

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

*Copy of one 11/14/11*

PRINTED: 11/02/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/28/2011
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NAME OF PROVIDER OR SUPPLIER  CHOWAN RIVER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 566 EDENTON, NC 27932
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F 000	<p>INITIAL COMMENTS</p> <p>Per request from the facility during IDR, this Statement of Deficiencies was amended on October 10, 2011. Information from the Minimum Data Set (MDS) with assessment reference date of 11/29/2010 was corrected, and information from the MDS with assessment reference date of 6/24/2011 and the Wandering Risk Assessment of 11/22/2010 was added.</p> <p>F 323 SS=J 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to prevent a cognitively impaired resident from exiting the facility without supervision for 1 of 6 residents with wandering behavior (Resident #1). Findings include: "Facility policy, Quality Improvement Action Team, Monitoring Wandering Residents, dated Version 12/2004 and revised 02/15/05, stated; The purpose of this Action Team is to assist the Administrator and Director of Nursing in the monitoring of residents with high potential for wandering, to monitor that routine equipment checks of wandering prevention devices have been done, and to monitor that appropriate</p>	F 000	<p>Past noncompliance: no plan of correction required.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 8-17-11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>documentation for residents with potential for wandering is in place. This Action Team should review the above documentation and equipment checks and should report to the Administrator the following information:</p> <ol style="list-style-type: none"> <li>1. Compliance with equipment checks of alert bracelets that are applied to wandering residents and the outcome of those equipment checks.</li> <li>2. Newly admitted residents have been assessed using the Wandering Risk Assessment tool and that residents identified as being at high risk for wandering have had an alert bracelet applied to the resident's ankle or other part of the body, if applicable.</li> <li>3. Door alarms have been checked by the Maintenance Director or designee on a routine basis for proper operation."</li> </ol> <p>The Nursing Policy Manual (Version 04/2007) page 38 under Missing Resident stated: "It is the policy of the facility that in order to prevent possible injury or death to a missing resident, the facility will provide an organized and systemic method for locating the resident. In the event a resident is identified as missing from their unit, employees will begin a search immediately."</p> <p>Resident #1 was admitted to the facility on 11/22/10 with a hip fracture that she sustained in the facility on 11/15/10. Cumulative diagnoses from the admission records include Hypertension, osteoporosis, difficulty in walking, paroxysmal supraventricular, recent hip fracture with tachycardia and dementia.</p> <p>Review of the "Wandering Risk Assessment" dated 11/22/10 revealed the resident had frequent periods of "fidgeting, repetitive physical movements, or verbalizations of fear, anxiety 4-6</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>of last 7 days ". The resident had a diagnosis of "dementias with moderate cognitive loss", has frequent "periods of altered perception and/or lack of awareness of surroundings, new onset." The resident had "frequent periods of confusion and mental impairment, moderately impaired."</p> <p>Review of the Minimum Data Set (MDS) with the assessment reference date of 11/29/10 revealed the resident was able to repeat three words after the first attempt, was able to report the correct year, and day of the week but not the month, was able to recall sock, blue and bed after cueing. Under the Behavior section, the resident did not exhibit wandering behaviors. There was no evidence of an acute change in mental status from the resident's baseline.</p> <p>The MDS with the assessment reference date of 6/24/11 revealed Resident #1 was able to repeat three words after the first attempt, was not able to report the correct year, month or day of the week, was able to recall sock, blue and bed after cueing. Under the Behavior section, the resident showed verbal behavior symptoms directed towards others such as threatening, screaming and cursing at others. These behaviors occurred 1 to 3 days during the MDS assessment period. The resident also wandered 1 to 3 days during the MDS assessment period. There was no evidence of an acute change in mental status from the resident's baseline.</p> <p>A revised care plan completed on 08/30/11 read "Problematic manner in which resident acts characterized by ineffective coping: Wandering and /or at risk for unsupervised exits from facility related to cognitive impairment due to dementia."</p>	F 323		

