STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345471	A. BUILDING _____ B. WING _____	C 03/29/2014

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MECKLENBURG HEALTH & REHABILITATION CENTER	2415 SANDY PORTER ROAD CHARLOTTE, NC 28273

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F 000	INITIAL COMMENTS 483.25 (F323) at J Immediate jeopardy began on 03/19/14 when Resident #5 exited the building and facility property without staff supervision or knowledge. Immediate jeopardy was removed on 03/29/14 at 3:39 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) for Resident #5 to ensure the monitoring of systems put into place are effective and completion of employee education.	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, a review of the medical record and facility records and interviews with the physician and staff, the facility failed to identify, assess, and implement elopement interventions, for a cognitively impaired resident who verbally expressed a desire to leave the facility in 1 of 3 sampled residents reviewed for their risk of elopement. (Resident #5)	F 323	Mecklenburg Health Care Center The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will	4/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/16/2014

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F 323	Continued From page 1 Immediate jeopardy began on 03/19/14 when Resident #5 exited the building and facility property without staff supervision or knowledge. Immediate jeopardy was removed on 03/29/14 at 3:39 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (an isolated deficiency, no actual harm with potential for more than minimal harm that is not immediate jeopardy) for Resident #5 to ensure the monitoring of systems put into place are effective and completion of employee education. The findings included: The facility's policy, "Behavioral Assessment/Behavior Monitoring", effective 09/01/11, recorded in part, "Problematic behavior shall be assessed and monitored. Factors influencing behaviors as well as management interventions shall be evaluated and care planned. Residents shall be observed by staff on all shifts and report any untoward behavior (unusual), that is observed to a licensed nurse. If a resident begins demonstrating unsafe aimless wandering behaviors after the initial admission to the center, utilize the Wandering/Elopement Risk Assessment form and re-evaluate at least quarterly and update care plan accordingly." Resident #5 was admitted to the facility on 03/04/14 from the hospital for rehabilitation services after sustaining a fall with lumbar (back) fracture at home. Diagnoses included lumbar fracture, confused state and mild/moderate dementia. A Wandering/Elopement Risk Assessment dated	F 323	take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F323 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: " On 3/20/2014 Resident # 5 at approximately 12:05 a.m. was reported to be at the hospital. The hospital nurse reported to our facility charge nurse that the Police Department, reported our resident walked to their station and asked for a ride home. The police assisted the resident. They attempted to take him to two different locations. Both of the locations were the incorrect home addresses for the resident. It was at this point the police realized the resident was possibly confused. Emergency Medical Services was called and the resident was transported to the hospital. The resident was evaluated by hospital ED, and it was determined no trauma or injury was experienced by the resident, which was confirmed by facility nurse upon his return. (3/20/14) " The Resident had a wander guard applied on him upon return to the facility and the Director of Nursing did every 30 minute checks from 0700 a.m. to 0600 p.m. on 03/20/2014. (3/20/14) " On 03/21/2014 resident #5 Wandering and Elopement Risk Assessment was	

