STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 2567 amended 11/20/2013 to change F323 immediate jeopardy beginning on 10/24/2013.	F 000		
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 observations, resident, staff and police interviews, record review and police report review, the facility failed to prevent a resident from exiting the facility's building. This was evident in 1 of 3 sampled residents at risk for elopement (Resident #1). Immediate Jeopardy began on 10/24/13 and was identified on 10/30/13 at 4:30 PM. Immediate Jeopardy was removed on 11/1/13 at 11:30 AM, when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy). The facility was in the process of full implementation and monitoring their corrective action. Findings include: Review of the facility 's Policy dated 1/1/2007	F 323	1. The corrective action taken for the resident affected by the alleged deficient practice was to have a 1:1 staff member assigned to him until the time of his discharge to ensure that he understands the need to sign out of the building if he chooses to leave and to accompany him if he exits the building to ensure his safety. The 1:1 staff member will be listed on the assignment sheet as dedicated to this resident. As well a lap top computer has been purchased by the facility that he may use to allow him to explore the internet as that is one of his interests. 2. The corrective action accomplished for those residents having potential to be affected by the same alleged deficient practice was for all other residents who have been assessed as at risk for elopement have been reviewed for the appropriateness of Wanderguard placement as related to cognition using the Brief Interview for Mental Status (BIMS). This criterion is a BIMS score of 12 or less as indicated by the MDS scale in order to be considered cognitively impaired. As well all current residents have been re-evaluated using the Elopement Risk Assessment Form	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/25/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 and revised on 9/1/2011 revealed, " POLICY It is policy of The Company that on admission and quarterly, all residents will be assessed for elopement risk. " " PROCEDURE 1. An elopement risk assessment will be completed on admission and quarterly by nursing. 2. If the resident is identified as an elopement risk based on assessment, the care plan will reflect the intervention (i.e. Wander Guard or Code Alert) and desired outcomes. Review and/or revised care plan following attempt to leave the facility. 3. Resident identified as at risk for elopement will require nursing to check resident regularly and document on Safety Checks (N-1275A). " Guide to the Elopement Risk Assessment (no date) revealed in part, 3. Interventions will be developed and entered on the interim plan of care for all residents identified as being an elopement risk. 4. Communication of residents ' risk and interventions will be completed daily at the morning meeting. 6. In-service education and elopement drill will be conducted quarterly on each shift to strive to assure that all staff is aware of what steps to take to prevent or interrupt elopement attempt. Resident #1 was admitted to the facility on 1/14/13, with the diagnoses of diabetes mellitus, hypertension, depression, cerebrovascular accident, and general muscle weakness. Review of nursing notes from 1/14/13 -8/25/13, indicated Resident #1 had no wandering	F 323	to identify any other resident at risk for elopement. These residents have also had their Care Plans evaluated and updated as necessary to reflect interventions to assist in preventing them from eloping from the building. 3. The systemic changes made to ensure that the deficient practice will not occur again are that the Elopement Risk Assessment will be completed by a licensed staff nurse for all new admissions, re-admissions, quarterly and with significant change. The Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Executive Director, Regional Director of Human Resources and Regional Director of Clinical Services participated in the re-education of the staff for the elopement process. 100% of the facility staff as well as 100% of contracted staff have been re-educated. Per facility policy, all new employees will receive elopement training during orientation prior to working an assignment. All contracted employees will also have this elopement training completed prior to their first assignment. To ensure the education was complete, the Executive Director, Director of Maintenance or his designee conducted or will conduct	

