STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An Abbreviated Survey investigating Complaints KY#33090, KY#33538, KY#31778, KY#33210, KY#32932, KY#32967, KY#31704, KY#32038, KY#32126, KY#32037, and KY#32941, was conducted on 03/30/2021 through 04/09/2021. Complaints KY#32941 and KY#32038 were substantiated with deficiencies cited at a Scope and Severity of a "D". Complaints KY#33538, KY#31778, KY#33210, KY#32932, KY#32967, KY#31704, KY#32126, and KY#32037 were unsubstantiated with no deficiencies cited.

Complaint KY#33090 was substantiated with a deficiency cited at a Scope and Severity of a "D" at past non-compliance.

Interviews revealed Resident #1 resided on the E wing and was ambulatory with a walker, but had never made any attempts to leave the facility. However, on 01/14/2021 at approximately 5:00 PM - 5:15 PM, Resident #1 exited through a window in a vacant room on E wing South (Room 24), without staff's knowledge. Observation revealed Room 24 was directly across the hall from Resident #1's room.

On 01/14/2021, at approximately 5:30 PM, Licensed Practical Nurse (LPN) #1 (C wing), received a phone call from Dispatch (Local Law Enforcement), who thought he/she might be a resident at the facility. LPN #1 confirmed he/she was a resident there. Dispatch informed LPN #1 that Resident #1 had exited the facility and was at the convenience store across the street. Certified Nurse Aide (CNA) #1 went across the street to accompany the resident back to the facility. At approximately 5:50 PM, Resident #1 and CNA #1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

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F 000	Continued From page 1 were accompanied back to the facility by Local Law Enforcement. The resident was returned to the facility with no injuries noted. The facility alleged the deficient practice was corrected on 01/22/2021, prior to the State Survey Agency (SSA) entering the building on 03/30/2021, indicating past non-compliance. The SSA determined the facility had corrected the deficient practice on 01/22/2021, prior to the SSA entering the building on 03/30/2021, resulting in past non-compliance.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

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	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

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F 609	Continued From page 2 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and the facility's policy review, it was determined the facility failed to report alleged violations related to mistreatment, neglect, or abuse, and report the results of all investigations to the proper authorities within prescribed timeframe's for three (3) of five (5) sampled Residents (#6, #7, and #8). A Visitor reported to the Administrator a staff member was "gruff" with residents on the Memory Care Unit on 03/08/2020. However, the Administrator failed to report the allegation to other officials in accordance with State law through established procedures (including the State Survey and Certification Agency and Adult Protective Services where State law provides for jurisdiction in long-term care facilities).	F 609		

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F 609	Continued From page 3	F 609		

The findings include:

Review of the facility's policy titled, "Abuse Prohibition" dated 07/01/19, revealed the facility prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited too, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident medical symptoms. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Chief Executive Officer (CEO) or designee will perform the following: enter allegation into the Risk Management System (RMS). Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of resident property within twenty-four (24) hours if the event does not result in bodily injury.

1. Record review revealed the facility admitted Resident #6 on 05/06/15 with diagnoses which included Alzheimer's Disease with Late Onset, Unspecified Macular Degeneration, Difficulty Walking, Hypothyroidism, and Other Symbolic Dysfunction. Review of the Annual Minimum Data Set (MDS), dated 02/05/2020, revealed the facility assessed Resident #6's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of two (2), which indicated the resident was not interviewable.

2. Record review revealed the facility readmitted Resident #7 on 08/23/18 with diagnoses which included Unspecified Dementia Without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 609	Continued From page 4	F 609		

Behavioral Disturbance, History of Falling, Lack of Coordination, Chronic Obstructive Pulmonary Disease (COPD), Unspecified Mental Disorder, and Major Depressive Disorder. Review of the Quarterly MDS, dated 02/12/2020, revealed the facility assessed Resident #7's cognition as severely impaired with a BIMS score of three (3), which indicated the resident was not interviewable.

3. Record review revealed the facility admitted Resident #8 on 04/28/19 with diagnoses which included Unspecified Dementia Without Behavioral Disturbance, Unspecified Abnormalities of Gait and Mobility, History of Falling, and Hypertension. Review of the Significant Change MDS, dated 02/12/2020, revealed the facility assessed Resident #8's cognition as moderately impaired with a BIMS score of seven (7), which indicated the resident was not interviewable.

