

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

AUG 19 2013

PRINTED: 07/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/24/2013
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NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST - ACUTE CARE OF DURHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705
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F 000	INITIAL COMMENTS	F 000		
	<p>The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section began a complaint investigation survey on July 18, 2013 through July 24, 2013. The survey team identified Immediate Jeopardy at 483.25 for Resident #1 on July 19, 2013. The Immediate Jeopardy began on July 12, 2013 and a partial extended survey was conducted on July 20, 2013. The Immediate Jeopardy was removed on July 21, 2013 and the facility was left out of compliance at a lower scope and severity of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy).</p> <p>This Statement of Deficiencies was amended to reflect that the Immediate Jeopardy began on July 12, 2013 and not on July 10, 2013.</p> <p>Pertinent staff interviews were conducted on July 24, 2013. Therefore, the survey exit date was changed to July 24, 2013.</p>		<p>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law</p>	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	<p>What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?</p> <p>A. On 7/9/13 at approximately 11:15pm The Resident #1 told the 11-7 and 3-11 nurses he was going to the VA and the nurses told resident to go back to room. At approximately 11:30 pm Certified Nursing Assistant reported resident was on facility grounds. Resident # 1 was brought back in facility and placed on every 15 minute checks for 24 hours. Nursing staff were responsible for 15 minute checks and visually layed eyes on Resident #1 at least every 15 minutes. 15 minute Patient Check Sheet includes Staff initials every 15 minutes and location of patient. On 7/10/13 the social worker called the guardian and asked the guardian to come talk to Resident # 1 because he wants to go home to Raleigh. Guardian came to facility and spoke with social worker and resident #1 to explain that his home was foreclosed on and this was the best place for him.</p>	8/12/13
	<p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lee Leopasde* TITLE: *Administrator* 8/12/13 (X6) DATE: *8/14/13*

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 323	Continued From page 1 interview and record review, the facility failed to put interventions in place to prevent elopement by 1 of 1 resident (Resident #1). On 7/9/13 Resident #1 exited the building unsupervised via the rehab door and was found in the facility parking lot. He was unharmed and placed on every 15 minute checks for 24 hours. On 7/10/13 the facility determined no further interventions to prevent elopement were needed and the 15 minute checks were discontinued. On 7/12/13 Resident #1 again left the building unsupervised via the main entrance door and walked 0.9 miles, crossing a 4 lane street, to a bus stop after obtaining a bus ticket. He was found unharmed. The facility implemented 1:1 supervision. On 7/13/13 Resident #1 again left the facility via the rehab door during a breach in the 1:1 supervision. He was found in the parking lot, unharmed.  Immediate Jeopardy began on 7/12/13 when Resident #1 exited the facility unsupervised via the main entrance door and walked 0.9 miles, crossing a 4 lane street, to a bus stop after obtaining a bus ticket. Immediate Jeopardy was identified on 7/19/13 at 3:51 PM and was removed on 7/21/13 at 11:23 AM when the facility provided a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training.  The findings included:  Resident #1 was admitted to the facility on 9/10/12. Diagnoses included a progressive neurologic disorder manifested by impaired	F 323	B. On 7/12/13 Resident was returned to facility by Director of Nursing Services and Rehabilitation Aide at 9:20 AM and was placed on one to one supervision and a wander guard transmitter was applied. 1:1 remains ongoing until more appropriate placement is found. A wander Guard transmitter was placed on the resident on 7/12/2013. This transmitter will set off an alarm if patient approaches the elevator. Other exit door on 3 <sup>rd</sup> floor are key pad coded and will alarm if door is left open. Door located at stairwells are key pad coded, the front door is locked at 8pm by the door monitor. Upon interview with resident # 1, conducted by the administrator resident # 1 stated he watched the nursing staff and waited till they were busy so he could go to the VA to get a bus ticket to Raleigh. Resident #1 stated he left around 5am and exited the building via the front door. Resident # 1 had no medications ordered during the 11pm-7am shift. The 7-3 Certified Nursing assistant and Licensed Nurse noted at 7am the resident was not in his room. At approximately 7:20am the Certified Nursing Assistant notified the Licensed Nurse that the resident was still not on the floor at this point the Licensed Nurse instructed the staff to search the floor and the courtyard.  C. On 7/13/13 at approximately 5:45am resident was noted at elevator with alarm ringing, Nurse asked resident to go back to room and resident continued to proceed in elevator. Nurse ran down the stairway to meet resident on the first floor, the elevator continued to basement. Nurse ran down the stairway to the basement and followed resident outside. Staff attempted to bring resident back in the facility resident began fighting and hitting staff.		