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F 323	Continued From page 2 behaviors. Review of the form titled " Elopement Risk Evaluation " , dated 8/25/13, indicated the resident was at risk for elopement. Review of Resident #1 care plan dated 8/25/13 and last revised on 8/26/13 revealed a plan of care for elopement prevention. The problem was exit seeking behavior. The goal was to minimize the risk of the resident's elopement (no goal date). The interventions included: · Initiate wander alert system Describe system used : no system described · Photograph resident /patient; Place on protected list for at risk resident/patient · Allow for safe wandering · Encourage movement and exercise · Enhance recreation exercises · Provide evening activities · Redirect resident/patient · Encourage family participation & support · Remove objects that are reminders of leaving (i.e. coat hat etc) · Offer reassurance if resident feels lost or abandoned · Encourage conversation about past experiences (i.e. children pets occupation) · Attempt to identify a need that the exit seeking behavior may be a result of(need to get home for children spouses etc). Provide activities at these times · Encourage involvement in productive daily activities (i.e. folding clothes cooking etc.) Review of the nursing notes dated 8/25/13 at 9:00 AM revealed in part, " Resident was brought	F 323	elopement drills daily times 7 days which began on 10-28-2013 for two weeks, then beginning the week of 11-4-2013 twice per week for three weeks, then beginning 11-25-2013 weekly for 4 weeks to ensure staff response is appropriate. Appropriate response will be demonstrated by all alarms being responded to by staff upon sounding and determining the cause of the alarm. This has been documented on our Quality Improvement monitoring tool for Elopement Drills. After this time frame, in the future elopement drills will be conducted at least one per shift per quarter as scheduled according to the facility policy and procedure. 4. This plan will be monitored by the Director of Clinical Services and the Executive Director to ensure orientation of new employees is completed, elopement drills are completed and any issues are addressed and re-education of staff is completed when needed. The Executive Director will report the findings of the QI monitoring tool to the Quality Assurance / Performance Improvement Committee monthly for review and recommendations.	11-2-13

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F 323	Continued From page 3 back into the building by a member of staff. He was spotted outside the building heading towards Tryron Rd. " SBAR (Situation, Background, Assessment, and Request), dated 8/25/13, revealed: S: Resident elopement due to loneliness, desire spouse to visit B: Dementia A: Loneliness R: Wander guard placement A Physician Order, dated 8/25/13, read " place wanderguard to left ankle. Check place q (every) shift. Visual check q 30 min x 3 days. " Review of the visual check list , revealed checks were done every 15 minutes from 8:45 AM until 2:45 PM on 8/25/13. Then checks were done every 15 minutes from 3:00 PM until 3:00 PM on 8/26/13. Checks were done every 15 minutes from 3:30 PM until 10:30 PM. No checks were documented for 8/27/13. An " Elopement Risk Care Plan " was initiated on 8/26/13. The " Problem " was the resident was at risk for elopement R/T (related to) exit seeking behaviors The " Goal " was not indicated, and there was no target date. The Approaches and Interventions included the following: Elopement Risk assessment per Protocol Re-direct resident from doors and exit PRN (as needed) Observe for exit seeking behaviors/Patterns Encourage and assist to activities when exit	F 323		

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F 323	Continued From page 4 seeking Use Diversion when exit seeking Personal wander prevention device Check bracelet for placement each shift Check function of bracelet daily Picture ID and face sheet in wander book Assess for wander/elopement patterns Assess for pain. The most current Minimum Data Set (MDS) dated 9/22/13, revealed he had intact long and short term memory. He was able to make his needs known and had no problems with hearing, speech or vision. He had no behaviors and was depressed. He was able to walk the corridor independently; his balance while walking was unsteady. Wandering behavior was not exhibited the previous seven days. He had no impairments to his upper or lower extremities. He received antidepressant and antipsychotic medications daily. Review of the nursing notes dated 9/23/13 at 1:55 PM, revealed in part, " Resident's window was opened all the way. Safety screw not in place, screw removed, maintenance fixed both screen and screw. " Review of nursing notes dated 9/23/13 at 7:10 PM revealed, " Resident tried to go out the back door of the 300 hall, asked resident why he was leaving and stated he wanted to go home. Advised C N A to monitor due to exit seeking behaviors. " Review of nursing notes dated 9/23/13 at 7:40 PM, read in part, " Resident tried to exit again through the door by nurses station on 300 hall.	F 323		

