

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

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345105	APR 3 2012 (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2012
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NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTHCARE OF HIGH POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 3830 N MAIN STREET HIGH POINT, NC 27265
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F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a complaint investigation survey on 3/21/12-3/23/12. It was determined the facility had provided substandard quality of care at the immediate jeopardy level. A partial extended survey was conducted on 3/22/12 and an exit conference was held with the facility on 3/23/12. The Immediate Jeopardy began on 1/6/12 and was present and on-going.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	For the Resident found to be affected by the alleged deficient practice: <ul style="list-style-type: none"> Resident #1 was placed on 1:1 supervision, around 9:15 pm when he was returned to the facility after exiting the facility, the shift supervisor sat with Resident #1 in the 200 hall dining room, until he was transferred to Carolina Rehab center at 11:45pm. Resident #1 was transferred to Carolina Rehab Center on 1/6/2012, at 11:45 pm by the facility transportation aide in the facility Van, and has not returned to the facility. Resident # 1 was then transferred by the facility transportation aide to Carolina Medical Center Emergency Room. Physician was notified of residents discharge on 1/7/2012, by the house supervisor around 12am, after resident was sent to Carolina Medical Center 	3/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wanda J. Ucc...</i> RW NWHA	TITLE	(X6) DATE 4-11-12
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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 157	<p>Continued From page 1</p> <p>regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and physician interview, the facility failed to notify family of the elopment from the nursing home for 1 of 3 sampled residents at risk for elopement (Resident #1) and the facility failed to notify family and physician of discharge for 1 of 2 residents with discharge plans (Resident #1). Immediate Jeopardy began on 1/6/12, when Resident #1 eloped from the facility and is ongoing.</p> <p>The adminstrator was notified of the Immediate Jeopardy on 3/22/12 at 2:56PM and facility was not able to provide an acceptable credible allegation of compliance and considered on-going at 483.10 (F157).</p> <p>The findings included:</p> <p>Resident #1 was admitted on 1/6/12 from a rehabilitation center, with multiple diagnoses including traumatic brain injury, diabetes, hypertension and hypercholestrolema. Resident #1 was a recent admission therefore a Minimum Data Set was not completed. Review of hospital admission records, nursing home admission/nursing evaluation assessments and interviews from family and staff at rehabilitation center and medical center revealed that Resident</p>	F 157	<p>For the Residents having the potential to be affected by the same alleged deficient practice:</p> <ul style="list-style-type: none"> Residents with any change in condition are at risk of potentially being affected. The Licensed Nurse is responsible for all physician notifications. The facility Social Worker / Activity Director and/or Admissions Director has validated all responsible party phone numbers on 3/22/12 . New Admission contact numbers are validated by the Admission Coordinator with the responsible party upon admission. The Social Worker / Charge Nurse will revalidate the responsible party number when the resident is admitted. This will be done by actually calling the number and validating it is correct and functioning. The second and third numbers will be validated if the first responsible party number is unable to be validated. In an emergency situation if no numbers are functioning the facility will notify the local police department for family notification, 		

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F 157	<p>Continued From page 2</p> <p>#1 had intermittent confusion, short term memory loss, flat affect, forgetfulness and repetitive thought process and unable to make informed decisions. The admission paperwork revealed that the parents were the responsible parties who admitted Resident #1.</p> <p>Review of Nurse #1 nurse 's note dated 1/6/12 at 3:00PM, revealed that Resident #1 was admitted for rehabilitation services with discharge plans to return home with family. Resident #1 was alert/verbal with flat affect, slow response to questions and confusion as to present location and other aspects of his life. There were no noted or documented behaviors on 1/6/12 during 7-3PM shift.</p> <p>Review of the nursing home assessment dated 1/6/12, revealed that Resident #1 needed assistance/encouragement with dressing/grooming and was independent with all other activities of daily living. Additionally, review of the elopement risk and fall form dated 1/6/12, completed by the nursing home revealed that Resident #1 had poor vision without glasses and " risk for elopement due to ambulatory with traumatic brain injury, intermittent confusion and forgetfulness noted. "</p> <p>Review of the admission interim care plan dated 1/6/12, identified a behavior problem of wandering. The goal included the resident would not harm themselves or others secondary to their behaviors through next 30 days. The interventions included intervene as needed to protect the rights and safety of others, approach in calm manner, divert attention, remove from situation and take to another location as needed</p>	F 157	<ul style="list-style-type: none"> Upon admission/readmission an Admission behavior log is initiated, the log includes a hour on the hour documentation of any behavior that has occurred including begging to go home, transferring unsafely, Wandering/ trying to get out the door, agitated or combative, falls without/with injury, Altercation. Any identified behavior, agitation, combative and/or wandering/trying to go home, that has the potential to escalate will have immediate interventions put in place to maintain safety and the well being of all residents. social worker will complete the behavior screen 72 hours after admission for further action, referral to psychiatric services, adding to the behavior management program, and referring to the physician for evaluation. <p>Prevention of Reoccurrence:</p> <ul style="list-style-type: none"> 24 hour reports will be monitored daily by the DHS (Director of Health Service)/ ADHS (Assistant Director of Health Services/UM(Unit Manager)/Week end manager to review for any change in condition including signs/symptoms of behavior related to risk of elopement, and notification for families and physician related to change in conditions . 		

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F 157	<p>Continued From page 3</p> <p>and administer and monitor the effectiveness and side effects of medications as ordered-see physician orders/MAR (medication administration record).</p> <p>Review of the nursing home behavior log form dated 1/6/12, revealed there were no documented behaviors of agitation or wandering before 8:00PM. Review of the MAR (medication administration record) and nurse ' s notes dated 1/6/12 at 8:00PM, revealed Resident #1 received the 2mg of avitan due to the wandering at his scheduled medication time at 8:00PM.</p> <p>Review of Nurse #2 nurse ' s note dated 1/16/12 at 8:00PM, revealed that the resident spent most of shift in bed and was able to make his needs known.</p> <p>Additionally, review of Nurse #2 nurse ' s note dated 1/6/12 at 10:00PM, revealed " (charge) nurse #2 went to resident room around 8:45PM to give PPD (purified protein derivative) test and noted that resident was no where to be found. " The first step PPD was given, Resident #1 had been given Ativan 2mg at 8:00PM, when he came out of room asking how he could get out of here. " His room window was noted wide open and cold air was gushing into the room. Nurse #3 was notified immediately and a search was initiated. The nurse supervisor searched outside the open window and up to front of the building. The supervisor delegated the (charge) nurse to go down Main Street. Resident was seen on main street heading toward [name of town]' Resident was stopped and (he cooperated in getting in the car and coming back to the facility). " He was asking to talk to his parents, giving all attempts to</p>	F 157	<p>Any identified issues will be reviewed to ensure follow –up was conducted. DHS (Director of Health Services) will bring findings and trends to the monthly Performance Improvement meeting</p> <ul style="list-style-type: none"> • 27 of 27 Licensed nurses have been in-serviced beginning on March 22, 2012 and completed on March 30, 2012, conducted by the DHS (Director of Health Services) and ADHS/Nurse Managers on: Elopement Policy • Notification of Family • Notification of Physician • Safe Discharge • Escalating Behaviors • Documentation <p>** Licensed Staff, who are PRN, or week-end only, out on sick or personal leave, will not be permitted to work until in-services are complete..</p> <ul style="list-style-type: none"> • Social Services / Activity Director and/or Admission Director reviewed all contact numbers 3/22/12 to ensure accuracy of contact information • Upon admission the admissions director will validate contact information with the Responsible party and/or the resident. 		

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F 157	<p>Continued From page 4</p> <p>get parents on the phone was unsuccessful. Message saying you have reached a number that has been disconnected or out of service. Resident was taken back to his room and a staff member was assigned to him 1:1. " There was no documented time of when the search was initiated or when the family, administration or physician was notified of the elopement.</p> <p>Nurse #2 final note dated 1/6/12 at 11:50PM, revealed that Resident #1 was packed up and transported with staff at 11:45PM. The location of where the resident was discharged to was not documented, nor was there any information of when contact was made with the rehabilitation center. The time of the resident ' s return to the facility was not documented and there was no further documentation/assessment of the behavior, mental or physical condition of the resident when the resident was returned to the facility. In addition, there was no information of whether the facility administration was contacted, or the physician or the family in accordance with the facility notification policy/procedure for elopement.</p> <p>During an interview on 3/21/12 at 11:19AM, the rehabilitation center SW (social worker) reviewed the notes of the treating social worker and notes of the medical center social worker. The notes revealed that Resident #1 was discharged from rehabilitation center on 1/6/12, and admitted to the nursing home for rehab services. The notes dated 1/7/12-2/7/12, indicated Resident #1 was returned from the nursing home in a cab following the resident elopement from a window in the facility. Notes also indicated that the nursing home facility staff informed the medical center</p>	F 157	<ul style="list-style-type: none"> The Unit manager/week-end manager will call the contact number listed on the face sheet upon admission. <p>Monitoring</p> <ul style="list-style-type: none"> 24 hour reports will be monitored daily by the DHS (Director of Health Service)/ ADHS (Assistant Director of Health Services/UM(Unit Manager)/Week end manager to review for any change in condition including signs/symptoms of behavior related to risk of elopement, and notification for families related to change in conditions . Any identified issues will be reviewed to ensure follow –up was conducted. DHS (Director of Health Services) will bring findings and trends to the monthly Performance Improvement meeting. After admission there will be a second check of phone numbers by Social Services to ensure numbers are accurate. This will be completed as part of the new admission check completed within 24 hours. Any identified issues will be reviewed to ensure follow –up was conducted. Social Worker will bring findings and trends to the monthly Performance Improvement meeting. 		

