STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 11/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(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 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility record review, the facility failed to clean resident equipment for two of five sampled residents who were receiving enteral feedings. (Residents #18 and #7) 1. On 11/3/11 at 4:15 PM, 11/4/11 at 9:40 AM and 12:45 PM Resident #18 was observed lying on an air mattress. To the left of her bed was an enteral tube feeding pump attached to an intravenous (IV) pole with a tube feeding product infusing. Observation of the left side of the air mattress, the enteral tube feeding pump and the IV pole revealed dried tan colored splatters on the air mattress, splatters and smudges covering the pump and splatters along the entire IV pole and base of the IV pole. The floor surrounding the IV pole was also observed sticky with dark stains. An interview with the housekeeping supervisor on 11/4/11 at 12:30 PM revealed that nursing and central supply staff was responsible for cleaning resident care equipment and house keeping staff was responsible for maintaining the resident's rooms and floors clean. An interview with licensed nurse #5 (LN) on 11/4/11 at 12:45 PM confirmed the IV pole and enteral feeding pump, floor and air mattress for	F 253	F253 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #18 and Resident #7, tube feeding poles, pumps, floor and mattress were identified on 11-4-11, as soiled with beige colored substance. Housekeeping Director immediately cleaned and sanitized identified pole, pump, floor and mattress for Residents #18 and #7. 2. Residents who receive tube-feeding supplement have the potential to be affected by the same alleged deficiency. The Director of Nursing identified residents with orders for tube feeding supplements. Housekeeping supervisor, Director of Nursing and Administrator observed feeding pumps, poles, floors and mattresses for cleanliness of the identified residents with tube feedings on 11/04/11. Poles, pumps, floors and mattresses were not soiled. Housekeeping supervisor in serviced the housekeeping staff beginning 11/04/11 regarding cleaning of resident equipment, which includes, feeding pumps, poles, floors and mattress during daily cleaning and as needed. 3. Measures put into place to ensure that the alleged deficient practice does not recur includes: Housekeeping Director began in service education for housekeeping staff on cleaning procedures for resident equipment which includes IV/feeding poles, feeding pumps, and mattress. Housekeeping Director will monitor IV/feeding poles, feeding pumps and mattress (5) five per week for four (4) weeks then (5) per month for (3) three months and keep a monitoring log of all tube feeding poles to maintain compliance. 4. Administrator and/or Housekeeping Director will analyze for patterns/trends and **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Melvin | TITLE: Licensed Administrator | (X6) DATE: 11/30/2011

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

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F 253	Continued From page 1 Resident #18 were all dirty and needed to be cleaned. LN #5 stated that nursing and housekeeping staff were responsible for maintaining resident care equipment clean. She further revealed that she had not taken the time to clean the equipment or ask housekeeping staff for assistance with cleaning. 2. Observation on 11/4/11 at 10:10 AM revealed the enteral feeding pump and stand for Resident #7 had dried beige substances on the front of the pump. Three areas, approximately 2 inches in diameter, of dried beige substance were on the pole above the pump. A soiled adhesive tape encircled the pole approximately 2 inched from the top. Upon observation of the pump and pole on 11/4/11 at 11:10 AM Licensed Nurse (LN) #4 reported the pole was dirty and required cleaning. LN #4 explained regular cleaning of the pump and pole was the responsibility of the housekeeping department but nursing staff should also clean any spills. LN #4 proceeded to clean the pump and pole. An interview with the housekeeping supervisor on 11/4/11 at 12:30 PM revealed that nursing and central supply staff was responsible for cleaning resident care equipment and house keeping staff was responsible for maintaining the resident's rooms and floors clean.	F 253	report in QA&A meeting weekly for 4 weeks and then monthly thereafter. The QA&A Committee will evaluate the effectiveness of the above plan and will adjust the plan based on outcomes/trends identified. 5. Date of completion November 30, 2011	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 2 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility staff failed to supervise and implement the facility's elopement policy for two (2) of eleven (11) sampled cognitively impaired residents at risk for wandering who exited the building unattended by staff (Resident #1 and Resident #11). Immediate jeopardy began on 10/22/11 when Resident #1 exited the building and facility property without staff supervision or knowledge. Immediate jeopardy was removed on 11/3/11 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) for Resident #1 and Resident #11 to ensure monitoring of systems put in place and completion of employee education. The findings are: Review of the facility's elopement policy dated 6/2007 revealed if an employee discovered a resident is missing from the facility, determination should be made to see if the resident is out on an authorized leave and if not; the Administrator and the Director of Nursing (DON) should be notified	F 323	**1)Residents affected by the alleged deficient practice.