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

PRINTED: 09/30/2011
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A BUILDING ______ B WING ______	C 09/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB AND HC CTR AT VILLAGE GR	1601 PURDUE DRIVE FAYETTEVILLE, NC 28304

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F 279 SS=J	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483 10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to develop a comprehensive care plan for 1(Resident #5) of 3 residents with a history of exit seeking behaviors, which resulted in an elopement. The findings include. The immediate jeopardy began on Resident #5 on 8/21/11 and was removed on 9/17/11. The facility remained out of compliance at the lower scope and severity level, an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate	F 279	This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that this Facility violated any federal or state regulation or failed to follow any applicable standard of care. F279 Resident #5 was discharged from the facility 9/4/2011 24 Residents with a diagnosis of dementia and/or Alzheimer's and that were coded as having Cognitive impairment in past 30 days were reviewed on 9/15/2011. Also all comprehensive assessments completed in the past 30 days were reviewed again on 9/15/2011. Care plans for 12 of these residents have been updated by the care plan team to reflect current condition of residents' functional and cognitive status. One resident was identified prior to 9/15/2011. No other residents were identified on this date. The MDS staff has attended training sessions, (9/15/11 & 9/21/11) participated in in-services and again has reviewed the guidelines for accurate timely assessment and care plans. MDS staff now manually updates care plans in charts as well as electronically when a new need is identified. MDS staff will thoroughly review all nursing notes and complete interviews as indicated to assess the resident accurately. The assessment and comprehensive plan of care is updated quarterly and in the event of a change in status of the residents mental or physical condition by the MDS staff.	10/14/11 9/21/11 9/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/7/11

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

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jeopardy. (D). The facility was in the process of implementing their corrective actions on training and monitoring for residents at risk of elopement. The findings include:

Resident #5 was admitted to the facility on 10/18/10 then re-admitted on 8/29/11. He had the following cumulative diagnoses: Alzheimer's dementia, atrial fibrillation, hypertension and cerebral vascular accident with right side weakness and aphasia.

On 1/29/11, Resident #5 received a quarterly Minimum Data Set (MDS) assessment, which determined that he had moderate cognitive impairments and exhibited wandering behaviors 4 to 6 days of the 7 days look back assessment, but less then daily.

The most recent quarterly Minimum Data Set (MDS) dated 5/01/11 assessed him with severe cognitive impairments, needing extensive assistance with ambulation in his room, and determined that he had limitations with his upper extremities. It was also noted that he wandered 4 to 6 days of the 7 days look back assessment, but less then daily.

Resident #5 was not care planned for wandering or exit seeking behaviors.

Resident #5 did not have an additional quarterly MDS in August, because he was discharged to the hospital and was not available for review.

A review of the nurse's notes revealed the following history. On 2/5/11, Nurse #1 recorded that "Resident #5 was very agitated throughout

Residents who have experienced a change in condition or a change in behaviors have been re-assessed and care planned by the care plan team. The communication form is used by all staff to share pertinent information about residents and/or facility. The communication forms are located within each department and at each nursing station. The communication form is initiated by any and every staff member when necessary including the observation of a resident with exit seeking behaviors. Also a communication form is initiated by the unit nurse when there is a change in status of the resident and distributed to all dept. managers. Residents are also discussed in our daily stand-up meeting to ensure communication between depts. Pictures of residents who have the potential to wander or have exit seeking behaviors are posted at the front desk and at every nurses' station by the Medical Records Director. Staff is made aware of potential behaviors through our communication form and face to face conversation.

9/21/11

10/14/11

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the day. Very angry that he had to get up for restorative. He yelled "Why" constantly throughout the morning. He continued to go into other resident's rooms and disturb them. He would not refrain from doing this. Then he attempted to leave the facility via the front doors 2x (twice). He went over to Unit 1 while Nurse #1 was in another patient's room and went in several rooms and disturbed residents there as well. Risperdone (an anti-psychotic medication) not effective at all for his agitation. Physician contacted several times already previously by this nurse and fully aware of these issues. Will continue to monitor. Oncoming nurse made aware of behavior."

On 2/19/11, Nurse #1 recorded in the nurse's notes that Resident #5 was agitated and yelling out sporadically at times. "Resident went down to Unit 2B station self propelled in wheelchair and attempted to open alarm door at end of hall and fell out of wheelchair. RN Supervisor present to observe incident. RN Supervisor assessed resident, no injuries observed RN Supervisor completed incident report, resident observed throughout day. Oncoming nurse made aware, will continue to monitor."

On 2/26/11. Nurse #2 recorded that Resident #5 tried to get out emergency door, was up and down the hallways, in and out of other resident's room. He was unable to be redirected and was given Xanax He continued to constantly try to go out exit doors 5x. Will monitor closely.

On 9/8/11 at 3:55pm, Nurse #1 was interviewed. He worked with the resident on weekends from 7:00am until 7:00pm. On 8/21/11 he was on duty

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Care plans are updated on at least a quarterly basis by the interdisciplinary care plan team. Care plans are also updated for each resident when there is a change of status of the resident's mental or physical condition by the care plan team. Once a new need is identified interventions are implemented immediately and the care plan is updated during that shift by the MDS staff, unit nurse or the nurse supervisor for that shift. The MDS coordinator and MDS assistant will monitor care plans weekly when a new need is identified to ensure compliance. Care plans are also checked for accuracy using the 'Clinical Record Audit Tool'. This audit tool is completed by the DON, MDS staff, Patient Care Coordinator, and SDC. The DON is responsible for reviewing the audits. 20 charts **(due to census)** are reviewed weekly for 4 weeks and then monthly thereafter. Each care plan team member has a calendar to track dates of each resident's upcoming care plan. — 10/14/11

The audits are a permanent part of the monthly QA collection and data process and are presented during the bi-monthly QA meeting that is attended by the Administrator, DON, Medical Director, owners and Pharmacy Consultant. This is presented by the DON. — 10/14/11

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and stated that the resident's routine was to wheel himself around the facility, visiting nurse ' s stations and activities. He witnessed him wandering into other resident's rooms on this day as well as on previous occasions, getting into others' belongings. Nurse #1 also stated that he has needed to intervene before when Resident #5 opened exit doors. He stated that Resident #5 since his admission had opened doors at the front lobby, on Unit 2 A and Unit 2 B. Each time he intervened, he recalled Resident #5 would resist coming back into the building, stating "Why do I have to go back?" Each time the door alarmed, either Nurse Aide #1 or Nurse Aide #2 helped to retrieve the resident who was only a few feet outside the door.

