STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD EXT BOX 1750 KING, NC 27021

(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 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide monitoring and modification of interventions to ensure a cognitively impaired resident, who had been identified as a wanderer, did not wander outside unsupervised from the facility for 1 of 3 residents (Resident #137) reviewed for accidents. On 4/22/15 the resident was found in the median of U.S. Highway 52 (a 4-lane highway) and assisted back across the highway toward the facility by an unidentified motorist. Immediate jeopardy began on 4/22/15 and was removed on 6/4/15 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D). Findings included: Resident #137 ' s Hospital Physical Therapy note dated 4/6/15 at 8:47 am stated, " Spoke with family who report [Resident #137] has been up most of the night walking halls. Has now been asleep 1 hour. Hold [therapy] per family request. " The Physician note, from the hospital record	F 323	Preparation and submission of this plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and federal law. F 323: (483.25) It is the policy of this facility to provide adequate supervision and assistive devices to minimize all incidents including any resident identified with the risk of elopement. Resident # 137 was discharged to a secured unit on May 06, 2015.	6/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/19/2015

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F 323	Continued From page 1 review, dated 4/6/15 at 3:31pm stated, " [Resident #137] with ongoing agitation. Behavioral problems at night. [Resident #137] noted to be walking the hallway at night. " Resident #137 was admitted to the facility on 4/8/15 from a hospital and was discharged from the facility on 5/6/15. Her diagnoses included dementia, difficulty walking, and chronic gout. She was admitted to room 411 and remained in that room until her discharge. Record review of the Admission Nursing Assessment dated 4/8/15 indicated Resident #137 was alert and oriented to person, was confused always, needed cueing/re-directing, had a memory problem, and needed staff assistance with transfers/walking. Record review of the Care Plan dated 4/8/15 indicated the following care areas: · Elopement risk. Intervention: Do elopement assessment · Safety needs. Intervention: Admission protocols are considered part of the initial care plan for 10 days. Record review of the facility Elopement Risk Assessment dated 4/8/15 indicated Resident #137 was fully ambulatory, disoriented, did not wander, and had no history of elopement. The Assessment further stated, " Resident is not considered an elopement risk. " Record review of the nurse ' s note dated 4/9/15 revealed Resident #137 was alert, confused and uncooperative with care. Record review of the nurse ' s note dated 4/12/15 at 1:28 am revealed Resident #137 was up walking the hall that shift, was " very confused " , and was assisted back to her bed. The note further stated the resident wandered the hall and " goes into other [residents '] rooms. "	F 323	For other residents identified with the potential to be affected by this cited deficient practice, the following has been achieved: An audit was completed using the electronic health record report for resident census and condition. This report is created by data which pulls from the most current MDS identifying any wandering resident coded under section E0900 (behaviors). The audit was completed by the MDS nurse and regional nurse consultant 06/04/2015. The audits performed included the following: Completion of an additional elopement assessment for each resident identified, updating each care plan, resident care guide, and ensuring that orders were scheduled in the electronic health care record for checking of safety devices by the licensed nurse each shift. Residents identified with elopement risk were reassessed for Current room placement and were relocated to rooms with closer proximity to the nurse station for better monitoring Specific measures and systematic changes implemented to prevent recurrence: To enhance currently compliant	

