| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>The survey team entered the facility on 08/28/18 to conduct a complaint survey and exited on 08/30/18. Event ID # MZQC11.<br><br>A complaint investigation was conducted 08/28/18 through 08/30/18.<br><br>Immediate Jeopardy was identified at: CFR 483.25 (d) for scope and severity J.<br><br>Tag F689 constituted substandard Quality of Care.<br><br>Immediate Jeopardy began on 08/17/18 and was removed 08/30/18. An extended survey was completed. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the | F 580 | | 9/17/18 |

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

Electronically Signed | 09/11/2018

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| F 580 | Continued From page 1<br>resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews and resident Guardian interviews the facility failed to notify the Guardian for an elopement of 1 of 3 residents (Resident #1) reviewed for providing supervision to prevent accidents.<br><br>The findings included: | F 580 | The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will | |

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| F 580 | Continued From page 2<br>Resident #1 was admitted to the facility on 02/26/18 with diagnoses including but not limited to Alzheimer's disease, arthritis and muscle weakness.<br><br>The admission Minimum Data Set (MDS) dated 03/05/18 revealed Resident #1 had moderately impaired cognition and required assistance with bed mobility, transfers, hygiene and toileting. The MDS also revealed Resident #1 used a walker or a wheelchair for mobility and had no instances of wandering. The Care Area Assessment (CAA) for cognitive loss revealed Resident #1 had "decreased safety awareness related to diagnosis of dementia and late onset Alzheimer's."<br><br>The quarterly MDS dated 06/05/18 revealed Resident #1 had severely impaired cognition and required only supervision with bed mobility, transfers and hygiene, and limited assistance with toileting. The MDS also revealed Resident #1 used a walker or wheelchair for mobility and had no instances of wandering.<br><br>On 08/17/18 at 11:20AM, Nurse #1 received a phone call informing her that Resident #1 was outside in a vehicle and the driver had reported she picked him up on the road.<br><br>During an interview with Resident #1's Guardian on 08/28/18 at 3:04 PM, the Guardian stated she had received a phone call from the Administrator on 08/17/18 indicating Resident #1 was exit seeking and the discharge planner would try to find him more suitable placement. The Guardian was not aware Resident #1 had gotten out of the facility and stated she would have expected the facility to share this information with her. | F 580 | take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.<br><br>580<br><br>The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The facility notified the Guardian that resident #1 was having exit seeking behaviors on 8/17/18. The facility failed to notify the Guardian that resident # 1 was out of the facility between approximate times of 10:26am and 11:20am and was found on Brookshire Blvd 2.5 miles from facility.<br><br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited.<br>Licensed Nurses will be educated on When there is a change in your resident□s physical, mental, or psychosocial status, presence of clinical complications, or life-threatening conditions involving the resident, then the residents legal representative/or person of interest, must be notified immediately as well as the resident<br>Any Licensed Nurse that has not been educated will not be allowed to work until education is completed<br><br>The monitoring procedure to ensure that | |

