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	345280	A. BUILDING _____ B. WING _____	C 04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF RAEFORD	1206 N FULTON STREET RAEFORD, NC 28376

(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 did not monitor 1 of 2 cognitively impaired sampled residents (Resident #1) who exhibited exit seeking behaviors and exited the facility without staff knowledge and was found in the parking lot unattended placing Resident #1 at risk for serious bodily injury. Findings included: Immediate Jeopardy for Resident #1 began on 03/28/16 when Resident #1 exited the facility by going out of the 200 hall exit door into the parking lot unattended. Immediate Jeopardy was removed on 04/15/16 at 5:40 PM when the facility provided and implemented 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 of corrective action at that time. Resident #1 was admitted to the facility on 03/10/16. Diagnoses included dementia with behaviors, diabetes mellitus and hypertension. An elopement assessment of 03/10/16 noted Resident #1 received a score of 8 which	F 323	For the resident affected: On 3/28/16 at approximately 7:35pm, dietary staff notified nursing staff that identified resident was outside the 200 hall doors. Resident was identified to be there for less than three minutes and was brought back inside per nursing staff. Resident was assessed with no injuries noted. Resident stated he was getting some fresh air, I told you I was getting out of here. Resident then proceeded to tell nurse that he watches people go in and out of that door all day long, and just went out the door. Residents wander guard was checked for Door alarm did not sound with resident exiting the facility, but alarmed when bringing resident back inside. This clarified that door and alarm was working properly, but upon investigation it was believed that resident may have entered the master code. Residents wander guard was checked for placement and function. Wander guard found to be on resident and working properly. Resident was placed on Q 15 minute safety checks. On 3/29/16, Resident was moved to the	4/16/16

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

Electronically Signed | 05/04/2016

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according to the document a score greater than 5 placed him at high risk for elopement. The assessment noted Resident #1 was mobile and cognitively impaired with poor decision making skills. It also noted Resident #1 verbalized statements such as wanting to go home or go on a trip or going to meet someone.
Resident #1's care plan, dated 03/11/16, identified him as being at risk for falls related to dementia and impaired safety awareness. On 03/14/16, the care plan was revised to include being at risk for injury related to elopement and/or wandering and had impaired cognition. He was unaware of safety needs. The goal noted he would not elope from the facility through the next review. Interventions included:
. assess risk factors per routine
. family conference to discuss attempts to leave per routine
. follow facility elopement procedures
. involve in activities
. monitor and report changes in behavior
. re-direct as needed
. wanderguard
A physician's order of 03/11/16 noted to apply a wanderguard to Resident #1.
A progress note of 03/15/16 at 3:48 PM documented Resident #1 had been agitated throughout the shift and Ativan was given with effectiveness noted. It also documented he ambulated but his gait was unsteady.
The Admission Minimum Data Set (MDS) assessment of 03/17/16 noted he was severely impaired in decision making and exhibited no behaviors and no wandering. The resident needed extensive assistance with transfers but needed limited assistance from staff for walking in his room. He was independent with locomotion on and off the unit. According to the care area

secured unit. Resident was discharged home on 3/31/16 with son.

For the resident with the potential to be affected: All exit doors in the facility were checked to ensure locking and working properly on 3/28/16 at approximately 2pm by Administrator. All exit doors found to be locked and working properly. On 3/28/16 at approximately 8pm, Maintenance Supervisor reported to facility to check all doors of locking and alarming properly. All exit doors were found to be locked and working properly. Maintenance Supervisor changed all employee codes and master codes to all exit doors in facility. All residents with wander guards were checked by Nurse Supervisor for placement and function on 3/28/16. All found to be on and working properly. All residents are assessed for elopement risk upon admission, quarterly, and as needed basis. Care plans updated accordingly.