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F 157	<p>Continued From page 5</p> <p>SW that they did not have current phone numbers for the responsible party of the resident and that the resident wanted to return to the facility, therefore the resident was return in a cab. The medical social worker provided two contact numbers for the responsible party, that were active. The medical social worker indicated that the nursing home did not notify the rehabilitation staff or the medical center in advance of the return of the resident or arrangements for readmission. The rehabilitation social worker added that the resident was in the rehabilitation center prior to hospitalization and subsequent to discharge to the same rehabilitation center, however the rehabilitation center would not accept any resident after hours and any admission would have to been arranged through the medical emergency room services.</p> <p>During an interview on 3/21/12 at 11:27AM, the responsible person stated Resident #1 had not had an elopment history. Alternate placement had been investigated prior to admission to nursing home. The responsible person assisted with the admission to the nursing home completing the required forms and submitting contact information. Resident #1 and family was assisted to the designated room and got the resident settled down. Resident was upset and tearful as they attempted to get Resident #1 settled down. The responsible person left between 4:30-5:00PM. The responsible party went to an local hotel to get settle down and be closer to resident. Around 3:00AM in the morning the family received a call from the medical center SW that the resident was readmitted back into their care from the nursing home. The medical center SW informed them that the resident had eloped</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>from the nursing home through a bedroom window and that staff found the resident 1.5 miles away from the facility. He was not aware of any police report or any paper work filed when the resident got out of the facility. The responsible party stated that he had no further contact with the nursing home and no-one from the facility called either of the numbers that was left when they did the initial paperwork. He added that the resident was unable to make informed decision and was confused due to the brain injury. The Responsible party stated that he was very upset and annoyed at the facility for not calling them and letting them know what was happening and that their son had been taken somewhere else. He added that he left other family numbers(home), any one of them could have been called and they would have called them. In addition, " It was sad the way the situation was handle, we didnt even know if our son had been hurt or how long he had been outside. No-one told us anything. We had to get that call from the hospital in the middle of the morning. So we went up to the hospital immediately in [name of town] to get further details.</p> <p>During an interview on 3/21/12 at 9:32PM, the medical center SW contacted the family at the two numbers available on record to inform them of Resident #1 return to their facility. Due to the hour the family was contacted the family came in later the next day upset because they were not contacted about the elopement or discharge.</p> <p>During an interview on 3/21/12 at 2:552PM, Nurse #2 indicated the reason Resident #1 was transferred was due to the facility could not provide for his safety since he exited out of the</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>window. Nurse #2 also indicated that he was unaware of the resident ' s potential for elopment, as the resident was very calm, non-threatening, just paced the floor and wanted to go home. Nurse #2 stated that he did not give the resident the IM (intramuscular medication (Ativan) because the resident was gone. Nurse #3 had called the doctor for the IM medication because the resident was pacing the floor after the per oral medications were given. Nurse #2 added that he did not have any trouble with resident after the 8:00PM medication and that he did not do any of the reoprts because the Nurse #3 stated he would handle all the paperwork and discussion with transfers. Nurse #2 indicated that he did not talk with doctor or anyone else and that Nurse #3 did all the contacting of people and he returned to his medication pass. Nurse #2 added that he was uncertain how long the resident had been gone or what time he brought the resident back.</p> <p>During an interview on 3/21/12 at 3:32PM, the admission director indicated that she met with the responsible party to review and discuss the admission packet and the completion of the basic contact information. She indicated that all contact information provided on the admission data collection sheet and the face sheet was verified with the responsible party during the admission interview. She added that the responsible party provided two additional numbers of family that could be used as contacts. The information was then given to the financial manager. She further stated that the social worker was responsible for discharge plans and the person who would inform her of when discharges were planned. However, she found out about Resident #1 ' s discharge Monday morning when she was doing her daily</p>	F 157			

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F 157	<p>Continued From page 8 rounds.</p> <p>During an interview on 3/21/12 at 3:49PM, the financial officer reviewed the admission packet and contact information: Level of care screening tool, which identifies contact information. The contact number on the financial profile sheet and resident admission data collection had one number and the contact sheet used by nursing had a different telephone number. The financial officer reviewed the face sheet and other contact sheets and verified the inaccurate numbers. The financial manager indicated that the admission person was responsible for ensuring that the phone numbers were accurate and entered into the system correctly. Then she would re-check the information, however she did not check on this resident.</p> <p>Reviewed of the facility contact verification forms revealed that the responsible person contact numbers were incorrect. The admission data collection form, resident financial profile and face sheet had different numbers for the responsible person.</p> <p>During an interview on 3/21/12 at 5:50PM, the administrator reviewed the record and he acknowledged that there were no documents or evidence that supported or warrant the action taken regarding the elopement process according to facility policy/expectation for elopement, notification of family/physician or the appropriateness of the discharge. He added that he was unaware that the contact information for the family was inaccurate.</p> <p>During an interview on 3/21/12 at 5:58PM, the</p>	F 157			

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F 157	Continued From page 9 physician indicated that she was contacted after hours, could not recall the exact time via cell phone. The physician did not know the resident had eloped at the time of the call for the request for the IM medication. She was informed that Resident #1 had been given oral Ativan around 8:00PM, by Nurse #2. Nurse #3 had called to request an order for 2mg of IM (intramuscular) Ativan, because Resident #1 was agitated and upset and wanted to go home with family. She was not aware of any noted behaviors of attempts to get out building prior to the call for the IM medication. It wasn't until the request for the IM medication that she was informed Resident #1 had eloped from the facility when Nurse #2 went to administer the IM medication. The physician indicated there was no medical reason for the discharge. Resident #1 was discharged based on the facility inability to handle the resident as the result of the elopement and information that Nurse #3 had received that Resident #1 had elopement/exit seeking behaviors. The facility was unable to safely protect the resident from continued elopement. The physician further stated that she was not contacted or consulted prior to the discharge and that she was informed of the administrative decision to return to the previous facility on Monday. She added that she was unaware the family had not been contacted or informed of the discharge. The physician added after review of the record, the expectation was that nursing staff would document the events of the situation and note the condition of the resident upon return from the elopement and re-contact the treating or on-call physician. She further stated that a physician's order and discussion was part of protocol for discharges.	F 157			

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F 157	Continued From page 10 During a follow-up interview on 3/22/12 at 8:48AM, Nurse #3 and DON, revealed that Nurse #3 indicated that during his interaction/observation with Resident #1 during the shift the resident was calm. He did not note any behaviors issues with resident prior to report by Nurse #2. It was not until Nurse #2 reported to him that the resident was violently trying to break/shake down the door because he wanted to get out. Nurse #2 had reported to him that when he went to the resident room to give him the newly ordered IM ativan the resident was not in the room and the window was open. A search for the resident began and phone calls were made to family unsuccessful and administration. Nurse #3 acknowledged that he was uncertain of the time frame of the incident, phone calls or when the resident was actually returned to the facility. Nurse #3 further stated that he did not document the events, nor did he contact the physician for discharge orders. He acknowledged that discharge was based on the discussion with director of nursing. During same interview the director of nursing indicated that the expectation was the nursing supervisor follow and implement the policy/procedures for elopement, proper notification of all required person, assessment/condition of the resident and documentation of the date, time and location of the event in the resident record and on the designated facility forms/reports.	F 157			
F 204 SS=J	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.	F 204	F 204 For the Resident found to be affected by the alleged deficient practice: • Resident #1 was placed on 1:1 supervision, around 9:15 pm when he was returned to the facility after exiting the facility, the shift supervisor sat with Resident #1 in the 200 hall dining room, until he was transferred to Carolina Rehab center at 11:45pm.	3/30/12	

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F 204	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interview, the facility failed to provide an organized transfer of a resident that had eloped from the nursing home. When the resident was located he was taken to the rehabilitation center where he had been a former resident and then driven to the medical center when the rehabilitation center refused to take him. The facility failed to implement the discharge planning policy/procedures for 1 of 2 residents with discharge plans (Resident #1). The Immediate Jeopardy began on 1/6/12 when Resident #1 eloped from facility and is ongoing. The administrator was notified of the Immediate Jeopardy on 3/22/12 at 2:56PM and facility was not able to provide an acceptable credible allegation of compliance and considered on-going at 483.12 (F204).</p> <p>Review of the facility policy titled " Discharge Planning " dated 2/11, read in part: The discharge planning would begin with each resident upon admission. It would involve the resident, authorized individuals or responsible party, interdisciplinary staff and other resources coordinated by social service director and/or senior care partner. When working with residents and authorized individuals in preparation for discharge and the healthcare center anticipates discharge, a post discharge plan of care would be developed. The healthcare center would provide resident guardian/representative with information</p>	F 204	<ul style="list-style-type: none"> Resident #1 was transferred to Carolina Rehab Center on 1/6/2012, at 11:45 pm by the facility transportation aide in the facility Van, and has not returned to the facility. Resident # 1 was then transferred by the facility transportation aide to Carolina Medical Center Emergency Room. Physician was notified of residents discharge on 1/7/2012, by the house supervisor around 12am, after resident was sent to Carolina Medical Center <p>For the Residents having the potential to be affected by the same alleged deficient practice:</p> <ul style="list-style-type: none"> Resident that are discharged from the facility are at risk of potentially being affected. Licensed Nurses (27 of 27) have been educated regarding physician and responsible party notification of change in condition and requiring a physician orders for discharging a resident and ensuring appropriate transport to another setting. The Licensed nurse is responsible to notify and obtain appropriate physician orders to transport a resident to another setting. 27 of 27 licensed nurses have been educated. 	

