STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345310	A. BUILDING _____ B. WING _____	05/23/2013

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, pharmacy consultant interview and record review the facility failed to transcribe a physician's order to decrease the dose of the medication Prilosec for one (Resident #71) of ten sampled residents for medication review. The findings included: Resident #71 was admitted to facility on 1/8/12 with diagnosis of reflux esophagitis. The pharmacy consultant's recommendations dated 3/12/13 documented Resident #71 had a history of Gastroesophageal reflux disorder (GERD). She had received Prilosec 40 milligrams (mg) daily since her admission to facility in January 2012. The pharmacist explained the long term use of proton pump inhibitor (PPI) (which suppresses acid production in the stomach) may increase the risk of Clostridium Difffifficle colitis, pneumonia and possibly fractures. If continued acid suppression is required, the recommendation to use a lower maintenance PPI dose was provided to the physician. The rationale for a lower dose would be to minimize the potential for adverse drug events. The documented recommendation was to consider reducing omeprazole (Prilosec) to 20 mg by mouth once daily for GERD. The pharmacy recommendation was signed by the	F 281	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance. Prefix Tag: F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Douglas P. Russell	NHA	6/14/13

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

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F 281	Continued From page 1 physician and he agreed to the dose reduction. The date of the physician's signature was 3/26/13. Review of the monthly orders for April 2013 included the medication Prilosec. The dose remained 40mg every day. Review of the Medication Administration Records (MAR) for April 2013 revealed Prilosec 40mg had been administered every day. Review of the MAR for May 2013 included the medication Prilosec. The dose remained 40mg every day. The medication had been administered on May 1, 2013. Interview on 5/1/13 at 4:03 PM with the 7-3 supervisor revealed once the physician signs the pharmacy recommendation, it is considered an order. The orders would be faxed to the pharmacy. It was her understanding she did not have to write another order, i.e. telephone order. The pharmacy would then change the order on the monthly MARs. The 7-3 supervisor did not know how the order was missed and the medication error occurred. The order to change the dose was missed during the March and April MAR checks. Interview on 5/3/13 at 1:30 PM with the Director of Nursing was conducted to explain the process for transcribing orders. The MARs for the next month would usually come to the facility from the pharmacy around the 21st of the month. A nurse was assigned to check orders at the end of the month against the next month's MARs. This was done by the 11-7 nurses. The 7-3 nurses were to transcribe new orders to the current MAR and the next month's MAR. An extra nurse works on the	F 281	It is the intent of this facility to provide or arrange services which meet professional standards of quality. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Corrective action for the affected resident was accomplished by transcribing the order. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: For those residents with potential to be affected, we completed a 100% review of all of the March Drug Regiment reviews to ensure that no other orders had been missed. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Nurse will be required to write "Transcribed/faxed to pharmacy" on every review that requires a change. This in-service was	5/3/13 5/3/13

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F 281	Continued From page 2 11-7 shift on the night the MARs are changed out. This nurse assists in checking the MARs and doing the changeover. The Director of Nursing was asked how the order may have been missed. The response provided " It was a transcription error. The nurses missed the pharmacy recommendation in the chart. " Interview with the pharmacy consultant was conducted on 5/3/13 at 1:32 PM. It was explained his monthly review conducted in April involved the previous month (March).He would not have reviewed the April MAR until May and would not have noticed the medication error until the May visit.	F 281	completed with all licensed nursing staff Pharmacy consultant will continue to review 100% of all current healthcare charts for drug regimen review on a monthly basis. 4) Facility's plan to monitor its performance so solutions are sustained, evaluated for effectiveness, and integrated into the facility's QAPI process.	6/17/13 5/3/13
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to prevent 2 of 3 cognitively impaired residents (#32 and #176) from exiting the facility without the knowledge of staff. Resident #32 fell outside and sustained a fractured humeral neck (a fracture of the upper arm bone, near the top, just under shoulder joint). Resident #176 walked 8/10 of a mile from the facility on a two lane road with no shoulder.	F 323	To monitor the effectiveness of this plan on-going, we will audit 100% of Drug Regimen reviews each month for three months, followed with an audit of 10% of Drug Regimen reviews each month for three months. At that time, the Quality Assurance and Performance Improvement Committee will evaluate the need for continued audits. These measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process. The Director of Nursing will report on the measures implemented to the QAPI Committee which will monitor for effectiveness for a minimum of three months. The QAPI	6/17/13

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F 323	Continued From page 3 The Immediate Jeopardy began on 4/25/13 for Resident #32, and 5/7/13 for Resident #176. The immediate Jeopardy was identified on 5/22/13 at 9:40 am and was removed on 5/23/13 at 5:03 pm. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete implementation of system changes and monitoring the corrective action stated in the credible allegation. The findings included: 1. Resident #32 was originally admitted to the facility on 8/1/99 and readmitted on 2/13/09 with diagnoses that included senile dementia, psychosis, depressive disorder, organic brain syndrome, and dementia with behavior. The Minimum Data Set (MDS) dated 4/4/13 revealed Resident #32 required limited assistance to complete activities of daily living. The MDS further identified the resident as being severely cognitively impaired. Resident #32 did not exhibit wandering during the assessment period. Review of the Elopement Risk Assessment dated 8/13/12, 10/31/12, 1/16/13 and 4/5/13 revealed Resident #32 had a score of 12 identifying the resident was at risk for elopement. A Review of the Fall Risk Assessments dated 8/18/12, 10/31/12, 1/16/13, and 4/5/13 revealed the resident had a score not to exceed 17 indicating the resident was a high risk for falls. A review of Resident #32's Care Plan dated 8/13/12 and quarterly review dated 4/10/13 revealed the resident had a Care Plan for	F 323	Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that QAPI recommendations are acted upon in a timely manner. Prefix Tag: F323 FREE OF ACCIDENT HAZARDS/ SUPERVISION / DEVICES It is the intent of this facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Incident dated 4/25/13 Resident (#32) was located and assessed by Registered Nurse supervisor. Emergency medical services were summoned, arrived and transported resident to hospital. Resident (#32) was diagnosed with a right humerus fracture with orders for orthopedic follow-up. Resident (#32) returned same day to facility.	4/25/13