** The resident identified as leaving the Center on 10/22/11 at approximately 11:03am was returned safely. A licensed nurse completed an assessment of the resident upon return to facility on 10/22/11 and there were no injuries. The resident was re-assessed for elopement risk on 10/22/11 by the Unit manager. The resident was placed on one on one monitoring by the direct care staff on 10/22/11 upon return to facility approximately 1:15pm, and remained until the wander guard system was checked again by the Division Director of Facility Engineering for proper functioning on 10/24/11. The physician and family members were notified that the resident exited the building on 10/22/11 at approximately 1:15pm. The resident's wander guard bracelet was checked for placement and functioning upon return to facility. Alarm sounded when resident returned to facility. The bracelet was moved to the left wrist due to recommendation by the Wander guard **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 3 and a thorough search of the building and premises conducted. The Administrator, DON or designee will notify the resident's legal representative, physician, local law enforcement, state agency, if required, provide search teams with resident identification information and make an extensive search of the surrounding area. 1. Resident #1 was admitted to the facility in 2009 with diagnoses which included Parkinson's Dementia with a prior elopement history. Review of Resident #1's quarterly elopement risk assessment on 9/26/11 revealed he was assessed as at risk for elopement. Review of Resident #1's annual Minimum Data Set dated 9/26/11 assessed intact cognition with limited assistance of one person for transfers and ambulation. Review of Resident #1's care plan dated 9/28/11 revealed elopement identified as a problem with interventions which included redirection as needed and a safety monitoring device to the right wrist. Physician's orders dated 10/4/11 included directions to visually check the safety monitoring device every shift in addition to a check via an electron machine every shift. Review of a nursing note dated 10/22/11 at 6:00 PM by Licensed Nurse (LN) #1 revealed Resident #1's safety monitoring device check at 8:30 AM that morning showed active function. Resident #1 required redirection from another resident's room during the morning. Resident #1 left the	F 323	technician to have bracelet on same side as sensor. The Licensed Nurse checked the bracelet and door alarm using the tester and was noted to be functioning properly. The Maintenance Director checked the wander guard system, which includes the door module, range of door module, cables and wires and the alarm sound at the nurse's station on 10/22/11 at approximately 2pm, and called the Wander Guard technician on 10/22/11 approximately 2:30pm. All checks performed at that time indicated that the system was working properly. Resident #11 was identified as exiting through the front lobby doors on 10/30/11 at approximately 3:33pm. A staff member returned Resident #11 to facility at approximately 3:34pm and notified a licensed nurse. The Licensed nurse assessed Resident #11 for injuries. No injuries were noted. Wander guard bracelet was not on residents left arm as was noted earlier on 10/30/11. The licensed nurse replaced the monitoring device on Resident #11's left ankle on 10/30/11 upon return to facility. The licensed nurse notified family member and **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 4 facility unsupervised and without an alarm sounding. Resident #1 returned with a staff member after a search. Family members, the physician and facility management received notification. Resident #1 received a full physical assessment after the elopement and there were no injuries noted. The care plan was updated to include application of the safety monitoring device to the left wrist and one to one monitoring. Review of the security video taken on 10/22/11 revealed Resident #1 exited the building at 11:17:13 AM. Resident #1 attempted to open the door at the hinges then pressed the disabled door release button on the right side. The door opened automatically and Resident #1 ambulated out of the front door using a rolling walker. A dietary aide, identified by the Maintenance Director, entered the facility at 11:17:42 AM. Observation of Resident #1 on 11/1/11 at 9:26 AM revealed he ambulated independently with a rolling walker on the nursing unit. Resident #1 was unable to state the location of his room. The safety monitoring device was observed on his left wrist. Interview with Nursing Assistant (NA) #2 on 11/1/11 at 11:00 AM revealed she last saw Resident #1 after breakfast at approximately 10:00AM when he required redirection from another resident's room. NA #2 was at the nursing desk on 10/22/11 "around 11:30 AM" when a visitor approached inquiring the location of Resident #1. NA #2 explained she went to Resident #1's room which was at the beginning of the hall. When Resident #1 was not there, she went to another resident's room at the far end of	F 323	physician regarding the elopement. The licensed nurse on 10/30/11 completed an Elopement Risk Review and Care plan was updated on 11/01/11 to include the monitor device on resident #11's left ankle. The C N A assignment sheet was updated to include the monitor device on resident #11's left ankle. **2. Residents with the potential to be affected by the alleged deficient practice.