DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

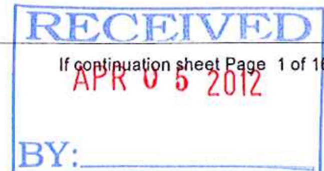
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345171	A. BUILDING ______ B. WING ______	C 03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK MANOR - SHELBY	401 N MORGAN ST BOX 790 SHELBY, NC 28150

(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 000	INITIAL COMMENTS Immediate jeopardy began on 3/2/12 when staff failed to prevent the elopement of Resident #2 without staff supervision. The administrator was notified of immediate jeopardy on 3/13/12. Immediate jeopardy was removed on 3/14/12 when the facility provided and implemented an acceptable credible allegation of compliance.	F 000		
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 observations, record review and staff interviews, the facility failed to prevent one (1) of fifteen (15) sampled cognitively impaired residents, who were at risk for elopement, from exiting the facility. Resident #2 eloped from the facility on 3/2/12 while unsupervised and was found by staff walking in the middle of the roadway approximately 0.3 miles away from the facility. (Resident #2). Immediate Jeopardy began on 3/2/12 when Resident #2 eloped from the facility without staff's knowledge that she was outside unsupervised. Immediate Jeopardy was removed on 3/14/12 when the facility provided and implemented a credible allegation of compliance. The facility	F 323	White Oak Manor-Shelby is submitting this POC to comply with the State Operations Manual section 7304D. This plan of correction does not constitute an admission of any facts, allegations or conclusions stated in the CMS 2567 and is not intended for any other purpose other than compliance with section 7304D of the State Operations Manual and authorizing regulations. F323 White Oak Manor-Shelby does ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. 1. How Corrective Action will be Accomplished for Each Resident Found to Have Been Affected by the Deficient Practice: Resident #2 no longer resides at White Oak Manor-Shelby.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sonia Crisp
TITLE: Administrator
(X6) DATE: 4.4.12

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 323	Continued From page 1 remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings are: Resident #2 was admitted from home to the facility on 5/16/11. Diagnoses included Alzheimer's Disease. The "Exit Seeker" evaluation dated 5/16/11 assessed Resident #2 as ambulatory, seeking an exit for the reason of wanting to go home, had been located just outside the door, i.e. porch, patio, and had easily altered exit desires. On 5/16/11 a watch mate bracelet was applied to her ankle. The facility was equipped with a watch mate alarm system on the front entrance. This system works via a watch mate bracelet which contains a transmitter which will lock the front door if the transmitter comes within several feet of the closed front door. If the front door is already opened, the transmitter will set off an alarm to alert staff that a watch mate bracelet has come within feet of the open door. Nursing notes revealed the following behaviors/events: *11/20/11 at 10:11 AM Resident #2 was packing clothes and stating she was going home. *12/22/11 at 11:17 AM Resident #2 was packing her clothing and personal items and stating she was going home. She became agitated when redirected. *1/16/12 at 2:31 PM the physician visited Resident #2 as responsible party had concerns about the resident packing her clothes and	F 323	2. How Corrective Action will be Accomplished for Those Residents Having a Potential to be Affected by the Same Deficient Practice: An Inservice for Nursing Assistants and Nurses on the three Nursing Units was initiated on March 2, 2012 by RN Unit Coordinator. The inservice was titled "Front Door Alarm" and was presented by RN Unit Coordinator. The content of this inservice was to address door alarms sounding and immediately responding to the door alarm; and if the door alarm is sounding and it cannot be determined why alarm is sounding, staff should begin a search outside. All residents who are assessed as a resident with the potential to exit-seek have been reviewed by the Interdisciplinary Care Plan team and all of these residents locomote via wheelchair and are not ambulatory without assistance. The plans of care for these specific residents were also reviewed to ensure there was a plan of care in place to address the potential for exit-seeking behavior and resident specific approaches. This was completed by 3-12-12. The Social Service Director has also reviewed the photo boards which contain the pictures and names of the residents who have the potential for exit-seeking. These photo boards are maintained on each of the three Nursing Units, as well as in the front lobby. All residents who have been assessed as a Resident with the potential to exit-seek do	

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requested urinalysis. Physician denied request for urinalysis due to resident's denial of symptoms.
*1/22/12 at 1:45 PM Resident #2 packed belongings in a pillow case and walked down hall with jacket and purse. She was redirected with no further episodes.