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F 323	Continued From page 4 Elopement. The care plan revealed a goal of " Resident will remain within the health care unit x 90 days " . The approaches on the plan of care were listed as, " maintain wanderguard bracelet and check battery weekly, re-direct resident when she tries to leave the building, attempt diversional activities such as a magazine, walking to the courtyard, going to activities, speak to resident in a calm quiet voice, wandergaurd for safety, and encourage participate in diversional activities after supper. " The Care plan identified Resident #32 had an episode of elopement on 4/25/13. Review of Resident #32's care plan further revealed the resident was care planned for falls, and cognitive loss. A review of nursing notes written by nurse #2 dated 4/25/13 revealed the facility was notified that a resident was outside on the ground at 11:30 am. The note further revealed Resident #32 was found on her left side complaining of right shoulder pain and right hip pain. The note further indicated the resident's walker was 4 feet behind her. The nursing note revealed the residents vital signs were taken and wanderguard taken from her right ankle prior to transport to the hospital via stretcher. Nursing note dated 4/25/13 revealed Resident #32 returned to the facility with a diagnosis of a right humeral neck fracture at 3:25 pm. The medical record revealed a physician order dated 4/25/13 indicating Resident #32 was to be sent to the Emergency room for evaluation of pain in arm and hip due to a fall. Resident #32's medical record further revealed an order written 4/25/13 to apply body alarm, bed alarm, and chair alarms. Review of Hospital Discharge records dated 4/25/13 reveal the resident had a right	F 323	A one-to-one in-service was conducted with each Homemaker Guide with instructions, "Effective immediately, no residents with wander bracelet will be taken out of the healthcare secured area to attend activities. The only exception to this policy will be circumstances where arrangements have been made for the resident to have constant one-to-one supervision while they are outside the secure area."	4/29/13
			Incident dated 5/7/13 One-on-one supervision (24-hours) was immediately assigned to this resident. Resident (#176) was reassessed and determined to be a high risk of elopement. Executive Director and Healthcare Administrator met with the resident's family immediately after the incident to relate details of the incident, interventions taken, and to solicit their input as to any other action they would like from the facility	5/7/13
			Nursing supervisor and Director of Nursing assessed resident (#176) for injury, none found. Director of Nursing initiated every 15min staff checks at 4:15PM. At 7:00PM, one-on-one nursing assistant/ sitter supervision was initiated and	

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F 323	Continued From page 5 humeral neck fracture due to a fall. Hospital discharge records dated 4/25/13 indicated the resident was prescribed Lortab 5 milligrams every 6 hours for pain. A review of the facility Unanticipated Occurrence Report and Investigation revealed a visitor had found Resident #32 out to the front left of the building in the grass on the ground on 4/25/13 at 11:30 am. The resident's walker was near side. The report further revealed the resident was calling for help and was lying on her left side. The Occurrence Report revealed that prior to the incident on 4/25/13, Resident #32 was in an activity in which staff had taken the resident to Unity (spiritual singing). The Incident Report revealed the staff member that was responsible for the resident (Home Maker Guide #2) left Resident #32 due to another resident that required medical assistance. When the staff member returned to Resident #32 the activity had concluded and there were no more residents remaining in the activity upon the staff 's return. The Investigation report indicated the facility checked all exits doors, initiated a head count of all residents, and initiated maintenance requests to check all doors. Review of the Home Maker Guide Job description revealed Essential duties and responsibility included; " Maintain a safe, comfortable and functional environment by assessing the household for potential hazards, implementing practices utilizing appropriate techniques regarding sanitation, infection control, fire safety, disaster preparedness and emergency care, attending or assuring the household is presented on all appropriate councils and team of the community, investigation and reporting all	F 323	continued until resident's discharge. The family declined facility's offer and recommendation to have resident transferred to a local closed (double-locked) facility stating, "We like it here." Resident (#176) was discharged home on 5/10/13 per family request. Family arrived at 8:30AM on 5/10/13 and stated, "I'm taking her home." Resident stayed with family prior to admission to the facility. Resident received "Notice of Medicare Provider Non-Coverage" on 5/9/13. Post Discharge Plan of Care included contact information for NC Ombudsman and follow up with physician for surgical appointment on 5/15/13, presurgical assessment appointment on 5/1013 and followup with primary care physician. Prescriptions were called to pharmacy for medications. <u>2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:</u> Incident dated 4/25/13 Residents having the potential to be affected by this deficient practice were identified by receiving an elopement risk	5/7/13 5/10/13

