STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345561	A. BUILDING _____ B. WING _____	06/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

(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 483.20 (F 278) at J The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. 483.20 (F 280) at J The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. 483.20 (F 282) at J The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. 483.25 (F 323) at J The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. 483.75 (F 529) at J The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge.	F 000		
F 278 SS=J	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		

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

Electronically Signed

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F 278	Continued From page 1 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain an accurate Minimum Data Set (MDS) for a cognitively impaired wandering resident who had known exit-seeking behaviors for 1 of 2 sampled residents (Resident #147). Findings included: The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. Immediate jeopardy was identified on 06/24/16 at 3:20 PM. Immediate jeopardy is present and ongoing. Findings included: Review of the Elopement/Wandering Risk Review dated 04/02/16 revealed Resident #147 had cognitive impairment with poor decision making. Resident #147 wandered aimlessly and ambulated independently. Resident #147's family had expressed concerns that indicated that	F 278		

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F 278	Continued From page 2	F 278		

Resident #147 had wandering tendencies or may try to leave the facility. Resident #147 was deemed to be at risk for wandering as evidenced by poor safety awareness, decreased memory retention, and verbalizations of desire to leave without supervision. Interventions to prevent elopement included frequent monitoring, medication review, wanderguard bracelet placement to the left lower extremity, and to make sure staff were aware of Resident #147's wandering risk.

Review of the Physicians Telephone orders dated 04/02/16 showed an order for a wanderguard bracelet to be placed on Resident #147 for the prevention of elopement. The wanderguard bracelet's function was to be checked every shift.

Review of the Elopement/Wandering Risk Review dated 04/05/16 revealed Resident #147 was cognitively impaired with poor decision making skills and wandered aimlessly while ambulating independently in the facility. Resident #147 had a history of eloping from home, leaving the facility without needed supervision and leaving the facility without informing staff. Resident #147 had expressed the desire to go home and was not accepting of the situation. Resident #147 received medications that increased restlessness and/or agitation. Resident #147 expressed the desire to go home. Resident #147 was deemed to be at risk for elopement/wandering as evidenced by frequent wandering in the afternoons. No interventions were noted.

Review of Resident #147's Annual Minimum Data Set (MDS) dated 04/08/16 showed Resident #147 was admitted on 04/20/15 with diagnoses of anxiety disorder, psychotic disorder, depression and dementia. Resident #147 had short and long term memory problems and was severely impaired in cognitive skills for daily decision

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F 278	Continued From page 3 making. The assessment showed resident #147 did not wander. Review of the 7:18 PM Nursing Departmental Notes dated 04/19/16 revealed Resident #147 was found out the front door across the parking lot in the grass with her walker, starting to climb the hill. The alarm was going off. Another resident's family called (on the telephone) and alerted the staff that Resident #147 was outside. The wanderguard bracelet was in place on the right ankle. Resident #147 stated the door opened and she walked through and she didn't do anything wrong. Resident #147 had been noticed 10 minutes before walking in the hall between the end door and the dining area. In an interview on 06/24/16 at 6:15 PM the Director of Nursing (DON) stated it was her expectation that the MDS nurses would update resident information during the assessment period. She indicated she expected assessments to be done accurately. In an interview on 06/24/16 at 7:40 PM the Administrator indicated she expected information to be disseminated appropriately, carried out correctly and documented. The Administrator was notified of the immediate jeopardy at 10:40 AM on 06/29/16.	F 278		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280		

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F 280	Continued From page 4 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to update an inaccurate care plan for a cognitively impaired wandering resident who had known exit-seeking behaviors for 1 of 2 sampled residents (Resident #147). Findings included: The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. Immediate jeopardy was identified on 06/24/16 at 3:20 PM. Immediate jeopardy is present and ongoing. Findings included: Review of the Physician's Telephone orders dated 04/02/16 showed an order for a wanderguard bracelet to be placed on Resident #147 for the prevention of elopement. The wanderguard bracelet's function was to be checked every shift. Review of Resident #147's Annual Minimum Data Set (MDS) dated 04/08/16 showed Resident #147 was admitted on 04/20/15 with diagnoses of anxiety disorder, psychotic disorder, depression and dementia. Resident #147 had short and long term memory problems and was severely	F 280		

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F 280	Continued From page 5	F 280		

impaired in cognitive skills for daily decision making. The assessment showed resident #147 did not wander.
Review of Resident #147's Care Plan (CP) with a problem onset date of 04/15/16 showed Resident #147 had a wanderguard bracelet due to exit seeking behaviors at times. The goal was to have no attempts to exit the building through the next review. Interventions included: Wanderguard bracelet in place, staff to monitor the function of the wanderguard bracelet and to change the batteries as needed, place resident in the elopement risk book, and educate staff on the risk for elopement.
Review of the 7:18 PM Nursing Departmental Notes dated 04/19/16 revealed Resident #147 was found out the front door across the parking lot in the grass with her walker, starting to climb the hill. The alarm was going off. Another resident's family called (on the telephone) and alerted the staff that Resident #147 was outside. The wanderguard bracelet was in place on the right ankle. Resident #147 stated the door opened and she walked through and she didn't do anything wrong. Resident #147 had been noticed 10 minutes before walking in the hall between the end door and the dining area.
In an interview on 06/23/16 at 7:19 PM the Environmental Services Manager stated when the wanderguard bracelets came within one month of the expiration date the bracelet was sent back to the manufacturer for replacement. He indicated battery changes were not performed by the facility.
In a follow-up interview on 06/24/16 at 6:15 PM the DON stated the MDS/CP nurses should update a CP. The DON verified it was not the process in the facility to change batteries in the wanderguard bracelets. The bracelets were sent