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| F 580 | Continued From page 3<br>During an interview with the Discharge Planner (DP) on 08/28/18 at 3:25PM, the DP stated the Administrator had asked her to start looking for placement for Resident #1 in a locked unit because he was exit seeking. The DP stated she called the Guardian on 08/21/18 and informed her that Resident #1 had been exit seeking and she was researching facilities that would be appropriate for his needs. The DP also stated she was not aware Resident #1 had gotten out of the facility until after she had spoken with his Guardian.<br><br>During an interview with Nurse #1 on 08/29/18 at 9:24AM, Nurse #1 stated after she received the phone call that Resident #1 was outside the front of the facility, she proceeded to go outside and witnessed Resident #1 sitting in a vehicle. Nurse #1 stated she talked with Resident #1 and he stated he was not in any pain, but he stated he was thirsty. Nurse #1 also stated Resident #1 was able to get out of the car on his own. Nurse #1 further stated she completed a head to toe assessment, took vital signs, and determined there were no injuries to Resident #1. Nurse #1 stated she did not contact the doctor, a family member or his Guardian, because the Administrator made all the phone contacts. Nurse #1 verified she had not been aware he was outside of the facility.<br><br>During an interview with the Administrator on 08/29/18 at 4:20PM, the Administrator stated that he had called and left a message for Resident #1's Guardian indicating only that he was exit seeking and an effort was being made by the discharge planner to find him placement in a more appropriate facility. The Administrator also stated he called the Medical Director to inform | F 580 | the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.<br>Any new Licensed nurse will be educated in orientation on When there is a change in your resident□s physical, mental, or psychosocial status, presence of clinical complications, or life-threatening conditions involving the resident, then the residents legal representative/or person of interest, must be notified immediately as well as the resident<br>The Unit Manager/Coordinator or Director of Nursing will audit the 24 hour summary daily Monday through Friday, and Saturday/Sunday on Mondays for 4 weeks, weekly X 4 weeks and monthly X 1 month for on When there is a change in your resident□s physical, mental, or psychosocial status, presence of clinical complications, or life-threatening conditions involving the resident, then the residents legal representative/or person of interest, must be notified immediately as well as the resident<br>Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X1 for further problem resolution if needed.<br>The Director of Nursing is responsible for implementing the acceptable plan of correction by 09/17/2018 | |

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| F 580 | Continued From page 4<br>him of what occurred with Resident #1. | F 580 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, Guardian interview, Family Nurse Practitioner (FNP) and Medical Director (MD) interview, the facility failed to provide supervision for a cognitively impaired resident who exited the facility and left the facility's property while unsupervised for 1 of 3 sampled residents (Resident #1) reviewed for provision of supervision to prevent accidents. Resident #1 exited the facility and left the facility's property unsupervised and was returned by an unknown driver who gave him a ride back to the facility where he was assessed to have no injuries.<br><br>Immediate jeopardy began on 08/17/18 when Resident #1 exited the facility and left the facility property unsupervised for over 45 minutes without the knowledge of facility staff. The Immediate jeopardy was removed on 08/30/18 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm | F 689 | F 689<br><br>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;<br><br>" Facility failed to provide supervision for a cognitively impaired resident who exited the facility and left the facility□s property while unsupervised, and was returned by an unknown driver who gave him a ride back to the facility where he was assessed to have no injuries. Resident #1 had a wander guard applied on him on 08/17/2018 at 12:50 PM. Wander guard was tested prior to placement and worked per manufactures guidelines. The resident refuses to wear the wander guard and therefore 15 minute checks have been in place since 8/17/18 until discharge on 8/31/2018.<br><br>The procedure for implementing the | 9/17/18 |

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| F 689 | Continued From page 5<br>that is not immediate jeopardy) to ensure monitoring systems put into place are effective.<br><br>The findings included:<br><br>Resident #1 was admitted to the facility on 02/26/18 after a hospitalization. Record review of hospital records indicated Resident #1 was living at home by himself prior to his hospitalization. The discharge assessment indicated a diagnosis of late onset Alzheimer's disease without behavioral disturbances" and no history of wandering was mentioned.<br><br>The admission Minimum Data Set (MDS) dated 03/05/18 indicated Resident #1 had moderately impaired cognitive skills and required assistance with bed mobility, transfers, hygiene and toileting. The MDS also revealed Resident #1 used a walker or a wheelchair for mobility and had no instances of wandering. The Care Area Assessment (CAA) for cognitive loss revealed Resident #1 had "decreased safety awareness related to diagnosis of dementia and late onset Alzheimer's."<br><br>Review of a wandering risk assessment dated 02/27/18 and completed by nurse #1 indicated the following: "admission within past month - ambulates with 1 assist - medication changes."<br><br>Review of a care plan for Resident #1 dated for 03/21/18 indicated Resident #1 was "at risk for falls related to deconditioning, weakness, impaired balance, impaired safety aware with Alzheimer's and dementia, history of chronic infarcts, unsteady gait."<br><br>Review of a wandering risk assessment dated | F 689 | acceptable plan of correction for the specific deficiency cited;<br>" Education with receptionist and front office staff complete on 8/17/18 to ensure 100% watch on front door. Education was documented and included that in absence of the receptionist a front office staff member will watch the front door for visitors and residents entering and exiting. Education was complete by the Administrator. Any new receptionist or front office staff will receive education during orientation.<br>" Education to all staff started on 8/17/18 by department managers on the following policies to ensure understanding. New hires will be educated during general orientation. Any staff member who did not receive education will not be allowed to work until education received.<br>1) Nursing Policy and Procedure Code Orange, the reasons of Resident #1 leaving the facility without us knowing, and the importance of Code Orange, which covers the immediate notification of a missing resident, Code Orange will be activated throughout the Center. All established search and recover plans will be initiated in full force to locate and secure the resident as quickly as possible. All staff will be pre-assigned and trained on their duties and responsibilities during this critical event. Training included the above mentioned and education on increased awareness for change in behavior such as packing belongings, statements of wanting to leave, and exit seeking to all nursing staff, dietary staff, | |