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F 323	<p>Continued From page 3</p> <p>Under Goals: "Whereabouts will be known to staff as demonstrated by no event of leaving facility unsupervised." Approaches on the care plan were: to administer medication as ordered, allow resident to ventilate feeling regarding nursing home placement, allow resident to wander on unit, check daily to ensure resident has an alarm bracelet on and that it functioning properly, ensure ID bracelet is in place, and ensure alarmed exits are functional.</p> <p>Record review of the resident's drug regimen (July 2011 physician's orders) revealed orders for Remeron 15 mg (milligrams) to help with her anxiety and depression, Seroquel (an antipsychotic) was prescribed for delusional behaviors, Ativan 1 mg every six hours as needed for anxiety/agitation /pain and Haldol injection 1 mg (0.2 ml (milliliters)) every six hours as needed for severe agitation.</p> <p>Record review of the nurses' notes revealed, that on 05/17/11 "Resident stated to aide (CNA) that she wish she would die and she has nothing to live for. Then she pushed the CNA and went back to her room."</p> <p>A nurses' note on 05/31/11 under "Wander Review" read: Resident [sic] continue to wander around the facility asking where 'the door out' is located. Resident is often agitated. Medication adjustment made on 06/01/11." Seroquel (an antipsychotic) was increased.</p> <p>Nurses' notes on 06/17/11 at 2:48 AM indicated: "Resident alert, oriented to self. Poor safety awareness, does not remember to use call bell. Frequently anxious, rec (eived) Ativan pm (as needed) with fair effect." At 7:38 PM, a note revealed "Resident alert with confusion noted. Resident moving self around the facility this</p>	F 323			

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F 323	<p>Continued From page 4 evening via wheelchair. No behaviors currently noted."</p> <p>On 06/20/11 at 9:14 PM, a nurses' note revealed "Resident alert but confusion noted, Resident spoke with family member this evening. Resident was anxious and upset/crying. Ativan given to calm the resident."</p> <p>On 08/23/11 at 10:34 AM, nurses' notes revealed "Resident continuously inquiring about how to leave the facility to visit her mother and father and continuously inquires about stairs and elevator to go upstairs to balcony. Staff members continuously have to redirect resident, provide diversion and reorient resident, often with little success. Resident is monitored closely by staff members. Resident continues to have personal and bed alarm in place, in addition to safety harness in wheelchair related to resident's [sic] decrease safety awareness."</p> <p>Record review of a nurses' note dated 07/02/11 revealed; "writer (Nurse #1) informed by facility social worker that resident was outside coming around the side of building at 3 PM. All staff members at main nursing station exited building and found resident outside near breezeway, self-propelling in her wheelchair down sidewalk." Resident was uninjured, alert to self and others and confused. Resident redirected into the facility with no incident." "Writer performed full body check of resident with no injuries noted at this time. Writer also checked resident's personal alarm system to insure proper functioning with no malfunction noted. Will continue to monitor resident one-on-one and inform incoming staff members."</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>The resident had exited through a door at the end of A Hall. The door leads to a sidewalk, makes a right turn and continues on to the breezeway. The facility is set back from the city road about 200 yards and adjacent property is wooded. In front of the facility is a large field with a radio tower. The surveyor and the maintenance director measured the distance from the exit door to the point where Nurse #1 found the resident to be a total of 41 feet; Seventeen feet from the door to where the sidewalk turns right and 25 feet along the sidewalk toward the breezeway.</p> <p>In an interview with the RN Supervisor (Nurse #1), on 07/27/11 at 4:15 PM, she stated that at change of shift on 07/02/11, the facility's social worker came up the B wing hall and asked who was the charge nurse for the "A" wing? The supervisor indicated that she was the nurse for that hall. The social worker then said Resident #1 was 'outside' the building. The supervisor stated that was all the information the social worker gave. Social worker did not indicate where the resident was located on the property. The Supervisor said there were six nurses and numerous CNAs at the nursing station because it was change of shift. The Supervisor stated that she told two nurses to stay on the station and the other four nurses and some CNAs exited the building through the front entrance. The supervisor veered left as she exited the building and when she got to the area called the breezeway (a roofed structure with no walls containing picnic tables) she saw Resident #1 self propelling her wheelchair along the side walk on the other side of the breezeway. She returned the resident to the building. She stated the social worker had exited the building for the day.