Interview with the Visitor, on 04/06/2021 at 11:47 AM , revealed on 03/08/2020 a staff member identified as State Registered Nurse Aide (SRNA) #10 was observed grabbing Resident #6 by the wrist and said "come sit over here". Visitor stated "She pulled (resident) really hard, had she not held onto the resident he/she would have fallen". Further interview revealed Resident #7 was standing at the doorway with his/her walker when dietary staff attempted to enter the unit with the food cart. SRNA #11 told the resident to "get out of the way" and took his/her walker in an effort to get him/her to move which left the resident without his/her walker. Additionally, Resident #8 was in the common dining room seated and waiting to eat when SRNA #10 told him/her to get up and move to another table. Resident #8 got up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 609	Continued From page 5	F 609		

because the SRNA wanted him/her to sit in a chair in front of the window facing the table. Interview revealed SRNA #10 was rushing the resident and when the resident began to sit, a chair was not underneath him/her. Visitor stated "I yelled "stop" however, the resident proceeded and his/her bottom hit half the chair". Additional interview with the Visitor, on 04/08/2021 at 8:56 AM, revealed he informed the Administrator of the observations he witnessed and his concerns when SRNA #10 cared for Residents (#6, #7, and #8). Interview revealed the Administrator was notified on 03/08/2020 when incident occurred.

Attempted interview with SRNA #10 by phone was unsuccessful. Voice message left to return call. SRNA #10 terminated employment with the facility on 09/09/2020.

Interview with the Director of Nursing (DON), on 04/07/2021 at 2:30 PM, revealed the Administrator informed her the Visitor reported some observations of concern SRNA #10 displayed with residents on the Memory Care Unit however, the Administrator did not consider the reported observations were abuse or neglect. The DON stated the Administrator wanted me to address (staff member) "gruff demeanor". Further interview revealed the DON did not know what observations and concerns were reported other than SRNA's "gruff tone of voice".

Interview with the Administrator, on 04/08/2021 at 9:50 AM, revealed she was informed of the observations of concern by the Visitor however, he did not go into detail. She stated she asked the Visitor if he felt (staff member) was abusive. Interview revealed the reported observations were not considered abuse therefore, an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

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F 609	Continued From page 6 investigation was not conducted.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 610		

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	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

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CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 610	Continued From page 7	F 610		

Based on interview, record review, and the facility's policy review, it was determined the facility failed to investigate an alleged violation related to mistreatment, neglect, or abuse, and report the results of all investigations to the proper authorities within prescribed timeframe's for three (3) of five (5) sampled Residents (#6, #7, and #8).

A Visitor reported to the Administrator a staff member was "gruff" with residents on the Memory Care Unit on 03/08/2020. However, the Administrator failed to thoroughly investigate the alleged violation and take appropriate corrective action.

The findings include:

Review of the facility's policy titled, "Abuse Prohibition" dated 07/01/19, revealed the facility prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. This includes, but is not limited too, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident medical symptoms. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or the neglect, the Chief Executive Officer (CEO), or designee will perform the following: initiate an investigation within twenty-four (24) hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent. The investigation will be thoroughly documented within RMS. Ensure that documentation of witnessed interviews interviews is included. The Center will protect residents from further harm during an investigation.

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	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

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F 610	Continued From page 8	F 610		

1. Record review revealed the facility admitted Resident #6 on 05/06/15 with diagnoses which included Alzheimer's Disease with Late Onset, Unspecified Macular Degeneration, Difficulty Walking, Hypothyroidism, and Other Symbolic Dysfunction. Review of the Annual Minimum Data Set (MDS), dated 02/05/2020, revealed the facility assessed Resident #6's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of two (2), which indicates the resident was not interviewable.

2. Record review revealed the facility readmitted Resident #7 on 08/23/18 with diagnoses which included Unspecified Dementia Without Behavioral Disturbance, History of Falling, Lack of Coordination, Chronic Obstructive Pulmonary Disease (COPD), Unspecified Mental Disorder, and Major Depressive Disorder. Review of the Quarterly MDS, dated 02/12/2020, revealed the facility assessed Resident #7's cognition as severely impaired with a BIMS score of three (3), which indicates the resident was not interviewable.

3. Record review revealed the facility admitted Resident #8 on 04/28/19 with diagnoses which included Unspecified Dementia Without Behavioral Disturbance, Unspecified Abnormalities of Gait and Mobility, History of Falling, and Hypertension. Review of the Significant Change MDS, dated 02/12/2020, revealed the facility assessed Resident #8's cognition as moderately impaired with a BIMS score of seven (7), which indicates the resident was not interviewable.

