STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____ APR 05 2011	C 03/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DR BOX 379 CLINTON, NC 28328

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to care plan interventions for one resident who wandered throughout the facility and was assessed as a wandering risk for one (Resident #5) of four residents reviewed. The findings are: Resident #5 was admitted to the facility on 9/25/09 with diagnoses including Alzheimer ' s Disease, Aftercare Traumatic Hip Fracture and Anxiety Disorder. According to the most recent Annual Minimum Data Set (MDS) dated 10/1/10,	F 279	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. **Corrective Action for Resident Affected** Resident # 5 care plan was reviewed and updated on 2/14/11 by the MDS nurse. This revision did not include wandering behavior as the resident has experienced a change and no longer wanders in the facility. The care plan was updated to include a history of wandering and to notify nurse managers if wandering begins again. **Corrective Action for Resident Potentially Affected** All residents who are able to move around the facility either by wheelchair or ambulation are at risk for these alleged deficient practices. All residents who are able to move around the facility either by wheelchair or ambulation were reviewed on 4/1/2011 by the Director of Nursing, MDS nurses and Unit managers. All residents who wander in the facility were identified by this review. Care plans were then updated by the MDS nurse to include a problem, goal and interventions for wandering behaviors. This included at a minimum that all staff should notify the charge nurse if resident begins to verbalize the desire to leave, sitting or standing at doors for prolonged periods of time or trying to exit doors.	4/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 4/4/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 Resident #5 was unable to complete the cognitive portion of the MDS. In the area of " Wandering, - Presence & Frequency, " Resident #5 was coded on the MDS as behavior of this type occurred 4 to 6 days, but less than daily. In the area of " Wandering-Impact, " the MDS revealed that Resident #5 ' s wandering significantly intruded on the privacy or activities of others. In the area of bed mobility, the MDS revealed that Resident #5 required limited assistance, which indicated that the resident was highly involved in the activity with one person physical assistance. In the area of transfer, Resident #5 required limited assistance of one person to move between surfaces, (self sufficient once in wheelchair) from bed to wheelchair to standing position. Resident #5 was independent in moving from her room (using wheelchair) to the adjacent corridor with no physical help from staff. Resident #5 was also independent (using wheelchair) in moving to and returning from off-unit locations, such as dining or other activities. Review of the facility ' s Nursing Assessment on 3/10/10 revealed that Resident #5 had an elopement risk of 13. A score of 10 or greater, was considered at risk for elopement and a Care Plan and elopement prevention measures were to be initiated, in addition a list of interventions were to be initiated to prevent elopement. On 4/2/10, Resident #5 ' s elopement risk was 16. On 7/5/10, the resident ' s elopement risk was 15. There was no Care Plan, elopement prevention measures, or interventions to prevent elopement initiated for either one of those dates. Review of the facility ' s Nursing Assessments on 10/18/10, 12/31/10 and 1/17/11 revealed that Resident #5 ' s elopement risk was 14. There was no Care Plan or elopement prevention measures initiated for	F 279	**Systemic Changes** Additionally, all nurses (RN and LPNs) and Nursing assistants who currently work in the facility were in-serviced on 4/7/11 by SDC on wandering and exit seeking behaviors. Areas covered include: Definition and examples of wandering, wandering that poses no harm, wandering that intrudes on others and wandering that poses an elopement risk, interventions to minimize the risk can be obtained on the resident care plans, and to notify the nurse managers immediately anytime wandering that was identified as not posing a risk changes. These changes may include exit seeking behaviors such as verbalizing a desire to leave, sitting for long periods of time at the doors, trying to open the doors and other activities that involve trying to leave the facility. If these are identified one on one supervision should be initiated immediately. Any staff member who does not receive training on 4/7/11 will not be allowed to work until in-service training has been completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The MDS nurses were also educated on 4/1/11 by the QA nurse consultant on the need to include wandering risk to the care plans for all residents. This education included ensuring that as part of the care plan process and new admission process that residents were reviewed for wandering tendencies. If identified then a problem, goal and interventions that are appropriate for that resident must be implemented. **Quality Assurance** The Director of Nursing will monitor this issue using the "Care Plan Audit Tool". The monitoring will include conducting 10 chart reviews of residents who have had a care plan initiated since the last review to ensure that the wandering risk are included as appropriate. This will be done weekly for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	

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F 279	Continued From page 2 those dates, however, a wander guard was used as an intervention. Resident #5 ' s Care Plan which was reviewed and revised on 1/7/11, revealed that the resident ' s wandering behavior and risk for elopement was not addressed. Review of the facility ' s " Resident Incident Report " dated 2/13/11 at 1:51AM revealed Resident #5 ' s elopement from the facility. There was no apparent injury and the location was the 600 hall. The property involved was a wheelchair and the activity at the time was propelling the wheelchair independently. The narrative of the incident and description of injuries, read, " CNA (Nursing Assistant) reports that she could not locate resident on the hall, facility wide search was indicated, resident was located on facility grounds. " The immediate action taken was the resident was placed with one-on-one care. The resident ' s mental condition at the time of the incident was confused. The medical risk factors possibly related to the incident was confusion/disorientation. An additional narrative description of the incident, read, " 1:30AM, staff unable to locate resident - search initiated at 1:50AM - states pt. (patient) was found on facility grounds does not say where. Pt. (patient) was given Ativan 0.25 milliliters IM. " Review of a facility document dated 2/14/11 and titled, " QA (Quality Assurance) Elopement Review, " revealed a written statement by NA#1, and read, " I, (NA#1) was working the night of (2/13/11) (with) the patient, (Resident #5) when the incident occurred. At approximately 1:15AM I noticed (Resident #5) had traveled farther than her usual wandering spots, as I notified	F 279		

