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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/21/18 through 5/25/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/28/18 and was removed on 5/25/18. An extended survey was conducted.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636		7/8/18

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

Electronically Signed | 06/18/2018

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F 636	Continued From page 1 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code sections A 1500,	F 636	This plan of correction constitutes a written allegation of compliance.	

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F 636	Continued From page 2 A 1510 and A 1550 of the Minimum Data Set (MDS) to reflect the Level II Preadmission Screening Resident Review (PASRR) determination for 1 of 3 residents reviewed for Level II PASRR (Resident # 19). Resident # 19 was admitted to the facility on 06/17/2011 and readmitted to the facility on 08/04/2014 with diagnoses that included anxiety, depression, psychotic disorder and schizophrenia. A significant change in status MDS dated 03/09/2018 indicated a "No" to question A 1500 which asked if Resident # 19 had been evaluated by a level II PASRR and determined to have a serious mental illness and/or mental retardation or related condition. A review of a PASRR screening form from the PASRR Department of the state of North Carolina revealed that Resident # 19 received an approval of a Level II PASRR from 03/18/2018 through 06/16/2018 and that Resident # 19 had been approved with a Level II PASRR since 04/07/2011. An interview was conducted on conducted on 05/22/2018 at 2:43 PM with the MDS coordinator #1 and MDS coordinator #2. MDS coordinator #1 revealed that a PASRR level status should be coded on each comprehensive MDS if a resident had a Level II PASRR. MDS coordinator #1 revealed that the PASRR status form could be located in the medical record and recorded on the resident face sheet at the front of the resident's medical record and that both MDS coordinators were responsible for the review of the resident PASRR status in the medical record for accurate	F 636	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. The facility failed to accurately code sections A 1500, A 1510 and A 1550 of the Minimum Data Set to reflect the Level II Preadmission Screening Resident Review (PASRR) determined for 1 or 3 residents reviewed for Level II PASARR (Resident 19). Process that lead to the Deficiency On 6/17/2011 resident #19 was admitted to facility. Resident #19 was readmitted to facility on 8/4/2014 with diagnosis of anxiety, depression, psychotic disorder, and schizophrenia. A significant change in status that was dated 3/9/2018 indicated no to question A 1500. Resident #19 received an approval letter for a level II PASRR from 3/18/2018 through 6/16/2018 and that resident #19 had already been approved with a level II PASRR since 4/7/2011. Another significant change or modification of MDS was not completed to correct the coding of the PASRR level II with most recent update on 3/19/2018.	

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F 636	Continued From page 3 MDS coding. MDS coordinator #2 revealed that he was not aware of the PASRR level II status of Resident # 19 until after the MDS dated 03/09/2018 was completed. MDS coordinator #2 revealed that he placed a yellow sticky note on the MDS dated 03/09/2018 for Resident # 19 as a note to himself to code the PASRR status of Resident # 19 when the next comprehensive MDS when it was completed. Neither MDS coordinator could explain why the significant change in status MDS dated 03/09/2018 had not been coded with Resident # 19's PASRR Level II status or why a modification of the MDS was not completed to correct the coding of the PASRR Level II when the most recent update had been received on 03/19/2018. An interview was conducted with the facility administrator on 05/22/2018 at 2:43 PM. The administrator revealed that Level II PASRR status forms were placed in the front of the medical record for all PASRR Level II residents and that it was also recorded on the resident's face sheet at the front of the medical record. The administrator stated that she believed that Resident # 19 had been a Level II PASRR since he had been readmitted to the facility many years ago. The administrator stated that the expectation was the all MDSs be coded accurately and that any resident with a Level II PASSR should be coded on the assessments correctly.	F 636	The corrective action for Resident #19 was accomplished by MDS Coordinator completing a Significant Change Assessment on 5/22/18. Process for implementing the acceptable plan of correction for specific deficiency Administrator and MDS Coordinator completed a 100% audit on 5/31/18 to ensure PASRR II□s were being completed accurately and on a timely basis. Education was initiated on 6/11/18 to MDS and Interdisciplinary Team by the Administrator on Significant Change as defined in the CMS-specified Resident Assessment Instrument (RAI) Significant Change in Status Assessment, and level II PASRR referral as and completion of such assessment within a designated timeframe after the determination has been made. In addition, education for MDS was initiated on June 14, 2018 by Administrator in a computerized learning/educational system called Relias Learning on Significant Changes with 100% completion by June 20,2018. Monitoring procedure to ensure that the plan of correction is effective As of 5/31/2018 a weekly monitoring audit tool was created and being utilized by the Administrator regarding 100% audit of residents for significant changes and level II PASRR□s to discuss with MDS and	

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F 636	Continued From page 4	F 636	Interdisciplinary team. Results from the monitoring tool will be brought to the Quality Assurance Performance Improvement meetings on a weekly basis for review by the QAPI team, by Administrator and or/Designee for 3 months, and then ongoing. Title of Person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementing the acceptable plan of correction.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to complete a comprehensive assessment after a Pre-Admission Screening and Resident Review	F 637	The facility failed to completed a comprehensive assessment after a Pre-Admission Screening and Resident Review (PASRR) Level II authorization	7/8/18