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| F 689 | Continued From page 6<br>05/27/18 completed by nurse #1 indicated the following: "forgetful/short attention span - combative/severely agitated - independent with mobility." Review of nursing progress notes after 05/27/18 through 08/16/18 gave no indication of any follow up with this decline for Resident #1 from the previous wandering risk assessment dated 02/27/18. There were no interventions to address Resident #1's forgetfulness and mobility independence, which potentially placed the resident at a higher risk to wander/elope.<br><br>The quarterly MDS dated 06/05/18 revealed Resident #1 had severely impaired cognition (a decline from the previous assessment) and required only supervision with bed mobility, transfers and hygiene, and limited assistance with toileting. The MDS also revealed Resident #1 used a walker or wheelchair for mobility and had no instances of wandering.<br><br>Record review of the August 2018 Medication Administration Record (MAR) indicated on 08/17/18, Resident #1 was administered medication at 10:26 AM.<br><br>During an interview with the day Receptionist on 08/28/18 at 4:40 PM, she stated on 08/17/18 she was sitting at the front desk when a woman came into the facility around 11:20 AM and told her that Resident #1 was in her car. The Receptionist stated she went out to see him then came back inside and got 2 NAs from the dining room to come outside and verify it was Resident #1. The Receptionist further stated she had never seen Resident #1 come up to the front or go outside to sit down before and that's why she got the 2 NAs to make sure that it was him since she was unfamiliar with him. The Receptionist added she | F 689 | environmental service staff, therapy staff and administrative staff.<br>2) Nursing Policy and Procedure, Search and Reporting, in the event a resident is reported missing, all available resources will be utilized to search for and find the resident as quickly as possible. Anyone that suspects or realizes that a resident is missing must notify a licensed nurse and/or the Nursing Supervisor immediately. A Nursing Supervisor on duty must immediately initiate a search of the Center and grounds, and at the same time report to the Administrator, the Director of Nursing and Nurse Consultant that the resident is missing.<br>3) Nurses and receptionists will be in-serviced, by the Administrator or their designee, on resident check in/out procedures. Facility will utilize a single check in/out book for all residents that enter and leave the facility. All visitors will receive a visitor pass. Visitor passes must be worn during visit and returned to the front desk upon exiting the building. Any person to be a visitor in the building will be required to have a pass. Those that do not have passes will be residents. Receptionist to nurse verification will be required for any resident that signs out that is leaving unattended. Between the hours of 8:00PM and 9:00AM a clinical staff member will then make the determination as to let a resident out unattended or not.<br><br>" All current residents with a diagnosis of Alzheimer□s and/or Dementia will have a wander guard placed if the resident is | |