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F 323	Continued From page 2 Record review of the nurse ' s note dated 4/13/15 at 1:30 am revealed Resident #137 has been up wandering into other rooms and was redirected back to her room. Record review of the nurse ' s note dated 4/13/15 at 11:04 pm revealed Resident #137 ambulated out of her room and down the hall into other resident ' s room, staff attempted redirection, and Resident #137 raised her voice at the redirection attempt. Resident #137 continued walking up and down the hallway, was placed back in her bed where she slept for 1 hour and then repeated the same process. The Admission Minimum Data Set (MDS) dated 4/15/15 indicated Resident #137 was severely cognitively impaired, exhibited wandering behavior on 4-6 of 7 days, her wandering placed her at significant risk of getting to a potentially dangerous place, and her wandering significantly intruded on the privacy or activities of others. She required limited assistance with walking. The Event Investigation dated 4/16/15 at 11:00 am stated, " Resident had attended activity in dining room and walked out with volunteers, redirected and brought back in. [A wandering prevention system] placed on resident. [Family member] aware. " The witness on the report was Activity Assistant #1. The report further stated the incident was " avoidable. " Record review of the nurse ' s note dated 4/16/15 at 1:23 pm indicated Resident #137 had attended an activity in the dining room and wandered out the front door with volunteers. She was easily redirected and a wandering prevention system was placed. Record review of the nurse ' s note dated 4/16/15 at 3:11 pm stated, " [Resident #137] out 400 hall door, redirected. " The Physician Order dated 4/16/15 stated, "	F 323	operations and under the direction of the Director of nurses on 06/04/15 all staff were in serviced for the facility¿s wandering/missing persons policy and state and federal regulation for unsafe wandering or elopement F 323, 06/10/2015. All new hires are informed for the facility¿s policy for wandering and missing residents during orientation. The employee is required to sign the policy which is maintained in the personnel file. Each new resident has an elopement assessment risk questionnaire completed in the electronic health record on the day of admission. Any resident identified at risk for wandering or elopement will have a wander guard bracelet applied, care plan documented, and order for licensed nurse to check the placement of the wander guard each shift. Residents identified with elopement potential will be located in rooms with close proximity to nurses stations. On 6/4/15 The maintenance supervisor installed additional alarms to exit doors, on 100, 200, and 400 halls as these doors are not attached to the wander guard code alert system. The alarms installed are loudly audible on the unit. The state Surveyor tested these new alarms for audibility on 6/4/15	

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F 323	Continued From page 3 [Wandering prevention system] on continuous. " Record review of the Care Plan dated 4/17/15 indicated the following updated care area: · Elopement risk - [Wandering prevention system] to left ankle. Intervention: [A wandering prevention system] bracelet on to left ankle at all times. Check for proper functioning [every] shift. The activity note dated 4/20/15 at 9:58 am stated, " [Resident #137] up daily in [wheelchair]. She will get up out of [wheelchair] and walk off and leave [wheelchair] behind. She attended music program and when it was over [I] was taking another [resident] back to their room and by the time I got back she was gone and [wheelchair] was left at table. She had walked outside with our volunteer. She came back in and [I] went to her nurse and told her what had happened. " Record review of the Care Plan dated 4/21/15 indicated the following updated care area: · Elopement risk - Needs cueing, supervision/oversight, re-directing/distracting, [wandering prevention system] bracelet related to wandering, cognitive impairment, poor safety awareness. [Wandering prevention system] to left ankle. The Event Investigation dated 4/22/15 at 8:00 pm stated, " Saw [Resident #137] standing in the median of US [Highway] 52. [Resident] was assisted across the road by a motorist and nursing staff assisted resident to room. [Family member] came to facility and stayed with resident until she fell asleep. No injuries noted. Staff will continue to monitor location frequently. Follow up necessary: 15 minute watches. Staff reported resident noted to be agitated and restless. " The witness on the report was Nurse Aide (NA) #1. The report further stated the incident was " avoidable. " The report indicated frequent	F 323	The Director of nursing further scheduled a follow up elopement assessment risk questionnaire In the electronic health record for each resident currently residing in the facility and no other residents were identified 06/10/15. Effective 06/04/15 under the supervision of the director of nurses an audit tool was devised for MDS nurses to complete within 15 days of a resident¿s admission to the facility. Quality assurance monitoring plans: Under the supervision of the director nursing the MDS nurses will Complete follow up audits for each new admission: Within 15 days after admission the MDS nurses will schedule and complete a 2ndelopement assessment risk questionnaire in the electronic health record. The MDS nurses then audit the care plan, care guide, and orders to ensure wander guards are scheduled in the electronic record and to be initialed each shift by the respective licensed nurse for placement. The Director of nursing reviews the completed audits 2 x weekly for 4 weeks, then the Director of nurses reviews the audits weekly x 3 months. The director of nurses is responsible for monitoring of compliance	

