

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ MAR 01 2012 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2011
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NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306
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F 323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interviews and record review, the facility failed to prevent one (1) of four (4) cognitively impaired residents (Resident # 2) who exhibited wandering behaviors from eloping from the facility. On February 4, 2011, Resident #2 exited the building unattended by staff. The facility failed to utilize the WanderGuard system according to manufacturers guidelines for 2 of 2 (Resident #6 and #7) sampled residents identified at risk of wandering.</p> <p>Immediate Jeopardy began on 2/4/2011 and was identified on 2/10/2011 at 4:10 p.m. Immediate Jeopardy was removed on 2/11/2011 at 5:00 p.m. when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and 100% completion of employee training. Findings include:</p> <p>1. Resident #2 was admitted to the facility 5/13/2010 and readmitted to the facility</p>	F 323	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance, All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice. – On 2/4/11, Resident #2 was reported to be outside at approximately 6 AM. The wander guard alarm in the front lobby entrance was going off. Nurse and CNA staff responded and found Resident #2 sitting in the lobby. At approximately 6:30 AM, nurse notified Unit Manager, DON, and Administrator. Nurse immediately checked Resident #2's wander guard bracelet to confirm that it was operational by walking Resident #2 through the interior lobby doors, which are also equipped with the wander guard alarm system. Nurse #1 completed a head to toe assessment of the resident (#2) when he was brought back to the unit. The assessment revealed no injury, which was documented in the nurse's note. Fifteen minute checks were initiated for Resident #2 which were completed by nursing staff on the unit. After 24 hours, the</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Scharee L. Cain* TITLE *Administrator* (X6) DATE *2-24-11*

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 323	<p>Continued From page 1 12/16/2010. Cumulative diagnoses included: Anoxic encephalopathy (brain damage due to lack of oxygen) and Dementia.</p> <p>An annual Minimum Data Set (MDS) dated 11/05/2010 indicated Resident #2 had short term and long term memory impairment. Cognitive skills for daily decision-making were severely impaired. Resident #2 was dependent on staff for bed mobility. He required extensive assistance with transfers. Ambulation and balance during transitions (moving from seated to standing position, walking, turning around, moving on and off toilet, surface-to-surface transfer) did not occur during the seven day assessment period. Functional limitation in range of motion was noted to both lower extremities.</p> <p>A care plan initiated on June 1, 2010 and updated on 12/23/2010 indicated Resident #2 was at risk for wandering due to dementia. Approaches included the use of a " security alarm bracelet (WanderGuard bracelet) or other sensor system to reduce the risk of elopement from the facility, encourage rest periods as needed; keep same routines and monitor behavior and attempt to determine pattern, frequency and intensity for wandering. "</p> <p>The use of a WanderGuard bracelet was initiated in September, 2010. A Wandering Elopement Risk Assessment done 12/16/2010 indicated Resident #2 did not have a history of wandering/ elopement at home. He did not have a history of leaving the facility without informing staff and had not left the facility without needed supervision. A WanderGuard bracelet continued to be used on Resident #2 in December, 2010.</p>	F 323	<p>resident was not demonstrating any exit-seeking behaviors and the 15-minute checks on the patient were then stopped after the initial 24 hours. The maintenance assistant tested all doors equipped with a wander guard alarm system at approximately 7:00 AM on 2/4/11 and door alarm checks were documented on the Building Engines system (maintenance computer program) as being operational. Fifteen (15) minute checks on both the day room and dining room doors were initiated for 24 hours and were to be completed by the nurse on the unit using the wander guard testing device to confirm that the door alarms were operational. The door alarms were documented as being operational during this time and this was documented on the Observation Record. All other door alarms were checked by the maintenance assistant, and on the weekend, the Manager on Duty (MOD) completed the wander guard system checks which was documented on the MOD Wanderguard/Door Checks Log, and were documented as being operational.</p> <p>The nurse practitioner (NP) was notified on 2/4/11 at approximately 8:30 AM. At approximately 9 AM, the NP assessed resident #2 and gave orders for a urinalysis, complete blood count, comprehensive metabolic panel, and vital signs to be checked each shift for 3 days and then daily for 7 days. Results from the urinalysis were obtained on 2/5/11 which revealed a positive diagnosis of a urinary tract infection (UTI), and antibiotic treatment was ordered for resident #2.</p> <p>Resident #2 had been assessed as a wandering risk on 9/18/10, 12/16/10, and again on 2/4/11. A wander guard bracelet</p>	2/5/11	