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F 280	Continued From page 6 back to the manufacturer for battery changes. She indicated she expected a CP to be individualized and felt the intervention regarding the staff changing the batteries was a "canned" statement that had just not been removed. The Administrator was notified of the immediate jeopardy at 3:30 PM on 6/24/16.	F 280		
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to follow the Care Plan for a cognitively impaired wandering resident who had known exit-seeking behaviors for 1 of 2 sampled residents (Resident #147). Findings included: The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. Immediate jeopardy was identified on 06/24/16 at 3:20 PM. Immediate jeopardy is present and ongoing. Findings included: Review of the Physician's Telephone Orders dated 04/02/16 showed an order for a wanderguard bracelet to be placed on Resident #147 for the prevention of elopement. The wanderguard bracelet's function was to be checked every shift. Review of Resident #147's Treatment Administration Record (TAR) and for	F 282		

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04/02/16-04/22/16 revealed placement was being checked every shift. There was no documentation that the wanderguard bracelet's expiration date was being checked.
Review of Resident #147's Annual Minimum Data Set (MDS) dated 04/08/16 showed diagnoses of anxiety disorder, psychotic disorder, depression and dementia. Resident #147 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The assessment showed resident #147 did not wander.
Review of Resident #147's Care Plan (CP) with a problem onset date of 04/15/16 showed Resident #147 had a wanderguard bracelet due to exit seeking behaviors at times. The goal was to have no attempts to exit the building through the next review. Interventions included:
Wanderguard bracelet in place, staff to monitor the function of the wanderguard bracelet and to change the batteries as needed, place resident in the elopement risk book, and educate staff on the risk for elopement.
Review of the 04/20/16 Action Plan, designed in response to Resident #147's 04/19/16 elopement, revealed documentation that the transmitter in the resident's wanderguard bracelet had an expiration date of February 2016.
In a telephone interview on 06/24/16 at 12:18 PM the wanderguard bracelet manufacturer stated that although the batteries should be good for 12-15 months, they should be returned by the eleventh month for refurbishment. He indicated a tester was available for the facility so they could monitor the functionality of the bracelets.
Review of the 7:18 PM Nursing Departmental Notes dated 04/19/16 revealed Resident #147 was found out the front door across the parking lot in the grass with her walker, starting to climb

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F 282	Continued From page 8 the hill. The alarm was going off. Another resident's family called (on the telephone) and alerted the staff that Resident #147 was outside. The wanderguard bracelet was in place on the right ankle. Resident #147 stated the door opened and she walked through and she didn't do anything wrong. Resident #147 had been noticed 10 minutes before walking in the hall between the end door and the dining area. In an observation on 06/23/16 at 7:12 PM the Environmental Services Manager (ESM), who was not employed by the facility during April was able to show that the expiration date was inscribed on the wanderguard bracelet. The date was very difficult to visualize. In an interview on 06/23/16 at 7:15 PM Nurse #4 stated nurses checked the placement of the wanderguard bracelet every shift. She indicated they only checked that the bracelet was on the resident. They did not check for the expiration date or if the battery was working. In an interview on 06/23/16 at 7:19 PM the ESM stated when the wanderguard bracelets came within one month of the expiration date the bracelet was sent back to the manufacturer for replacement. He indicated battery changes were not performed by the facility. In an interview on 06/24/16 at 6:15 PM the DON stated she expected the nurses to follow the CP. In an interview on 06/24/16 at 7:40 PM the new Administrator stated any information regarding the residents should be carried out correctly and documented. The Administrator was notified of the immediate jeopardy at 3:30 PM on 06/24/16.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews the facility failed to measure and record the weekly size and description of two pressures ulcers for 1 of 4 residents (Resident #1) who was reviewed for pressure ulcers.
Findings included:
Review of Resident #1's Quarterly Minimum Data Set (MDS) dated 04/01/16 revealed a readmission date of 03/22/16 and diagnoses of peripheral vascular disease, Multiple Sclerosis, and depression. Resident #1 was severely cognitively impaired and did not reject care. The MDS showed Resident #1 had one stage 4 pressure ulcer.
Review of the Physician's Orders dated 03/30/16 showed an order to cleanse the right ischium (hip) with Normal Saline, pack with silver alginate (a highly absorbent dressing), and cover with a foam dressing three times each week.
Review of Resident #1's Care Plan updated 03/31/16 revealed a stage 4 pressure ulcer to the right hip. Interventions included to complete weekly skin documentation with measurements and wound narrative.
Review of the Physician's Orders dated 05/25/16 showed an order to apply skin prep (forms a

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protective film) to the left foot pad/great toe and cover with a dressing daily.
Review of the Wound Assessment Report dated 05/25/16 for Resident #1's right hip showed the wound was a stage 4 pressure ulcer. The measurements of the wound were 3cm x 1 cm x 0.5 cm (centimeters). There was 30% granulation tissue (new vascular tissue) and 70% slough (dead tissue) in the wound. No further weekly measurements or descriptions completed by staff were found for the wound. Weekly measurements and descriptions were missing for the weeks of 06/01/16, 06/08/16, 06/15/16 and 06/22/16.
Review of the Wound Assessment Report dated 05/25/16 for Resident #1's left foot pad showed the wound was a stage 2 pressure ulcer. The measurements of the wound were 0.7cm x 0.5cm. There was 100% eschar (thick, leathery, devitalized tissue) in the wound. No further weekly measurements or descriptions completed by staff were found for the wound. Weekly measurements and descriptions were missing for the weeks of 06/01/16, 06/08/16, 06/15/16 and 06/22/16.
A wound care observation/interview was done on 06/23/16 at 8:00 AM. Wound care for Resident #1's right hip and left foot pad were observed. When removed, the right hip wound dressing had brownish drainage. The wound bed was dark pink with a small area of white scar tissue located at 10 o'clock on a clock face. The tissue surrounding the wound was dark pink. The left foot pad area was noted to be reddened with two small, dark/black spots. The area was not open and there was no scab over the wound. Nurse #6 stated she did not measure or assess Resident #1's wounds.
In an interview on 06/23/16 at 6:00 PM the