The quarterly Minimum Data Set (MDS) dated 2/7/12 coded her with severe cognitive impairment, being independent with ambulation and having no wandering behaviors. The care plan reviewed on 2/7/12 identified the problem that Resident #2 had a watch mate due to the potential for exit seeking due to confusion. The goal was for the resident to have no attempts to exit building during the next assessment. Interventions included to monitor placement of watch mate every shift; monitor resident every fifteen minutes to know of her whereabouts; encourage resident to come to out of room for activities for socialization and diversion; report increases in exit attempts to medical doctor as needed; monitor watch mate for proper functioning; and redirect resident if seen packing up her things to leave.

Nursing notes dated 2/14/12 at 11:27 PM revealed Resident #2 was extremely confused, dressed in coat waiting and watching for someone. When questioned, her response was garbled. She was out of her room in the hall and was very anxious.

Nursing notes dated 3/2/12 at 10:13 PM revealed that at 4:45 PM, Licensed Nurse (LN) #2 received a phone call that Resident #2 had exited the building. LN #2 approached the front of the

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have their photo with their name on these boards. This was reviewed by 3-12-12. The Social Service Director updates the photo boards when a resident is identified with the potential to exit-seek, or when a resident needs to be removed from this list. The Social Services Department is also responsible for assessing new admissions for potential exit-seeking behavior(s). This process is ongoing.

The Quality Assurance RN also reviewed the CQI Checklist to ensure any resident wearing a door alarm bracelet/anklet had this device indicated on the CQI Checklist along with the month and year the device is due to be changed. This was completed on 3-12-12. The CQI Checklists are maintained by the three nursing units, as well as staff members who attend the morning meeting. Any changes are discussed at the morning meeting and new Checklists are printed weekly to reflect any updates made during that week. The Quality Assurance Nurse conducts weekly, ongoing checks of the door alarm bracelets/anklets to ensure devices are functional. Weekly documentation of these checks began March 5, 2012 and is ongoing.

White Oak of Shelby also implemented a written procedure for responding to a secured door alarm (which is separate from the existing Missing Resident/Code Adam procedure) and began inservicing on this procedure March 5, 2012.

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F 323	Continued From page 3 building and noted the resident was being assisted inside the facility by staff members. The watch mate was in place and working properly. No acute distress was noted upon assessment. Notification to family and physician was made. Resident #2 was placed on one to one supervision. On 3/12/12 at 12:32 PM a phone interview was conducted with Nurse Aide (NA) #1. NA #1 stated she was off duty and running errands on 3/2/12 at approximately 4:40 - 4:45 PM when she heard cars honking their horns. She stated she saw Resident #2 in the middle of the road near railroad tracks and identified the street corner. NA #1 stated after a few minutes, she was able to convince Resident #2 to get into the car. NA #1 stated she called the facility as she was getting the resident into the car. She returned the resident to the facility. On 3/12/12 at 12:45 PM surveyors observed the location Resident #2 was found by NA #1 as approximately 0.3 miles away from the facility. The road in front of the facility being a 35 miles per hour zone and then changing to 20 miles per hour zone closer to the corner where Resident #2 was found by staff. On 3/12/12 at 1:52 PM the Administrator stated that she believed Resident #2 was let outside by a visitor. She confirmed no one knew Resident #2 was missing until NA #1 called the facility notifying staff she had found the resident. On 3/12/12 at 2:01 PM LN #2 stated she was Resident #2's floor nurse on 3/2/12, on the South unit. LN #2 stated Resident #2 had been active	F 323	The new procedure involves the person hearing the alarm is responsible for responding to the alarm and then determining why the alarm is sounding; if a determination cannot be made as to why the alarm is sounding, then another staff member or members should be immediately contacted to assist; one staff member shall do a thorough assessment of the outside area of the building while the other staff member(s) contacts each of the Nursing Units to begin an immediate count of the exit-seeking residents (those residents wearing a door alarm bracelet/anklet for exit-seeking behavior);and the investigation may not stop until all the exit-seeking residents have been accounted for. This inservicing was completed by the Administrator, the Staff Development Coordinator, the Human Resource Manager and Department Heads. The inservice has been communicated by both 1:1 inservicing and reviewing written inservice material on the procedure. This inservice was conducted on multiple days and as of March 26, 2012, 194 of 194 employees have been inserviced on the new procedure (one employee was out of the country until March 26, 2012). The facility also had larger signage made for the front lobby area that asks visitors to not assist unfamiliar persons outside without first checking with staff (as it could be a resident) and if the door alarm is sounding to remain in place until staff assists. This new signage was placed on March 14, 2012.	