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F 279	Continued From page 3 neighboring Nurse & other (NAs) that she was missing (& the Supervisor) and we all began the search for her at about 1:30AM. " During an interview on 3/8/11 at 11:15AM, the Minimum Data Set (MDS) Coordinator stated that a Care Plan for elopement/wandering was completed in February, 2011, but there was no Care Plan on elopement/wandering initiated prior to the 2/13/11. During another interview on 3/10/11 at 9:40AM, the Unit Manager for Resident #5 ' s unit revealed that a resident could score higher on the elopement risk assessment. The Unit Manager explained that if a resident was able to walk the resident could score higher on the elopement risk assessment and there were other factors that could increase the resident ' s elopement risk assessment such as if the resident was taking medication, if the resident had an elopement in the past or if the resident was agitated. In reference to elopement risk assessments impact on Care Plans, the Unit Manager stated that assessments were put into the computer and the MDS Coordinator pulled the information off of the computer. She explained that Nurses completed Nursing Assessments quarterly and the MDS Coordinator would review the information quarterly. The Unit Manager stated that she tried to attend Care Plan meetings but it was not always possible. She stated that she usually signed off on Care Plans. The Unit Manager stated that if a wander guard was added to a resident ' s Care Plan, the information was passed on from one shift to another. The Unit Manager named five other residents on her unit that were wanderers and had wander guards. She stated that Resident #5 ' s wander guard was	F 279		

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F 279	Continued From page 4	F 279		

placed on her leg. The Unit Manager indicated that Nursing Assistants were good about making more frequent checks on wandering residents. She stated that she was not aware that there was no information about wandering in Resident #5 ' s Care Plan prior to her elopement.

During an interview on 3/10/11 at 9:15PM, the MDS Coordinator stated that she was making a lot of corrections on Care Plans and Resident #5 was one that she missed. She explained that she tried to keep Care Plans current with all the information that she could. The MDS Coordinator stated that the Unit Manager usually printed out risk assessments for her. She indicated that the resident ' s Care Plan got overlooked. She stated maybe she should have looked for the Resident #5 ' s risk assessment in the computer. She revealed that she did not know that the resident had an elopement risk assessment. She stated that she did not pick up on Resident #5 as a wanderer and she did not know how she missed the resident. The MDS Coordinator stated that she knew Resident #5 and she talked to her.

During an interview on 3/10/11 at 10:05AM, the Director of Nursing (DON) stated that she did not notice any mention of a Care Plan for Resident #5 prior to her elopement from the facility. She revealed that Nursing Assistants had worksheets on residents that they used as a reference on the hall. The DON indicated that the Nursing Assistant ' s worksheets noted the wanderers as well as the Care Plan. She explained that although the Resident #5 Care Plan on elopement/wandering was not initiated prior to the incident, elopement was covered in orientation. The DON revealed that the elopement policy was reviewed in orientation by the Staff Development

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F 279	Continued From page 5 Coordinator. She stated that staff have computer in-services and the Staff Development Coordinator reviewed the elopement policy once a year.	F 279	Resident # 1 was noted missing by night shift staff on 2/13/2011. An immediate search began and she was located behind Southwood Nursing Center near the utility shed by a staff nurse and was brought back into the facility. The resident was assessed by the staff nurse on 2/13/2011 and no injuries were noted. A nursing assistant was assigned to provide direct one-on-one supervision with this resident until it was determined that all elopement prevention systems (doors, alarms and locks) were properly functioning as described below on 2/13/2011 at 3 PM. The exits were checked on 2/13/2011 by the maintenance supervisor and nurse supervisor on duty. They verified that all (15 out of 15) doors latched and locked. They also verified that doors with alarms (4 out of 4), alarmed when the door is open and the transmitter is within range. The front entrance door was checked by bringing the transmitter bracelet within range and verified that it did not open. They also verified that the door would open and alarm when transmitter was not in range. And that the door opened when the code was keyed into the keypad and transmitter was not in range. No problems were identified. The transmitter bracelet for resident # 1 was also checked by the nursing supervisor on 2/13/2011 and was identified as being "weak" according to manufacturer's guidelines. The transmitter was replaced by nursing staff on 2/13/2011. Resident # 1 care plan was reviewed on 2/14/2011 by the care plan nurse and was updated. The updated care plan included elopement, elopement risk, goals, and intervention for elopement risk and wandering. Interventions on 2/14/2011 included wanderguard transmitter in use at all times, notifying nurse of mental status changes, redirecting resident when she is wandering, providing diversional activities, engage her in conversation, give anti-anxiety medications, consult with physician, check transmitter bracelet weekly for proper functioning, place picture in wanderguard book for all staff, staff to monitor her where about at all times and offer activity as a diversion. On 2/13/2011, the nursing supervisor checked all residents who currently utilized wander guard transmitters and ensured that the transmitters were on the 17 residents. The transmitters were tested using the manufacturer testing device and there were three transmitter bracelets that were determined to be weak according to the manufacturer's guidelines. These three transmitters were replaced with new transmitter on 2/13/2011 by the nursing supervisor.	4/11/11
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to supervise one of four residents reviewed with exit seeking and wandering behavior, which resulted in the resident's elopement from the facility. (Resident #5) The Immediate Jeopardy began on 2/13/11 at 1:15AM and was identified on 3/10/11 at 2:00PM. The Immediate Jeopardy was removed on 3/11/11 at 3:45PM, when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of D (with more than minimal potential for harm that is not immediate jeopardy). The facility remained out of compliance to complete additional care plan audits, in-service nursing staff who had not received training on frequent monitoring and supervision to ensure resident safety and notifying nurse management when residents exhibit exit seeking behaviors. The	F 323		