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F 314	Continued From page 11 Director of Nursing (DON) stated Nursing Supervisor #1 usually obtained the wound measurements. She indicated Nursing Supervisor #1 had been reassigned as a hall nurse and was not taking measurements or assessing Resident #1's wounds. When asked who should have been taking measurements and assessing the wounds in place of Nursing Supervisor #1, the DON stated she was the one who should have been doing it and she had not.	F 314		
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 observation, record review, service representative and manufacturer interviews, and staff interviews the facility failed to supervise a cognitively impaired wandering resident who had known exit-seeking behaviors. The facility also failed to monitor the expiration date of the wanderguard bracelet which had expired in February 2016 for 1 of 2 sampled residents (Resident #147). Findings included: The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. Immediate jeopardy was identified on 06/24/16 at 3:20 PM. Immediate jeopardy is present and ongoing. Findings	F 323		

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included:
Review of the Elopement/Wandering Risk Review dated 04/02/16 revealed Resident #147 had cognitive impairment with poor decision making. Resident #147 wandered aimlessly and ambulated independently. Resident #147's family had expressed concerns that indicated that Resident #147 had wandering tendencies or may try to leave the facility. Resident #147 was deemed to be at risk for wandering as evidenced by poor safety awareness, decreased memory retention, and verbalizations of desire to leave without supervision. Interventions to prevent elopement included frequent monitoring, medication review, wanderguard bracelet placement to the left lower extremity, and to make sure staff were aware of Resident #147's wandering risk.
Review of the Physician's Telephone Orders dated 04/02/16 showed an order for a wanderguard bracelet to be placed on Resident #147 for the prevention of elopement. The wanderguard's function was to be checked every shift.
Review of Resident #147's Treatment Administration Record (TAR) dated 04/02/16-4/21/16 revealed the times the wanderguard (bracelet) should be checked were 8:00 AM and 8:00 PM. For the 8:00 AM checks there was one box that was not initialed by the nurse. (Initials in the box signified the order was done.) For the 8:00 PM shift there were 10 boxes with missing initials.
Review of the Daily Wanderguard Checklist (utilized by the former maintenance manager to document functionality of resident and front door wanderguard alarms) revealed documentation was missing for 04/08/16 through 04/21/16.
Review of the Elopement/Wandering Risk Review

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE/FUQUAY-VARINA	410 S JUDD PARKWAY SE FUQUAY VARINA, NC 27526

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dated 04/05/16 revealed Resident #147 was cognitively impaired with poor decision making skills and wandered aimlessly while ambulating independently in the facility. Resident #147 had a history of eloping from home, leaving the facility without needed supervision and leaving the facility without informing staff. Resident #147 had expressed the desire to go home and was not accepting of the situation. Resident #147 received medications that increased restlessness and/or agitation. Resident #147 expressed the desire to go home. Resident #147 was deemed to be at risk for elopement/wandering as evidenced by frequent wandering in the afternoons. No interventions were noted.

Review of Resident #147's Annual Minimum Data Set (MDS) dated 04/08/16 showed an admission date of 04/20/15 and diagnoses of anxiety disorder, psychotic disorder, depression and dementia. Resident #147 had short and long term memory problems, and was severely impaired in cognitive skills for daily decision making. The assessment showed resident #147 did not wander.

Review of the 12:49 PM Nursing Departmental Notes dated 04/14/16 revealed an interdisciplinary team (IDT) meeting was held, and it was decided to keep Resident #147's wanderguard bracelet in place.

Review of the 5:49 PM Nursing Departmental Notes dated 04/14/16 revealed Resident #147 was wandering and looking for food and money.

Review of the 8:02 PM Nursing Departmental Notes dated 04/15/16 showed Resident #147 met up with another resident earlier in the day, and began exit seeking with her.

Review of Resident #147's Care Plan with a problem onset date of 04/15/16 showed Resident #147 had a wanderguard bracelet due to exit

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seeking behaviors at times. The goal was to have no attempts to exit the building through the next review. Interventions included: Wanderguard bracelet in place, staff to monitor the function of the wanderguard bracelet and to change the batteries as needed, place resident in the elopement risk book, and educate staff on the risk for elopement.
In a telephone interview on 06/24/16 at 11:30 AM the service representative for the wanderguard alarm system stated on 04/15/16 the facility asked him to evaluate and assess the system because it was taking the front doors longer to lock and alarm when wanderguard residents approached and touched them. The service representative reported he found nothing wrong with the actual system or the front doors, but shared with the former administrator and former maintenance manager that the resident being used to check the system had a weak transmitter/battery in the wanderguard bracelet.
Review of the 4:45 PM Nursing Departmental Notes dated 04/18/16 revealed Resident #147 was restless and looking for a way to go home.
Review of the 7:18 PM Nursing Departmental Notes dated 04/19/16 revealed Resident #147 was found out the front door across the parking lot in the grass with her walker, starting to climb the hill. The alarm was going off. Another resident's family called (on the telephone) and alerted the staff that Resident #147 was outside. The wanderguard bracelet was in place on the right ankle. Resident #147 stated the door opened, she walked through, and she didn ' t do anything wrong. Resident #147 had been noticed 10 minutes before walking in the hall between the end door and the dining area.
In an interview on 06/23/16 at 3:37 PM Nurse #1 who was Resident #147's nurse on 04/19/16

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stated the resident had a wanderguard bracelet in place. She reported the transmitter in the bracelet was supposed to make the door lock so a resident could not exit. She commented if a resident did get out the door the alarm would sound. She indicated the front lobby doors did not lock, and Resident #147 was able to exit the building. Nurse #1 stated the nursing station doors were required to be kept closed and the alarms could not be heard inside the station. She indicated she had seen Resident #147 in the hall looking out the door by her room 10 minutes prior to finding out the resident was outside, and did not know she had left the unit.

