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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING ______ B. WING ______	C 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a complaint investigation survey on 01/23/15. During the complaint survey, the survey found the facility had provided substandard quality of care at the Immediate Jeopardy level. The Immediate Jeopardy began on 01/10/15 and was removed on 01/23/15. IDR 3/23/15 resulted in deletion of F 241, F 278 and F 280	F 000		
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 reviews and staff interviews, the facility failed to prevent 1 of 7 cognitively impaired residents from exiting the facility by failing to follow wanderguard manufacturer instructions in regard to placement of the wanderguard, resulting in the resident being admitted to the hospital with Hypothermia (dangerously low body temperatures).(Resident #1) The Immediate Jeopardy began on 1/10/2015 when Resident #1 exited the facility unattended	F 323	Corrective action for those residents found to be affected Resident #1 was put on one to one monitoring 24 hours per day immediately upon his return to the facility on 1/13/15. A WanderGuard bracelet was applied to the left ankle of resident #1 upon his return to the facility on 1/13/15. It was changed to his left wrist by the Assistant Director of Nursing on 1/22/15 and applied according to the manufacturer's	2/13/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/10/2015

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 by the facility staff, and was found beside the storage building. The Immediate Jeopardy was removed on 1/23/2015 at 3:45 PM when the facility provided an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action and monitoring for Resident #1. The findings included: The manufacturer's instruction on wanderguards was reviewed. The instruction indicated under warning "Do not place the signaling device on or next to metal such as wheelchair frames, jewelry, watches, etc (etcetera) or allow it to come in contact with a door or associated hardware, such as crash bar, push bar, etc. Metal could interfere with the signal sent to the door module." Resident #1 was admitted to the facility on 3/4/2014 with diagnoses of chronic systolic congestive heart failure, venous stasis ulcer, peripheral vascular disease, severe cardiomyopathy, chronic obstruction pulmonary disease, hypertension, dementia and loss of ambulation. Review of the Physician order dated 4/12/2014 revealed the wanderguard for Resident#1 was implemented due to increased wandering. The order was changed on November 2014 indicating the wanderguard was to be placed on the wheelchair of the resident ' s wrist.	F 323	recommendations. An additional alarm was added by the Maintenance Director on 1/22/15 to the door from which resident #1 exited. This alarm will be activated any time the door is opened regardless as to whether a person is wearing a WanderGuard bracelet or not. In the event a resident that is wearing a WangerGuard bracelet attempts to exit through the door, both alarms will sound. Resident # 1 will remain on one to one monitoring until 1/24/15 and then will be placed on hourly visual checks for a period of three (3) months and will be reevaluated at that time for need of hourly checks An audit of each door leading to outside the facility was completed on 1/22/15 by the Maintenance Director to determine if the door is alarmed and if the alarm is in working order. As of 1/23/15 every exit door is equipped with a WanderGuard monitor and an additional alarm that will sound any time the door is opened regardless as to whether a person is wearing a WanderGuard bracelet. The main entrance is manned with a receptionist from 8am to 8pm. The receptionist is relieved for breaks by the Business Office Manager Monday through Friday and the Manager on Duty on the weeked. The additional alarm on the main entrance that will be armed from 8pm to 8am when the receptionist leaves that will sound any time the door is opened regardless as to whether a person is wearing a WanderGuard bracelet. The receptionist will be	