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F 323	Continued From page 6 incidents and accidents, observing the team for safe work habits and addressing observations, and develops and implements social programs which will provide communication among residents through group activities and recreations. " Interview with nurse # 2 on 5/21/13 at 11:07 am revealed the she was approached by the Director of marketing on 4/25/13 at 11:30 am. Nurse #2 indicated the Director of Marketing revealed a Resident was outside of the facility lying on the grass in the front of the building. Nurse#2 indicated Resident #32 was located outside the front of the building lying on her side. Nurse #2 identified the location Resident #32 was found. The location was beyond main entrance (3) to left of the building. The Resident was just beyond the sidewalk at the beginning of a decline in the grass. The identified area was visible to the main parking lot. Nurse#2 further revealed Resident #32's walker was just behind the resident and the resident was wearing a wanderguard on her ankle. Nurse #2 revealed she provided Resident #32 with a pillow for comfort and stayed with the resident until EMS arrived. Nurse#2 indicated that she was unaware of how long Resident #32 was outside of the facility. Nurse #2 revealed Resident #32 had never made attempts to exit the building. Nurse#2 further revealed Home Maker Guides took the resident to an activity prior to the incident occurring. Nurse #2 stated Home Maker Guides did not communicate to the Nursing staff when they escorted residents to the non-skilled side of the building. Nurse #2 further indicated that Home Maker Guides did not communicate when they return a resident from an activity and there was currently no log that would relay information regarding a resident that had	F 323	assessment (a tool to evaluate mental status, mobility, elopement history and emotional status to determine if interventions are needed to prevent elopement)upon admission, quarterly and as need indicates (exit seeking behavior). The Administrator in-serviced all Homemaker Guides that residents who wear wander bracelets can no longer leave the HC secure area without one-to-one supervision. Instructions stating, "CNAs – DO NOT take residents with wandering bracelets outside of the healthcare unit." were placed in the nursing assistants' daily assignment notebook. Incident dated 5/7/13 A root cause analysis was conducted to identify the factors leading to the deficiency. The following systemic changes have been implemented to address these factors: 1. Staff member failed to identify individual as a healthcare resident with risk for elopement. Action Taken: An in-service was placed in the nursing in-service notebook at the 500 nursing station to clearly establish the expectation staff are to determine the identity of an individual before permitting them to exit the facility. Training included	4/29/13

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F 323	Continued From page 7 been taken from the skilled area. Interview with Home Maker Guide #2 on 5/21/13 at 1:16 pm revealed Resident #32 was escorted to an activity at " Unity Place " by Home Maker Guide #2. The Home Maker Guide revealed " Unity Place " was area of the facility used for various activities or church events. The Home Maker Guide indicated she escorted Resident #32 to the Unity place with one other resident. The Home Maker Guide #2 further revealed Home Maker Guide #3 had also taken 2 residents to the activity at " Unity Place. " Home Maker Guide #2 indicated the activity was full of residents from the skilled side of the facility and residents from independent living. The Home maker guide revealed there were over 30 residents in the activity. The Home Maker Guide revealed one of the residents had an emergent health concern that required immediate attention. The Home Maker Guide revealed she left Resident #32 in the activity. The Home Maker Guide indicated that she did not inform any staff member that she was leaving Resident #32 unattended while she sought out medical attention for the other escorted resident. The Home Maker Guide stated Resident #32 was only left unattended for 10 minutes. Home Maker Guide #2 revealed that when she returned to Resident #32 the activity had concluded and the there were no residents remaining in " Unity Place. " The Home Maker Guide indicated she was under the impression that another staff member had escorted Resident #32 back to the skilled side of the facility. The Home Maker Guide reveled she does not communicate to nursing staff that she is escorting a resident to an activity on the non-skilled side of the facility. The Home Maker Guide further revealed she was	F 323	instruction on how to properly identify whether an individual is an at-risk resident or visitor to include visual inspection for wander bracelets and appropriate questions to ask the individual to make the determination. Staff were required to sign acknowledging receipt of this in-service. 2. Assure only those who need door codes know the door codes. Action Taken: All door codes were changed within the facility to ensure only those who need the codes know them. 3. Restrict use of the 500 ambulance door to authorized staff only. Action Taken: On 5/8/13, established a unique code for the 500 ambulance door, known only to the Executive Director, Healthcare Administrator, Director of Nursing, Assistant Director of Nursing, nursing shift supervisors and security. 500 door was retrofitted on 5/10/13 to incorporate the Secure Care System wander sensor/locking mechanism by the contractor. 4. Assure proper operation of existing security measures and wandering system operation.	5/8/13 5/8/13 5/10/13

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F 323	Continued From page 8 unaware of how long Resident #32 had been outside of the facility. Interview with Home Maker Guide #3 on 5/21/13 at 1:42 pm revealed she did not see Resident #32 in the activity on 4/25/13. The Home Maker guide indicated she had taken a small group of residents to the activity with the assistance of the facility Chaplin. The Home Maker Guide further indicated that there were more residents in the activity from the skilled side of the facility than were escorted by Home Maker Guide #2 and Home Maker Guide #3. The Home Maker Guide revealed at the conclusion of the activity she had to assist with escorting the residents back to the skilled side of the facility. The Home Maker guide indicated a lot of wheelchair residents were in attendance that required assistance back to the skilled side of the facility. At no time did Home Maker Guide #3 see Resident #32 while providing residents assistance back to the skilled side of the facility. Home Maker Guide indicated that she does not communicate to nursing staff when residents are taken to activities on the non-skilled side of the facility. Home Maker Guide further revealed she does not communicate to nursing staff when a resident has been returned to the skilled side of the facility. Interview with the Maintenance Director on 5/21/13 at 3:20 pm revealed the facilities only alarmed doors were located within the skilled area of the facility. The Maintenance Director further indicated the alarms on the doors were routinely monitored on a weekly basis. The Maintenance Director further revealed the 3 main entrance doors into the facility would not alarm if a resident with a wanderguard were to exit.	F 323	Action Taken: All exit doors were tested by the Director of Plant Operations, to assure proper working order. 5. Assess elopement risk for other healthcare residents. Action Taken: Reviewed 100% of healthcare residents to ensure all residents at risk for elopement had proper identifiers and interventions in place (wander bracelet, photo in Elopement Book, wrist band). Each resident at risk for elopement (determined by licensed nurse using elopement risk assessment tool) was determined to have bracelet in place, photo in notebook, and monitoring on MAR for placement every shift and weekly function test. 6. Increase awareness of visitors to the potential for elopement. Action Taken: New larger signs have been posted at all exit doors, replacing smaller older signs, instructing visitors to not allow residents to follow them as they exit the facility. <u>3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur.</u>	5/7/13 5/8/13 5/8/13