</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>Resident #1 said "Don't take me back in there; I have to go home and cook dinner for my children." After a nursing assessment, the supervisor took Resident #1 to the door she had exited from and the body alarm (wander guard) was functional. The supervisor stated that she had taken care of Resident #1 for a while, and the resident often stayed with her as she went down the "A" hall on the medication pass. Resident #1 frequently has to be redirected or distracted from verbalizations of leaving but she had never actually left the building prior to 07/02/11. When asked when was the last time the supervisor saw Resident #1 prior to retrieving her from outside the building; she stated it was about 2:55 PM because all the nurses were gathered at the nurses' station to give report and then make walking rounds.</p> <p>The supervisor stated she saw Resident #1 on the A hall self propelling in her wheelchair. Resident #1 resided on the A hall near the nurses station so she can be kept in sight since she did wander around the facility in her wheelchair. When asked if she heard the alarm, she stated "no or I would have gone toward the alarm to see what was happening." It was the protocol for on going and off going nurses to make walking rounds for the hall to which they were assigned. She stated that the walking rounds included observation of the exit doors to make sure the alarms were functional. The CNAs made separate walking rounds.</p> <p>In an interview on 07/28/11 at 11 AM, the nurse working the B hall (nurse #2) on the 7-3 shift on 07/02/11 confirmed that no one at the nurses' station heard an alarm.</p>	F 323		
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F 323	<p>Continued From page 7</p> <p>In an interview with the Administrator on 07/27/11 at 4:PM, she stated she was called at 3:05 PM by the supervisor (Nurse #1) to state that Resident #1 had exited the building but was found almost immediately and the resident was unhurt. The Administrator stated she immediately called the maintenance supervisor and told him to go to the facility and check the alarm system.</p> <p>In an Interview with the maintenance director on 07/27/11 at 4:30 PM, he stated that he was off on 07/02/11 but had received a call from the supervisor and the administrator to come to the facility. He stated that it took about 45 minutes to arrive and he immediately started with the door the resident had exited from. He could find nothing wrong with the door or the alarm system. He stated that the alarm system was very sensitive and the facility has been experiencing brown outs from the local power company due to the extreme heat. He said sometimes the contacts can malfunction but he could find nothing wrong with the system on that day. He stated it was possible that someone could have hit the over ride switch but he could not state that had happened as a certainty.</p> <p>He stated that Monday through Friday, even prior to the elopement he personally checked the alarms on every exit door every day. On weekends another staff was tasked with checking each exit door. A log was kept of the rounds. When asked about preventative maintenance, he stated that he did his own maintenance and if he discovered something unusual he could just reset the system. He also could call the company that made the alarm system and receive advice and if the difficulty could not be solved by phone, the</p>	F 323		
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F 323	<p>Continued From page 8            company would dispatch a technician.</p> <p>In an interview with the Administrator on 07/28/11 at 7:30 AM, she stated that Resident #1 had exited the building at change of shift on 07/02/11. The Incident log indicated Resident #1 had only one unsupervised exit incident. The Administrator confirmed that the resident was last seen by the supervisor about 2:55 PM that day as the nurses were preparing to give report. She confirmed that she had been called at 3:05 PM, as indicated in the nurses' notes, and had immediately called the maintenance director to go to the facility and check the system. The Administrator stated that her primary concern was for the resident and that the staff had initiated and completed the missing resident directions. She called the directions an 'elopement mode'. The Administrator stated that she was not in the facility on 07/02/11 (a Saturday) or on 07/03/11, but was in the facility on 07/04/11. She stated the RN supervisor (nurse #1) came to her and remarked that the social worker had not acted appropriately as the incident of 07/02/11 was unfolding. The RN supervisor stated to the administrator that her expectation and training indicated that the social worker should have brought the resident back inside the building and not left her outside alone while the social worker came back into the building to report it to the nursing staff. A resident incident witness statement, signed by the RN supervisor (nurse #1) on 07/02/11 stated: "Social worker came into building and informed all nurses that resident was outside of the building. Social worker then exited the building to go home. There was no one with the resident when I found resident on side of building by breezeway sidewalk."</p>	F 323		
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F 323	Continued From page 9  The Administrator concurred with the supervisor's written statement from 07/02/11; and attempted to counsel the social worker on the expectation that the social worker should have brought the resident back in the building and not left her outside. From the same incident report but dated 07/05/11 the social worker's written statement read, "I was going home after weekend hostess duty and noticed that resident was coming toward the breeze way outside." SW (social worker) called staff outside to aid resident. SW said she left "my son in attendance with resident, while seeking staff."  The Administrator rebutted that statement on 07/28/11 at 7:30 AM by saying, "It is my expectation that any staff who sees a resident outside, unsupervised will immediately bring the resident back inside the facility." The Administrator stated she could not get the social worker to acknowledge that she had not acted appropriately and as a result the social worker was terminated.  In an interview with the Director of Nursing on 07/28/11 at 9:28 AM, she stated that during the orientation program for new hires, she used the Facility Orientation Checklist which included: "Explanation and Demonstration of the sounds of: Door alarms, including Alzheimer's Unit; Facility Identification system/symbols, i.e. Falls, Wandering Residents." The Director stated employees were given the universal code to the doors after the demonstration of the systems (the alarms were set off so new employees can recognize the sound) so that if an evacuation of the facility was necessary, they would be	F 323		

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F 323	<p>Continued From page 10</p> <p>prepared. The Director of Nursing (DON) expectation was that if any employee sees a resident unsupervised and unattended not in the safe area of the facility, the employee will immediately bring the resident back to the confines of the building.</p> <p>The scheduler was interviewed on 07/28/11 at 9:05 PM as to how the wander guards were maintained and tested. The scheduler stated that wander guards were monitored for placement and functionality by the nursing staff every shift and the results were documented on the Personal Alarm/Sensor Pad Monitoring Form. This record was kept in the Medication Administration Record on each hall. Additionally, on Monday through Friday, the scheduler used a special transmitter to check functionality. Each wander guard was checked to make sure the batteries were live and the unit was within the expiration date. If the expiration date has passed, the scheduler can get a new unit from the Quality Assurance nurse. She stated that most malfunctioning wander guards were usually related to batteries. She had access to additional batteries at the medication room. A supply of batteries and an additional wander guard unit were kept in the medication room in case the night shift has problems. After she checked the six wander guards that were currently in use, she also checked the exit doors to make sure the correct lights were flashing. The results of the inspection were entered onto the Transmitter Testing Log. On weekends, another staff was charged with testing the wander guards and observing the exit doors. This process existed prior to the elopement of Resident # 1 and is ongoing. The scheduler could offer no reason why the</p>	F 323		

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(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)	(X6) COMPLETION DATE