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F 323	Continued From page 2 03/05/14, completed by nurse #1 documented Resident #5 had dementia, intermittent confusion, ambulated independently with a walker and had no history of wandering/elopement behavior. There were no wandering/elopement interventions documented on this assessment for Resident #5. Instructions for the completion of this risk assessment included "Complete with behavior and cognitive changes. Revise/update the care plan as indicated." A nurse's note by nurse #2 dated 03/06/14 03:39 AM recorded in part, "Was noted to be up wandering in hallway earlier, attempting to use BR (bathroom) in another res (resident's) room and was redirected without incident to his own BR." A clarification nurse's note by nurse #3 from 03/08/14 (3-11 PM shift) dated 03/27/14 4:03 AM recorded in part, "During rounds this resident told this writer he wanted to go home to South Boulevard and requested to speak to his son." The nurse's note further clarified that when asked if he required assistance to contact his son, the Resident informed the nurse that he did not have a son. An admission Minimum Data Set and Care Area Assessment dated 03/11/14 assessed Resident #5 with moderately impaired cognition, without wandering behavior and at risk for increased cognitive decline related to an acute disease process. Resident #5 was not care planned for the risk of wandering/elopement. A nurse's note dated 03/11/14 04:36 PM recorded that Resident #5 was moved on this date to a new room on the same hall.	F 323	re-evaluated to ensure appropriate interventions were in place. (3/21/14) " Power of Attorney for Resident #5 decided to transfer resident #5 to a different facility on 3/28/14 as previously planned. Resident #5 is no longer in the facility. (3/28/14) " All staff was in-serviced on 3/20/2014 for "code orange" including elopement procedures, patient rounding, and responding to alarms. (3/20/14) " On 3/20/14 maintenance director contacted Fire Monitoring Company who performed in house testing of all doors and alarms. All door alarms were found to be properly working with no malfunctions (Note: An event history report of the alarm system showed two alarms were signaled on the facility□s 100 hall. Both were accounted for). (3/20/14) " As a routine practice the Maintenance Director or designee will test door alarms daily. (ongoing) " As a routine practice, Housekeeping will strip and wax hallways in halves to allow passage for walking rounds. How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice: " The Director of Nursing (DON) arrived at the facility on 3/20/14 and verified that all residents were accounted for. (3/20/14) " As a routine practice, visual rounds and cross shift communication will be done by nursing every shift to observe and ensure all residents are accounted	

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F 323	Continued From page 3 A nurse's note by nurse #2 dated 03/12/14 02:29 AM recorded in part, "(Resident) wandering in hallway, confused due to room change. Easily redirected to new room and shown where BR is." A Physician's Admission Medical Care Plan dated 03/12/14 assessed Resident #5 with dementia, unable to initiate conversation, but able to answer yes/no questions. The physician's assessment also documented that Resident #5 possibly needed a closed memory care unit. A nurse's note by nurse #4 dated 03/19/14 10:24 PM recorded in part, "Resident has increased confusion in the evening." Review of the facility's Incident Report and investigation revealed that Resident #5 exited the facility on 03/19/14 between 8:30 - 9:30 PM through the front doors unsupervised by staff. Staff were unaware that Resident #5 was not in the facility until the hospital called the facility at approximately 12:05 AM on 03/20/14. Nurse #2 was notified by the hospital that police called emergency medical services (EMS) after Resident #5 walked to the police station on 03/19/14 at approximately 10:00 PM asking for a ride home. After two failed attempts to take Resident #5 home, the police determined that Resident #5 was confused and called EMS for hospital transport. The hospital reported to nurse #2 that Resident #5 arrived to the hospital on 03/19/14 with no apparent injury and would be transferred back to the facility. Nurse #2 notified the director of nursing (DON) on 03/20/14 at 12:15 AM of the elopement. Additionally, the physician, administrator and Resident's Power of Attorney (PoA) were also notified.	F 323	for. This will be reviewed in Risk Management Meeting on a weekly basis and through quarterly QA as needed. (4/21/14) " On 3/20/2014, under the direction of DON, all current residents with a wander guard in place were assessed for placement. All were in place. All staff was in-serviced on 3/20/2014 for "code orange" including elopement procedures, patient rounding, and responding to alarms. (3/20/14) " On 3/20/14 the maintenance director contacted Fire Monitoring Company who performed in house testing of all doors and alarms. All door alarms were found to be properly working. As a routine practice the Maintenance Director or designee will test door alarms daily. (3/20/14) " On 03/21/2014 all residents in house on this date, Wandering and Elopement Risk Assessments were re-evaluated and revised as needed by the DON and Registered Nurse Minimum Data Set (MDS) Coordinator. (3/21/14) " On 03/27/2014 all residents in house on this date, Wandering and Elopement Risk Assessments were re-evaluated by the DON and Registered Nurse Minimum Data Set (MDS) Coordinator. A facility employee was posted in the front lobby by the door to monitor for any attempts by any resident to exit the facility until all wander-guards were checked and in place. (3/27/14) " 03/27/2014 Initially at 05:00 p.m. every 15 minute visual checks were completed on residents that could be at risk based on Wandering Assessment and	