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F 204	<p>Continued From page 12</p> <p>regarding available resources and appropriate state or social services organization. The physician ' s order must be placed on resident ' s medical record and the discharge procedures should be documented.</p> <p>Resident #1 was admitted on 1/6/12 from a rehabilitation center, with multiple diagnoses including traumatic brain injury, diabetes, hypertension and hypercholesterolemia. Resident #1 was a recent admission therefore a Minimum Data Set was not completed. Review of hospital admission records, nursing home admission/nursing evaluation assessments and interviews from family and staff at rehabilitation center and medical center revealed that Resident #1 had intermittent confusion, short term memory loss, flat affect, forgetfulness and repetitive thought process and unable to make informed decisions. The admission paperwork revealed that the parents were the responsible parties who admitted Resident #1.</p> <p>Review of Nurse #1 nurse ' s note dated 1/6/12 at 3:00PM, revealed that Resident #1 was admitted for rehabilitation services with discharge plans to return home with family. Resident #1 was alert/verbal with flat affect, slow response to questions and confusion as to present location and other aspects of his life. There were no noted or documented behaviors on 1/6/12 during 7-3PM shift.</p> <p>Reviewed of the facility contact verification forms revealed that responsible person contact numbers were incorrect. The admission data collection form, resident financial profile and face sheet had different numbers for the responsible</p>	F 204	<p>Prevention of Reoccurrence</p> <ul style="list-style-type: none"> 24 hour reports will be monitored daily by the Director of Health Services/ADHS (Assistant Director of Health Services)s/Unit Managers/Week end manager to review for discharge from the facility. Any identified issues will be reviewed to ensure follow –up was conducted. DHS(Director of Health Services) will bring findings and trends to the monthly Performance Improvement meeting for three months. Upon admission/readmission an Admission behavior log is initiated, the log includes a hour on the hour documentation of any behavior that has occurred including begging to go home, transferring unsafely, Wandering/ trying to get out the door, agitated or combative, falls without/with injury, Altercation. Any identified behavior, agitation, combative and/or wandering/trying to go home, that has the potential to escalate will have immediate interventions put in place to maintain safety and the well being of all residents. social worker will complete the behavior screen 72 hours after admission for further action, referral to psychiatric services, adding to the behavior management program, and referring to the physician for evaluation. 		

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F 204	<p>Continued From page 13 person.</p> <p>Review of the nursing home nurse practitioner medication order dated 1/6/12, revealed an order for 2mg of Ativan (anti-anxiety medication) per oral intake at bedtime and 2mg/ml of Ativan, every 4 hours as necessary for agitation in conjunction with other medications. Additionally, review of medications ordered dated 1/7/12, revealed orders for routine standard of care/treatments and medications. There were no discharge orders.</p> <p>Review of the nursing home assessment dated 1/6/12, revealed that Resident #1 needed assistance/encouragement with dressing/grooming and was independent with all other activities of daily living. Additionally, review of the elopement risk and fall form dated 1/6/12, completed by the nursing home revealed that Resident #1 had poor vision without glasses and " risk for elopement due to ambulatory with traumatic brain injury, intermittent confusion and forgetfulness noted. "</p> <p>Review of the admission interim care plan dated 1/6/12, identified a behavior problem of wandering. The goal included the resident would not harm themselves or others secondary to their behaviors through next 30 days. The interventions included intervene as needed to protect the rights and safety of others, approach in calm manner, divert attention, remove from situation and take to another location as needed and administer and monitor the effectiveness and side effects of medications as ordered-see physician orders/MAR (medication administration record).</p>	F 204	<ul style="list-style-type: none"> Any discharge to the hospital will be transferred by EMS(Emergency Medical Services). Discharge d residents charts will be reviewed by the Director of Health Services/ADHS(Assistant Director of Health Services)s/Unit Managers/Week end manager to ensure all components to ensure safe discharge was conducted. (Discharge order, MD notification, RP notification, and proper documentation.) Any identified issues will be reviewed to ensure follow –up was conducted. DHS(Director of Health Services) will bring findings and trends to the monthly Performance Improvement meeting for three months In-services were begun immediately by Licensed staff on March 22, 2012 and completed on March 30, 2012, (27 of 27 Licensed nurses completed) conducted by the DHS (Director of Heath Services) and ADHS/Nurse Managers on: <ul style="list-style-type: none"> Elopement Policy Notification of Family Safe Discharge Documentation <p>** Licensed Staff, who are PRN, or week-end only, out on sick or personal leave, will not be permitted to work until in-services are complete..</p>	

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F 204	Continued From page 14 Additionally, review of Nurse #2 nurse ' s note dated 1/6/12 at 10:00PM, revealed " (charge) nurse #2 went to resident room around 8:45PM to give PPD (purified protein derivative) test and noted that resident was no where to be found. " The first step PPD was given, Resident #1 had been given Ativan 2mg at 8:00PM, when he came out of room asking how he could get out of here. " His room window was noted wide open and cold air was gushing into the room. The supervisor was notified immediately and a search was initiated. The nurse and supervisor search outside the open window and up to front of the building. The supervisor delegated the (charge) nurse to go down Main Street. Resident was seen on main street heading toward [name of town]' Resident was stopped and (he cooperated in getting in the car and coming back to the facility). " He was asking to talk to his parents, giving all attempts to get parents on the phone was unsuccessful. Message saying you have reached a number that has been disconnected or out of service. Resident was taken back to his room and a staff member was assigned to him 1:1. " There was no documented time of when the search was initiated or when the family, administration or physician was notified of the elopement. Nurse #2 final note dated 1/6/12 at 11:50PM, revealed that Resident #1 was packed up and transported with staff at 11:45PM. The location of where the resident was discharged to was not documented, nor was there any information of when contact was made with the Rehabilitation Center. The time of the resident ' s return to the facility was not documented and there was no further documentation/assessment of the	F 204	Monitoring • 24 hour reports will be monitored daily by the Director of Health Services/ADHS(Assistant Director of Health Services)s/Unit Managers/Week end manager to review for discharge from the facility. Any identified issues will be reviewed to ensure follow –up was conducted. DHS (Director of Health Services) will bring findings and trends to the monthly Performance Improvement meeting for three months, then quarterly thereafter.. a. Discharged residents charts will be reviewed by the Director of Health Services/ADHS (Assistant Director of Health Services)s/Unit Managers/Week end manager to ensure all components to ensure safe discharge was conducted. (Discharge order, MD notification, RP notification, and proper documentation.) Any identified issues will be reviewed to ensure follow –up was conducted. DHS(Director of Health Services) will bring findings and trend s to the monthly Performance Improvement meeting for three months then quarterly thereafter.	

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F 204	<p>Continued From page 15</p> <p>behavior, mental or physical condition of the resident when the resident was returned to the facility. In addition, there was no information of whether the facility administration was contacted, or the physician or the family in accordance with the facility notification policy/procedure for elopement.</p> <p>During an interview on 3/21/12 at 11:19AM, the rehabilitation center SW (social worker) reviewed the notes of the treating social worker and notes of the medical center social worker. The notes dated 1/7/12-2/7/12, indicated Resident #1 was returned from the nursing home in a cab following the resident elopement from a window in the facility. The medical social worker indicated that the nursing home did not notify the rehabilitation staff or the medical center in advance of the return of the resident or arrangements for readmission. The rehabilitation social worker added that the resident was in the rehabilitation center prior to hospitalization and subsequent to discharge to the same rehabilitation center, however the rehabilitation center would not accept any resident after hours and any admission would have to be arranged through the medical emergency room services.</p> <p>During an interview on 3/21/12 at 11:27AM, the responsible per stated that around 3:00AM in the morning the family received a call from the medical center SW that the resident was readmitted back into their care from the nursing home. The medical center SW informed them that the resident had eloped from the nursing home through a bedroom window and that staff found the resident 1.5 miles away from the facility. He was not aware of any police report or</p>	F 204			

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F 204	<p>Continued From page 16</p> <p>any paper work filed when the resident got out of the facility. The responsible person indicated that he was told by the medical center SW that the nursing home staff stated that they could not take care of the resident needs and that he continued to cry and wanted to return to the previous facility, so the nursing home staff made transportation arrangements and sent him back. The responsible party stated that he had no further contact with discharging [name] facility and no-one from the facility called either of the numbers that was left when they did the initial paperwork.</p> <p>During an interview on 3/21/12 at 2:552PM, Nurse #2 indicated the reason Resident #1 was transferred was due to the facility could not provide for his safety since he exited out of the window. When the resident returned he told Nurse #3 that he needed to be watched 1:1 and that he could not watch resident independently and that staff needed to sit with resident. The resident was crying a lot and sobbing for his parents. Nurse #3 in the mean time was calling parents and the only number listed was the home number. There was no cell number available since the family was staying in the hotel. The adminsitator and DON instructed Nurse #2 and Nurse #3 to make arrangments to send the resident to his previous envrionment. The facility transportation staff took the resident back to [name] town at the instruction of administrator/DON. Nurse #2 also stated that he was unaware of the resident potential for elopment, as the resident was very calm, non-threatening, just paced the floor and wanted to go home. Nurse #2 stated that he did not give the resident the IM medication(ativan) because</p>	F 204			