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| F 689 | Continued From page 7<br>had never seen Resident #1 exit the facility and she always had another staff member at the front desk for her meal and bathroom breaks.<br><br>Record review of a progress note by Nurse #1 on 08/17/18 revealed the following: "Resident had head to toe assessment with no areas noted when he returned to facility from getting some fresh air." Further review of Resident #1's medical record revealed no documentation in the record that reflected that on 08/17/18 the resident exited the facility while unsupervised, left the facility property for over 45 minutes without staff ' s knowledge and was returned to the facility by an unknown driver.<br><br>During an interview with Nursing Aide #1 (NA #1) on 08/28/18 at 8:14 AM, NA #1 stated that she regularly worked with Resident #1 and he always stayed in his room, did not go outside, refused activities, often refused showers but would wash up in the bathroom. NA #1 also stated Resident #1 always said he was leaving. NA #1 further stated he kept his belongings in bags tied to his wheelchair and didn ' t like them touched.<br><br>During an interview with the FNP on 08/28/18 at 10:58 AM, the FNP stated that she was aware Resident #1 had gotten outside the facility unsupervised. The FNP also stated this was very out of character him and she was very shocked this had happened because he rarely came out of his room. She also stated she had seen him yesterday and observed that he had several bags tied to his walker. When she asked him about the bags, he reportedly told her he was trying to keep bugs out of his belongings and if he kept them up high on his walker the bugs could not get to them. The FNP stated she saw no bugs in his | F 689 | assessed for being independently mobile in a wheelchair or independently ambulatory, if currently has or has potential for exit seeking behaviors. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team will occur to accurately assess safety of the resident. This was complete on 08/30/2018<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;<br><br>" All new admissions will be audited by the Director of Nursing or Regional Nurse Consultant for accurate identification for assessment and risk based on residents with a diagnosis of Alzheimer□s and/or Dementia, independently mobile in a wheelchair or independently ambulatory, if currently has or has potential for exit seeking behaviors, and if wander guard placed if deemed at risk. Audits will be weekly for one month, bi-weekly for 2 weeks, and monthly for one month. Determination included discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team. Audits will be reviewed in quarterly quality assurance process improvement meeting X□s 1 quarters.<br>" Administrator or their designee will audit lobby twice daily between the hours of 9:00AM to 5:00PM daily for two weeks, two times daily one time a week for 2 weeks, and monthly for two months. | |

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| F 689 | Continued From page 8<br>room.<br><br>During an interview with the Maintenance Director on 08/28/18 at 1:03 PM, he stated the only doors open are the facility's main entrance doors from 9:00 AM to 5:00 PM daily. There is a front desk receptionist present during this time 7 days a week. The Maintenance Director proceeded to explain all other doors in the facility could not be entered or exited without an employee badge. The Maintenance Director also stated that electronic alert devices worn by some of the residents cause the front door to lock if they approach it and will alarm if they go through the front door. The Maintenance Director acknowledged that Resident #1 did not have an electronic alert device when he left the facility unattended, but if he would have had the alert device he would have not been able to exit the facility without the alarm alerting staff.<br><br>During an interview with Nursing Aide #2 (NA #2) on 08/28/18 at 2:56 PM, NA #2 stated she had worked with Resident #1 the morning he left the facility unsupervised. NA #2 also stated she had last seen Resident #1 between 9:45 AM and 10:00 AM in his room and he was acting no differently than usual. She stated Resident #1 was usually quiet, stayed in his room, didn ' t want to take showers or give up his clothes to be washed and sometimes would refuse food. NA #2 also stated Resident #1 had told her he did not like being in the facility because it was like jail, but never spoke of actually leaving the facility. NA #2 further stated she worked with Resident #1 the day before he exited the facility unsupervised and he was not acting any different than he usually did. NA #2 stated he had always kept his belonging tied in bags on his wheelchair, so this | F 689 | Administrator will audit for coverage presence, the sign in/out book is complete, and that the receptionist or front office staff is validating that the resident is safe to go out unattended.<br><br>The title of the person responsible for implementing the acceptable plan of correction.<br><br>" Administrator.<br>" Date of Completion 09/17/2018. | |

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| F 689 | Continued From page 9 | F 689 | | |

was not new for him.