Interview with the Visitor, on 04/06/2021 at 11:47

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 610	Continued From page 9	F 610		

AM , revealed on 03/08/2020 a staff member identified as State Registered Nurse Aide (SRNA) #10 was observed grabbing Resident #6 by the wrist and said "come sit over here". Visitor stated "She pulled (resident) really hard, had she not held onto the resident he/she would have fell". Further interview revealed Resident #7 was standing at the doorway with his/her walker when dietary staff attempted to enter the unit with the food cart. SRNA #11 told the resident to "get out of the way" and took his/her walker in an effort to get him/her to move which left the resident without his/her walker. Additionally, Resident #8 was in the common dining room seated and waiting to eat when SRNA #10 told him to get up and move to another table. Resident #8 got up because the SRNA wanted him to sit in a chair in front of the window facing the table. Interview revealed SRNA #10 was rushing the resident and when the resident began to sit, a chair was not underneath him/her. Visitor stated "I yelled "stop" however, the resident proceeded and his/her bottom hit half the chair". Additional interview with the Visitor, on 04/08/2021 at 8:56 AM, revealed he informed the Administrator of the observations he witnessed and of concern when SRNA #10 cared for Residents (#6, #7, and #8). Interview revealed the Administrator was notified on 03/08/2020 when incident occurred.

Attempted interview with SRNA #10 by phone was unsuccessful. Voice message left to return call. SRNA #10 terminated employment with the facility on 09/09/2020.

Interview with the Director of Nursing (DON), on 04/07/2021 at 2:30 PM, revealed the Administrator informed her the Visitor reported some observations of concern SRNA #10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 610	Continued From page 10 displayed with residents on the Memory Care Unit however, the Administrator did not consider the reported observations were abuse or neglect. The DON stated the Administrator wanted me to address (staff member) "gruff demeanor". Further interview revealed the DON did not know what observations and concerns were reported other than SRNA's "gruff tone of voice". Interview with the Administrator, on 04/08/2021 at 9:50 AM, revealed she was informed of the observations of concern by the Visitor however, he did not go into detail. She stated she asked the Visitor if he felt (staff member) was abusive. Interview revealed the reported observations were not considered abuse therefore, an investigation was not conducted.	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		

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	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 689	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility investigation, and facility policy review, it was determined the facility failed to have an effective system in place to ensure one (1) of six (6) sampled residents was provided adequate supervision (Resident #1). Resident #1 was not assessed nor care planned to be at risk for elopement due to his/her history at the facility since admission to the Personal Care Unit on 10/07/2014. On 03/18/2020 and again on 07/03/2020, after a cardiac event which required hospitalization, the resident was re-admitted to the skilled area of the facility. Interviews with staff revealed the resident was very sick for awhile, but made a full recovery. Further interview revealed he/she resided on the E wing and was ambulatory with a walker, but had never made any attempts to leave the facility. However, on 01/14/2021 at approximately 5:00 PM - 5:15 PM, Resident #1 exited through a window in a vacant room on E wing South (Room 24), without staff's knowledge. Observation revealed Room 24 was directly across the hall from Resident #1's room. On 01/14/2021, at approximately 5:30 PM, Licensed Practical Nurse (LPN) #1 (C wing), received a phone call from Dispatch (Local Law Enforcement), who thought he/she might be a resident at the facility. LPN #1 confirmed he/she was a resident there. Dispatch informed LPN #1 that Resident #1 had exited the facility and was at	F 689	Past noncompliance: no plan of correction required.	

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	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12	F 689		

the convenience store across the street. Certified Nurse Aide (CNA) #1 went across the street to accompany the resident back to the facility. At approximately 5:50 PM, Resident #1 and CNA #1 were accompanied back to the facility by Local Law Enforcement. The resident was returned to the facility with no injuries noted.

The facility alleged the deficient practice was corrected on 01/22/2021, prior to the State Survey Agency (SSA) entering the building on 03/30/2021, indicating past non-compliance. The SSA determined the facility had corrected the deficient practice on 01/22/2021, prior to the SSA entering the building on 03/30/2021, resulting in past non-compliance.

The findings include:

Review of the facility's policy titled, "Elopement of Patient", revised 05/15/2014, revealed "patients will be evaluated for elopement risk upon admission, re-admission, quarterly, and with a change in condition as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Elopement occurs when a patient leaves the premises without authorization". Further review of the Elopement Policy, under "Unwitnessed Elopement" revealed "staff will search room to room and all areas of the Center to include patient rooms, closets, under beds, shower rooms, utility rooms, offices, dining rooms, stairwells, laundry, kitchen (including walk-in refrigerators and freezers), bathrooms, dayrooms/lounges, courtyards, employee lounges, and outside building perimeter and grounds. If the patient is not found after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

search of the Center and grounds, notify law enforcement. Provide law enforcement and other search party members a copy of the "Elopement Risk Identification form".