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F 323	Continued From page 5 Also walke (sic) up 400 hall and tried to leave out door by MDS office but was redirected. " A Physician order dated 9/26/13, was given to increase Cymbalta (antidepressant) to 90 mg (milligrams) and to decrease Prozac (antidepressant) to 10 mg every day for two weeks then discontinue. Review of the " Alarm response and elopement protocol " (no date) revealed In part: · When a door alarm is sounding and the source for the alarm is not identifiable. The expectation is to exit the facility to search the surrounding areas. Behind bushes, between cars, etc .... Review of the weather for 10/24/13 revealed the temperature at Raleigh Durham Airport between 9 and 10 PM was 47 degrees with a wind at 4 miles per hour west to North West. Review of Cary police report dated 10/24/13 at 9:05 PM revealed, an officer was called to the facility for a missing person. A canine officer was deployed at 9:06 PM and arrived to the scene at 9:27 PM, the deployment time of the canine officer was 9:35 PM. Clear time (the time the officer left the facility) was 10:19 PM. The woods were slightly illuminated from the parking lot lights. A flashlight was required to see. The canine officer went to the end of a split rail fence (off from the parking lot) and walked through 25-30 yards of woods. On the other side	F 323		

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F 323	Continued From page 6 of the woods was an embankment that sloped down onto Tryon Road. The embankment had numerous small pine trees growing on the slope. Once at the top of the slope the canine officer turned East and in a few feet the resident was laying face down on the slope with his head towards the top of the slope. Only his head and face were observed. Blood was noted on the right side of his face. " The area where the subject (Resident #1) was located was on a slope. The slope was covered with pine straw, which made it very slippery, even for me (the officer) to walk on. The pine straw under the subject (Resident#1) had been pushed away, which indicated to me (the officer) that he (Resident#1) was trying to climb up the embankment but could not. I (the officer) also located both of his (Resident #1) sneakers were on top of the embankment about 15 feet from where he was located. " Hospital discharge record dated 10/25/13, (time seen was 10:15 PM and discharge time was 12:05 AM), revealed a diagnosis of closed head injury while on blood thinners and forehead abrasion. During an interview on 10/28/13 at 3:33 PM, Resident #1 indicated he got the abrasion above his right eye when he had " escaped " out of the door at the end of 300 hall. He said the alarm made a sound and he kept going. He said it was dark and he fell and laid in the dark for about an hour. He said he didn ' t want to talk any more. Observation revealed Resident #1 was standing in his doorway wearing slippers socks, sweat pants and a t-shirt and a wander guard on the left ankle. During an interview on 10/28/13 at 3:38 PM, the	F 323		

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F 323	Continued From page 7 Maintenance Director indicated when the alarm is activated at the door, the panel at each of the nurses stations will light up. The wander guard device worked at the front door only. The other five doors can be exited after 15 seconds of pushing on the exit bar. The locking magnet would release. He indicated all doors were checked daily. To track the doors were checked the Maintenance Director logged into the computer system at 3:58 PM and demonstrated once the task was acknowledge it was completed it was removed from the screen. To ensure compliance any weekly maintenance tasks was not completed were automatically send via email to the Administrator. He indicated residents can leave the building, by " pushing the door until the door alarm sounds and the door can be open in 15 seconds " . Usually when a resident does get out the staff are able to get the resident before they leave the building. Review of " Check Operation of magnetic door locks " printed 10/28/13 revealed In part, 1. Inspect door lock mounting and operation and panic hardware on egress doors 5. Check patient transmitter to make sure the door stays locked and alarm sounds Check delayed egress operation 1. Push door release hard for a fraction of a second-door should not open and alarm should not sound 2. Apply pressure to the door release for the pre-determined nuisance period setting (normally 1-3 seconds) 3. Door should go into irreversible unlocking sequence · Door alarm will sound · Door will automatically open within (15-30	F 323		