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F 323	Continued From page 2 cognition, emotional instability and uncontrolled movement.  The most recent Minimum Data Set (MDS) was a quarterly assessment dated 6/7/13. The MDS indicated Resident #1 was severely cognitively impaired, had no wandering behavior, ambulated in room with supervision and had unsteady balance but was able to stabilize without human assistance.  The care plan dated 9/17/12 indicated a problem of "scores poorly on the BIMS (Brief Interview for Mental Status) due to not answering questions or unable to understand due to poor speech, with poor safety awareness placing him at risk for decline in cognitive status r/t (related to) (neurologic disorder)." Goal: "will remain alert and oriented x 3 (to person, place and time) through next review." Approaches included "Monitor for increased safety issues."  "Elopement Risk Observation" assessments, dated 9/10/12, 12/10/12, 3/5/13 and 6/5/13 indicated Resident #1 was at low risk for elopement. The assessments indicated he was alert and oriented to person, place and time and had no known exit-seeking behavior.  Nurse's Notes by Nurse #1, dated 7/10/13 on the 11 PM - 7 AM shift 7/9/13 indicated that around 11:15 PM she observed Resident #1 approach the elevator and tell the 3-11 shift nurse (Nurse #2) that he was going to the VA (Veterans' Administration). Nurse #2 told him he cannot go to the VA now and to go back to his room. Around 11:30 PM a nursing assistant (NA #1) came to the floor and informed staff that Resident #1 was on the facility grounds. The resident became	F 323	Administrator was able to coax the resident back in the facility. The resident was placed on 1:1 and the administrator spoke with staff about expectations of 1:1.  Resident care plan updated by MDS Coordinator to include elopement risk on 7/12/13. Interventions included 1:1 and a wander guard transmitter. The Nurse Practitioner assessed the resident on 7/12/13, Nurse Practitioner assessed resident for complaint of anxiety.  The Guardian was called by the Social Worker and the Social Worker left a message for the Guardian to return call on 7/12/13. Guardian did not immediately return call. Follow up calls were made by Social Worker to Guardian on 7/15, 7/16, 7/18, 7/19 and Guardian has not yet return any of these phone calls.  Elopement Books were updated by the Medical Records Coordinator to include Resident #1 on 7/12/13. Elopement books contain a picture and physical description, diagnosis and contact information on any resident with exit seeking behaviors. Elopement books are kept at the nurse's stations, receptionist, and the therapy desk.  How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?  Elopement Risk observation forms which includes; residents cognition, sensory deficit, predisposing conditions, ambulation and mobility, pain were completed by the Unit Coordinator/Managers, Director of Nursing and Case Mix Director for all residents on 7/12/13. None of the Residents' Elopement Risk observation forms revealed that any new identified interventions were indicated.		

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F 323	Continued From page 3 agitated and uncontrollable when asked to go back inside the facility. He was given Ativan (an antianxiety drug) 1 milligram (mg) intramuscularly. The resident calmed down a short time later and slept well. Frequent checks were done while the resident was in his room. The resident woke up at 6:30 AM with no mood and behaviors noted. The plan was to continue to monitor behavior.  During an interview on 7/18/13 at 5:25 PM, Nurse #2 recalled on the night of 7/9/13 she had reported off to Nurse #1 and was finishing her paperwork. The resident went to the elevator and said he was going outside to smoke. Nurse #2 indicated this was normal behavior for him and she had never known him to try to get away from the facility or to talk about leaving the facility. Nurse #2 denied hearing the resident say he was going to the VA.  During an interview on 7/19/13 at 3:45 PM, Nurse #1 stated she recalled Resident #1 approaching the elevator, while she and Nurse #2 were counting narcotics, shortly after 11 PM, and telling Nurse #2 he was going to the VA. Nurse #1 said Nurse #2 told the resident to go back to his room and he did. Nurse #1 said a little bit later NA #1 came to the floor to report the resident was in the basement headed towards the exit into the courtyard. Nurse #1 indicated she immediately left to go check, going to the basement and out through the rehab door. She did not see him and walked through the courtyard into the parking lot. She saw the resident in the front of the building with two male nurses assisting him inside. He was agitated. One of the nurses called the physician and gave Ativan. The male nurses then assisted the resident to his room and put him in	F 323	Education was provided by the RN Clinical Competency Coordinator, Director of Health Services and Administrator to all staff, including licensed and unlicensed Nursing Staff, and all staff in each department. Education involved discussion of elopement procedure, including assessment of risk, signs of exit seeking behavior and who to report signs of exit seeking behavior to, prevention and what to do if a patient is unaccounted for and what to do upon return to facility if a patient elopes. Education began on 7/12/13, the education is ongoing and those employees who have not worked will be educated prior to their next schedule shift. This education has been completed at 95%. The assigned licensed nurse assigned for each resident is responsible for completing the Elopement Risk Observation form, and completing the care plans with the interventions. Identifying/exit seeking behavior ie: voicing desire to go home, packing clothes and attempting to exit doors and history of leaving the center without needed supervision. Elopement Risk Observation forms are completed on admission/readmission, quarterly and change of condition i.e. exhibiting exit seeking behaviors. Care plans are updated with change in conditions and with assessment/observation updates. Once a resident exhibits exit seeking behavior the assigned licensed nurse will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be in the wander guard notebook with description of resident and a wander guard will be placed on the resident.  Education completed by the Administrator, Director of Health services; and the Clinical Competency Coordinator, for all licensed nurses		