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F 323	<p>Continued From page 2</p> <p>On 2/8/2011 at 9:40 a.m., Resident #8 revealed she was sitting with Resident #9 smoking under the front shed in the front of building (covered portico outside of the front doors) on 2/4/2011 at 5:30 a.m. She stated she saw Resident #2 coming across the parking lot pushing his wheelchair. It was raining and he did not have a jacket on. She said he told them he had gone home. Resident #9 opened the front lobby door and helped Resident #2 go inside the building. She stated she did not understand how Resident #2 got out of the building because they had alarms on the doors. Resident #8 said they would have seen Resident #2 if he had come out the front door. She did not indicate that she heard the alarm sounding when Resident #2 went into the facility.</p> <p>A review of the weather record for February 4, 2011 in Fayetteville, NC revealed light rain was noted during the hours of 4:53 a.m. through 8:53 a.m.</p> <p>On 2/10/2011 at 4:10 p.m., the Director of Nursing stated she had not interviewed any residents until yesterday (2/9/2011). She stated she had spoken to Resident #8 and, basically, Resident #8 had stated the same information (e.g. Resident #8 and Resident #9 were outside at 5:30 a.m. on 2/4/2011 and saw Resident #2 coming across the parking lot) but said Resident #8 told her Resident #2 was coming across the parking lot as if coming from the store (left side of parking lot). The quarterly MDS dated 1/7/2011 indicated Resident #8 was cognitively intact. Resident #8's name was provided by the facility as a reliable and interviewable resident.</p> <p>On 2/8/2011 at 5:40 p.m., Resident #9 stated she</p>	F 323	<p>was placed on the resident (#2) on 9/18/10. The resident's care plan dated 12/23/10 included interventions: Provide program of activities to minimize potential for wandering while meeting need for social/cognitive stimulation, use security/alarm bracelet (wander guard bracelet), praise purposeful movement for non-wandering behavior, and anticipate resident's needs as much as possible. The resident's care plan was updated on 2/4/11 to include 15 minute observation checks by the nursing staff for a period of 24 hours. The resident's care plan was updated on 2/8/11 with a goal evaluation to include "new DX (diagnosis) UTI with antibiotic therapy which may have influenced desire to leave facility and go home." The change in behavior was thought to be related to the UTI 2/5/11 and a new diagnosis of acute delirium was added 2/4/11 related to symptoms of the UTI. There were no further attempts of resident #2 to elope. Licensed nurses will continue to check all resident wander guard bracelets every shift to verify that they are in place, that there is correct placement of the wander guard bracelet per manufacturing guidelines, and are operational. Documentation of verification will be completes on the medication administration records (MARs).</p> <p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – DON arrived at facility at 6:47 AM. The DON immediately verified the location of resident #2 in his room. The DON gathered staff from the unit as well as</p>		

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F 323	<p>Continued From page 3</p> <p>and Resident #8 were smoking outside the front doors on 2/4/2011 early in the morning. She said they saw a black man coming across the parking lot. He was pushing a wheelchair and he was wet. She stated he was not wearing a coat. She opened the front door for Resident #2. She did not indicate if she heard the alarm sounding when Resident #2 entered the facility. The quarterly MDS dated 1/25/2011 indicated Resident #9 was severely cognitively impaired; however, Resident #9's name was provided by the facility as a reliable and interviewable resident.</p> <p>A nursing note dated 2/04/11 at 06:57 a.m. written by Nurse #1 revealed Resident #2 was observed on the front porch of the facility by a dietary employee. Employee brought the resident back inside. Resident #2 was taken back to the unit. He was slightly wet due to the rain. Resident's WanderGuard was in place.</p> <p>The investigative report dated 2/4/2011 was reviewed. Staff that had worked on the unit where Resident #2 resided as well as the adjacent unit were interviewed. Staff on the adjacent unit stated they heard the WanderGuard alarm sounding in the front lobby around 6:00 a.m. When they arrived in the lobby, Resident #2 was in the front lobby. They did not see Resident #2 on their unit until he was being returned after he went outside. Nurse #1 stated that she received a phone call at approximately 6:05 a.m. from someone who stated "One of your residents is underneath the tree out in the rain by the gate." Staff from that unit went to the front lobby and observed Resident #2 in the front lobby and the WanderGuard alarm was sounding. Staff reported Resident #2 stated he was going home. Staff noted he had "drizzles"</p>	F 323	<p>the staff from the adjoining unit to in-service the staff on responding to alarms, verifying location of their residents, and elopement. In-servicing on the wander guard system, response to alarms, and elopement began on 2/4/11, 2/8/11, and 2/9/11. All employees not yet in-serviced will be in-serviced upon arrival for their next shift. Beginning on 2/11/11, in addition to the above mentioned topics to be covered during in-servicing, keeping 2 wander guard bracelets on the medication carts (1 on each cart) on Dogwood Unit, 2 on Magnolia Unit (1 on each cart), and 1 bracelet to be kept on Independence Unit (the majority of these residents are more independent and are receiving short-term stay rehabilitation) in a medication cart. In the event that there is not a wander guard bracelet available, the resident at risk will be assigned a staff member to stay with him or her until a wander guard bracelet is able to be placed on the resident.</p> <p>In-servicing on the wander guard system, response to alarms, and elopement began on 2/4/11, 2/8/11, and 2/9/11. All employees not yet in-serviced will be in-serviced upon arrival for their next shift. If door alarms are found to be non-functioning or malfunctioning, a staff member will be assigned to stay at the door until the door is repaired. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. Completion date: 2/14/11.</p> <p>On 2/4/11, the administrator called the door alarm company prior to 9 AM. The door alarm company verified that they would be at the facility at approximately 5:30 PM to move the wander guard door alarms from</p>	2/11/11	2/14/11

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F 323	<p>Continued From page 4</p> <p>of rain on his sweater and his wheelchair seat was wet. NA #1 stated she assisted the resident out of bed at 5:30 a.m. and had observed him in the dining room at 5:40 a.m. Nurse #1 had documented that a dietary staff member brought the resident back into the building. The Director of Nursing (DON) indicated no staff member was able to validate that a dietary staff member brought Resident #2 in and no staff member actually observed him outside.</p> <p>On 2/8/2011 at 5:15 p.m., Nurse #1 stated, on 2/4/2011, NA #1 got Resident #2 out of bed around 5:45 a.m. She said Resident #2 did not normally get out of bed at this time but he was awake and staff was trying to help the day shift out by getting him up. Nurse #1 stated Resident #2 had a WanderGuard bracelet on his ankle and was sitting in his wheelchair at the nurse 's station. The WanderGuard alarm system at the dining room door kept alarming every time he tried to go into the dining room and they had to reset the alarm each time it went off. At 6:00 a.m., she was doing her last rounds when someone (person did not identify themselves) called on the telephone and told her one of the patients was outside the facility. She stated her WanderGuard alarm was not sounding at the time of the phone call. She and nursing staff from her unit ran toward the front lobby and someone was bringing him back inside. She did not see who was bringing Resident #2 inside the building and stated she heard a voice that sounded like one of the dietary employees. She indicated the front lobby WanderGuard alarm was sounding when she arrived in the lobby area. She stated, from the Dogwood area (700 and 800 halls), the front door alarm could not be heard.</p>	F 323	<p>the interior doors to the exterior doors in both the day room and dining room. The door alarm company completed the moving of the wander guard alarm system to the exterior dining room door on 2/4/11. The day room door alarm was moved to the exterior door on the morning of 2/5/11. Fifteen minute door checks were complete during this transition until all work was completed and the doors were functioning properly. On 2/5/11 and 2/6/11 the Manager on Duty completed wander guard checks on all perimeter doors equipped with the wander guard alarm system. The maintenance assistant completed wander guard door checks daily throughout the week and the manager on duty completed the checks on weekends previous to 2/4/11. Checks continue daily since 2/4/11. There have been no reports of any of the wander guard door alarms not functioning properly. Signs stating, "Do not assist resident outside" were placed on all egress doors by the administrator. This was completed on 2/10/11.</p> <p>All residents currently residing in the facility have been assessed for wandering risk using the appropriate form (At Risk to Wander Assessment Form) on admission and quarterly or as soon as they display signs/symptoms of wandering. All residents assessed as wanderers have been, and will continue to be, given a wander guard bracelet, a wander risk care plan to include interventions to prevent elopement and will be communicated via care plan to direct care staff. The at risk resident's picture will be posted at each nurses' station, at the back door, and at the lobby/receptionist area.</p>	2/5/11 2/10/11