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F 637	Continued From page 5 (PASRR) Level II authorization was obtained for 1 of 3 residents reviewed for PASRR Level II (Resident #27) and failed to complete a significant change comprehensive assessment for 1 of 1 residents reviewed for significant behavior changes (Resident #27). Findings included: 1. Resident #27 was admitted to the facility on 3/25/2017 and readmitted 12/19/2017. Diagnoses for Resident #27 included brain stem stroke syndrome, hemiplegia following stroke, dementia and diabetes. A. The annual Minimum Data Set (MDS) assessment dated 12/15/2017 assessed the resident to be severely cognitively impaired and had no behaviors towards others. The most recent quarterly MDS assessment dated 3/15/2018 assessed Resident #27 to be severely cognitively impaired and physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) was scored "1, behavior of this type occurred 1 to 3 days". Resident #27 ' s care plans were reviewed and a care plan addressing medication use for depression and anxiety was reviewed. The care plan was most recently updated on 3/14/2018 and it documented labs were drawn due to an increase in agitation. The care plan was modified again on 3/16/2018 due to a change in medication, on 4/7/2018 for aggression towards staff members and 5/22/2018 with noted episodes of anxiety and a referral had been made to psychiatric services.	F 637	was obtained for 1 of 3 residents reviewed for significant behavior changes (resident #27) Process that lead to the deficiency On 3/25/17 resident #27 was admitted to facility and was readmitted on 12/19/2017. Resident #27 had diagnosis of brain stem stroke, hemiplegia following stroke, dementia, and diabetes. An annual Minimum Data Set (MDS) assessment dated 12/15/2017 assessed resident to be severely cognitively impaired and had no behaviors towards others A quarterly MDS assessment dated 3/15/2018 assessed resident #27 to be severely cognitively impaired and physical behavioral symptoms directed towards others such as hitting kicking, pushing, scratching, grabbing Level II PASRR referral was sent and authorization was received 3/22/2018 and noted in medical record. A comprehensive assessment was not completed after resident #27 was assessed and Level II PASRR was authorized. The corrective action for Resident #27 was accomplished by MDS Coordinator completing a Significant Change Comprehensive Assessment on 5/22/18. Administrator and MDS Coordinator completed a 100% audit on 5/31/18 to ensure PASRR II□s were being completed accurately and on a timely basis. Process for implementing the acceptable	

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F 637	Continued From page 6 A care plan for cognitive communication deficit was most recently updated on 3/9/2018 when Resident #27 displayed aggressive behaviors towards another resident, on 4/6/2018 when he struck a staff member, on 4/8/2018 when he threatened another resident and on 4/9/2018 when he attempted to bite a staff member. A report was reviewed dated 3/28/2018 that documented an incident between Resident #27 and another resident. Resident #27 was bitten by the other resident during an altercation. A care plan meeting date 3/29/2018 was reviewed and the note documented Resident #27 continued antipsychotic medications for psychosis and as needed (PRN) medication for anxiety. A psychiatric progress note dated 3/31/2018 documented Resident #27 ' s worsening behaviors since a gradual dose reduction (GDR) of medication for behaviors. Resident #27 ' s medication orders were reviewed and he was prescribed: 12/11/2017 Buspirone 10 milligrams three times a day by mouth for anxiety; 12/20/2017risperidone 0.5 mg three times per day by mouth for behaviors; 12/20/2017 trazodone 50 mg at bedtime by mouth for depression; 5/1/2018 Depokote 125 mg twice per day by mouth for behaviors; 5/18/2018 lorazepam 0.5 mg as needed three times per day by mouth for agitation.	F 637	plan of correction for the specific deficiency Education was initiated on 6/11/18 to MDS and Interdisciplinary Team by the Administrator on Significant Change as defined in the CMS-specified Resident Assessment Instrument (RAI) Significant Change in Status Assessment, and level II PASRR referral as and completion of such assessment within the designated timeframe after the determination has been made. In addition, on June 14, 2018 the Administrator initiated education for MDS on a computerized learning/ educational system by Relias Learning called, Significant Changes with 100% completion by June 20, 2018. Monitoring procedure to ensure that the plan of correction is effective As of 5/31/2018 a weekly monitoring audit tool was created and being utilized by the Administrator and/or Designee regarding 100% audit of residents for significant changes and level II PASRRs to discuss with MDS and Interdisciplinary team. Results from the monitoring tool will be brought to the Quality Assurance Performance Improvement meetings on a weekly basis for review by the QAPI team, by Administrator and or/Designee for 3 months, and then ongoing. Title of the person responsible for implementing the acceptable plan of	

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F 637	Continued From page 7	F 637		

Resident #27 was observed on 5/21/2018 at 11:03 AM. He did not answer questions and would not open his eyes.

An interview was conducted with Nursing Assistant (NA) #2 on 5/23/2018 at 11:44 AM. She reported she was familiar with Resident #27 and had been assigned to him frequently. She further reported Resident #27 had behaviors of aggression and agitation towards staff and other residents. She concluded by relating she often had to re-approach Resident #27 to provide care if he was agitated.

Nurse #2 was interviewed on 5/24/2018 at 10:41 AM. She reported she was familiar with Resident #27 and had provided care for him frequently. She reported he had PRN medication for anxiety, and he also could be redirected from agitation by providing him with headphones and music.

Nurse #3 was interviewed on 5/24/2018 at 10:49 AM. She reported she was familiar with Resident #27, and that he was best redirected with headphones and music.

An interview was conducted with MDS Nurse #1 on 5/23/2018 at 2:05 PM. MDS Nurse #1 reported she did not think the resident ' s behaviors warranted a significant change MDS comprehensive assessment.

An interview was conducted with MDS Nurse #2 and #3 on 5/25/2018 at 9:25 AM. MDS Nurse #2 reported he completed the MDS assessment for Resident #27. He further related resident information was shared with the interdisciplinary team at the morning meeting. He went on to explain that residents who were due for an

correction

The Administrator is responsible for implementing the acceptable plan of correction.

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F 637	Continued From page 8	F 637		

assessment had a sheet at the nurse ' s station and the NAs documented behaviors and he used that sheet to complete the assessment for the residents. MDS Nurse #2 concluded by reporting he would talk to the staff to ensure he was getting a complete picture of the resident. MDS Nurse #3 added the lookback period does not always accurately describe the resident and staff interviews should be completed to get the complete picture of the resident ' s issues and abilities. Both MDS Nurse #2 and #3 reported they did not feel the resident required a significant change of status comprehensive assessment for the increased behaviors.

An interview was conducted with the Administrator on 5/23/2018 at 3:10 PM. She reported it was her expectation a comprehensive MDS was completed when a resident had significant changes in behavior.

The Director of Nursing was interviewed on 5/25/2018 at 11:59 AM. He reported it was his expectation that a significant change comprehensive MDS was completed when a resident had significant changes in behavior.