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F 323	Continued From page 4 that day, visiting another resident on the Skilled unit and walking around the facility. She stated that approximately 4:30 PM on 3/2/12 Resident #2 had her purse in hand and stated she was going to eat and headed in the direction of the dining room. LN #2 stated although the resident frequently packed clothes, she did not pack or speak of leaving that day. LN #2 stated within the next twenty minutes she received word that Resident #2 was found out of the facility. LN #2 stated she did not know the resident was missing. LN #2 stated Resident #2 always wore a watch mate that alarmed the doors, which was checked daily for placement by nurses. She stated the quality assurance (QA) nurse checked the functioning of the watch mate. LN #2 stated she did not hear the front door alarm and further stated the front door alarm could not be heard on the South unit (where Resident #2 resided) but should ring on the North unit. LN #2 stated she determined via interviews with social service staff (SS) #1 that the alarm sounded. Social service staff had to deactivate the alarm via a code and looked but saw no residents outside. LN #2 then decided to inservice staff about ensuring that alarms are answered and staff thoroughly look for the cause of the alarm. LN #2 stated Resident #2 was placed on one to one supervision throughout the remainder of the shift. Interview with the Social Service Director (SSD) on 3/12/12 at 2:25 PM revealed she and SS#1 were in a meeting when they heard an alarm sounding. She stated she thought it was a bathroom door alarm from a resident's room on North unit that frequently goes off. She stated it went off for approximately 20 seconds when a male visitor stopped by her office and requested	F 323	New residents and family members are now being provided an information sheet in the New Admission packet that asks to please not assist unfamiliar people with exiting the building without first checking with a Staff member (as it could be a resident) and to remain in place until a staff member arrives if the door alarm begins sounding. This was implemented on March 21, 2012 and will be ongoing. The facility conducted a thorough assessment of the secure door alarm system, which included the sound relay system. Two additional secure door alarm sound relays have been installed. As of March 15, 2012, all three Nursing Units now have these sound relays (which indicate the secure door alarm is sounding). In addition, seven (7) sound relay speakers were installed throughout each of the three Nursing Units. This provides additional coverage range of the alarm when the secure door system alarm is sounding. This installation was completed on April 4, 2012. The Quality Assurance Nurse is also responsible for checking the door alarm system and door sound relay systems weekly. These checks are also documented weekly and now include the door sound relay systems from all three Nursing Units. The Quality Assurance Nurse checks the secure front door for proper functioning and then confirms with all three Nursing Units the alarm was heard. This is evidenced by a Nurse from each unit initialing the weekly check log. The Quality Assurance Nurse also conducts weekly,	

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to be let out of the facility as the front door was locked. She stated it was at this time she realized it was the front door alarm that was sounding. She stated she had to use the code to stop the alarm and open the door. Once she opened the door, SSD stated she looked across the parking lot, right and left, on the porch and upon seeing no residents, SSD went back inside. She stated she left the facility for the day without further intervention. SSD stated Resident #2 packed things up almost every day but did not check doors in attempts to leave the facility.

On 3/12/12 at 2:46 PM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated he was working back on the Skilled unit on 3/2/12. The ADON stated he was informed by LN #2 that Resident #2 was found down the street and that he should go help NA #1 who was with her. Per interview, when he got to the front door, NA #1 was already in the parking lot with Resident #2 so he assisted the resident inside. He stated the front door locked down as they neared it, indicating Resident #2's watch mate was working. The ADON stated he had not heard the front door alarm. He stated the front door alarms at the front door and on the North unit. He stated the front door alarm could not be heard on the Skilled unit where he was working. The ADON stated Resident #2 frequently packed her things and would talk about going home but he did not recall her every trying to leave the facility.