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F 323	Continued From page 4 re-direction from staff / increase visual checks as an intervention. Record review of Nurse #1 ' s note dated 4/22/15 at 11:24 pm stated, " [Resident] very agitated and wandering. At [8 pm] was noted to be out of the building. Administrator, [Staff Development], husband and doctor were notified. No injuries were noted. New orders were received. " During an interview with NA #1 on 6/4/15 at 2:52 pm, regarding Resident #137 ' s elopement on 4/22/15, NA #1 stated, " I was on the hall that night and knew [Resident #137] had a [wandering prevention system]. I was entering room 414 to do care. There was also an aide, NA #2, doing baths and she walked in and said where ' s [Resident #137]? [NA #2] said she had just looked for her. We looked out of the 414 window and could see traffic backed up on Ingram (the 2-lane street in front of the facility). We looked out the door (outside door at the end of the 400 hallway) and looked toward the highway past Ingram and [the resident] had gotten out. [Resident #137] was in the median and a motorist was standing with her. He made it back across the highway with her. We ran out there to get to her. We took [the resident] under the arms and escorted her back to the building. We got [Resident #137] back in her wheelchair and reattached her shirt alarm. She was able to and would un-attach her own [personal body alarm] and had had it on before she left the building that night. [Resident #137] was very steady on her feet and walked very briskly. The nurse was already made aware before we went out the door that the resident was gone. We called the administrator and he came to the building. I did not hear the door alarm go off that night. I had been in the 414 room, the [television] was on and I didn ' t hear [the 400 door] alarm. You really	F 323	And any concerns are immediately addressed on the spot. The findings of the audit are documented and submitted at the quarterly quality assurance meeting for further review or corrective action.	

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couldn ' t hear [the door alarm] if you were in a room. " NA #1 indicated the personal body alarm had been placed on the resident to alert staff when she would get out of her wheelchair to. She further indicated the resident would pull her clothing around and detach the personal body alarm clip from her clothing.

During an interview with NA #2 on 6/4/15 at 5:57 pm, regarding Resident #137 ' s elopement on 4/22/15, she stated, " I was in the tub room and had gone down the hall to get [Resident #137] for her shower and she wasn ' t in [her room]. Her wheelchair was there but she wasn ' t in it. I walked to find [NA #1] to ask where she was. We started looking for her and we looked out the 400 door and saw cars backed up on Ingram then we saw her in the median in between the north and southbound lanes [of U.S. Highway 52]. There was a man out there with her. We yelled for the nurse and went out to get her. I did not hear [the door alarm] go off. We assisted her back into the building. "

The Event Investigation dated 4/24/15 at 8:00 pm stated, " Resident was wandering up and down 400 hallway, [Nurse aide] stepped out into hallway to see resident opening door. Resident stepped out onto sidewalk and then came back in to hallway as staff got to her. Resident stated, ' I just wanted to know what was out there. ' " The witness on the report was Nurse Aide (NA) #1. The report further stated the incident was " avoidable. " The report indicated interventions were frequent re-direction from staff, increase visual checks, and the resident was brought to the nursing station for one on one observation to promote safety.