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F 323	Continued From page 6 facility also planned to inservice nursing staff on redirecting residents that exhibit exit seeking behavior, notifying Director of Nursing immediately when residents cannot be redirected and nurse rosters maintained at nurse's station that include care plan interventions on how to intervene to prevent elopement. The findings are: Resident #5 was admitted to the facility on 9/25/09 with diagnoses that included Alzheimer's Disease, Aftercare Traumatic Hip Fracture and Anxiety Disorder. According to the most recent Annual Minimum Data Set (MDS) dated 10/1/10, Resident #5 was unable to complete the cognitive portion of the MDS. In the area of "Wandering, - Presence & Frequency," Resident #5 was coded on the MDS as behavior of this type occurred 4 to 6 days, but less than daily. In the area of "Wandering-Impact," the MDS revealed Resident #5's wandering significantly intruded on the privacy or activities of others. In the area of bed mobility, the MDS revealed Resident #5 required limited assistance, which indicated that the resident was highly involved in the activity with one person physical assistance. In the area of transfer, Resident #5 required limited assistance of one person to move between surfaces, (self sufficient once in wheelchair) from bed to wheelchair to standing position. Resident #5 was independent in moving from her room (using wheelchair) to the adjacent corridor with no physical help from the staff. Resident #5 was also independent (using wheelchair) in moving to and returning from off-unit locations, such as dining or other activities. Wander guard (Bracelet) A device worn by	F 323	All residents with a wanderguard bracelet were reviewed on 2/14/2011 by the quality assurance team to ensure that anyone who was identified at risk for elopement by scoring a 10 or higher on the most recent elopement risk assessment were on the wanderguard list. This wanderguard list is kept current because the transmitter bracelets are obtained by the nursing staff from the nursing secretary. The nursing secretary then records the resident name and room number on the wanderguard testing list. The wanderguard list is a list used by the nursing secretary to ensure that the weekly transmitters test is completed. There was no resident identified as being at risk for elopement that was not on the list or not currently using a transmitter. An additional audit of all care plans was conducted on 3/10/2011 by the care plan nurses to verify that all residents who are identified at risk for elopement have a care plan that addresses elopement risk and exit seeking tendencies. Care plan interventions on how to intervene to prevent elopement were added to the nursing rosters on 3/10/2011 by the support nurses. This nurse aide roster will be copied and kept at the nurses' station. Copies will be available so that every nurse and nursing assistant can have a copy each shift for the hall they are assigned. See below for staff in-service on this intervention. These rosters are updated by the support nurse for that unit and by the MDS nurses. They are updated daily (Monday-Friday) with new admissions, changes in conditions and care plan updates. This includes risk for elopement and how to intervene to prevent elopements. When updated the support nurse will then make new copies, place them at the nurse's station and remove the out dated copies. On 3/10/2011, the RN nurse managers in-serviced RNs, LPNs and nursing assistants. All RNs, LPN, and nursing assistants that worked evening and night shift on 3/10/2011 were in-serviced on 3/10/2011. All day shift RNs, LPNs and NAs that were scheduled to work on 3/11/2011 were in-serviced prior to the start of the shift at 7 AM on 3/11/2011. Telephone in-services were completed on 3/11/2011 by the RN nurse managers for any RNs, LPNs and NAs that had not received the training. Currently there are 18% nursing staff who has not received training. The staff development coordinator will ensure that these employees do not work until training has been completed.	

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F 323	Continued From page 7 wandering residents that sound an alarm when residents wearing the device travel close to a door equipped to detect wander guards. Review of the facility's Nursing Assessment on 3/10/10 revealed Resident #5 had an elopement risk of 13. A score of 10 or greater, was considered at risk for elopement. A Care Plan and a list of elopement prevention measures were to be initiated, to prevent elopement. On 4/2/10, Resident #5's elopement risk was 16. On 7/5/10, the resident's elopement risk was 15. There was no Care Plan, elopement prevention measures, or interventions to prevent elopement initiated for either dates. Review of the facility's Nursing Assessments on 10/18/10, 12/31/10 and 1/17/11 revealed Resident #5's elopement risk was 14. There was no Care Plan or elopement prevention measures initiated for the dates. However, a wander guard was used as an intervention. Resident #5's Care Plan which was reviewed and revised on 1/7/11, revealed the resident's wandering behavior and risk for elopement was not addressed. Review of the facility's "Resident Incident Report" dated 2/13/11 at 1:51AM revealed Resident #5 eloped from the facility. There was no apparent injury and the location was the 600 hall. The property involved was a wheelchair and the activity at the time was propelling the wheelchair independently. The narrative of the incident and description of injuries, read, "CNA (Nursing Assistant) reports that she could not locate resident on the hall, facility wide search was indicated, resident was located on facility grounds." The immediate action taken was the	F 323	This training included the following: 1. Do not forget that frequent monitoring and supervision are needed in order to ensure resident safety. This means that you should be aware of the at risk resident's location. Do not accept the wanderguard system as a substitution for resident supervision. 2. If a resident begins to exhibit exit seeking behaviors then make sure that nurse management is aware of this and make sure to provide frequent monitoring. Examples of exit seeking behavior include sitting for long periods of time at the doors, verbalizing a desire to leave the facility, trying to open the doors and other activities that involve trying to leave the facility 3. Try to redirect residents who are exit seeking by encouraging them to participate in activities that they enjoy or meeting physical needs such as toileting or hunger/thirst. The care plan or nurse roster is a good resource for additional interventions. 4. If the exit seeking behavior cannot be redirected then call Director of nursing immediately and initiate one-on-one supervision. Resident is not to be left unsupervised at any time. 5. The nurse rosters will be maintained at the nurse's station for you to use during your shift. They will include care plan interventions on how to intervene to prevent elopement. On February 22 and 23 2011, in-services were completed by the staff development coordinator. All full time and part time RNs and LPNs, nursing assistants attended this in-service. Any staff member who has not attended this in-service will not be allowed to work until this in-service is completed. The in-service included how residents are identified at risk, reviewing the wandering poster to verify who was at risk, that staff needed to closely monitor or be aware of the location of those at risk and report any at risk behavior such as trying to get out or verbalizing a desire to get out of the facility to the nurse manger ensure that transmitter bracelet are in place, what to do when an elopement occurs, what to do when a resident is missing and about elopement drills. This in-service was incorporated into the new employee facility orientation.	