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F 323	Continued From page 9 Interview with the Director of Marketing on 5/23/13 at 8:57 am revealed she takes lunch around 11:30 am. The Director of Marketing further revealed that upon exiting the building for lunch she and a visitor observed Resident #32 lying in the grass in front of the building. The Director of Marketing indicated she left the visitor with the Resident #32 while she retrieved Nurse #2. The Director of Marketing stated that she was unaware of which exit Resident #32 exited the building. Interview with NA# 3 on 5/23/13 at 9:12 am revealed she was the Aide assigned to Resident #32 at the time of the incident on 4/25/13. NA# 3 indicated she was unaware the resident did not return from the activity and was told Resident #32 was found injured outside of the facility. NA# 3 further indicated that Home Maker Guides do no communicate when residents are taken from assignment due to an activity or when the resident is returned following an activity. NA #3 indicated that Resident #32 was confused often but never attempted to exit the building. Interview with the Director of Nursing (DON) on 5/2/13 at 10:40 am revealed Resident #32 did sustain an injury following a fall outside of the facility. The DON indicated that the resident did have a wanderguard on at the time of the incident. Resident #32 was located outside the facility in the grass. The DON indicated the resident was in the grass before the facility parking lot. The DON further indicated the Home Maker Guide responsible for Resident #32 had briefly left resident while in activity in the non-skilled side of the building due to the illness of another resident. The DON indicated that when the Home Maker Guide returned to the	F 323	a) The Director of Plant Operations will continue to monitor and check the Secure Care System on a weekly basis to ensure proper operation. This has been and will continue to be ongoing. b) An in-service was placed by the Assistant Director of Nursing in the nursing in-service notebook located at the 500 nursing station to clearly establish the expectation nursing staff are to determine the identity of an individual before permitting them to exit the facility. Training included instruction on how to properly identify whether an individual is an at-risk resident or visitor to include visual inspection for wander bracelets and appropriate questions to ask the individual to make the determination. Questions include "May I help you?" "Are you a resident or a visitor?" "Who are you visiting?" "What is the room number of the resident?" If any question is inappropriately answered, staff was instructed to get assistance from a nurse and make the individual aware that this is protocol to ensure all residents' safety. The nursing assistant who noted resident (#176) on the loading dock received an one-on-one in-service with the instructions, "Staff member	4/25/13

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F 323	Continued From page 10 activity it had concluded and Resident # was not in " Unity Place. " The DON revealed the responsible Home Maker Guide had assumed that another staff or Home Maker Guide had escorted Resident#32 back to the skilled side of the facility. The DON indicated the skilled side of the facility had alarms for residents with wanderguards. The DON indicated that due to the resident being in an activity on the non-skilled/unalarmed area of the facility, no alarm would sound in the instance Resident #32 eloped from the building. Interview with the Administrator on 5/3/13 at 3:30 pm revealed Resident #32 had a fall outside of the facility that resulted in fracture of the resident arm. The Administrator revealed the facility immediately implemented preventative measures following the elopement of Resident #32. The Administrator indicated preventative measures included checking the facility wanderguard alarm system, revising the ratio of Home Maker Guides to resident, and any resident who wears a wanderguard would not be taken out of the secure unit unless one-on-one supervision could be provided. 2. Resident #176 was admitted to the facility on 5/2/13. Diagnoses included dementia without behavior disturbance, anorexia and atrial fibrillation. The admission assessment dated 5/2/13 indicated the resident required assistance of 1 person for transfers and ambulation. An "Elopement Risk Assessment" dated 5/2/13 revealed that Resident #176 was assessed as being at low risk for elopement due to the	F 323	should not assist individuals in exiting the facility before establishing their identity." c) Elopement drills will be held monthly for a three-month period, followed by quarterly drills for a six-month period by Director of Plant Operations. A sign-in sheet will be used to reflect all those staff members participating in the elopement drill. Following the drill, a review of the event will be held to evaluate the process and responses and to make changes to the process as needed. d) Weekly testing of the wandering locking system at all egress sites will be conducted by Director of Plant Operations. During weekly tests by the Director of Plant Operations, a wander bracelet will be used to test the locking mechanism and audible alarms of each exit door within facility. e) Director of Nursing completed Post Hazardous Wandering and Elopement Assessment to review the actions of the facility in response to the elopement, its evaluation and assessment of the resident's risk of elopement before the incident and environmental factors contributing to the incident.	5/9/13 5/9/13 4/25/13

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F 323	Continued From page 11 resident having no history of wandering or attempting to leave the building, no expressed desire to leave the premises or display of restlessness or anxiousness, and required assistance with ambulation. Nurse's Notes dated 5/2/13 at 1:30 PM, written by Nurse #1, revealed that a door alarm transmitter band was placed on Resident #176's ankle due to possible wandering. (The transmitter will signal a sensor near an exit door to engage a magnetic door lock to prevent the resident from opening the door, or if the door is ajar, will activate an audible alarm to alert staff that a resident is attempting to leave the building.) During an interview on 5/22/13 at 2:30 PM, Nurse#2 indicated she talked with Resident #176 on admission and believed a door alarm transmitter was appropriate because the resident was confused and very mobile. Nurse#2 did not know if the resident had a history of wandering but recognized the potential. Nurse#2 indicated she instructed Nurse#1 to put a transmitter on the resident. Nurse's Notes dated 5/2/13 at 6 PM revealed the resident was alert with some intermittent confusion, oriented to person only. Physician orders dated 5/3/13 included skilled physical therapy (PT) for therapeutic exercises and activities, and training for transfers, balance and gait. Physical Therapy Notes dated 5/6/13 indicated that Resident #176 walked 100 feet with only "contact guard assist" (physical therapist has one or both hands on the resident's body to help with balance if needed) and on 5/7/13 walked 300 feet with contact guard assist. Additional PT notes dated 5/7/13 revealed the physical therapist met with a family member to discuss discharge around the 14th day of the resident's stay due to her high level of mobility. The family member was	F 323	This assessment summarizes the circumstances from the beginning to the end of the event and care plan review and follow-up action. f) We determined the clear glass door and mini-blinds on nearby windows at the end of 500 Household could serve as an attraction to the outdoors to a resident with dementia. Environmental Director has ordered blinds which diffuse light but reduce the visual ability to see outdoors. Further, a stop sign and Velcro strip barrier was placed on this egress. g) A "Wandering Resident In-service" was conducted with staff on 5/22/13. All other staff will be in-serviced during their next shift worked until 5/29/13, at which time, those who have not completed the mandatory in-service will be removed from the work schedule until they have completed this in-service. New employees will receive this in-service during new employee orientation. The "Wandering Resident In-service" included: Wandering Resident In-service	5/8/13 5/9/13 5/29/13