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F 323	<p>Continued From page 5</p> <p>Interviews were conducted with NA #1 and NA #2 on 2/8/2011 between 5:25 p.m. and 5:30 p.m., Both NAs stated Resident #2 was in his wheelchair around 5:30 a.m., He kept rolling in his wheelchair near the dining room door and trying to go in the dining room and caused the Wander Guard alarm to go off. About 6:00 a.m., Nurse #1 asked NA#1 to look for Resident #2 because she had received a phone call about a patient being outside the building. Both NAs went to the front lobby area and found Resident #2 sitting in a regular chair in the front lobby with his wheelchair parked beside him. He had some sprinkles of water on his clothing. A small amount of water (drizzles) was on his wheelchair. Resident # 8 and Resident #9 were outside the front door. NA #2 stated they had the front door open and were coming in the building. When they saw NA #1, they stated Resident #2 had come up walking but did not state he was outside. They stated the alarm was sounding in the front lobby area.</p> <p>On 2/8/2011 at 12:00 p.m., the nurse practitioner stated she received a call from nursing staff on 2/4/2011. Staff informed her that Resident #2 was found outside of the building early in the morning alone. She stated Resident #2 was not known to try to exit the building. He was not known to ambulate but mobilized about the facility in a wheelchair. She examined Resident #2 later that morning, ordered laboratory tests and determined Resident #2 had a urinary tract infection. She stated there were no physical and/or mental changes noted except for verbal responses (Resident #2 had increased verbalizations).</p> <p>On 2/8/2011 at 4:20 p.m., the Director of Nursing</p>	F 323	<p>Measures to be put in place or systemic changes made to ensure practice will not re-occur- On 2/9/11 the administrator contacted the door alarm company and the manufacturer of the wander guard system to discuss the possibility of changing the door alarms to alarm when a resident approaches the door rather than when the door is opened. All doors were programmed to alarm when opened by a resident wearing a wander guard bracelet and the lobby doors were set to alarm when a resident wearing a wander guard bracelet approached the door. The door alarm company advised the facility on how to make the changes and the regional maintenance consultant changed the door alarms accordingly so that when a resident wearing a wander guard approached the door, the alarm would sound before the door was opened. This was completed on 2/9/11 on all egress doors.</p> <p>On 2/10/11 the regional maintenance consultant adjusted the system so that the alarm field was expanded in order to capture the resident's signal prior to reaching the door in an effort to ensure the optimal effectiveness of the system.</p> <p>On 2/10/11, after the system was adjusted, two checks were completed on all doors with alarms and the system was working properly each time. No other residents have been determined to exit in similar circumstances.</p> <p>DON and unit managers verified that all residents have been assessed for wandering risk using the Wandering Assessment form. This was completed 2/10/11.</p> <p>Residents who had wander guard bracelets placed on their chairs have had the bracelet removed from the chair and placed in a</p>	<p>2/9/11</p> <p>2/10/11</p> <p>2/10/11</p>
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F 323	<p>Continued From page 6</p> <p>(DON) stated Resident #2 was not known to ambulate and/or try to exit the building. She said no one actually verified that Resident #2 was outside and no staff member actually saw him outside of the building. The DON stated NA #1 got Resident #2 up at 5:40 a.m. At 6:00 a.m., he walked in the main lobby door. When he came in the front door, the WanderGuard alarm sounded. Staff from his unit and the adjacent unit came to the lobby area. She indicated staff believed he went out of one of two doors (the day room door or dining room door). Staff had informed her that Resident #2 came in the door by himself and did not mention that there were any other residents in the area at that time. Resident #2 did not usually ambulate.</p> <p>On 2/9/2011 at 12:10 p.m., the DON stated there were nine residents with WanderGuard bracelets and two residents (Resident #2 and Resident #3) had exhibited exit seeking behavior as of 2/9/2011. In November 2010, she stated she had instructed nursing staff to check the WanderGuard bracelets every shift for function and placement and expected the information to be documented on the Medication administration record. Medication administration records (MARS) were reviewed. The following was noted: Resident #2's WanderGuard bracelet checks for function and placement (to be done every shift) was not noted on MARS for November 2010, December 2010 and January 2011. WanderGuard checks for function and placement every shift was documented on February 's MAR beginning 2/4/2011.</p> <p>The Administrator was notified of the Immediate Jeopardy on 2/10/2011 at 4: 10 p.m.</p>	F 323	<p>location acceptable to the manufacturer's recommendations. This was completed 2/10/11.</p> <p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- To verify that the wander guard system continues to function properly, the maintenance assistant or manager on duty will continue to check all egress doors daily. The maintenance assistant will document the findings on the Building Engines System and the manager on duty on the weekends will document the tests of the doors on the Weekend MOD wander guard/door check log form. Forms will be audited by the administrator. The audit will be 5 times per week for 1 month, and will include some weekend shifts. Audit will be completed 3/11/11.</p> <p>In-servicing on the wander guard system, response to alarms, and eplacement began on 2/8/11 and 2/9/11 including how to react if door alarms are found to be non-functional. If a wander guard door alarm is found to be non-functioning, a staff member will be assigned to stay at the door until the door is repaired. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. Completion date 2/14/11.</p> <p>Tests will be conducted by the DON or unit managers by setting off alarms and timing the response to the door alarm. Findings will be documented on the Door Alarm Response Time audit form. Audits will be conducted 5 times weekly for one month and will include some weekend shifts (end 3/11/11), followed by 2 times weekly for one month to include weekend shifts (end 4/11/11), and</p>	2/10/11 3/11/11 2/14/11