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F 323	Continued From page 8 Seconds) 4. Close door and reset the alarm 5. Ensure signs are place on doors adjacent to the release device that read ' Keep pushing. Door will unlock after 15 seconds. ' Test doors and hard ware for proper operation and condition Document results of inspection in log book 1. Note any discrepancies 2. Contact manufacturer with any questions During an interview on 10/28/13 at 4:00 PM, Aide #5 indicted she was not aware of a resident who had eloped recently from her assigned hall. To her knowledge all the doors were equipped with the wander guard alarm system. During an interview on 10/28/13 at 4:20 PM, Nurse #1 indicated she was working the upper hall and assisted living with Aides #1 and #2 on 10/24/13 Aide #1 came at 8:30 PM, and told her Resident #1 was missing. Nurse #2 called the Director of Nurses, the Administrator, family and police. During an interview on 10/28/13 at 4:30 PM, Aide #1 indicated he was working on 10/24/13. He was working with Aide #2 on the upper 300 hall. He indicated he told Nurse #1 he was going on break with Aide #2. He heard the 300 door alarm went off. Aide #2 said to him she saw laundry aide #2 turn off the alarm. Break ended between 8:30 PM and 8:45 PM. Three call lights were going off on the lower hall 300 hall He indicated he went into Resident #6 room, who said he saw Resident #1 go down the hall and heard the 300 hall door alarm and didn ' t see him return. Aide # 1 revealed that " (Aide #2) and I both went out to	F 323		

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F 323	Continued From page 9 check outside. We didn ' t see (Resident #1). We got into my car and drove Tryon Road looking for him. We called (Nurse #1) and returned to the facility. An observation on 10/28/13 at 4:56 PM, was conducted with Aide #1 of the route taken to look for Resident #1. Exiting the 300 hall door looking to the right was the corner of the building. There was a dumpster, a generator and an out building. To the left was a picnic table. Straight ahead was the parking lot, with lighting. No lighting was in any other areas. A split rail fence was noted along the edge of the tree line and the woods, which ended at the end of the parking lot. Aide #1 indicated he used his cell phone for light in the dark areas. He was unable to see past the tree line into the woods. The route continued to around the front of the building where there was a long driveway which led to Tryon Road. He indicated he entered the building through the 200 hall door and reported to Nurse #1 he had not located Resident #1. During an interview on 10/28/13 at 5:55 PM, laundry aide #1 indicated 300 door alarm can be heard in the laundry room. It will continue until the code was put into the box to silence the alarm. He said the front door was the only door the wander guards worked. All other doors have the alarm that required a code to silence. He indicated he had turned off the alarm when he had seen a staff member sitting outside in the past. During an interview on 10/28/13 at 6:10 PM, Aide #2 indicated she was aware Resident #1 had made previous elopement attempts. On the evening of 10/24/13 between 8:20 -8:25 PM she	F 323		

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F 323	Continued From page 10 and Aide #1 were coming off of break from the break room behind the nursing station, and Aide #3 was going on break. She indicated she heard the 300 hall alarm go off, she looked down the hall and saw laundry aide #2 come out of the laundry room and go to the door and turn off the alarm. Aide #2 said " I assumed he had looked to see who had gone outside. Aid #1 and I continued to work on the upper hall between 8:35 PM and 8:40 PM. We observed 3 call lights on the lower hall. (Aide #1) went into (Resident #6 room). He reported he had seen (Resident #1) go toward the exit and the alarm had gone off. (Aide #1) and I put it together and checked (Resident #1) room. We both went outside to check and reported it to (Nurse #1 and Nurse #2) and started to look for (Resident #1). We continued to look until the police took over about 9:20 PM. " During a telephone interview on 10/29/13 at 10:06 PM, laundry aide #2 indicated on 10/24/13 he was working for laundry aide #1 who was on vacation. The laundry room was divided into two areas the washer and dryer area and the folding area. The alarm was audible in the folding area. He indicated he came from the washing area to the folding area and heard the alarm. He came out of the laundry room, looked down the hall and saw two nurses sitting at the nursing station. He looked outside to see if he saw anyone. It was dark and he didn ' t see anyone. He disengaged the alarm and went back to work. He indicated the door was used heavily by staff to go out to smoke, for deliveries, and by housekeeping. He said he left at approximately 9:15 PM and was not aware a resident was missing until he was called by the administrator at 10:00 PM. He had no in-service on elopement with the facility until after the elopement.	F 323		