Record review revealed the facility admitted Resident #1 to the skilled area of the facility on 03/18/2020 with diagnoses to include Alzheimer's Disease, Unspecified; Paranoid Schizophrenia; Muscle Weakness generalized; Difficulty Walking; Abnormal Posture: Unsteadiness of feet; Unspecified Dementia with Behavioral Disturbance; Cognitive Communication Deficit; Non-ST Elevation Myocardial Infarction; and Non-Compliance with Medication Regimen.

Review of a Significant Change Minimum Data Set (MDS) assessment, dated 08/28/2020, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident was not interviewable at this time. Further review of the assessment in Section "E" Behavior, revealed no wandering behaviors were exhibited.

Review of a Significant Change MDS assessment, dated 01/18/2021, revealed the facility assessed Resident #1 as cognitively intact with a BIMS score of twelve (12), which indicated the resident was interviewable. Further review of the assessment in Section "E" Behavior, revealed wandering behaviors were exhibited.

Review of an Elopement Evaluation, dated 05/04/2020, revealed Resident #1 was not at risk for elopement.

Review of an initial facility investigation, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

01/14/2021, revealed, at approximately 5:30 PM, Resident #1 exited the facility without supervision. The resident was brought back in to the facility and assessed for injuries. No injuries were identified. Vital signs were taken and found to be at baseline. The resident had a BIMS score of eleven (11). He/she was safe and a thorough investigation regarding the incident would be conducted.

Review of the facility's final investigation, dated 01/21/2021, revealed, on 01/14/2021, Resident #1 disarmed the safety feature on the window in Room 24 of the E wing and exited the facility unwitnessed, sometime between 5:00 PM and 5:15 PM. Local law enforcement contacted the facility clarifying the resident's identity at approximately 5:30 PM and the resident was safely returned to the facility at approximately 5:50 PM. Upon return to the facility, the resident was wearing navy blue sweatpants, a long sleeved blue sweater type shirt, white socks, and black shoes. The resident also had a blanket wrapped around his/her shoulders. The resident described to the Director of Nursing (DON) how he/she forced open the window in a vacant room stating "I yanked it up and it went pop and it bent the screw like that right there (made a crooked gesture with his/her finger)". When asked how he/she got across the street to the convenience store, he/she stated "I watched the cars both ways and I stood and waited until I knew I had time to cross". The resident typically ambulated with a rollator; however, he/she walked independently without incident, at the time of the incident. Staff interviews indicated that the resident was thought to be in his/her bathroom when his/her supper tray was delivered at 5:00 PM - 5:15 PM. The resident typically went to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

bathroom prior to supper as part of his/her normal routine. The tray was placed on the overbed table, which was located against the wall in his/her room. The CNA (#2) returned to the room a short time later and reported that the overbed table with the resident's supper tray had been moved over beside the bed. Presumably, the resident moved the table from the wall to the bed at some point between 5:00 PM - 5:15 PM. Interview with the resident's roommate revealed that he/she saw the resident exit the bedroom and go into the hall, but did not see him/her exit the facility. The window in the resident's room (Room 25 on the E wing), was examined by the DON on 01/14/2021 for any signs that the resident exited the facility through the window, and it was found closed and locked. Further audits on 01/14/2021, of the windows on the unit, revealed the window in Room 24 across the hall, was found open. The window appeared to have been forced open and the safety mechanism had been broken allowing the window to open wide enough to exit the facility. The window was immediately secured. All windows were audited by the Maintenance Director on 01/15/2021 and no other windows were compromised. All staff working on the day of the event were interviewed by the DON for any details related to the resident's exit from the facility. The resident remained alert and oriented and was able to review the details of the event with great detail.

According to the website "timeanddate.com", the temperature in Owensboro on 01/14/2021 at 4:56 PM was 51 degrees Fahrenheit (F) and overcast, with twelve (12) mile per hour (mph) winds, and the humidity was 59%.

Interview with LPN #1 (C wing), on 03/31/2021 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

10:41 AM, revealed she was new to the facility at the time of the resident's elopement, and did not know the resident that well, but on 01/14/2021, she received a phone call from Dispatch, "who thought he/she was our resident", and she was able to confirm that he/she belonged at the facility. She stated "I called the DON around 5:45 PM, did a head count of the whole facility, and saw him/her briefly when he/she got back. CNA #1 went to get him/her, from the store across the street".