Review of the nurse ' s note dated 4/24/15 at 8:00 pm revealed Resident #137 had exited the building to the outside sidewalk through the 400

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hall door. Staff heard the alarm sound and the resident was coming back into the building as staff got to door.
The physician order dated 4/24/15 stated, " Check personal alarm. Alarm to alert staff if [resident] transfers without assist. "
Record review of the Care Plan dated 4/24/15 indicated the following updated care area:
· Safety needs - personal alarm to resident to alert staff if resident transfers without assistance to promote safety. Intervention: check personal alarm [every] shift continuous.
During an interview with NA #1 on 6/4/15 at 3:02pm, regarding Resident #137 ' s exiting of the building on 4/24/15, she stated, " The nurse told me the door alarm was ringing. I was about half way down the hall and it was very faint ringing. [Resident #137] had just made it out the door. She would get very anxious when we would try to redirect her and so we walked with her back in through the front door. "
Review of the nurse ' s note dated 4/25/15 at 12:19 am indicated Resident #137 was sitting with staff at the nurses ' desk. She continued to wander up and down the hall and was redirected with no success.
The Event Investigation dated 4/25/15 at 2:40 am stated, " Resident stated she wasn ' t staying here and needed to go and she was going to drive herself home. " The report indicated the nurse supervisor observed Resident #137 walking towards the 400 hall door, went down the hall to redirect the resident and the resident opened the door and walked out onto the sidewalk. Staff redirected the resident back into the building and the resident was attempting to push staff away. The report further stated the incident was " avoidable. " The report indicated interventions were frequent re-direction from

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staff, increase visual checks, and the resident was brought to nurses ' station for one-on-one observation.
Review of the nurse ' s note dated 4/25/15 at 2:46 am indicated Resident #137 continued to wander up and down the halls, attempting to go outdoors. Staff attempted to re-direct her with little success. The resident began to get combative with staff when being redirected. The nurse supervisor noted Resident #137 walking out into the hallway on 400 hall, heading toward [exit] door and went outside onto the sidewalk. Staff redirected the resident back into the building.
The Event Investigation dated 4/28/15 at 10:45 pm indicated Resident #137 opened the 300 hall [exit] door, opened the 400 hall [exit] door and walked approximately 15 feet into the yard. She became combative when nursing staff assisted her back into the building. The witness on the report was Nurse #2. The report further stated the incident was " avoidable. " The report indicated a bed alarm, chair alarm, frequent re-direction from staff, monitoring the resident ' s location every 30 minutes and increased visual checks were interventions.
Nurse #1 ' s note dated 4/28/15 at 11:04 pm stated, " [Resident #137] exhibited wandering behavior. Opened 300 hall door and 400 hall door and walked [approximately] 15 [feet] into yard. "
During an interview with Nurse #2 on 6/4/15 at 3:10pm, regarding Resident #137 ' s exiting of the building on 4/28/15, she stated, " We could not keep her in the room. I was the nurse on 300 that night and [Nurse #1] was the nurse on 400. I put [Resident #137] at the nurses ' station. I put a chair next to [Nurse #1] at the station so she could keep an eye on [the resident]. The aide was talking to me and noticed [Resident #137]

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was not there. The aide and I ran down the hall to get her. She was outside on the sidewalk walking away from the building. We were trying to get her back in and she was slapping at us, elbowing us. She was so quick. I don ' t remember hearing the door alarm that night. Sometimes we heard the alarm, but once you are down the hall you couldn ' t hear it. I would never have been able to hear the alarm if I was in a resident room. We talked about that among the nurses and mentioned it to maintenance. [The facility] would always say, ' They go off at the nurses ' station so you should be able to hear when a door is opened ' but you couldn ' t hear them. We don ' t just sit at the nurses ' station and couldn ' t hear them if we were in a room. [Resident #137] wore a personal alarm but knew how to take it off. We would try to move her personal alarm but she was able to get it off herself. She would just come walking down the hall with the alarm in her hands. "