Measures put in place: All exit doors in the facility were immediately checked to ensure locking and working properly on 3/28/16 by Maintenance Supervisor. All found to be locked and working properly. All wander guards were checked by Nurse Supervisor for placement and proper functioning on 3/28/16. No issues were noted. In-service was started by Administrator on 3/29/16 with maintenance staff regarding master code to exit doors should not be used unless in emergency situations. Starting 3/29/16 only Maintenance Supervisor and

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F 323	Continued From page 2 assessment for this MDS, he triggered in several areas which included cognitive loss. A physician's order of 03/18/16 noted Resident #1 was to have a wander guard to his ankle and it was to be checked for placement/functioning every shift. The electronic medication administration record (eMAR) of March 2016 noted Resident #1's wanderguard was checked for placement/functioning daily at 6:00 AM, 2:00 PM and 10:00 PM. An electronic medication administration (eMAR) note of 03/20/16 at 12:44 PM indicated Resident #1 was given Lorazepam 1 milligram (mg) for agitation due to he was looking for his keys and was asking if someone had stolen his car. He was redirected several times. There was a wanderguard in place to his ankle. A progress note written by Nurse #2 of 03/22/16 at 10:48 AM indicated Resident #1 had delusions and thought he was applying for a job. Nurse #2 was interviewed on 04/14/16 at 5:10 PM. She stated Resident #1 liked to sit at the nurse's station and would say he wanted to go home. She reported at times he was capable of walking but used his wheelchair most of the time to self-propel about the hall. Resident #1 was encouraged to go to activities and would attend. Nurse #2 stated he needed re-orientation often and would become more confused in the evenings. She stated she never observed Resident #1 try to get out and did not observe him sitting near the 200 hall exit door. She stated he would spend time in his room talking with his roommate. Nurse #2 stated she was surprised when she heard that Resident #1 had gotten out of the facility as she had never seen any exit seeking behaviors from Resident #1. Nurse #2 stated the exit door should have locked when he	F 323	Maintenance Assistant have access to the master code. In-service was started by Administrator on 3/29/16 with nursing staff regarding responding to residents voicing or showing exit seeking behaviors. On 4/14/16 an all staff in-service was initiated by Staff Development Coordinator regarding notifying management (DON and Administrator) when residents show signs of exit seeking behaviors and how to manage these behaviors. Identifying behaviors that may be considered as an elopement risk and what to do if a resident appears to be attempting to elope to include immediate supervisor notification. All employees completed in-service before next scheduled shift and were not allowed to work until re-education completed. On 4/15/16, during complaint survey, elopement risk assessments were initiated on all residents currently in the facility with completion date of 4/15/16. Those which scored high risk were reviewed by interdisciplinary team and interventions put in place as indicated and care plan updated. Monitoring: All master codes will be changed weekly X 1 month by Maintenance Supervisor. If after 1 month of auditing master code, no issues are noted, facility will change code monthly and on as needed basis. All exit doors in the facility will be checked daily X 1 month by Maintenance Supervisor and/or Administrator, DON, ADON, SDC, Nursing Supervisor. If after 1 month of auditing no issues were found, facility will	

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approached it wearing a wanderguard. She reported staff were monitoring him and did not know how he got out without staff seeing him.
A progress note of 03/22/16 at 10:48 PM written by Nurse #3 documented Resident #1 was disoriented with confusion noted and wandered.
A progress note of 03/23/16 at 10:48 PM written by Nurse #3 documented Resident #1 was disoriented. It noted he wandered and was easily re-directed.
A nursing note of 03/24/16 at 4:50 AM written by Nurse #3 documented Resident #1 had been ambulating in the hallway seeking exits stating "How the h--- do you get out of here?" It noted he was walking from door to door attempting to open them. Resident #1 was resistive to re-direction and stated "You can't make me stay here." Resident #1 was verbally abusive and made threats of physical harm towards staff. He was re-directed to his room without incident.
The 14 Day MDS assessment of 03/24/16 noted no change in Resident #1's cognition but he exhibited verbal behavior symptoms towards others for 1 to 3 days, he rejected care for 1 to 3 days and was wandering 1 to 3 days.
A skilled nursing note of 03/25/16 at 10:48 PM from Nurse #3 documented Resident #1 was disoriented and anxious looking for a way out stating he had to go. It documented he was wandering and looking for a way out but was easily re-directed.
A skilled nursing note of 03/27/16 at 10:48 AM from Nurse #3 noted Resident #1 was anxious and wanted to go home.
A skilled nursing note of 03/27/16 at 10:48 PM from Nurse #3 noted Resident #1 wandered and attempted to find exits.
Nurse #3 was interviewed via telephone on 04/14/16 at 8:53 PM. He reported Resident #1 as