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F 323	<p>Continued From page 7</p> <p>The facility presented a credible allegation of compliance on 2/11/2011 at 5:00 p.m. which included:</p> <p>Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 2/4/11, Resident # 2, at approximately 6a.m., was reported to be outside. The alarm on the front lobby was going off. Nurse and CNA responded and found Resident #2 sitting in lobby. Approximately 6:30 a.m., Nurse notified DON, Administrator and Unit Manager. Nurse #1 immediately checked the resident's wander guard bracelet to confirm that it was operational by walking Resident #2 through interior lobby doors. Door alarm sounded indicating that the bracelet was operational. The maintenance assistant tested all doors alarms with tester at approximately 7am on 2/4/11 and door alarm checks were documented on the computer building engine system as being operational. Fifteen (15) minute checks on dayroom and dining room doors x 24 hrs were initiated to be done by Nurse on unit using tester confirming that door alarms indicating operational. Door alarms were documented as operational. This was documented on the Observation Record; All other door alarms were checked daily by Maintenance assistant and Manager on duty on the weekend (days). Checks were documented on the Building engine system by Maintenance assistant or WanderGuard/door alarm check form. Nurse #1 completed a head to toe assessment of the resident when he was brought back to the unit. Assessment of the resident showed no injury and this was documented in the progress note. Fifteen (15) minutes checks x 24 hrs were</p>	F 323	<p>then once per week for one month, to include weekend shifts, to be completed 5/11/11. Any concerns will be taken to daily stand-up meetings and quarterly Quality Assessment and Assurance meetings for review and resolution.</p> <p>Licensed nurses will continue to check all resident wander guard bracelets each shift to ensure they are in place, are properly placed per manufacturing guidelines, and operational. Documentation of verification will be on the Medication Administration Record (MAR) of each resident with a wander guard bracelet. Documentation will be audited 5 times a week for one month by DON or unit managers. This was completed 2/10/11.</p> <p>The regional maintenance consultant will continue to complete quarterly inspections of the door alarm system. The administrator will audit for completion. Completed 2/10/11 with quarterly repeats thereafter. All residents currently residing in the facility have been assessed for wandering risk using the Wandering Assessment Form. New admissions will be assessed using the wandering assessment form and quarterly thereafter. All residents assessed as wanderers have been and will continue to be given a wander guard bracelet, a wander risk care plan, and their picture will be posted at each nurses' station, at the back door, and lobby/receptionist area. All licensed nursing staff have access to residents' care plans on the Optimum Clinical System. CNAs have access to care plan interventions for CNAs through the care plan confirm button on the ADL system. This will be audited weekly by the DON or unit managers using the wandering/elopement risk audit form that</p>	5/11/11 3/10/11 2/10/11	

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NAME OF PROVIDER OR SUPPLIER CAROLINA REHAB CENTER OF CUMBERLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 4600 CUMBERLAND ROAD FAYETTEVILLE, NC 28306		
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F 323	Continued From page 8 initiated for Resident #2 to be done by nursing staff on the unit. After the 24 hrs, Resident #2 was not demonstrating any exit seeking behaviors and fifteen (15) minute checks stopped. . The Nurse Practitioner (NP) was notified 2/4/10 at approximately 8:30a.m. At approximately 9 a.m., NP assessed Resident #2 and gave orders for UA (urinalysis), CBC (complete blood count), CMP (comprehensive metabolic panel), and VS (vital signs) every shift x 3 days and then daily x 7 days. Results received for UA on 2/5/11 with positive results for Diagnosis of UTI and resident placed on antibiotic therapy. Resident #2 had been assessed as a wandering risk on 9/18/10, 12/16/10 and again on 2/4/11 and a WanderGuard bracelet had been placed on resident 9/18/10. Care plan dated 12/23/10 included interventions: Provide program of activities to minimize potential for wandering while meeting need for social/cognitive stimulation, use security alarm bracelet (WanderGuard), praise purposeful movement for non wandering behavior and anticipate resident needs as much as possible. Care plan was updated on 2/4/11 to add Q15 (every fifteen) minute observation checks on resident by staff for 24 hrs. Care plan was updated on 2/8/11 with a goal evaluation done stating "new DX (diagnosis) UTI with antibiotic therapy which may have influenced desire to leave facility and go home". Change in behavior was thought to be related to UTI 2/5/11 and new Diagnosis of Acute Delirium dated 2/4/11 related to symptoms of UTI was added. No further attempts by resident #2 to elope. Licensed nurses will continue to check all resident WanderGuard bracelets every shift to verify they are in place, correct placement per manufacturing guidelines, and are operational. Documentation of verification will be on the Medication	F 323	includes date of last wandering assessment, bracelet placed appropriately, care plan for wandering, and a picture of the resident. Completion of 2/10/11. In-servicing on the wander guard system, response to alarms, and elopement began on 2/4/11, 2/8/11, and 2/9/11, including how to react if door alarms are found to be non-functional. If door alarms are found to be non-functioning, a staff member will be assigned to stay at the door until the door alarm is repaired. In the event that there is not a wander guard available, a staff member will be assigned to stay with the resident until a wander guard bracelet is placed on the resident. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. Completion date of 2/14/11. Nursing staff will be in-serviced on 2/15/11 by the Geriatric Specialty Team to include how to recognize exit-seeking behavior. All employees who have not been in-serviced will be in-serviced upon arrival for their next shift after 2/15/11. The DON or staff development coordinator will provide education on how to recognize exit-seeking behavior to start May 2011 with repeats quarterly thereafter. Completion date 2/18/11. A technician from the wander guard manufacturer will test the wander guard system to ensure that the system is working properly. This was completed 2/10/11. A technician from the wander guard system manufacturer will test the wander guard system to ensure that the system is working properly once per month for the next 3 months beginning in March 2011. This will	2/10/11 2/14/11 2/18/11 2/10/11	