F 323	<p>Continued From page 11</p> <p>wander guard did not alarm when the resident approached the exit door, but did alarm when the resident was taken back to the same door after the incident by nurse #1</p> <p>During an observation on 07/28/11 at 8:45 AM, another resident (Resident #2) with a wander guard on each ankle approached the door adjacent to the nursing station which led to a service corridor for laundry and housekeeping. Within five feet of the door, the alarm sounded and the magnetic locks clicked closed. The Administrator was at the nursing station and volunteered to take the surveyor and resident #2 on a tour of other doors. We walked down "C" Hall through to "D" Hall, through "R" hall and back past the two exit doors at the end of "A" hall where Resident #1 had eloped. At each of four exits the alarm sounded and the doors locked. In an interview with the Regional Vice President, Administrator, and DON on 07/28/11 at 9:30 AM, the Regional Vice President indicated her expectation "is that the social worker should have stayed with the resident outside or pushed the resident back into the facility. If the resident became combative or resisted, the social worker could have yelled for help. There is no reason why the resident should not have been brought back into the facility right away, when she (SW) identified the resident was outside unaccompanied. The staff (nurse #1) was able to bring the resident back into the facility without any behaviors indicated. Staff are trained that the residents are everybody's job, especially the social worker.</p> <p>Observation of the resident's room on 07/27/11 at 3:30 PM revealed that the resident had a low bed,</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/28/2011
NAME OF PROVIDER OR SUPPLIER  CHOWAN RIVER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 588 EDENTON, NC 27932	
(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 323	Continued From page 12 bed alarm, fall floor mats at night, a wander guard applied to her right ankle and as of 07/27/11 a soft self-release seat belt was added to remind the resident not to stand up unassisted; the resident can remove the seat belt at will. The resident was in the bathroom at the time. The Administrator gave the surveyor a tour of the building and the alarm system. Hall A, from where the resident eloped, starts at room 101 and goes to room 117. At the end of the resident rooms, the corridor makes a slight turn to the left. As the hall turns into a corridor to the R Hall, there are two exit doors. A resident would be visible from the nursing station until the hall jogs left. The first of the two exit doors is not visible from the nursing station. Facing the door, there is a numbered keypad about 4 feet from the floor. There is also a clear plastic box attached to the wall, when the door to the plastic box is lifted, a shrieking alarm is instantly activated. Inside the box is a toggle switch which staff could use to disable the alarm if evacuation of the facility was necessary. The Administrator stated that when a resident with a wander guard (personal alarm) approached any exit door in the facility, a system called a 'magnetic lock' would activate and the door would lock. The alarm would sound so staff could redirect the resident back to the safe areas. The Administrator stated that Resident # 1 had been assessed for wandering and the wander guard was applied to her ankle to prevent her exiting. The Facility wrote a Corrective Plan of Action which was accepted at 4:54 PM on 07/28/11.  Chowan River Nursing and Rehabilitation Corrective Action Plan 7/28/11	F 323		

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NAME OF PROVIDER OR SUPPLIER  CHOWAN RIVER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 568 EDENTON, NC 27932	
(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 323	Continued From page 13  1. The resident in question was at nurse's station at 2:55 p.m. At 3:00 p.m. the Social Worker reported to the charge nurse that the resident was sitting outside of the facility. Four of the six nurses at the station at the change of shift exited the facility to locate the resident in question. The resident was sitting in her chair, unharmed, and was returned to her room without incident. The Nurse Supervisor contacted the ADON, the Administrator, the family and the MD by phone then completed a full body assessment. There were no noted injuries or other issues noted. The resident's personal alarm was checked by the Nursing Supervisor to ensure proper function. The alarm was functioning properly. The Nursing supervisor reset the door alarm system under instructions from the Maintenance supervisor until he could arrive at the facility. The Nursing supervisor then took the involved resident around to all of the doors to ensure the alarms and doors were functioning properly. At this time the alarms and the door system was functioning properly. (date: 7/2/11) 2. All residents determined to be at risk for wandering had all of their alarms checked. All of the nursing staff went to high alert for those residents determined to be at risk for wandering. The personal alarms of residents determined to be at risk for wandering are checked every shift to assure the alarms are in place and functioning properly. (July 2, 2011) 3. The Maintenance supervisor arrived to the facility within 45 minutes of being notified of the possible alarm system failure. He checked the door in question to make sure it was functioning properly. He then checked all alarmed exit doors in the facility to assure proper function. There	F 323		