On 8/21/11 Nurse #1 described the Resident #5 exhibiting exit seeking behavior. He stated that during 1st shift (7:00am to 3:00pm), Resident #5 opened a door and again on 2nd shift (3:00pm to 11:00pm) before succeeding from exiting the building at 5:00pm With each earlier attempt, Nurse #1 stated that they would bring Resident #5 to the nurse's station to help keep an eye on him.

On 8/21/11, Nurse #1 said that he became aware of Resident #5 eloping, after a sitter of another resident, saw him outside of the facility, tipped over in his wheelchair and reported it at the nurse's station.

The chart review did not reflect that Resident #5 had any revision to his care plan after the 8/21/11 to reflect wandering or exit-seeking behaviors.

On 9/17/11 at 11:30am, a follow up interview was

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conducted with Nurse #1. He indicated that once Resident #5's medication was adjusted he saw improvements in his behaviors, so there wasn't much to document He never shared his concerns with the Director of Nursing because he stated that she wasn't in the building on weekends

Then he recalled an incident in July, 2011 when Resident #5 opened an alarmed door. He placed both of his hands inside the door well, with the alarm sounding. but did not go out of the building. They were able to hear the alarm and redirect him. Nurse #1 stated that he might have forgotten to document this incident in his nurse's notes.

The morning of 8/21/11, Nurse #1 stated that Resident #5 kept going into a room next to the exit door on Unit 2 A. He would be brought back to the nurse's station and given a snack or he would converse with another resident. Nurse #1 said that he remained at the station to do his charting. Then after lunch, he recalled that Resident #5 was heading toward the exit door again and Nurse Aide #1 had to redirect him.

Nurse #1 stated that he did not feel that Resident #5 exhibited increased confusion on 8/21/11; however felt that his overall confusion was more of a factor then the resident trying to exit the facility. Nurse #1 shared that a few days before the elopement on 8/21/11, Resident #5 said that he wanted to go home and would ask him, " Why Am I here?"

On 9/8/11 at 2 10pm, Nurse Aide #2 was interviewed She worked with Resident #5 on 1st shift, 8/21/11. She stated that Resident #5 was

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very confused that day and kept going in another resident's room, near the exit door on Unit 2 A and was imagining seeing a bug in the room. He became difficult to redirect, so she summoned help from Nurse #1. On 9/15/11 at 11:28am, during a follow up interview, Nurse Aide #2 relayed each time she redirected Resident #5 on 8/21/11 she would place him at the nurse ' s station. She stated that staff was present, including herself, because "We know how he likes to wander." She stated that he remained at the station with her, while she charted.

Nurse Aide #1 was interviewed on 9/8/11 at 3:45pm. She stated that she worked 2nd shift on 8/21/11 and was assigned to Resident #5. She commented that he liked to roam around the building but always came back to his area. He would visit the café and the other nurse's stations. She stated that she had never witnessed him trying to leave the building on her shift. As well as she never considered him an elopement risk, because she could always calm him. She did mention that he would tell her that he wanted to go home

A follow up interview was held with Nurse Aide #1 on 9/15/11 at 1:23pm. She stated that on 8/21/11 she did not receive a report from Nurse Aide #2 that Resident #5 ' s behavior was out of the ordinary. During her shift, she recalled having to bring him back to the nurse's station while she worked, a few times. He was known to wander into female resident's rooms, according to her, and would mess with their belongings. Whenever he roamed, he always found his way back to his room

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On 2nd shift, she relayed that Resident #5 usually visited others and participated in activities. He would stay in his room, watching TV or go to the halls. Sometimes he would go sit by the doors and soak up the sunshine. She did share that in general, he was confused more on 2nd shift then when she worked with him at other times of day.

On 9/8/11 at 5:45pm the evening receptionist was interviewed. She stated that she worked the reception desk in the lobby from 4 to 8pm. She commented that Resident #5 was one of the residents that she would keep her eye on if he came into the area. She shared that he liked to sit in his wheelchair in front of the door and watch the fountain. One day she remembered that he opened the lobby door and she went over to him, she turned him back around. Then she reported the incident to the nurse on duty She stated that there hasn't been an incident in months.

On 9/15/11 at 1:00pm, the Social Worker was interviewed. She was responsible for completing the behavior section on his 5/24/11 MDS and had stated that he exhibited wandering. The Social Worker acknowledged that she did often see Resident #5 roam through the building, visit the front lobby and go into other's rooms, however, she never viewed him as an elopement risk.

She would return him to his unit because it didn't appear to her that he was oriented enough to return there by himself. She shared that had he been an elopement risk, the facility would have discussed with his family, the option of exploring a locked unit to keep him safe. She commented, "We would be negligent if we didn't keep him safe and he was at risk as an elopement "

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The MDS Nurse was interviewed on 9/15/11 at 12:05pm. She stated that she had difficulty assessing Resident #5 because he was Aphasic but she did not feel that he was cognitively intact.

She shared that she was aware that we wandered around the building but she had never known him to try to get out, in fact, there were times when staff tried to lead him outside to the courtyard, and he would resist, planting his feet firmly on the ground. She further stated that no one had ever reported to her that Resident #5 had tried to leave the building or opened doors

The MDS Nurse stated that if she was aware of those behaviors, she would have care planned him for wandering and she would have advocated for a placement in a locked unit, stating that it would be too dangerous to have those behaviors here

She stated that she had reviewed the Social Worker's comments about Resident #5's wandering, but she never considered it to mean that he was an elopement risk.

At 2:05pm, the discussion continued with the DON. She was asked to define exit seeking behavior. She replied that it meant anytime a resident tried to get out of the building, through physical attempts to go through the door. She had never considered Resident's #5 an elopement risk due to roaming about the facility, nor was she informed of his prior successful attempts in opening the doors

The DON stated that once a resident showed exit

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seeking behavior, staff should keep the resident in close supervision and attempt to discuss with their family if another placement, to a locked unit, should be pursued. She emphasized that Nurse #1 had never discussed any of Resident #5's behaviors with her and stated that he had the opportunity because sometimes he would be in the building, during weekdays.

On 9/15/11 at 2:33pm, the Administrator was interviewed. She was on medical leave 9/7/11 to 9/9/11 and was not available for interview.

The Administrator shared that she regularly meets with the nurses and did rounds on the floors. No one had ever discussed that Resident #5 had tried to open the doors before the incident on 8/21/11. She stated that she was aware that he roamed the building, and they motivated him to ambulate freely; due to this being very social for him.