** The Licensed Nursing staff reassessed 100% of current residents beginning 10/22/11 with completion on 10/24/11, using the elopement risk assessment to determine if they are at risk for elopement. There are eleven total residents identified to be at risk for elopement. The Licensed Nursing staff checked placement and function of wander guard bracelets for the residents identified at risk for elopement on 10/22/11. Licensed Nursing staff performed every fifteen-minute checks on 10/22/11 through 10/24/11 for those residents identified at risk for elopement. The Division of **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 5 the hall where Resident #1 had been redirected earlier that morning. NA #2 immediately reported to Licensed Nurse (LN) #1 that Resident #1 could not be located. NA #2 explained Resident #1's safety monitoring device was on that morning since no alarm sounded, she did not think he was out of the building. NA #2 revealed Resident #1 frequently walked with his walker in the facility so she expected he was in the dining room or on another hall. NA #2 explained Resident #1 required redirection to his room, but usually went on his own to the dining room. NA #2 reported she checked the rooms of the hall, the television room and the dining room. Interview with LN #1 on 11/1/11 at 12:30 PM revealed she had checked Resident #1's safety monitoring device for function around "8:30 AM." She was notified by NA #2 that Resident #1 was not in his room and could not be found on the unit "around 11:15 AM." LN #1 explained she was not too worried because no alarm sounded. LN #1 reported all staff on the unit checked all of the residents' rooms and closets at that time. LN #1 reported Resident #1 ambulated slowly with his walker and she thought he had left the unit, but was in the building. LN #1 reported after a search on the unit which took ten to twenty minutes, she notified LN #2, unit manager, of the inability to locate Resident #1. She explained she called Resident #1's family to see if they had taken him out without signing him out shortly after 11:30 AM. LN #1 reported Resident #1 returned to the facility with the Human Resources Coordinator (HRC) and his safety monitoring device sounded. Interview with the Staff Development Coordinator	F 323	Facility Engineering on 10/24/11 checked the wander guard system, and the system was working properly, so therefore, the every fifteen-minute checks were discontinued. The Administrator and/or the Director of Nursing will discuss all attempted elopements during the morning meeting Monday through Friday and will discuss residents at risk for elopement weekly for one month. The licensed nurses will complete the Elopement Risk Assessment form for all residents upon admission, quarterly, annually, and with significant change of condition. The Director of Nursing and/or RN supervisors will evaluate each assessment and update care plans and certified nursing assistant assignment sheets, as necessary. The Director of Nursing and/or the Unit Managers will observe the residents identified at risk for elopement each day to assure that wander guard placement is verified and documented on the Treatment Administration Record (TAR) by the Licensed nursing staff. The Director of Nursing, Unit managers and RN **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 6 (SDC) on 11/1/11 at 1:20 PM revealed LN #2, unit manager, informed her Resident #1 could not be located. The SDC reported she knew the time of her notification was 12:25 PM. The SDC explained she directed the unit manager (LN #2) to implement the facility's elopement procedure which included police and administration notification. The SDC reported she also directed the elopement code to be announced over the speakers. The SDC recalled a search was in place outside of the building on the grounds at the time she was informed of the missing resident. Interview with the Maintenance Director on 11/1/11 at 1:50 PM revealed he received notification of Resident #1's elopement on 10/22/11 by the Director of Nursing (DON). The Maintenance Director explained Resident #1's safety monitoring device caused the alarm to sound upon his reentry to the building. The Maintenance Director explained when the safety monitoring device worked not only an alarm sounded but the exterior doors automatically locked. He explained that there would be a one to two second delay before the exterior door locked if a person was entering at the same time a resident with a safety monitoring device approached. Interview with the HRC on 11/1/11 at 4:12 PM revealed she heard the overhead page on 10/22/11 which announced a resident was missing. She reported she and the SDC left the facility in their private vehicles to search at 12:30 PM. The HRC explained she crossed the main road with stoplights and saw Resident #1 standing on the corner at the next two lane road,	F 323	Supervisors will review the TAR's daily