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F 204	<p>Continued From page 17</p> <p>the resident was gone. He stated that Nurse #3 had called the doctor for the IM medication because the resident was pacing the floor after the PO medications were given. Nurse #2 added that he did not have any trouble with resident after the 8:00PM medication. Nurse #3 further stated that he did not do any of the reoprts because Nurse #3 stated he would handle all the paperwork and discussion with transfers. He stated that he did not talk with doctor or anyone else and Nurse #3 did all the contacting of people he returned to his medication pass. He added that he was uncertain how long the resident had been gone or what time he brought the resident back. There was no documentation available of the times when the administration, family or physician were contacted. In addition, there were no assessments documented regarding the condition of the resident ' s mental, behaviors or physical condition in accordance with the facility policy/procedure for elopement or discharge.</p> <p>During an interview on 3/21/12 at 4:04PM, Nurse #3 indicated that he did not know how long the search took or exact time when resident was returned to building. Nurse #3 stated that he called the numbers listed of family and did not get answer or numbers were not right. Nurse #3 also stated he called admininstrator and director of nursing and told them about resident leaving building and they both said to transfer resident back to other facility. Nurse #3 stated that he searched for telephone numbers and address of the other facility to make arrangements to send resident back since the resident said he wanted to go back home. Nurse #3 added that the DON/administrator told him that since the resident had not been in the building for 30 days</p>	F 204			

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F 204	<p>Continued From page 18</p> <p>and nursing home was not informed of Resident #1 elopement history it was ok to send him back. Nurse #3 stated that resident was calm when he got back and vital signs was taken, while he made arrangements. He stated that the Nurse #2 did a report of what happen and it was given to director of nursing. Nurse #3 further stated that he did not document the events of what he did or whom he spoke with because everything happened so fast. Nurse #3 added that he did not contact the doctor for discharge or call back about the IM medication because the resident was gone to another facility and he was instructed to send resident back. The arrangements for a NA(nursing assistant to sit with the resident was about 11:30PM, until transportation could be arranged. Nurse #3 stated that he spoke with someone at medical center to let them know resident was returning, but could not recall who the staff person was. He stated that the transportation staff person returned the resident to the rehabilitation center based on the address that they goggled on the internet for the facility. Nurse #3 indicated that he was unable to locate the address of the previous facility on the provided paperwork.</p> <p>During an interview on 3/21/12 at 4:30PM, the DON indicated that she had received a call from Nurse #3, could not recall time, stating that Resident #1 had eloped from the building through the bedroom window. DON added that she instructed Nurse #3 to search the building and surrounding areas. She contacted the administrator who also contacted the corporation consultant. The administrator gave instruction for the nursing staff to discharge the resident back to the previous facility. The reason for the discharge</p>	F 204			

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F 204	<p>Continued From page 19</p> <p>was the nursing home could not safely protect/monitor the resident and they were not informed of the resident ' s elopement history/exiting seeking behavior. The administrator further informed and instructed her that since Resident #1 had not been a 30 day admission it was ok to return resident to previous facility. DON added that the physician had not been contacted following the return of the resident or consulted regarding the discharge. The director of nursing reviewed the facility record and documentation and stated " I do not have any documentation, incident reports of what action took place and the nursing notes do not reflect the condition of Resident #1 behaviors, mental or physical well being during the course of the shift or return from the elopement. The expectation would have been once the nursing assessment had been completed and the resident was identified as a risk for elopement, whether high or low, the current elopement protocol, monitoring, assessment and follow-up should have been done. The nursing staff should have documented all parties that were contacted, completed an incident/accident report, notify family, physician and ensure all information regarding Resident #1 needs were accurate and available. " Additional, interventions would have included, a wander guard, 15 minute checks, updating of elopement risk book and revisions to care plan.</p> <p>Further review of the record revealed that was no evidence of an incident report or the protocol for elopement and discharge was reviewed or implemented. The administrative staff was unable to provide any documents or supporting information to indicate that an investigation was</p>	F 204			

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F 204	<p>Continued From page 20</p> <p>conducted regarding the elopement. There was no documentation of any changes of the resident behaviors, mental or health status noted in nurse 's note or other facility forms within facility. There was no consultation/discussion or physician orders for discharge noted in the facility records. Reviewed social worker section of record and there was no indication of contact made with the resident or family during admission.</p> <p>During an interview on 3/21/12 at 5:20PM, the SW indicated that she had briefly met Resident #1 and family while the resident was getting settled. The resident was lying in bed and was not agitated, but the family was encouraging the resident to give the facility a chance and to stay. SW indicated that she was made aware of the situation on Monday and typically she would be involved in the arrangements for the discharge process. She was informed by the administrator and director of nursing the resident was return to previous facility due to the inability to protect and provide a safe environment for the resident. She was unaware of any medical reason that the resident could not be treated at facility, since he was admitted for short term rehab services.</p> <p>During an interview on 3/21/12 at 5:50PM, the administrator indicated that the director of nursing contacted him and informed him of Resident #1 's elopement from the bedroom window. The administrator added that based on the conversation held with Nurse #3 and the information that was gathered from the medical center indicating Resident #1 had an incident of elopement/exit seeking behaviors decision was made by management to return the resident back to previous facility due to the inability to protect</p>	F 204			

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F 204	<p>Continued From page 21 and provide a safe environment for Resident #1. In addition, since the resident had not been in the facility more than 30 days and lack of additional information from the rehabilitation center, management felt that it was best to return the resident because his needs could not be maintained at the facility.</p> <p>During an interview on 3/21/12 at 5:58PM, the physician indicated that indicated there was no medical reason for the discharge. Resident #1 was discharged based on the facility inability to handle the resident as the result of the elopement and information that Nurse #3 had received that Resident #1 had elopement/exit seeking behaviors. The facility was unable to safely protect the resident from continued elopement. The physician further stated that she was not contacted or consulted prior to the discharge and that she was informed of the administration decision to return to the previous facility on Monday. She added that she was unaware the family had not been contacted or informed of the discharge. The physician added after review of the record, the expectation was that nursing staff would document the events of the situation and note the condition of the resident upon return from the elopement and re-contact the treating or on-call physician. She further stated that a physician order and discussion was part of protocol for discharges.</p> <p>During an interview on 3/21/12 at 9:32PM, medical center SW indicated that he received a call from the rehabilitation center staff that the nursing home staff had brought Resident #1 back for re-admission. The rehabilitation center staff indicated they were unable to accept admission</p>	F 204			

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F 204	<p>Continued From page 22</p> <p>after hours and they were unaware the resident would be returned. The medical center SW stated that Resident #1 arrived with a female staff and Resident #1 was very confused and disoriented to surrounding, unable to make decisions or able to discuss the events of the day. The SW asked the transporting staff the reason for the admission and was told that Resident #1 eloped from a bed room window and the facility was not aware of the resident exit seeking behaviors. SW added that he immediately contacted the nursing home and spoke with Nurse #2 about why the resident was sent back to the rehabilitation center. SW was told by Nurse #2 the resident eloped and he was crying to be return home. Nurse #2 stated he was instructed by Nurse #3 to return the resident to the facility because Resident #1 could not be protected or properly monitored. Resident was found wandering outside of the facility and they were not a locked down facility. Nurse #2 also informed him the numbers for the family on file was not working. SW added that the emergency room physician evaluated the resident and could not find any medical problems and decided to admit the resident for further observation and lack of placement. In addition, Resident #1 did not have an elopement issue that he was aware and remained very calm and cooperative upon return. SW contacted the family at the two numbers available on record to inform them of Resident #1 return to their facility. Due to the hour the family was contacted the family came in later the next day upset because they were not contacted about the elopement or discharge.</p> <p>During an interview on 3/22/12 at 10:42AM, the director of nursing and van driver stated that she was called around 10:30PM or 11:00PM, by</p>	F 204			

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F 204	Continued From page 23 Nurse #3 and DON and told that she needed to come in and take a resident home [name] town. The van driver stated that when she arrived the resident was lying in bed fully dressed with bags packed on the floor. She was asked by Nurse #3 if she wanted another person to ride with her and she replied no since the resident was calm. Resident #1 continued to state he wanted to go home to [name] town to see his family. Resident #1 was not crying or doing any unusual behaviors. The resident was loaded in the van and taken to the address provided by Nurse #3. She was uncertain where she was taking the resident, but when she got to the address it was the rehabilitation center. When she spoke with the staff at the center, the staff informed her they were not aware the resident was coming for admission and that they did not accept residents after hours and she needed to take the resident to the emergency room. Van driver added that she met the emergency room nurse supervisor who asked why the resident was being admitted. She indicated that she gave her the director of nursing number who spoke with the nurse about why the resident was being admitted. She was unable to recall the nurse she spoke with. The director of nursing stated that she spoke directly with the emergency room nurse and informed her of the reason why the resident was sent back. She stated that she told emergency room nurse that facility could not provide a safe environment for the resident due to the elopement/exit seeking behavior that occurred at the facility.	F 204			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean,	F 252			