return to checking doors weekly. DON and/or ADON, SDC, Nursing Supervisor will audit all new admissions weekly X 4 weeks to ensure all elopement assessments were completed and interventions put into place as indicated. All new admits and readmits with high elopement risks will be monitored weekly X 4 weeks in weekly PAR meeting by DON/ADON/Administrator/Admin nurses. This will be on-going. All residents with wander guards will continue to be checked daily by restorative aides, Floor Nurses, DON, or Administrator to ensure proper placement and functioning per facility protocol. These audits will be reviewed by QAPI committee until deemed no longer necessary.

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being polite and ambulatory and used a wheelchair. He reported Resident#1 had frequent wandering and exit seeking behaviors on almost a daily basis. He reported Resident #1 would go from door to door trying to push the door open. Nurse #3 stated he always stayed on the A hall (a very long hall which extended from one end of the building to the other and included the 100 and 200 halls, both of which had an exit door). He stated the 200 hall exit door (located on the A hall) was Resident #1's favorite because it was close to his room. He stated there was another exit door at the end of the 100 hall (located on the A hall) and he had observed Resident #1 going to that door and would stand to push on it. He reported Resident #1 stated frequently that he wanted to go home. Nurse #3 stated staff monitored him closely and would go to the exit doors on the A hall and attempt to re-direct him away from the doors. He stated Resident #1 was usually easily re-directed and might curse at staff but would move. Nurse #3 reported "everyone" in the building was aware of his exit seeking behaviors but he had not personally reported them to management because all staff were aware. He stated staff that worked on the A hall knew Resident #1 roamed on the halls. Nurse #3 stated he felt Resident #1 was "sun-downing" because his exit seeking started almost the same time every night on the nights that he wandered. He commented that he had witnessed Resident #1 sitting in the foyer near the 200 hall exit door and just watch people come and go. He stated if someone went out of the 200 hall door, Resident #1 would ask them to let him out. Nurse #3 stated he really never thought Resident #1 would get out but felt Resident #1 was capable of it. He also stated Resident #1 was wearing a wanderguard that was

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functioning properly but if Resident #1 had the right code for the exit door keypad and if Resident #1 entered the right code then the door would open. When questioned about the night of 03/28/16, Nurse #3 stated he was working on the A hall and Resident #1 had told him that night he wanted to go outside but wasn't sure exactly when. Nurse #3 could not provide Resident #1's exact location prior to the incident. When questioned if staff had taken Resident #1 out under supervision, he responded that they had not. Nurse #3 stated he should have communicated Resident #1's exit seeking behaviors to the Director of Nurses (DON).
Nurse #3 was interviewed again via telephone on 04/15/16 at 9:18 AM. He stated Resident #1 had exit seeking behaviors since the day he was admitted. He stated Resident #1 received physical therapy and as he became more mobile his behaviors increased. Nurse #3 stated staff had been out to smoke that night (03/28/16) but didn't remember what time. He added that he went out to smoke and thought he had been back in about 5 minutes prior to dietary staff calling to report Resident #1 was out of the building. Nurse #3 stated he was told that Resident #1 was sitting on the bench underneath the canopy just outside of the exit door when staff retrieved him. He was not aware that Resident #1 was found walking in the parking lot.
A nursing note of 03/28/16 at 9:09 PM from Nurse #1 documented that around 7:40 PM Resident #1 was observed by kitchen staff (KS #1) coming out of the door in the smoking area. It noted that kitchen staff (KS #2) contacted the hall and staff had returned him to the inside of the building. His wanderguard was checked and was functioning properly. Nurse #1 noted the maintenance supervisor was contacted and came to the