In a telephone interview on 06/23/16 at 5:19 PM Nursing Assistant (NA) #1 who assisted with bringing Resident #147 back inside after the elopement on 04/19/16, stated when she went to assist other staff with Resident #147 the alarm was not sounding. She indicated that normally she could hear the alarm because it was very loud. She indicated even if she were in a room with a closed door she would have been able to hear the alarm. She indicated she was not aware the resident was not on the unit.

In a telephone interview on 06/23/16 at 5:23 PM NA #2 stated she was passing dinner trays on the hall on 04/19/16 when the telephone rang at the nursing station. She answered the telephone, and was told there was a resident outside the building. She reported she dropped the phone, and ran down the hall and out the door next to the Director of Nursing ' s (DON) office. NA #2 stated she was the first staff member outside. She indicated she did not remember an alarm sounding, but was focused on getting to the resident so she was not sure. She stated the lobby doors were supposed to lock so no one could open them, and if they were locked, it would

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have been impossible for Resident #147 to open them.
In an interview on 06/23/16 at 6:00 PM the DON stated it was her expectation that residents did not get out of the building. She indicated the front doors should have locked, and if the front doors were touched the alarm should have sounded. She stated wanderguard bracelets had been checked and Resident #147's had been found to be weak. She stated a new wanderguard bracelet had been placed on Resident #147 after the elopement.
In an observation on 06/24/16 at 2:30 PM the path out the front lobby doors was hard top to a six inch curb. On the other side of the curb was a hilly, grassy area. A busy road was on the other side of the grassy area.
Resident 147's Care Plan was updated on 04/19/16, and documented Resident #147 had been found outside the building in the parking lot. The goal was to have no further attempts to exit the building through the next review. Added interventions included: 1:1 observation for 24 hours, wanderguard bracelet expiration date checks every shift, and to seek placement in a secure unit due to the resident ' s continuous exit-seeking behaviors.
Review of the Action Plan dated 04/20/16 revealed all residents with wanderguard bracelets had their bracelets exposed to the front door, and none set off the locks on the doors. For the remainder of the night, the residents were kept in line of vision until they went to bed. They were checked frequently throughout the night. At 8:30 AM the next day the front desk was constantly manned to prevent any resident with a bracelet from walking through the door. The plan documented the wanderguard installer was contacted on 02/20/16 (04/20/16) to test and

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repair the system. The work was completed by 5:00 PM. The bracelet on resident #147 was noted to have an expiration date of February 2016. To prevent the incident from happening in the future the facility continued to check the wanderguard doors and bracelets daily for functionality. The expiration date was to be checked daily. The wanderguard testing documentation would be submitted to the Director of Nursing weekly for review. The DON was to monitor resident elopements and report to the Quality Assurance Committee monthly. The previous Administrator created the Action Plan and listed the date of repair of the system as 02/20/16 (04/20/16). (In interviews with current staff and the wanderguard alarm system service representative no one was aware of any problems/repairs of the actual front door alarm system). The DON revealed on 06/24/16 at 6:15 PM she had never seen the Action Plan and the QA book was missing.

Review of the undated In-service for (Resident #147) which was also part of the action plan showed all wanderguard bracelets would be checked for placement daily by the nurse. The expiration dates would be placed on the wanderguard bracelets and the Medication Administration Record (MAR). Residents who appeared to be wander seeking needed to be reported to the nurses immediately. If a wanderguard bracelet was placed on a resident there needed to be an order, the MDS nurses should be made aware so it could be care planned and the wanderguard bracelet list should be updated. The wanderguard alarm was now wired at the nurse ' s station to alarm anytime a resident was near or trying to exit the front door. Response to the alarm was to be immediate if heard.

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F 323	Continued From page 18 In an interview on 06/23/16 at 7:00 PM the DON provided a list of current residents who wore wanderguard bracelets. There were two residents on the list. Review of the April, May and June TAR's for these residents revealed that one of the two did not have the expiration date of the wanderguard bracelet documented. Review of the Physician's Telephone Orders dated 04/21/16 revealed a new order to change the placement of Resident #147 ' s wanderguard bracelet to the right wrist. Review of the Nursing Departmental Notes dated 04/22/16 showed Resident #147 was discharged to a memory care unit in a nearby town. In an interview and observation on 06/23/16 at 4:20 PM the Environmental Services Manager (ESM) stated the front door was the only door on the wanderguard alarm system. The other doors leading outside were kept locked except for the courtyard doors which allowed residents to sit outside safely in an enclosed area. He reported he used a tester to check and make sure the wanderguard bracelets used by the residents were functioning. He stated he used a spare transmitter to test the functioning of the wanderguard alarm system at the front doors. He stated when a resident with a wanderguard bracelet got down the hallway to the foyer doors leading to the lobby the front doors would lock automatically. The EMS manager stated it would take a lot of continuous pressure on the push bars to open the front doors once locked. He indicated the alarm would sound when the front doors were opened and the threshold was crossed by a resident wearing a wanderguard. The ESM commented there was an alarm box in each nursing station, and the front door alarm sounded in each station. He indicated he did	F 323		

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weekly rounds to check the wanderguard alarm in the lobby. The ESM provided a tour of the nursing stations to describe the alarm system. Station 1's alarm box was mounted high on the wall and 6 bulbs were seen. Each bulb was labeled unit 1 through unit 6. There was a sign posted below the alarm that indicated which light corresponded to which door. For example, unit 1= 100 hall door. Station 2 had the same alarm box labeled unit 1 through unit 6 and also had a sign posted below it. However, these alarms were for 6 different doors. For example, unit 1= front lobby. Station 3 had the same alarm system but no sign was noted telling which light corresponded with which door. A test was conducted by the ESM and it was discovered that the lobby door alarm did not ring in all the nursing stations. It only rang in Station 2.