During an interview with the Maintenance Director on 6/1/15 at 11:12 am he indicated the facility ' s 4 resident halls were formed in the shape of an " H " with exit doors at the end of each hall and a nurses ' station at the midpoint of each hall. He indicated the resident halls were the vertical lines of the " H " and the 2 nurses ' stations were located where the horizontal line met the vertical lines. He further stated, " On the 300 hall people can come and go (through the exit door at the end of the hallway) throughout the day. It is locked at 9pm at night. At 9pm if the door is opened then it will alarm and it will alarm at any time of the day with a resident who has a [wandering prevention system]. The laundry and the front doors are the same. Door alarms are checked every morning by maintenance using the tester. There are testers on the medication carts

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that are used by the nurses to check the residents who have [wandering prevention systems]. " The Maintenance Director further clarified the 300 hall exit door, laundry door, and front door were the doors that are monitored with the [wandering prevention system] and the alarm sounds at those doors. The 100 hall, 200 hall, and 400 hall doors were not monitored with the [wandering prevention system] but alarmed at the nurses ' station when those doors were opened by anyone.

On 6/1/15 at 11:45 am an observation was made as the Maintenance Director tested the [wandering prevention systems] functioning of the 300 hall exit door, laundry door, and front door of the facility. The doors each alarmed, at the door, with a sound sufficiently loud enough to alert staff and others in the immediate area who turned toward the loud alarming.

During an interview on 6/1/15 at 12:20 pm with the Administrator he indicated Resident #137 had been discharged from the facility to a locked assisted living facility due to her numerous attempts at exiting the building and her ability to ambulate very quickly. He stated, " [The resident] got out of the building multiple times and was wearing a [wandering prevention systems] that worked. The furthest she got was out of the building to the parking lot and she was not injured. That elopement was in the evening and [Resident #137] left out of the door on 400 hall that alarms at all times when it is opened. "

On 6/1/15 at 12:50 pm an observation was made as Maintenance #1 opened the 100 hall exit door. There was no alarm heard. When asked why there was no alarm sounding, Maintenance #1 indicated the alarm only sounded at the nurse ' s station. Upon turning toward the nurse ' s station, there was a very faint beeping that Maintenance

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F 323	Continued From page 10 #1 indicated was the alarm. He further stated, " The 100, 200, and 400 doors alarm only at the nurse ' s station and if they go off [the nurses] will come and get whoever is going out the door. " During an interview on 6/1/15 at 3:10 pm the Administrator stated, " When a door alarm goes off, the instrument panel at the nurse ' s station lights up. It shows any (alarmed) door in the facility. You should be able to hear the alarm even if you are on the hallway, but it sounds the loudest at the nurse ' s station. There is always someone sitting at the nurse ' s station who would hear the alarm and see which door had been exited. " An observation on 6/1/15 at 4:50 pm revealed there were no staff present at the nurse ' s station between 100 and 200 halls. On 6/2/15 at 9:30 am an observation was made as the Administrator opened the 100 hall exit door. A very faint beeping was heard while standing in the hallway, but the beeping was unable to be heard when this surveyor stepped into several resident rooms. The administrator indicated he also could not hear the alarm beeping when he stepped into a resident ' s room. On 6/2/15 from 1:15 - 1:20 pm a continuous observation was made of the 100 hall/200 hall nurse ' s station. There was a call bell ringing at the nurse ' s station and there were no staff present at the station. On 6/2/15 at 5:00 pm an observation was made of Room 411. The room door was located 29 feet from the exit door at the end of hall 400. It was the last resident room on the right side of the hallway going from the nurse ' s station to the outside of the facility. On 6/2/15 at 5:05 pm an observation was made of the Maintenance Director opening the alarm door at the end of 400 hall. A faint, barely	F 323		

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VILLAGE CARE OF KING	**440 INGRAM ROAD EXT BOX 1750 KING, NC 27021**