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NAME OF PROVIDER OR SUPPLIER  CHOWAN RIVER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1341 PARADISE RD P O BOX 566 EDENTON, NC 27932
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F 323	<p>Continued From page 14</p> <p>were no issues noted with any door at that time. On (July 4, 2011) the Administrator activated a secondary alarm system (Radio Shack) which had already been in place, but was inactivated when the new system was put in. It was then rechecked by the maintenance supervisor on (July 5, 2011) and new batteries placed into the system to assure on-going proper function. The maintenance supervisor and/or designee now checks the doors daily, the Radio Shack back up alarms, and the full security system and documents the results. The WEEKEND HOST OBSERVATION REPORT FORM was revised to include checking function of all door alarms and if they are functioning properly. Any identified concerns will be reported to the Administrator, the Nursing Supervisor and the Maintenance Supervisor immediately and corrective action taken as indicated. This form will be used on weekends by the weekend managers and supervisors and turned in to the Administrator on Mondays for review. The weekend Janitor staff has been trained by Maintenance to check all doors on the weekends to ensure all doors are functioning. Nursing staff are continuing to make their dual shift rounds, both nurses and nursing assistants and accounting for all of their residents. 100 percent of all staff has been in serviced on wandering residents and elopements (started 7/4/11 and was completed by 7/7/11).</p> <p>4. The resident personal alarms are checked by the unit nurses every shift and documented on the MARs. The resident personal alarms are checked by the scheduler daily and documented in the notebook. The doors are checked daily by the Maintenance supervisor and documented on a monthly calendar and on the weekends by the Janitorial staff on the calendar. In any case of</p>	F 323		
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F 323	<p>Continued From page 15</p> <p>any failure of any portion of the system while being checked will be cause for immediate notification of the Administrator, the Maintenance Supervisor, the Director of Nursing and the Regional staff to ensure immediate safety for all residents in the facility. The Administrator will review the reports weekly and make recommendations as necessary. The results of the reports will be reported to the monthly QA committee and revisions made as necessary. The QA reports and audits will remain on going for one year due to the nature of this Issue and the safety of all residents. (July 2, 2011). These reports will be reviewed by the quarterly Executive QI committee to assure changes made remain compliant.</p> <p>Validation of past non-compliance statement: In an interview with the Administrator, RVP (Regional Vice President), DON and RN supervisor (Nurse #1) on 07/28/11 at 4 PM, the administrator stated that when she came into the facility on 07/04/11, she could not figure out why the alarm had not sounded. She stated that before they had the current system of alarms, they had purchased alarms from a national retail outlet. When the new alarm was installed, the old alarms were not removed from the doors. She ordered on 07/04/11 that the old alarms be activated as a redundant system. The maintenance director confirmed that he installed batteries in the old alarm system so now two systems would be in place as of 07/05/11. The Administrator directed that the SDC (staff development coordinator) to conduct a re-education program for all staff in all department which commenced on 07/07/11. A copy of the re-education syllabus stated: "Elopement/Wandering Policy; 1) If a resident is</p>	F 323		



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F 323	<p>Continued From page 18</p> <p>found outside the building alone. It is the employee's responsibility to stay with resident until resident has returned to the building to ensure resident's safety; 2) When door alarms sound it is [sic] everybody's responsibility to respond." The administrator stated that 100% of the staff has been in serviced.</p> <p>Wander guard alarms and door alarms continue to be checked on a daily basis by the maintenance director, the scheduler and the nursing staff on rounds.</p> <p>A second alarm system has been reactivated as a back up and it was functional as of 07/05/11. The entire staff (100%) had been re-educated on responsibility for alarms, the new hire orientation is on-going, completed on 07/07/11.</p> <p>The employee who did not bring the resident back into the building has been terminated.</p>	F 323		