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F 323	Continued From page 4 bed. The nurse stated she checked Resident #1's vital signs and encouraged him to lie down. He was checked every 15 minutes and made no further elopement attempts that night.	F 323	and direct care nursing staff on walking rounds to include Certified Nursing Assistant to walk there assignment with the oncoming shift to visualize each resident if resident not in room Certified Nursing Assistant are to report to the assigned licensed nurse, licensed nurses are to walk there assignment with the oncoming shift to visualize and give verbal report on each resident then sign the 24		
	During an interview on 7/20/13 at 9:45 AM, NA #1, who was assigned to Resident #1 on 7/9/13, recalled that she was leaving the floor to go home after working the 3-11 shift on 7/9/13. As she got on the elevator, Resident #1 got on with her. She said she went to the basement to clock out. (The "Time Card Report" revealed NA #1 clocked out at 11:32 PM on 7/9/13.) When she got off the elevator she turned left to the time clock and expected the resident to do the same since she thought he was going to the nearby vending machine, but the resident turned right to walk down the hall towards the exit door going into the courtyard. (The courtyard is a fenced in area with 2 gates that are always kept open.) NA #1 said she asked Resident #1 where he was going and he pointed down the hall and said, "over there". NA #1 stated she immediately went back upstairs to report that Resident #1 was going outside. She said 2 nursing assistants (NA #2 and another) immediately left the floor, taking the stairs while NA #1 took the elevator. She went to the basement hall and out the door to the courtyard but did not see the resident. She said she got into her car, drove to the front of the building and saw the resident with several staff members. NA #1 indicated she had never known Resident #1 to try to get away from the facility before, and had not heard him say anything about leaving.		hour report, if resident is not found in room Licensed nurse will start the elopement procedure 1. Note the time the resident was discovered missing and by whom. 2. Notify the Administrator or highest ranking supervisor on duty and note time they were alerted. 3. Determine the time the resident was last seen. 4. Begin the search by organizing healthcare center staff to search building and grounds. Note time it was begun. 5. Note who participated in the search and which areas were searched. 6. After initial search of the facility and facility grounds and determined residents is not on center property then notify the police and note the times and name of police officer involved and information offered to police. 7. Notify and note the time Administrator and Director of Health Services were notified, if not on premises. 8. Notify the family, note the time and their reactions. 9. Notify the physician. Note time and any orders given. 10. Notify management company staff. 11. The highest ranking supervisor will begin documentation of all events. The supervisor will stay abreast of the situation updating the record at least every 15 minutes. 12. When resident is located the supervisor, police, physician, family, and corporate		
	During an interview on 7/20/13 at 12:34 PM, NA #2 recalled that Resident #1 had walked out of the facility on the night of 7/9/13, shortly after her shift started. NA #2 stated she had never known				

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F 323	Continued From page 5 the resident to try to elope or talk about leaving the facility. NA #2 indicated she was not aware of anything that might have caused the resident to want to leave.	F 323	13. The time the resident is located, where they were found, and resident condition will be noted and documented. Any employee that has not had the education related to walking rounds will not be allowed to work until the education is completed.		
	Review of "Fifteen Minute Check" forms dated 7/9/13 - 7/10/13 indicated Resident #1's location was documented every 15 minutes from 7/9/13 at 11:45 PM - 7/10/13 at 11 PM.  During an interview on 7/18/13, Administrative Staff #1 indicated Resident #1's elopement was discussed in the morning meeting on 7/10/13. During the meeting Administrative Staff #3, the unit coordinator for Resident #1, voiced that she believed the elopement was an isolated incident. Administrative Staff #1 stated she talked with Resident #1 who said his plan was to go to his home in (name of town). She told the resident the facility would arrange for him to be moved to that town and he agreed to wait. Administrative Staff #1 said that since the resident made no further attempts to leave the facility during the 24 hour period he was on 15 minute checks, the checks were stopped and no further interventions were warranted.		What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?  1. Walking rounds initiated for shift change for licensed nurses and certified nursing assistants began on 7/12/13 on 11-7 shift and will continue every shift indefinitely. Licensed Nurses began signing the 24 hour report on 7/12/13. The Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor will review the 24 hour reports to ensure the licensed nurses are signing the 24 hour reports to validate that walking rounds were completed. Audits of the 24 hour report sheet will be completed daily by the Director of Health Services, Clinical Competency Coordinator and/or Week-end Supervisor for one week and weekly thereafter for two (2) months. The Director of Health Services, Clinical Competency Coordinator, Administrator, and/or Week-end Supervisor will observe Certified Nursing Assistants completing walking rounds for two shifts daily times one week, and weekly thereafter for two months.		
	During an interview on 7/19/13 at 9:30 AM, Administrative Staff #3 said it was completely out of character for Resident #1 to leave the building, and since he made no further attempts to leave during the next 24 hours; she felt no additional measures were needed after completion of the 15 minute checks.  Nurse's Notes by Administrative Staff #2 dated 7/12/13 at 8:50 AM indicated she and Administrative Staff #1 were notified that staff were unable to locate Resident #1 in the facility.		2. All new admitted and readmitted Residents will have their Elopement Risk Observation form completed on admission by the assigned license nurse for that resident. Any Resident who voices desire to leave facility or exhibits exiting seeking behaviors will also have an Elopement Risk Observation form filled out and intervention will be put in place immediately, by the nurse completing the observation form, to include but not limited to placing a wander guard on resident, move resident		

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F 323	<p>Continued From page 6</p> <p>At 8:55 AM a complete head count of residents and search of entire facility and grounds was initiated. Staff were deployed via vehicles to surrounding area and community. At 9:05 AM confirmed Resident #1 was not in facility or grounds. Staff continued the search of surrounding area and community. At 9:15 AM Resident #1 was located by facility staff and returned to the facility.</p> <p>During an interview on 7/20/13 at 11:46 AM, Nurse #3 acknowledged she worked on 7/11/13 from 11 PM to 7/12/13 at 7 AM. Nurse #3 stated she arrived on duty after 11 PM but before midnight, and she was the only licensed nurse scheduled for the floor. The nurse indicated she was very busy and did not see Resident #1 that night. She said when she went into his room to give the roommate medications the curtain was pulled between the two beds. Since Resident #1's bed was on the far side of the curtain she did not see him. The nurse added that she was not concerned because the resident was fairly independent and could let staff know if he needed anything.</p> <p>During an interview on 7/24/13 at 6:55 AM, NA #3 acknowledged Resident #1 was on her assignment beginning 7/11/13 at 11 PM. The NA stated the resident was not in his room when she made her first rounds at approximately 11:05 PM, but the curtain between the two beds was open. NA #3 thought he was downstairs, which was not unusual. NA #3 said when she made subsequent rounds the curtain was pulled so she assumed he was in bed. NA #3 recalled the resident had told her in the past that if his curtain was pulled that meant he did not want to be touched. She added she had seen how combative he had been the</p>	F 323	<p>to the 3<sup>rd</sup> floor, which is equipped with the wander guard system and door key pads, and start 1:1 for 24 hours then reassess which is determined by the license nurse. The care plan will be updated with interventions, by the nurse completing the observation form, at this time. Care Plans will be reviewed by the Interdisciplinary Team to ensure interventions were appropriate. Findings will be reported to the Director of Health Services and or Clinical Competency Coordinator and/or Weekend Supervisor. If the Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor is not in facility then the assigned nurse will notify Director of Health Services and/or Administrator via phone.</p> <p>3. Upon completion of the Elopement Risk Observation form the licensed nurse will copy the elopement risk observation and give to the Director of Health Services, clinical Competency Coordinator and/or Weekend Supervisor to ensure completion of the form and intervention initiated if indicated with review of the care plan. The Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor will complete review of Elopement Risk Observation form daily for two weeks, weekly for four weeks and then monthly for two months to ensure measures are in place for identified areas.</p> <p>4. Employees hired after 7/12/13 will be educated by the Clinical Competency Coordinator and/or the Director of Health Services on the elopement policy and procedures and walking rounding during orientation. Audits of the 24 hour report sheet will be completed daily by the Director of Health Services, Clinical Competency Coordinator and/or Week-end Supervisor for one week and weekly thereafter by for two (2) months.</p>		