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F 323	Continued From page 11	F 323		

audible, beeping was heard at the nurse ' s station. Upon entering a resident room the Maintenance Director confirmed he was no longer able to hear the exit door alarm that continued beeping at the nurse ' s station.
On 6/2/15 from 5:17 - 5:22 pm a continuous observation was made of the 300 hall/400 hall nurse ' s station. There were no staff present at the station.
During an interview on 6/3/15 at 9:51 am with the Administrator he stated, " After the elopement on 4/22 we in-serviced all staff on the alarm to make sure they could hear them. The resident ' s family was staying all day, and we began attempting a discharge to a locked location. When [Resident #137] was agitated, two nurses would watch her at the nurse ' s station. Knowing there are alarms on the doors and the family would sit with her during the day, we felt she was being monitored. The nurse who worked the hall that night is no longer here, [Nurse #1]. She indicated to me that night (4/22/15) that she was not sure she even heard the alarm go off. When I came in right after the elopement I checked the alarms and they worked. She had been in-serviced on the alarms, but I am not sure she understood how they worked. The lights can be confusing. "
During an interview on 6/3/15 9:58 am the Director of Nursing (DON) stated, " I was [out of town] when the elopement occurred on 4/22. Staff called the [Assistant Director of Nursing] and the Administrator. They had a family conference on that Friday after the incident occurred, an aide stayed with [the resident] until the family came the day of the elopement. [Staff] put a personal alarm on her when she was in her bed and wheelchair. My expectation is that the facility put steps in place to ensure [the resident ' s] safety. One thing we discussed with the family was that

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F 323	Continued From page 12 we did not feel this was an appropriate environment for her. She was a high elopement risk. Her room was the last resident room on the right before the exit on the hall. It is not a [wandering prevention systems] door. " During a subsequent interview on 6/3/15 at 11:10 am with the DON she indicated she was not notified of the elopement until she returned to work from training on 4/24/15, the family and the administrator were having a conference about the elopement and she was instructed by the administrator that she was not needed in the meeting. She further indicated that more could have been done to ensure the safety of this resident, including moving her room closer to the nurse ' s station or providing continuous one-on-one until placement in a more appropriate facility could be arranged. During an interview on 6/4/15 at 4:37 pm with the MDS Nurse she indicated an elopement risk assessment was done on 4/8/15 for Resident #137 and there were no more done. She further stated, " Whoever identified and investigated the elopement should have done another risk assessment. " On 6/4/15 at 6:00 pm an observation was made of the distance between the exit door on 400 hall, across the 2-lane road in front of the facility, to the median of the 4-lane divided highway where Resident #137 was found by a motorist. The distance was approximately 240 feet (80 yards). Nurse #1 was no longer an employee of the facility and was not interviewed. The Administrator was notified of the Immediate Jeopardy on 6/2/15 at 6:20 pm. The facility presented a credible allegation of compliance on 6/4/15 at 2:30pm which included: Please accept this Credible Allegation of	F 323		

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F 323	Continued From page 13 Compliance as of 06/04/2015 A. Corrective action was accomplished for resident #137 as follows: 1. Resident # 137 admitted to the facility 04/08/2015. Diagnosis on admission: Dementia with Behaviors, and Cerebral Degeneration. 2. On admission day to facility of 04/08/15 this resident was assessed by the licensed nurse using the electronic healthcare record elopement questionnaire and was not identified to be an elopement risk at the time of admission. 3. Resident #137 had a wander guard placed on 04/16/2015 when identified to be an elopement risk. This intervention was care planned and placed on the care guide, as well as orders written by the nurse to check wander guard placement each shift 4. Resident #137 was assessed on the 14 day MDS 04/20/2015 section E0900 coded as " 2 " for wandering with in the facility based on documentation in the resident record during the look back period in the electronic record. 5. Resident #137 eloped from facility on 04/22/15. Nursing staff were in-serviced by the maintenance supervisor for Door alarm operation. Although not documented the nurse specified in writing on the event report every 15 minute checks as new intervention. Also a chair alarm was applied to resident wheelchair. The social worker began to seek alternate placement in a secured unit on 04/23/15 after meeting with the family. 6. Resident #137 did not experience any harm or negative outcomes related to the elopement. 7. Resident # 137 discharged from the facility to a secured unit on 05/06/15. B. To identify other residents with the potential	F 323		