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F 323	Continued From page 8 resident was placed with one-on-one care. The resident's mental condition at the time of the incident was confused. The medical risk factors possibly related to the incident was confusion/disorientation. An additional narrative description of the incident, read, "1:30AM, staff unable to locate resident - search initiated at 1:50AM - states pt. (patient) was found on facility grounds does not say where. Pt. (patient) was given Ativan 0.25 milliliters IM." Review of Resident #5's Care Plan, updated on 2/14/11, under "Problem Onset," read, "Patient has had an elopement and is at risk for recurrent elopements (due to) dx (diagnosis) of dementia and poor safety awareness." Under "Approaches," read, in part, "Wander guard in use at all times. Redirect patient when she is wandering. Provide diversional activities for her. Place patient's picture in wander guard notebook for all staff to recognize as wanderers. Staff to monitor her whereabouts at all times and offer an activity as diversion." Review of a facility document dated 2/14/11 titled, "QA (Quality Assurance) Elopement Review," revealed a written statement by NA#1, and read, "I, (NA#1) was working the night of (2/13/11) (with) the patient, (Resident #5) when the incident occurred. At approximately 1:15AM I noticed (Resident #5) had traveled further than her usual wandering spots, and I notified neighboring Nurse & other (NAs) that she was missing (& the Supervisor) and we all began the search for her at about 1:30AM." During an interview on 3/10/11 at 9:20PM, NA#1, revealed prior to Resident #5's elopement on 2/13/11, she saw the resident a little after	F 323	Systemic changes that were put into place included changing the transmitters when the tester indicated that they were weak and monitoring by the director of nursing that the testing was being completed by the nursing secretary weekly according to manufacture's guidelines. To accomplish this, the nursing secretary checks all transmitters currently in use weekly according to manufacture's guidelines. She uses the wanderguard list that is updated with all new admissions or newly identified at risk resident by the unit manager to verify that she has checked all transmitters currently in use. If weak, the transmitter is replaced with a new transmitter. These monitoring sheets are taken weekly to quality of life/quality assurance meeting where the director of nursing verifies that the transmitters have been checked and changed appropriately. On February 14, 2011, the facility had a quality assurance plan in place that included a weekly check of all transmitter bracelets, monthly elopement drills and monitoring of doors and alarms. This process will continue as outlined. The nursing secretary will conduct transmitter strength test as outlined by the manufacturer guide lines for the transmitters. If the transmitter is noted to be weak according to manufacturer's guidelines the transmitter will be replaced and this will be identified on the audit tool. This will be completed weekly according to the manufacturer's guidelines and is an on-going audit. At least monthly, the staff development coordinator will conduct an unannounced elopement drill. The drill is alternated on different shifts so that all three shifts participate in a quarter. This drill is conducted by asking a resident to go into one of the offices. Staff is then timed to see how long it takes to miss the resident and if the search is conducted according to the policies and procedures. Educational feedback is conducted by the staff development coordinator at the time of the drill for all employees who participate. A sign in sheet will be maintained by the staff development coordinator. Educational feedback will also be shared with all employees at the monthly in-service training or by posting educational notes at the time clock for review and signature by staff. Concerns are also shared at the monthly Quality Assurance Committee meeting and recommendations for improvement are identified and implemented. This is an on-going audit.	

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F 323	Continued From page 9 1:00AM. She stated that Resident #5 was at the end of the 500 hall rolling around in her wheelchair, NA#1 revealed Resident #5 was not agitated and she acted normal. She stated when she did not see Resident #5 after she completed her rounds, she went down the 500 hall to the 400 hall. NA #1 revealed after she did not see the resident, she alerted everyone. She stated they started the initial search and she then asked others for help. NA#1 stated she completed her rounds in the last room on the 600 hall and she did not hear any alarms sounding. She stated when Resident #1 was roaming, she usually did not let the resident get too far out of sight. She stated she usually checked for her whereabouts every 15 to 30 minutes. NA#1 revealed that Resident #5 would usually stay on her unit if someone was talking to her. NA#1 explained that Resident #5 would sometimes sit up half the night or all night. She revealed the resident became agitated if someone tried to assist her in going to bed and that Resident #5 could walk with assistance. She stated if any double doors were closed the resident would open them. She stated that Resident #5 would try to open the doors at the end of the 500 and 600 hall, but she did not push on them very hard. On the night Resident #5 eloped from the facility after 1:00AM, the Monthly Weather Forecast for the named city on Sunday, 2/13/11, the lowest temperature was 27 degrees (Fahrenheit). During another review, the "QA (Quality Assurance) Elopement Review, dated 2/14/11, revealed a written statement by Staff Nurse #1, and read, "After all rooms were checked inside the facility we started an outside search. Staff	F 323	The exits are checked weekly according to manufacture's guidelines by the maintenance supervisor. He verifies that all (15 out of 15) doors latched and locked. They also verified that doors with alarms (4 out of 4), alarmed when the door is open and the transmitter is within range. The front entrance door was checked by bringing the transmitter bracelet within range and verified that it did not open. They also verified that the door would open and alarm when transmitter was not in range. And that the door opened when the code was keyed into the keypad even when the transmitter was in range. If problems were identified immediate corrective action would be initiated and reported to the Administrator and Quality Assurance committee for additional interventions or monitoring. This will be an on-going audit. An additional audit will be initiated on 3/10/2011. This audit will be completed by the care plan nurses and will review all residents identified at risk for elopement to ensure that the care plan includes elopement risk and exit seeking tendencies. This will be done weekly times three months or until resolved by QOL/QA committee. Reports of the care plan audit will be given by the director of nursing to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly.	

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F 323	Continued From page 10 Nurse #2 and I started searched the grounds in front of the building & toward (Nursing facility next door). I walked around the pavement which goes around (Nursing facility next door). I noticed something moving to the left of me. When I shined my flashlight in the direction of the movement I noticed resident sitting between (Nursing facility next door) and the storage building in the back of the facility. Resident #5 had gotten off the pavement, into the grass and could not move. I said "(Resident #5), what are you doing." She said "I'm freezing honey, I need to get in the car." Writer then took her coat off and draped it around resident. Writer yelled. "I found her." Writer was met by other staff members with blankets & helped to get (her) back into facility. We entered through the employee entrance. Resident was wearing a wander guard but no alarm sounded." During an interview on 3/8/11 at 10:45AM, Staff Nurse #1 stated she saw Resident #5 at 11:00PM.(start of night shift). She revealed the resident was sitting at the corner in front of the Nurse's station, (300 and 400 hall). Staff Nurse #1 stated she was getting ready to start medication pass between 11:00PM and 12:00AM. She revealed she took Resident #5 back to the 600 hall nurse's station. Thereafter, she indicated she did not know where the resident went. Staff Nurse #1 stated that NA#1 walked through and asked if they had seen Resident #5. Staff Nurse #1 stated that they checked doors that opened and they walked from the end of the 400 hall to the (front door) entrance. Staff Nurse #1 indicated facility staff got flashlights and went outside. Staff Nurse #1 stated that Staff Nurse #2 walked around one end of the facility next door and she walked around the other end of the facility next	F 323		