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F 323	Continued From page 2 The quarterly Minimum Data Set (MDS) dated 11/28/2014 indicated Resident #1 had long and short term memory problems, required assistance of one person with mobility, dressing and hygiene. The assessment also indicated the resident needed supervision with ambulation in the room and corridor. The MDS further indicated the resident needed limited assist with locomotion on and off the unit. The resident was not coded for wandering behavior. The resident initially was care planned for wandering behaviors on 4/12/2014. The care plan was updated on 6/11/2014, 9/10/2014 and 12/3/2014. The resident was identified with wandering behaviors creating the potential for elopement and needed continual monitoring for attempts at elopement. The goal stated for this problem was that the resident would not present with any episodes of elopement daily over the next review. The interventions listed for this problem included: 1- "Monitor resident for behaviors (attempts at elopement, wandering) every shift record any incident of elopement in nurse's note. Notify physician of any increased moods or behaviors." 2- "Apply wanderguard for safety." 3- "Provide redirection when wandering." Review of the nurse's note dated 1/8/2015 at 9:00 PM, read "Resident #1 sitting up in wheelchair in hallway. Refuse to go to bed. Blanket is over his head. Stated, "I'm ok right here, I don't want to go to bed." Review of the nurse's note date 1/10/2015 at 5:00 AM indicated "Resident continue to sit up in wheelchair near front door all night. Encourage	F 323	responsible for arming and disarming the alarm. An alarm log was developed by the Director of Clinical Services on 1/23/15 to be filled out daily by the receptionist to document arming and disarming the alarm. All facility staff regardless position or title were in-serviced by Director of Nursing and/or Administrative nursing team regarding all staff members are responsible for responding to any alarm sounding in the facility on 1/22/13 and 1/23/15. Any facility staff that were not in-serviced on these dates will not be allowed to work until the in-service is completed. Corrective action for residents with the potential to be affected A one hundred percent head count was completed on all residents on 1/11/15 at 12:30 a.m. by the Administrator, Director of Nursing, Assistant Director of Nursing, and two police officers to verify each residents presence and location in the facility. A one hundred percent chart audit was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers on 1/11/15 of all residents to determine which residents are identified to be at risk for elopement/wandering. All residents that were identified to be at risk for wandering/elopement were checked for placement and function of their WanderGuard bracelets with the WanderGuard wand by the Director of	

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F 323

Continued From page 3

several times to go to bed. Refuse."

Review of the nurse's note date 1/10/2015 at 10:35 PM read "Resident has been sitting in wheelchair in front of heater all day. He has refused all attempts to clean or change him today."

Review of the nurse note dated 1/10/2015 at 11:20 PM revealed "When doing rounds found resident
w/c (wheelchair) empty sitting beside heater in hallway, search of building completed by all staff and resident not found on call RN (Registered Nurse) (Assistant Director of Nursing) phoned, emergency services notified."

Review of the nurse note's dated 1/11/2015 at 3:00 AM documented "Resident found and transferred to the hospital."

Review of Resident #1's facility's timeline dated 1/11/2015 revealed on Saturday, 1/10/205 between 10:30 PM-10:50 PM, the resident was last seen sitting by heater (preferred area for patient). At 11:00 PM,
Nurse #1 saw an empty wheelchair, assumed patient was in the bathroom. Between 11:30PM-11:35PM,
a Missing patient code was activated Assistant Director of Nursing (ADON) who was on call was notified and staff started searching building and grounds for patient. At 11:40 PM, police department was called and they arrived immediately. At 11:40PM, ADON called Director of Nursing (DON) and administrator (both arrived shortly thereafter). At 11:45PM, police and emergency management "search term"

F 323

Nursing. All residents that were identified to be at risk for wandering/elopement were rechecked by Administrative Nursing Team on 1/22/15 to ensure all WanderGuard bracelets were placed according manufacturers recommendation. Any resident that was found with an improperly placed bracelet, was corrected at that time to be in adherence with manufacturers recommendations. The facility doors were also checked with the Wandergaurd wand according to the manufacturers recommendations by the Director of Nursing for functionality of the Wandergaurd door alarm. All doors were functioning properly.
The nurse on duty determined the resident to be missing between 11:30 and 11:35 pm 1/10/15 and activated the Missing Person Policy. The nurse on call (Assistant Director of Nursing) was notified at that time and a search of the building and grounds was initiated. The Assistant Director of Nursing instructed the nurse on duty to notify the Police Department at that time and called to notify the Administrator and Director of Nursing. The Police Department was dispatched at 11:41 p.m. and arrived at approximately 11:44 p.m. The Director of Nursing and the Administrator arrived to the building within approximately five minutes of being called. The Police Officer, Administrator and Director of Nursing completed a one hundred percent head count of the residents in the building and activated a city and county