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building to inspect the doors for malfunction. It noted all doors to be functioning properly. The codes were changed on all of the doors. The DON was made aware. Resident #1 was placed on 15 minute checks. Nurse #1 noted that Resident #1 was agitated and stated he wanted some fresh air. He also stated "I told you I was getting out of here." Resident #1 reported when asked how he got out that he had watched people go out of that door all day.
Nurse #1 was interviewed via telephone on 04/13/16 at 8:01 PM. She stated she was working on the 100 hall the night (03/28/16) that Resident #1 had gotten out. Nurse #1 stated Resident #1 usually self-propelled in his wheelchair but was capable of walking although his gait was unsteady at times. Nurse #1 stated she had not witnessed Resident #1 watching any of the exit doors when she worked. She stated she remembered he kept rolling around saying he was going home that night (03/28/16) but couldn't say where he was just prior to exiting the building. Nurse #1 stated she was notified by kitchen staff (KS #2) that Resident #1 was seen outside and she sent staff outside to retrieve him (she did not remember which staff). She stated the door alarm sounded when they were bringing him back inside but did not sound when he went out. She commented that Resident #1 must have gotten the code otherwise he couldn't have gotten out because the exit door locked automatically when a wanderguard was close by. When questioned about his statements of wanting to get out, she stated she thought he was just talking and didn't think he would actually try to get out. Nurse #1 stated he was placed on visual checks upon being brought back inside. Nurse #1 stated wanderguards were checked for placement every shift and she usually checked when she made

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rounds but had no specific time to do her rounds.
Kitchen staff #1 (KS #1) was interviewed on 04/13/16 at 5:30 PM. She stated she had just walked over to the kitchen door (that had a small glass window and was located at the back of the kitchen that overlooked the parking lot in full view of the 200 hall exit doors) to look to see if her ride was in the parking lot. She stated she saw a man pushing a wheelchair standing by the transport van in the parking lot. KS #1 stated she asked KS #2 if she knew who it was and KS #2 responded it was Resident #1. KS #1 stated he was walking behind his wheelchair pushing his wheelchair. She stated she didn't see him exit from the 200 hall exit door and didn't know how long he had been in the parking lot. KS #1 stated KS #2 telephoned the nurse and they came outside and took him back inside the building.
KS #2 was interviewed on 04/14/16 at 3:19 PM. She stated the door in the back of the kitchen had a window and the parking lot and the 200 hall exit door was visible from this door. She stated KS #1 went to the door to look for her ride and saw Resident #1 in the parking lot. KS #2 stated KS #1 asked her if she knew that man and when she looked out of the window, she saw Resident #1 pushing his wheelchair by the vans in the parking lot. She stated she went outside to check on him. She stated she immediately went back inside to alert the nurses that he was outside. KS #2 stated she asked KS #1 to watch him from inside the door while she placed the telephone call. KS #2 stated after she alerted the nurse she was headed back out to the parking lot to stay with him but staff had come out of the 200 hall exit door to get him before she could get there.
A skilled nursing note of 03/28/16 at 10:48 PM from Nurse #3 documented Resident #1 was disoriented but alert with intermittent confusion. It

