STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185090	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIDGE POINT CENTER	**7300 WOODSPOINT DRIVE FLORENCE, KY 41042**

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, review of the facility's Policies, and review of the facility's Investigation, it was determined the facility failed to have an effective system to ensure the resident environment remained free of accident hazards as is possible and each resident receives adequate supervision for one (1) of eleven (11) sampled residents (Resident #1). Resident #1 eloped from the facility sometime after 8:00 PM on the evening of 06/25/2020 without staff knowledge. Resident #1 had ambulated approximately seven tenths (0.7) of a mile down a sidewalk beside a roadway, before being identified around 9:00 PM by an off duty facility staff. The findings include: Review of the facility policy titled Accidents/Incidents, revised 05/02/18, defined an incident as any occurrence not consistent with the routine operation of the center, which may result in an injury, and can involve an observation of a situation that poses a threat to safety or security. Continued review revealed the policy for situations posing a threat to safety or security, staff will secure the area to prevent further incidents from occurring, and the appropriate department manager will be notified for correction of the situation. Review of the facility's Policy titled Elopement of Patient, revised 05/15/14, defined elopement as a resident leaving the facility without authorization or necessary supervision to do so. Continued review revealed patients would be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the nursing assessment process. Per the policy, those determined to be at risk would receive appropriate interventions to reduce the risk and minimize injury. Further review revealed the facility would complete an Elopement Investigation/QA tool within five (5) days of the resident's elopement. Review of Long Term Care Facility - Self-Reported Incident Form, dated 06/30/2020, revealed Resident #1 was observed walking down the sidewalk on Houston Road in Florence, KY, at approximately 9:00 PM on 06/25/2020 by an employee who was driving home after her shift. Continued review revealed the employee alerted the facility to the elopement, and returned Resident #1 to the facility, at which point the resident was assessed to have no injuries and a wander guard was applied to Resident #1's ankle and his/her plan of care was updated to reflect his/her needs regarding being at risk for elopement. Further review revealed a butter knife was located on Resident #1's window ledge, along with a screw that had been taken from the window. Per the report, Resident #1 had not been assessed as an elopement risk prior, but was identified as such on his care plan following the elopement. Per the final report, all residents in the facility were re-assessed for elopement risk with no additional concerns identified. Review of the Elopement Investigation/QA tool, undated, revealed Social Services interviewed Resident #1. Per the interview, Resident #1 revealed he/she had been planning to leave for a while, with plans to purchase alcohol and get arrested so that he/she could have appeared before a judge to get his/her rights back. Continued review revealed Resident #1's sister (Sister #1) had been appointed his/her legal guardian upon admission to the facility in 2017. Continued review revealed on 06/26/2020, the Director of Maintenance ensured Resident #1's window was re-secured. Per the investigation, the facility identified and additional four (4) residents that were assessed to be at risk for elopement and independently ambulatory. Review of Google Maps, after interview with Licensed Practical Nurse (LPN) #1, revealed Resident #1 had ambulated approximately seven-tenths (.7) of a mile from the facility when found by LPN #1. Review of Resident #1's medical record revealed Resident #1 was admitted by the facility on 09/25/17 with [DIAGNOSES REDACTED]. Continued review of Resident #1's medical record revealed Resident #1's sister (Sister #1) was appointed his/her legal guardian and conservator on 11/01/17. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating no cognitive impairment. Continued review revealed Resident #1 was assessed with [REDACTED]. Further review revealed Resident #1 was documented as independently ambulatory. Review of an Elopement Evaluation, completed for Resident #1 on 05/26/2020, revealed the only risk factor Resident #1 had for elopement were [DIAGNOSES REDACTED]. Continued review revealed Resident #1 did not exhibit for any behaviors associated with an elopement risk, nor did he/she trigger for any other risk factors for elopement, indicating no elopement risk at that time. Review of an Elopement Risk Evaluation, completed for Resident #1 on 06/25/2020, revealed Resident #1 continued to trigger for [DIAGNOSES REDACTED]. Observation of Resident #1, on 07/06/2020 at 10:40 AM, revealed he/she was in the room seated on his/her bed watching television. Resident #1 was appropriately groomed and dressed. The privacy curtain was drawn and a facility staff member was seated on the opposite side of the curtain. Resident #1 was noted to have a wander guard to his/her right ankle. Continued observation revealed the window was noted to have screws in the pane and unable to open more than approximately two (2) inches. Interview with Resident #1, on 07/06/2020 at 10:40 AM, revealed he/she had been in the facility for three years, and felt it was time to go. Resident #1 stated he/she could make his/her own decisions, and despite writing two different letters to the judge regarding