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F 323	Continued From page 9 Administration Record. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: DON arrived at the facility 2/4/11 at 6:47 a.m. DON verified location of resident in his room. DON in-serviced the staff on the units in approximate surrounding at the time of elopement (which are Magnolia and Dogwood) on responding to alarms, verifying location of their residents and elopement. In-servicing on wander guard system, response to alarms, and elopement began on 2/4/11, 2/8/11 & 2/9/11. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. Beginning 2/11/11, in-service will include that a minimum of 2 WanderGuard bracelets will be kept in a medication cart on Dogwood and Magnolia units and 1 WanderGuard bracelet on Independence unit (as the majority of these residents are more independent and receiving rehab short term stay) in a medication cart. In the event that there is not a WanderGuard available, the resident at risk will be assigned a staff member to stay with that resident until a wander guard bracelet is placed on resident. In-servicing on WanderGuard system, response to alarms and elopement began on 2/4/11, 2/8/11 & 2/9/11 including how to react. If door alarms are found to be non-functioning, a staff member will be assigned to stay at the door until the door is repaired. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. This was completed 2/14/11. On 2/4/11, the Administrator called (name of environmental services company) at	F 323	be audited by the administrator. Completion of May 2011. Resident #2's elopement was addressed in the morning stand-up meeting and daily falls committee on 2/7/11. Results of the door alarm and wander guard checks will be reviewed during quarterly Quality Assurance meetings until compliance is achieved with the committee and recommendations made when appropriate. Between quarterly QAA meetings, any elopement incidences will be reviewed by the falls committee (Administrator, DON, unit manager, and other attendees) during daily stand-up meetings. This will be audited by the administrator or designee. This was completed 2/7/11 with quarterly reports until compliance is achieved. The facility will continue to provide adequate supervision to all of its residents. In particular, where residents are identified as being at risk for elopement, the facility will assess the necessary level and type of supervision that may be required and will provide that supervision based on the individual resident's assessed needs and the risks identified in the environment.	May 2011	

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F 323	<p>Continued From page 10</p> <p>approximately 9 a.m. (Name of environmental services company) verified that they would be at the facility approximately 4:30 to 5p.m. to switch the WanderGuard Door alarm to the outside doors in both the dining room and dayroom. (Name of environmental services company) changed the alarm on the dining room door at approximately 6:30 p.m. The dayroom door was changed on 2/5/11 at approximately 10 a.m. Fifteen minute door checks continued until the door alarms were working properly. On 2/5 & 2/6/11, the manager on duty completed WanderGuard door checks. The maintenance assistant completed WanderGuard door checks daily during the week and the manager on duty completed WanderGuard door checks on weekends previous to 2/4/11. Checks continue daily since 2/4/11. There have been no reports of system not working properly.</p> <p>Signs stating "Do not assist resident outside" were placed on all doors available to exit by visitors by DON. This was completed 2/10/11</p> <p>All residents currently residing in facility have been assessed for wandering risk using the At risk to Wander assessment form. New admissions will be assessed using the At Risk to Wander Assessment Form on admission and quarterly or as soon as they display s/s of wandering. All residents assessed as wanderers have been, and will continue to be, given a WanderGuard bracelet, a wander risk care plan to include interventions to prevent elopement, and will be communicated via care plan confirm to direct care staff. Their picture will be posted at each nurse ' s station, back door and lobby receptionist area.</p>	F 323		

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F 323	<p>Continued From page 11</p> <p>Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur:</p> <p>On 2/9/11 the facility contacted (name of Wander Management Company) and (name of environmental services company) to discuss the possibility of changing the door alarms to alarm when a resident approaches the signal field before a door is opened. All doors currently alarmed when opened by a resident with a WanderGuard and the lobby doors already were set to alarm when a resident with a wander guard approached the signal field before the door was opened. (Name of Wander Management Company) advised how to make the changes and the Regional Maintenance Director changed the door alarms accordingly so that when a resident with a WanderGuard approached the signal field, the alarm sounds before the door was open. This was completed on 2/9/11.</p> <p>On 2/10/11, the Regional Maintenance Director adjusted the system so that the alarm field is expanded to capture the resident 's signal before reaching the door in an effort to ensure the optimal effectiveness of the system.</p> <p>On 2/10/11, after the system was adjusted, checks were completed x 2 (two) on all doors with alarms and the system was working properly. No other residents have been determined to exit in similar circumstances.</p> <p>DON and unit managers verified that all residents have been assessed for wandering risk using the Wandering Assessment form. This was completed 2/10/11.</p>	F 323		