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F 252	<p>Continued From page 24</p> <p>comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain an odor free environment for four of four halls.</p> <p>The findings included:</p> <p>Upon entry in to the facility on 3/21/12 at 9:00am, a strong odor of stale urine and musty air was noted. Strong odors of urine and feces were noted and were prevalent throughout the all of the hallways. The strongest prevalence of the odors was in the back entry area and on 300 halls. There was housekeeping staff on all of the halls. During observations on 3/21/12 at 1:39pm, upon reentry into the building from the lobby area, the 200 hall had a strong odor of feces, urine and stale musty body odor. Hall 100 was noted to have a less odor, going up to hall 300 the smell was stronger lingering throughout the hall.</p> <p>Upon entry into the facility 3/22/12 at 8:00am, an odor was noted from the rear entrance. The odor continued throughout the 300 hall, 200 hall and was less noticeable on the 100 hall.</p> <p>During an interview with a family member on 3/22/12 at 10:00am, revealed the facility couldn't help how bad it smelled.</p> <p>During an interview with a family member on 3/22/12 at 4:43pm, revealed the building looked clean and the odor could not be helped.</p>	F 252	<p>F 252</p> <p>For the Resident found to be affected by the alleged deficient practice:</p> <ul style="list-style-type: none"> • Carpet was cleaned • Resident rooms were identified as needing deep cleaning <p>Residents Potentially Affected</p> <ul style="list-style-type: none"> • All residents have the potential to be affected • Re-education with housekeepers in regards to the deep cleaning schedule and what is involved in deep cleaning. Education was conducted by the Housekeeping supervisor. • The carpets are being cleaned with a carpet extractor twice a day. <p>Prevention of Reoccurrence:</p> <ul style="list-style-type: none"> • The housekeeping supervisor will review the deep cleaning schedule daily and will check rooms that were deep cleaned to ensure they are odor free. • The housekeeping supervisor will monitor that the carpets are being cleaned twice a day with approved solutions. 	4/4/12	

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F 252	<p>Continued From page 25</p> <p>Housekeeping was on all hallways throughout the day.</p> <p>During an interview on 3/23/12 at 10:00am, nurse #4 indicted she did notice a strong unpleasent lingering odor on the hall way especially the 300 hall all the time. She indicated visitors had noticed it as well. The staff was used to the smell.</p> <p>During an interview on 3/23/12 at 2:05pm, Housekeeping/Laundry Supervisor indicated that was aware of the odor in the facility. He indicated spray was not used to kill the odors. The house keepers use two types of cleaners to disinfect the rooms which are provided by the company. A neutral disinfectant cleaner was used on the floors, mattresses, and other hard surfaces in the resident ' s rooms an acid free disinfectant was used in the bathroom. The carpet was cleaned using an water extractor cleaner every night and every morning.</p> <p>During an interview on 3/23/12 at 2:36pm, with housekeeper #1, indicated there was a bad odor every where there was carpet. The carpet was cleaned every day and night, by the floor technicians. She indicated resident rooms were cleaned using the designated disinfectant to clean the rooms, and bathrooms.</p> <p>During an interview on 3/23/12 at 2:45pm, aide #5 indicated there was an odor in the building when it rained it was a musty soil smell.</p> <p>During an interview on 3/23/12 at 2:50pm, housekeeper #2 indicated there was a bad smell in the facility and she did not know what the cause of the odor. She indicated when she</p>	F 252	<p>Monitoring</p> <ul style="list-style-type: none"> The housekeeping supervisor will review the deep cleaning schedule daily and will check rooms that were deep cleaned to ensure they are odor free. Finds will be brought the monthly Performance Improvement meeting times 3 monthly then quarterly after. The housekeeping supervisor will monitor that the carpets are being cleaned twice a day with approved solutions. Finds will be brought the monthly Performance Improvement meeting times 3 monthly then quarterly after. 		

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F 252	Continued From page 26 cleaned the residents rooms she used the disinfected designated for the surface. During an interview with the administrator on 3/23/12 at 3:09pm, indicated there had been a complaint regarding unpleasant odors, the director of nursing indicated expectation was the building was to be odor free or an isolated incident. If there was an odor it should be determined where the odor was coming from and correct it.	F 252		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews, physician interview and record review the facility failed to safely provide supervision for 1 of 3 sampled residents at risk for elopement (Resident #1). Immediate Jeopardy began on 1/6/12 and is on going. The administrator was notified of the Immediate Jeopardy on 3/22/12 at 2:56PM and facility was not able to provide an acceptable credible allegation of compliance and considered on-going at 483.25 (F323).	F 323	For the Resident affected by the alleged deficient practice: <ul style="list-style-type: none"> Resident #1 was placed on 1:1 supervision, around 9:15 pm when he was returned to the facility after exiting the facility, the shift supervisor sat with Resident #1 in the 200 hall dining room, until he was transferred to Carolina Rehab center at 11:45pm. Resident #1 was transferred to Carolina Rehab Center on 1/6/2012, at 11:45 pm by the facility transportation aide in the facility Van, and has not returned to the facility. Resident # 1 was then transferred by the facility transportation aide to Carolina Medical Center Emergency Room. Physician was notified of residents discharge on 1/7/2012, by the house supervisor around 12am, after resident was sent to Carolina Medical Center 	3/30/12

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F 323	<p>Continued From page 27</p> <p>The findings included:</p> <p>Review of the facility policy titled " Elopement Prevention Program " dated 2/11, read in part; " residents would be assessed on admission utilizing the elopement risk assessment risk for. Any resident with a score of 18 or higher would be considered high risk and interventions put in place. Any resident that verbally express the desire to go home, has a prior history of elopement, or history of leaving the center without needed supervision or informing staff, will be placed on Behavior Management Program.</p> <p>If elopement occurs the following interventions would be followed and documented; note the time the resident was discovered missing by whom, notify administrator or the highest ranking supervisor on duty and note the time they were alerted. The highest ranking supervisor will begin documentation of all events. The record would be updated at least every 15 minutes, determine the last time the resident was seen, begin search by organizing healthcare staff to search the building and grounds, note the time it was begun, note who participated in the search and which area was search, notify the police and note the time and name of the police officer involved and information offered to police, notify and note the time the administrator, DHS and family was notified and their response, notify management company staff, the time resident was located and where they were found, condition should be noted and documented, vital signs taken upon return and every 4 hours for 24 hours, including neuro checks and any nursing assessment that may be indicated. The care plan would be revised with goals that are specific to the resident and location</p>	F 323	<p>Residents Potentially Affected</p> <ul style="list-style-type: none"> Elopement risk assessments were completed, utilizing the original Elopement Risk Assessment, by DHS(Director of Health Services)/Nurse Managers on 3/22/12 for all residents in house. Elopement risk assessments will then be conducted quarterly and with significant changes to assess risk status. Residents identified as high risk will have upon completion of assessment: <ul style="list-style-type: none"> A picture and description placed in a wander book that will be kept at the reception desk and at each nurse's station. Interventions will be noted to assist in preventing elopements Upon admission/readmission an Admission behavior log is initiated, the log includes a hour on the hour documentation of any behavior that has occurred including begging to go home, transferring unsafely, Wandering/ trying to get out the door, agitated or combative, falls without/with injury, Altercation. Any identified behavior, agitation, combative and/or wandering/trying to go home, that has the potential to escalate will have immediate interventions put in place to. 	

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F 323	<p>Continued From page 28 monitoring or alarm bracelet would be instituted.</p> <p>Resident #1 was admitted on 1/6/12 from a rehabilitation center, with multiple diagnoses including traumatic brain injury, diabetes, hypertension and hypercholesterolemia. Resident #1 was a recent admission therefore a Minimum Data Set was not completed. Review of hospital admission records, nursing home admission/nursing evaluation assessments and interviews from family and staff at rehabilitation center and medical center revealed that Resident #1 had intermittent confusion, short term memory loss, flat affect, forgetfulness and repetitive thought process and unable to make informed decisions. The admission paperwork revealed that the parents were the responsible parties who admitted Resident #1.</p> <p>Review of Nurse #1 nurse 's note dated 1/6/12 at 3:00PM, revealed that Resident #1 was admitted for rehabilitation services with discharge plans to return home with family. Resident #1 was alert/verbal with flat affect, slow response to questions and confusion as to present location and other aspects of his life. There were no noted or documented behaviors on 1/6/12 during 7-3PM shift.</p> <p>Review of the nursing home nurse practitioner medication order dated 1/6/12, revealed an order for 2mg of Ativan (anti-anxiety medication) per oral intake at bedtime and 2mg/ml of Ativan, every 4 hours as necessary for agitation in conjunction with other medications. Additionally, review of medications ordered dated 1/7/12, revealed orders for routine standard of care/treatments and medications. There were no</p>	F 323	<p>maintain safety and the well being of all residents. social worker will complete the behavior screen 72 hours after admission for further action, referral to psychiatric services, adding to the behavior management program, and referring to the physician for evaluation..</p> <ul style="list-style-type: none"> Security devices will be placed on windows in the building to alert staff when a window is being opened. TeleHealth Company (CANA) was at the Facility 3/23/12 to assess the Facility for security of windows and install a security system for the windows. The window security system installation was completed on 3/26/12. Upon admission the admissions director will validate contact information with the Responsible party and/or the resident. The Unit manager/week-end manager will call the contact number listed on the face sheet upon admission. Social Services reviewed all contact numbers 3/22/12 to ensure accuracy of contact information. <p>Moving forward, 24 hours after admission there will be a second check of phone numbers by Social Services / charge nurses to ensure numbers are accurate. The social worker/charge nurse will physically call the number and validate the phone number is accurate and functioning.</p>	