getting his/her rights returned, per guidance from legal aid, nothing had been accomplished. Resident #1 stated his/her sister was his/her guardian when he/she was placed in the facility following dementia, which resulted from bad [MEDICAL CONDITION]. Resident #1 stated this was no longer an issue, and he/she wanted his/her rights back. Continued interview revealed Resident #1 was aware of the facility's alarm system, and actively sought to exit without setting off any alarms. Resident #1 reported that since he/she left the facility without staff knowledge, there had been staff in his/her room watching him/her. Interview with Sister #1, on 07/07/2020 at 9:14 AM, she was Resident #1's sister and legal guardian and conservator. Per interview, she was contacted at 9:30 PM on 06/25/2020, regarding Resident #1 eloping and being returned to the facility. She revealed, prior to Resident #1 entering the facility with her as guardian, she found him/her homeless and took Resident #1 home. She revealed Resident #1 showed poor safety awareness and made poor choices at home, and had wandered off from her home a couple of times and gotten lost. She revealed she didn't feel Resident #1 would be safe on his/her own, but stated that would be up to the court system. Per interview, she did have a 07/15/2020 court date. Interview with Licensed Practical Nurse (LPN) #1, on 07/06/2020 at 11:23 AM, revealed she observed Resident #1 at 8:45 PM on 06/25/2020. Per interview, she had left the facility at the end of her shift and was driving home when she identified Resident #1 off facility property. Per interview, Resident #1 was walking on a sidewalk beside a highway. She stated she turned her car around and found a place to park and met with Resident #1. She revealed Resident #1 initially pretended to be someone else, but after a few minutes, gave up and stopped pretending to be someone else. She revealed Resident #1 had been wearing a mask, and was [MEDICATION NAME] safety by crossing at stoplights and making sure there was no oncoming traffic. She went on to reveal Resident #1 stated he had left the facility fifteen (15) to twenty (20) minutes prior, and stated he/she had removed the window screws with a butter knife. Per her interview, Resident #1 agreed to return to the facility if allowed to smoke. Resident #1 also revealed to her that he/she had been planning to elope for a few days, and had been saving his/her money and had managed to save one-hundred nineteen dollars ($119.00). She stated she contacted the facility at 8:53 PM, and had returned Resident #1 to the facility by 9:06 PM, at which point she sat outside

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) with Resident #1 while he/she smoked a couple of cigarettes. LPN #1 revealed she had worked with Resident #1 before, and stated Resident #1 had never made any attempts to elope or even talked about leaving the facility. LPN #1 revealed Resident #1 was at the facility for monitoring his/her [MEDICAL CONDITION], failure to thrive in the community, and not making smart choices in the community. Interview with LPN #2, on 07/06/2020, at 3:29 PM, revealed nothing out of the ordinary was going on with Resident #1 the day of 06/25/2020, and reported she gave him/her the nightly medications at 8:00 PM. Per interview, he/she was sitting on the bed and watching television, which was his/her routine. She stated Resident #1 had not stated anything about leaving or wanting to leave, and she was horrified to learn he/she had eloped. She revealed she had worked with Resident #1 on and off for a little over a year, and described him/her as laid back and only ever getting agitated when weather or now COVID-19 prevented him/her from going outside and smoking, or when his/her tray wasn't the way he/she wanted it. Interview with State Registered Nursing Aide (SRNA) #3, on 07/06/2020 at 3:14 PM, revealed she had delivered Resident #1's dinner tray at approximately 5:45 PM on 06/25/2020 and had picked it up at approximately 6:15 PM. Per interview, Resident #1 was still in his/her room at that time. She revealed when the elopement was called later that evening, they found a butter knife and screw in his/her open window. Interview with Social Services, on 07/06/2020 at 10:21 AM, revealed she spoke with Resident #1 on 06/26/20, the day following his/her elopement from the facility. She stated Resident #1 had revealed to her that he/she planned to get in trouble and get arrested so that when brought before a judge he/she could plead his/her case to reverse the court decision that had given his/her sister guardianship. Social services revealed she has helped Resident #1 contact legal aide on two occasions, and Resident #1 had written two different letters to the judge at their advice in an effort to get guardianship annulled. She revealed she had also assisted Resident #1 in contacting an independent attorney, who had directed them back to legal aid. Social Services also revealed, following this incident and consultation with other social workers and the area ombudsman, she had provided Resident #1 KY Legal Form 795 to petition to have his/her rights restored, and as a result Resident #1 had a court date set for 07/15/2020. Social Services revealed Resident #1 had never directly or indirectly indicated any desire to elope from the facility. Interview with SRNA #1, on 07/06/2020 at 1:44 PM, revealed Resident #1 never talked about wanting to leave the facility, and never tried to leave the facility. Continued interview revealed he/she never appeared confused when she provided him/her care. Interview with SRNA #2, on 07/06/2020 at 1:56 PM, revealed Resident #1 was a private person who did not require much physical care. She stated