to ensure that nurses have checked wander guard placement and have documented the same for the residents identified as an elopement risk. The wander guard bracelets are changed according to manufacturers recommendation, which is the expiration date stamped on the bracelet device. The Director of Nursing and/or the unit managers maintains a log and changes the bracelets according to the expiration date on the bracelet or if the bracelet does not function when tested. The night shift nurse will verify function of the wander guard bracelet each night by use of a testing device. The nurse will document on the TAR once every twenty-four hours in accordance with the Elopement Management Policy. The Maintenance Director checked the wander guard system, which includes the door module, range of door module, cables and wires and the alarm sound at the nurse's station on 10/22/11 at approximately 2pm, and called the Stanley Wander Guard Corporation on 10/22/11 approximately 2:30pm. All checks **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 7 three-way intersection with stoplights. (This corner is 0.34 miles from the facility according to an Internet map. The main road is a four lane state highway with a speed limit of 35 miles per hour according to the transportation department. The temperature on 10/22/11 was a high of 66 degrees Fahrenheit according to an Internet weather organization.) The HRC reported she assisted Resident #1 into her van and returned to the facility. He told her it was a good day for a walk. The HRC added she asked other staff to return to the intersection to look for his walker. She reported the staff found Resident #1's walker next to the sidewalk away from the street. Interview with LN #2, unit manager, on 11/1/11 at 4:25 PM revealed LN #1 informed her Resident #1 was not able to be found on 10/22/11 "around 12:30 PM." LN #2 explained LN #1 told her all resident rooms were searched and the grounds were being checked. LN #2 notified the DON and directed staff to continue to search the grounds and independent living section. LN #2 reported the SDC and HRC began to search for Resident #1 in their private vehicles. LN #2 explained she called the police after notifying the DON and left a message with the emergency 911 number at approximately 12:30 PM. LN #2 explained the 911 operator told her the police would return the call. When the police returned the call "about 1:10 PM," Resident #1 was reentering the facility at the same time so no police involvement was requested. Interview with the dietary aide on 11/1/11 at 5:00 PM revealed she passed Resident #1 when he exited and she entered the facility on 10/22/11. The dietary aide explained she noticed Resident	F 323	performed at that time indicated that the system was working properly. **3. Systemic Changes** The Administrator, Director of Nursing, Maintenance director and other members of the management and nursing team has reviewed the Elopement Management Policy on 10/22/11 at an ad hoc Quality Assessment and Assurance Committee meeting and has determined that it is appropriate for the Center's use. The Licensed Nursing staff checked placement and function of wander guard bracelets for the residents identified at risk for elopement on 10/22/11. Licensed Nursing staff performed every fifteen-minute checks beginning 10/22/11, for those residents identified at risk for elopement through 10/24/11. All newly admitted residents will be assessed on the day of admission then weekly for a total of four weeks, by licensed nurses to determine whether they are at risk for elopement. Residents will **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 8 #1 leaving but thought he was going to sit outside and did not know he required supervision. The dietary aide explained Resident #1 did not appear confused and was dressed in slacks, shirt, jacket, socks, shoes and cap. She stated she did not notice a wrist band on Resident #1. She explained when she heard of the missing resident, she realized it was Resident #1 and reported seeing him earlier in the day. Interview on 11/2/11 at 8:15 AM with NA #1, who was assigned to Resident #1 on 10/22/11, revealed she assisted Resident #1 with dressing and bathing before breakfast on 10/22/11. NA #1 remembered seeing him in the hallway between 9:00 AM and 10:00 AM. NA #1 explained Resident #1 wandered in the facility and usually required redirection. NA #1 reported she assisted in the search on the hall but was not too concerned at first because there was no alert from the safety monitoring device. Interview with the DON on 11/2/11 at 8:25 AM revealed she received notification of the search for Resident #1 on 10/22/11 around 12:30 PM. The DON explained the search of the facility and grounds had been initiated by staff and she directed staff to notify the police. The DON reported Resident #1's safety monitoring device was checked and moved to the left wrist upon recommendation of the Maintenance Director. Interview with the DON on 11/2/11 at 11:35 AM revealed a search of the facility and property would be done before notification of the police and family. The notification of these parties would not necessarily be immediate since the resident missing could be still on the grounds.	