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F 323	Continued From page 7 night of 7/9/13 and she did not want to take any chance of irritating him.  On 7/19/13 at 2:35 PM, NA #4, assigned to Resident #1 for the 7-3 shift on 7/12/13, was interviewed. NA #4 stated Resident #1 was not in his room when she made her first rounds a few minutes after 7 AM, but she was not concerned since she knew him to get around the building independently and thought he might be out smoking or walking around. NA #4 roughly estimated that 45 minutes later the nurse (Nurse #4) asked if she had seen Resident #1 and she said no. NA #4 then started to look for him on the unit. NA #4 indicated that she floated to different assignments and this was the first time she had been assigned to Resident #1. She was not aware that he had any exit seeking behaviors.  On 7/19/13 at 10:06 AM, Nurse #4 was interviewed. She stated she first went to Resident #1's room between 7:50 AM and 8:00 AM and did not see him, but his cane and wheelchair were there so she thought he was with a nursing assistant in the shower. The nurse said she saw NA #4 around 8:15 - 8:20 AM and asked where the resident was. The NA said she had not seen him yet that morning. At that time the housekeeper (HK #1) was going down to the break area and the nurse asked her to check in the smoking area for Resident #1. HK #1 returned in about 10 minutes and said he was not there. Nurse #4 then checked both elevators and the 2nd floor but did not find him. She then called Administrative Staff #3.  During an interview on 7/19/13 at 9:30 AM, Administrative Staff #3 said that Nurse #4 called her around 8:50 AM to report that the resident	F 323	The Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor will review the 24 hour reports to ensure the licensed nurses and Certified Nursing Assistance is signing the 24 hour reports to validate that walking rounds were completed.  5. Staff assigned to sit 1:1 were educated and completed competency on expectations of 1:1 and use of 1:1 log form by the Director of Health Service, Administrator, Clinical Competency Coordinator and/or Week-End Supervisor on 7/20/13. No staff will be permitted to sit with resident unless competency is completed. The Director of Health Service, Administrator and/or Week-End Supervisor will review the 1:1 logs daily to ensure compliance. 1:1 logs contain Date, sign in time, and sign out time and signature of staff. Any issues identified will be handled immediately by the Director of Health Services, Administrator and/or week-end supervisor.  6. Staff placed in the basement to visualize exit doors. One staff member placed in area to observe elevator, therapy exit door and visualization of hallway. One staff member placed in hallway in front of the maintenance office for visualization of the other elevator, and door located by the time clock this staff member will also visualize the hallway. Staff were educated and completed competency on door observation form which included sign in and out at start of shift and relief for breaks and meals. Receptionist was educated on the responsibility of lobby door observation by the Director of Health Services.		