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F 323	Continued From page 4 instructed the staff to go in building (Interfering with (a dog) scent/ hunt). At 12:00 Midnight, the Administrator called and notify the Medical Director. At 2:50 AM, Emergency Management Director entered facility and stated resident had been found and being transported to the hospital. Hospital History and physical dated 1/11/2015 documented "apparently this patient wandered out of nursing home and was found under a building outside, this being January of a particular cold week. He was treated for hypothermia, his temperature was noted to be in 80s and he was transferred to (Hospital). They had him on warming blanket and given warm IV (intravenous) fluids and warm bladder irrigation and warm oxygen. His temperature increased to 99.3 and was admitted to the hospital for environmental hypothermia." Doctor's progress note dated 1/15/2015 documented "resident of nursing home who wandered out of the facility and he was found outside and he was sent to the hospital and he was treated for hypothermia, his temperature was noted to be in 80s and he was transferred to (Hospital). They had him on warming blanket and given warm IV fluids and warm bladder irrigation and warm oxygen. His temperature increased to 99.3 and was admitted to the hospital for environmental hypothermia. Initially he was placed in ICU (Intensive Care Unit) but once he improved he was transferred out. He was also treated for chronic systolic congestive heart failure and his Lasix, Spironolactone, Coreg were all held because of low normal blood pressure. He was also treated for hypothyroidism and mild acute kidney injury as well as chronic	F 323	unit search of perimeter of the building. The facility staff was asked by the Police Department to remain inside the building due to the K9 unit being utilized and not wanting the scent trail to be contaminated. The external search was wholly turned over to the city/county Police Departments at that time. Resident #1 was located at approximately 2:51 a.m. on 1/11/15. Measures put into place or systemic changes made A Wandergaurd bracelet flow sheet to be completed by the staff nurses each shift on each resident identified to be at risk for elopement/wandering, was developed and implemented by the Director of Nursing on 1/12/15 to document the nurse checking placement according to manufacturers recommendation and function of the Wandergaurd bracelet and if the resident was displaying any elopement behavior for the month of January and will be transcribed to the Treatment Record thereafter. A list of residents identified to be at risk for elopement/wandering was placed at the front of each Medication Administration book by the Assistant Director of Nursing on 1/21/15 to alert the staff nurses as to which residents will require documentation on the Wandergaurd bracelet flow sheet/Treatment Administration Record. The Assistant Director of Nursing will be responsible for updating and replacing the	

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F 323	Continued From page 5 obstruction pulmonary disease." During an interview on 1/21/2015 at 12:10 PM, Nurse Assistant (NA)#1 reported that she was sitting with the resident every day since he came back. NA #1 stated that the resident sometimes resisted care and refused to go to bed. She added Resident #1 was very unsteady when walking. NA #1 also reported that the wanderguard that the resident had on before was not placed around the wrist, it was placed on the wheelchair and clothes. She further stated that the wanderguard was too small to go around the resident's foot. The interview with Resident #1 on 1/21/2015 at 12:25 PM revealed that he was trying to go home the day he eloped from the building. Observation of the resident on 1/21/2015 at 12:30 PM revealed the resident appeared to be weak. Resident #1 had wanderguard applied on his arm and a body alarm attached to his wheelchair. The sitter was observed with the resident. During an interview on 1/21/2015 at 2:03 PM, the third shift NA #2 who was assigned to Resident # 1 when he eloped stated that she came to work at 11:00 PM, and the resident was already missing. She also stated the second shift nurse mentioned that the resident must have been missing from 10:45 PM because that was the time they thought he had gone to the bathroom. NA #2 further reported that the staff began to look for the resident throughout the building at 11:30 PM and they could not find him. She added the staff called the police immediately. NA #2 also	F 323	list and updating the Care Plans and Care Cards as changes occur. An elopement/wandering risk notebook to be kept at each nursing station and front desk, was implemented on 1/21/15 by the Director of Nursing with names and pictures of each resident that has been identified to be at risk for elopement/wandering. The notebook will be updated by the Assistant Director of Nursing as changes occur. The nursing staff was in-service was started on 1/12/15 by the Director of Nursing regarding elopement policy and procedure, missing resident policy and procedure, policy and procedure regarding checking the Wandergaurd bracelets and doors. All facility staff regardless of position or title were educated regarding the elopement policy and procedure, missing resident policy and procedure, it being the responsibility of all staff members to respond to any alarm sounding, by the Assistant Director of Nursing on 1/21/15 to 1/23/15. Any facility staff that were not in-serviced on these dates will not be allowed to work until the in-service is completed. The nursing staff was re-in serviced by the Assistant Director of Nursing on 1/22/15 and 1/23/15 regarding the process for placing a WanderGuard bracelet, placing the bracelet according to manufacturers recommendation, checking for placement and function, documenting wandering/elopement behaviors and checking the door monitors according to	