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F 323	Continued From page 11 During an interview 10/29/13 at 10:54 AM, the Administrator indicated he had worked the evening of 10/24/13 as the customer care liaison which entailed the 7:00 PM smoke break. Resident #1 was at the smoke break. He indicated 5 of the doors required staff to enter a code to silence the alarm once activated upon opening the door . If the door did not latch completely it would begin to alarm after 30 seconds, until the code was entered again. He indicated he had called laundry aide #2 and asked him if he had silenced the door alarm that night. The laundry aide said yes he had silenced the alarm and had looked outside to see if anyone had left. Resident # 6 was identified by the facility as reliable and interviewable. Review of the MDS dated 9/3/13 revealed some long or short term memory deficit. During an interview on 10/29/13 at 11:29 AM, Resident #6 was sitting in his bed at 7:00 PM watching television. He observed, Resident #1 shuffling past his room toward the 300 exit. He heard the door alarm go off and the resident didn ' t return. The alarm continued to sound for at least 30 minutes, which was not uncommon. Unsure of the time, he rang his call bell. Aide #1 answered the call bell, he told the aide what he saw and he gave a description of the resident he saw go toward the door. During an interview on 10/29/13 at 12:04 PM, Director of Nursing (DON) indicated she did not know if everyone knew Resident #1 was at risk for elopement. The DON indicated to prevent Resident #1 from elopement he had placed a wander guard on him. It does not work at the door nearest his room where he had eloped. She	F 323		

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indicated Resident #6 was reliable to interview. She had not interviewed him as part of her investigation.

During an interview on 10/29/13 at 2:24 PM, Nurse #3 indicated she was aware of Resident #1 previous elopement attempts. Resident #1 was a smoker and indicated he wanted to go home. His gait some days was steady and other days he used the hand rail. Smoke breaks lasted approximately 15 minutes. During an observation on 10/29/13 at 2:25 PM of the 300 hall door, the activity intern entered the code to the door and entered into the building and continued down the hall. The door did not latch completely and the alarm sounded. Nurse #3 indicated this was normal she shut the door entered the security code and the door became silent. She indicated the 300 door was used by the housekeepers, and staff who smoked. There was 194 feet from the nurse ' s station down a hall, then a left turn at the corner and 20 more feet to the 300 hall exit door. The exit was not visible from the nursing station.

During an interview on 10/29/13 at 3:02 PM, Aide #3 indicated on 10/24/13 he was assigned to Resident #1. He indicated Resident #1 wasn ' t exit seeking. He was standing at his doorway as usual. Aide #3 stated that night the resident had asked him a couple of times to help his room mate. He indicated the last time he saw resident #1 was at 8:20 PM standing in his room.

During an interview on 10/29/13 at 4:39 PM, Nurse #2 she saw Resident #1 at 7:45 PM at his doorway. Aide #3 was in the shower room giving a shower. She indicated she (Nurse #2) was sitting at the nursing station and did not hear the door alarm. On the night of 10/24/13 at 7:55 PM,