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documented he wandered seeking exits and was easily re-directed most of the time.
A social services note of 03/29/16 at 5:40 PM noted Resident #1 had been moved from his room on the A hall to the locked unit.
A skilled nursing note of 03/30/16 at 10:34 PM noted Resident #1 was anxious, combative and continuously attempting to call his family to pick him up. The note also indicated Resident #1 refused care most times and would ask staff to borrow money. When staff refused, he argued and cursed them.
Resident #1 was discharged from the facility on 03/31/16 at 3:15 PM with his family.
Nurse Aide #1 (NA #1) was interviewed on 04/13/16 at 5:05 PM. She had worked with Resident #1 and was familiar with him. She reported he rolled around the facility in his wheelchair. She denied ever noticing that he was "watching" the exit door of the smoking area (200 hall exit door). She reported Resident #1 had a wanderguard because she was the aide who had placed it initially. She commented if a resident was wearing a wanderguard and was within a certain distance from the exit doors the doors would lock automatically. NA #1 stated the door would not open even if the code was entered into the keypad beside the door if the wanderguard was working properly.
NA #2 was interviewed on 04/13/16 at 6:12 PM. She stated she had worked with Resident #1 and was familiar with him. She stated Resident #1 was confused at times and would ask why he was in the facility. She stated Resident #1 made comments about going home. She reported never seeing Resident #1 sitting at or near the smoking area door (200 hall exit door) but he would ask staff to let him out. NA #2 stated Resident #1 had a wanderguard and if Resident

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#1 got too close to the exit door, the door would automatically lock and would not open even if the code was entered.
Nurse #4 was interviewed on 04/14/16 at 10:25 AM. She stated Resident #1 was pleasantly confused and always wanted to call his family. She stated Resident #1 could walk but usually self-propelled around the facility in his wheelchair. Nurse #4 stated Resident #1 always talked about going home and wanting to get out and was at risk for elopement. She commented that she never witnessed Resident #1 sitting at any of the exit doors and didn't think it was possible for him to remember a code. She stated everyone including administration knew that Resident #1 talked about wanting to get out and wanting to go home. She reported being surprised when she was told that Resident #1 had gotten out of the building. Nurse #4 stated an elopement assessment was completed if a resident talked about leaving and if scored high enough they were deemed at risk and a wanderguard was placed on that resident. She went to the exit doors on the 200 hall with a wanderguard in hand. Both sides of the first double glass door were propped open with a wedge. When she approached the exit door, the red light was on in the box located to the right of the door. She stated even if she entered the code, the door would not open. She entered the code and the door remained locked.
The maintenance supervisor was interviewed on 04/14/16 at 10:40 AM. He reported there were 3 doors in the facility which were wanderguard protected. He stated the side entrance next to the kitchen, the 200 hall exit door and the front door were wanderguard protected. He stated the front door had an automatic time lock for evenings. He stated the door at the end of A hall

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(the 100 hall) was keypad locked and wouldn't open unless the proper code was entered. The maintenance supervisor went to the side entrance exit door located near the kitchen to demonstrate how the wanderguard system worked. He stated the door locked automatically if a resident came within 2 feet of the door with a wanderguard in place. The maintenance supervisor commented that even if a resident was in the therapy room which was behind the foyer wall of the side entrance, the wanderguard would activate the locking system and no one would be able to go out. He stated the door would not open even if the employee code was entered unless it was the master code which would override the system. The maintenance supervisor commented that in case of emergencies there was an override switch that could be flipped on that would override everything and the door would open. He pointed to the "override switch" which was a red switch located underneath a hard plastic cover and stated if that switch was flipped, the door would open but a very loud alarm would sound. He flipped the switch and the alarm sounded. He commented the exit doors that had the wanderguard locks did not have alarms that sounded they just locked in response to the wanderguard.