On 3/12/12 at 3:12 PM interview with LN #3 revealed she was working on 3/2/12 and answered the phone on the South unit when an employee called to report Resident #2 was found

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ongoing checks of the door alarm bracelets/ anklets to ensure devices are functional. Weekly documentation of these checks began March 5, 2012 and is ongoing. The sound relays were all checked upon installation on March 15, 2012 and then began being included in the weekly secure door alarm system on March 19, 2012. The Administrator will monitor the weekly checks of the secure door alarm system and the sound relays. This will be done weekly and evidenced by the Administrator's initials on the weekly checklist. This is ongoing.

The facility has also had an additional camera and video monitor screen installed. The additional camera installed in the front lobby views the secure front door, the swinging lobby door leading to the secure front door, and a third door from the Dining Room which also leads to the front lobby. The video camera monitor has been installed at the North Nurse's Station and shows real-time video feed of the front lobby coverage provided by the new camera installed. Both the camera and monitor were installed on April 2, 2012.

3. Address What Measures Will be Put Into Place or Systemic Changes Made to Ensure the Same Deficient Practice Does not Recur:

On March 5, 2012, an inservice was initiated on a new procedure for what to do when responding to a secured door alarm for all facility staff. The new procedure involves the person hearing the alarm is responsible

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F 323	Continued From page 6 down the street. LN #3 stated no one knew the resident was missing and she reported the phone call to LN #2. LN #3 stated she did not hear the front door alarm when working on the South unit. It could only be heard on the North unit. LN #3 stated Resident #2 walked around the facility often, verbalized a desire to go home but wore a watch mate for safety. Interview with NA #2 on 3/12/12 at 3:40 PM revealed he was working on the South unit during the second shift of 3/2/12. NA #2 stated he did not know Resident #2 was missing until she was brought back to the facility. NA #2 stated he did not hear the front door alarm and further stated the alarm did not sound on the South unit. Interview with NA #3, second shift staff, on 3/12/12 at 3:46 PM revealed she worked during second shift on 3/2/12. NA #3 stated she generally worked all halls. She recalled seeing Resident #2 around 4:30 PM and again around 4:45 PM when she was talking to LN #2. NA #3 was unaware Resident #2 was missing until she was returned to the unit. NA #3 stated she did not hear any door alarms and further stated the front door alarm could be heard on the North unit only. NA #4 was interviewed on 3/12/12 at 3:55 PM. She worked on the South unit during the second shift on 3/2/12. NA #4 stated she did not hear the front door alarm and was unaware Resident #2 was missing until someone called the facility. NA #4 was sent to the front to assist Resident #2 back to her room. NA #4 stated Resident #2 was disoriented, crying and more quiet than usual.	F 323	for responding to the alarm and then determining why the alarm is sounding; if a determination cannot be made as to why the alarm is sounding, then another staff member or members should be immediately contacted to assist; one staff member shall do a thorough assessment of the outside area of the building while the other staff member(s) contacts each of the Nursing Units to begin an immediate count of the exit-seeking residents (those residents wearing a door alarm bracelet/anklet for exit-seeking behavior);and the investigation may not stop until all the exit-seeking residents have been accounted for. This inservicing was completed by the Administrator, the Staff Development Coordinator, the Human Resource Manager and Department Heads. The inservice has been communicated by both 1:1 inservicing and reviewing written inservice material on the procedure. As of March 26, 2012 194 of 194 employees have been inserviced on the new procedure (one employee was out of the country until March 26, 2012). The Staff Development Coordinator will be responsible for inservicing this procedure for all new hires during Orientation. This will also be included as part of the annual inservice training employees participate in. This protocol has been integrated into the standard orientation training for all new hires and the annual inservice training for all employees.	