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F 323	Continued From page 11 door. Staff Nurse #1 revealed that she found Resident #5 located in the back of the Nursing facility next door between the building and a storage building. Staff Nurse #1 explained the resident was found between the middle of another nursing facility (facility where the resident did not reside) and the storage building. She stated Resident #5 had on a pink light short sleeve house coat and a t-shirt with a night gown underneath. Staff Nurse #1 stated the resident was found sitting up in her wheelchair. She revealed that Resident #5 seemed to be okay when they looked at her. Staff Nurse #1 stated staff assisted the resident through the employee entrance upon return to the facility, where Resident #5 resided. She indicated Resident #5 had on her wander guard. She revealed that they had to put in a code to get in or out of the building. Staff Nurse #1 stated when the resident was assisted back into the facility where she resided, no alarm sounded on the door, upon entry. (The employee entrance door was not equipped with the wander guard detector. Therefore, no alarm would have sounded). Staff Nurse #1 stated she had worked with Resident #5 before and indicated the resident traveled throughout the facility. Staff Nurse #1 stated that Nursing Assistants were supposed to check on Resident #5. She stated in the past she had called the unit, (600 nurse's station) and told staff where the resident was located. Staff Nurse #1 revealed Resident #5 would look out the door of the smoking area, but did not attempt to get out of the building. Staff Nurse #1 stated she did not hear any alarms the night the resident eloped from the facility. During an interview on 3/8/11 at 12:10AM, Staff Nurse#2, who worked the night	F 323		

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F 323	Continued From page 12 Resident #5 eloped from the facility, indicated the resident was found behind another nursing facility, where the resident did not reside. He stated it was 20 degrees that night and Resident #5 looked like she was cold. Staff Nurse #2 stated Resident #5 seemed to be okay and his coworker put her jacket on the resident to try to keep her warm. He stated that Resident #5 roamed throughout the building anywhere there was an open area. On 3/8/11 at 12:45AM, with the assistance of Staff Nurse #2, an observation was made of the area where Resident #5 was found. The area was located in the back of another nursing facility, where Resifdent #5 did not reside, behind a storage building on the left side in a grassy area. Staff Nurse#2 stated the area observed was where he saw her when he arrived at the location. During an interview on 3/8/11 at 10:55AM, Staff Nurse #3 stated Resident #5 was up at the Nurse's station (500 and 600 hall) in her wheelchair prior to her elopement. She stated that the resident went down the hallway wandering around in her wheelchair. She stated that she watched Resident #5 while she was on the unit. She stated that Resident #5 normally stayed on the 600 hall, and if the resident went of the unit (600 hall) someone would return her to the unit or her Nursing Assistant brought the resident back the unit. Staff Nurse #3 indicated prior to Resident #5's elopement the resident's Nursing Assistant could not locate the resident and they searched for her on different halls. She stated when staff was not able to locate the resident after twenty minutes, they started to search for her. Staff Nurse	F 323		

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F 323	Continued From page 13 #3 stated that Resident #5 was returned to the Nurse's station two times the night of the elopement. She stated both times the Nursing Assistant on the 600 hall that night, returned the resident to her unit. She stated Resident #5 wandered off again after redirected. Staff Nurse #3 stated she helped to search for the resident. She stated she notified the Nursing Supervisor Resident #5 could not be located. Staff Nurse #3 revealed staff searched different rooms for Resident #5 and then proceeded to search outside. She stated one nurse remained at the Nurse's station. During an interview on 3/8/11 at 4:35PM, Staff Nurse #4 revealed she saw Resident #5 go around the nurse's station (100 and 200 hall) and it was hour or so before she was notified the resident had eloped from the facility. She indicated she thought the resident was on the 200 hall that night. She stated Resident #5 would usually circle around unit 1 (100 and 200 hall) and unit 2 (300 and 400 hall). She stated occasionally the resident would go to unit 4 (700 and 800) hall. Staff Nurse #4 revealed everyone knew how Resident #5 roamed throughout the building. She stated that she was sitting at the 200 hall nurse's station charting when she saw Resident #5 heading back toward her unit. Staff Nurse #4 stated she spoke to Resident #5 as the resident went around the corner, toward unit 2 (300 and 400 hall). Staff Nurse #4 revealed one of the nurse aides informed her the resident was missing, and she asked the aide if she had checked her unit. Staff Nurse #4 stated staff immediately searched the building. She revealed she did not think Resident #5 left the building because she thought she would have heard an alarm once the resident got close to the door. (If a	F 323		

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F 323	Continued From page 14 door with a wander guard detector was open and if Resident #5 who was wearing her wander guard came close to the door, an alarm would sound.) Staff Nurse #4 revealed all doors were supposed to alarm. (The front door alarm was supposed to sound when the front door was open and a resident wearing a wander guard came close to the door. If the front door was closed the door would lock when a resident with a wander guard got close to it.) Staff Nurse #4 stated she did not know which door staff brought Resident #5 through when they returned her to the building. She revealed after the staff returned Resident #5 to the building, she checked all doors to ensure all doors latched properly. She stated the door at the end of the 500 hall would not latch properly. She revealed when someone pushed against the door, the bottom of the door would open, but it would not open all the way, because the door was locked at the top with a mag lock. On 3/10/11 at 6:00PM, accompanied by the Maintenance Director, the distance was measured from the facility where Resident #5 eloped, to where the resident was found in a grassy area in the back of another nursing facility. The measurements were taken on the left side of the facility. The distance was measured from a facility door, referred to as the laundry door, which was between the corridor of the 400 and 500 hall. (facility where the resident resided). The passage from the laundry door led to a sidewalk, which led to a gravel lot which joined a paved road (one of the access roads to both facilities.) From the facility to where the resident was found was an estimated 272 feet. The storage building behind the nursing facility where Resident #5 was found was 20 feet long and 12 feet wide. There was a wooded area along the	F 323		