B. The annual Minimum Data Set (MDS) assessment dated 12/15/2017 assessed the resident to be severely cognitively impaired and had no behaviors towards others. Section A1500 "Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?" was answered "0-no".

The most recent quarterly MDS assessment dated 3/15/2018 assessed Resident #27 to be severely cognitively impaired and displayed

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F 637	Continued From page 9 physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing) was scored "1, behavior of this type occurred 1 to 3 days". PASRR Level II authorization dated 3/22/2018 was noted in the medical record. An interview was conducted with MDS Nurse #1 on 5/23/2018 at 2:05 PM. MDS Nurse #1 reported she was not aware a comprehensive assessment had to be completed after a resident was assessed to be PASSR Level II. An interview was conducted with the Administrator on 5/23/2018 at 3:10 PM. She reported during the morning meetings Resident #27 ' s behavioral changes were discussed and she made the referral for a PASSR Level II assessment. She reported it was her expectation a comprehensive MDS was completed when a resident was assessed as a Level II PASSR. The Director of Nursing was interviewed on 5/25/2018 at 11:59 AM. He reported it was his expectation that a significant change comprehensive MDS was completed when a resident received a PASSR Level II authorization.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident and staff interviews the facility failed to accurately assess upper body range of motion (ROM) for 1	F 641	The facility failed to accurately assess upper body range of motion (ROM) for 1 of 1 residents reviewed for	7/8/18

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F 641	Continued From page 10 of 1 residents reviewed for position/mobility (Resident #21). Findings included: Resident #21 was admitted to the facility on 12/13/2011 and readmitted 4/12/2016. Diagnoses for Resident #21 included congestive heart failure, chronic obstructive pulmonary disease, osteoarthritis and diabetes. An occupational therapy plan of care dated 3/17/2017 assessed Resident #21 to have limited ROM of both upper extremities. The plan of care assessed the resident to have 30 degrees of ROM in the right shoulder and 70 degrees of movement in the left shoulder. The quarterly Minimum Data Set (MDS) assessment dated 12/11/2017 assessed the resident to be cognitively intact. Section G question 0400 "functional limitation in Range of Motion" was coded "0- no impairment upper extremity" and "1- impairment on one side lower extremity". The most recent quarterly MDS assessment dated 3/12/18 assessed the resident to be cognitively intact and he required one-person supervision for bed mobility, transfers, dressing, hygiene, toileting and bathing. Section G question 0400 "functional limitation in Range of Motion" was coded "0- no impairment upper extremity" and "1- impairment on one side lower extremity". A care plan dated 6/26/2017 and updated 4/18/2018 addressed Resident #21 ' s need for assistance with activity of daily living (ADLs) and	F 641	position/mobility (Resident #21) Process that lead to the deficiency Resident #21 was admitted to facility on 12/13/2011 and readmitted on 4/12/2016. Resident #21 has diagnosis of congestive heart failure, chronic obstructive pulmonary disease, osteoarthritis, and diabetes. Resident #21 had an occupational therapy care plan dated 3/17/2017 assessed to have limited ROM of bilateral upper extremities. A quarterly Minimum Data Set (MDS) dated 12/11/2017 assessed resident #21 to have no impairment upper extremity. A most recent quarterly MDS assessment dated 3/12/18 assessed the resident and was coded 0 □no impairment upper extremity Interviews conducted with resident #21, nursing staff, and the therapy manager revealed that he had limited ROM in both shoulders. An interview was conducted with MDS nurse #2 and he was not aware of limited ROM in both shoulders. The corrective action for Resident #21 was accomplished by MDS Coordinator on 6/7/2018. The process for implementing the acceptable plan of correction for specific deficiency On 5/29/2018 an audit was initiated to assess all residents for limited range of motion. Licensed Nursing staff to complete 100% audit of all resident for limited range of motion by June 22, 2018.	

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F 641	Continued From page 11 interventions to include assistance with daily grooming, oral, hair and skin care, bath/shower assistance and nail and hair care as needed. A quarterly care plan meeting note of the interdisciplinary team dated 3/29/2018 was reviewed and a handwritten notation regarding Resident #21 ' s "limitations of shoulders and needs extensive assist with dressing most times." Resident #21 was observed on 5/21/2018 at 10:55 AM. He was unable to lift his right hand to touch his face, and could lift his left hand to eye level. An interview was conducted with Resident #21 on 5/21/2018 at 10:55 AM. He reported he had arthritis in his shoulders and if he attempted to lift his hands to his head, he had intense pain. He further reported the nursing assistants (NA) would assist him with grooming and dressing if he was unable to complete the tasks. An interview was conducted with Nurse #1 on 5/23/2018 at 3:36 PM. The nurse reported she was familiar with Resident #21. She further reported Resident #21 had limited ROM of both shoulders and he rarely used the right arm due to pain and limited ROM. The nurse went on to explain that Resident #21 will use a reacher and his left hand to perform tasks. NA #1 was interviewed on 5/23/2018 at 3:39 PM. NA #1 reported she was familiar with Resident #21 and had assisted him with pulling clothing over his head and applying compression hose due to limited ROM of his shoulders. NA #3 was interviewed on 5/23/2018 at 4:06 PM.	F 641	Education was initiated June 14, 2018 for MDS by the Administrator on Functional Status from a computerized based learning/ educational system by Relias Learning called Assessment and Intelligence Systems (AIS) with 100% completion by June 20, 2018. Monitoring procedure to ensure that the plan of correction is effective On 5/29/2018 a monitoring tool was created and being utilized by the Administrator and/or Designee to collect data on 100% audit of all residents with functional limited range of motion to discuss with MDS and Interdisciplinary Team. On 6/15/2018 a monitoring tool was created and utilized by MDS Coordinator and/or Designee to review 5 charts a month for 6 months and then ongoing for accuracy of functional limitation of range of motion Results from the monitoring tool will be brought forth to the Quality Assurance Performance Improvement (QAPI) meeting on a weekly basis for review by the QAPI team by the Administrator and or Designee for 3 months and then ongoing. Title of person responsible for implementing the acceptable plan of correction	