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F 323	Continued From page 13 Aide #1 came and told her Resident #1 was missing. Staff searched for Resident #1 for 10 minutes, and then she called the DON and Administrator, family and the police. It took 2 hours for Resident #1 to be found. During an interview on 10/30/13 at 8:57 AM, Aide #4 indicated she worked on the evening of 10/24/13 on the same hall Resident #1 resided the last time she saw Resident #1 was at 7:00 PM. She was made aware Resident #1 was missing at 8:30 PM. During an interview on 10/31/13 at 10:39 AM, social worker indicated Resident #1 was very depressed that his roommate went out on pass often. He has stated he wanted to go home and he missed his dogs. He had a computer that got a virus from a website and the family elected not to have it fixed. During a telephone interview on 11/6/13 at 12:54 PM, police (canine) officer who located Resident #1 indicated the area was very dark where Resident #1 was found. It was very slippery and he had difficulty navigating the area. Resident #1 was lying on the ground and it looked as though he were making a snow angel in the pine needles. All the pine needles had been removed completely and the dirt was exposed. The temperature was in the 40 degree Fahrenheit range. Resident#1 was not dressed for the weather. He was bleeding and disoriented. Once the search was started it took approximately 20 minutes to locate the resident. The EMS and Rescue had to assist to get him (Resident #1) out of the wooded area. The facility was notified of the Immediate	F 323		

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F 323	Continued From page 14 Jeopardy on 10/30/2013. The credible allegation was accepted on 10/31/2013. Credible Allegation of Compliance for Cary Health and Rehabilitation 1.Resident #1 admitted on 1/14/2013 with diagnoses of Vascular Dementia, history of Multiple CVA, Hyperlipidemia, DM Type 2, HTN, and Depression. Elopement risk assessment completed on 1/15/2013 determined resident was not at risk for elopement. Resident #1 has a BIMS of 14 according to the MDS with an ARD of 7/3/2013 and 9/22/2013. Resident #1 has a BIMS of 15 as of 10/31/2013. On, 8/25/2013 at approximately 9:00 AM, Resident #1 was spotted outside of the building by a Certified Nursing Assistant and was brought back into the building by the staff member. Resident #1 suffered no injuries and his vital signs were stable at that time. Resident had last been visually placed at 0830 at the nurses ' station by a staff nurse. Nurse notified Resident #1 ' s second contact who translated the information to the Responsible Party. Nurse Supervisor notified the Director of Clinical Services. MD was notified of event on 8/25/2013 and a new order was written to place Wanderguard on Resident #1. The Wanderguard was placed on Resident #1 ' s left ankle by Nurse Supervisor. At that time, there was no further exit seeking attempts noted. Visual checks every 30 minutes maintained. Resident #1 's Elopement Risk Assessment was updated along with Resident #1 ' s Plan of Care on 8/25/2013 by the Nurse Supervisor. On 10/24/2013, at approximately 8:45 pm, the alarm on the exit door alarmed at the end of 300 hall, per one Staff Nurse #1 and two Certified Nursing Assistants #1 and #2 scheduled on the	F 323		

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unit at that time. Staff Certified Nursing Assistant witnessed the Housekeeping Supervisor walk from the laundry room toward the door on 300 hall and silence the alarm. At approximately 8:50 pm, per Certified Nursing Assistant #2 stated that the Resident in room 320 stated that a resident had shuffled past his door toward the door on 300 hall just before the alarm sounded. Certified Nursing Assistant #2 said that Resident #1 immediately came to mind and notification was made to Resident #1 ' s assigned Nurse #1, and a search for Resident #1 began at approximately 8:55 PM. Nurse #2 on unit got the elopement kit which contains flash lights, floor plan of the building for systematic checks, walkie talkie for each of the four leaders of the teams, whistles, magnetic check marks for placing on the doors of rooms to indicate areas already checked during the search process. Staff members on duty searched the interior and the exterior of the facility. Per Nurse #1, at approximately 9:02pm, notification was made to the Director of Clinical Services, local police and Resident #1 ' s Responsible Party. The Director of Clinical Services notified the Executive Director of the facility at approximately 9:03 PM. Both the Director of Clinical Services and the Executive Director immediately made their way to the building upon notification. At approximately 9:10 PM and Nurse #1 provided a description of Resident #1 as well as a picture from the elopement book. Facility staff continued their searching of the building. Then the police brought in K-9 dogs to aide in the search for the resident. At 9:23 PM the Director of Clinical Services notified the Regional Director of Clinical Services of the events surrounding Resident #1. At approximately 10:05 PM, Resident #1 was found by the police about 135 feet from the 300