F 323	be assessed by the licensed nurses using the Elopement Risk Assessment form. Residents will be reassessed quarterly, annually, and with significant change of condition. Based on these evaluations, care plans will be updated by the licensed nurse when identified to include intervention to address exit-seeking behavior. Licensed nurses will be responsible for assuring that physicians and family members are contacted of any identified changes within twenty-four hours. The Interdisciplinary Team will discuss all attempted elopements during the morning meeting Monday through Friday and will discuss residents at risk for elopement weekly for one month. The team includes the Administrator, Director of Nursing, Unit Mangers, and other members of the management and nursing team. The certified nursing assistants' assignment sheets will be updated by the Licensed nursing for each resident identified as having exit seeking behaviors. If such behaviors have occurred during the shift the nursing assistant will immediately report the **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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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)	(X5) COMPLETION DATE
F 323	Continued From page 9 The DON explained she was notified when Resident #1 could not be found after a facility wide search. The facility presented a credible allegation of compliance which included: 1. Residents affected by the alleged deficient practice. The resident identified as leaving the Center on 10/22/11 at approximately 11:03 am was returned safely. A licensed nurse completed an assessment of the resident upon return to facility on 10/22/11 and there were no injuries. The resident was re-assessed for elopement risk on 10/22/11 by the Unit manager. The resident was placed on one on one monitoring by the direct care staff on 10/22/11 upon return to facility approximately 1:15 pm, and remained until the wander guard system was checked again by the Division Director of Facility Engineering for proper functioning on 10/24/11. The physician and family members were notified that the resident exited the building on 10/22/11 at approximately 1:15 pm. The resident's wander guard bracelet was checked for placement and functioning upon return to facility. Alarm sounded when resident returned to facility. The bracelet was moved to the left wrist due to recommendation by the Wander guard technician to have bracelet on same side as sensor. The Licensed Nurse checked the bracelet and door alarm using the tester and was noted to be functioning properly. The Maintenance Director checked the wander guard system, which includes the door module, range of door module, cables and wires and the	F 323	behavior to the charge nurse for review and/or implementation of the facility elopement policy. The Maintenance Director and the Division Director of Facility Engineering checked the wander guard system again on 10/24/11 and determined that the system is functioning properly. The range limit was increased to approximately eight feet to allow the system to alarm once the resident was within approximately eight feet of the door. An additional alarm was placed on the administrative hallway prior to entrance of the front lobby on 11/02/11. Current employees which includes nursing, housekeeping, dietary, therapy and management staff, have been re-educated by the Director of Nursing, Staff Development Nurse, Unit Managers and Weekend supervisor beginning October 22, 2011, regarding the door alarm system and the Elopement Policy and Procedure. All current staff has been in serviced as of 10/28/11, excluding three prn therapy staff and one licensed nurse that is on FMLA and will not return until January 2012. Staff will not be allowed to resume work until education is complete. The in service **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 10 alarm sound at the nurse's station on 10/22/11 at approximately 2 pm, and called the Wander Guard technician on 10/22/11 approximately 2:30 pm. All checks performed at that time indicated that the system was working properly. 2. Residents with the potential to be affected by the alleged deficient Practice: The Licensed Nursing staff reassessed 100% of current residents beginning 10/22/11 with completion on 10/24/11, using the elopement risk assessment to determine if they are at risk for elopement. There are eleven total residents identified to be at risk for elopement. The Licensed Nursing staff checked placement and function of wander guard bracelets for the residents identified at risk for elopement on 10/22/11. Licensed Nursing staff performed every fifteen-minute checks on 10/22/11 through 10/24/11 for those residents identified at risk for elopement. The wander guard system was checked by the Division of Facility Engineering on 10/24/11, and the system was working properly, so therefore, the every fifteen minute checks were discontinued. The Administrator and/or the Director of Nursing will discuss all attempted elopements during the morning meeting Monday through Friday and will discuss residents at risk for elopement weekly for one month. The licensed nurses will complete the Elopement Risk Assessment form for all residents upon admission, quarterly, annually, and with significant change of condition. The Director of Nursing and/or RN supervisors will evaluate each assessment and update care plans and certified nursing assistant assignment sheets, as necessary. The Director of Nursing