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F 323	<p>Continued From page 29 discharge orders.</p> <p>Review of the nursing home assessment dated 1/6/12, revealed that Resident #1 needed assistance/encouragement with dressing/grooming and was independent with all other activities of daily living. Additionally, review of the elopement risk and fall form dated 1/6/12, completed by the nursing home revealed that Resident #1 had poor vision without glasses and " risk for elopement due to ambulatory with traumatic brain injury, intermittent confusion and forgetfulness noted. "</p> <p>Review of the admission interim care plan dated 1/6/12, identified a behavior problem of wandering. The goal included the resident would not harm themselves or others secondary to their behaviors through next 30 days. The interventions included intervene as needed to protect the rights and safety of others, approach in calm manner, divert attention, remove from situation and take to another location as needed and administer and monitor the effectiveness and side effects of medications as ordered-see physician orders/MAR (medication administration record).</p> <p>Review of the nursing home behavior log form dated 1/6/12, revealed there were no documented behaviors of agitation or wandering before 8:00PM. Review of the MAR (medication administration record) and nurse ' s notes dated 1/6/12 at 8:00PM, revealed Resident #1 received the 2mg of Ativan due to the wandering at his scheduled medication time at 8:00PM.</p> <p>Review of Nurse #2 nurse ' s note dated 1/16/12</p>	F 323	<ul style="list-style-type: none"> In-services were begun immediately for Licensed staff on March 22, 2012 and completed on March 30, 2012, (27 of 27 completed) conducted by the DHS (Director of Heath Services) and ADHS/Nurse Managers on: <ul style="list-style-type: none"> Elopement Policy Notification of Family Safe Discharges Documentation Escalating Behaviors <p>** Licensed Staff, who are PRN, or week-end only, out on sick or personal leave, will not be permitted to work until in-services are complete..</p> <ul style="list-style-type: none"> As a facility practice and as a systematic approach to ensure the staff at the facility has knowledge of and understands the risk of elopement, and the use of the admission behavior log to aide in the identification of escalating behaviors, any employees observing any behavior, to include but not limited to self inflicted injury, threaten elopement, attempting to elope, hitting at self or other, will report the behavior to the charge nurse and the charge nurse will assess 		

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F 323	<p>Continued From page 30</p> <p>at 8:00PM, revealed that the resident spent most of shift in bed and was able to make his needs known.</p> <p>Additionally, review of Nurse #2 nurse 's note dated 1/6/12 at 10:00PM, revealed " (charge) nurse #2 went to resident room around 8:45PM to give PPD (purified protein derivative) test and noted that resident was no where to be found. " The first step PPD was given, Resident #1 had been given Ativan 2mg at 8:00PM, when he came out of room asking how he could get out of here. " His room window was noted wide open and cold air was gushing into the room. Nurse #3 was notified immediately and a search was initiated. The nurse supervisor searched outside the open window and up to front of the building. The supervisor delegated the (charge) nurse to go down Main Street. Resident was seen on main street heading toward [name of town]' Resident was stopped and (he cooperated in getting in the car and coming back to the facility). " He was asking to talk to his parents, giving all attempts to get parents on the phone was unsuccessful. Message saying you have reached a number that has been disconnected or out of service. Resident was taken back to his room and a staff member was assigned to him 1:1. " There was no documented time of when the search was initiated or when the family, administration or physician was notified of the elopement.</p> <p>Nurse #2 final note dated 1/6/12 at 11:50PM, revealed that Resident #1 was packed up and transported with staff at 11:45PM. The location of where the resident was discharged to was not documented, nor was there any information of when contact was made with the rehabilitation</p>	F 323	<p>resident and notify the physician , family and interventions will be put in place. the Inclusion of the 24 hour report, the healthcare center will have mandatory training of all new staff members during orientation and at least annually with all staff Licensed and non licensed staff. In-servicing will also be completed when needs are identified by facility management.</p> <ul style="list-style-type: none"> • 24 hour reports will be monitored daily by the DHS/CCC/UM/Week end manager to review for discharge from the facility, identification of escalating behaviors, and change of condition of the resident. Any identified issues will be reviewed to ensure follow –up was conducted. DHS will bring findings and trends to the monthly Performance Improvement meeting. • On 3/22/12 a piece of blue tape was placed on the outside window screens, where the screen meets the window casing on all facility window, The facility Housekeeping/maintenance continually walked the outside of the facility to monitor the window screens for any tapering through 3/26/12. The monitoring was concluded when the security contacts (alarm system) was placed on each screen in the facility. This will allow the facility to know when a screen has been breached. 		

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F 323	<p>Continued From page 31</p> <p>center. The time of the resident 's return to the facility was not documented and there was no further documentation/assessment of the behavior, mental or physical condition of the resident when the resident was returned to the facility. In addition, there was no information of whether the facility administration was contacted, or the physician or the family in accordance with the facility notification policy/procedure for elopement.</p> <p>Further review of the record revealed that was no evidence of an incident report or the facility policy protocol for elopement was reviewed or implemented. The administrative staff was unable to provide any documents or supporting information to indicate that an investigation was conducted regarding the elopement. There was no documentation of any changes in resident behaviors, mental or health noted in nurse 's note or other forms of documents within facility. There was no consultation/discussion or physician orders for discharge noted in the facility records. Reviewed social worker section of record and there was no indication of contact made with the resident or family during admission.</p> <p>During a facility tour on 3/21/12 at 9:30AM, the location where Resident #1 resided was conducted. Resident #1 was the only resident residing in the room at the time of elopement. The window did have a screen present. The window position was situated in an alcove section in the back of the building. There was a small air condition unit at the base of the window with sand bags at base of building. The window could be overseen by the maintenance building,</p>	F 323	<ul style="list-style-type: none"> • Security surveillance of Facility grounds will be in effect twenty four hours a day to monitor that window screens are intact. The surveillance is conducted by Housekeeping/Maintenance staff and will be in effect until the window security system is installed. Completion date was 3/26/12. • Binders for at-risk residents are placed at the reception desk and at each nurses station. At-risk status for residents is determined by clinical evaluation and resident-specific behaviors. Nine residents have been identified. <p>Prevention of Reoccurrence:</p> <ul style="list-style-type: none"> • 24 hour reports will be monitored daily by the Director of Health Services/ADHS (Assistant Director of Health Services)s/Unit Managers/Week end manager to review for discharge from the facility. Any identified issues will be reviewed to ensure follow -up was conducted. DHS will bring findings and trends to the monthly Performance Improvement meeting for three months. 	

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F 323	<p>Continued From page 32</p> <p>occupational therapy department, several other resident rooms and side staff parking lock. The surrounding location of the facility was fenced in and heavily wooded with bamboo trees. Additional, observations included checking the front area lobby and other exits within the facility that had key pad entrance/exit codes.</p> <p>During an interview on 3/21/12 at 11:19AM, the rehabilitation center SW reviewed the notes of the treating social worker and notes from the medical center social worker. The routine paperwork was sent to the facility (FL2, discharge summary and medical records etc). Since Resident #1 was unable to make decisions due to TBI (traumatic brain injury) the responsible party was involved in the discharge process and confirmed that the resident did not have an elopement history, but did have periods of agitation, mental confusions due to TBI. The notes revealed that Resident #1 was discharged from rehabilitation center on 1/6/12, and admitted to nursing home for rehabilitation services.</p> <p>During an interview on 3/21/12 at 11:27AM, the responsible person stated that prior to resident admission to rehabilitation center resident had been hit by a car on 9/13/11 and was sent to medical center D until 10/13/11. Medical Center D sent the resident to rehabilitation center due to TBI. While the resident was at rehabilitation center, Resident #1 had not had an elopment history. Alternate placement had been investigated prior to admission to the nursing home. The responsible person assisted with the admission to the nursing home by completing the required forms and submitting contact information. Resident #1 and family was assisted</p>	F 323	<ul style="list-style-type: none"> Upon admission/readmission an Admission behavior log is initiated, the log includes a hour on the hour documentation of any behavior that has occurred including begging to go home, transferring unsafely, Wandering/ trying to get out the door, agitated or combative, falls without/with injury, Altercation. Any identified behavior, agitation, combative and/or wandering/trying to go home, that has the potential to escalate will have immediate interventions put in place to maintain safety and the well being of all residents. social worker will complete the behavior screen 72 hours after admission for further action, referral to psychiatric services, adding to the behavior management program, and referring to the physician for evaluation. New admission charts will be reviewed with in 24 hours by the Director of Health Services/ADHS (Assistant Director of Health Services) /Unit managers/ Week-end managers to ensure elopement assessment is completed and inventions in place. . Any identified issues will be reviewed to ensure follow –up was conducted. DHS will bring findings and trends to the monthly Performance Improvement meeting for three months. 		