A clarification interview was conducted with the maintenance supervisor along with his 2 staff members (Staff #1 and Staff #2) on 04/15/16 at 10:40 AM. The maintenance supervisor stated there were 2 codes-an employee code and a master code and the only way Resident #1 could have gotten out of the 200 hall exit door without supervision was if he had the master code because the wanderguard system was functioning properly. He stated if Resident #1 was wearing a wanderguard the door would have

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locked preventing him from leaving if Resident #1 entered the employee code. The maintenance supervisor stated prior to Resident #1 exiting the building he had been checking all of the exit doors for proper functioning on a daily basis. He also stated that when he himself used any of the exit doors he didn't usually notice who was sitting at or around the doors because the system was functioning. Staff #1 and Staff #2 both stated they did not notice who would be sitting at or near the exit doors when they went out. Both Staff #1 and Staff #2 stated they used that door (200 hall exit door) on a daily basis as well as the other exit doors and used either the employee code or the master code to come and go. Staff #1 stated the first double glass door leading to the 200 hall exit door was usually left open. He also stated that some of the other staff in the building besides the maintenance staff had the master code as well and didn't know how they got it. The maintenance supervisor stated that the 200 hall exit door was also the emergency entrance for ambulances. None of the 3 staff remembered anything about events on 03/28/16 prior to Resident #1 going out of the building other than they had used that door (the 200 hall exit door) during the day and left between 4:00 PM and 4:30 PM. The maintenance supervisor commented that he was the only person who knew what the master code was now since the 03/28/16 incident because he was changing the codes weekly and was not giving it to anyone.

NA #3 was interviewed on 04/14/16 at 3:30 PM. NA #3 had worked with Resident #1. He stated he remembered Resident #1 and he would "sundown" at night and become more confused. NA #3 stated one night Resident #1 wanted to go to his truck to go home. He stated as time went by, his behaviors became more frequent

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occurring daily. NA #3 stated Resident #1 was ambulatory but mostly used his wheelchair as a walker to get around. He commented Resident #1 would go to the 200 hall exit door and just sit there. NA #3 stated Resident #1 had told him previously he wanted to get out and he had passed it on to the nursing staff. He didn't remember who he told or when this happened. He stated because of Resident #1's behaviors, staff kept a close eye on him. NA #3 stated Resident #1 would become combative if staff attempted to remove him from the exit doors. He commented he had seen him go to the exit doors on A hall (100 hall) and attempt to push the door open. He also commented he had seen Resident #1 push and kick both of the doors on A hall (100 and 200 hall) trying to get out (he couldn't provide specific dates or times). NA #3 stated he spent as much time as he could sitting and talking with Resident #1 in an effort to decrease his anxiety level. He commented he was working the night Resident #1 went out of the building (03/28/16) but he was on the locked unit and didn't see anything. When questioned if he felt Resident #1 could have memorized a code, he stated he felt that Resident #1 could because some days he was having a "good day" and was totally alert.
Transport staff #1 (TS #1) was interviewed on 04/15/16 at 3:05 PM. She stated Resident #1 would sit in front of the restroom that was adjacent to the 200 hall exit doors. She stated he liked to watch staff in the hall. TS #1 stated she had never seen him try to keypunch numbers into the keypad located just inside the 200 hall exit door. She also stated she had never observed him trying to exit the building.
During an observation of the 200 hall exit doors which lead out into the smoking area and the parking lot, on 04/13/16 at 5:45 PM, it was noted

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that there were 2 sets of double glass doors. The first set of double glass doors was propped open with wedges underneath both doors. There was a short hallway (approximately 4 feet) between the 2 doors. There was a keypad on the left side of the door and another box on the right side of the door. The second double glass exit door was closed and was locked when pushed on. There was a bench noted on the left side just outside the exit door which was covered by a large canopy. There was a concrete drive which lead from the parking lot through the canopy area and back out into the parking lot. The facility's transport van was parked in the first parking space directly adjacent to the canopy approximately 25 feet from the exit door. The back door of the kitchen was visible from the 200 hall exit door.

An observation was made of the 200 hall exit door foyer on 04/15/16 at 10:00 AM. The first set of double glass doors was propped open on both sides with wedges. The 200 hall exit door was closed and was locked when pushed.