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F 323	Continued From page 12 agreeable. During an interview on 5/22/13 at 2:11 PM, the Physical Therapist Assistant (PTA) indicated Resident #176 was at high risk for falls when first admitted due to balance problems, but made rapid progress to the point of just needing stand by assistance for stabilization when first standing. The PTA added he had never witnessed the resident wandering in the facility or trying to exit. Nurse's Notes from 5/2/13 - 5/6/13 revealed no documentation of exit seeking behavior. Nurse's Notes dated 5/7/13 at 4:20 PM read, "Found that Res. (Resident #176) walked away from facility, was found on (name of road) by a good citizen and kept at his home until (family member) went and picked her up, she returned to facility with (family member)." Review of an "Unanticipated Occurrence Report and Investigation" for Resident #176's elopement of 5/7/13 revealed that a family member called the facility on 5/7/13 to report that the resident had walked away from the facility. A written statement from Nurse#2 revealed a family member (FM#1) called to report that the resident had gotten out of the facility and was at a man's house but she did not know where. FM#1 reported that the resident had remembered FM#2's phone number and the resident called FM#2. FM#2 called FM#1 to report the resident had left the facility and was at a man's house. The statement revealed that RN#2 checked the resident's room, did not find her, and called a "Code Purple" (the code used when a resident is missing, announced over the public address system, to alert staff on other units to participate in the search). During an interview on 5/23/13 at 8:58 AM, FM#2 stated she had received a phone call on 5/7/13 at 3:35 PM from an unknown man who said her	F 323	1. All residents will receive an Elopement Risk Assessment on Admission, quarterly, and as need indicates (exit seeking behavior). 2. Residents who are identified as being as being at risk will have a wander bracelet placed, picture place in notebook, information placed on Kardex, care plan, and Medication administration record with location of bracelet. 3. Presence of wander bracelet will be confirmed each shift by the nurse on the hall. Wander bracelet function will be tested daily by 11-7 nurses. Maintenance will monitor the function of Secure Care System weekly. 4. Effective 05/22/13, each resident who wears a wander bracelet will also have a wrist bracelet applied (red in color, (temporarily); purple has been ordered and will be used as identifier when received). 5. Residents with wander bracelets will not be allowed to leave the HC unit without 1:1 supervision. 6. All exit doors are alarmed. When alarm sounds, ALL staff, who hear alarm regardless of discipline,	

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F 323	Continued From page 13 relative (Resident #176) was with him. FM#2 then spoke with the resident who reportedly said, "Come and get me and take me home." FM#2 indicated she again spoke with the man who said he would stay with the resident until someone could come and pick her up, and gave directions to their location. FM#2 indicated she called FM#1, then FM#3 who said he would pick up the resident. During an interview on 5/22/13 at 3:10 PM, FM#3 stated he picked up the resident about 8/10 of a mile down the road from the facility, in front of a house. FM#3 recalled several facility staff walking alongside the road as he drove past the facility. Shortly thereafter he saw the resident and a man standing in a yard. FM#3 stated they were on the same side of the road as the facility. FM#3 said it started raining right after he picked up the resident and the resident was dry. FM#3 indicated he was unsure of the time they returned to the facility. A written statement (undated) by Nurse#1 revealed the resident and FM#3 arrived at the facility around 3:50 PM on 5/7/13. According to www.wunderground.com <http://www.wunderground.com>, the area temperature in the afternoon of 5/7/13 was 67-68 degrees Fahrenheit with scattered clouds. Nurse's Notes dated 5/7/13 at 4:20 PM indicated Resident #176 was assessed for injuries with none noted. Blood pressure was 120/70, temperature 98 degrees Fahrenheit, pulse 78 and respirations 20. (Vital signs on the 7-3 shift were 118/56, 97.6, 54 and 18.) The resident was positioned in bed, given a snack and fluids and placed on every 15 minute checks. FM#3 remained with the resident. There was no documentation that Resident #176 made any further attempt to exit the building.	F 323	will respond immediately to determine cause. 7. Elopement Books with purple colored inserts will be located at each nurses station with pictures of residents and location of wander bracelet. Licensed nurses will update Elopement Books when a nursing order is written. 8. Nursing assistants will "lay eyes" on all residents who are considered to be wanderers at least every two hours. 9. If system has "locked down" door, staff will identify whether person trying to leave is a visitor or a resident before disarming door. Check to see if wander bracelet is present. Check to see if red/purple bracelet is present on wrist. Check notebook on unit. You may ask these questions to help identify: May I help you? Are you a resident or visitor?, Who are you visiting?, What is the room number of the resident? If any question is inappropriately answered, get assistance from a nurse. Make person aware that this is our protocol to ensure ALL resident's safety.	