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F 323	<p>Continued From page 33</p> <p>to the designated room and got the resident settled down. Resident was upset and tearful as they attempted to get Resident #1 settled down, the responsible person left between 4:30-5:00PM. The responsible person did not get a call about the elopement of his son until 3:00AM.</p> <p>During an interview on 3/21/12 at 2:42PM, Nurse #1 indicated being the admitting nurse for Resident #1. Nurse #1 indicated that Resident #1 was admitted with family present for rehabilitation services. She added that resident and family walked around building and there were no behaviors. The post discharge plan was for Resident #1 to receive rehab service and return home with family. Nurse #1 indicated that part of the new admission assessment process included observing for agitation, determining whether a resident was going to be an elopement risk, behavior changes, medication issues and wandering/elopement. The protocol would have been, if there was a problem with elopment the resident would have been put on 1:1. The family did not report that the resident had any behaviors issues and he was stable on his medications. Resident #1 spent most of the time in room in a calm relaxed state on the 7-3pm shift. Nurse#1 added that Resident #1 had a blank stare. Nurse#1 indicated that verbal communication was the format used to communicate new admission information. There was no formalized document or process used to share new admission information other than what was sent from the facility or hospital. Nurse#1 added that a verbal report was given to Nurse #3 and the admission paperwork/nursing assessment forms was provided to Nurse #3 and potential behaviors was also discussed. Nurse#1 added that Resident #1</p>	F 323	<p>Monitoring Compliance:</p> <ul style="list-style-type: none"> • 24 hour reports will be monitored daily by the Director of Health Services/ADHS(Assistant Director of Health Services)s/Unit Managers/Week end manager to review for discharge from the facility. Any identified issues will be reviewed to ensure follow –up was conducted. DHS will bring findings and trends to the monthly Performance Improvement meeting for three months, then quarterly thereafter. • New admission charts will be reviewed with in 24 hours by the Director of Health Services/ADHS (Assistant Director of Health Services)s /Unit managers/ Week-end managers to ensure elopement assessment completed and inventions in place. . Any identified issues will be reviewed to ensure follow –up was conducted. DHS will bring findings and trends to the monthly Performance Improvement meeting for three months, then quarterly thereafter. 		

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F 323	<p>Continued From page 34</p> <p>remained in his room most of shift unless for meals. Staff would do periodic checks and he was still calm. She indicate that she did not give the resident any medications. There was no documentation presented or available of the checks that were done during the 7-3PM shift. During an interview on 3/21/12 at 2:52PM, Nurse #2 stated that he was doing med pass when he noticed Resident #1 continued pacing up and down the hall calmly. He was not agitated or upset other than wanting to go home. He would have periods of crying out for his parents. He stated that he asked the resident several times how he could help him get adjusted and resident just wanted to go home. There was no documentation of interventions done when the agitation was first noticed. Nurse #2 saw the resident in hall at 8:00PM pacing and touching the door handle and walking away stating he wanted to go home. Nurse #2 gave the resident his 8:00PM, ativan 2mg per oral while in passing other medications due to the resident pacing up and down hall. The resident was not aggressive or excessively agitated other than pacing. Nurse #2 stated that he continued to give meds on the hall and when he got to the resident end of the hall he went back to the resident 's room around 8:45PM to give him his IM(intra muscle) ativan, the door was closed so he knocked no answer and he went into the room and discovered a chill in the room and the room was very cold. As he entered the room the window was wide open.</p> <p>Nurse #2 immediately informed the Nurse #3 that the resident was not in the room. A building and room to room search was done. However, since he saw the window was open, his immediate resposne was to search outside. Nurse #3</p>	F 323			

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F 323	<p>Continued From page 35</p> <p>instructed him to begin a search outside while he contacted the DON/Administrator. Nurse #2 got in his car after searching around facility and went out of the drive way toward the left first to the gas station. The resident was not seen along the side of highway. Nurse #2 called back to building to let them know he would continued search in opposite direction. He turned around and went in other direction and saw resident walking about 1.5 mile on the grassy part of the road. He put on the high beam of car lights, parked car and began walking toward resident. He let the resident know who he was and the resident had recognized him from the soda he had given him earlier.</p> <p>The nurse indicated that when he approached the resident, the resident seemed to be unaware of his surroundings and continued to state that he wanted to go home, but could not say where home was. So he encouraged the resident to get into the car and he was brought back to the facility. Nurse #3 was kept informed of all the events during the search via cell phone. When the resident returned he told the supervisor that he needed to be watched 1:1 and that he could not watch resident independently and that staff needed to sit with resident. Resident crying a lot and sobbing for his parents. Nurse #3 in the mean time was calling parents and the only number listed was the home number. There was no cell number available since the family was staying in the hotel. The adminsitator and DON instructed him and nurse supervisor to make arrangments to send the resident to his previous envrionment. The facility transportation staff took the resident back to [name] town at the instruction of administrator/DON. Nurse #2 stated that the reason Resident #1 was transferred was that the</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>facility could not provide for his safety since he exited out of the window. Nurse #2 added that he was unaware of the resident potential for elopment, as the resident was very calm, non threatening, just paced the floor and wanted to go home.</p> <p>Nurse #2 stated that he did not give the resident the IM medication (ativan) because the resident was gone. Nurse #3 had called the doctor for the IM medication because the resident was pacing the floor after the PO medications were given. Nurse #2 added that he did not have any trouble with resident after the 8:00PM medication. Nurse #2 also indicated that he did not do any of the reports because the Nurse#e stated he would handle all the paperwork and discussion with transfers. Nurse #2 stated that he did not talk with doctor or anyone else and that Nurse #3 did all the contacting of people and he returned to his medication pass. He added that he was uncertain how long the resident had been gone or what time he brought the resident back.</p> <p>During an interview on 3/21/12 at 4:04PM Nurse #3 stated that he was the nurse supervisor on duty. He stated that around 8:45PM or 9:00PM, Nurse #2 informed him that the Resident #1 was not in the room when he went down to give him his IM medication. Nurse #3 indicated he could not recall what time it was when he called the physician to get the order for the IM ativan. He stated that the he informed the physician that Resident #1 was agitated and crying/tearful and wanting to home. In addition, he did not document when he made the call or why he needed an IM medication, since Resident #1 had already received the 2mg orally.</p>	F 323		

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F 323	Continued From page 37 Nurse #3 further stated that Nurse #2 informed him that the resident had been trying to get out of the front lobby door and that he was violently banging and shaking on the door trying to get out of the facility. Nurse #3 stated that he was on another hall and that all the NA (nursing assistants) was in resident rooms providing care when the behaviors were occurring with Nurse #2, roughly around 8:00PM/8:15PM. He stated that when he came from the other hall to nurse station, Nurse #2 had given the resident the 8:00PM medication and resident went back to room calmly. Later when Nurse #2 called him between 8:45PM to 9:00PM, to let him know resident was gone, staff started building search, Nurse #3 and Nurse #2 went outside to search and Nurse #2 got in car and went down the road to search. He did not know how long the search took or exact time when resident was returned to building. He stated that Nurse #2 reported that the resident was running down the street and did not want to get in the car and the resident was about 1.5 miles down the road. The resident was crying and wanted to go home. Nurse #3 stated that he called the numbers listed of family and did not get answer or numbers were not right. Nurse #3 indicated that he called the administrator and director of nursing and told them about resident leaving building and they both said to transfer resident back to other facility. Nurse #3 reported that he searched for telephone numbers and address of the other facility to make arrangements to send resident back since the resident said he wanted to go back home. He added that the DON/administrator told him that since the resident had not been in the building for	F 323			

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F 323	Continued From page 38 30 dyas and we were not informed of his elopement history it was ok to send him back. Nurse #3 stated that resident was calm when he got back and vital signs was taken of resident, while he made arrangements. He stated that the Nurse #2 did a report of what happen and it was given to Director of Nursing. Nurse #3 further stated that he did not document the events of what he did or whom he spoke with because everything happened so fast. He added that he did not contact the doctor for discharge or call back about the IM medication because the resident was gone to another facility. And he was instructed to send resident back. So he made arrangements with for NA to sit with resident about 11:30PM until transportation could be arranged. He stated that he spoke with someone at medical center to let them know resident was returning, but could not recall who the staff person was. He stated that the transportation staff person returned the resident to the rehabilitation center based on the address that they searched online for the facility. During an interview on 3/21/12 at 4:30PM, the DON indicated that she had received a call from Nurse #3, could not recall time, stating that Resident # 1 had eloped from the building through the bedroom window. DON added that she instructed Nurse #3 to search the building and surrounding areas. She contacted the administrator who also contacted the corporation consultant. The administrator gave instruction for the nursing staff to discharge the resident back to the previous facility. The reason for the discharge was the nursing home could not safely protect/monitor the resident and they were not informed of the resident ' s elopement history/exiting seeking behavior.	F 323			

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F 323	<p>Continued From page 39</p> <p>The administrator further informed and instructed DON that since Resident #1 had not been a 30 day admission it was ok to return resident to previous facility. DON added that the physician had not been contacted following the return of the resident or consulted regarding the discharge. The director of nursing reviewed the facility record and documentation and stated " I do not have any documentation, incident reports of what action took place and the nursing notes do not reflect the condition of Resident #1 behaviors, mental or physical well being during the course of the shift or return from the elopement. The expectation would have been once the nursing assessment had been completed and the resident was identified as a risk for elopement, whether high or low, the current elopement protocol, monitoring, assessment and follow-up should have been done. The nursing staff should have documented all parties that were contacted, completed an incident/accident report, notify family, physician and ensure all information regarding Resident #1 needs were accurate and available. " Additional, interventions would have included, a wander guard, 15 minute checks, updating of elopement risk book and revisions to care plan.</p> <p>During an interview on 3/21/12 at 4:37PM, NA (nursing assistant) #1 indicated that she was Resident #1 primary worker for the evening. She indicated during the course of the shift the resident was in a good mood and calm. She performed vital signs and basic health care while family was present. Resident #1 didn ' t verbally communicate much, but did walk around the facility up and down the hall. NA#1 further stated</p>	F 323			