In an observation on 06/23/16 at 6:10 PM the DON escorted a resident wearing a wanderguard bracelet to the foyer doors and opened them. The front doors locked automatically.

In an observation on 06/23/16 at 6:24 PM the front door alarm system was activated by the ESM. At 6:29 PM two nurses entered the lobby to check the alarm. Nurse #1 indicated Station 1 had received a telephone call from Station 2 that the unit 1 alarm was sounding. The nurses immediately came down to check the alarm because they knew that unit 1 in station 2 was the lobby alarm.

In an interview on 06/23/16 at 6:32 PM Nurse #2 stated she was in a room and heard an alarm sounding but did not know where it was coming from (during the test that day). She looked at the alarm box and saw the unit 1 light was on so she called unit 1 (station 1) to let them know about the alarm. She stated she did not know unit 1 meant the front doors.

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F 323	Continued From page 20 In an interview on 06/23/16 at 6:35 PM Nursing Supervisor #1 stated it had been reported to her that Resident # 147 had eloped from the building. She indicated she was told all the residents who had wanderguard bracelets were checked for placement and functionality but she had not done this herself. The Nursing Supervisor commented that the front doors should lock down when activated by wanderguard transmitters and the alarm should sound if the door does got opened. She stated this might not happen if the wanderguard bracelet was expired or was weak. She indicated the alarm sounded when a resident was trying to get out of the building. When informed a test of the wanderguard alarm system had been performed by the ESM on 06/23/16 at 6:24 PM, and that it took staff five minutes to answer the wanderguard alarm, she expressed surprise and stated that was too long. She stated a lot could happen to a resident in five minutes including injury, death, or kidnapping. She stated there had been no further elopements from the lobby. In an interview on 06/23/16 at 8:15 PM Nurse #3 stated she did not hear the alarm sound during the test that day. She indicated she did not know if the lobby door alarm sounded in all three nursing stations. She indicated when an alarm sounded she looked at the alarm box to see where it was activated. Nurse #3 stated if the light for unit 1 was lit (front lobby alarm) that meant it was on station 1. In an interview on 06/23/16 at 8:18 PM NA #1 confirmed she had heard the alarm sounding earlier. She thought it was a room alarm and looked on her assignment to see which resident needed assistance. She did not see any room lights on, and did not do anything else about the alarm.	F 323		

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F 323	Continued From page 21 In a follow-up interview on 06/24/16 at 11:01 AM the DON stated the activation distance for the wanderguard alarm was problematic. She indicated if a resident had the wanderguard bracelet on their leg they could get closer to the door before the locks engaged. If the wanderguard bracelet was on the arm the door locks would activate sooner. The DON stated when the lobby doors opened the alarm only sounded in Station 2, and there were no plans to make the alarm sound in all three nursing stations. The DON stated she expected the nurses to respond to alarms in a "timely" manner. She indicated the nurses in Station 2 should have known what the alarm was for and responded to it. In a follow-up interview on 06/23/16 at 7:19 PM the ESM stated when a wanderguard bracelet came close to the expiration date it was sent back to the manufacturer for replacement or refurbishment. He indicated the staff did not change the batteries on the wanderguard bracelets. In a telephone interview on 06/24/16 at 12:18 AM the wanderguard bracelet manufacturer stated that although the batteries should be good for 12-15 months, they should be returned by the eleventh month for refurbishment. He indicated a tester was available for the facility so they could monitor the functionality of the bracelets. The Administrator was notified of the immediate jeopardy at 3:30 PM on 6/24/16.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 356		7/8/16

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F 356	Continued From page 22 o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to post nursing staffing for 4 consecutive days for staff, residents, and visitors in the nursing facility. Findings included: At 9:20 AM on 6/20/2016, an observation of the posted nursing staffing revealed that nursing staffing had not been posted since 6/16/2016. The staff posting displayed on Monday, 6/20/16	F 356	Immediate Action Staffing hours posted immediately after being noted to be out dated on 06/20/2016 by supervisor #1. Identification of Others All current residents are at risk for this alleged non-compliance.	