During an interview with Resident #1's Guardian on 08/28/18 at 3:04 PM, the Guardian stated she had received a phone call from the Administrator on 08/17/18 indicating Resident #1 was exit seeking and the discharge planner would try to find him more suitable placement. The Guardian was not aware Resident #1 had gotten out of the facility and stated she would have expected the facility to share this information with her.

During an interview with Nurse #1 on 08/29/18 at 9:24 AM, Nurse #1 stated after she received a phone call at 11:20 AM on 08/17/18 that Resident #1 was outside the front of the facility, she proceeded to go outside and witnessed Resident #1 sitting in a vehicle. Nurse #1 stated she talked with Resident #1 and he stated he was not in any pain, but he stated he was thirsty. Nurse #1 also stated Resident #1 was able to get out of the car on his own. Nurse #1 further stated she completed a head to toe assessment, took vital signs, and determined there were no injuries to Resident #1. Nurse #1 verified she had not been aware prior to her phone call that Resident #1 had been outside the facility unsupervised.

During an interview with Nurse #2 on 08/29/18 at 11:27 AM, Nurse #2 stated she had worked with Resident #1 the morning he exited the facility. Nurse #2 also stated this was the first and only time she worked with Resident #1. Nurse #2 stated she remembered giving him his medication and that he was sitting up on the side of his bed with his legs crossed and seemed very pleasant. Nurse #2 further stated she was not aware he was out of the facility and did not see him again after she gave him his medication until he was

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returned to the facility.

During an interview with the Director of Nursing (DON) on 08/29/18 at 11:55AM, the DON stated that after Resident #1 was returned to the facility on 08/17/18, that the Administrator, Unit Manager and she met with him to discuss what happened. The DON added that Resident #1 had stated he had just went outside for a walk and to get some fresh air. The DON also stated they put an electronic alert device on his wrist upon his return, but he was able to remove it, so he was started on 15-minute checks and has remained on them until they are able to find appropriate placement for him on a secured unit.

During an interview with the Administrator on 08/29/18 at 4:20 PM the Administrator stated that Resident #1 had been returned to the facility by an unknown driver who transported Resident #1 from Brookshire Boulevard which was 2.5 miles from the facility. The Administrator also stated that he called and left a message for Resident #1's Guardian indicating that he was exit seeking and an effort was being made by the discharge planner to find him placement in a more appropriate setting. The Administrator also stated he called the MD to inform him of the incident.

During an interview with the Medical Director (MD) on 08/30/18 at 8:45 AM, the MD stated the incident with Resident #1 exiting the facility "totally out of character for this guy" and he had not had exit seeking behaviors prior to this incident. The MD further stated he was surprised to hear this had happened and verified the Administrator had notified him about the incident on the day of the occurrence.
Notification of Immediate Jeopardy was given to

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the Administrator on 08/29/18 at 2:03 PM. The credible allegation for immediate jeopardy removal was verified on 08/30/18 at 1:05 PM.

Plan of Correction and Credible Allegation of Immediate Jeopardy Removal

The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. This plan of correction is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center ' s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.

The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;

·Deficient practice is evident by, on 8/17/18, between the times of approximately 10:26AM and 11:20AM, upon which he was returned, Resident #1 left from the facility unattended from the front lobby door. He was transported from an unknown location on Brookshire Blvd., approximately 2.5 miles away, to the facility by an unknown person who noticed his yellow identification bracelet. The resident did not have a wander guard on as he was never deemed to have exit seeking behaviors. Receptionist was unaware of what the resident looked like, had never been to the front lobby, and had not been assessed to need a wander guard. Facility failed to determine he was at risk, related to his diagnosis of dementia and Alzheimer's, and independently ambulating.

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Facility could have prevented this by determining the resident could have been at risk based on diagnosis and ambulation status. Facility determined that a contributing factor of this event occurred due to the receptionist not understanding her responsibility of monitoring who goes in and out of the facility front door. All doors are locked 24 hours per day with the exception of the front door and back door. The front door is unlocked from 9:00AM to 5:00PM.