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hall exit door in the wooded area behind the parking lot. Resident #1 had fallen down in the wooded area. Upon assessment by the EMS, there was a noted abrasion to Resident #1 ' s head, but there were no complaints of pain and vital signs were within normal limits. First aide was provided to the abrasion by EMS. Resident #1 was taken to the Emergency Room for further evaluation and treatment.
At approximately 9:00 PM a whole house check to account for all residents was begun.
· The residents at risk for elopement were checked for the placement of the wanderguard.
· All residents were accounted for.
· All wander guard devices were present for the residents assessed as at risk for elopement. All were checked for function on 10/24/2013.
· The elopement books that are located at each nurse ' s station and the front desk were checked for complete information on all residents at risk for elopement.
· All exit door alarms were assessed for function. All alarms were functioning properly.
At approximately 1:15am on 10/25/2013, Resident #1 returned to the facility from the ER with no new orders. The resident denied any pain. Resident #1 was settled into bed with every 15 minute checks that began at that time.
At approximately 3:30 pm on 10/31/2013, the MD gave a verbal order to have the wanderguard removed from Resident #1. Resident #1 will have a 1:1 staff member assigned to him until the time of his discharge to ensure that he understands the need to sign out of the building if he chooses to leave and to accompany him if he exits the building to ensure his safety. The Director of Clinical Services and/or Executive Director will ensure that the 1:1 is assigned every shift by approving the schedule the day before the

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F 323	Continued From page 17 assignment. The staff members assigned will be listed on the assignment sheet as dedicated to Resident #1 each shift. 2.On 10/30/2013 all other residents who have been assessed as at risk for elopement were reviewed for the appropriateness of wanderguard placement as related to cognition using the Brief Interview for Mental Status (BIMS). This criterion is a BIMS score of 12 or less as indicated by the MDS scale in order to be considered cognitively impaired. On 10/30/2013 all current residents were re-evaluated using the elopement risk assessment form to identify any other resident at risk for elopement. This will be done on admission/re admission, quarterly and with significant change. The assessment will be completed by a licensed staff nurse. The form consists of 7 yes or no questions with an answer to questions 4, 5, or 6 automatically placing the resident at risk. 1. Is the resident cognitively impaired? 2. Is the resident independently mobile (ambulatory or wheel chair)? 3. Does the resident have poor decision-making skills? 4. Has the resident demonstrated exit seeking behavior? 5. Does the resident wander oblivious to safety needs? 6. Does the resident have a history of elopement? If yes, # of times, if known:____ 7. Does the resident have the ability to exit the facility? The re-education of the staff for the elopement process was begun by the Director of Clinical Services and Executive Director for all individuals who work in the building as soon as the resident was secured. The re-education was continued by	F 323		

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F 323	Continued From page 18 the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Regional Director of Human Resources, and Regional Director of Clinical Services. The education included: · When a door alarm is sounding and the cause of the alarm is not identifiable, the expectations are to exit the facility to search to identify the cause of the alarm in the surrounding. · If the source of the alarm is not identified, immediate head count of the residents is to be done. · If a resident is determined to be missing, the elopement protocol begins. An over head announcement is made " (resident) is looking for room (resident room number) three times over head. · At that time the building is divided into 4 teams. Each team is provided with a whistle and a walkie talkie. 1 team is assigned the outside search of the property; the other teams are searching the interior of the building. The floor plan of the building is used to assign the teams areas of the building to search. A check mark magnet is placed outside of any are that has been completely searched. · If the resident has not been located within 10 minutes of the initial page, the Executive Director, Director of Clinical Services, police, and responsible party are to be notified while the searching continues. 100% of all current employees were re-educated by 10:00 pm on 10/25/2013, including contracted employees. Those not educated by that time were removed from the schedule until they could be re-educated prior to the start of their next scheduled shift.	F 323		