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F 323	Continued From page 7 During an interview on 3/12/12 at 4:10 PM LN #4 stated on 3/2/12 during second shift she saw Resident #2 approximately fifteen minutes prior to receiving the notification that she was found outside the facility. She stated no one knew the resident left the facility. LN #4 stated she did not hear the front door alarm, as she was working on the South unit, when the resident exited the building. On 3/12/12 at 2:57 PM an interview was conducted with the Quality Assurance (QA) nurse. She stated up until a month ago, the SSD was responsible for checking watch mate alarms. QA nurse stated the floor nurses check every shift for the presence of the watch mate bracelet. QA nurse stated she checked weekly that each watch mate bracelet was functioning. She stated each watch mate's battery had an expiration date that she monitored weekly. QA nurse also stated she checked the front door weekly to ensure the watch mate will lock the door and or alarm if the door was open when a resident wearing a watch mate was with in range. QA nurse stated maintenance staff check the front door alarms. QA nurse stated she was not sure how far the front door alarm could be heard when activated. She did not think it alarmed at the nursing stations. On 3/12/12 at 5:10 PM, observations were made of the front door/lobby area. The front door entering the facility was equipped with an alarm system for a watch mate bracelet. The front door led to a small lobby. From the lobby a person had to enter another unalarmed door to access the resident areas. The front door was checked with the Administrator using a watch mate and	F 323	At least monthly, the Staff Development Coordinator, Administrator, Director of Nursing, or the Social Service Director will conduct an unannounced secure door alarm drill. The drill is alternated on different shifts so that all three shifts participate in a quarter. The drill is conducted by sounding the secure door alarm, timing response to the alarm sounding, and ensuring staff responding are following the proper procedures for response to the secure door alarm. Educational feedback is conducted by the staff member conducting the drill and will be provided to all employees who participate in the drill. A sign in sheet will be maintained by the Staff Development Coordinator. Educational feedback will be shared with all employees either through additional inservicing or by posting educational notes at the time clock for review and signature by staff. The results of the drills and any concerns about the drills will be shared by the Administrator at the quarterly QA/QI Committee meeting and recommendations for improvement shared and implemented. This is an on-going audit. The facility conducted a thorough assessment of the secure door alarm system, which included the sound relay system. Two additional secure door alarm sound relays have been installed. As of March 15, 2012, all three Nursing Units now have these sound relays (which indicated the secure door alarm is sounding). In addition, seven (7) sound relay speakers were installed throughout each of the three Nursing Units.	

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F 323	Continued From page 8 noted the front door locked when the watch mate came within 3-6 feet of the door. When the door was already opened and the watch mate came within the same range, a high pitched screeching alarm sounded. On 3/12/12 at 5:15 PM observations were made to determine if the watch mate alarm system was functioning properly and how far the alarm could be heard. The front door alarm could be heard approximately five resident rooms down the North hall. At the nursing station, the alarm was barely audible. There was no additional alarm or light at the North station to alert anyone that the front door alarm was sounding. The Director of Nursing (DON), who was also involved in this observation confirmed that the North unit was supposed to have an alarm that sounded to alert staff the watch mate alarm system on the front door activated. The DON confirmed this alarm was not working. On 3/13/12 at 8:24 AM, the Administrator stated maintenance determined the fuse was not working at the North station which was the only one of three nursing stations equipped with an alarm signaling the front door alarm was activated by a watch mate bracelet. Interview with the maintenance supervisor on 3/13/12 at 8:28 AM revealed he was not responsible for checking the door alarms unless a problem was reported. He further stated that was the QA nurse's responsibility to check to ensure the front door and North unit alarms were functional. The administrator was notified of the Immediate Jeopardy on 3/13/12 at 9:41 AM. The facility provided a credible allegation of compliance on 3/14/12 at 9:48 AM. The following interventions	F 323	This provides additional coverage range of the alarm when the secure door system alarm is sounding. This installation was completed on April 4, 2012. The Quality Assurance Nurse is also responsible for checking the door alarm system and door sound relay systems weekly. These checks are also documented weekly and now include the door sound relay systems from all three Nursing Units. The Quality Assurance Nurse checks the secure front door for proper functioning and then confirms with all three Nursing Units the alarm was heard. This is evidenced by a Nurse from each unit initialing the weekly check log. The Quality Assurance Nurse also conducts weekly, ongoing checks of the door alarm bracelets/ anklets to ensure devices are functional. Weekly documentation of these checks began March 5, 2012 and is ongoing. The sound relays were all checked upon installation on March 15, 2012 and then began being included in the weekly secure door alarm system on March 19, 2012. The Administrator will monitor the weekly checks of the secure door alarm system and the sound relays. This will be done weekly and evidenced by the Administrator's initials on the weekly checklist. This is ongoing. 4. Indicate How the Facility Plans to Monitor Its Performance to Make Sure That Solutions are Sustained and Dates When Corrective Action will be Complete:	