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F 323	<p>Continued From page 12</p> <p>Residents who had wander guards placed on their chairs have had the WanderGuard removed from the chair and placed in a location acceptable per manufacturer ' s recommendations. This was completed 2/10/11</p> <p>Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility:</p> <p>To verify that the system continues to function properly, the maintenance assistant or manager on duty will continue to check all egress doors daily. The maintenance assistant will document on the Building Engine System and the manager on duty will document on the Weekend MOD (manager on duty) wander guard/door check log form. Forms will be audited by the Administrator. The audit will be 5 times a week to include weekend shifts x 1 month. This was completed 2/10/11.</p> <p>In-servicing on WanderGuard system, response to alarms and elopement began on 2/8/11 & 2/9/11 including How to react if door alarms are found to be non-functional. If a WanderGuard is found to be non-functioning, a staff member will be assigned to stay at the door until the door is repaired. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. This has a completion date of 2/14/11.</p> <p>Tests will be done by DON or the unit managers</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>by setting off alarms and timing the response to the door alarm. Findings will be documented on the Door alarm response time audit form. Audit response time to door alarms will be done 5 (five) times weekly x 1(one) month to include weekend shifts, 2 (two) times weekly x 1(one) month to include weekend shifts, and then weekly x 1(one) month to include weekend shifts. Any concerns will be taken to daily stand up meetings and Quarterly Quality Assurance meetings for review and resolution. This was completed 2/10/11.</p> <p>Licensed nurses will continue to check all resident WanderGuard bracelets every shift to ensure that they are in place, correct placement per manufacturing guidelines, and operational. Documentation will be on the Medication Administration Record. Documentation will be audited 5 times a week x 1 month by DON or unit managers. This was completed 2/10/11</p> <p>The Regional Maintenance Director will continue to complete quarterly inspections of the door alarm system. The Administrator will audit completion. This was completed 2/10/11 with quarterly repeats thereafter.</p> <p>All residents currently residing in facility have been assessed for wandering risk using the At risk to Wander assessment form. New admissions will be assessed using the At Risk to Wander Assessment Form on admission and quarterly. All residents assessed as wanderers have been, and will continue to be, given a WanderGuard bracelet, a wander risk care plan, and their picture will be posted at each nurse 's station, back door and lobby receptionist area. All Licensed nursing staff have access to residents care plan on the Optimum Clinical system and</p>	F 323		
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F 323	<p>Continued From page 14</p> <p>NAs will have access to care plan interventions for NAs by care plan confirm button on ADL system. This will be audited weekly by DON or unit managers using the Wandering/elopement risk audit form that includes date of last wandering assessment, bracelet placed appropriately, care plan for wandering, and picture. This was completed 2/10/11</p> <p>In-servicing on WanderGuard system, response to alarms, and elopement began on 2/4/11, 2/8/11 & 2/9/11, including how to react if door alarms are found to be non-functional. If door alarms are found to be non-functioning, a staff member will be assigned to stay at the door until the door alarm is repaired by nursing staff. In the event that there is not a WanderGuard available, a staff member will be assigned to stay with resident until a WanderGuard bracelet is placed on the resident. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift. This has a completion date of 2/14/11.</p> <p>All nursing staff will be in-serviced on 2/15/11 by Geriatric Adult Specialty Team from (name of Mental Health Service) to include how to recognize exit seeking behavior. All employees who have not yet been in-serviced will be in-serviced upon arrival for their next shift after 2/15/11. The DON or Staff Development Coordinator will provide education on how to recognize exit seeking behavior to start May 2011 with repeats quarterly. This has a completion date of 2/18/11.</p> <p>A (name of Wander Management Company) technician will test the Wander guard system to ensure that the system is working properly. This</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>was completed 2/10/11. A (Name of Wander Management Company) technician will test the Wander guard system to ensure that the system is working properly monthly times 3 months beginning in March, 2011. This will be audited for completion by Administrator.</p> <p>Resident #2's elopement was addressed in the daily stand up meeting & daily falls committee 2/7/11. Results of door alarm and wander guard checks will be reviewed during Quarterly Assurance Meetings quarterly until compliance is achieved with the committee and recommendations made where appropriate. Between meetings, any elopement incidences will be reviewed by the Falls Committee (DON, Administrator, UM and other attendees) during daily stand up meeting. This will be audited by the Administrator or designee. This was completed 2/7/11 with quarterly reports until compliance achieved.</p> <p>The facility will continue to provide adequate supervision to all of its residents. In particular, where residents are identified as being at risk for elopement, the facility will assess the necessary level and type of supervision that may be required and will provide that supervision based on the individual resident's assessed needs and the risks identified in the environment.</p> <p>Immediate Jeopardy was removed on 2/11/2011 at 5:00 p.m. Observations of residents with WanderGuard bracelets revealed bracelets were appropriately placed on the residents and/or on the wheelchairs. Interviews with direct care staff and licensed staff confirmed they had received in-servicing on responding to the alarm system, monitoring of the WanderGuard alarm bracelets,</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>checking the bracelets for proper function and appropriate documentation and what to do if the system (door alarm and/or bracelet) does not function properly. Licensed staff demonstrated proper Wander Guard function tests. Documentation was provided by the facility that the WanderGuard alarm system had been serviced by the company and functioned properly. Documentation was provided by the facility and observations confirmed staff responded to alarms promptly. Documentation was also provided by the facility of WanderGuard alarm door checks. The maintenance assistant was observed checking the WanderGuard door alarms to determine if they alarmed and functioned properly. Checks were done per policy and there were no problems noted.</p> <p>2. Wanderguard E departure alert system manufacturer guidelines stated, " Do not place the signaling device on or within 2 " metal, such as wheelchair frames, jewelry, watches etc. or allow it to come in contact with a door or associated hardware such as crash-bars, push-bars, etc. Metal could interfere with the signal sent to the door modules." The wheelchair placement guidelines stated "Mount the signaling device away from the metal frame of a wheelchair at a height of approximately 3 feet from the floor (in the center of the back of the wheelchair). Use only plastic clips or plastic (non-metallic) tape to attach the device."</p> <p>Resident #6 was admitted to the facility on 6/9/06. His diagnoses included cerebral vascular accident, dementia and anxiety.</p> <p>An annual Minimum Data Set assessment, dated 7/21/2010, indicated Resident #6 had short term</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>and long term memory impairment. He was moderately impaired for decision making. He required extensive assistance for transfers and walking in his room. His primary mode of locomotion was his wheelchair.</p> <p>A 10/26/10 care plan included the problem of wandering related to dementia. Approaches included wanderguard bracelet to wheelchair, verify placement every shift, provide diversional activities and encourage rest periods.</p> <p>A Wandering/Elopement risk assessment, dated 1/21/11, indicated Resident #6 was cognitively impaired with poor decision-making skills. He was able to ambulate independently in a wheelchair. He did not have a history of elopement at home or leaving the facility without supervision. A personal alarm safety device was initiated on 3/10. A wanderguard was initiated 12/08.</p> <p>February 2011 Medication Administration Record (MAR) documented checking of the wanderguard bracelet on 2/8/11 and 2/9/11. The December 2010 MAR documented no wanderguard bracelet checks.</p> <p>During an interview, on 2/10/11 at 11:00 am, Nurse #2 indicated the wanderguard was placed on Resident #6's wheelchair due to his history of removing from his wrist and ankle. The wanderguard bracelet should be checked every shift and documented on the MAR.</p> <p>On 2/10/11 at 11:03 am, Resident #6 was in his bed with a personal alarm device in place. His wheelchair had a wanderguard bracelet attached to the metal wheelchair frame within one inch of</p>	F 323		