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F 323	Continued From page 14 A "Post Hazardous Wandering & Elopement Assessment" dated 5/9/13 indicated that 1:1 supervision was started at 7:00 PM on 5/7/13. During an interview on 5/22/13 at 8:55 AM, NA#5 acknowledged she worked the 7-3 shift on 5/7/13 on the hall where Resident #176 resided. NA#5 said the resident walked independently and was usually in the 300 hall dining area when she was not in therapy. NA#5 indicated that she had never observed Resident #176 to wander or attempt to exit the building. On the day the resident eloped, NA#5 recalled last seeing her at 3:10 PM in the dining area, sitting at the counter. During an interview on 5/22/13 at 4:59 PM, NA#6 acknowledged she was assigned to Resident #176 on the 3-11 shift of 5/7/13. NA#6 said she was familiar with the resident and knew the resident walked around the unit independently. She had never seen Resident #176 attempt to exit the building. NA#6 recalled last seeing the resident shortly after 3 PM on 5/7/13. At that time the resident was in the dining area. NA#6 stated she then made her first rounds on her residents which took 20 -30 minutes. When she was done, NA#6 said she noticed Resident #176 was not in the dining room but she was not concerned because she knew the resident to walk around the unit independently and go to and from her room. NA#6 added that she checked her residents visually every hour when they were up, then every 2 hours after they were in bed. During an interview on 5/23/13 at 11:42 AM, Nurse#1 indicated that on 5/7/13, she last saw Resident #176 around 3:15 PM, sitting in the dining area talking with NA#5. Nurse#1 said she	F 323	h) A wrist bracelet, presently red, was applied by the Staffing/Purchasing Coordinator to all residents identified as at risk for wandering. The purple wrist bracelets ordered on 5/8/13 will be exchanged for the red bracelets when they arrive. 4) Facility's plan to monitor its performance so solutions are sustained, evaluated for effectiveness, and integrated into the facility's QAPI process. The frequency of completing the "Watchmate Audit Log" will be increased from once per month to weekly X4, biweekly X4, then once per month. The "Watchmate Audit Log" documents the name, location of Watchmate, picture in notebook, presence of red/purple bracelet on wrist, that MAR reflects daily check of function and per shift verification placement of bracelet and verification on the Kardex and Care Plan reflect that resident wears a bracelet. The Director of Nursing will be responsible for monitoring this action. These measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process. The	5/22/13 5/22/13

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F 323	Continued From page 15 had never witnessed Resident #176 attempt to leave the facility. Nurse#1 added that Resident #176 walked very well independently with no notable difficulty. Nurse#1 was not aware that the resident left the building. A written statement dated 5/7/13 by NA#4 revealed, "Around 3:15 or 3:30, I saw a couple of men coming in the 500 hall door and a woman in a yellow jump suit going out. The door did not alarm and she said her daughter was picking her up at the back door. She asked if I could find a number for someone and I explained my phone doesn't work. She didn't say anything and left walking." During an interview on 5/21/13 at 3:06 PM, NA#4 indicated she did not work on the hall where Resident #176 resided and did not know the resident. NA#4 explained that on 5/7/13, shortly after 3:00 PM she saw a woman (Resident #176), dressed in a pantsuit and carrying a purse, walking out the door at the end of the 500 hall. No alarm sounded. NA#4 stated there was a lot of activity on the hall that afternoon due to construction workers going in and out the exit door as a new shelf was being installed at the 500 hall nursing station. NA#4 said she then noticed the resident standing on the loading dock and looking kind of confused. NA#4 said the resident asked to use her cell phone; NA#4 told her she did not have a working cell phone that day. NA#4 indicated the resident then said she was waiting for her daughter to pick her up. NA#4 added that it was unusual for family to pick up residents at that location since the door was always locked and required a code to open it, but it was possible. NA#4 went on to say that following the elopement, she had received additional training	F 323	Director of Nursing will report on the measures implemented to the QAPI Committee which will monitor for effectiveness for a minimum of six months. The QAPI Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that QAPI recommendations are acted upon in a timely manner.	

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F 323	Continued From page 16 and would take measures to verify the identity of a person before assisting them to exit the facility or leave them outside unattended. She would ask the person if they lived at the facility or were visiting, and get their name. She would verify whether or not the name was on the resident roster. She would also visually check for a transmitter band on their wrists and ankles. During an interview on 5/23/13 at 8:30 AM, the Maintenance Director stated at the time Resident #176 eloped, the door on the 500 hall was the only exit door in the skilled section of the facility that was not equipped to lock or alarm if a resident with a transmitter approached the door. Rather, the 500 hall door was always kept locked and a code was required to open it. All employees in the skilled section were given the code. On 5/23/13 at 10:54 AM, observation of the loading dock/ambulance entrance outside the 500 hall door revealed a concrete pad with a ramp going down to a paved surface which led to the main road. The distance from the 500 hall door to the front yard of the home where Resident #176 was found was clocked at 8/10 of a mile per odometer. This distance was then walked at a moderate pace and took 16 minutes. The road had 2 lanes and several curves. The speed limit was posted at 45 miles per hour (mph) with the exception of 1 curved span that was 30 mph. During the walk, 25 cars passed by. The pavement did not extend to provide a shoulder. The terrain adjacent to the pavement was uneven and grassy. One section of the road, approximately 30 feet long, had a span approximately 6 feet wide from the edge of the pavement to a sharp drop-off of an estimated 12-15 feet. The embankment was lined with rocks. The area walked was on the same side of	F 323		