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F 356	Continued From page 23 was dated for Thursday, 6/16/2016 and there were no sheets available with the staffing for information for 6/17/16, 6/18/16, 6/19/16, and 6/20/16 at that time. At 2:15 PM on 6/20/2016, an observation of the posted nursing staffing revealed that it had been updated to reflect staffing on 6/20/2016. In an interview on 06/24/16 at 6:46 PM with Nurse Supervisor #1, the staff member responsible for posting nursing staffing, she stated that she posted staffing daily after finding out the census and schedule information in the morning meeting. She reported that the Director of Nursing (DON) was the person who would post the staffing in her absence. Nurse Supervisor # 1 reported that staffing was not posted over the weekends, but she would arrive at the facility on Mondays and find out what the census and staffing was for Saturday and Sunday and fill out the sheets so the facility could have them for their records. She only posted staffing for Monday through Friday. At 7:06 PM on 6/24/16, the DON stated that the nursing staff posting was posted daily and the information included the date, resident census, and the number of registered nurses (RNs), licensed practical nurses (LPNs), and certified nursing assistants (CNAs) hours for the day posted. She said that she would be the person to post the staffing when Nurse Supervisor # 1 was not there and that the Administrator would do so if both she and Nurse Supervisor #1 were out. She reported that it was expected that an RN supervisor would do the posting on the weekends. The DON stated that both she and Nurse Supervisor #1 were out on Friday, 6/17/16, and that the previous Administrator would do the	F 356	Systemic changes On 7/6/2016, Regional Clinical Director reviewed and revised the daily "staffing sheet" to include facility name, date, census for each shift, the total number and actual hours for Registered nurses (RNs), Licensed Practical Nurses (LPNs)and Certified Nursing Aides (CNAs) directly responsible for resident care per shift. Regional Clinical Director will educate Nursing administrative staff,DON, ADON, SDC, and supervisor on the proper ways of completing and posting nursing staffing hours on 7/6/2016 & 7/7/2016. This education will put an emphasis on timely completion and posting of nursing hours per regulation. Effective 7/7/2016 nursing administrative staff will start utilizing a revised form. Information will be completed and posted when daily schedule is posted. Census numbers will be altered as changes happens in a daily basis. Evening shift Nurse supervisor will ensure nursing hours for next day is prepared and ready to be posted before the beginning of next day shift. The Director of Nursing or designated staff will be responsible to ensure nursing hours are posted on Monday thru Friday. Weekend Supervisor will be responsible for weekend posting effectively 7/7/2016 Monitoring Process Posted hours will be discussed in Daily stand up meeting by the administrator	

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F 356	Continued From page 24 posting when they were both out, but the new Administrator had not been informed of that expectation. At 7:20 PM on 6/24/16, the current Administrator stated that Nurse Supervisor #1 and the DON were responsible for the staffing postings daily and she was not sure if the DON had delegated who would be responsible for postings in their absence, but as the administrator, she was ultimately responsible for anything that was not being done in the facility. She stated that it would be her expectation that staff posting was done daily including weekends.	F 356	daily x 30 days starting 7/7/2016. Findings will be forwarded to monthly QAPI meeting for further action when necessary.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to air dry kitchenware before stacking it in storage areas, failed to monitor kitchenware to prevent contamination from dried food particles, cracks, and stains, failed to clean the tops of microwaves in auxiliary kitchens, and failed to label and date opened food items. Findings included:	F 371		

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1. During initial tour of the kitchen on 06/20/16, beginning at 10:40 AM, 24 of 30 tray pans stacked on top of one another on a storage shelf had moisture trapped inside of them. At this time a dietary aide stated all these tray pans were washed and stacked the night before.
During a follow-tour of the kitchen on 06/22/16, beginning at 9:03 AM, 12 of 18 tray pans stacked on top of one another on a storage shelf had moisture trapped inside of them. At this time the cook stated all these tray pans were washed and stacked the night before.
At 10:30 AM on 06/23/16 the dietary manager (DM) stated in monthly in-services dietary staff were instructed that kitchenware should be clean and dry before being stacked in storage. She reported moisture trapped in kitchenware which was stacked wet could increase the chance of bacterial formation. She commented this could ultimately lead to residents getting sick.
At 10:48 AM on 06/23/16 a dietary aide stated through in-servicing she learned that kitchenware was to be air dried before it was stacked in storage. She reported moisture trapped in stacked kitchenware overnight increased the chance that residents could get sick from the food.
2. During an inspection of kitchenware on 06/22/16 at 10:04 AM 27% of small china bowls were compromised with 2 of 15 bowls having dark brown stains, and 2 of 15 bowls having dried food particles on interior surfaces. 35% of eight-ounce cups were compromised with 4 of 20 cups having cracks in the bottoms, and 3 of 20 having dark brown stains. 33% of china coffee cups were compromised with 3 of 15 having dried food particles on interior surfaces, and 3 of 15 having dark brown stains. 40% of plastic coffee mugs were compromised with 2 of 15 having

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dried food particles on interior surfaces, and 4 of 15 having dark brown stains.
At 10:30 AM on 06/23/16 the dietary manager (DM) stated stained kitchenware should never be placed in storage. She reported staff were supposed to soak stained kitchenware in a stain-removing solution as it was found so that it was clean and stain-free before being placed in storage. According to the DM, she thought the dietary staff was also supposed to be completing weekly de-staining, but that was questionable due to the amount of stained items and the darkness of the stains found during the 06/22/16 inspection. The DM also stated the dietary staff was instructed to bring cracked and chipped kitchenware to her so that she could count/inventory it and reorder replacements. She reported the dietary aide retrieving sanitized kitchenware from the dish machine was supposed to inspect kitchenware for dried food particles and send contaminated kitchenware back through the dish machine. The DM explained finding dried food particles on kitchenware in storage was unacceptable.
At 10:48 AM on 06/23/16 a dietary aide stated kitchenware was supposed to be de-stained once weekly, but she was unsure when the task was last completed. She reported stained kitchenware was not attractive to residents, and could attract bacteria and accelerate the breakdown of the items. The aide commented she tried to box up cracked and chipped kitchenware so it could not harm residents and staff. She explained she then took it to the DM so she could replace it with new items. According to the aide, kitchenware was supposed to be run back through the dish machine until it was free of food particles which could cause cross-contamination.