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F 323	Continued From page 6 stated before the resident eloped from the building, for 3 days he had refused to get out of his wheelchair and go to bed. She stated the resident sat beside the exit door next to the heater everyday. NA #2 also mentioned that the resident had refused to be cleaned up and just wanted to sit beside the heater the days before he eloped from the facility. During an interview with Director of Nursing (DON) on 1/21/2015 at 2:30PM, she stated the staff was not checking to make sure the wanderguard was present on the resident's wrist or ankle. She further stated that the staff began checking the placement as a plan of correction after the resident came back from the hospital. The DON also reported that the resident used the exit door which is beside the office to exit the building. The DON further reported the resident had not been himself since he came back from the hospital. She also stated that Resident #1 had been in bed since the incident happened on 1/10/2015. The DON further reported the day the resident eloped, he was found after 4 hours by the emergency and search rescue team. She added the rescue team found the resident at 3 AM. DON also reported that the resident had crossed the road and was found under a storage building across the street. The DON also reported that she was not aware that the wanderguard was being placed on the wheelchair by staff on the unit. The DON added that she just became aware that wanderguard was being placed on the resident ' s wheelchair. She also stated the staff had been in serviced that they are not to place the wanderguard on the wheelchair.	F 323	manufacturers recommendations. Any facility staff that was not in-serviced on these dates will not be allowed to work until the in-service is completed. Monitoring The Wandergaurd bracelet flow sheet/Treatment Administration Record of all residents identified to be at risk for wandering/elopement will be audited by the Director of Nursing daily Monday through Friday and by the Nursing Supervisor on weekends for completion for four weeks, two times per week for one month, then weekly for one month. Monitoring Elopement drills directed by the Nursing Administration Team will be completed weekly on varying shifts for three months to ensure the facility staff follow policy regarding elopements The Director of Nursing will present results of those audits and drills to the Quality Assurance Performance Improvement Committee for three months for review and recommendation. The Administrator will be responsible to carry out any further recommendations that may come from the committee. The Director of Nursing and/or the Administrative Nursing team will complete weekly audits times four weeks and monthly audits times 3 more months of the Wandergaurd bracelet flow sheet to assure completion of the sheets and ensure the bracelets and doors remain in working order.	

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F 323	Continued From page 7 During an interview with Nurse#1 on 1/21/2015 at 3:38PM, who was assigned to work second shift on 1/10/2015, revealed she saw the resident at 10:30 PM sitting beside the heater by the exit door. She added the resident had resisted going to bed stating to the second shift NA #3 that he was just fine sitting by the heater and did not want to go to bed. Nurse #1 reported that she did not see the resident again until she was called on the phone while on her way home that the resident was missing. Nurse #1 also indicated that the resident's wanderguard was on the wheelchair because the resident was able to remove the wanderguard from the wrist and the resident's feet were swollen so the wanderguard could not fit the resident's ankle. During the interview with NA#3 on 1/21/2015 at 3:45 PM, who was assigned to Resident #1 second shift on 1/10/2015, she stated she saw the resident shortly before shift change and she did not recall what time the resident went missing. NA#3 further stated when she saw the resident around 10:45 PM, he was not agitated and recalled seeing the wanderguard on wheelchair. NA#3 also reported that the resident was dressed in khaki pants, a blue hoodie and black tennis shoes. She further stated the resident had resisted the effort to get him to go to bed for at least 3 days before his elopement. During an interview with Nurse # 2 on 1/21/2014 at 4:43 PM, who was assigned to Resident #1 third shift on 1/10/2015, she reported that when she came on her shift, the resident was missing from his wheelchair after she looked at the monitor. She added that she thought that the resident had gone to the bathroom but after 15	F 323	The Director of Nursing will follow-up with the nurses failing to complete the Wandergaurd bracelet flow sheet as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for four months for review and recommendations. The function of the door alarms will be audited by the Maintenance Director weekly for four weeks and monthly thereafter. The Maintenance Director will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for four months for review and recommendations. The WanderGaurd door monitors will be audited for function daily Monday through Friday by the Central Supply Clerk and Saturday and Sunday by the Nursing Supervisor continuous. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for four months for review and recommendations.	