Interview with CNA #1 (C wing), on 03/31/2021 at 9:54 AM, revealed on 01/14/2021, LPN #1 (C wing) got a call from the gas station across the street. He stated "the resident had given the person at the gas station a false first name, but I recognized the middle initial of the resident's name. I went to the E wing to see if it was the same person I knew. LPN #2 (E wing) and I started checking E wing rooms, and also opened the back door to check outside, and checked toward the parking lot and dumpsters. After checking and unable to find him/her, I went over to the gas station. The police got there right after I got there. There was still a little daylight left, a little bit of traffic in the area, and had taken me about two (2) to three (3) minutes to cross the street. The resident was just walking out of the store, and was a little shaky and agitated. He/she wouldn't talk to me or the officer. He/she wasn't resistive and was able to follow direction. The resident was alert and oriented, speech was clear; however, he/she gave the officer a false first name, but was cooperative during the ride back to the facility, in the police cruiser. He she was dressed in a sweatshirt, sweatpants, shoes, and had a blanket across his/her shoulders. I'm not sure how long he/she had been gone. During

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

the times I've worked with the resident, I've not heard him/her voice anything about wanting to leave the facility. He/she had been at the facility for awhile, and wanted to see his/her family; however, he/she had not tried to get out before this time".

Interview with LPN #2 (E wing), on 03/31/2021 at 11:22 AM, revealed, on 01/14/2021, "CNA #1 came from the C wing to my wing (E wing) saying they got a call about Resident #1 at the convenience store. I said "what?". She further stated "we checked rooms, bathrooms, everywhere, to include outside. He/she was not an elopement risk and had no wanderguard. I had seen him/her about an hour or so prior to the incident. The resident never said anything and was acting fine. He/she had a walker that he/she used a lot, although he/she could get around without the walker, a little. I don't recall anything unusual going on with him/her". She also revealed "a code yellow was called and everyone checked their units for their residents. CNA's took off over to the convenience store across the street. The temperature outside was in the 50's, no rain, and all of this was around 5:00 PM - 5:30 PM. The resident was brought back to the facility around 6:00 PM. I conducted a skin assessment on the resident, with no concerns noted. He/she never said anything to me during this time. He/she was calm and quiet, sitting in a chair. I notified the Physician and the Power of Attorney (POA). He/she was then transferred to the C wing, which was our locked Alzheimer's Unit, within the facility".

Interview with CNA #2 (E wing), on 03/30/2021 at 3:07 PM, revealed, prior to the incident, there was nothing unusual going on, and the resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

not voiced anything about leaving. She stated once in awhile, he/she talked about missing his/her family, due to the quarantine situation. She stated "I'd tell him/her, so let's call them, but then he/she wouldn't do it". She stated, that on 01/14/2021 around 5:00 PM - 5:15 PM, we didn't notice he/she was gone. I had set his/her meal tray in his/her room and thought he/she was in the bathroom, and told him/her that his/her tray was here, but I didn't wait for a response, and I didn't knock on the bathroom door to check or make sure he/she was in there. His/her rollator was by the bathroom door, so I thought he/she was in there. She added "It was the nurse on the C wing who told me he/she had gotten out of the facility, and I was freaking out because I never heard a door alarm go off". She stated when he/she got back to the facility, he/she "wouldn't tell me how he/she got out".

Interview with CNA #3 (E wing), on 03/30/2021 at 4:00 PM, revealed, on 01/14/2021 during the supper meal, "I was assisting a resident, and CNA #2 was doing rounds. There were just two (2) CNA's on the E wing at that time, and we worked together to get everything done. Nothing unusual was going on with Resident #1, he/she's a jokester, had a good personality, got along with everyone, and could do a lot for himself/herself. He/she talked about his/her daughter a lot, but had a phone if he/she wanted to call her. He/she had never tried to leave before this incident, and we didn't realize he/she was gone until after the fact. When he/she got back to the facility, he/she had a smile on his/her face, but didn't say anything that stood out. I was just glad he/she was back, and I didn't ask any questions. I then left for the evening after doing report".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

Interview with Resident #1's roommate, on 03/31/2021 at 4:25 PM, revealed he/she "did not recall if Resident #1 ever wanted to leave or not".

Interview with the Maintenance Director, on 03/30/2021 at 1:05 PM, revealed he was not at the facility at the time of the elopement on 01/14/2021, but was notified by the Administrator about the incident. He stated he came back to the facility and checked the door system, because at that time, they did not know how or where he/she got out. He indicated there were no issues regarding the door system. He stated he then went home. He stated he was notified by the Administrator through a text message that the resident had gotten out of a window. He revealed when he saw the window the next day, he found that the resident must have circumvented or forced the outer edge of the tab on the window. He stated "all windows have that tab". He stated this window opened to the parking lot. He added that the resident had been on the facility's Personal Care hall at one time, and he/she was never exit seeking.