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F 323	<p>Continued From page 40</p> <p>that Resident #1 continued to repeat that he wanted to go home with family after they left. NA#1 added that Resident #1 was not observed crying or being agitated when she last past resident in the hall between 7:30PM to 8:00PM. She further stated that it wasn ' t till she returned from dinner break around 9:00PM, when she was informed by other NAs and Nurse #3 that the resident had gotten out of the building. She began the search of resident rooms and building with the rest of the staff. She added that she had seen Nurse #2 give Resident #1 medication around 7:45PM, to 8:00PM in the hall. In addition, she could not recall how long it took for the resident to be found or what nursing did after the resident return. She added that no-one asked her to document anything or was asked any questions once the resident returned to the building. She ended her shift at 11:00PM and that all she was aware of was that the resident was being sent to another facility.</p> <p>During an interview on 3/21/12 at 5:05PM, NA#2 indicated that she had passed the resident and family earlier during the shift and Resident #1 was calm and getting settled with family. NA#2 indicated that she was unaware of any behaviors of Resident #1 attempting to exit the building and only knew that the resident wanted to return home with family. NA#2 stated that she was later informed after 9:00 PM or later that the resident had gotten out of the building by Nurse #3 and that all staff had to assist with the search of the resident.</p> <p>During an interview on 3/21/12 at 5:20PM, SW indicated that she had briefly met Resident #1 and family while the resident was getting settled.</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>The resident was lying in bed and was not agitated, but the family was encouraging the resident to give the facility a chance and to stay. She further stated that she did not do any of the admission process and that the admission coordinator handled all the paperwork and contact information. In addition, she was unaware of Resident #1 behavior history due to she had not reviewed any of his paperwork.</p> <p>During an interview on 3/21/12 at 5:50PM, the administrator indicated that the director of nursing contacted him and informed him of Resident #1 's elopement from the bedroom window. The administrator added that based on the conversation held with Nurse #3 and the information that was gathered from the medical center indicating Resident #1 had an incident of elopement/exit seeking behaviors decision was made by management to return the resident back to previous facility due to the inability to protect and provide a safe environment for Resident #1. In addition, since the resident had not been in the facility more than 30 days and lack of additional information from the rehabilitation center, management felt that it was best to return the resident because his needs could not be maintained at the facility.</p> <p>The Administrator indicated the expectation would have been during the pre-screening process all the information regarding the resident behavior, mental and health status, FL2 and discharge summary would have been reviewed by director of nursing and/or admitting nurse once the resident was accepted to the facility. In addition, if the sending facility had completely informed them of the elopement risk/exit seeking</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>behavior, the resident would not have been accepted to the facility. The administrator reviewed the record and he acknowledge that there was no documents or evidence that supported or warrant the action taken regarding the elopement process according to facility policy/expectation for elopement, notification of family/physician or the appropriateness of the discharge. He added that he was unaware that the contact information for the family was inaccurate.</p> <p>During an interview on 3/21/12 at 5:58PM, the physician indicated that she was contacted after hours, could not recall exact time via cell phone. The physician did not know the resident had eloped at the time of the call for the request for the IM medication. She was informed that Resident #1 had been given oral Ativan around 8:00PM, by Nurse #2. Nurse #3 had called to request an order for 2mg of IM Ativan, because Resident #1 was agitated and upset and wanted to go home with family. She was not aware of any noted behaviors of attempts to get out building prior to the call for the IM medication. It wasn't until the request for the IM medication that she was informed Resident #1 had eloped from the facility when Nurse #2 went to administer the IM medication. The physician indicated the there was no medical reason for the discharge. Resident #1 was discharged based on the facility inability to handle the resident as the result of the elopement and information that Nurse #3 had received that Resident #1 had elopement/exit seeking behaviors. The facility was unable to safely protect the resident from continued elopement. The physician further stated that she was not contacted or consulted prior to the</p>	F 323			

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F 323	<p>Continued From page 43</p> <p>discharge and that she was informed of the administrative decision to return to the previous facility on Monday. She added that she was unaware the family had not been contacted or informed of the discharge. The physician added after review of the record, the expectation was that nursing staff would document the events of the situation and note the condition of the resident upon return from the elopement and re-contact the treating or on-call physician. She further stated that a physician order and discussion was part of protocol for discharges.</p> <p>During an interview on 3/21/12 at 9:32PM, the medical center indicated that he received a call from the rehabilitation that staff from the nursing home had brought Resident #1 back for re-admission. The rehabilitation center staff indicated they were unable to accept admission after hours and they were unaware the resident would be returned. The SW reported that the emergency room physician had evaluated the resident and could not find any medical problems and decided to admit Resident for further observation and lack of placement. In addition, Resident #1 did not have an elopement issue that he was aware and remained very calm and cooperative upon return. Resident #1 remained in the medical center from 1/7/12-2/7/12, before being transferred to another facility.</p> <p>During a follow-up interview on 3/22/12 at 8:30AM, Nurse #1 indicated that she did the elopement/fall risk assesement. She indicated that if Resident #1 was not a high risk(18 or above) a wander guard would not be applied per assessment form. Nurse #1 indicated that she</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>had identified and documented on the elopement form that Resident #1 was at risk for elopement. Even though during her observation/interaction the resident did not indicate that he wanted to leave or exit building, nor did he look like a person that had exit seeking behaviors, as he was calm when his family were present. She further stated that she gave report to Nurse #3 regarding Resident #1 medication, issues with agitation per review of hospital documents and that Nurse #3 should keep an eye on Resident #1 and that the resident would be a possible elopement risk based on diagnoses and potential for agitation based on the blank stares and demeanor. She informed Nurse #3 to observe for potential changes. She further stated that she did not add the resident to the typical monitoring of resident that have elopement history because he did not show actual signs. She added that usually within 48 to 72 hours resident behaviors do change that was why she reported the information to 2nd shift charge nurse verbally. She acknowledged that she did not document her concerns just gave verbal report.</p> <p>During an interview on 3/22/12 at 8:48AM, the Director of nursing acknowledged that documentation did not support the behavior or the receipt of the additional medication. DON indicated that she did the pre-screening of the FL2 and resident medical history, based on what was reviewed he was an appropriate admission. The resident was sent back to rehab facility in charlotte based on the instruction from administration and the fact that the facility was unable to safely provide for the resident. She further stated that she was unaware of a medical reason why Resident #1 's needs could not be</p>	F 323			

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F 323	<p>Continued From page 45</p> <p>met at the facility. She further stated that due to the lack of documentation of the events of what happened and who did what part, or noted behaviors the facility process/procedures were not implemented or followed. She added that the process for monitoring a resident would include 15 minute checks, wander guard, revision of care plan if needed. She indicated that the resident was sent back to the previous facility, because he said he wanted to return. There was no response noted as to why the resident was not sent to near by facility when it was reported that the resident's behaviors had increased. She was informed that the resident was calm prior to discharge, so she felt ok to send the resident back to other facility with only one staff. She added that the family and physician should have been properly notified.</p> <p>Follow up interview on 3/22/12 at 9:00AM, the administrator indicated that the expectation was that staff document all the events of the situation using the facility provided forms/assessments and follow protocol for residents at risk for elopement. He added without the documentation of what did happen and the action that was taken, if it was not documented it was not done. He added that the sending facility had not provided his facility with appropriate information concerning the resident behaviors and that he would not have been accepted had they known of the exit seeking or elopement behaviors. In addition, the facility was responsible for ensuring that each shift received report on the condition of the resident.</p> <p>During a telephone interview on 3/22/12 at 10:04AM, NA#3 indicated that Resident #1 was</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>not assigned to her, but she observed the resident confused and walking up and down the hall. The resident was holding on door handle as if he wanted to go out around 5:00 and 6:00PM. He was standing and looking out door, he wanted to go out when others was entering/exit door. He just grab door but it was not viloent nature. NA#3 indicated that she last saw resident around 5:30 to 6PM. She revealed that she was uncertain of the time when staff started for the resident. She added that she was not asked to do anything after the resident had been found.</p> <p>During an interview on 3/23/12 at 8:50AM, NA #5 indicated that she was informed that the resident had been missing and was part of the building search. She was unable to recall when she was asked to take part in the search or time frame she was asked by Nurse #3 to sit with the resident in the room until discharge. She added that during the 1:1 observation resident was calm lying in bed repeating that he wanted to go home. There were no other noted behaviors and she was unaware of any behaviors before she took part in the search. She added that she was relieved by another NA to watch resident when her shift was over.</p> <p>During an interview on 3/23/12 at 9:20AM, NA #6 indicated that she was asked to stay over and provided 1:1 for Resident #1 around 11:30PM by Nurse #3. She added that she was unaware of any of the resident ' s behaviors prior to the elopement, when all staff had to search for the resident. She could not recall the time of the search. Resident #1 was quiet and she was unaware the resident was in the building because she was working on another hall.</p>	F 323			

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F 323	Continued From page 47 During a follow-up interview on 3/23/12 at 1:42PM, Nurse #2 added that when he arrived to work at three o ' clock Nurse #3 was still working on the new admission so he went onto do his medication pass. He acknowledged that he didn ' t see the resident after 8:00PM, because he was in and out of resident rooms giving medications until he got to the end of the hall where the resident resided. He also acknowledged that he did not document all the events of the evening since Nurse #3 was handling all the paperwork and phone calls. Resident #1 was not returned to the facility and he remained in the hospital and did not have any injuries.	F 323			