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F 323	Continued From page 4 Resident #5 was observed in his room on 03/26/14 at 4:53 PM with a wander guard to his left ankle. The Resident stated "I want to go home", but did not recall the events of 03/19/14. On 03/26/14 at 5:00 PM, nurse aide #1 (NA #1) stated in interview that she was accustomed to working with Resident #5 on the 3-11 PM shift, but was off the evening he left the facility. NA #1 described Resident #5 as intermittently confused and independent with ambulation. NA #1 stated Resident #5 routinely walked into the hallway looking for his room or the bathroom and often expressed a desire to go home. NA #1 stated Resident #5 did not have a wander guard and never made any previous attempts to leave the facility. On 03/26/14 at 5:16 PM, the administrator was interviewed and revealed that he received notification from the DON on the morning of 03/20/14 that Resident #5 left the facility unsupervised and without staff knowledge on 03/19/14, walked to the police station and was currently in the hospital for evaluation. The administrator stated he notified the Resident's PoA on 03/20/14 of this incident. The administrator also stated he contacted the police station and was informed that Resident #5 walked up to a police officer in the parking lot of the police station requesting a ride home. Resident #5 was unable to accurately state his address and after two attempts the police determined Resident #5 was confused and called EMS for a hospital transport. On 03/26/14 at 7:27 PM, the maintenance director stated in interview that the front door was	F 323	then at 1100 p.m. an employee was posted at the front door until 2:45 a.m. when all wander-guards were verified to be in place. (3/27/14) " On 3/27/2014 all staff were in-serviced by Director of Nursing, Staff Development Coordinator, Unit Manager and one done by the Regional Vice President of Operations on the following policies and procedures to ensure understanding. New hires will be educated during general orientation. All staff will be in-serviced before returning to work. (3/27/14) 1) Nursing Policy and Procedure #401, Behavioral Assessment/Behavior Monitoring, which states that problematic behavior shall be assessed and monitored. Factors influencing behaviors as well as management interventions shall be evaluated and care planned. Under this policy Residents will be observed by staff on all shifts and immediately report any untoward (untoward meaning unusual behavior) behavior that is observed to a licensed nurse. On 03/28/2014 the facility immediately began in-service on wandering/elopement risk assessment form. Department Heads and Nurse Administration re-in serviced all staff on the Stop and Watch Tool which is utilized by all staff in helping to identify and communicate changes in patients, even subtle changes and communicate those changes to nursing staff immediately so that appropriate interventions can be put in place. (3/28/14) 2) Policy and Procedure #1539,	

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F 323	Continued From page 5 armed with a wander guard system and was locked by staff around 10:00 PM each night. If a resident, who did not have on a wander guard approached the front door, the resident could exit the front door without incident. The maintenance director stated he checked the wander guard system to the front door daily to ensure it functioned and then provided a return demonstration. He further stated he was notified on 03/20/14 that Resident #5 left the facility unsupervised and did not have a wander guard in place at the time of exit. All other exit doors to the outside were observed with egress bars that alarmed when the bars were pushed. The maintenance director stated the exit doors with egress bars were monitored remotely by a security company which documented each time the egress bars were pushed. Review of the report dated 03/19/14 revealed the egress bar was not pushed on the 200 hall where Resident #5 resided. A physician's interview occurred on 03/27/14 at 08:41 AM and revealed that when Resident #5 was assessed on 03/12/14 the physician had concerns that the Resident was at risk for elopement and needed a memory care unit. The physician further stated she did not verbally share this with the facility, but expected staff to review the progress note and follow-up with her recommendation. On 03/27/14 at 09:04 AM, NA #2 stated in interview that she cared for Resident #5 on 03/19/14 during the 3-11 PM shift. NA #2 stated she received Resident #5 in bed at the beginning of the shift and he spent most of the shift in his room. NA #2 stated that around 9:00 PM "out of nowhere" Resident #5 stated he was leaving the	F 323	Safety/Security Systems (Wandering), which states Residents identified as at risk for wandering away from the Center will have the least restrictive monitoring device is in use. This policy gives guidance to initiate safety/security devices as deemed appropriate to minimize the potential for leaving the Center unsupervised. Per this policy complete the appropriate assessments. (3/28/14) 3) Nursing Policy and Procedure #802, Potential Transfer/Discharge Due to Behavior, which states Discharge planning staff, in conjunction with the Administrator and designated nursing staff will evaluate patients who exhibit untoward behaviors. Immediately notify the Administrator, DON or Nursing Supervisor. Proper investigation report will be directed by the Administrator. If there is reason that the patient is a danger to self or others then a review of the medical record with the licensed nurse, CNA and interview with patient/responsible party, to determine what triggers the behavior (i.e. bath time, time of day, room change, loud noise, difficulty hearing/understanding, fear, unfamiliar caregivers, unfamiliar surroundings). (3/28/14) 4) Nursing Policy and Procedure # 1801, Code Orange, which covers the immediate notification of a missing resident, Code Orange will be activated throughout the Center. All established search and recover plans will be initiated in full force to locate and secure the resident as quickly as possible. All staff will be pre-assigned and trained on their duties and responsibilities during this	