and/or the Unit Managers	F 323	will be part of the new hire orientation for all newly hired employees. Elopement notebook, which includes pictures and any pertinent information about the resident identified at risk for elopement, will be kept at receptionist desk and each nursing station. Notebooks were reviewed and updated on 10/22/11 by the licensed nurses. Licensed nurses will update notebook when as necessary as changes occur. Notebook was reviewed with staff during the in service education beginning 10/22/11. The Director of Nursing and/or Unit Managers will audit TAR's daily for one week then weekly for one month, then monthly thereafter. The Director of Nursing or designee will trend the results of the audits and will discuss the results during the monthly Quality Assessment and Assurance Committee meeting. **4. Quality Assessment and Assurance Committee** On 10/22/11 an ad hoc subcommittee of the Quality Assurance and Assessment Committee met to discuss and approve this **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 11 will observe the residents identified at risk for elopement each day to assure that wander guard placement is verified and documented on the Treatment Administration Record (TAR) by the Licensed nursing staff. The Director of Nursing, Unit managers and RN Supervisors will review the TAR's daily to ensure that nurses have checked wander guard placement and have documented the same for the residents identified as an elopement risk. The wander guard bracelets are changed according to manufacturers recommendation, which is the expiration date stamped on the bracelet device. The Director of Nursing and/or the unit managers maintains a log and changes the bracelets according to the expiration date on the bracelet or if the bracelet does not function when tested. The night shift nurse will verify function of the wander guard bracelet each night by use of a testing device. The nurse will document on the TAR once every twenty-four hours in accordance with the Elopement Management Policy. The Maintenance Director checked the wander guard system, which includes the door module, range of door module, cables and wires and the alarm sound at the nurse's station on 10/22/11 at approximately 2 pm, and called the Wander Guard Corporation on 10/22/11 approximately 2:30 pm. All checks performed at that time indicated that the system was working properly. 3. Systemic Changes The Administrator, Director of Nursing, Maintenance director and other members of the management and nursing team has reviewed the Elopement Management Policy on 10/22/11 at an ad hoc Quality Assessment and Assurance Committee meeting and has determined that it is	F 323	plan. The Medical Director was informed and approved the plan on 10/22/11. The Committee will meet on a weekly basis for one month then monthly thereafter. Finding from the results of audits and oversight will be reported to the Committee on a monthly basis. The Committee will make recommendations for policy changes or further education where necessary. The Regional Clinical Director will review the meeting minutes monthly for three months. 5. Date of Completion November 30, 2011. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 12 appropriate for the Center's use. The Licensed Nursing staff checked placement and function of wander guard bracelets for the residents identified at risk for elopement on 10/22/11. Licensed Nursing staff performed every fifteen-minute checks beginning 10/22/11, for those residents identified at risk for elopement through 10/24/11. All newly admitted residents will be assessed on the day of admission then weekly for a total of four weeks, by licensed nurses to determine whether they are at risk for elopement. Residents will be assessed by the licensed nurses using the Elopement Risk Assessment form. Residents will be reassessed quarterly, annually, and with significant change of condition. Based on these evaluations, care plans will be updated by the licensed nurse when identified to include intervention to address exit-seeking behavior. Licensed nurses will be responsible for assuring that physicians and family members are contacted of any identified changes within twenty-four hours. The Interdisciplinary Team will discuss all attempted elopements during the morning meeting Monday through Friday and will discuss residents at risk for elopement weekly for one month. The team includes the Administrator, Director of Nursing, Unit Mangers, and other members of the management and nursing team. The certified nursing assistants' assignment sheets will be updated by the Licensed nursing for each resident identified as having exit seeking behaviors. If such behaviors have occurred during the shift the nursing assistant will immediately report the behavior to the charge nurse for review and/or implementation of the	F 323		