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minutes she became concerned as to the reason he had not come back to sit in his wheelchair. Nurse #2 also reported as soon as she realized the resident was not back in 15 minutes they began to search for him in all the rooms in the building. She added after they could not find him, they called the administration staff and also called the police. Nurse #2 further reported that the resident had been sitting next to the heater with hands in front of the heater for about five days. She added the resident did not want to be bothered. Nurse #2 also reported that the resident ' s wanderguard was not placed on his wrist because the resident was able to remove it. She reported that the wanderguard was placed on wheelchair because the resident had edema in his ankle.

During an interview on 1/22/2015 at 11:00 AM, the administrator reported that after it was found that the resident was missing at the facility, she was notified immediately. She further reported that the rescue team was also notified and the search for the resident was started immediately. She further stated it took long, about 4 hours to find the resident because the rescue dog was having hard time finding a scent. The Administrator further stated the staff was asked to go back into the building for the rescue team to continue with search outside with facility. The Administrator reported the resident exited the facility using the exit door near the front office. The door did not alarm when the resident exited the facility. The administrator also reported she just became aware that the wanderguard was being placed on the
resident's wheelchair instead of the wrist. The Administrator further reported after the resident

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came back from the hospital the interventions put in place was to have one on one sitter to make sure he was safe and a wander guard was placed on the resident's wrist. The Administrator also indicated the facility had 5 main doors and all of them were equipped with wanderguard. She further stated that the doors alarms when a resident with a wanderguard approaches the door.

On 1/10/2015, the night the resident went missing according to the metrological website channel the weather was fair and 19 degrees at 11:00 PM and 15 degrees on 1/11/2015 at 3:00 AM when the resident was found.

During a drive between the facility and the storage building, revealed the distance was 0.2 miles.

An observation on 1/22/2015 at 5: 00 PM revealed the road that the resident crossed to reach storage building was a two way street and it had several houses and trees beside it. A vacant parking lot was observed between the storage building and the facility. The pavement from the facility to the storage building was uneven. One street light and one stop sign were also observed beside the street.

The Administrator was notified of the Immediate Jeopardy on 1/22/2015 at 1:41 PM.

The facility provided the following Credible Allegation on 1/23/2015 at 3:45 PM.

Credible Allegation of Compliance:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING ______ B. WING ______	C 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON HEALTH AND REHABILITATION	405 SOUTH GREENE STREET WADESBORO, NC 28170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 Corrective action which will be accomplished for those residents found to be affected by the deficient practice: The Resident #1 was put on one to one monitoring 24 hours per day immediately upon his return to the facility on 1/13/15. A wanderguard bracelet was applied to the left ankle of resident #1 upon his return to the facility on 1/13/15. It was changed to his left wrist by the Assistant Director of Nursing on 1/22/15 and applied according to the manufacturer's recommendations. An additional alarm was added by the Maintenance Director on 1/22/15 to the door where the resident exited that will sound any time the door is opened regardless as to whether a person is wearing a wanderguard bracelet. In the event a resident that is wearing a wanderguard bracelet attempts to exit through the door, both alarms will sound. Resident # 1 will remain on one to one monitoring until 1/24/15 and then will be placed on hourly visual checks for a period of three (3) months and will be reevaluated at that time for need of hourly checks An audit of each door leading to outside the facility was completed on 1/22/15 by the Maintenance Director to determine if the door is alarmed and if the alarm is in working order. As of 1/23/15 every exit door is equipped with a wanderguard monitor and an additional alarm that will sound any time the door is opened regardless as to whether a person is wearing a wanderguard bracelet. The main entrance is manned with a receptionist from 8am to 8pm. The receptionist is relieved for breaks by the Business Office Manager Monday through Friday and the Manager on Duty on weekends.The	F 323		

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F 323	Continued From page 11 additional alarm on the main entrance that will be armed from 8pm to 8am when the receptionist leaves that will sound any time the door is opened regardless as to whether a person is wearing a wanderguard bracelet.The receptionist will be responsible for arming and disarming the alarm. An alarm log was developed by the Director of Clinical Services on 1/23/15 to be filled out daily by the receptionist to document arming and disarming the alarm. All facility staff regardless of position or title was in-serviced by Director of Nursing and/or Administrative nursing team regarding all staff members are responsible for responding to any alarm sounding in the facility on 1/22/13 and 1/23/15. Any facility staff that was not in-serviced on these dates will not be allowed to work until the in-service is completed. How the facility will identify other residents having the potential to be affected by the same deficient practice: A one hundred percent head count was completed on all residents on 1/11/15 at 12:30 a.m. by the Administrator, Director of Nursing, Assistant Director of Nursing, and two police officers to verify each resident's presence and location in the facility. A one hundred percent chart audit was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers on 1/11/15 of all residents to determine which residents are identified to be at risk for elopement/wandering. All residents that were identified to be at risk for wandering/elopement were checked for placement and function of their wanderguard bracelets with the wanderguard wand by the	F 323		