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F 323	Continued From page 14 to be affected by the deficient practice, the facility performed the following audits. Utilizing the 672 Census and Condition electronic health care record report, specifically focusing on behaviors triggered from current MDS a total of 9 residents were identified as having the potential to be affected by this deficient practice. This audit began by the MDS nurse and Regional Nurse Consultant 6/2/15 and completed 06/3/15. Audit results revealed these 9 residents all have current interventions in place per care plan, care guide, and orders scheduled in the electronic healthcare record for the licensed nurse to check placement of the safety devices each shift. None of these residents were identified as having any elopement attempts or having any compliance issues since this immediate jeopardy was identified during the current state survey. C. Corrective action completed 06/03/15. 1. On 6/2/15 and 6/3/15 The MDS nurses, DON, ADON, began reeducating all staff in all departments on the Wandering/missing resident policy and procedure. 2. No staff members will be allowed to work their scheduled work day until receiving mandatory reeducation for the wandering/missing resident policy and procedure. Reeducation of the wandering/missing resident policy and procedures includes: · Protocol/guidelines when door alarm sounds. · Facility full search procedure · What to do when resident has not been located by the room search. · High risk missing resident protocol 3. All new employees receive in-service education on Village care of King ' s	F 323		

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F 323	Continued From page 15 wandering/missing resident policy. 4. An audit tool has been incorporated to monitor compliance for wandering/missing residents identified by assessment to be at risk. 5. The 100 hall, 200 hall and 400 hall exit doors are not protected with the wander guard alert system, but have a low audible tone alarm, therefore new door alarms with louder, audible sounding tones were applied to these doors on 6/3/15 by the maintenance supervisor. 6. Any residents identified with risk potential to elope from facility will be placed in a room with closer proximity to the nurse ' s station and further distance from exit doors. D. New Monitoring systems/ interventions have been placed in effect to prevent recurrence 1. Within 15 days after admission the MDS nurse will complete a follow up (2nd) elopement assessment to ensure residents are identified for risk 2. A thorough investigation for any elopement event will be completed by the DON or other designated administrative staff member under the supervision of the DON. · Investigation will include: · Document means of egress where resident exited facility · What was direct care staff doing when elopement occurred? · Where was resident located? · Ask and document what resident states trying to do. · Who returned resident to facility? · Was resident experiencing behaviors? · Document immediate intervention/s placed to maintain resident safety	F 323		

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F 323	Continued From page 16 (guidelines/suggestions) staff member stay with resident one on one, 15 minute checks, inform MD and Responsible party, inform Administrator and Director of nursing immediately for additional suggestions, nurse placing the interventions edits care plan and care guides 3. Residents identified will have the following completed by the MDS nurse: · Update and revise Care plan to address elopement risk · Update Care guide with risk for wandering/elopement · Order scheduled in electronic healthcare record for nursing to check the wander guard placement each shift to better ensure resident safety. Immediate Jeopardy was removed on 6/4/15 at 7:00 pm when interviews with nursing staff confirmed they had received in-service training on the Wandering/Missing Resident Policy and Procedure. Record reviews confirmed 9 residents were identified by the facility as having the potential to be affected by the deficient practice and an audit tool was in place to identify residents with an elopement risk upon admission and to ensure a 2nd evaluation for elopement at 15 days. Two residents were identified as having a high risk of elopement and were being moved closer to the nurse ' s station. Observations confirmed alarms were placed on the 100, 200, and 400 hall exit doors. The alarms were tested by the Maintenance Director and revealed loud alarms that were audible in resident rooms with the doors closed. The alarms were able to be heard with the doors closed even in rooms with televisions on, oxygen on, and residents conversing.	F 323		