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F 641	Continued From page 12 She reported Resident #21 was unable to lift his right hand to his head and she had assisted him with shaving, removing and applying his clothing and bathing. An interview was conducted with the Therapy Manager on 5/23/2018 at 4:26 PM. She reported Resident #21 had been seen by Occupational Therapy in the past for problems with the ROM of his arms and shoulders. The Therapy Manager further explained Resident #21 had the type of arthritic changes to his shoulders that caused him to have increased pain with movement. The Therapy Manager went on to report that Resident #21 will ask for an Occupational Therapy assistance if he notices a change in his shoulders ROM. The Therapy Manager concluded by reporting Resident #21 was stable, but he had very limited ROM in both shoulders. An interview was conducted with MDS Nurse #2 on 5/25/2018 at 9:42 AM. He reported he completed the most recent quarterly MDS for Resident #21. He further reported he reviewed NA documentation for one week prior to the MDS completion date and found the NA were not assisting Resident #21 with ADLs during that lookback period. MDS Nurse #2 went on to explain he had assessed Resident #21 in the past and he had pain and limited movement in his right leg, but had not known Resident #21 had limited ROM of his shoulders. The Director of Nursing was interviewed on 5/25/2018 at 12:01 PM. He reported he expected the MDS assessments to be completed accurately for all residents. The Administrator was interviewed on 5/25/2018	F 641	The Administrator is responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 13 at 3:39 PM. She reported it was her expectation that MDS assessments were completed accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		7/8/18

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F 656	Continued From page 14 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, this facility failed to develop a comprehensive care plan to address elopement for 1 of 3 residents sampled. (Resident #6). The findings Included: Resident # 6 was admitted to the facility on 6/5/2017 with a diagnosis that included muscle weakness, repeated falls, localized edema and congestive heart failure. Resident # 6's most recent quarterly Minimum Data Set (MDS) assessment dated 2/22/2018 revealed the resident had moderately impaired cognition, a brief interview of mental status (BIMS) score of 8, rejected care 1-3 days, required extensive one person assistance with transfers, and supervision with locomotion on and off the unit. Resident #6's MDS further revealed that he utilized a wheelchair for mobility and was admitted to the facility with a history of falls. The MDS was not coded for wandering behaviors. Review of the quarterly Elopement Risk Observation Form dated 2/3/2018, revealed the resident scored a 12 (11 or greater indicated high risk of elopement).	F 656	Based on record review and staff interviews, the facility failed to develop a comprehensive care plan to address elopement for 1 of 3 resident sampled (Resident #6). The corrective action for Resident #6 was accomplished by reassessing veterans risk for elopement by completing the Elopement Risk Observation Form and completing the Elopement Care Plan. The process for implementing the acceptable plan of correction for specific deficiency A 100% audit on the Elopement Risk Observation Forms were completed on 5/24/18. Care Plans completed for Moderate to High Risk Residents on 5/25/18. On 5/24/2018 the Administrator, Director of Health Services, and MDS Coordinator completed a 100% audit to ensure that moderate to high risk elopement residents have a comprehensive person-centered care plan in place.	

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F 656	Continued From page 15 Review of the quarterly care plan dated 3/8/2018 revealed no care plan for risk for elopement. During an interview on 5/25/2018 with the MDS Nurse # 1 at 3:47 pm, revealed she did not complete an updated care plan. Her expectations were "that any resident that is determined to be a risk for falls or elopement would have a care plan initiated. An interview with the Administrator on 5/25/2018 at 4:38 pm, revealed that her expectations was for the high risk for elopement residents to have a risk for elopement care plan.	F 656	Education was initiated on June 14, 2018 for MDS by the Administrator on Care Plans from computerized based learning/educational system by Relias Learning called Assessment and Intelligence Systems (AIS) with 100% completion by June 20, 2018. Monitoring procedure to ensure that the plan of correction is effective On 5/24/2018 a weekly monitoring audit tool was created and implemented by the administrator regarding 100% audit of residents moderate to high risk for elopement to discuss with Interdisciplinary Team. Five random charts will be reviewed by MDS Coordinator and/or Designee monthly for 6 months and then ongoing for accuracy of care plans for residents that are moderate to high risk for elopement Results from the monitoring tool will be bought forth to the Quality Assurance Improvement Performance (QAPI) meetings on a weekly basis for review by the QAPI team, Administrator and/or Designee for 3 months, and then on going. Title of Person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementing the acceptable plan of correction.	

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and Medical Director interviews the facility failed to provide supervision to prevent a cognitively impaired resident (Resident #6), who was assessed at high risk for elopement, from exiting the facility. Resident # 6 exited the facility unsupervised, self-propelled his wheelchair to the parking lot through the unlocked front entrance door and was located outdoors 100 feet away in 61 degree Fahrenheit temperature. This was evident in 1 of 3 cognitively impaired residents who were reviewed for risk of elopement. Immediate jeopardy (IJ) began on 4/28/2018 for Resident # 6 at 11: 20 pm, when Resident #6 was observed outside the facility in the parking lot and the IJ was removed on 5/25/2018 at 5:15 pm, when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education. The findings included:	F 689	Process that led to the deficiency Resident #6 was admitted to the facility on 1/26/2017. The facility failed to provide supervision to prevent elopement. Front lobby door left unlocked by staff after 9pm. Facility failed to supervise resident because after front door to lobby was locked by nursing supervisor on 4/28/2018, staff unlocked door to allow change of shift staff to enter and did not re-lock door. Staff is not to utilize front door after 9:00 pm. Facility failed to ensure front lobby door was locked. The facility staff failed to recognize the resident's exit seeking behaviors and failed to have a care plan in place to prevent the resident from exiting the facility. On 4/28/2018 Resident #6 was last observed on first floor at approximately 11:00 pm by Nurse #6 stated resident was sitting at Nurse's station with jacket on while she was giving report to oncoming Nurse #7. Nurse #6 then asked resident "are you cold" resident stated, "no I just	7/8/18