The DON was interviewed on 04/14/16 at 5:40 PM. She stated if a resident was identified as being an elopement risk, a wanderguard was placed on their person if their score on the elopement assessment was 5 or greater. She stated elopement assessments were completed upon admission, quarterly and as needed if a resident exhibited behaviors. She reported interventions in place prior to Resident #1 going out of the exit door included one on one social visits to occupy his attention and the placement of a wanderguard. She commented she was aware of his behaviors but was not informed of his specific exit seeking behaviors. The DON stated the exit doors had alarms. She commented that Resident #1 would sit at the nurses' station and

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liked to talk. She stated he was alert. She stated a wanderguard had been placed on Resident #1 on 03/18/16. The DON reported that she was on vacation when Resident #1 went out of the 200 hall exit door. She stated she received a telephone call from Nurse #1 informing her of his elopement. She stated she told Nurse #1 to verify that his wanderguard was in place. The DON stated there was an investigation completed but she had not been involved in it because of being out on vacation. She commented that she did not expect him to try to elope from the facility. During an interview with the Administrator, on 04/15/16 at 9:40 AM, she stated she had received a call from facility staff on 03/28/16 reporting that Resident #1 had gotten out of the building. She stated she immediately started asking questions. She stated she told the nurse to start visual checks on Resident #1. The Administrator stated she contacted the maintenance supervisor and asked him to come to the facility and check all of the exit doors. She stated Resident #1's wanderguard was in place and was functioning prior to his leaving out of the 200 hall exit door. She stated the wanderguard system was functioning properly when checked. The Administrator stated her investigation had shown that Resident #1 could not have been outside more than 3 minutes because dietary staff had seen him outside but no one actually saw him exit the door. She stated all wanderguards of the residents who had wanderguards were checked that night for proper functioning and no issues were identified. The Administrator stated the employee codes and the master codes were being changed on a weekly basis and all exit doors were being checked daily. She reported that she herself had checked the 200 hall exit door on 03/28/16 and the system was functioning

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properly. When questioned if she had been made aware of Resident #1's exit seeking behaviors on the 7:00 PM - 7:00 AM shift, she responded that she had not been informed. She reported that her expectation was for staff to report these behaviors to the management team. She commented that she had never witnessed any exit seeking by Resident #1 when she was in the building and only saw him going up and down the halls. She also commented that he was assessed for elopement upon his admission to the facility.

On 04/13/16 at 2:30 PM, the Administrator provided the investigation of the incident of 03/28/16 regarding Resident #1, which was entitled "Plan of Correction for Incident on 03/28/16", regarding Resident #1's elopement. It documented that on 03/28/16 at approximately 7:35 PM, dietary staff notified nursing staff that Resident #1 was outside the 200 hall doors. He was identified to be there less than 3 minutes and was brought back inside per staff. He was assessed with no injuries and proceeded to tell the nurse he was getting some fresh air and had told staff he was getting out of there. Resident #1 reported watching people go in and out of that door all day long and just went out. His wanderguard was checked. Door alarm did not sound with resident exiting the facility but alarmed when bringing resident back inside. The door and alarm was working properly but Resident #1 had observed the master code by employees. His wander guard was found to be in place and working properly. He was placed on 15 minute safety checks. All exit doors were checked to ensure locking and working properly. All employee codes and master codes were changed to all exit doors. All residents with wanderguards were checked for placement and function.

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In-services were started on 03/29/16 with maintenance staff regarding master codes not to be used except in emergencies. Effective 03/29/16 only the maintenance supervisor and his assistant would have access to this code.
In-services were started with nursing staff regarding responding to residents voicing or showing exit seeking behaviors. It was noted that monitoring would include changing the master codes on a weekly basis for one month and if after one month no issues were noted, the facility would return to normal facility practices.
A "Wanderguard Door Alarm Check" sheet for 03/28/16 noted that all of the doors in the building including the exit door on the 200 hall had been checked to ensure proper functioning and no concerns were noted on the document.
The Administrator was notified of Immediate Jeopardy at 10:15 AM on 04/15/16.