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	345171	A. BUILDING ______ B. WING ______	C 03/14/2012

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F 323	Continued From page 9 were put into place by the facility to remove the Immediate Jeopardy: The Credible Allegation of Compliance: 1. CORRECTIVE ACTION FOR RESIDENT #2 · Resident #2 assisted back into the facility on March 2, 2012. Res was unharmed. · The following interventions were implemented on March 2, 2012: · Resident's alarm device was immediately checked by RN working on the South Unit and the device was operational, secured the front door correctly, and alarm relay sounded on the North Unit. · Resident was placed on 1:1 supervision during hours awake from March 2, 2012 until March 5, 2012. · Inservice for Nursing Assistants and Nurses on the three Nursing units was immediately initiated on March 2, 2012 by RN Unit Coordinator. Title of Inservice: "Front Door Alarm" and presented by RN Unit Coordinator. Content of inservice was to address: door alarms sounding and immediately responding to the door alarm; if door alarm sounding and cannot determine why alarm is sounding, staff should walk outside and do a thorough search. · RN Unit Coordinator completed the inservice on the South Unit and verbally communicated the new inservice to a Nurse on both the North and Skilled Units. The written inservices were given to a Nurse on each Unit by RN Unit Coordinator. The Nurses were then instructed to inservice the Nursing Assistants. The inservice material was then placed in each Unit's inservice books and the Nurses were informed to communicate the inservice to oncoming shifts. The information	F 323	To assure ongoing compliance to F323, the facility's quality assurance plan for monitoring and response to the secure door alarm system includes weekly checks of the door alarm system and sound relays and monthly drills that will evaluate response and following procedure when the secure door alarm is sounding. The results of these audits, as well as any trends and/or are discussed during the daily morning QI meetings (Monday-Friday), as well at the quarterly Quality Assurance/Quality Improvement Committee meetings. Compliance to F 323 is the responsibility of the Administrator. Compliance date for F 323 is April 4, 2012.	4.4.12

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about the resident exiting and being on 1:1 observation was communicated on the 24-hour Nursing Report by RN Unit Coordinator.

· On March 5, 2012, the following interventions were implemented:
· Quality Assurance/Quality Improvement initiated for responding to secure door alarm by Administrator. This entailed development of a new procedure for what to do when responding to a secured door alarm for facility staff. The new procedure involves the person hearing the alarm is responsible for responding to the alarm and then determining why the alarm is sounding. If a determination cannot be made as to why the alarm is sounding, then another staff member or members should be immediately contacted to assist. One staff member shall do a thorough assessment of the outside area of the building while the other staff member(s) contacts each of the Nursing Units to begin an immediate count of the exit-seeking residents (those residents wearing a door alarm bracelet/anklet for exit-seeking behavior). The investigation may not stop until all the exit seeking residents have been accounted for. Staff inservicing for this new procedure was initiated on March 5, 2012. Inservicing completed by the Administrator, the Staff Development Coordinator, the Human Resource Manager and Department Heads. The inservice has been communicated by both 1:1 inservicing and reviewing written inservice material on the procedure. As of March 14th, 173 of 194 employees have been inserviced on the new procedure. The remaining 21 employees will receive inservicing prior to the start of their next shift.
· Sign at lobby door to alert visitors to not

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F 323	Continued From page 11 assist unfamiliar persons outside without first checking with staff was checked by the Administrator and was in place. · Administrator placed additional and larger signage about not assisting unfamiliar persons outside without first checking with staff, as well as what to do if you are a visitor and note the alarm sounding (stay in place until a Staff member arrives) was added to both the front and backside of the swinging lobby door near the front entrance. · On March 6, 2012, the following interventions were implemented: · Social Service Director met with resident's two daughters to discuss resident's safety and possible transfer to a secure unit. · On March 7, 2012, the following interventions were implemented: · Deputy placed "Project Lifesaver" device on resident. · On March 8, 2012, Maintenance Supervisor checked the front door and the door was functioning correctly and the sound relay to the North Unit was operational as noted by the Maintenance Supervisor, NHA, and Receptionist. · On March 9, 2012, Maintenance Supervisor checked the front door and the door was functioning correctly and the sound relay to the North Unit was operational as noted by the Maintenance Supervisor, NHA, and Receptionist. · On March 12, 2012, the front door alarm system was checked by the Administrator and QA Nurse and sounded and locked correctly. The	F 323		

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North Unit sound relay did not sound at this time. The Administrator immediately called Maintenance Supervisor to check the relay. The Administrator monitored the door until corrective action was taken. Upon inspection, the fuse operating the North Unit sound relay was found to have been blown and was immediately replaced. The Administrator verified the North Unit sound relay functioned appropriately after the fuse was replaced.