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F 689	Continued From page 17 Resident # 6 was admitted to the facility on 6/5/2017 with a diagnosis of muscle weakness, repeated falls, localized edema and congestive heart failure. Resident # 6's most recent quarterly Minimum Data Set (MDS) assessment dated 2/22/2018 revealed the resident had moderately impaired cognition, a brief interview of mental status (BIMS) score of 8, rejected care 1-3 days, required extensive one person assistance with transfers, and supervision with locomotion on and off the unit. Resident #6's MDS further revealed that he utilized a wheelchair for mobility and was admitted to the facility with a history of falls. The MDS was not coded for wandering behaviors. Review of the quarterly care plan dated 3/8/2018 revealed no care plan for risk for elopement. Review of the quarterly Elopement Risk Observation Form dated 2/3/2018, revealed the resident scored a 12 (11 or greater indicated high risk of elopement). The section of the elopement risk observation form "Summary of Interventions and Explanation of action" was not completed. There were no interventions documented on the form. Nurses note dated 2/22/2018 at 10:00 pm, wrote by Nurse # 5, read in part, "Staff noted resident sitting outside. RP (responsible party) notified of possible applying roam alert, stated OK. CNA (Certified Nurses Aide) stated resident always outside and return on his own without problem. Resident stated, 'I am just looking to see what is out there', 'I am not going anywhere, I hate it when people make up stories'. DON/Admin agreed not to apply roam alert."	F 689	wanted my coat". Nurse #6 stated while she was giving report, NA #3 approached the nurses station at approximately 11:15 pm and asked, "where did Resident #6 got' Nurse #6 stated, "he was sitting right here at the Nurse's station at approximately 11:15 pm, maybe he went back to his room". NA #3 stated "I was just doing rounds, and no, he is not there". Nurse's #6 & 7, and NA #3 immediately began searching for Resident #6. Nurse #6 went outside and she noted VA campus police making rounds and she asked for assistance in the search. VA campus police noted Resident #6 in the front parking lot of facility. Nurse #6 redirected the resident back into the facility without difficulty or incident from front parking lot at approximately 11:20pm and stated Resident #6 was unable to state where he was going. A head-to-toe assessment/body audit was completed by Nurse #7 on 4/28/2018 and no injuries or abnormalities were noted. Resident #6 did not voice any pain or discomfort. An Elopement Risk Observation Assessment was completed by Nurse #6 on 4/28/2018, resulting in a high risk score of 13, and the intervention of an electronic monitoring device/Roam-Alert was placed on the resident #6's left ankle for safety by Nurse #6. The front doors were relocked at approximately 11:20pm after bringing resident #6 back into the facility. A resident census count was initiated on 4/28/2018 at approximately 11:25 and confirmed to be at 100% at 12:00am 4/29/2018. Nurse #7 notified the Director of Health Services regarding the	

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F 689	Continued From page 18 Resident # 6 was observed on 5/21/2018 at 5:03 pm, self-propelling in his wheelchair. Resident left his room and travelled towards the nursing station. Resident # 6 was observed on 5/24/2018 at 10:17 am, self-propelling wheelchair down the unit towards the nursing station. Interview with Nurse Supervisor (Nurse # 5) on 5/23/2018 on 11:28 am, revealed (Resident #6) "has behaviors which leads to his elopements. He doesn't want anyone to tell him what to do. He refuses his medications a lot. I think he fell one time. Once in a while he is confused, it's difficult to determine when he is confused or not because he jokes a lot. He gets mad when you call his daughter." Nurse # 5 acknowledged that she completed the elopement risk assessment on 2/3/2018 and she "failed to complete the portion of the elopement risk observation form" titled summary of interventions and explanation of action. She revealed that she expected all residents, scored as elopement risk, to receive the elopement risk interventions but she did not implement any interventions for Resident # 6. Nurse # 5 further revealed that on 2/22/2018, she made the nursing decision to write the order for the roam bracelet. She did not remember calling the resident's doctor or the nurse's aide (NA) name who reported that the resident was sitting outside. She reported that the Director of Nursing (DON) and administrator agreed that he did not need it (roam alert bracelet). She reported that staff "kept our eyes on him". Nurse # 5 further revealed that she did not implement the 15 minutes observation checks. She reported that "we closely monitored him and there is no	F 689	elopement on 4/28/2018 at approximately 11:50pm, at which time the Director of Health Services educated the nurse supervisor to ensure front door is secured at 9pm and employees are not to enter/exit the front entrance after the door is locked/secured. The Director of Health Services notified the Administrator regarding the elopement on 4/28/2018 at approximately 11:55 pm. Nurse #7 notified the Medical Director and Responsible Party on 4/28/2018 and 4/29/2018. The Resident #6's description and picture were placed in the Roam-Alert/Wander-Guard book by the Nurse Navigator. Process for implementing the acceptable plan of correction for specific deficiency On 4/29/2018, all other residents were accounted for in the facility by conducting a head count. 100% Elopement Assessments were initiated and completed on 5/24/2018 by the Director of Health Services and the Nurse Management team. Residents with a score of 11 or above, indicating a high risk for elopement with exit seeking behaviors had interventions put in place as to include a Roam-Alert/Wander-Guard placed immediately upon notification of the resident representative and the Physician. The residents at risk are reviewed weekly by the Interdisciplinary Team for any further interventions as needed. Behavior documentation on the MAR's was initiated on 5/24/2018 for residents that are able to move self	