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F 323	<p>Continued From page 18 metal wheel.</p> <p>3. Wanderguard E departure alert system manufacturer guidelines stated warning "Do not place the signaling device on or within 2" metal, such as wheelchair frames, jewelry, watches etc. or allow it to come in contact with a door or associated hardware such as crash-bars, push-bars, etc. Metal could interfere with the signal sent to the door modules." The wheelchair placement guidelines stated "Mount the signaling device away from the metal frame of a wheelchair at a height of approximately 3 feet from the floor (in the center of the back of the wheelchair). Use only plastic clips or plastic (non-metallic) tape to attach the device."</p> <p>Resident #7 was admitted to the facility on 2/1/10. Her diagnoses included diabetes, hypertension and Alzheimer's dementia.</p> <p>A 12/18/10 annual Minimum Data Set assessment indicated she had short term and long term memory problems. She was moderately impaired in decision making. She required extensive assistance with transfers and locomotion on the unit. Her primary mode of locomotion was a wheelchair.</p> <p>A 12/26/10 care plan included a problem of risk of wandering due to dementia. Approaches included encourage rest periods, provide program of activities, use wanderguard system, wanderguard bracelet to wheelchair.</p> <p>A 2/3/11 Wandering/Elopement assessment indicated Resident #7 was cognitively impaired with poor decision making. She wandered</p>	F 323		

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F 323	<p>Continued From page 19</p> <p>aimlessly and had no history of leaving the facility without supervision. A wanderguard was initiated on 2/2/10 with bed alarm.</p> <p>Review of the November 2010 and December 2010 Medication Administration Record (MAR) documented no check of the wanderguard bracelet. The January 2011 MAR documented no check of the wanderguard bracelet. The February 2011 MAR documented one check of wanderguard bracelet on 2/9/11.</p> <p>On 2/10/11 at 10:25 am, Resident #7 was in the activity room in her wheelchair. The wanderguard bracelet was attached to the metal wheelchair frame by within one inch of the metal wheel.</p> <p>During an interview, on 2/10/11 at 10:53 am, Nurse #2 stated the wanderguard had been placed on Resident #7's wheelchair in 2010 due to her taking the bracelet off her wrist. The wanderguard bracelet should be checked every shift and documented on the MAR</p> <p>4. On 2/8/2011 at 8:25 a.m., 12:45 p.m. and 4:30 p.m., the Administrator stated, near the end of January 2011, residents from the Memory Care Unit and the unit just outside of that area (400, 500, 600 hall) had relocated to the other side of the building (700, 800 hall). At the time of the move, there were WanderGuard alarms on all of the doors in the facility except the door leading to the service area and the two exterior doors in the dining room and day room/ activity room. Both rooms were adjacent to the nursing station on the 700, 800 halls. The dining room and the day room/activity room had interior doors that had WanderGuard alarms. When the alarm was activated by the Wander Guard bracelet, staff had</p>	F 323		

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F 323	<p>Continued From page 20</p> <p>to manually punch in a code in order to turn the alarm off. The two exterior doors had a magnetic alarm system in place that would sound an alarm or chime when the door was opened. She stated on 1/27/2011, maintenance personnel adjusted the magnetic alarm system on both exterior doors to activate when the door was opened and to remain alarming until someone shut it off. The magnetic alarm was located at the top of the door. There were three settings (continuous alarm, chime alarm, turned off) and the alarm could be placed in any of these three positions. This alarm was not activated by the WanderGuard bracelet.</p> <p>On 2/8/2011 at 12:30 p.m., a visitor exited the exterior dining room door. The alarm sounded when the door was opened and stopped within thirty seconds of the door being closed.</p> <p>On 2/8/2011 at 12:45 p.m. and 4:30 p.m., the Administrator stated on February 5-6, the WanderGuard system was moved from the interior dining room and activity room doors to the exterior doors of both rooms. She indicated the WanderGuard bracelets are checked every shift and Maintenance personnel check the door alarms daily (Monday through Friday). On weekends, the leadership manager was responsible for door alarm checks.</p> <p>On 2/9/2011 at 11:10 am., the DON stated the doors did not lock when the WanderGuard system was activated. She stated an alarm sounded when a resident wearing a WanderGuard bracelet went near or opened the door.</p> <p>On 2/9/2011 at 12:05 p.m., the DON took a</p>	F 323		