The facility provided an acceptable credible allegation of compliance as follows:
For the resident affected: On 3/28/16 at approximately 7:35pm, dietary staff notified nursing staff that identified resident was outside the 200 hall doors. Resident was identified to be there for less than three minutes and was brought back inside per nursing staff. Resident was assessed with no injuries noted. Resident stated he was "getting some fresh air, I told you I was getting out of here." Resident then proceeded to tell nurse that he watches people go in and out of that door all day long, and just went out the door. Residents wanderguard was checked for Door alarm did not sound with resident exiting the facility, but alarmed when bringing resident back inside. This clarified that door and alarm was working properly, but upon investigation it was believed that resident may have entered the

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master code. Residents wanderguard was checked for placement and function. Wander guard found to be on resident and working properly. Resident was placed on Q 15 minute safety checks. On 3/29/16, Resident was moved to the secured unit. Resident was discharged home on 3/31/16.

For the resident with the potential to be affected: All exit doors in the facility were checked to ensure locking and working properly on 3/28/16 at approximately 2pm by Administrator. All exit doors found to be locked and working properly. On 3/28/16 at approximately 8pm, Maintenance Supervisor reported to facility to check all doors of locking and alarming properly. All exit doors were found to be locked and working properly. Maintenance Supervisor changed all employee codes and master codes to all exit doors in facility. All residents with wanderguards were checked for placement and function. All found to be on and working properly. All residents are assessed for elopement risk upon admission, quarterly, and as needed basis. Care plans updated accordingly.

Measures put in place: All exit doors in the facility were immediately checked to ensure locking and working properly on 3/28/16 by Maintenance Supervisor. All found to be locked and working properly. All wanderguards were checked for placement and proper functioning. No issues were noted. In-service was started by Administrator on 3/29/16 with maintenance staff regarding master code to exit doors should not be used unless in emergency situations. Starting 3/29/16 only Maintenance Supervisor and Maintenance Assistant have access to the master code. In-service was started by Administrator on 3/29/16 with nursing staff regarding responding to residents voicing or showing exit seeking

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behaviors. On 4/14/16 an all staff in-service was initiated by Staff Development Coordinator regarding notifying management (DON and Administrator) when residents show signs of exit seeking behaviors and how to manage these behaviors. Identifying behaviors that may be considered as an elopement risk as of what to do if a resident appears to be attempting to elope to include immediate supervisor notification. All employees are to complete in-service before next scheduled shift and will not work until re-education completed. On 4/15/16, during complaint survey, elopement risk assessments were initiated on all residents currently in the facility with completion date of 4/15/16. For those that score high risk will be reviewed for further interventions as indicated.
Monitoring: All master codes will be changed weekly X 1 month by Maintenance Supervisor. All exit doors in the facility will be checked daily X 1 month by Maintenance Supervisor and/or Administrator, DON, ADON, SDC, Nursing Supervisor.

Validations of the above credible allegation of compliance were completed on 04/15/16 ending at 5:40 PM and included:
In-services were provided to all staff (including maintenance, dietary and housekeeping) on all 3 shifts beginning on third shift 04/14/16 and ending on second shift 04/15/16. In-service records were reviewed and staff were interviewed as to attendance. There were no concernsidentified.

High risk residents were the first residents to have elopement assessments completed on 04/15/16. Elopement assessments of the other residents were completed by the end of day on 04/15/16.

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F 323	Continued From page 19 The maintenance supervisor was interviewed on 04/15/16 at 10:40 AM to ensure that he was monitoring exit doors on a daily basis and that the employee codes as well as the master codes were being changed on a weekly basis per the credible allegation of compliance. All doors were locked. There were no concerns identified. Residents at risk for wandering were observed to be wearing wanderguards. The 200 hall exit door was observed to lock when a wanderguard was within a few feet of the door.	F 323		