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

PRINTED: 07/30/2013  
FORM APPROVED  
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F 323	<p>Continued From page 8</p> <p>was missing. She instructed the nurse to start searching rooms and bathrooms. Administrative Staff #3 indicated she was with all the administrative staff and managers getting ready for the morning meeting, and immediately a full search was organized to include the facility and grounds.</p> <p>During an interview on 7/18/13 at 12:08 PM, Administrative Staff #1 said when the call came that Resident #1 was missing she deployed staff immediately to count all residents in the building and search all areas of the facility. Others were to search the grounds and community. The search began at 8:50 AM and the resident was found at the bus stop by the VA Hospital between 9:10 - 9:15 AM.</p> <p>Resident #1 was interviewed on 7/19/13 at 11 AM. His voice was soft and speech difficult to understand at times but he willingly repeated what he said and was understood. Resident #1 said he wanted to go home and to die at home. In the meantime, he did not belong at the facility with all the old, sick people since he still had a lot of life to live. He stated he was a soldier and will always be a soldier. He saw an opportunity to leave the facility and he took it. Resident #1 explained that around 4:30 AM on 7/12/13 he left the building with the plan to walk to the VA Hospital to get a bus ticket for (name of home town). He indicated he left through the front door by pushing the handicap button that automatically opens the doors. He relayed how he walked to the VA and entered the emergency room. The attendant asked if he had an emergent condition and he said no, he needed a bus ticket to his home town. He stated the attendant got a social worker for him who issued the ticket, then he</p>	F 323	<p>Receptionist responsibilities include monitoring who is leaving through the front. If a resident is in question about being outside or before leaving the receptionist will notify the unit where the resident resides. Receptionist will observe the front door while on duty once receptionist leaves for the day, the door monitor will observe the lobby front door until 8pm at this time the door monitor will lock the front lobby door. Door monitor responsibilities include observing who is leaving through the front door. If a resident is in question of being outside or before leaving the Door Monitor will notify the unit where the resident resides to inform the unit of the residents' location. Education was conducted by the Director of Health Service, Clinical Competency Coordinator, and/or Week-end Supervisor on 7/20/13. Once the front door is locked at 8pm the door will remain locked with the door monitor in place until 8am, at which the receptionist will be at the desk. No staff will be permitted to sit in the basement or at front door unless competency is completed. 1:1 in basement and front door monitor will continue until the installation of locking key pads, on doors that will remain locked and a number code will be needed to unlock the door, and/or wander guard system, bracelets will be applied to residents and if the resident attempts to open door the door will lock and alarm, is installed. Wander guard system and locking key pad will be tied into the nurse call system and if an alarm goes off it will read out on the nurse call board for location. 1:1 logs for basement and front door monitor will be reviewed daily by the Director of Health Service, Administrator, and/or Week-end Supervisor. Any issues identified will be handled immediately by the Director of Health Services, Administrator and/or week-end supervisor.</p>		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345061	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/24/2013
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F 323	<p>Continued From page 9</p> <p>proceeded to the bus stop. Resident #1 said he still had the bus ticket, and produced it on request.</p> <p>During an interview on 7/19/13 at 9:30 AM, Administrative Staff #3 said she had searched via car and found Resident #1 at the bus stop. Additional facility staff arrived and convinced him to return to the facility.</p> <p>The distance from the facility to the VA hospital was clocked on an odometer at 0.9 miles. There was a city sidewalk from the facility to the VA. Seven cross streets were counted between the facility and the VA. The bus stop where Resident #1 was found was directly across a 4 lane street from the VA.</p> <p>On 7/20/13 at 2:00 PM, the Administrator on Duty (AOD) at the VA hospital was interviewed. She stated that the VA did issue bus tickets to veterans but only tracked those who seemed to be over-using the system. She pulled up Resident #1 and said there was no record of him being at the VA on 7/12/13 or getting a bus ticket and could not say who the social worker may have been.</p>	F 323	<p>How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance.</p> <ol style="list-style-type: none"> <li>1. The findings of Walking round audits with tracking and trending will be done by the Director of Health Services and taken to the Quality Assurance/Performance Improvement (QA/PI) Committee by the Director of Health Services or the Administrator for review, revision and recommendations from the QA/PI Committee monthly for three months.</li> <li>2. The results of collected data and interventions implemented of the elopement risk observation audits with tracking and trending by the Director of Health Services will be taken to the Quality Assurance /Performance Improvement (QA/PI) Committee by the Director of Health Services or the Administrator for review, revision and recommendations from QA/PI Committee monthly for three months</li> <li>3. The results from the 1:1 resident observation, 1:1 logs for basement and front door monitor will be tracked and trended by the Director of Health Services will be taken to the Quality Assurance /Performance Improvement (QA/PI) Committee by the Director of Health Services or the Administrator for review, revision and recommendations from QA/PI Committee monthly for three months.</li> </ol>	
	<p>Per Nurse's Notes by the Administrative Staff #2 dated 7/12/13 at 9:20 AM, the resident returned to his room; he was severely agitated. One-on-one (1:1) supervision was initiated. Continual attempts by staff to redirect the resident failed. At 9:45 AM the physician was notified and Ativan was ordered. At 11 AM the resident was calm. At 11:15 AM a Wanderguard was placed to the resident's left ankle. 1:1 supervision continued. At 10:15 PM he continued to be calm; 1:1 supervision was maintained.</p>			

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

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FORM APPROVED  
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F 323	Continued From page 10  The Care Plan was updated on 7/12/13 for the problem of risk for elopement. Interventions included 1:1 supervision, do not allow resident to leave the facility without supervision and ensure Wanderguard is in place and functioning every shift.  Nurse's Notes, written by Nurse #5, dated 7/13/13 at 3:45 AM read, "Resident sitting up in bed. Has put all of his clothes and shoes on. When asked what he is doing, resident stated 'Going to the bathroom.' After using restroom, resident layed [sic] back down." Notes at 5:45 AM indicated Resident #1 was at the elevator with alarm ringing. He was asked to return to his room, glared at the nurse and got on the elevator. He exited the building through the basement and was seen in the parking lot. He ignored staff requests to stop and kept walking toward the street. Staff intercepted and the resident became combative; he placed himself on the sidewalk in a prone position. The notes indicated Administrative Staff #1 arrived and coaxed the resident back into the building. He was escorted back to his room and remained on 1:1 watch.	F 323			
	On 7/24/13 at 5:10 AM, Nurse #5 was interviewed. She stated there were 3 staff members present on the unit that shift and they rotated doing 1:1 supervision for Resident #1. She recalled that NA #5, with her permission, left her station outside the resident's door to help a resident across the hall who was calling out for the bedpan. The nurse said she herself went to the bathroom and was off the hall for less than a minute. When she came out, Resident #1 was at the elevator, the alarm was ringing and he glared at her. Nurse #5 opted to let the resident get on				