She stated that his roaming did not raise the concern for her to inquire if he also exhibited exit seeking behaviors because she never saw him try to touch any of the doors. She also did not recall him expressing that he wanted to leave the facility. Some residents would say that they wanted to leave, and then she would view them as elopement risks.

The Administrator commented that if she knew that Resident #5 was at risk for an elopement she would have expected for him to be care planned for elopement. Lastly, she would have spoke to family members about considering another placement for him, where he could be safe on a locked unit

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On 9/15/11 at 5:38pm, the Administrator was informed of the Immediate Jeopardy involving Resident #5.

On 9/17/11 at 5:30pm, the facility had provided an acceptable credible allegation.

A. Address how corrective action will be accomplished for each resident found to have been affected by the deficient practice.

Resident #5 was discharged from the facility on 9/4/2011.

Residents with a diagnosis of dementia and/or Alzheimer ' s and that were coded as having cognitive impairment in past 30 days was reviewed on 9/15/2011. Also all comprehensive assessments completed in the past 30 were reviewed on 9/15/2011.

Care plans for these residents have been updated by the care plan team to reflect current condition of residents' functional and cognitive status. One resident was identified prior to 9/15/2011. No other residents were identified on this date. The MDS staff were in-serviced on 9/15/11 and were instructed to review the guidelines for accurate timely assessment and care plan. MDS staff will now manually update care plans in charts as well as electronically. The assessment and comprehensive plan of care is updated quarterly and in the event of a change in status of the residents' mental or physical condition. 9/15/2011

B Address how corrective action will be

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accomplished for those residents having potential to be affected by the same deficient practice.

Residents who have experienced a change in condition or a change in behaviors has been re-assessed and care planned by the care plan team. A communication form will be initiated by the unit nurse when there is a change in status of the resident and distributed to all dept. managers. Residents are discussed in our daily stand-up meeting to ensure communication between depts. Pictures of residents who have the potential to wander or have exit seeking behaviors are posted at the front desk and at every nurse's station. Staff is made aware of potential behaviors through our communication form and face to face conversation 9/15-16/2011

C. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.

Care plans are updated on at least a quarterly basis by the interdisciplinary care plan team. Care plans are also revised for each resident when there is a change of status of the residents' mental or physical condition, or when they become a known elopement risk by the care plan team. Additional monitoring tools (30 minute checks for residents identified as elopement risks and completed documented behaviors forms) are contained on the nurses' cart to assist with care plan objectives.

D. Indicate how the facility will monitor to make sure that the solutions are sustained. The facility

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must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and corrective action evaluated for its effectiveness. The POC must be integrated into the QA system of the facility. Include dates when corrective action will be taken. The corrective dates must be acceptable to the State.

Care plans will be monitored during monthly chart audits by the nursing department. A chart audit tool has been developed to ensure compliance. The audits are a part of the monthly QA process and are presented during the monthly QA meeting along with an action plan as needed by the DON

On 9/17/11 at 5:30pm, validation of the credible allegation was done

Residents identified as potential elopement risks were photographed with their photographs placed behind the nurse's stations for easy recognition.

Residents identified as potential elopement risks, were placed on a 30 minute monitoring schedule, which went into effect on 9/17/11. Both nurse aides and nurses are responsible for knowing the resident's exact whereabouts. The nurse recorded the resident's location on a log, which was kept on the nurse's cart.

Residents identified as potential elopement risks, were care planned by the MDS department staff with interventions outlined to prevent unsupervised exits from the facility. On 9/17/11, each care plan was reviewed and verified that

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F 279	Continued From page 12 they were placed on the resident's medical chart, for quick access by all staff and measurable goals for preventing an unsupervised exit from the facility As of 3:00pm on 9/17/11, 55% of the staff was in-serviced on Elopement and how to document behaviors. The remaining staff will be in-serviced on the material, before they can return to the floor. The MDS nurse was interviewed and was able to explain the criteria used to identify residents with cognitive impairments, who either have a history of wandering or expressed desire to leave the facility, as well as how they are now identified as potential elopement risks, for care plan assessments. The Staff Development Nurse was interviewed, and the course material was reviewed for in-services on Elopement and Behavior Monitoring. The attendance record for the 9/17/11 in-services was reviewed. Nurse Aides that began their shift at 3:00pm were instructed to complete new training (elopement and documentation of behavior) before beginning their assignments The Director of Nursing and Administrator were interviewed and expressed satisfaction in the manner, staff has implemented the new policies and procedures to help identify residents at risk for elopement, who need comprehensive care plan assessments.	F 279		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

F 323 Continued From page 13

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 policy review, record review as well as interviews with a private sitter, security guard and staff, the facility failed to prevent 1 (Resident #5) of 3 cognitively impaired , from leaving the facility as well as sustaining an injury, requiring hospitalization. The facility failed to implement their elopement policy to identify residents with a history of wandering for elopement risk assessment and monitoring schedules to be developed. The facility failed to monitor to prevent an unsupervised exit from the facility.

The immediate jeopardy began on Resident #5 on 8/21/11 and was abated on 9/17/11. The facility remained out of compliance at the lower scope and severity level, an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, (D). The facility was in the process of implementing their corrective actions on training and monitoring for residents at risk of elopement. The findings include:

The facility's policy and procedures, dated 8/27/03 on Resident Elopement was reviewed. It read, "It is the policy of the facility to make every effort to prevent Elopement episodes while

F 323

F323

Resident #5 was discharged on 9/4/2011. — 9/4/11

During his stay the facility implemented a personal alarm on his wheelchair, a sensory pad on his bed and in his wheelchair as well as frequent monitoring and supervision by staff. The bed for resident #5 remained in the low position with mats beside the bed when resident was in bed. These interventions were imposed for resident safety.

A falls risk assessment is completed upon admission on all residents by the admitting nurse as well as quarterly and when there is a significant change in status noted by any staff utilizing a communication form. Every nursing station is checked for communication forms by the Medical Records Director daily. The unit nurse also delivers the form to the DON or Patient Care Coordinator and is reviewed immediately. — 10/14/11

The communication form is delivered to all Managers. The forms are discussed and reviewed daily at stand-up meetings. All residents identified by nursing staff as high risk for falls have a current fall risk assessment and care plan with fall risk interventions identified.