Facility Action
·At 12:45 on 8/17/18 voicemail was left with responsible party to update her on resident exit seeking behaviors.
·The Resident had a wander guard applied on him on 08/17/2018 at 12:50 PM. Wander guard was tested prior to placement and worked per manufacturers guidelines. The resident refuses to wear the wander guard and therefore 15-minute checks have been in place since 8/17/18.
·On 08/17/2018 Resident #1's Wandering and Elopement Risk Assessment was re-evaluated. It was determined that Resident #1 is at risk due to him leaving the building unattended, ambulating independently, and has a diagnosis of Alzheimer's and Dementia.
·A Skin Assessment was also complete on 08/17/2018 at 11:45AM. No skin changes noted.
·08/17/2018 initially at 11:20AM resident was supervised one to one. Since 12:00 p.m., on 8/17/2018, every 15-minute visual checks continue on Resident #1 until safe placement can be found for him. The Director of Nursing initiated this and informed nursing staff.
·Education with receptionist and front office staff complete on 8/17/18 to ensure 100% watch on front door. Education was documented and included that in absence of the receptionist a front

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office staff member will watch the front door for visitors and residents entering and exiting. Education was complete by the Administrator. Resident #1 photograph was placed at the reception desk on 8/17/18 so all receptionists and front office staff would know what Resident #1 looked like. Any questions of the identity of a resident that the receptionist or front office staff have, can be validated by reviewing the resident picture in the electronic medical record.
·On 08/17/2018 the Director of Nursing conducted a resident wandering assessment on all current residents with a dementia diagnosis.
·Under direction of DON, all current residents with a wander guard in place was assessed for placement. All were in place on 8/17/2018.
In-servicing began on 08/17/2018 for missing resident/search and reporting that included in the event a resident is reported missing, Code Orange is to be immediately activated. The Administrator and Director of Nursing are to be immediately notified. All available resources are to be utilized to search and find the resident as quickly as possible. Immediately upon notification of a missing resident, Code Orange will be activated throughout the Health and Rehabilitation Center. All established search and recover plans will be initiated in full force to locate and secure the resident as quickly as possible. All staff members will be pre-assigned and trained on their duties and responsibilities during a critical event.
·On 08/17/18 the door was tested and the wander guard that is on Resident #1 was tested. Both worked according to manufacturer's guidelines. Maintenance Director or designee will test door alarms daily for one month.

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| F 689 | Continued From page 14<br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited;<br><br>·08/17/2018 every 15-minute visual checks were conducted on Resident #1.<br>·The DON rounded facility ensuring all residents with wander guards were accounted for on 8/17/18.<br>·On 08/17/2018 all residents in house on this date with a diagnosis of dementia and Alzheimer's, Wandering and Elopement Risk Assessments were re-evaluated by the DON.<br>·On 8/17/2018 and ongoing, facility receptionist remained posted in the front lobby to monitor for any attempts by any resident to exit the facility. The hours of this were 9AM-8PM. From 8PM to 9AM the doors remain locked and any person has to be badged out by a staff member.<br>·All residents with a diagnosis of Alzheimer's and/or Dementia will have a wander guard placed if the resident is assessed for being independently mobile in a wheelchair or independently ambulatory, if currently has or has potential for exit seeking behaviors. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team will occur to accurately assess safety of the resident. This was complete on 8/17/2018.<br>·Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team will occur to accurately assess safety of the resident, that have been deemed at risk, based off diagnosis of Alzheimer's and/or Dementia will have a wander guard placed if the resident is assessed for being independently mobile in a wheelchair or independently ambulatory, if currently has or has potential for exit seeking behaviors, between the hours of 9:00a.m. and 5:00p.m. will have 15 minute checks until wander guards can be placed | F 689 | | |