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

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F 323	<p>Continued From page 11</p> <p>the elevator by himself. He went to the basement. Nurse #5 immediately went downstairs and enlisted the help of the first floor nurse. They went to the basement and saw the resident just outside the courtyard going into the parking lot. Nurse #5 said she called him and he just walked faster. When they passed by the front of the building 2 nursing assistants came out to help. As the staff approached him, he started shouting and swinging his arms at them. He sat down on the sidewalk (parallel and just off the 4-lane street in front of the facility). Nurse #5 indicated Administrative Staff #1 arrived and talked the resident into coming back into the facility.</p> <p>During an interview on 7/24/13 at 5:18 AM, NA #5 stated she thought she would be able to maintain the 1:1 while helping the resident across the hall with the bedpan. NA #5 said was just getting the bedpan under the resident when she heard the alarm at the elevator. When she came out of the room the nurse had already left to find him. NA #5 added, "When he came back to the floor he told me he had been listening for me, did not hear me so he made a move for it."</p> <p>On 7/19/13 at 10:26 AM, Administrative Staff #1 said she often came to work early, and she happened to be pulling into the facility parking lot and saw 4 or 5 staff standing at the end of the driveway on the sidewalk. Resident #5 was sitting on the sidewalk. She said she talked to him and said they would get a plan together on Monday (7/13/13 was a Saturday) for him to move back to his hometown. He agreed to remain at the facility until Monday. He then willingly went back inside the facility. Administrative Staff #1 added that normally the facility had a designated staff member to do 1:1 supervision, with the 1:1 being</p>	F 323		

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

PRINTED: 07/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 12</p> <p>the only assigned responsibility. She said her expectation was for the resident to have continuous supervision and that did not happen.</p> <p>During an interview on 7/19/13 at 11 AM, Resident #1 indicated he left the morning of the 13th because he had another opportunity (the resident laughed when he said this), and that he thought the staff were lying to him about helping him to go home.</p> <p>Subsequent Nurse's Notes from 7/13/13 at 7-AM - 7/17/13 at 6:30 AM revealed no exit seeking behavior and continuous 1:1 supervision.</p> <p>Throughout the survey, Resident #1 was observed to have a designated staff member sit with him or stand immediately outside his door.</p> <p>On 7/18/13 at 11:30 AM, Resident #1 was observed in his room, lying on the bed. His left leg had large involuntary movements, other extremities had finer involuntary movements. Upon request and without assistance, Resident #1 sat up, then rose and walked from his bed to the doorway and back. His gait was unsteady and balance impaired but he was observed to correct his balance without any assistance or devices.</p> <p>NA #6 stood outside his door and said her assigned duty for the day was 1:1 supervision of the resident. The resident said that he wanted to go home, but was now waiting to move to a facility in his hometown where he will get the assistance he needs.</p> <p>A tour of the facility was conducted on 7/20/13 at 3:15 PM with Administrative Staff #2 and Maintenance Director. The only doors with</p>	F 323			

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

PRINTED: 07/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

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F 323	Continued From page 13 Wanderguard sensors were two of two elevator doors on the third floor. The Maintenance Director indicated that the sensor will cause an alarm to sound when a resident wearing a Wanderguard transmitter approaches the elevator but the elevator will continue to function normally. The second and third floors each had 3 doors leading to stairwells. The doors were locked. To unlock the door from inside the unit, a code could be entered on a keypad. To unlock the door from the stairwell a green button, adjacent to the door frame, could be pushed. From inside the unit, the door could be pushed open without entering a code and an alarm would sound. Staff demonstrated during the tour that the door could be opened and the green button immediately pushed and the alarm would stop. On the ground/basement floor, exit doors from the physical therapy gym could be opened after pressing on the bar for 15 seconds. The door was not alarmed. The door exited to a fenced in courtyard with two gates that were continually open. A door at the rehab reception area also exited directly to the courtyard and was not alarmed. A door near the elevator closest to the kitchen was also not alarmed. This door exited to the back of the building. An additional door, just outside the kitchen and leading to the side of the building, had no alarm. The Maintenance Director indicated that the 3-11 shift laundry staff locked the basement doors at night. An interview with the 3-11 laundry staff on 7/20/13 at 5:05 revealed she was the only staff in the laundry that shift and she did not know who was responsible for locking the exit doors. The tour continued to the first floor. Double doors were observed in the main entrance/lobby. Buttons for handicapped were situated on the front porch and on the main hall near the lobby. Facing the entrance doors from	F 323			