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

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F 323	Continued From page 14 maintaining the least restrictive environment for residents who are risk for elopement. Please note that elopement differs from wandering in that a dependent resident leaves the facility without nursing observation or known knowledge of their departure. Residents at risk for elopement include those who have: delusions, hallucinations, Alzheimer's disease or other dementia, anxiety disorder, manic depression, schizophrenia and history of wandering." "Documentation/Assessments: Elopement Risk Assessment, Elopement Risk Tracking Log, Documentation of Elopement episodes in nurse's notes and implementation of monitoring schedule." "Elopement Prevention: assess, communicate, ensure resident safety, document, investigate and QA (quality assurance) monitoring." "Procedures: The nursing unit will assess all residents who are risk for harm because of elopement. The resident's current MDS (Minimum Data Set) will be reviewed to determine what changes have occurred that would trigger elopement episodes. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. If a resident repeatedly wanders off the unit, a monitoring schedule will be implemented to ensure the resident ' s safety." Resident #5 was admitted to the facility on 10/18/10 then re-admitted on 8/29/11. He had the following cumulative diagnoses: Alzheimer's dementia, atrial fibrillation, hypertension and cerebral vascular accident with right side weakness and aphasia.	F 323	Residents who display exit seeking behaviors are assessed using the 'Potential for Elopement Profile' form by the unit nurse and a care plan is initiated by the MDS staff. One (1) new resident was identified with potential exit seeking behaviors on 9/17/11 making a total of three in facility. MDS staff, DON, and nursing supervisor will perform daily rounds to each nursing station for reports on each resident. Information will be discussed daily at stand up meetings and will be acted upon immediately. A communication form will also be distributed to all depts. The care plan will be on the charts and verbally communicated to each unit. The CNA will review the care plan and document as well as the nurse. (The Activity Department has been in-serviced on exit seeking and wandering behaviors of residents) 9/17/2011 and 9/23/2022 by the SDC. A new program - memory enhancement volunteers 3 volunteers will be in-serviced on 10/17/2011 when they orientate for this new program by the Activity Director and SDC. All new volunteers in the future will receive this in-service prior to working with residents	10/14/11 10/17/11

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On 1/29/11, Resident #5 was assessed using the Minimum Data Set (MDS), which determined that he had moderate cognitive impairments. He also exhibited wandering behaviors 4 to 6 days of the 7 days look back assessment, but less then daily.

He was not care planned for wandering or exit seeking behaviors

On the most recent quarterly MDS dated 5/01/11, Resident #5 was assessed with severe cognitive impairments, needing extensive assistance with ambulation in his room, and had limitations with his upper extremities. It was also noted that he wandered 4 to 6 days of the 7 days look back assessment, but less then daily.

Resident #5 was not care planned for wandering or exit seeking behaviors.

Resident #5 did not have an additional quarterly MDS in August because he was discharged to the hospital and was not available for review.

A review of the nurse's notes revealed the following history. On 2/5/11, Nurse #1 recorded that
"Resident #5 was very agitated throughout the day. Very angry that he had to get up for restorative. He yelled "Why" constantly throughout the morning. He continued to go into other resident's rooms and disturb them He would not refrain from doing this. Then he attempted to leave the facility via the front doors 2x (twice). He went over to Unit 1 while Nurse #1 was in another patient's room and went in several rooms and disturbed residents there as well.

F 323

The staff provides additional supervision to these residents by involving them more frequently in activities, including them in groups that routinely sit together, and positioning the resident at the nurses' station for closer observation when the nurse or CNA is at the nurses' station. Residents who present a safety risk are moved to a room closer to the nurses' station with the permission of the resident/family. The family/responsible party is included in the care plan meeting to discuss interventions including providing sitters for additional supervision and their option to move to another facility with a secure unit when all other interventions have been implemented. 10/14/11

All staff including Activity Department regularly participates in ongoing in-services pertaining to wandering, resident behaviors and elopement by the SDC, DON, consultant Pharmacy, and outside training specialists. 10/14/11
100% of staff, (all employees, including dietary, Housekeeping and maintenance) working in the facility, has been in serviced again on accidents/incidents and identifying exit seeking and wandering behaviors of residents

All other staff (PRN staff that only work occasionally and staff out on LOA) will be in serviced prior to returning to work on the floor. All new employees will receive this in-service during orientation prior to working on the floor by the SDC. 10/14/11

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Risperdone (an anti-psychotic medication) not effective at all for his agitation. Physician contacted several times already previously by this nurse and fully aware of these issues. Will continue to monitor. Oncoming nurse made aware of behavior."

On 2/19/11, Nurse #1 recorded in the nurse's notes that Resident #5 was agitated and yelling out sporadically at times. "Resident went down to Unit 2B station self propelled in wheelchair and attempted to open alarm door at end of hall and fell out of wheelchair. RN Supervisor present to observe incident. RN Supervisor assessed resident, no injuries observed. RN Supervisor completed incident report, resident observed throughout day. Oncoming nurse (7pm-7am shift) made aware, will continue to monitor."

On 2/26/11, during the 7am-7pm shift, Nurse #1 documented in his nurse's notes that Resident #5 yelled throughout the day and frequently went into other residents' rooms disturbing them. He wrote, "He attempted to leave the facility via the alarm door and set off the alarm."

On 2/26/11, during the 7pm-7am shift, Nurse #2 recorded that Resident #5 continued to go in and out of other residents' rooms and tried to get out of the emergency door. Resident #5 was unable to be redirected and was given Xanax; however it was found to be ineffective. It was recorded that he made five attempts to go out of the exit doors. Nurse #2 wrote that she monitored him closely.

Nurse #2 was unavailable for interview during the survey. A copy of the incident report was

F 323

Description of in-service - Staff was in serviced on reporting requirements when a resident demonstrates such behaviors. — 10/14/11

Staff is to report to their supervisor, nursing supervisors, DON and Administrator verbally and in writing. Interventions include posting pictures at the front desk, all nursing stations and the break room by the Medical Record Director. Nursing staff will not disarm door alarms except in a non-emergency event (ex. - funeral home director) and to check door alarms on their unit each shift and document. The nursing supervisor for each shift will have possession of the 'door alarm key'. If there is a malfunction with the door alarm the nurse is to notify maintenance on -call immediately.

Maintenance staff or security personnel will man the door until it is repaired. Gates entering the facility have been adjusted to close properly by the maintenance dept on 9/8/2011. Maintenance will check daily. Maintenance will be notified by staff if gates are observed to be ajar. Adjustments to the gate will be made immediately by the Maintenance Dept.

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requested for this event and the Director of Nursing stated on 9/15/11 that she did not have a copy

The resident's mental health consultation, dated 5/26/11 assessed him to have vascular dementia with delusions. It was noted that he had off and on agitation and appear to be Sundown in nature Staff had relayed that he was manageable when redirected and current medications.

