STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185298	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKS GOLDEN YEARS NURSING HOME	1901 WEST HIGHWAY 90 BYPASS MONTICELLO, KY 42633

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 observation, interview, record review, and review of the facility policy it was determined the facility failed to provide adequate supervision to prevent one (1) of three (3) sampled residents (Resident #1) from exiting the facility. On 04/22/2020 at 11:55 AM, Resident #1 was observed, on video, to exit the facility via the front door. Review of the facility investigation of the incident revealed Housekeeper #1 heard the door alarm, went to the door, looked out but did not see anyone and turned off the alarm. Per the investigation, the resident was brought back inside the facility unharmed and with no injuries at 11:59 AM. The findings include: Review of the facility policy, Elopements, dated December 2007, revealed staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. Review of the facility policy, Accidents/Incidents, dated 02/21/2017, revealed the facility was to monitor all accidents and incidents that occur with residents in an effort to reduce and/or eliminate injuries and accidents from occurring. Observation of Resident #1 on 04/28/2020 at 10:42 AM, revealed the resident up in a wheelchair in his/her room. Observation also revealed the resident was performing exercises with the therapist, was following directions, and was cooperative. Further observation, at 11:36 AM, revealed the resident in his/her room, sitting on the side of the bed while eating lunch. When asked about lunch, the resident replied his/her lunch was just fine. Review of the medical record revealed the facility admitted Resident #1 on 12/19/2019 and the resident had [DIAGNOSES REDACTED]. Further review of the record revealed on 04/22/2020, the resident was diagnosed with [REDACTED]. This was a decline from the admission assessment BIMS score of twelve (12), which indicated the resident had moderate cognitive impairment. The MDS revealed no behaviors of wandering or elopement on the admission or the 03/05/2020 assessment. Further review of the 03/05/2020 MDS revealed the resident required limited assistance of one (1) person for locomotion on the unit. Review of the Risk for Elopement/Wandering Reviews, dated 12/24/2019, 01/10/2020, 03/05/2020, and 04/22/2020 revealed the first three (3) showed the resident was not at risk for elopement. Those reviews revealed no history of elopement while at home, no wandering behavior in the facility, and no other exit-seeking behaviors. The review, dated 04/22/2020, revealed the resident was at risk for elopement related to a new behavior of exiting via the front door of the facility and going outside on 04/22/2020. Review of the facility investigation related to an allegation of elopement for Resident #1 on 04/22/2020 revealed the incident occurred at 11:51 AM. The investigation further revealed the resident was observed to be sitting outside the front door of the facility on the porch area by the Housekeeping Supervisor at 11:59 AM. Per the facility investigation, on 04/22/2020 Housekeeper #1 heard the front door alarm sounding and stated she had gone to the front door, looked out but did not see anyone, so she turned the alarm off. The investigation conclusion revealed the resident was brought back into the facility by the Housekeeping Supervisor at 11:59 AM and the incident was immediately reported to the Quality Assurance Nurse and the Director of Nursing. Per the investigation, Resident #1 was assessed to have no injury and the weather on 04/22/2020 was sunny and warm. The resident was placed on one-on-one supervision for twelve (12) hours and a code alert bracelet was placed on the resident. The conclusion also included that all residents were reassessed for elopement risks on 04/22/2020, the codes to all doors were changed, and Maintenance ensured all doors were working properly. Observation of exiting the door with the Housekeeping Supervisor on 04/28/2020 at approximately 11:30 AM, revealed a code was required to be entered on the keypad in order to unlock the door and prevent the door alarm from sounding. Further observation revealed the egress bar could be pushed in for fifteen (15) seconds and then the door would release and open but the alarm would sound. Review of the comprehensive care plan for Resident #1 revealed the facility identified the resident to be at risk for elopement on 04/22/2020 and revised the resident's plan of care. The facility added interventions addressing the resident's elopement risk which included the resident was to wear a code alert bracelet at all times, redirect the resident if near an outside exit doorway, and monitor for proper functioning of the code bracelet. Interview with Housekeeper #1 on 04/28/2020 at 11:12 AM, revealed on 04/22/2020 she was cleaning handrails and heard the alarm sounding for the front door. She stated she walked to the front door and looked out the window but did not see anyone so she shut off the alarm. Housekeeper #1 stated she was familiar with Resident #1 and had never observed the resident to go out any of the doors. She further stated the resident would come out of his/her room to ask for something or to use the phone. Per Housekeeper #1, she had received training/instruction on what to do when responding to a door alarm and had taken a posttest. She also stated she had been suspended on 04/22/2020 related to the incident and had just returned to work on 04/27/2020. Interview with the Housekeeping Supervisor on 04/28/2020 at 10:52 AM, revealed on 04/22/2020 she observed a visitor through one of the