Interview with the MDS Coordinator, on 04/01/2021 at 10:30 AM, revealed she had only been at the facility for seven (7) weeks. She stated "Elopement Evaluations" should be done with the MDS's (admission, quarterly, annual, and significant change). She stated "I schedule the elopement evaluation when I schedule the MDS, and the nurse on the floor does the assessment. It comes up on daily assignments when they log in, and shows which one to do. We have a Clinical meeting the next morning and review all that got done. I have not found any issues with them not being done".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

Interview with the DON, on 03/30/2021 at 2:40 PM, and on 04/01/2021 at 4:15 PM, revealed the resident was alert and oriented, and when he/she was brought back to the facility that evening on 01/14/2021, he/she made a statement about getting out of a window. She stated no one had checked the windows, except for the one in his/her own room. The incident happened around supper time; however, no one knew he/she was gone until the C wing nurse got a phone call from Dispatch. A random customer at the convenience store had called the police. She stated "the C wing nurse then notified me". She stated the resident wanted a cab to go home (Sacramento, KY). She added that she had notified the Administrator about the incident on 01/14/2021, around 5:48 PM. She added that the resident was unhappy and wanted to be near family. She stated he/she was higher functioning, and both his/her daughters were involved. She stated a discussion with the family and Guardian revealed they were agreeable to a move to a Personal Care Home.

Interview with the Guardian, on 04/05/2021 at 8:39 AM, revealed the facility made her aware of the incident in January. She stated "he/she told them that he/she was going to try and keep getting out, and that next time he/she would take his/her walker". She added that the resident's discharge was discussed with her, and that they discussed trying to get him/her closer to one of his/her daughters. She stated he/she was cognizant and aware, and needed to do what was best for him/her.

Interview with the Center Executive Director (CED)/Administrator, on 03/30/21 at 10:50 AM, revealed the incident occurred on 01/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

when the resident broke a piece off the window in another room and got out. She stated the convenience store that he/she got to, was across the road. The police or store called and he/she was brought back to the facility, by the police. She stated she was notified by the DON, and investigation was initiated immediately.

*The facility implemented the following actions to correct the deficient practice:

1. At the time of the incident on 01/14/2021, a "code yellow" was called which signified a missing resident and staff began accounting for all residents. 105 Skilled Nursing Facility (SNF) residents and six (6) Personal Care (PC) residents were accounted for, including Resident #1.

2. A complete head to toe skin assessment was conducted for Resident #1, upon return to the facility on 01/14/2021, by LPN #2, to include a complete set of vital signs. No injuries were noted. The resident was transferred to the C wing accompanied by staff, on 1:1 monitoring.

3. The resident's daughter, emergency contact #2 was notified of the event at 6:00 PM on 01/14/2021. The State Guardian and emergency contact for Resident #1 was contacted on 01/15/2021 at 9:00 AM.

4. The Maintenance Director completed a door audit on 01/14/2021 at 7:10 PM. All door alarms were functioning within normal parameters.

5. The Primary Care Physician (PCP), who also serves as the Medical Director was notified of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

event at 7:18 PM on 01/14/2021, no injuries, room change and the application of a wanderguard with one to one (1:1) supervision.

6. On 01/14/2021 at 11:09 PM, an audit of E wing windows was completed after a statement made by the resident that he/she crawled out of a window in a vacant resident room (Room 24), on the E wing. In addition, on 01/15/2021 at 7:55 AM, the Maintenance Director completed a window audit of the entire facility. The window in Room 24 on the E wing was repaired. No other windows were compromised.

7. Elopement drills were initiated on 01/15/2021, and will be completed twice daily for seven (7) days, then once daily for fourteen (14) days, then three (3) times per week for sixty (60) days, then one (1) time per week for thirty (30) days, then two (2) times per month for sixty (60) days by the DON, Nursing Manager, or designated licensed nurse.

8. A Significant Change of Condition based on improvement was initiated on 01/18/2021. Based on the outcome of the assessment, the Interdisciplinary Team determined that continued one on one (1:1) supervision was necessary. The resident indicated he/she wanted to be home on or before his/her birthday on 02/27/2021. The use of the wanderguard bracelet was continued and a discharge was planned to a destination with a lower level of care.

9. On 01/18/2021, the Social Services Director completed a BIMS. Resident #1 scored an eleven (11).

10. Staff re-education was completed 01/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

through 01/21/2021 regarding the facility elopement policy and procedure. A post-test to validate learning was completed with each employee. A score of 100% was required. The test was administered and graded by the DON, Nursing Manager, or designated licensed nurse. Staff not available for education/post-test were required to complete mandatory re-education and post-test upon return to work. New staff hired will be provided education and complete a post-test during the orientation process. Re-education and education was provided by the DON, Nursing Manager, or designated licensed nurse. Re-education was completed as of 01/21/2021.