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F 323	<p>Continued From page 21</p> <p>wheelchair resident with a WanderGuard bracelet on her ankle to the exterior door in the dining room located on 700, 800 hall. The alarm did not activate until the door was opened. The DON checked the WanderGuard bracelet with the universal tester and noted the bracelet was functional.</p> <p>On 2/10/2011 at 10:30 a.m., all of the doors of the facility were tested with a WanderGuard bracelet to ensure safety and proper functioning of the alarm system. A WanderGuard bracelet was worn by the surveyor on her right ankle. The administrator, DON, regional consultant for environmental services and the maintenance assistant were present during the test of the alarm system. When the WanderGuard alarm boxes were approached with the WanderGuard bracelet worn on the right ankle, the following was noted:</p> <ul style="list-style-type: none"> a. Front door of facility -alarmed three (3) feet away from door b. Inside door at the front lobby-alarmed six (6) feet away from door c. 601-610 hall (former Memory Unit)-entrance to the area alarmed when the door was opened. There was another door in the former Memory Unit area that opened to an entrance leading to a road. The alarm sounded when the surveyor was directly at the door. The Regional maintenance consultant stated the door that opened to the entrance leading to the road is kept locked, is tied into the fire alarm system and will unlock if the fire alarm is activated. d. 500 hall exit door to parking lot-alarm did not sound until door opened, then alarm sounded at the nursing station. The DON and surveyor went into room 501 (approximately 22 feet away from the nursing station). The alarm could not be 	F 323		
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F 323	<p>Continued From page 22</p> <p>heard with the door closed.</p> <p>e. 400 interior door (between 400 hall and the service area)-alarm did not sound until WanderGuard bracelet was directly at the alarm box.</p> <p>f. Service hall back entrance door-alarm sounded when the door was opened.</p> <p>g. 200 hall exit door-alarmed two (2) feet away</p> <p>h. 700 hall exit door-alarmed one (1) foot away</p> <p>i. 800 hall exit door-alarm did not activate until the door was opened. Door was tested again. The second time, the door did not alarm at all and surveyor was able to exit the building to the outside. The regional consultant stated the alarm did not reset for fifteen (15) seconds. After one minute, the alarm was retested and the alarm did not activate when the door was opened. There was also a magnetic alarm at the top of this door that sounded a continuous alarm when the door was opened. The magnetic alarm could also be turned to chime or be turned off. An observation from this exit door revealed that the distance from this door to the highway was approximately 216 feet from the door, through an unsecured gate to the parking lot, across a grassy area, over a ditch that was approximately 2-3 feet deep to a five lane highway that had a speed limit of 45 miles per hour.</p> <p>j. Day room/ activity room exterior door exit-alarmed one (1) foot away</p> <p>k. Dining room exterior door exit-alarmed eight (8) feet away</p> <p>On 2/10/2011 at 12:00 noon, the Regional consultant for environmental services indicated the WanderGuard alarm was designed to alarm when the resident with the WanderGuard bracelet opened the door. He said there were two magnets in the alarm box. When the door</p>	F 323			

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F 323	<p>Continued From page 23</p> <p>opened, the magnets pulled apart and sent a signal to the controller to alarm. He could not explain why the alarm on the 800 hall exit door did not work when it was tested.</p> <p>Wander Guard alarm check log sheets done by the maintenance department were reviewed for the period 1/27/2011 through 2/9/2011. Daily door security included the following steps with steps to be checked as done or not applicable: "</p> <ol style="list-style-type: none"> 1. For all doors with wandering protection equipment. 2. Insure that the equipment is working properly. 3. All patient protection systems (i.e. Wander Guard, Code Alert) that are installed on facility entrance/ egress doors are to be activated and inspected daily by maintenance to ensure that " lock down " devises and alarm sensors are fully operational and audible. 4. Any and all malfunctioning must be repaired immediately to ensure protection of patients from elopement. " <p>All log sheets verified that Lobby 1 " passed " the maintenance check. There were no other locations verified as being checked on the Wander Guard alarm check log sheets. Documentation that the appropriate steps were taken to verify the WanderGuard alarm system operated properly was noted on 1/30, 1/31, 2/5, 2/6, 2/7, 2/8 and 2/9/2011.</p> <p>On 2/10/2011 at 11:35 a.m., the Regional consultant for environmental services stated the Maintenance logs for the WanderGuard checks had been developed by one of two Maintenance directors that no longer worked for the facility. He said he did not know why there was only one location (Lobby1) noted on the form. He stated all Maintenance directors are instructed to follow the steps listed on the form (as noted above) and he expected them to complete the forms as</p>	F 323			

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F 323	<p>Continued From page 24 directed.</p> <p>The User Manual and User instructions for the WanderGuard system indicated the signaling device should not be placed on or next to metal, such as wheelchair frames, jewelry, watches, etc. or allow it to come in contact with a door or associated hardware such as crash-bars, push-bars, etc. Metal could interfere with the signal sent to the door modules. Sudden impacts could damage signaling device components. Test signaling devices immediately after impact. Record the results in the resident ' s records. Test each signaling device before using. Thereafter, test the device daily and record the results in the resident ' s records. Wheelchair placement-Facilities often ask about attaching the signaling devices to a wheelchair. If attempts to use wrist or ankle placement have failed, mount the signaling device away from the metal frame of a wheelchair at a height of approximately 3 feet from the floor in the center of the back of the wheelchair. Use only plastic clips or plastic non-metallic tape to attach the device. Do not use a metal safety pin to attach the device. Call Technical Service at 800-824-2996 before putting the signaling device on a wheelchair.</p>	F 323		
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