· On March 13, 2012, the following interventions were implemented:
· Front door alarm system and the North Unit relay were checked in the am by Maintenance Supervisor and were noted to be fully functional.
· Resident was again placed on 1:1 supervision (there had been no further attempts to exit). At approximately 2pm, the resident was transferred to a secure unit at another facility.

2. CORRECTIVE ACTION FOR CURRENT RESIDENTS AT RISK:
· There are no other residents at the facility who are ambulatory and exhibit exit-seeking behaviors. All other residents who are identified as potential exit-seekers locomote via wheelchair. On March 5, 2012 the Quality Assurance Nurse checked and documented the checks of all door alarm bracelets/anklets to ensure devices were functional. The Quality Assurance Nurse is responsible for weekly checks of the door alarm bracelets/anklets and documenting these weekly. The Quality Assurance Nurse is also responsible for checking the door alarm system and documenting this weekly. The North Unit sound relay was fully functional after a blown fuse was replaced by maintenance on March 12, 2012.

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3. INSERVICE

· Inservice initiated on new procedure for what to do when responding to a secured door alarm for facility staff. The new procedure involves the person hearing the alarm is responsible for responding to the alarm and then determining why the alarm is sounding. If a determination cannot be made as to why the alarm is sounding, then another staff member or members should be immediately contacted to assist. One staff member shall do a thorough assessment of the outside area of the building while the other staff member(s) contacts each of the Nursing Units to begin an immediate count of the exit-seeking residents (those residents wearing a door alarm bracelet/anklet for exit-seeking behavior). The investigation may not stop until all the exit seeking residents have been accounted for. Staff inservicing for this new procedure was initiated on March 5, 2012. Inservicing completed by the Administrator, the Staff Development Coordinator, the Human Resource Manager and Department Heads. The inservice has been communicated by both 1:1 inservicing and reviewing written inservice material on the procedure. As of March 14th, 173 of 194 employees have been inserviced on the new procedure. The remaining 21 employees will receive inservicing prior to the start of their next shift. The Staff Development Coordinator will be responsible for inservicing this procedure for all new hires during Orientation.

4. MONITORING:

· Developed new procedure for staff response to door alarm on March 5, 2012. The new

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F 323	Continued From page 14 procedure involves the person hearing the alarm is responsible for responding to the alarm and then determining why the alarm is sounding. If a determination cannot be made as to why the alarm is sounding, then another staff member or members should be immediately contacted to assist. One staff member shall do a thorough assessment of the outside area of the building while the other staff member(s) contacts each of the Nursing Units to begin an immediate count of the exit-seeking residents (those residents wearing a door alarm bracelet/anklet for exit-seeking behavior). The investigation may not stop until all the exit seeking residents have been accounted for. Whomever hears the door alarm is expected to respond immediately to that alarm and follow this procedure. Immediate Jeopardy was removed on 3/14/12 at 3:25 PM. Review of the 24 hour report,used for relaying information shift to shift, revealed Resident #2 was assigned a sitter from 3/2/12 through 3/5/12. Review of facility documentation revealed that each watch mate was being checked weekly for function and battery expiration dates and the front door alarm and North Nursing unit alarms were being checked weekly. All residents identified as having a watch mate were observed with a watch mate in place. Their pictures were located at each nursing station and the placement of the watch mate bracelets were documented in the QA book for safety devices. All facility doors were checked and found to be operational with alarms in working order. Signs were posted in the front door/lobby area instructing visitors not to allow residents out of the facility. Interviews with staff from all three shifts were completed confirming	F 323		

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F 323	Continued From page 15 they had received inservice training on how to respond when they hear the door alarms.	F 323		