11. Re-education between 01/14/2021 and 01/15/2021 regarding significant resident behaviors and appropriate interventions initiated with all nurses. A post-test to validate learning completed with each employee with a score of 100% required, graded by the DON, and/or ADON. Any nurse not available for education/post-test were required to complete mandatory re-education and post-test upon the day of return to work. New staff hired will be provided education and complete a post-test during the orientation process. Re-education and education was provided by the CED, DON, and ADON. All nurses had re-education completed as of 01/21/2021.

12. On 01/18/2021, the Maintenance Director re-audited windows to ensure windows were secure and unable to be opened greater than six (6) inches.

13. On 01/20/2021, elopement evaluations were completed by the DON, Nursing Manager, or designated licensed nurse on 100% residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24	F 689		

(103/103) with any changes updated in the Elopement Book and/or care plan.

14. On 01/21/2021, all residents at risk for elopement care plans (3/105) were reviewed by the DON, Nursing Manager, or designated licensed nurse, for exit seeking behaviors to ensure appropriate interventions were in place with no additional corrective action required.

15. As of 01/21/2021, re-education regarding updating resident care plans to represent behaviors and interventions was completed with all nurses. A post-test to validate learning completed with each nurse with a score of 100% required, graded by the DON, Nursing Manager, or designated licensed nurse. Any nurse not available for re-education and post-test were required to complete mandatory re-education and post-test upon the day of return to work. New staff hired will be provided education and complete a post-test during the orientation process. Re-education and education was provided by the DON, Nursing Manager, or designated licensed nurse. Twenty-five (25) of twenty-five (25) nurses had re-education completed as of 01/21/2021.

16. The nursing notes will be audited for exit seeking behaviors to determine if appropriate interventions are in place by the DON, Nursing Manager, or designated licensed nurse, daily for two (2) weeks, then five (5) days per week for two (2) weeks, then three (3) days per week for four (4) weeks, then two (2) days per week for eight (8) weeks, then one (1) day per week for eight (8) weeks.

17. Any resident whose nursing notes show exit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

seeking behavior will have his/her care plan audited to ensure appropriate interventions by the DON, Nursing Manager, or designated licensed nurse, daily for two (2) weeks, then five (5) days per week for two (2) weeks, then three (3) days per week for four (4) weeks, then two (2) days per week for eight (8) weeks, then one (1) day per week for eight (8) weeks.

18. Quality Assurance Performance Improvement (QAPI) meeting held on 01/21/2021 to discuss the action plan including audits reeducation and compliance monitors. QAPI members in attendance are as follows: CED, DON, Program Director, Human Resources, Food Services Director, Health Information Manager, ADON, Regional Medical Director, Facility Medical Director, Housekeeping Manager, Business Office Manager, Clinical Reimbursement Specialist, Admissions Director, Director of Rehabilitation, and Maintenance Director.

19. Audits will be reviewed by the DON, Nursing Manager, or designated licensed nurse, daily with correction upon discovery. Trends from the Elopement Drills, work order audits, and nurses notes audits to include care plan audits for appropriate interventions will be identified and brought to QAPI Committee for review monthly times six (6) months which consists of CED, DON, Program Director, Human Resources, Food Services Director, Health Information Manager, ADON, Facility Medical Director, Housekeeping Manager, Business Office Manager, Clinical Reimbursement Specialist, Admissions Director, Director of Rehabilitation, and Maintenance Director for any additional follow-up and/or in-servicing until the issue is resolved and ongoing as determined by the QAPI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185236	A. BUILDING _____ B. WING _____	C 04/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAUTAUQUA HEALTH AND REHABILITATION	1205 LEITCHFIELD ROAD OWENSBORO, KY 42303

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F 689	Continued From page 26	F 689		

committee.

20. Resident #1 remained on 1:1 supervision until the date of discharge to a Personal Care Home closer to family, on 02/02/2021.

**The State Survey Agency validated the corrective action taken by the facility as follows:

1. Interviews on 03/30/2021 with CNA #2 at 3:07 PM, CNA #3 at 4:00 PM; on 03/31/2021 with CNA #1 at 9:54 AM, LPN #1 at 10:41 AM, LPN #2 at 11:22 AM; on 04/02/2021 with Scheduling #1 at 9:55 AM, CNA #4 at 10:10 AM, LPN #3 at 8:50 AM, Registered Nurse (RN) #1 at 8:34 AM; on 04/08/2021 with LPN #4 at 9:10 AM, CNA #5 at 9:35 AM, CNA #6 at 9:50 AM, CNA #7 at 10:00 AM, CNA #8 at 2:30 PM, CNA #9 at 3:08 PM, and with the Dietary Manager at 3:15 PM, revealed they were in-serviced on "code yellow" which signified a missing resident and to begin accounting of all residents.