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Per facility policy, all new employees receive elopement training during orientation prior to working an assignment. All contracted employees will also have this done prior to their first assignment.
On 10/30/13 the Executive Director and Director of Clinical Services were re- educated by the Vice President of Clinical Services concerning the expectations when an elopement occurs. This includes the reporting requirements within the corporation, the investigation scope, and the interventions to be implemented.
On 10/30/3013 the incident log was reviewed to ensure that no other elopement occurred that was not investigated. There were no other elopements listed.
On 10/30/13, the Social Worker for Resident # 1 called for a Care Plan meeting with the resident ' s family, the interdisciplinary team, the MD, and the Ombudsman. The invitations were extended at 5pm on 10/30/2013 to have a meeting on 10/31/2013 at a time convenient to the attendees.
On 10/31/2013, the family of Resident #1 arrived to attend a care plan meeting with the resident. The root cause of Resident #1 exit seeking behavior is his expectation and desire to be living at home with his family. The family was informed of the resident ' s BIMS indicating that he is cognitively intact. The meeting focused on the need to find a setting that he found acceptable with specific goals to be set leading to more time spent at home. The decision was made during the meeting to present options for an appropriate setting at an appropriate level of care per the most recent FL2 closer to home to act as a bridge to home. The BIMS was repeated today with a score of 15. The MD has given a verbal order for the cessation of wanderguard placement.
Resident #1 has been evaluated and treated by

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psychiatric services since admission and will continue under psychiatric care. Resident#1 will be on 1:1 while in the building to ensure the resident ' s safety. This will continue until discharge.
On 10/31/2013 a lap top which had been ordered for activities has arrived and been connected to the internet which will be available to Resident #1 to check out as he wishes for his entertainment. Resident #1 has also been showed where the piano is located and he has been playing the piano.
3.Beginning 10/25/2013, the facility conducted elopement drills by the Executive Director/Director of Clinical Services/Assistant Director of Nursing/ Maintenance Director every shift for 10/25/2013, 10/26/2013, and 10/27/2013, then daily x 7 days beginning 10/28/2013, ý2 x week for 3 weeks, then weekly for ý4 weeks to ensure staff response is appropriate. Appropriate response will be demonstrated by all alarms being responded to by staff upon sounding and determining the cause of the alarm. This will be documented on the Quality Improvement (QI) monitoring tool for Elopement Drills. Elopement drills will be conducted quarterly each shift pattern as scheduled according to the facility policy and procedure.
All wanderguard devices will be checked for placement of the device on the resident at risk every shift and will have function of the device checked every day. This will be the responsibility of the staff nurse assigned to the resident. This will be documented on the MAR.
All residents identified as at risk for elopement have behavior monitoring sheets that include target behavior identification of exit seeking and verbalization of exiting the facility. The behavior monitoring tool has non pharmacological

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F 323	Continued From page 21 interventions that are listed to be used if behavior arises. 4.An Ad-Hoc Quality Assurance Performance Improvement (QAPI) meeting was held at 3:30 pm on 10/25/13, by the Executive Director with members of the Interdisciplinary Team. At that time, the interventions and plan for correction from the elopement on 10/24/2013 were reviewed. The Interdisciplinary Team members accepted the plan that included the re-education of all employees, ongoing drills schedule as listed above, and the monitoring tools to be used. The Executive director will report the findings of the QI monitoring tool to the QAPI committee monthly for review and recommendations. 5.Allegation of Compliance is 10/31/2013 Validation of the facility's credible allegation was conducted on 11/1/13. Resident #1 was observed to have 1:1 staffing on all shifts. The facility had provided to him a computer at no cost for his use. The staffing schedule was reviewed to ensure dedicated staffing was scheduled for all shifts. Review of the assessment of resident's who were at risk for elopements were reviewed. Documentation was reviewed of all in-serviced education on the elopement process. Staff were interviewed to ensure they were aware of the procedure when the door alarm was sounding. All employees who were interviewed were able to verbalize correctly the elopement procedures. Elopement kits were updated, with complete and accurate information.	F 323		