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F 323	Continued From page 17 the road as the facility. Nurse's Notes through 5/10/13 revealed no indication of further attempt to exit. 1:1 supervision round-the-clock was maintained. Therapy notes dated 5/10/13 revealed the family announced they were taking the resident home. The therapist advised family to see the charge nurse so proper discharge arrangements could be made. A physician order was obtained for discharge on 5/10/13. A "Post Discharge Plan of Care" form was completed with instructions for activity, diet, medications and follow-up appointments. During an interview on 5/21/13 at 3:10 PM, the Director of Nursing (DON) stated when the facility was made aware that Resident #176 was missing, immediate action was taken in accordance with the "Missing Residents" policy, including to first check the resident's room, doing a resident head count and calling a "Code Purple" over the public address system to signal other staff to participate in the search. The search was still in process when the resident returned. The resident was assessed and there was no indication of injury. Every 15 minute checks were initiated immediately, then changed to 1:1 supervision. The DON indicated staff members were educated on the importance of ensuring that they were not inadvertently assisting a resident out of the facility by asking the person if they lived at the facility and to state their name. Staff members were expected to compare the stated name with the resident roster. Staff members were also instructed to look for a transmitter band on the wrist or ankle. The DON added that she	F 323		

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F 323	Continued From page 18 could not verify that a staff member had held the door open for the resident since there were contracted workers using the 500 hall door that day. She said the facility immediately changed the code to the door, and only the executive director, administrator and she had the new code. The DON explained that if ambulance service was needed, there was a button at the nurse's station that would unlock the door. The Administrator and Director of Nursing were notified of Immediate Jeopardy on 5/22/13 at 9:40 am. The Allegation of Compliance was received on 5/23/13 at 9:19 pm. The Allegation of Compliance was accepted on 5/23/13 at 5:03 pm. 1) Address how corrective action has been or will be accomplished for those residents found to have been affected by the deficient practice. Incident dated 4/25/13 Resident (#32) was located and assessed by Registered Nurse supervisor. Emergency medical services were summoned, arrived and transported resident to hospital. Resident (#32) was diagnosed with a right humerus fracture with orders for orthopedic follow-up. Resident (#32) returned same day to facility. 4/25/13 A one-to-one in-service was conducted with each Homemaker Guide with instructions, " Effective immediately, no residents with wander bracelet will be taken out of the healthcare secured area to attend activities. The only exception to this policy will be circumstances where arrangements have been made for the resident to have constant one-to-one supervision while they are outside the secure area. " 4/29/13 Incident dated 5/7/13	F 323		

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F 323	Continued From page 19 One-on-one supervision (24-hours) was immediately assigned to this resident. Resident (#176) was reassessed and determined to be a high risk of elopement. Executive Director and Healthcare Administrator met with the resident ' s family immediately after the incident to relate details of the incident, interventions taken, and to solicit their input as to any other action they would like from the facility. 5/7/13 Nursing supervisor and Director of Nursing assessed resident (#176) for injury, none found. Director of Nursing initiated every 15min staff checks at 4:15PM. At 7:00PM, one-on-one nursing assistant/sitter supervision was initiated and continued until resident ' s discharge. The family declined facility ' s offer and recommendation to have resident transferred to a local closed (double-locked) facility stating, " We like it here. " Resident (#176) was discharged home on 5/10/13 per family request. 5/7/13 2) Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. Incident dated 4/25/13 Residents having the potential to be affected by this deficient practice were identified by receiving an elopement risk assessment upon admission, quarterly and as need indicates (exit seeking behavior). The Administrator in-serviced all Homemaker Guides that residents who wear wander bracelets can no longer leave the HC secure area without one-to-one supervision. Instructions stating, " CNAs - DO NOT take residents with wandering bracelets outside of the healthcare unit. " were placed in the nursing assistants ' daily assignment notebook.	F 323		

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	345310	A. BUILDING _____ B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 20 4/29/13 Incident dated 5/7/13 A root cause analysis was conducted to identify the factors leading to the deficiency. The following systemic changes have been implemented to address these factors: 1. Staff member failed to identify individual as a healthcare resident with risk for elopement. Action Taken: An in-service was placed in the nursing in-service notebook at the 500 nursing station to clearly establish the expectation they are to determine the identity of an individual before permitting them to exit the facility. Training included instruction on how to properly identify whether an individual is an at-risk resident or visitor to include visual inspection for wander bracelets and appropriate questions to ask the individual to make the determination. 5/8/13 2. Assure only those who need door codes know the door codes. Action Taken: All door codes were changed within the facility to ensure only those who need the codes know them. 5/8/13 3. Restrict use of the 500 ambulance door to authorized staff only. Action Taken: On 5/8/13, established a unique code for the 500 ambulance door, known only to the Executive Director, Healthcare Administrator, Director of Nursing, Assistant Director of Nursing, nursing shift supervisors and security. 500 door was retrofitted on 5/10/13 to incorporate the Secure Care System wander sensor/locking mechanism by the contractor. 5/10/13 4. Assure proper operation of existing security measures and wandering system operation.	F 323		

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F 323	Continued From page 21 Action Taken: All exit doors were tested by the Director of Plant Operations, to assure proper working order. 5/7/13 5. Assess elopement risk for other healthcare residents. Action Taken: Reviewed 100% of healthcare residents to ensure all residents at risk for elopement had proper identifiers and interventions in place. Each resident at risk for elopement was determined to have bracelet in place, photo in notebook, and monitoring on MAR for placement every shift and weekly function test. 5/8/13 6. Increase awareness of visitors to the potential for elopement. Action Taken: New larger signs have been posted at all exit doors, replacing smaller older signs, instructing visitors to not allow residents to follow them as they exit the facility. 5/8/13 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. (The measures must include all staff that could be involved and all residents that could be involved.) a) The Director of Plant Operations will continue to monitor and check the Secure Care System on a weekly basis to ensure proper operation. 4/25/13 b) An in-service was placed by the Assistant Director of Nursing in the nursing in-service notebook located at the 500 nursing station to clearly establish the expectation they are to	F 323		