2. Review of Resident #1's medical record, dated 01/14/2021, revealed a head to toe assessment with vital signs within normal limits was completed by LPN #2.

3. Several attempts were made to contact the resident's daughter, emergency contact #2, to verify notification of the elopement and safe return of Resident #1; however, the surveyor was unable to make contact with her. On 04/05/2021 at 8:39 AM, the State Guardian was contacted by the surveyor, who verified she was notified by the facility of the event, on 01/15/2021.

4. Interview with the Maintenance Director, on

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F 689	Continued From page 27	F 689		

03/30/2021 at 1:05 PM, revealed he completed a door audit on 01/14/2021 at 7:10 PM. All door alarms were functioning within normal parameters

5. Verified through interview with the DON that the Primary Care Physician (PCP) was notified of the event on 01/14/2021, at 7:18 PM.

6. Review of work order #2787, dated 01/15/2021, created by the Maintenance Director, revealed he completed a window audit of the entire facility. The window in Room 24 on the E wing was repaired. No other windows were compromised.

7. Review of the Elopement Notebook revealed Elopement drills were completed on all shifts starting on 01/15/2021 through 01/21/2021 by the DON, Nursing Manager, or designated licensed nurse.

8. Review of a Significant Change MDS assessment, dated 01/18/2021, revealed the facility assessed Resident #1 as cognitively intact with a BIMS score of twelve (12). Further review of the assessment in Section "E" Behavior, revealed wandering behaviors were exhibited. The resident remained on 1:1 supervision until his/her discharge from the facility to a Personal Care Home, on 02/02/2021.

9. Interview with Social Services revealed the resident was cognitively intact with a BIMS score of eleven (11).

10. Review of in-service sign-in sheets, dated 01/15/2021, revealed education was completed on the elopement policy and procedure for all

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F 689	Continued From page 28	F 689		

staff. Review of post-tests and scores of 100% were verified by the surveyor.

11. Review of in-servicing, dated 01/15/2021, revealed education was completed regarding significant resident behaviors and appropriate interventions initiated with all nurses. Review of licensed nurse post-tests and scores of 100% were verified by the surveyor.

12. Observation, on 04/01/2021, with the Maintenance Director, revealed all windows had been reinforced by drilling additional screws into the casement, opening no greater than six (6) inches.

13. Record review of six (6) additional residents were reviewed. Elopement evaluations were accurately documented. Interview with the DON revealed the evaluations were completed facility-wide with any changes updated in the Elopement Book and/or care plan.

14. Review of "at risk for elopement care plans" were reviewed for exit seeking behaviors to ensure appropriate interventions were in place with no additional concerns identified. Interview with the DON revealed updates to care plans were completed facility-wide.

15. Review of in-servicing, completed as of 01/21/2021, revealed re-education regarding updating resident care plans to represent behaviors and interventions was completed with all nurses. Review of licensed nurse post-tests and scores of 100% were verified by the surveyor.

Interviews on 03/31/2021 with LPN #1 at 10:41

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F 689	Continued From page 29	F 689		

AM, LPN #2 at 11:22 AM; on 04/02/2021 with LPN #3 at 8:50 AM, Registered Nurse (RN) #1 at 8:34 AM; on 04/08/2021 with LPN #4 at 9:10 AM, revealed they were in-serviced on updating resident care plans.

16. Review of nursing notes for six (6) additional residents, related to exit seeking behaviors, revealed no concerns.

17. Review of care plans for six (6) additional residents, related to exit seeking behaviors, revealed no concerns.

18. Interview with the DON, on 03/31/2021 at 2:35 PM, and on 04/01/2021 at 11:13 AM, revealed elopement evaluations were done facility-wide at the time of the incident, there were Elopement Guard Books on each unit of the facility showing residents' pictures and information, education was completed with all staff, unannounced elopement drills were completed, Maintenance conducted an audit of all windows, and also did another re-enforcement of the windows. Resident #1 was moved to a locked unit with 1:1 monitoring until discharge from the facility on 02/02/2021. While on the locked unit, Resident #1 had a wanderguard in place and there was an alarm on his/her window, as well. She stated elopement evaluations were completed with the admission, annual, quarterly, and significant change MDS's. If any answers were "yes" on the elopement evaluation, it triggered that he/she was an elopement risk.

19. Interview with the DON, on 04/06/2021 at 4:10 PM, revealed "myself, the Nurse Practice Educator (NPE), and Administrator ensured the education, monitoring, and elopement reviews

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F 689	Continued From page 30 were done, with no issues thus far". 20. Confirmation through record review and interview with staff, revealed Resident #1 remained on 1:1 supervision until the date of discharge to a Personal Care Home, on 02/02/2021. The Personal Care Home was closer to his/her family. .	F 689		