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F 323	Continued From page 13 facility elopement policy. The Maintenance Director and the Division Director of Facility Engineering checked the wander guard system again on 10/24/11 and determined that the system is functioning properly. The range limit was increased to approximately eight feet to allow the system to alarm once the resident was within approximately eight feet of the door. An additional alarm will be placed on the administrative hallway prior to entrance of the front lobby on 11/02/11. Current employees which includes nursing, housekeeping, dietary, therapy and management staff, have been re-educated by the Director of Nursing, Staff Development Nurse, Unit Managers and Weekend supervisor beginning October 22, 2011, regarding the door alarm system and the Elopement Policy and Procedure. All current staff has been in serviced as of 10/28/11, excluding seven prn therapy staff and one prn dietary staff. Staff will not be allowed to resume work until education is complete. The in service will be part of the new hire orientation for all newly hired employees. Elopement notebook, which includes pictures and any pertinent information about the resident identified at risk for elopement, will be kept at receptionist desk and each nursing station. Notebooks were reviewed and updated on 10/22/11 by the licensed nurses. Licensed nurses will update notebook when as necessary as changes occur. Notebook was reviewed with staff during the in service education beginning 10/22/11.	F 323		

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F 323	Continued From page 14 The Director of Nursing and/or Unit Managers will audit TAR's daily for one week then weekly for one month, then monthly thereafter. The Director of Nursing or designee will trend the results of the audits and will discuss the results during the monthly Quality Assessment and Assurance Committee meeting. 4. Quality Assessment and Assurance Committee On 10/22/11 an ad hoc subcommittee of the Quality Assurance and Assessment Committee met to discuss and approve this plan. The Medical Director was informed and approved the plan on 10/22/11. The Committee will meet on a weekly basis for one month then monthly thereafter. Finding from the results of audits and oversight will be reported to the Committee on a monthly basis. The Committee will make recommendations for policy changes or further education where necessary. The Regional Clinical Director will review the meeting minutes monthly for three months. Immediate jeopardy was removed on November 3, 2011 at 5:00 PM with interviews of direct care, dietary, business office, housekeeping and licensed nursing staff who confirmed they received in-service training on the facility's elopement and safety monitoring device policy and procedures prior to reporting on duty. Interviews with facility staff revealed awareness of how to respond to a missing resident and implement the elopement procedure. Facility	F 323		

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F 323	Continued From page 15 staff indicted awareness of the safety monitoring device function, wristband checks and location of wandering resident binders. Facility staff interviewed reported direction to notify a licensed nurse or department head immediately when a resident is missing. Interview with licensed nurses revealed awareness of the procedures. Record review of sampled residents revealed documentation of safety monitoring device checks. Observations of the sampled residents revealed safety monitoring devices located on left wrists or left ankles. 2. Resident #11 was admitted to the facility in September 2010. Diagnoses included advanced dementia with a history of wandering behavior. A safety monitoring device was placed on the Resident's right wrist on admission due to a statement in which she expressed a desire to leave the facility. Resident #11 had a prior history of elopement attempts from the facility in 2010. An annual minimum data set dated 9/26/11 assessed Resident #11 with impaired cognition and daily decision-making skills. An elopement risk review dated 9/29/11 assessed Resident #11 at low risk for elopement for reasons to include no history of elopement within the prior six months and no verbal expressions to leave the facility. A care plan dated 9/29/11 identified Resident #11 at risk for elopement due to her dementia with approaches to include evaluation for placement of safety monitoring device and redirection as	F 323		

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needed. On 10/24/11, the Resident's care plan was updated and a physician's order written to place the safety monitoring device to the Resident's left wrist as a follow-up intervention to another resident's elopement from the facility. Additionally, on 10/24/11 an elopement risk review was completed. Resident #11 was again assessed at low risk for elopement for reasons to include no history of elopement within the prior six months and no verbal expressions to leave the facility.

A nurse's note dated 10/30/11 at 4:00 PM written by licensed nurse #3 (LN #3) documented that Resident #11 was noted outside of the building in the parking lot in her wheel chair. No injuries were noted after an assessment. The nurse's note also documented that the Resident removed the safety monitoring device from her left wrist. The nurse's note continued that the safety monitoring device was replaced to the Resident's left ankle area on 10/30/11 upon her return to the facility.

An elopement risk review was completed again on 10/30/11 and assessed Resident #11 at high risk for elopement due in part to her elopement from the facility on 10/30/11.

On 11/1/11 the care plan was further updated and a physician's order was written to add a replacement safety monitoring device to her left ankle instead of her left wrist.