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F 323	Continued From page 22 determine the identity of an individual before permitting them to exit the facility. Training included instruction on how to properly identify whether an individual is an at-risk resident or visitor to include visual inspection for wander bracelets and appropriate questions to ask the individual to make the determination. Questions include " May I help you? " " Are you a resident or a visitor? " " Who are you visiting? " " What is the room number of the resident? " If any question is inappropriately answered, staff was instructed to get assistance from a nurse and make the individual aware that this is protocol to ensure all residents ' safety. The nursing assistant who noted resident (#176) on the loading dock received an one-on-one in-service with the instructions, " Staff member should not assist individuals in exiting the facility before establishing their identity. " 4/29/13 c) Elopement drills will be held monthly for a three-month period, followed by quarterly drills for a six-month period by Director of Plant Operations. A sign-in sheet will be used to reflect all those staff members participating in the elopement drill. Following the drill, a review of the event to evaluate the process and responses and to make changes to the process as needed. 5/9/13 d) Weekly testing of the wandering locking system at all egress sites will be conducted by Director of Plant Operations. During weekly tests by the Director of Plant Operations, a wander bracelet will be used to test the locking mechanism and audible alarms of each exit door within facility. 4/25/13 e) Director of Nursing completed Post Hazardous Wandering and Elopement Assessment to review the actions of the facility in	F 323		

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F 323	Continued From page 23 reaction to the elopement, its evaluation and assessment of the resident ' s risk of elopement before the incident and environmental factors contributing to the incident. This assessment summarizes the circumstances from the beginning to the end of the event and care plan review and follow-up action. 5/8/13 f) We determined the clear glass door and mini-blinds on nearby windows at the end of 500 Household could serve as an attraction to the outdoors to a resident with dementia. Environmental Director has ordered blinds which diffuse light but reduce the visual ability to see outdoors. Further, a stop sign and Velcro strip barrier was placed on this egress. 5/9/13 g) A " Wandering Resident In-service " was conducted with staff on 5/22/13. All other staff will be in-serviced during their next shift worked until 5/29/13, at which time, those who have not completed the mandatory in-service will be removed from the work schedule until they have completed this in-service. New employees will receive this in-service during new employee orientation. The " Wandering Resident In-service " included: 5/29/13 Wandering Resident In-service 1. All residents will receive an Elopement Risk Assessment on Admission, quarterly, and as need indicates (exit seeking behavior). 2. Residents who are identified as being as being at risk will have a wander bracelet placed, picture place in notebook, information placed on Kardex, care plan, and Medication administration record with location of bracelet. 3. Presence of wander bracelet will be confirmed each shift by the nurse on the hall. Wander bracelet function will be tested daily by 11 -7 nurses. Maintenance will monitor the function of Secure Care System weekly.	F 323		

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F 323	Continued From page 24 4. Effective 05/22/13, each resident who wears a wander bracelet will also have a wrist bracelet applied (red in color, (temporarily); purple has been ordered and will be used as identifier when received). 5. Residents with wander bracelets will not be allowed to leave the HC unit without 1:1 supervision. 6. All exit doors are alarmed. When alarm sounds, ALL staff, who hear alarm regardless of discipline, will respond immediately to determine cause. 7. Elopement Books with purple colored inserts will be located at each nurses station with pictures of residents and location of wander bracelet. Licensed nurses will update Elopement Books when a nursing order is written. 8. Nursing assistants will "lay eyes" on all residents who are considered to be wanderers at least every two hours. 9. If system has "locked down" door, staff will identify whether person trying to leave is a visitor or a resident before disarming door. Check to see if wander bracelet is present. Check to see if red/purple bracelet is present on wrist. Check notebook on unit. You may ask these questions to help identify: May I help you?, Are you a resident or visitor?, Who are you visiting?, What is the room number of the resident?, If any question is inappropriately answered, get assistance from a nurse. Make person aware that this is our protocol to ensure ALL resident's safety. 5/22/13 h) A wrist bracelet, presently red, was applied by the Staffing/Purchasing Coordinator to all residents identified as at risk for wandering. The purple wrist bracelets ordered on 5/8/13 will be exchanged for the red bracelets when they arrive.	F 323		

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F 323	Continued From page 25 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The frequency of completing the " Watchmate Audit Log " will be increased from once per month to weekly X4, biweekly X4, then once per month. The " Watchmate Audit Log " documents the name, location of Watchmate, picture in notebook, presence of red/purple bracelet on wrist, that MAR reflects daily check of function and per shift verification placement of bracelet and verification on the Kardex and Care Plan reflect that resident wears a bracelet. The Director of Nursing will be responsible for this action. These measures will be monitored by the Director of Nursing, with oversight by the Administrator through the Quality Assurance process. The Director of Nursing will report on the measures implemented to the Quality Assurance and Performance Improvement Committee which will monitor for effectiveness for a minimum of six months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner. 5/22/13 Beginning at 3:30 PM on 5/23/13, interviews were conducted with staff members in various departments to determine compliance. Interviews revealed staff had been provided in-services and were able to repeat procedures for identifying residents who were known elopement risk. These staff members knew their role and what action to take for residents with known elopement risks. All residents assessed	F 323		

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F 323	Continued From page 26 to be at risk for elopement were observed to have red bracelets in place and photos in an elopement book. All exits doors were observed to lock with the approach of residents wearing a wanderguard and to alarm when a wanderguard passed through the secured area. Documentation was reviewed that was used in the in-service training, and the signature lists of all staff in-serviced on 5/23/13. Other Information reviewed consisted of the QI tool, " Watchmate Audit Log. " The " Watchmate Audit Log " identified residents ' name, location of resident watchmate, a picture of the resident, presence of red bracelet on wrist, and the MAR reflects daily check of function and per shift.	F 323		