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F 323	Continued From page 15 access road and a creek was beyond the wooded area. The facility access road extended to stop a sign at the main road and there were ditches, which dropped below the road surface on both sides of the road, which intersected the main road. The distance from the facility to the main road was 990 feet. The speed limit for the main road in front of the facility was 35 miles per hour. During an interview on 3/7/11 at 5:45PM, the Director of Nursing (DON) stated they never determined which door Resident #5 went out through when she eloped from the facility. She indicated the door at the end of the 500 hall had a mag lock (locked from the top) on it. The DON revealed Resident #5 had one-on-one staff with her after the incident. She stated they checked the resident's wander guard to determine if it was working and they discovered the wander guard had a weak signal. The DON revealed the wander guard with the weak signal was thrown away and replaced with a new one. She stated the maintenance man made sure the mag locks were working when he came in on Sunday. The DON revealed staff checked the facility to verify all residents were in the building on the night Resident #5 eloped from the facility. The DON revealed the 7:00AM to 3:00PM supervisor checked every wander guard bracelet and changed out all bands that morning. During an observation on 3/7/11 at 3:30PM, Resident #5 was awake in bed. The head of her bed was elevated with both side rails up. During an observation on 3/8/11 at 10:30AM, Resident #5 was awake in bed with both side rails up.	F 323		

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F 323	Continued From page 16 During an interview on 3/9/11 at 12:10PM, the Nursing Secretary revealed she tested wander guards weekly. She indicated she took residents up to the front door to test wander guards. The Nursing Secretary indicated the front door would lock if a resident with a wander guard approached the front door. She revealed even if the wander guard was weak, the front door still would lock when a resident approached it. She stated that when a wander guard was weak, she would order another one. The Nursing Secretary further stated if there was a problem with the wander guard, she would document the wander guard was weak. She revealed the last time Resident #5's wander guard was tested was on 2/8/11. She stated even if a wander guard was weak, the front door would still lock when a resident with a wander guard approached it. The Nursing Secretary stated a door alarm would sound even if a wander guard was weak. She stated the other doors in the facility were always locked. The Nursing Secretary explained if the front door was open as a resident approached with a wander guard, an alarm would sound, and if the front door was closed when a resident approached with a wander guard, the front door would lock down. The Nursing Secretary revealed the wander guards were good for one year and two or three months. She stated the wander guard might not start getting weak until after twelve or thirteen months. The Nursing Secretary stated she could not remember the last time she changed out Resident #5's wander guard. She stated if she had to change a wander guard for another one, she would try to have another one within a week or two. The Nursing Secretary stated she did not know how long a wander guard lasted before it stopped working, because they changed the wander guard before that happened.	F 323		

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F 323	Continued From page 17 During an interview on 3/7/11 at 3:30PM, NA#2 stated she had been working in the facility for 2 ½ years. She revealed Resident #5 rolled around in her wheelchair and the resident could walk with assistance to and from the bathroom. NA#2 stated Resident #5 could get around in her wheelchair very well. She revealed the resident would go up and down the 600 hall, through the great room (dining room) to unit 2 (300 and 400) hall. She stated the resident would make a circle, going from the 300 and 400 hall to the 100 and 200 hall and back to 500 and 600 hall. NA#2 stated everyone knew Resident #5 and the location of her unit. She revealed she would check Resident #5 for toileting every two hours. NA#2 stated she did not have to constantly check on Resident #5. She indicated Resident #5 stayed on her unit most of the time. NA#2 revealed Resident #5 had a wander guard and an alarm on her wheelchair. She stated if Resident #5 tried to stand up, the alarm (on her wheelchair) would sound. NA#2 revealed Resident #5 had the wander guard since she was admitted to the facility. NA#2 explained there was a sheet at the Nurse's station that staff reviewed which listed residents that had to be lifted or if the residents had alarms on their bed or wheelchair. During an interview on 3/8/11 at 12:15AM, NA#3, stated Resident #5 wore a wander guard at all times. She stated the resident used to be up out of bed before she got sick. She revealed Resident #5 would roam throughout the unit and call for her husband. NA#3 stated she tried to make sure Resident #5 stayed on the unit. She stated the resident would travel up to unit 2, (300 and 400 hall) and unit 1 (100 and 200 hall). Na#3 stated she tried to keep an eye on Resident #5 if	F 323		

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F 323	Continued From page 18 she (resident) was off the unit. NA#3 stated if Resident #5 was off the unit for more than 15 to 20 minutes, she would check on her. NA#3 revealed she did not work the night of the elopement. During an interview on 3/9/11 at 12:30PM, Staff Nurse #5 revealed Resident #5 was able to propel herself in her wheelchair independently. She stated the resident would propel her wheelchair to other units, and she seemed to be confused while propelling herself through the halls. Staff Nurse #5 stated she had to redirect Resident #5 back to her unit. She stated that she was sure that she had to redirect the resident from the front lobby back to her unit. During an interview on 3/9/11 at 12:45PM, NA #4 stated that prior to Resident #5 being sick, Resident #5 was able to move from her bed to her (room) door unassisted and would come to the door and say hello. She indicated the resident could walk by herself. NA #4 revealed that Resident #5 would roam throughout the entire facility, and would say she was looking for her (named) husband. She stated every other day, Resident #5 would sometimes state that she wanted to go home. NA #4 revealed Resident #5 liked to look out of the exit doors and she liked the 500 and 600 hall exit doors at the end of each hall. During an interview on 3/9/11 at 2:30PM, the Rehab. NA#5 stated Resident #5 was confused at times. She revealed the resident looked for her husband throughout the facility. Rehab. NA#5 stated Resident #5 could walk to and from her bed with one arm assistance. She revealed she had seen the resident once or twice at the smoke	F 323		