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F 689	Continued From page 19 documentation of this". Interview with Nurse # 6 on 5/23/2018 at 9:09 am, revealed Resident # 6 had an elopement "around April 28th, a Saturday night. I considered it an elopement. I had actually worked a double, 16 hours on first and second shift. I reported off and counted. I spoke to him (Resident # 6) and said see you later, around 11:10 or 11:15 pm at the nurse's station. One of the girls asked where did he go. Everybody started looking for him. I went out the back, where you need a code to get out. At first, I went out the front, but I didn't see him. He was wearing a black coat, he has dark skin and his wheelchair is black. I have known him to sit out front with people. I have never known him to go out on his own. I saw a VA (Veteran's Administration) policeman out in the parking lot to the right. I asked the policeman to help me. He (Resident # 6) was at the first parking space, near the (facility) van in the parking lot. I saw him right away with my car lights. I considered that elopement. He (Resident #6) was sitting there just laughing. It was change of shift and there (were) people going in and out the door." Interview with Campus Police on 5/24/2018 at 12:48 pm, revealed "in late April" he received a radio call "about one of the veterans being missing". Campus Police further revealed that he drove near the building and observed Resident # 6 immediately. He reported, "the nurse was coming up on him (Resident # 6) as soon as I shined my lights". Campus Police further revealed that Resident #6 was sitting right across from the helicopter pad in front of Building 10 (the facility) in his wheelchair. Interview with Nurse Aide (NA) # 3 on 5/24/2018	F 689	throughout the facility who scored 5-10, identified as medium risk on Elopement Risk Observation Form, and were placed on behavior management for 4 weeks. Care plan interventions were reviewed and/or revised as needed by the Interdisciplinary Team based on assessments. Education was initiated on 5/24/2018 by the Administrator, Director of Health Services, Clinical Competency Coordinator, Nurse Management team, Department Managers (to include rehab, dietary, maintenance, and housekeeping departments) on elopement and facility securement, which includes signs of exit seeking behavior, front door security protocol, checking doors for Roam-Alert/Wander-Guard compliance, and who to report signs of exit seeking behavior too. 100% education was completed by 6/12/2018. Staff members who have not completed education, will not be allowed to work until they have been educated. All newly hired staff will be educated on elopement during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Education for all licensed nurses including Nurse #6, Nurse #7, and all Nursing Aides on identifying and reporting behavior changes was initiated on 5/24/2018 and completed on 6/12/2018. Licensed Nurses and Nurse Aides who have not completed education, will not be allowed to work until they have been educated. All newly hired	

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F 689	Continued From page 20 at 1:18 pm, revealed she was assigned to Resident # 6 on 4/28/2018. The NA # 3 reported, "right after I did my round I went to the nursing station and asked the nurse where was (Resident # 6). The NA # 3 further revealed that Nurse # 6 told her that Resident # 6 was just sitting at the nursing station. She was unable to locate Resident # 6 and a search ensued. She revealed that her shift began on the unit at approximately 11:00 pm. She further revealed that the search for Resident # 6 lasted 15 - 20 minutes. She described the outside temperature as being warm to her. NA # 1 stated Resident # 6 "likes to sit at the nursing station during the night, is known to wheel up and down the unit and sometimes is confused." She also stated, "sometimes he gets a little upset if you try move him". Interview with Nurse # 7 on 5/24/2018 at 9:51 am, who worked 11 pm - 7 pm on 4/28/2018, revealed she "got to the building approximately at 10:50 pm. All employees come through the back door downstairs. The RN Supervisor was in charge of locking the front door at around 9:00 pm on 2nd shift." Nurse # 7 further revealed that the exterior doors must physically be locked, so residents do not leave. She stated Resident # 6 "is always up at night." Nurse # 7 revealed that Nurse # 6 told NA # 3, Resident # 6 was just at the nursing station while they were doing the medication count. She revealed that Resident # 6 frequently asked for people to take him home. Nurse # 7 also stated "I saw (Nurse # 6) bring the resident back in about 10 -15 minutes after 11:00 pm". Nurse # 7 revealed that Resident # 6 went out the front entrance doors. She stated "the weather was not cold to me. He (Resident # 6) had on all black; coat, pants and the wheelchair."	F 689	staff will be educated on identifying and reporting behavior changes during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Education was also initiated on 5/24/2018 and completed on 6/12/2018 for all Licensed Nurses including Nurse #6 and Nurse #7 on assessing residents for elopement risk upon admission and/or change in condition using the Elopement Risk Assessment Form and initiating interventions as needed. Licensed Nurses who have not completed education, will not be allowed to work until they have been educated. All newly hired Licensed Nurses will be educated on assessing residents for elopement risk during admission and/or change of condition using the Elopement Risk Assessment Form during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services. Elopement risk observation forms will be completed on admission/readmission, quarterly and change of condition for all residents at risk for elopement. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed Nurses will place immediate interventions to include but not limited to completing and Elopement Observation Assessment Form, a picture will be placed in the Roam-Alert/Wander-Guard notebook/elopement risk book with description of the resident; a	

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(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 689	Continued From page 21 Interview on 5/25/2018 at 3:47 pm, with the MDS Nurse revealed Nurse # 5 "didn't complete the elopement risk assessment on 2/22/2018", so she did not complete an updated care plan as the result. The MDS Nurse # 1 revealed she wasn't aware that Resident # 6 "was an elopement risk until this survey". Her expectations were "that any resident that is determined to be a risk for falls or elopement would have a care plan initiated. Her expectations for the nursing staff is that all assessments are completed so that she could construct a care plan". Interview on 5/23/2018 at 9:37 am, with the Maintenance Director revealed the distance from the front door entrance to the parking lot is "approximately 100 feet". The roam alert bracelet sensor on the inner front entrance door would prevent any resident with the bracelet, from getting outside door. The front door entrance consisted of two sets of double doors that slid open and closed. Follow up interview on 5/25/2018 at 8:20 am, with the Maintenance Director revealed on the night of 4/28/2018 there were 6 canned lights directly under the brick awning/circular driveway. These lights are outside the front door entrance. There was one streetlight in proximity to where Resident # 6 was reportedly located and spot lights along the top perimeter of the building. On this tour, the Maintenance Director demonstrated how the visual axis could be obstructed due to the brick awning supports. He further revealed that all the lights are photocells and would have been on at 11:00 pm because they come on at dusk and go off at dawn. Interview with director of nursing (DON) on	F 689	Roam-Alert/Wander-Guard will be placed on the resident as needed. The Maintenance Supervisor and/or maintenance staff will check all doors for wander guard compliance using the Roam-Alert/Wander-Guard tester every day. The Maintenance Director initiated education to all department heads and weekend supervisors on 5/24/2018 on checking doors for Roam-Alert/Wander-Guard compliance. On the weekend, the supervisor and/or the manager on duty will check the doors for Roam-Alert/Wander-Guard compliance. Monitoring procedure to ensure that the plan of correction is effective As of 5/28/2018, an Elopement Observation Audit Tool is being utilized by Licensed Nurses and reviewed by the Director of Health Services and/or the Nurse Management team daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 4 months. The results of the data collected and interventions implemented of the Elopement Risk Observation Audit with tracking and trending by the Director of Health Services will be taken to the Quality Assurance / Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained (then quarterly thereafter). A questionnaire on Elopement will be completed with 10% of all staff by the	