the only time Resident #1 required more care was after a [MEDICAL CONDITION], and that he/she had had one (1) [MEDICAL CONDITION] that she was aware. Per interview, Resident #1 appeared confused to her after the [MEDICAL CONDITION]. She stated, Resident #1 would ask for coffee, or to go smoke, but rarely anything else. She revealed when she heard Resident #1 had eloped, she was shocked, as she never would have thought of him/her doing anything like that. Interview with LPN #3, on 07/06/2020 at 3:47 PM, revealed she had worked with Resident #1 extensively during his/her time on the 100 unit, and revealed when he/she first got here, he/she would talk about leaving the facility and getting his/her own apartment, when his/her sister said he/she could. She revealed Resident #1 was really confused after having [MEDICAL CONDITION], but does not seem confused normally. Continued interview revealed Resident #1 has a good memory and he/she was able to remember days LPN #3 was off work and conversations from a month prior. She stated the big thing on Resident #1's mind recently was when residents would be allowed to smoke again. She stated she spoke with Resident #1 after she returned to work following his/her elopement, and Resident #1 started laughing about it. She revealed Resident #1 reported to her that he/she wanted to go out and get drunk and get arrested so he/she could have his/her day in court and talk to the judge. Interview with the Activities Director, on 07/06/2020 at 2:13 PM, revealed Resident #1 preferred self-guided activities and rarely or never participated in group activities. She went on to reveal the only time Resident #1 had ever conversed with her was when asking about the smoking situation, specifically when residents would again be able to go out and smoke, and when she shared she was uncertain, he/she just laughed about it. She revealed Resident #1 never seemed confused to her. Interview with the Maintenance Director, on 07/07/2020 at 2:34 PM, revealed he checks the windows in the resident rooms once a week during his rounds and following Resident #1's elopement, he double-checked everything. He revealed he found no concerns in any other rooms, but did replace the screws in Resident #1's window. He revealed the placement of screws is to prevent resident windows from opening more than four (4) inches. Per interview, he had placed an order for [REDACTED].#1, he planned to install them in all resident windows. Interview with the Center Nurse Executive (CNE), on 07/06/2020 at 2:38 PM, revealed windows in resident rooms have screws in them to prevent them from opening more than four (4) inches. She revealed Resident #1 used a butter knife as a screwdriver to remove the screws from his/her window. Continued interview revealed after Resident #1's elopement, all windows were checked, with only Resident #1's window having any issues. Per interview, the Maintenance Director replaced the screws in Resident #1's window. The CNE further revealed Resident #1 had been on one-on-one (1:1) supervision following the incident, and his/her care plan had been updated to include only plastic utensils on his/her tray to prevent a reoccurrence. She revealed on 07/06/2020, the facility had started back allowing the residents to smoke. Per interview, Resident #1 was on the isolation unit, as all residents who had left facility grounds were required to be on isolation after re-entry to the facility due to COVID-19. Per interview, arrangements had been made for staff to take residents in isolation out one resident at a time for smoking breaks. Interview with the CNE, on 07/08/2020 at 11:06 AM, revealed as a result of Resident #1's elopement, a wander guard had been placed on Resident #1, and he/she had been placed on one-on-one (1:1) supervision, which may continue through the court process regarding his/her guardianship, depending on how things go. She revealed there had been a whole house education, as well as elopement drills to include drill related to residents not listed as an elopement risk. She revealed sometimes door alarms have been set off to determine staff response, and daily audits have been conducted to determine staff knowledge of facility elopement practices. She revealed all residents had been re-evaluated for elopement following the incident. Per interview, the Social Workers interviewed residents with high BIMS and residents with guardians to determine their feelings regarding isolation due to COVID-19. Per interview no other residents were determined to be at risk. The CNE went on to reveal, although she felt the elopement of Resident #1 was an isolated event, she felt the special screws maintenance would be installing in resident windows would prevent any similar incident from occurring. Interview with the Center Executive Director (CED), on 07/08/2020 at 12:38 PM, revealed he believed the situation with Resident #1 was one the facility could not have predicted. He revealed Resident #1 had no behaviors or comments associated with elopement, no indication prior to elopement that he/she had plans to elope. CED revealed he had read letters Resident #1 had written to the judge in an effort to regain his/her legal rights, and described the letters as coherent and clear, although without the best grammar due to educational limits. He felt the root cause of Resident #1's elopement was in effort to appear before a judge, which had now been scheduled for him on 07/15/2020. The CED stated he did not feel the facility did anything wrong, but stated once the screws were changed in all resident windows to the new ones maintenance has ordered, there should be no further risk of Resident #1, or any other resident from eloping through resident windows.