An Incident/Accident Report, dated 8/21/11 at 5:00pm, documented that Resident #5 tipped over in his wheelchair and sustained a small cut to his left arm below the elbow and to his left forehead above the eyebrow. Bruising was noted. His personal alarm was in place. Resident #5 was observed by a visitor, who notified the nurse. Nurse Aide #1 assisted the nurse with placing the resident back in his wheelchair. His physician was notified on 8/21/11 at 5:30pm. The resident was sub sequentially transported to the emergency room.

The facility's Exit Door Alarms document was viewed. It documented that the maintenance supervisor last checked the functioning of Unit 2 A door on 7/2/11. On 9/8/11 at 5:00pm the Maintenance Director was interviewed. He shared that prior to Resident #5's accident; he would check 10 exterior doors in the facility which had alarms, once a month. He would document the audit on a log. The door alarms he stated always functioned. He had not discovered any alarm turned off. In between his monthly visits, he indicated that a security guard would do evening rounds and check all doors. Since the incident on 8/21/11 he stated he has begun to

F 323

All areas of the facility have been assessed to ensure the safety of our residents. Residents with exit seeking behaviors will be monitored closely with staff checks every 30 minutes by the charge nurse for that resident and documented. The designated nursing supervisor will review staff checks to ensure compliance each shift. This log is kept with the MAR. All doors with access to the outside are alarmed. These doors are checked and monitored by the nursing staff each shift, by the security personnel nightly and by the maintenance dept. weekly. Nursing log is kept in the narcotic book, security logs are kept in plant manager office with a copy for Administrator daily and maintenance log is kept in maintenance office and reviewed by the Administrator weekly.
These logs are maintained to ensure compliance. In the event the log is not maintained as required, the employee will be counseled up to termination. The logs are checked daily by nursing supervisors. This log/ QA tool is included and discussed in our monthly QA meeting by the DON. The door alarm logs will be a permanent line item for the QA agenda.

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check the doors weekly. The log indicated that he checked all exit doors on 8/24/11 and 9/6/11. He relayed there were no problems with the alarms during these checks.

The maintenance supervisor mentioned that the facility has electronic gates at their exits. The visitor parking lot has a gate which can be electronically opened when needed by the receptionist from 8:00am until 8:00pm. The employee parking lot's electronic gate remained open until 6:00pm when it gets shut, in order to secure the premises. The employee parking lot gate was out of site and a considerable distance from the facility's corridors.

On 9/8/11 at 8:40am, upon arrival at the facility, the exit side of the electronic visitor's lot gate was open. There was no car at the gate. On 9/9/11 at 8:30am and 8:45am, the exit side of the electronic visitor's lot gate remained open. There was no car at the gate. The main street adjacent to the gate served a mixed residential -commercial area with the posted speed limit of 35mph. The gate was positioned less then 30 feet from the street

On 9/9/11 at 10:05am, an exterior tour was conducted of the facility's grounds. The visitor parking lot gates were now closed, however it was noted that on the parameter of the small parking lot, there was a small grassy area with full shrubbery and trees that had a significant drop to the ground, with a pond at the bottom. At the rear of the building, was the employee parking lot. It had moderate traffic activity with staff coming and going, as well as deliveries being made. To the left of Unit 2 B, near the restorative dining room

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was a steep stairwell, leading to the basement. The stairwell's entrance was available for entry.

The door that Resident #5 exited on Unit 2A faced the visitor parking lot. Once outside the door, there was a small ramp, leading to the parking lot, approximately 20 feet from the door. To the right of the doorway, was a narrow winding sidewalk, which led to the entrance of the lobby doors. It was also parallel to the drop off area for vehicles. To the left of the door on Unit 2A was a narrow sidewalk which led to Unit 3. The area was not visible from the lot and had a narrow grassy area, East of the sidewalk, with a steep drop to the ground. The abundance of shrubs and trees prevented a safe evaluation of the bottom.

A review of the facility's Continuation Sheet, documented that the security guard made rounds on 8/20/11 at 8:00pm. The guard wrote that when he performed his rounds in the rehabilitation center,
"All the exit doors alarm. All secure." On 9/15/11 at 11:55am. an interview was held with the security guard. He stated that he completed the Continuation Sheet form on 8/20/11 and that when he was on duty, he checked every door. He emphasized that if the alarm doesn't sound when I check, then I am expected to reset it. The doors always made a sound when he checked. To his knowledge, he had never discovered a door with the alarm turned off. The alarms can only be operated with a key

The Fall Investigation dated 8/22/11 stated that Resident #5 was last toileted 10 minutes prior to the accident. The investigation determined that Resident #5 was not left unattended

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inappropriately. However, in a written statement, dated 8/21/11 at approximately 4:05pm which was attached to the Fall Investigation, Nurse Aide #1 stated that she was attending to another resident on the Unit when she received a page to come to the lobby. She discovered that Resident #5 had fallen on the ground.

Resident #5's hospital records were contained within his chart. It revealed that on 8/21/11 he was sent to the emergency room and was diagnosed with pneumonia. A CT scan (computed tomography) without contrast was performed on 8/26/11. It was compared to a previous CT scan that Resident #5 had on 10/13/10 after his stroke. It found that he still had severe atrophy with old left cerebral infarct in the frontal lobe with some degree of encephalomalacia. The condition was a stable mild distention of lateral ventricles. He had no acute bleed; no acute intracranial hemorrhage, midline shift, or mass lesion.

When Resident #5 returned to the facility on 8/27/11, he had significant changes to his health. A review of nurse's notes on 8/27/11 and 8/28/11 relayed that he was more lethargic, ran a fever and had a decrease in appetite and fluids. He was re-hospitalized on 8/28/11 for altered mental status and a urinary tract infection.

On 8/29/11, he returned to the facility with orders for comfort care measures. On 9/4/11, Resident #5 expired at the facility.

On 9/8/11 at 2:10pm, Nurse Aide #2 was interviewed. She worked with Resident #5 on 1st shift, 8/21/11. She stated that Resident #5 was

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very confused that day and kept going in another resident's room, near the exit door on Unit 2 A and was imagining seeing a bug in the room. He became difficult to redirect, so she summoned help from Nurse #1. On 9/15/11 at 11:28am, during a follow up interview, Nurse Aide #2 relayed each time she redirected Resident #5 on 8/21/11 she would place him at the nurse ' s station She stated that staff were present, including herself, because "We know how he likes to wander." She stated that he remained at the station with her, while she charted.

