensure the program included the facility's policy and procedure for abuse recognition, abuse reporting, and abuse/incidents to include elopement investigation, wandering behavior interventions, reporting, care planning and documentation. 10. The facility will train all agency staff and require completion of a pre- and post-test derived from Valhalla Post-Acute policy and procedures. The Director of Staff Development, ADON, DON, and/or QA Nurse will conduct the training. 11. The Maintenance Director and the RN House Supervisor checked the wanderguard checkpoints and/or exit doors on 05/15/2020, 05/16/2020, and 05/17/2020 to ensure all were functioning. No issues were identified. The facility will check the wanderguard checkpoints and exit doors weekly beginning 05/17/2020. The Administrator will monitor the checks weekly and report findings to the QA Committee. The staff are now able to hear the alarm on 12. On 05/15/2020, the Administrator created an Action Plan to submit to the Ad Hoc QA meeting on 05/17/2020. The Action Plan included review of all resident medical records that were currently identified as a wanderer or as an elopement risk to include Nurses Notes, Progress Notes, eMAR Notes, Behavior Monitoring Notes and Social Services Notes to identify any unknown behaviors along with review of care plans to assure appropriate interventions for supervision were addressed and appropriate. The facility completed new elopement assessments for all residents; updated 'Valhalla Voyager' elopement binders as indicated after new

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALHALLA POST ACUTE	**300 SHELBY STATION DRIVE LOUISVILLE, KY 40245**

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) assessments were completed; checked function of all wanderguard checkpoints and exit doors daily through 05/17/2020, weekly for three (3) months, then re-evaluate frequency; reviewed the IPOC meeting checklist to ensure meetings held Monday through Friday were functioning properly, reviewed all incident reports for the last 60 days to ensure incidents were investigated, root cause identified, and care plan updated appropriately. 13. The Administrator conducted an Ad Hoc QA meeting on 05/17/2020 to review the facility's Action Plan, audits, findings, and actions taken by the clinical team. 14. The facility conducted a weekly Ad Hoc QA meeting on 05/13/2020, 05/17/2020, 05/19/2020, and 05/25/2020. Weekly QA meetings will be held until IJ is removed and monthly thereafter. The committee will discuss current AOC measures and evaluate the effectiveness of the AOC for on-going compliance with Accidents, Supervision, and Care Planning. The State Survey Agency verified the facility implemented the following actions to remove the Immediate Jeopardy: 1. Review of the clinical record revealed the facility transferred Resident #1 to a behavioral health facility on 05/05/2020. Notifications were made according to policy. 2. Review of the 'Valhalla Voyager' binder on four (4) of four (4) halls (English Oaks Terrace, Cherokee Oaks Terrace, English Oaks Garden, and Cherokee Oaks Garden) revealed seventeen (17) residents at risk for elopement, including eight (8) residents with a wanderguard bracelet. Residents #1, #2, #3, #5, and #6's facesheet and pictures were filed in each binder, which included the facility's policy and procedure for Wandering and Elopements, and Emergency Procedure - Missing Resident. Review of Residents #2, #3, #5, and #6's clinical record revealed physician's orders [REDACTED]. 3. Interview with the Administrator, on 05/28/2020 at 2:47 PM, revealed she revised the Wandering and Elopement Policy on 05/17/2020 and implemented a secondary Wandering/Elopement Risk Assessment form to be completed when a resident triggered at risk or high risk for elopement. Interview with the QA Nurse, on 05/27/2020 at 2:01 PM, revealed she reviewed the wandering/elopement risk assessments during the daily Interdisciplinary Plan of Care (IPOC) meeting to ensure secondary assessments were completed according to the revised policy. She stated the DON recorded the findings on the IPOC meeting form and new residents identified at risk or high risk were included in the weekly QA meeting report. Record review revealed the SSD conducted secondary Wandering/Elopement assessments on 05/17/2020 for thirteen (13) residents identified as At Risk or High Risk for wandering/elopement. Review of the clinical record for Resident