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3. Beginning at 10:53 AM during the 06/20/16 initial tour of the auxiliary kitchens on the 100, 300, 400, 600, and 700 halls interior tops of the microwaves in all the kitchens were coated with dried food particles.
At 11:50 AM on 06/22/16 the interior top of the microwave in the 300 auxiliary kitchen was coated with dried food particles.
At 12:12 PM on 06/22/16 the interior top of the microwave in the 600 hall auxiliary kitchen was coated with dried food particles.
At 10:30 AM on 06/23/16 the dietary manager (DM) stated during monthly in-services staff were instructed to clean all interior surfaces of the microwaves at least daily, but preferably after serving each meal. She reported the condition of the interior tops of the auxiliary kitchen microwaves was unacceptable during the 06/20/16 and 06/22/16 observations.
At 10:48 AM on 06/23/16 a dietary aide stated all interior surfaces of the microwaves were cleaned as needed. She reported there should not be dried food particles on the interior tops of the microwaves because these food particles could be loosened during heating of food items, and the dried particles could contaminate fresh foods.
4. During initial tour of the kitchen on 06/20/16, beginning at 10:40 AM, two 42-ounce boxes of rolled oats, a bag of rotini pasta, and a 16-ounce box of corn starch were opened but without labels and dates in the dry storage room. A bag of corn found in the walk-in freezer was opened and also without a label and date.
Beginning at 10:53 AM during the 06/20/16 initial tour of the auxiliary kitchens an opened 32-ounce bag of brown sugar, an opened 4-pound container of grape jelly, a storage container of brown sugar, and three storage containers of cereal were without labels and dates in the 300

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F 371	Continued From page 28 hall kitchen. In the 400 hall kitchen a storage container of brown sugar and a storage container of cereal were without labels and dates. A storage container of cereal in the 700 hall kitchen and three storage containers of cereal in the 600 hall kitchen were all without labels and dates. At 9:20 AM on 06/22/16 an opened 42-ounce container of rolled oats in the dry storage area was without a label and date. At 9:48 AM on 06/22/16 a brown bag of French fries was found opened in the walk-in freezer without a label and date. At 10:30 AM on 06/23/16 the dietary manager (DM) stated she checked storage areas daily to make sure foods in storage areas were labeled, dated, and within the expiration/use-by date. She reported staff were in-serviced about the need to place labels and dates on opened food items and foods removed from their original packaging to ensure the freshest foods were received by residents. She explained labeling and dating helped ensure that the " first in, first out " principle was being followed. At 10:48 AM on 06/23/16 a dietary aide stated opened food items and items removed from original packaging were supposed to be placed in a resealable bag, dated, and labeled. She stated all employees who opened food items or removed them from their original packaging were responsible for going behind themselves to make sure they did not forget to apply labels and dates.	F 371		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to safeguard records resulting in missing documentation and failed to complete an accurate wandering assessment for 1 of 1 sampled residents (Resident #147) whose record was reviewed. Findings included:
Review of Resident #147's Annual Minimum Data Set (MDS) dated 04/08/16 showed an admission date of 04/20/15 and diagnoses of anxiety disorder, psychotic disorder, depression and dementia. Resident #147 had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The assessment showed resident #147 did not wander.
A. Review of the Daily Wandergaurd Checklist (Front Door Only) the facility provided from 03/30/16-04/28/16 revealed the checklists for the dates 04/08/16-04/21/16 were missing.
In an interview on 06/23/16 at 7:19 PM the Environmental Services Manager (ESM) looked through the checklist binder and indicated he was unable to find the checklists for the two weeks in question.
In a follow-up interview on 06/24/15 at 6:02 PM the ESM stated that he safeguards his records by

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never letting them leave his sight. He stated he was not working in the facility during the time period of the missing documentation and did not know what happened to the records.
B. Review of the Elopement/Wandering Risk Review assessment dated 04/05/16 revealed Resident #147 was cognitively impaired with poor decision making skills and wandered aimlessly while ambulating independently in the facility. Resident #147 had a history of eloping from home, leaving the facility without needed supervision and leaving the facility without informing staff. Resident #147 had expressed the desire to go home and was not accepting of the situation. Resident #147 received medications that increased restlessness and/or agitation. Resident #147 expressed the desire to go home. Resident #147 was deemed to be at risk for elopement/wandering as evidenced by frequent wandering in the afternoons. No interventions were noted.
Review of Resident #147's April 2016 Medication Administration Record (MAR) revealed no medications that would have caused increased restlessness and/or agitation. Resident #147 received several medications to help calm restlessness and agitation.
In an interview on 06/24/16 at 6:15 PM, the DON stated she expected assessments to be completed accurately. She indicated she would have expected a nurse who was documenting about medications to review the MAR. The DON reviewed Resident #147's April 2016 MAR and confirmed there were no medications listed that would cause restlessness or agitation.
In a telephone interview on 06/24/16 at 6:38 PM, Nurse #5 verified she had completed the Elopement/Wandering Risk Review dated 04/05/16. She indicated she reviewed Resident

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F 514	Continued From page 31 #147's MAR and felt she must have misread the question. She stated she saw Resident #147 received several medications that would help decrease restlessness and agitation.	F 514		
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop and sustain an effective action plan following the elopement of a	F 520		

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cognitively impaired wandering resident who had known exit-seeking behaviors for 1 of 2 sampled residents (Resident #147). Findings included:
The immediate jeopardy began on 04/19/16 when Resident #147 eloped from the facility without staff knowledge. Immediate jeopardy was identified on 06/24/16 at 3:20 PM. Immediate jeopardy is present and ongoing. Findings included:
Review of the 2016 Staff In-service Attendance Record provided by the Administrator and Maintenance Manager revealed an elopement in-service had been provided to 140 out of 201 listed staff members between 04/05/16 and 04/10/16. An undated Power Point In-service that had been used for the In-service was provided by the facility and reviewed. Titled: Elopement Code Green, it revealed staff were to be aware of where the residents were in the facility, that staff should know the difference in wandering and exit-seeking, and were to immediately report if an individual was exit-seeking. Routine door checks were to be done and any door that did not close was to be reported immediately.
Review of the 7:18 PM Nursing Departmental Notes dated 04/19/16 revealed Resident #147 was found out the front door across the parking lot in the grass with her walker, starting to climb the hill. The alarm was going off. Another resident's family called (on the telephone) and alerted the staff that Resident #147 was outside. The wanderguard bracelet was in place on the right ankle. Resident #147 stated the door opened and she walked through and she didn't do anything wrong. Resident #147 had been noticed 10 minutes before walking in the hall between the end door and the dining area.
Further review of the 2016 Staff In-service