She shared that nurse aides do not check the alarms on the door, that task was left for the maintenance department. However, she stated she had never seen Resident #5 open the doors on her shift. At 3pm, she positioned Resident #5 at the Unit 2 A nurse's station and found him to be drowsy. She did not report to Nurse Aide #1, coming on duty, that she felt Resident #5 to be more confused then usual, however, she did express her concerns with Nurse #1.

Nurse Aide #1 was interviewed on 9/8/11 at 3 45pm. She stated that she worked 2nd shift on 8/21/11 and was assigned to Resident #5. She commented that he liked to roam around the building but always came back to his area. He would visit the café and the other nurse's stations. She stated that she had never witnessed him trying to leave the building on her shift. As well as she never considered him an elopement risk, because she could always calm him. She did mention that he would tell her that he wanted to go home

She recalled that on 8/21/11 she had changed

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Resident #5 then placed him at Unit 2 A nurse's station, ten minutes before she was paged to the lobby, to be alerted that he had fallen outside. She stated that at the time of his fall, she was in another resident's room, diagonal from the nurse's station, performing personal care. When she helped to bring him back into the facility, she stated that she noticed that he had blood on his forehead and cleaned him up.

Nurse Aide #2 stated that all of the doors have alarms on them but the one that Resident #5 exited, did not sound. She continued by saying that the nurses are supposed to check them, but she does not witness them checking the alarms. At night when she worked, she would see the security guard making rounds and checking the alarms. She stated that the alarm was set the night before

A follow up interview was held with Nurse Aide #1 on 9/15/11 at 1:23pm. She stated that on 8/21/11 she did not receive a report from Nurse Aide #2 that Resident #5's behavior was out of the ordinary. During her shift, she recalled having to bring him back to the nurse's station while she worked, a few times. He was known to wander into female resident's rooms, according to her, and would mess with their belongings. Whenever he roamed, he always found his way back to his room.

She remembered that after his fall on 8/21/11 she was told by some of the staff that he had tried to get out on 1st shift and the alarm went off. They were able to stop him from exiting, but it was reported that he pushed the door and it sounded. The nurse would have to reset the door alarms.

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she commented

On 2nd shift, she relayed that Resident #5 usually visited others and participated in activities. He would stay in his room, watching TV or go to the halls. Sometimes he would go sit by the doors and soak up the sunshine. She did share that in general, he was confused more on 2nd shift then when she worked with him at other times of day. He would tell her that he wanted to go home or would ask for his wife, who lived at his former residence She would always explain to him that he was at the facility now and he would calm down. She would then give him a snack.

She shared that another way, they monitored him was to have him follow Nurse #3 while she passed medications since he responded positively to her. If Nurse Aide #1 was busy, then perhaps another aide from another station would come over to Unit 2 A and watch him

Nurse Aide #1 did note that on Sundays, there were no planned activities after 2:30pm. He would normally sit in the hallway or roam the facility until dinner time at 5:25pm.

The day of his accident, she stated that "He wasn't acting weird. I was never told to keep a close eye on him." In fact she recalled that Nurse #1 told her that he was in a good mood and did not share that he had tried to open doors earlier his shift

On 9/8/11 at 3:55pm, Nurse #1 was interviewed. He worked with the resident on weekends from 7:00am until 7:00pm. On 8/21/11 he was on duty and stated that the resident's routine was to

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wheel himself around the facility, visiting nurse's stations and activities. He witnessed him wandering into other resident's rooms on this day as well as on previous occasions, getting into others' belongings. Nurse #1 also stated that he has needed to intervene before when Resident #5 opened exit doors. He was aware that he had previously opened doors at the front lobby, on Unit 2 A and Unit 2 B. Each time he intervened, he recalled Resident #5 would resist coming back into the building, stating "Why do I have to go back?" Each time the door alarmed and Nurse Aide #2 helped to retrieve the resident who was only a few feet outside the door.

On 8/21/11 he described the resident exhibiting exit seeking behavior He stated that during 1st shift (7:00am to 3:00pm), Resident #5 opened a door and again on 2nd shift (3:00pm to 11:00pm) before succeeding from exiting the building at 5:00pm. With each earlier attempt, Nurse #1 stated that they would bring Resident #5 to the nurse ' s station to help keep an eye on him.

On 8/21/11, Nurse #1 said the alarm did not go off on Unit 2 A, he only heard a beeping sound. Nurse #1 became aware of the elopement, after a sitter of another resident, saw Resident #5 outside of the facility, tipped over in his wheelchair and reported it at the nurse's station. He stated that along with maintenance and the security guard, nurses have keys to the alarms

After the incident on 8/21/11, Nurse #1 stated he got a doctor's order to send Resident #5 to the hospital since he hit his head and was on Coumadin (a blood thinner)

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On 9/17/11 at 11:30am, a follow up interview was conducted with Nurse #1. He indicated that Resident #5 had several documented elopement attempts in February and he sought interventions through his physician for medication management. He recalled that the doctor told him that he would re-assess Resident #5 later in the week and that he didn't want to adjust his medications until then. He was told that Resident #5's agitation was within normal limits. He continued to express his concerns about Resident #5' s to his unit supervisor and the on-coming nurse.

Nurse #1 continued by saying that once Resident #5's medication was adjusted he saw improvements in his behaviors, so there wasn't much to document. He never shared his concerns with the Director of Nursing because he stated that she wasn't in the building on weekends.

Then he recalled an incident in July, 2011 when Resident #5 opened an alarmed door. He placed both of his hands inside the door well, with the alarm sounding, but did not go out of the building. They were able to hear the alarm and redirect him. Nurse #1 stated that he might have forgotten to document this incident in his nurse's notes.

The morning of 8/21/11, Nurse #1 stated that Resident #5 kept going into a room next to the exit door on Unit 2 A. He would be brought back to the nurse's station and given a snack or he would converse with another resident. Nurse #1 said that he remained at the station to do his charting. Then after lunch, he recalled that Resident #5 was heading toward the exit door

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again and Nurse Aide #1 had to redirect him.

Nurse #1 stated that he did not feel that Resident #5 exhibited increased confusion on 8/21/11; however felt that his overall confusion was more of a factor then the resident trying to exit the facility. Nurse #1 shared that a few days before the elopement on 8/21/11, Resident #5 said that he wanted to go home and would ask him, "Why Am I here?"

Nurse #1 shared that it was never his practice to check the door alarms on his unit and that he did not check the door on Unit 2 A on 8/21/11. The security guards made rounds at night and checked all the doors He couldn't recall unlocking the doors. not even to allow the release of a resident's body, within the last 30 days. He stated that visitors would accidentally open the door. because it faced the parking lot and they wouldn't read the sign that it was alarmed.