Review of the security video taken on 10/29/11 at 3:32 PM revealed Resident #11 self propelled to the facility's front door, then stopped and waited while another resident entered the facility. At 3:33

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F 323	Continued From page 17 PM Resident #11 was observed to self propel out of the facility into the parking lot. At 3:34 PM Resident #11 was observed returned to the facility by a staff member. An interview on 11/2/11 at 5:17 PM with restorative aide #1 (RA #1) revealed that Resident #11 attempted to leave the facility in 2010 when the Resident stated "gotta go" and self propelled outside the front door of the facility after a visitor opened the front door; the alarm sounded and staff responded. RA #1 further stated that on 10/30/11 "between 2:30 and 3:00 PM", she heard a buzzing sound coming from the unit on the opposite side of the facility and then the buzzing stopped. Restorative aide #1 further stated she decided to check the front door of the facility. She observed Resident #11 self propelling down the left side of the building into the parking lot. The Resident was wearing a long sleeved shirt and pants, socks and shoes and said "Gotta go" when the Resident was approached. RA #1 checked the Resident, but a safety monitoring device was not found on Resident #11. RA #1 returned Resident #11 to the facility. An interview with nursing assistant #2 on 11/2/11 at 5:20 PM revealed she was familiar with Resident #11 and was assigned to care for her in the past. NA #2 stated that she was aware that Resident #11 would remove her safety monitoring device a lot. An interview with the director of nursing (DON) on 11/2/11 at 5:21 PM revealed that upon admission to the skilled nursing unit a safety monitoring device was placed on the Resident. Resident #11's care plan was updated December 2010 and	F 323		

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F 323	Continued From page 18 a physician's order was written to apply the safety monitoring device to her right ankle due to the Resident's ability to remove it from her wrist. The interview continued that when Resident #1 eloped from the facility on 10/22/11, all residents with wandering behavior were reassessed for risk of elopement and safety monitoring devices were all moved to the residents' left wrists, including Resident #11. The DON further stated that the safety monitoring device was placed on the Resident's left wrist on 10/24/11 despite her previous history of removing the safety monitoring device from her right wrist. When asked if Resident #11's ability to remove the safety monitoring device from her wrists was considered, the DON replied the safety monitoring devices were moved to the left wrist for all residents due to a recommendation from the facility's safety monitoring device vendor. The DON stated that on 10/30/11, Resident #11 was found in her wheel chair outside the facility in the parking lot by a staff member. The safety monitoring device was not located on Resident #11 when she was returned to the facility and still had not been found. A safety monitoring device was replaced on Resident #11 on her left ankle on 10/31/11 because of her ability to remove the safety monitoring device from her wrists. Review of an incident report dated 10/29/11 during the interview with the DON revealed Resident #11 was found at 3:30 PM outside in the parking lot area in her wheel chair. The safety monitoring device was replaced to the left ankle. The DON stated the date of the incident report should have been 10/30/11. An interview with LN #3 on 11/3/11 at 10:30 AM revealed that she checked the safety monitoring	F 323		

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F 323	Continued From page 19 device for Resident #11 on 10/30/11 during med pass "between 8:00 and 9:00 AM" and it was on and functioning. LN #3 also stated that staff would often find Resident #11 on the other side of the facility at the entrance of the independent apartments where the Resident lived before admission to the facility. LN #3 stated she last observed Resident #11 on 10/30/11 "about 1 PM after lunch." LN #3 also stated that Resident #11 was found outside the facility about 3:30 PM on 10/30/11 without the safety monitoring device to her right wrist. LN #3 explained she was not sure how the Resident got the safety device off, but stated she had observed Resident #11 "fidget with it" in the past by moving the band up and down her forearm and towards her hand. Interview with the administrator on 11/3/11 at 11:40 AM revealed she was informed of the elopement for Resident #11 on 10/30/11 and discussed the incident during a staff meeting on the evening of 11/2/11. Staff was in the process of developing a plan for implementation to further prevent elopements in the future. Staff would need to be re-educated regarding elopements and to check placement more frequently. An interview with licensed nurse #4 (nurse supervisor) on 11/3/11 at 12:07 PM revealed that it was the responsibility of the nurse managers to apply safety monitoring devices to residents. LN #4 further stated that on 10/24/11 safety monitoring devices were replaced for all residents with a risk of elopement to the left wrist due to an elopement by Resident #1. LN #4 stated she applied the safety monitoring device to the left wrist on Resident #11 on 10/24/11 and checked to make sure it fit correctly. LN #4 also stated that	F 323		

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F 323	Continued From page 20 LN #3 reported that Resident #11 would "play" with the band of her safety monitoring device by moving it up and down her arm and hand.	F 323		