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	345531	A. BUILDING _____ B. WING _____	C 05/25/2018

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F 689	Continued From page 22 5/23/2018 at 10:26 am, revealed "the RN supervisor is usually the one who does the Elopement Risk Assessment. Based off the Elopement form, we would assess for the roam guard, it depends on the physician or how we feel they (residents) are at risk. I don't think everyone who scores high needs all the interventions. So many residents need the monitoring only because medication changes alone, give you four points. If they got a 12, this is where you should do a summary of interventions and explanation of actions. The person should complete and get input from staff, physician and family to determine nursing judgements. I would expect them to at least put the monitoring in effect. They need to consider risk factors. He (Resident #6) is not somebody I would say depends on a lot of assistance. He resists assistance often. Probably the assessment on 2/22/2018, we did not put the roam alert bracelet on at that time. I was new and they told me he never eloped before. So, we decided not to place the roam alert bracelet on. I expected him (Resident # 6) to be closely monitored by the staff at all times. If the resident is showing signs of elopement like, wanting to go or getting the coat then I expect the staff to implement interventions." A follow up interview on 5/24/2018 at 3:37 pm, the DON revealed that the RN Supervisor is in charge of locking the door. He stated that he expected the door to be locked at 9:00 pm. The DON further revealed there is always a RN Supervisor on 1st, 2nd and 3rd shifts. Interview with the Administrator on 5/23/2018 at 12:06 pm, revealed "my expectation is that the staff follows the elopement assessment. At any score, I expect the staff to follow the elopement	F 689	Administrator, Director of Health Services, Clinical Competency Coordinator and Department Managers weekly for 4 weeks then monthly for 3 months to ensure compliance is maintained. The results of the Elopement questionnaire will be correlated by the Administrator and reported in the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained (then quarterly thereafter). Title of Person Responsible for implementing the acceptable plan of correction The Administrator is responsible for implementing the acceptable plan of correction. Date of Compliance: 07/08/2018	

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interventions. On the 2/22/2018, I was not aware the elopement risk assessment score from 2/3/2018, so we didn't implement the roam alert. On 3/1/2018, I would have expected the staff to do an elopement assessment and implement the interventions."

Follow up interview on 5/25/2018 at 4:38 pm, with the Administrator revealed that her expectations are that the nurses will complete the elopement risk assessments and for the high-risk residents, a care plan is initiated by the MDS/Care Plan nurse.

Interview with the Medical Director on 5/24/2018 at 1:30 pm, revealed that he was notified by the staff that Resident # 6 had eloped on 4/28/2018. He further revealed that the resident "was always talking about going home but I was surprised that he actually did it." The Medical Director reported that he "he has never received prior word about any other attempts".

The Administrator was informed of Immediate Jeopardy on 5/24/2018 at 2:15 pm for Resident # 6.

A Credible Allegation of Compliance was accepted on 5/25/2018 at 5:15 pm as follows:

Process that lead to the Deficiency:
Resident (#6) was admitted to the facility on 1/26/2017.
Root Cause Analysis: Failure to provide supervision to prevent elopement.
Front lobby door left unlocked by staff after 9pm.
Facility failed to supervise resident because after front door to lobby was locked by nursing supervisor on 4/28/2018, staff unlocked door to

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allow change of shift staff to enter and did not re-lock door. Staff is not to utilize front door after 9:00 pm. Facility failed to ensure front lobby door was locked. The facility staff failed to recognize the resident's exit seeking behaviors and failed to have a care plan in place to prevent the resident from exiting the facility.

On 4/28/2018 Resident # 6 was last observed on first floor at approximately 11:00 pm by Nurse # 6 stated resident was sitting at nurse's station with jacket on while she was giving report to oncoming Nurse # 7. Nurse # 6 then asked resident "are you cold" resident stated, "no I just wanted my coat". Nurse # 6 stated while she was giving report, NA # 3 approached the nurses station at approximately 11:15 pm and asked, "where did Resident # 6 go" Nurse # 6 stated, "he was sitting right here at the nurse's station at approximately 11:15 pm, maybe he went back to his room". NA # 3 stated "I was just doing rounds, and no, he is not there". Nurse's # 6 & 7, and NA # 3 immediately began searching for Resident # 6. Nurse # 6 went outside and she noted VA campus police making rounds and she asked for assistance in the search. VA campus police noted Resident # 6 in the front parking lot of facility. Nurse # 6 assisted the resident back in facility from front parking lot and stated Resident # 6 was unable to state where he was or where he was going. Resident # 6 was redirected back into the facility by Nurse # 6 at approximately 11:20 pm without incident. Resident # 6 did not voice any pain or discomfort. Elopement risk observation form completed by Nurse # 6 on 4/28/2018. Head to toe assessment/body audit noted no abnormalities and was completed by Nurse # 7 on 4/28/2018. Based on elopement risk score of 13 completed by Nurse # 6 on 4/28/18, a

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roam alert was placed on the resident by Nurse # 6. Roam alert is an electronic device utilized for elopement prevention of exit seeking residents. Nurse # 7 notified Director of Health Services regarding the elopement on 4/28/2018 at approximately 11:50pm. Director of Health Services notified the Administrator regarding the elopement on 4/28/2018 at approximately 11:55 pm. Nurse # 7 notified Medical Director and Responsible Party on 4/28/2018 and 4/29/2018. The Resident # 6's description and picture were placed in the wander guard book by the Nurse Navigator. Prior to this incident, all licensed staff are trained on hire to complete elopement risk assessment form on admission, re-admission, significant change in condition, when residents exhibit exit seeking behaviors, and at least quarterly by the Clinical Competency Coordinator.