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F 323	Continued From page 19 area waving at staff. During another interview on 3/10/11 at 11:45AM, NA #3, revealed Resident #5 would be at the doors every night, pushing on the handle of the exit door. She revealed Resident #5 would shake the handle back and forth and state, "Let's go home (named) husband. We have to go or we will miss the train." NA#3 stated Resident #5 would sit at the exit door from a few seconds to thirty minutes at night. She revealed the resident liked a certain room on the 600 hall and would go into that room a lot. NA#3 stated the room was next to the exit door on the 600 hall. During an interview on 3/10/11 at 12:20AM, NA #6 stated she saw Resident #5 a couple of hours before the resident was reported missing. She revealed Resident #5 was sitting in the large dining room near unit 3 (500-600 hall). NA #6 stated she was in the last room on the 800 hall when she was told that Resident #5 was missing. She stated she was told to check all of the rooms and start searching for the resident. NA#6 indicated Resident #5 would usually travel from one hall to another. She revealed most of the time the resident was in the unit 3 dining room watching television. During an interview on 3/10/11 at 12:15AM, NA #7 revealed the night of Resident #5's elopement she saw the resident at the beginning of the shift 11:15PM - 11:30PM. She stated Resident #5 was between the 300 hall (bottom portion of the hall) propelling herself around in her wheelchair. NA#7 stated she met the resident's primary Nursing Assistant at the end of the hallway, and the Nursing Assistant redirected Resident #5 to turn around in her wheelchair to go with her. NA	F 323		

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F 323	Continued From page 20 #7 revealed she did not see Resident #5 any other time during that night. She stated she was in a resident's room between 12:00AM-1:00AM and she did not hear any alarms throughout the night. NA #7 revealed at other times, every now and then (not often) she would see Resident #5 in her area, down the 300-400 hall and the resident would sometimes sit at the nurse's station. During an interview on 3/10/11 at 12:30AM, NA #8 revealed she was working on the 500 hall the night Resident #5 was reported missing. She stated on the night Resident #5 was reported missing, she saw the resident roaming around going into different rooms. NA #8 revealed Resident #5 went into a resident's room on unit 2 (300-400 hall) and another aide asked her to assist her in getting Resident #5 out of the resident's room. She stated the last time she saw Resident #5, she was still roaming throughout the facility. NA #8 stated she could not remember which area she last saw the resident, and she further stated she did not hear any alarms sounding. During an interview on 3/9/11 at 1:15PM, the Unit Manager stated Resident #5 was confused. She stated Resident #5 could propel herself in her wheelchair throughout the facility. The Unit Manager revealed that at times Resident #5 would state that she was going home to a named country. She stated Resident #5 liked the exit doors and she would sit up front at the exit doors. The Unit Manager revealed she had not observed the resident trying to leave the facility. She stated prior to Resident #5's elopement the resident was capable maybe of getting out of bed and walking to the doorway of her room, although she was unsteady on her feet.	F 323		

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F 323	Continued From page 21 The Administrator was notified of the Immediate Jeopardy on 3/10/11 at 2:00PM. The Immediate Jeopardy was removed on 3/11/11 at 3:45PM, when the facility provided a credible allegation of compliance. The allegation of compliance indicated: Resident # 1 was noted missing by night shift staff on 2/13/2011. An immediate search began and she was located behind Southwood Nursing Center near the utility shed by a staff nurse and was brought back into the facility. The resident was assessed by the staff nurse on 2/13/2011 and no injuries were noted. A nursing assistant was assigned to provide direct one-on-one supervision with this resident until it was determined that all elopement prevention systems (doors, alarms and locks) were properly functioning as described below on 2/13/2011 at 3 PM. The exits were checked on 2/13/2011 by the maintenance supervisor and nurse supervisor on duty. They verified that all (15 out of 15) doors latched and locked. They also verified that doors with alarms (4 out of 4), alarmed when the door is open and the transmitter is within range. The front entrance door was checked by bringing the transmitter bracelet within range and verified that it did not open. They also verified that the door would open and alarm when transmitter was not in range. And that the door opened when the code was keyed into the keypad and transmitter was not in range. No problems were identified. The transmitter bracelet for resident # 1 was also checked by the nursing supervisor on 2/13/2011 and was identified as being " weak " according to manufacturer ' s guidelines. The transmitter was replaced by nursing staff on 2/13/2011.	F 323		

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F 323	Continued From page 22 Resident # 1 care plan was reviewed on 2/14/2011 by the care plan nurse and was updated. The updated care plan included elopement, elopement risk, goals, and intervention for elopement risk and wandering. Interventions on 2/14/2011 included wander guard transmitter in use at all times, Notifying nurse of mental status changes, redirecting resident when she is wandering, providing diversional activities, engage her in conversation, give anti-anxiety medications, consult with physician, check transmitter bracelet weekly for proper functioning, place picture in wander guard book for all staff, staff to monitor her whereabouts at all times and offer activity as a diversion. On 2/13/2011, the nursing supervisor checked all residents who currently utilized wander guard transmitters and ensured that the transmitters were on the 17 residents. The transmitters were tested using the manufacturer testing device and there were three transmitter bracelets that were determined to be weak according to the manufacturer ' s guidelines. These three transmitters were replaced with new transmitter on 2/13/2011 by the nursing supervisor. All residents with a wander guard bracelet were reviewed on 2/14/2011 by the quality assurance team to ensure that anyone who was identified at risk for elopement by scoring a 10 or higher on the most recent elopement risk assessment were on the wander guard list. This wander guard list is kept current because the transmitter bracelets are obtained by the nursing staff from the nursing secretary. The nursing secretary then records the resident name and room number on the wander guard testing list. The wander guard list is a list used by the nursing secretary to ensure that the weekly transmitters test is completed. There was no resident identified as being at risk for	F 323		