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| F 689 | Continued From page 15<br>on the resident. All doors lock between the hours of 5:00PM and 9:00AM. To open doors, a person must be badged out by a staff member. Badging members out of the building has been in process since September 2017.<br>·Education to all staff started on 8/17/18 by department managers on the following policies to ensure understanding. New hires will be educated during general orientation.<br>1)Nursing Policy and Procedure Code Orange, the reasons of Resident #1 leaving the facility without us knowing, and the importance of Code Orange, which covers the immediate notification of a missing resident, Code Orange will be activated throughout the Center. All established search and recover plans will be initiated in full force to locate and secure the resident as quickly as possible. All staff will be pre-assigned and trained on their duties and responsibilities during this critical event. This was started on 08/17/2018 and complete on 8/29/18. No other employees will be allowed to work unless training is complete. Training included the above mentioned and education on increased awareness for change in behavior such as packing belongings, statements of wanting to leave, and exit seeking to all nursing staff, dietary staff, environmental service staff, therapy staff and administrative staff.<br>2)Nursing Policy and Procedure, Search and Reporting, in the event a resident is reported missing, all available resources will be utilized to search for and find the resident as quickly as possible. Anyone that suspects or realizes that a resident is missing must notify a licensed nurse and/or the Nursing Supervisor immediately. A Nursing Supervisor on duty must immediately initiate a search of the Center and grounds, and at the same time report to the Administrator, the | F 689 | | |

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Director of Nursing and Nurse Consultant that the resident is missing. This was started on 08/17/2018 and complete on 8/29/18. No other employees will be allowed to work unless training is complete

3)Nurses and receptionist's will be in-serviced, by the Administrator or their designee, on resident check in/out procedures. Education was provided on 8/17/18 and 8/30/18. Facility will utilize a single check in/out book for all residents that enter and leave the facility. All visitors will receive a visitor pass. Visitor passes must be worn during visit and returned to the front desk upon exiting the building. Any person to be a visitor in the building will be required to have a pass. Those that do not have passes will be residents. Receptionist to nurse verification will be required for any resident that signs out that is leaving unattended. Between the hours of 8:00PM and 9:00AM a clinical staff member will then make the determination as to let a resident out unattended or not.

4)No employee is allowed to work unless they have completed the required in-servicing

·All new admissions with a diagnosis of Alzheimer's and/or Dementia will have a wander guard placed if the resident is assessed for being independently mobile in a wheelchair or independently ambulatory, if currently has or has potential for exit seeking behaviors. Discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team will occur to accurately assess safety of the resident. The Director of Nursing, Unit Manager, and Admission Nurse will be educated to assess at risk status using the above criteria. Education complete on 8/30/18 by Regional Nurse Consultant.

The monitoring procedure to ensure that the plan

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of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;

·All new admissions will be audited by the Director of Nursing or Regional Nurse Consultant for accurate identification for assessment and risk based on residents with a diagnosis of Alzheimer's and/or Dementia, independently mobile in a wheelchair or independently ambulatory, if currently has or has potential for exit seeking behaviors, and if wander guard placed if deemed at risk. Audits will be weekly for one months, bi-weekly for 2 weeks, and monthly for one month. Determination included discussion with Responsible Party, Medical Doctor/NP, and Interdisciplinary team. Audits will be reviewed in quarterly quality assurance process improvement meeting X ' s 2 quarters.
·Administrator or their designee will audit lobby twice daily between the hours of 9:00AM to 5:00PM daily for two weeks, two times daily one time a week for 2 weeks, and monthly for two months. Administrator will audit for coverage presence, the sign in/out book is complete, and that the receptionist or front office staff is validating that the resident is safe to go out unattended.

The title of the person responsible for implementing the acceptable plan of correction.

·Administrator approved that the above is accurate and complete as of 8/30/18

The credible allegation for immediate jeopardy removal was verified on 08/30/18 at 1:05 PM as evidenced by the following: verification of

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| F 689 | Continued From page 18<br>re-education for licensed nurses, nursing assistants and other facility staff of Code Orange (covers the immediate notification of a missing resident), Nursing Policy and Procedure regarding search and reporting of a missing resident, in-servicing for licensed nurses and the receptionist for check-in and check-out procedures for residents and visitors, daily testing of the door locking mechanism by the Maintenance Director or designee and re-evaluation by the DON of all residents with dementia/Alzheimer ' s diagnoses of their Wandering Risk Assessment. | F 689 | | |