front windows and pecked on the window, beside the front door, to wave at the visitor. She stated she observed the visitor speaking to someone and looked out the front door to see whom she was speaking with but did not see anyone else. The Supervisor then stated she went to the big window in the lobby area, looked out, and saw Resident #1 sitting on the front porch. The Housekeeping Supervisor stated she immediately went outside, retrieved the resident, and informed the Quality Assurance Nurse and then the DON. She further stated she had never observed the resident to go to the door or display any type of exiting behaviors. Per the Supervisor, the front door was the door the resident normally exited when going to [MEDICAL TREATMENT] on Monday, Wednesday, and Friday. Interview with State Registered Nurse Aide (SRNA) #1 on 04/28/2020 at 11:38 AM, revealed the staff are knowledgeable of those residents at risk for elopement through the communication book and the care plans, which are in each resident room. She stated if staff hear a door alarm they go to that door and check the outside area for any residents. If no residents are observed, then staff are to return to the facility and check the facility to ensure all residents are present. Interview with Licensed Practical Nurse (LPN) #1 on 04/28/2020 at 11:45 AM, revealed each nurses' station has an elopement binder which lists all residents in the facility which are risk for elopement. She stated if someone new is placed on elopement risk, the name of the resident at risk is verbally communicated to staff and placed in the communication book. She then stated if she heard a door alarm, she would look at the video monitor to determine which door was alarming. The LPN stated she would then go to the alarming door and check the area outside. She added if no resident was found outside, she would then check the facility to ensure all residents were present. She revealed she was familiar with Resident #1 and had never observed the resident to have any exit seeking-behaviors. Interview with LPN #2 on 04/28/2020 at 4:38 PM, revealed he was the nurse assigned to B Hall, where Resident #1 resided, on 04/22/2020. He stated he had not observed Resident #1 display any exit-seeking behavior or any other behaviors. He further stated the resident was able to self-propel a wheelchair with his/her feet and could transfer and toilet himself/herself with some assistance. He then added that once the resident was returned to his/her room after exiting the facility on 04/22/2020, he/she was placed on one-on-one supervision and had no further exit-seeking behaviors that evening. Interview with the Quality Assurance (QA) Nurse on 04/28/2020 at 2:35 PM, revealed she was familiar with Resident #1. The QA Nurse stated Resident #1 had some behaviors since admission, but no exit-seeking behaviors. She stated

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) she had been part of a telehealth conference call on 04/22/2020 with the resident, the resident's son, and a physician from Vanderbilt just prior to the exiting incident. She stated the physician had informed them the resident had [MEDICAL CONDITION] and that medication would be ordered to address the [DIAGNOSES REDACTED].#1's [MEDICAL TREATMENT] schedule had just changed from three (3) days a week to two (2) days a week. Per the QA Nurse, the resident would now go on Monday and Friday only, and 04/22/2020 was the first Wednesday he/she did not have [MEDICAL TREATMENT]. The QA Nurse stated she wondered if the resident thought he/she was going to [MEDICAL TREATMENT]. Per the QA Nurse, all residents are assessed on admission for the risk of elopement. If they are assessed to be at risk for elopement then the risk is care planned and the care plan is located in the resident's room. She further stated there is a note indicating the elopement risk placed in the communication book, which is to be reviewed daily and signed by the staff. The QA Nurse then stated when the resident was returned to the unit after exiting he/she was immediately placed on one-on-one monitoring. Per the QA Nurse, Nursing documented on the resident every fifteen (15) minutes for one (1) hour, then every thirty (30) minutes for one (1) hour, and then hourly until completed at midnight on 04/22/2020. She stated the nurse was to also check to ensure the code alert was working properly and document this as well as any behaviors and mood the resident displayed. Interview with MDS Nurse #1 on 04/29/2020 at 9:10 AM, revealed she viewed the video as part of the investigation of the elopement by Resident #1 on 04/22/2020. She stated she was able to see the resident exiting the front door at 11:55 AM, but stated she could not determine exactly how the door was opened. She further stated she observed Housekeeper #1 walk over to the front door from the lobby area at 11:57 AM. The MDS Nurse stated could not see the housekeeper turn the alarm off but Housekeeper #1 stated this in the interview during the investigation. She revealed the fire doors were closed, between the front door and A Hall, so vision was limited. Per the MDS Nurse, the resident was observed to be brought back into the facility at 11:59 AM. Interview with the Director of Nursing (DON) on 04/29/2020 at 9:15 AM, revealed the staff have been taught to make sure a resident is not outside when a door alarm sounds. She stated the training provided to the staff on 04/22/2020 was to reinforce this. The staff should go outside and check the area to ensure a resident is not outside. She stated Housekeeper #1 failed to go outside and check for the resident. She further stated she was providing another training on 04/29/2020 on door alarms.