The private duty sitter was interviewed on 9/9/11 at 9:30am. She stated that on 8/21/11, during the afternoon, she was in the room of another resident, when the resident remarked that she saw a man lying on the ground outside of the facility She stated that when she approached the window, she could see an elderly man tipped over in his wheelchair on the sidewalk. At that point, she left the room and went to the nurse's station to tell someone

On 9/9/11 at 11:45am the Nurse Supervisor was interviewed She stated that she worked on weekends and often had interactions with Resident #5. On 8/21/11 she worked from

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6:00am until 11:00pm. She commented that earlier that day, Resident #5 traveled here and there around the building, into other resident's rooms and other nurse's stations. She stated that he was a "free agent and was a busy, busy guy". He was vocal and she always knew what he was up to. She did not witness any exit seeking behavior from him that day and did not receive any reports of him trying to leave the building before he succeeded. He did not appear agitated or more confused then usual. She stated that she didn't see anything different about him

The Nurse Supervisor shared that on 8/21/11, she was paged to the nurse's station. She went outside with Nurse #1, to assess Resident #5 who had fallen out of his wheelchair. Resident #5 had traveled a short distance from the doorway and was around the corner on the sidewalk, positioned between the exterior rooms of 201 and 203. His head had hit the pavement and he had almost fallen off of the sidewalk onto the pavement where cars drove. The incident report, dated 8/21/11 stated that the fall occurred at 5:00pm

She later discovered that the door on Unit 2 A did not have its alarm turned on. Every night, security was responsible for checking the light on the doors to make sure the alarm was turned on. She indicated that she did not check the alarms when she began her shift, because it was not expected or part of her routine, however, since the incident, she had checked the door and documented this on a log. She stated that "we never had a problem like this before."

To her knowledge, staff did not tamper with the

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alarms and only nurses had keys to the alarm In the event that a visitor exits from a door with an alarm, staff was expected to stand by and reset the alarm "

Had she known that he was exhibiting exit seeking behavior she stated she would expect her staff to evaluate if he had a change in his condition, like behaviors or a urinary tract infection. Also staff should try to determine what ' s going with him, was he hungry, wet, thirsty? She would expect staff to ensure his safety by double checking the doors and keep him close the station or the cart. to supervise him.

On 9/8/11 at 1 42pm. Nurse Aide #3 was interviewed She shared that Resident #5 often came on Unit 3 when he attended activities, then he would proceed to travel around the facility. She recalled that he would try to get out the doors on the hallway and they would catch him before he got out. They would redirect him and take him to a safer location. Twice she recalled he roamed to Unit 1.

On 9/8/11 at 5:45pm the evening receptionist was interviewed. She stated that she worked the reception desk in the lobby from 4 to 8pm. She commented that Resident #5 was one of the residents that she would keep her eye on if he came into the area. She shared that he liked to sit in his wheelchair in front of the door and watch the fountain. One day she remembered that he opened the lobby door and she went over to him, she turned him back around. Then she reported the incident to the nurse on duty. She stated that there hasn't been an incident in months.

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On 9/15/11 at 1:00pm, the Social Worker was interviewed. She was responsible for completing the behavior section on his 5/24/11 MDS and had stated that he exhibited wandering. The Social Worker acknowledged that she did often see Resident #5 roam through the building, visit the front lobby and go into other's rooms, however, she never viewed him as an elopement risk.

She would return him to his unit because it didn't appear to her that he was oriented enough to return there by himself. She shared that had he been an elopement risk, the facility would have discussed with his family, the option of exploring a locked unit to keep him safe. She commented, "We would be negligent if we didn't keep him safe and he was at risk as an elopement."

The MDS Nurse was interviewed on 9/15/11 at 12:05pm. She stated that she had difficulty assessing Resident #5 because he was Aphasic but she did not feel that he was cognitively intact. She shared that she was aware that we wandered around the building but she had never known him to try to get out. in fact, there were times when staff tried to lead him outside to the courtyard, and he would resist. planting his feet firmly on the ground. She further stated that no one had ever reported to her that Resident #5 had tried to leave the building or opened doors.

The MDS Nurse stated that if she was aware of those behaviors, she would have care planned him for wandering and she would have advocated for a placement in a locked unit, stating that it would be too dangerous to have those behaviors here. Other interventions that she might have recommended would have been to keep the fire

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doors closed on his unit to prevent wandering.

She stated that she had reviewed the Social Worker's comments about Resident #5 ' s wandering, but she never considered it to mean that he was an elopement risk

On 9/8/11 at 3:30pm, the Patient Care Coordinator was interviewed about in-servicing staff on securing the doors. She provided documentation which captured the names of staff, as well as material presented on 8/22/11 on the new requirement for nursing staff to check the alarmed doors daily and to document in on a log in their narcotic book. Nurses are now expected to check the doors prior to starting their Med Pass. Other staffs responsible for checking the doors are maintenance and security. The facility does not use security devices on residents, since there are no " locked down " units.

On 9/9/11 at 10:30am, the Director of Nursing (DON) was interviewed. She stated that only nurses, maintenance and security have keys to access the alarms She demonstrated how the alarms work and how staff should check the doors to make sure the alarms are turned on. She had not received any reports of staff de-activating the alarms to avoid the noise.

At 2:05pm, the discussion continued with the DON She was asked to define exit seeking behavior She replied that it meant anytime a resident tried to get out of the building, through physical attempts to go through the door. She had never considered Resident's #5 an elopement risk due to roaming about the facility, nor was she informed of his prior successful

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attempts in opening the doors

When a resident displayed wandering, she expected the staff to document the incidents on ADL (activities of daily living) behavior sheets, the pharmacy provided documentation of behavior forms or in the nurse's notes.

She relayed that it has always been her expectation for the nurses to check the alarms on the door, each shift. The DON produced a document, titled "Finger Tip" Reminders from the Personnel Policy Manual, dated July, 2009. In the document, in number 29, it read, "Nurses are to check alarm doors each shift." In the past, the facility did not require for the nurses to sign off that the doors were checked but still had the expectation that the task would be done.

The DON stated that once a resident showed exit seeking behavior, staff should keep the resident in close supervision and attempt to discuss with their family if another placement, to a locked unit, should be pursued. She emphasized that Nurse #1 had never discussed any of Resident #5's behaviors with her and stated that he had the opportunity because sometimes he would be in the building, during weekdays.