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

PRINTED: 07/30/2013  
FORM APPROVED  
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F 323	<p>Continued From page 14</p> <p>the lobby, a decorative column was situated just to the left of the doors. On the left side of the column was a switch similar to a single light switch. The top of the switch was labeled "Nite" and the bottom "Day". The Maintenance Director explained that when the switch was in the "Day" position the door was unlocked and the handicapped button, when pushed, would cause the doors to open. When in the "Nite" position, the door was locked but could be opened if the bar was pushed for 15 seconds. The handicapped button would not function when the door was locked. The door was not alarmed. Neither the Maintenance Director nor Administrative Staff #2 indicated who was responsible for locking the front door at night.</p> <p>An interview had been conducted with NA #2, who worked the 11-7 shift, on 7/20/13 at 12:34 PM. She stated that at night staff go out the front door to smoke because they cannot get back into the building if they go out the basement door to the courtyard where the designated smoking area is. NA #2 said when she steps out to smoke she flips the switch to unlock the door, pushes the door open and then flips the switch back before stepping outside. To re-enter, she puts the code into the keypad. NA #2 said staff could also elect to leave the door unlocked and flip the switch when they come back to save having to put the code into the keypad.</p> <p>The administrator was notified of the Immediate Jeopardy on 7/19/13 at 3:51 PM.</p> <p>A credible allegation of compliance was received on 7/21/13 at 11:23 AM. The credible allegation included:</p> <p>A. On 7/9/13 at approximately 11:30 PM Resident</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 323	Continued From page 15 #1 was found in the facility parking lot. B. On 7/12/13 Resident #1 left the building and walked a mile away, was found at a bus stop at 9:15 AM C. On 7/13/13 Resident # 1 got on the elevator in view of nurse and exited the building in view of nurse.	F 323			
	What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? A. On 7/9/13 at approximately 11:15 PM Resident #1 told the 11-7 and 8-11 nurses he was going to the VA and the nurses told resident to go back to room. At approximately 11:30 pm Certified Nursing Assistant reported resident was on facility grounds. Resident # 1 was brought back in facility and placed on every 15 minute checks for 24 hours. Nursing staff were responsible for 15 minute checks and visually layed eyes on Resident #1 at least every 15 minutes. 15 minute Patient Check Sheet includes Staff initials every 15 minutes and location of patient. On 7/10/13 the social worker called the guardian and asked the guardian to come talk to Resident # 1 because he wants to go home to Raleigh. Guardian came to facility and spoke with social worker and resident #1 to explain that his home was foreclosed on and this was the best place for him. B. On 7/12/13 Resident was returned to facility by Director of Nursing Services and Rehabilitation Aide at 9:20 AM and was placed on one to one supervision and a wander guard transmitter was applied - one staff person was in visual view of Resident at all times, 24 hours a day. 1:1 remains ongoing until more appropriate placement is found. A wander Guard transmitter was placed on the resident on 7/12/2013. This transmitter will set off an alarm if patient approaches the elevator. Other exit door				



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F 323	Continued From page 16 on 3rd floor are key pad coded and will alarm if door is left open. Door located at stairwells are key pad coded, the front door is locked at 8pm by the door monitor. Upon interview with resident # 1, conducted by the administrator resident # 1 stated he watched the nursing staff and waited till they were busy so he could go to the VA to get a bus ticket to Raleigh. Resident #1 stated he left around 5am and exited the building via the Therapy Door. Upon interview with staff the resident was observed in his bed around 5-5:30am while medication was given to the roommate. Roommate 's medication administration record was reviewed and was confirmed that the roommate was given a medication at 5:30am. Resident # 1 had no medications ordered during the 11pm-7am shift. The 7-3 Certified Nursing assistant and Licensed Nurse noted at 7am the resident was not in his room. At approximately 7:20am the Certified Nursing Assistant notified the Licensed Nurse that the resident was still not on the floor at this point the Licensed Nurse instructed the staff to search the floor and the courtyard. C. On 7/13/13 at approximately 5:45am resident was noted at elevator with alarm ringing, Nurse asked resident to go back to room and resident continued to proceed in elevator. Nurse ran down the stairway to meet resident on the first floor, the elevator continued to basement. Nurse ran down the stairway to the basement and followed resident outside. Staff attempted to bring resident back in the facility resident began fighting and hitting the staff. Administrator was able to coax the resident back in the facility. The resident was placed on 1:1 and the administrator spoke with staff about expectations of 1:1. Resident care plan updated by MDS Coordinator to include elopement risk on 7/12/13 Interventions included 1:1 and a wander	F 323			

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

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NAME OF PROVIDER OR SUPPLIER  UNIHEALTH POST - ACUTE CARE OF DURHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 ERWIN ROAD DURHAM, NC 27705		
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F 323	Continued From page 17 guard transmitter. The Nurse Practitioner assessed the resident on 7/12/13. Nurse Practitioner assessed resident for complaint of anxiety. The Guardian was called by the Social Worker and the Social Worker left a message for the Guardian to return call on 7/12/13. Guardian did not immediately return call. Follow up calls were made by Social Worker to Guardian on 7/15, 7/16, 7/18, 7/19 and Guardian has not yet return any of these phone calls. Elopement Books were updated by the Medical Records Coordinator to include Resident #1 on 7/12/13. Elopement books contain a picture and physical description, diagnosis and contact information on any resident with exit seeking behaviors. Elopement books are kept at the nurse's stations, receptionist, and the therapy desk. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?  Elopement Risk observation forms which includes; residents cognition, sensory deficit, predisposing conditions, ambulation and mobility, pain were completed by the Unit Coordinator/Managers, Director of Nursing and Case Mix Director for all residents on 7/12/13. None of the Resident 's Elopement Risk observation forms revealed that any new or current identified interventions were indicated. Education was provided by the RN Clinical Competency Coordinator, Director of Health Services and Administrator to all staff, including licensed and unlicensed Nursing Staff, and all staff in each department. Education involved discussion of elopement procedure, including assessment of risk, signs of exit seeking behavior and who to report signs of exit seeking behavior to, prevention and what to do if a patient is	F 323			