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F 323	Continued From page 12 Director of Nursing. All residents that were identified to be at risk for wandering/elopement were rechecked by Administrative Nursing Team on 1/22/15 to ensure all wanderguard bracelets were placed according manufacturer's recommendation. Any resident that was found with an improperly placed bracelet was corrected at that time to be in adherence with manufacturer's recommendations. The facility doors were also checked with the wandergaurd wand according to the manufacturer's recommendations by the Director of Nursing for functionality of the wandergaurd door alarm. All doors were functioning properly. The nurse on duty determined the resident to be missing between 11:30 and 11:35 pm 1/10/15 and activated the Missing Person Policy. The nurse on call (Assistant Director of Nursing) was notified at that time and a search of the building and grounds was initiated. The Assistant Director of Nursing instructed the nurse on duty to notify the Police Department at that time and called to notify the Administrator and Director of Nursing. The Police Department was dispatched at 11:41 p.m. and arrived at approximately 11:44 p.m. The Director of Nursing and the Administrator arrived to the building within approximately five minutes of being called. The Police Officer, Administrator and Director of Nursing completed a one hundred percent head count of the residents in the building and activated a city and county unit search of perimeter of the building. The facility staff was asked by the Police Department to remain inside the building due to the K9 unit being utilized and not wanting the scent trail to be contaminated. The external search was wholly turned over to the city/county Police Departments	F 323		

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F 323	Continued From page 13 at that time. Resident #1 was located at approximately 2:51 a.m. on 1/11/15. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. A wanderguard bracelet flow sheet to be completed by the staff nurses each shift on each resident identified to be at risk for elopement/wandering, was developed and implemented by the Director of Nursing on 1/12/15 to document the nurse checking placement according to manufacturer's recommendation and function of the wandergaurd bracelet and if the resident was displaying any elopement behavior for the month of January and will be transcribed to the Treatment Record thereafter. A list of residents identified to be at risk for elopement/wandering was placed at the front of each Medication Administration book by the Assistant Director of Nursing on 1/21/15 to alert the staff nurses as to which residents will require documentation on the wandergaurd bracelet flow sheet/Treatment Administration Record. The Assistant Director of Nursing will be responsible for updating and replacing the list and updating the Care Plans and Care Cards as changes occur. An elopement/wandering risk notebook to be kept at each nursing station and front desk, was implemented on 1/21/15 by the Director of Nursing with names and pictures of each resident that has been identified to be at risk for elopement/wandering. The notebook will be updated by the Assistant Director of Nursing as changes occur.	F 323		

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F 323	Continued From page 14	F 323		

The nursing staff was in-service was started on 1/12/15 by the Director of Nursing regarding elopement policy and procedure, missing resident policy and procedure, policy and procedure regarding checking the wanderguard bracelets and doors.

All facility staff was educated regarding the elopement policy and procedure, missing resident policy and procedure, it being the responsibility of all staff members to respond to any alarm sounding, by the Assistant Director of Nursing on 1/21/15 to 1/23/15. Any facility staff that was not in-serviced on these dates will not be allowed to work until the in-service is completed.

The nursing staff was re-in serviced by the Assistant Director of Nursing on 1/22/15 and 1/23/15 regarding the process for placing a wanderguard bracelet, placing the bracelet according to
manufacturer's recommendation, checking for placement and function, documenting wandering/elopement behaviors and checking the door monitors according to manufacturer's recommendations. Any facility staff that was not in-serviced on these dates will not be allowed to work until the in-service is completed.

On 1/23/2015 at 5:15 PM, verification of the Credible Allegation was evidenced by interview of all staff related to identifying residents at risk for elopement, ensuring placement and function of the wanderguard. The staff was also aware of whom to report the elopement behaviors.