On 9/15/11 at 2:33pm, the Administrator was interviewed. She was on medical leave 9/7/11 to 9/9/11 and was not available for interview

The Administrator shared that she regularly meets with the nurses and did rounds on the floors. No one had ever discussed that Resident #5 had tried to open the doors before the incident on 8/21/11. She stated that she was aware that

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he roamed the building, and they motivated him to ambulate freely; due to this being very social for him

She stated that his roaming did not raise the concern for her to inquire if he also exhibited exit seeking behaviors because she never saw him try to touch any of the doors. She also did not recall him expressing that he wanted to leave the facility. Some residents would say that they wanted to leave, and then she would view them as elopement risks

The Administrator could not ascertain how the alarm became turned off on Unit 2a on 8/21/11. She said that their investigation could not determine who was responsible The Administrator produced copies of her security guard rounds from 8/10/11 to 8/19/11, there were no incidents, when the guard found the doors unarmed

She shared, that she had already expected the nurses to check the alarms on the door, each shift. She has also conveyed to her Maintenance Supervisor, that he needed to ensure that the electronic gates to the visitor parking lot remained closed when not used, and quickly repaired, if they became inoperable.

On 9/15/11 at 5:38pm, the Administrator was informed of the Immediate Jeopardy involving Resident #5.

On 9/17/11 at 5:30pm, the facility had provided an acceptable credible allegation.

A Address how corrective action will be

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accomplished for each resident found to have been affected by the deficient practice.

Resident #5 was discharged on 9/4/2011. During his stay the facility implemented a personal alarm on his wheelchair, a sensory pad on his bed and in his wheelchair as well as frequent monitoring and supervision by staff. The bed for resident #5 remained in the low position with mats beside the bed when resident was in bed. These interventions were imposed for resident safety.

A falls risk assessment is completed upon admission on all residents by the admitting nurse as well as quarterly and when there is a significant change in status noted by any staff utilizing a communication form. All residents identified by nursing staff as high risk for falls have a current fall risk assessment and care plan with fall risk interventions identified. (6 of 79 residents) 9/17/2011 Residents who display exit seeking behaviors are assessed using the 'Potential for Elopement Profile' form and a care plan is initiated by the MDS staff One new resident was identified with potential exit seeking behaviors on 9/17/11 making a total of three in facility MDS staff, DON, and nursing supervisor will perform daily rounds to each nursing station for reports on each resident Information will be discussed daily at stand up meetings and will be acted upon immediately. A communication form will also be distributed to all depts. The care plan will be on the charts and verbally communicated to each unit. The CNA will review the care plan and document as well as the nurse.
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B. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice.

The staff provides additional supervision to these residents by involving them more frequently in activities, including them in groups that routinely sit together, and positioning the resident at the nurses' station for closer observation when the nurse or CNA is at the nurses' station. Residents who present a safety risk are moved to a room closer to the nurses' station with the permission of the resident/family. The family/responsible party is included in the care plan meeting to discuss interventions including providing sitters for additional supervision and their option to move to another facility with a secure unit when all other interventions have been implemented

C. Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not occur.

55% of staff has been in serviced on accidents/incidents and identifying exit seeking and wandering behaviors of residents 9/15-17/2011. The remaining staff will be in serviced prior to returning to work on the floor. Staff was in serviced on reporting requirements when a resident demonstrates such behaviors. Staff is to report to their supervisor, nursing supervisors, DON and Administrator verbally and in writing. Interventions include posting pictures at the front desk, all nursing stations and the break room. Nursing staff was instructed not to

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disarm door alarms except in a non-emergency event (ex. - funeral home director) and to check door alarms on their unit each shift and document. If there is a malfunction with the door alarm the nurse is to notify maintenance on call immediately. Maintenance staff or security personnel will man the door until it is repaired Gates entering the facility have been adjusted to close properly by the maintenance dept on 9/8/2011 Maintenance will check daily. Maintenance will be notified by staff if gates are observed to be ajar

D. Indicate how the facility will monitor to make sure that the solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and corrective action evaluated for its effectiveness The POC must be integrated into the QA system of the facility. Include dates when corrective action will be taken. The corrective dates must be acceptable to the State.

All areas of the facility have been assessed to ensure the safety of our residents. Residents with exit seeking behaviors will be monitored closely with staff checks every 30 minutes by the charge nurse for that resident The designated nursing supervisor will oversee staff checks to ensure compliance each shift. This log is kept with the MAR All doors with access to the outside are alarmed These doors are checked and monitored by the nursing staff each shift, by the security personnel nightly and by the maintenance department weekly Nursing log is kept in the narcotic book, security logs are kept in plant manager office with a copy for Administrator

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daily and maintenance log is kept in maintenance office. These logs are maintained to ensure compliance. In the event the log is not maintained as required, the employee will be counseled up to termination. The logs are checked daily by nursing supervisors. This log/ QA tool is included and discussed in our monthly QA meeting by the DON. A plan of action is initiated as needed.

8/30/2011

On 9/17/11 at 5:30pm, validation of the credible allegation was done.

Residents identified as potential elopement risks were photographed with their photographs placed behind the nurse's stations for easy recognition.

Residents identified as potential elopement risks, were placed on a 30 minute monitoring schedule, which went into effect on 9/17/11. Both nurse aides and nurses are responsible for knowing the resident's exact whereabouts. The nurse recorded the resident's location on a log, which was kept on the nurse's cart.

Residents identified as potential elopement risks, were care planned by the MDS department staff with interventions outlined to prevent unsupervised exits from the facility. The care plans were updated on 9/17/11 and placed on each resident's medical file, at the nurse ' s station.

As of 3:00pm on 9/17/11, 55% of the staff was in-serviced on Elopement and how to document behaviors. The remaining staff will be in-serviced

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on the material, before they can return to the floor

Both the oncoming and outgoing nurses are responsible for checking the door alarms each shift. Their actions were verified in the daily door alarm log, which was kept in the narcotic book. The facility has enforced door alarm monitoring since 8/30/11.

The Unit Nurses (7am-7pm) were interviewed and monitored. The MDS nurse was interviewed about how resident's who wander, would be assessed as potential elopement risks.

The Staff Development Nurse was interviewed, and the course material was reviewed for in-services on Elopement and Behavior Monitoring. The attendance record for the 9/17/11 in-services was reviewed. Nurse Aides that began their shift at 3:00pm were instructed to complete new training before beginning their assignments.

The Director of Nursing and Administrator were interviewed and expressed satisfaction in the manner, staff has implemented the new policies and procedures to keep residents at risk for elopement safe.