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F 323	Continued From page 23 elopement that was not on the list or not currently using a transmitter. An additional audit of all care plans was conducted on 3/10/2011 by the care plan nurses to verify that all residents who are identified at risk for elopement have a care plan that addresses elopement risk and exit seeking tendencies. Care plan interventions on how to intervene to prevent elopement were added to the nursing rosters on 3/10/2011 by the support nurses. This nurse aide roster will be copied and kept at the nurses ' station. Copies will be available so that every nurse and nursing assistant can have a copy each shift for the hall they are assigned. See below for staff in-service on this intervention. These rosters are updated by the support nurse for that unit and by the MDS nurses. They are updated daily (Monday-Friday) with new admissions, changes in conditions and care plan updates. This includes risk of elopement and how to intervene to prevent elopements. When updated the support nurse will then make copies, place them at the nurses station and remove the outdated copies On 3/10/2011, the RN nurse managers in-services RNs, LPNs and nursing assistants. All RNs, LPNs and nursing assistants that worked evening and night shift on 3/10/2011 were in-serviced on 3/10/2011. All day shift RNs, LPNs, and NAs that were scheduled to work on 3/11/2011 were in-serviced prior to start of the shift at 7AM on 3/11/2011. Telephone in-services were completed on 3/11/2011 by the RN nurse managers for any RNs, LPNs and NAs that had not received the training. Currently there are 18% nursing staff who have not received training. The staff development coordinator will ensure that these employees do not work until training has	F 323		

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F 323	Continued From page 24 been completed. This training included the following: 1. Do not forget that frequent monitoring and supervision are needed in order to ensure resident safety. This means that you should be aware of the at risk resident ' s location. Do not accept the wander guard system as a substitution for resident supervision. 2. If a resident begins to exhibit exit seeking behaviors then make sure that nurse management is aware of this and make sure to provide frequent monitoring. Examples of exit seeking behavior include sitting for long periods of time at the doors, verbalizing a desire to leave the facility, trying to open the doors and other activities that involve trying to leave the facility 3. Try to redirect residents who are exit seeking by encouraging them to participate in activities that they enjoy or meeting physical needs such as toileting or hunger/thirst. The care plan or nurse roster is a good resource for additional interventions. 4. If the exit seeking behavior cannot be redirected then call Director of nursing immediately and initiate one-on- one supervision. Resident is not to be left unsupervised at any time. 5. The nurse rosters will be maintained at the nurses station for you to use during your shift. They will include care plan interventions on how to intervene to prevent elopement. On February 22 and 23 2011, in-services were completed by the staff development coordinator. All full time and part time RNs and LPNs, nursing assistants attended this in-service. Any staff member who has not attended this in-service will not be allowed to work until this in-service is	F 323		

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completed. The in-service included how residents are identified at risk, reviewing the wandering poster to verify who was at risk, that staff needed to closely monitor or be aware of the location of those at risk and report any at risk behavior such as trying to get out or verbalizing a desire to get out of the facility to the nurse manager ensure that transmitter bracelet are in place, what to do when an elopement occurs, what to do when a resident is missing and about elopement drills. This in-service was incorporated into the new employee facility orientation.

Systemic changes that were put into place included changing the transmitters when the tester indicated that they were weak and monitoring by the director of nursing that the testing was being completed by the nursing secretary weekly according to manufacturer's guidelines. To accomplish this, the nursing secretary checks all transmitters currently in use weekly according to manufacturer ' s guidelines. She uses the wander guard list that is updated with all new admissions or newly identified at risk resident by the unit manager to verify that she has checked all transmitters currently in use. If weak, the transmitter is replaced with a new transmitter. These monitoring sheets are taken weekly to quality of life/quality assurance meeting where the director of nursing verifies that the transmitters have been checked and changed appropriately. On February 14, 2011, the facility had a quality assurance plan in place that included a weekly check of all transmitter bracelets, monthly elopement drills and monitoring of doors and alarms. This process will continue as outlined. The nursing secretary will conduct transmitter strength test as outlined by the manufacturer

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guide lines for the transmitters. If the transmitter is noted to be weak according to manufacturer ' s guidelines the transmitter will be replaced and this will be identified on the audit tool. This will be completed weekly according to manufacturer ' s guidelines and is an on-going audit.
At least monthly, the staff development coordinator will conduct an unannounced elopement drill. The drill is alternated on different shifts so that all three shifts participate in a quarter. This drill is conducted by asking a resident to go into one of the offices. Staff is then timed to see how long it takes to miss the resident and if the search is conducted according to the policies and procedures. Educational feedback is conducted by the staff development coordinator at the time of the drill for all employees who participate. A sign in sheet will be maintained by the staff development coordinator. Educational feedback will also be shared with all employees at the monthly in-service training or by posting educational notes at the time clock for review and signature by staff. Concerns are also shared at the monthly Quality Assurance Committee meeting and recommendations for improvement are identified and implemented. This is an on-going audit.
The exits are checked weekly according to manufacturer's guidelines by the maintenance supervisor. He verifies that all (15 out of 15) doors latched and locked. They also verified that doors with alarms (4 out of 4), alarmed when the door is open and the transmitter is within range. The front entrance door was checked by bringing the transmitter bracelet within range and verified that it did not open. They also verified that the door would open and alarm when transmitter was not in range. And that the door opened when the code was keyed into the keypad even when the

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F 323	Continued From page 27 transmitter was in range. If problems were identified immediate corrective action would be initiated and reported to the Administrator and Quality Assurance committee for additional interventions or monitoring. This will be an on-going audit. An additional audit will be initiated on 3/10/2011. This audit will be completed by the care plan nurses and will review all residents identified at risk for elopement to ensure that the care plan includes elopement risk and exit seeking tendencies. This will be done weekly times three months or until resolved by QOL/QA committee. Reports of the care plan audit will be given by the director of nursing to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse and Support Nurse and Health Information Management and meets weekly. Completion Date: 3/11/2011 On 3/11/11at 1:00PM the credible allegation was validated by reviewing all Care Plans of residents (17) identified by the facility as being at risk for elopement to verify that the Care Plans addressed elopement risks and exit seeking behaviors. Nurse Aide rosters that included Care Plan interventions on how to intervene and prevent elopement were reviewed. Staff inservice training which addressed monitoring and supervision of residents with attention seeking behaviors were reviewed. All 15 doors in the facility were checked to ensure that they latched and locked. The doors with alarms were checked to ensure that they alarmed when the door was opened and the transmitter was	F 323		

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F 323	Continued From page 28 within range. The front entrance door was also checked to verify that the transmitter and front door worked as indicated. The wander guard list was reviewed to verify that residents identified by the facility at risk for elopement were all included on the list. The wander guard list was also reviewed to verify that staff checked each resident's wander guard.	F 323		