Process for implementing the acceptable plan of correction for specific deficiency

On 4/29/2018 at 12 midnight a census count of 95 residents was conducted by Nurse # 7 to ensure all residents were accounted for in the facility. 100% resident count was initiated by Nurse # 7 on 4/28/2018 and completed on 4/28/2018. Doors were locked on 4/28/2018 after securing Resident # 6 back in facility at 11:20 pm upon reentry to prevent other residents from exiting the facility. On 5/24/2018 the Maintenance Director checked all doors for wander guard compliance using the wander guard tester. All doors functioned properly per manufacturer instructions. The maintenance director checked the doors compliance utilizing the wander guard tester. There are 16 exit doors that are all secured by roam alert/wander guard system. Those exit doors are checked for compliance

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daily by the maintenance department starting at approximately 8:00 am. The front door is locked at 9:00 pm by the nurse supervisor. The front door is the only door that is left unlocked during the day. The other 15 doors are locked at all times. In addition, on 5/24/2018 the Maintenance Director educated department heads and weekend supervisors on checking doors for wander guard compliance daily. The front door is locked each night at 9pm and rechecked at 11:30 pm by the Nurse Supervisor. On the weekend, maintenance, nurse supervisor and/or the Manager on Duty will check all doors for wander guard compliance daily and the Nurse Supervisor will lock the front door at 9:00 pm and recheck it at 11:30 pm. The facility will identify residents who are at risk for elopement by utilizing the elopement risk observation form on all residents on admission, re-admission, significant change in condition, when residents exhibit new exit seeking behaviors, and at least quarterly. On 5/24/2018 all residents with an elopement risk score of 11 or above, indicating a high-risk for elopement and who verbally expresses the desire to go home, has a prior history of elopement, history of leaving center without needed supervision were placed on a 3 day monitoring behavior management program with immediate interventions such as the wander guard program. The 3 day behavior monitoring program is a form placed on the MAR by the nurse to document any behaviors observed by the staff to include exiting seeking. The Social Worker conducts the behavior monitoring program. All resident's elopement risk assessments are completed by licensed staff for further intervention recommendations on admission, readmission, change in condition, and at least quarterly. If elopement risk score is 11 or greater they will be

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placed on weekly behavior management program until their next quarterly assessment or change in condition. The 3 day behavior log is the form that is utilized to document any behaviors noted during the 3 day observation time. The behavior management program consists of 3 day monitoring, weekly behavioral management, wander guard program. Residents at risk for elopement with moderate risk scores between 5-10 are placed on 3 day monitoring, 4 weeks behavior management program to determine appropriate interventions after 3 day evaluations and or quarterly assessments. Behavior management for elopement risk scores 11 or greater is at high risk for elopement, interventions to include but not limited to 3 day monitoring, weekly behavioral management, wander guard program and memory secure unit if available. Care plan interventions were implemented, reviewed and/ or revised as needed based on the assessment.

Education was initiated for all staff on 5/24/2018 by the Administrator, Director Health Services, Clinical Competency Coordinator, Nursing Management team regarding the front door security protocol. The front door security protocol consists of the 3-11:00 pm nursing supervisor is to lock the front lobby door at 9:00 pm and recheck the door at 11:30 pm. A Facility Security Door Monitoring tool is to be utilized and completed by nursing supervisors at 9:00 pm and 11:30 pm. Staff is not to utilize the front lobby door after 9:00 pm. The facility security monitoring tool is to ensure doors are locked.

Additional education for all staff was initiated on 5/24/2018 by Director of Health Services and Clinical Competency Coordinator on elopement including assessment of risk, signs of exit seeking behaviors and who to report signs of exit

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seeking behavior to immediately. Prior elopement education was completed on 1/25/2018, 3/2/2018, and 5/22/2018. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on door security protocol and elopement risk during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator. Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to complete an elopement observation form, a picture will be placed in the wander guard notebook/elopement risk book with description of the resident; a wander guard will be placed on the resident as needed. Staff should report to the RN supervisor and/or nurse any signs of residents seeking elopement when resident verbally expresses the desire to go home, attempts to exit doors, and resident stating they are wanting to leave facility. An elopement risk assessment is initiated with appropriate interventions implemented based on risk score noted on the elopement risk observation form (0-4 low risk, 5-10 moderate risk, 11 or greater high risk). Nurse is to notify medical director, director of health services, administrator and responsible party. Care plan to be updated based on assessment by nurse.

Monitoring procedure to ensure that the plan of correction is effective

As of 5/24/2018 a facility security monitoring and elopement risk audit tool which is a summary of

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all current resident's elopement risk score with current interventions to monitor resident behavior and plan of care. The tool is being utilized by licensed nurses and reviewed by the Director of Health Services, and/or Nurse Managers daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 1 month. The results of the data collected and interventions implemented of the facility security monitoring audit with tracking and trending by the Director of Health Services will be taken to the Quality Assurance / Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained (then quarterly thereafter).

A questionnaire on facility security and elopement risk is being completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months to ensure compliance is maintained. The results of the elopement questionnaire will be correlated by the Administrator and reported in the Quality Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained (then quarterly thereafter).

Title of Person Responsible for implementing the acceptable plan of correction

The Administrator is responsible for implementing the acceptable plan of correction.

Immediate Jeopardy was lifted on 5/25/2018. The facility provided evidence of in-service training for

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F 689	Continued From page 30 staff. Interviews of staff were conducted on all units. Staff interviews revealed they were now aware of what is elopement, what to do if a resident elopes, how to prevent elopement and the facility security monitoring tool.	F 689		