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

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F 323	Continued From page 18 unaccounted for and what to do upon return to facility if a patient elopes. Education began on 7/12/13, the education is ongoing and those employees who have not worked will be educated prior to their next schedule shift. This education has been completed at 95%. The assigned licensed nurse assigned for each resident is responsible for completing the Elopement Risk Observation form, and completing the care plans with the interventions. Identifying/ exit seeking behavior i.e.: voicing desire to go home, packing clothes and attempting to exit doors and history of leaving the center without needed supervision. Elopement Risk Observation forms are completed on admission/readmission, quarterly and change of condition i.e. exhibiting exit seeking behaviors. Care plans are updated with change in conditions and with assessment/observation updates. Once a resident exhibits exit seeking behavior the assigned licensed nurse will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be in the wander guard notebook with description of resident and a wander guard will be placed on the resident. Education completed by the Administrator, Director of Health services, and the Clinical Competency Coordinator, for all licensed nurses and direct care nursing staff on walking rounds to include Certified Nursing Assistant to walk there assignment with the oncoming shift to visualize each resident if resident not in room Certified Nursing Assistant are to report to the assigned licensed nurse, licensed nurses are to walk there assignment with the oncoming shift to visualize and give verbal report on each resident then sign the 24 hour report, if resident is not found in room. Licensed nurse will start the elopement procedure	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 19 which began on 7/12/13 on the 11-7 shift. Any employee that has not had the education related to walking rounds will not be allowed to work until the education is completed. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? 1. Walking rounds initiated for shift change for licensed nurses and certified nursing assistants began on 7/12/13 on 11-7 shift and will continue every shift indefinitely. Licensed Nurses began signing the 24 hour report on 7/12/13. The Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor will review the 24 hour reports to ensure the licensed nurses are signing the 24 hour reports to validate that walking rounds were completed. Audits of the 24 hour report sheet will be completed daily by the Director of Health Services, Clinical Competency Coordinator and/or Week-end Supervisor for one week and weekly thereafter for two (2) months. The Director of Health Services, Clinical Competency Coordinator, Administrator, and/or Week-end Supervisor will observe Certified Nursing Assistants completing walking rounds for two shifts daily times one week, and weekly thereafter for two months. 2. All new admitted and readmitted Residents will have their Elopement Risk Observation form completed on admission by the assigned license nurse for that resident. Any Resident who voices desire to leave facility or exhibits exiting seeking behaviors will also have an Elopement Risk Observation form filled out and intervention will be put in place immediately to include but not limited to placing a wander guard on resident, move resident to the 3rd floor, which is equipped with the wander guard system and door key pads, and start 1:1 if indicated. The care plan will be updated with	F 323			

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

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FORM APPROVED  
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F 323	Continued From page 20 interventions at this time. Findings will be reported to the Director of Health Services and or Clinical Competency Coordinator and/or Weekend Supervisor. If the Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor is not in facility then the assigned nurse will notify Director of Health Services and/or Administrator via phone. 3. Upon completion of the Elopement Risk Observation form the licensed nurse will copy the elopement risk observation and give to the Director of Health Services, clinical Competency Coordinator and/or Weekend Supervisor to ensure completion of the form and intervention initiated if indicated with review of the care plan. The Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor will complete review of Elopement Risk Observation form daily for two weeks, weekly for four weeks and then monthly for two months to ensure measures are in place for identified areas. 4. Employees hired after 7/12/13 will be educated by the Clinical Competency Coordinator and /or the Director of Health Services on the elopement policy and procedures and walking rounding during orientation. Audits of the 24 hour report sheet will be completed daily by the Director of Health Services, Clinical Competency Coordinator and/or Week-end Supervisor for one week and weekly thereafter by for two (2) months. The Director of Health Services, Clinical Competency Coordinator, and/or Week-end Supervisor will review the 24 hour reports to ensure the licensed nurses and Certified Nursing Assistance is signing the 24 hour reports to validate that walking rounds were completed. 5. Staff assigned to sit 1:1 was educated and competency on expectations of 1:1 by the Director of Health Service, Administrator, Clinical	F 323			

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

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F 323	Continued From page 21 Competency Coordinator and/or Week-End Supervisor on 7/20/13. No staff will be permitted to sit with resident unless competency is completed. The Director of Health Service, Administrator and/or Week-End Supervisor will review the 1:1 logs daily to ensure compliance. Any issues identified will be handled immediately by the Director of Health Services, Administrator and/or week-end supervisor. 6. Staff placed in the basement to visualize exit doors. One staff member placed in area to observe elevator, therapy exit door and visualization of hallway. One staff member placed in hallway in front of the maintenance office for visualization of the other elevator, and door located by the time clock this staff member will also visualize the hallway. Staff was educated and competency on door observation form which included sign in and out at start of shift and relief for breaks and meals. Receptionist was educated on the responsibility of lobby door observation by the Director of Health Services. Receptionist will observe the front door while on duty once receptionist leaves for the day, the door monitor will observe the lobby front door until 8pm at this time the door monitor will lock the front lobby door. Education was conducted by the Director of Health Service, Clinical Competency Coordinator, and/or Week-end Supervisor on 7/20/13. No staff will be permitted to sit in the basement unless competency is completed. 1:1 in basement will continue until the installation of locking key pads and/or wander system is installed. 1:1 logs for basement will be reviewed daily by the Director of Health Service, Administrator, and/or Week-end Supervisor. Any issues identified will be handled immediately by the Director of Health Services, Administrator and/or week-end supervisor. How will the corrective action be monitored to	F 323			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 22 assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. 1. The findings of Walking round audits with tracking and trending will be done by the Director of Health Services and taken to the Quality Assurance/Performance Improvement (QA/PI) Committee by the Director of Health Services or the Administrator for review, revision and recommendations from the QA/PI Committee monthly for three months. 2. The results of collected data and interventions implemented of the elopement risk observation audits with tracking and trending by the Director of Health Services will be taken to the Quality Assurance /Performance Improvement (QA/PI) Committee by the Director of Health Services or the Administrator for review, revision and recommendations from QA/PI Committee monthly for three months. 3. The results from the 1:1 resident observation and basement will be tracked and trended by the Director of Health Services will be taken to the Quality Assurance /Performance Improvement (QA/PI) Committee by the Director of Health Services or the Administrator for review, revision and recommendations from QA/PI Committee monthly for three months. Date Immediate Jeopardy was removed: July 21, 2013  Interviews were conducted with staff on all units after the credible allegation was received. Staff were knowledgeable about the elopement policy. Observations revealed staff posted in basement and front door as door monitors.	F 323			