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Attendance Record provided by the Administrator and the Maintenance Manager revealed on 04/22/16 an In-service had been held specifically regarding Resident #147 and was attended by 57 of the 201 listed staff members. The In-Service was provided by the facility and was reviewed. The In-service revealed all wanderguard bracelets would be checked for placement daily by the nurse. The expiration dates would be placed on the wanderguard bracelets and the Medication Administration Record (MAR). Residents who appeared to be wander seeking needed to be reported to the nurses immediately. If a wanderguard bracelet was placed on a resident there needed to be an order, the MDS nurses should be made aware so it could be care planned and the wanderguard bracelet list should be updated. The wanderguard alarm was now wired at the nurse's station to alarm anytime a resident was near or trying to exit the front door. Response to the alarm was to be immediate if heard.

Review of Resident #147's Treatment Administration Record (TAR) dated 04/02/16-4/21/16 revealed there was no expiration date for the wanderguard bracelet listed.

Review of current Resident #124's TAR for April, May and June 2016 showed an order for wanderguard placement for prevention of elopement. There was no expiration date listed for the wanderguard bracelet.

Review of the Action Plan dated 04/20/16 revealed all residents with wanderguard bracelets had their bracelets exposed to the front door, and none set off the locks on the doors. For the remainder of the night, the residents were kept in line of vision until they went to bed. They were checked frequently throughout the night. At 8:30 AM the next day the front desk was constantly

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manned to prevent any resident with a bracelet from walking through the door. The wanderguard installer was contacted on 02/20/16 to test and repair the system. The work was completed by 5:00 PM. The bracelet on resident #147 was noted to have an expiration date of 02/16. To prevent the incident from happening in the future the facility would continue to check the wanderguard doors and bracelets daily for functionality. The plan did not specify who would do the monitoring but did specify that the manufacturers' testing device would be used. The expiration date was to be checked daily and changed as the date arrived. The wanderguard testing documentation would be submitted to the Director of Nursing weekly for review. The DON was to monitor resident elopements and report to the Quality Assurance Committee monthly. The previous Administrator created the Action Plan and listed the date of repair of the system as 02/20/16. The DON revealed on 06/24/16 at 6:15 PM she had never seen the Action Plan and the QA book was missing.

In an interview on 06/23/16 at 3:37 Nurse #1 stated if she was in the nursing station with the doors closed as required by the facility, she was unable to hear the lobby door alarm sounding.

In an observation on 06/23/16 at 6:24 PM the lobby door alarm system was activated by the Environmental Services Manager (ESM). At 6:29 PM two nurses entered the lobby to check the alarm. Nurse #1 indicated they had received a telephone call from Station 2 that the unit 1 alarm was sounding. They had immediately come down to check the alarm because they knew that unit 1 in station 2 was the lobby alarm.

In an interview on 06/23/16 at 6:32 PM Nurse #2 stated she was in a room and heard an alarm sounding but did not know where it was coming

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from (during the test that day). She looked at the alarm box and saw the unit 1 light was on so she called unit 1 (station 1) to let them know about the alarm. She stated she did not know unit 1 meant the front lobby doors.
In an interview on 06/23/16 at 8:15 PM Nurse #3 stated she did not hear the alarm sound during the test that day. She indicated she did not know if the lobby door alarm sounded in all three nursing stations. She indicated when an alarm sounded she looked at the alarm box to see where it was activated. Nurse #3 stated if the light for unit 1 was lit (front lobby alarm) that meant it was on station 1.
In an interview on 06/23/16 at 8:18 PM NA #1 confirmed she had heard the alarm sounding earlier. She thought it was a room alarm and looked on her assignment to see which resident needed assistance. She did not see any room lights on and did not do anything else about the alarm.
In an interview on 06/24/16 at 11:01 AM the DON stated when the lobby doors opened the alarm only sounded in Station 2 and there were no plans to make the alarm sound in all three nursing stations. The DON stated she expected the nurses to respond to alarms in a "timely" manner. She indicated the nurses in Station 2 should have known what the alarm was for and responded to it.
In a follow-up interview on 06/24/15 at 6:15 PM the DON stated she expected the Quality Assurance (QA) recommendations to be followed. She indicated that if they were not aware of the recommendations they could not do them. The DON stated the previous Administrator did not let anyone know about the QA information. She indicated the facility had been unable to locate a large amount of records

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F 520	Continued From page 36 recently. In an interview on 06/24/16 at 7:02 PM the Minimum Data Set/Care Plan nurse indicated the 2016 Staff In-service Attendance Record had been used by the previous Administrator. She indicated the elopement In-services had been mandatory for all staff but the In-Service signature pages were missing. She indicated the previous Administrator shared some information at the time of In-services but not very much. In an interview on 06/24/16 at 7:40 PM the Administrator stated she expected any QA information to be disseminated properly, carried out correctly, and documented. She indicated she felt the QA action plan had not been successful because it lacked follow thru and follow-up. She stated there needed to be repercussions if things were not done. She acknowledged some things had not been done as they should have been. The Administrator was notified of the immediate jeopardy at 3:30 PM on 06/24/16.	F 520		