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F 323	Continued From page 6 facility. NA #2 further stated the Resident was "determined he was leaving" because he took off his pajamas, dressed himself in pants and a shirt and walked into the hallway. NA #2 informed nurse #4 who was on the hall administering medication of the Resident's behavior. Nurse #4 instructed NA #2 to encourage Resident #5 to put his pajamas back on and to tell the Resident it was night time. NA #2 then reported that she redirected the Resident back to his room, asked him to put his pajamas back on, but he refused. NA #2 informed the nurse that he was in his room, but that he refused to put his pajamas back on. NA #2 then stated she began her rounds around 9:30 PM checking/changing residents. NA #2 stated she did not see Resident #5 for the remainder of her shift which ended 11:00 PM. NA #2 also added that at the end of the shift she was unable to walk down the hall to the room of Resident #5 because the floor was being waxed from one side of the hall to the other. NA #2 stated she did not report off to the oncoming NA because the 11 PM - 7 AM NA assignment had not been completed prior to her leaving shift. On 03/27/14 at 09:22 AM, nurse #2 stated in interview that she cared for Resident #5 on 03/19/14 during the 11 PM - 7 AM shift. Nurse #2 stated that she was familiar with the care Resident #5 required. She described him as confused, easily redirected and independent with ambulation/toileting, but that he did not have a wander guard in place. Nurse #2 stated on 03/11/14 Resident #5 was moved to a new room on the same hall which seemed to cause him increased confusion. Nurse #2 stated after the room change Resident #5 walked to the door of his room or into the hallway and asked staff if he was in the right room, but he never expressed a	F 323	critical event. (3/28/14) 5) Nursing Policy and Procedure #1802, Search and Reporting, in the event a resident is reported missing, all available resources will be utilized to search for and find the resident as quickly as possible. Anyone that suspects or realizes that a resident is missing must notify a licensed nurse and/or the Nursing Supervisor immediately. A Nursing Supervisor on duty must immediately initiate a search of the Center and grounds, and at the same time report to the Administrator, the Director of Nursing and Nurse Consultant that the resident is missing. (3/28/14) " On 3/27/2014 Risk Meeting held consisting of Interdepartmental team members, RN Nurse Consultant, Director of Nursing, Minimum Data Set RN and RN Unit Manager and all in-house resident Wandering Assessments reviewed and updated as needed. (3/28/14) " Wander risk care plans were updated to include appropriate interventions. Pictures of residents at risk for elopement were added as needed to binders at each nurse□s station and secured behind the receptionist desk. All new staff will receive education on this binder during general orientation. (4/21/14) " Housekeeping will strip and wax hallways in halves to allow passage for walking rounds. This will remain in effect with no end date. (ongoing) Measures in place to ensure practices will not occur. " As a routine practice, visual rounds and cross shift communication will be	

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F 323	Continued From page 7 desire to leave the facility. Nurse #2 stated that although she described Resident #5 as "wandering" in her nurse's notes, she did not see this behavior as requiring further interventions to prevent elopement, because Resident #5 was easily redirected. Nurse #2 described the events of 03/19/14 when she came on shift and stated that she did not conduct walking rounds on the hall of Resident #5, because the entire hall was being waxed. Nurse #2 stated that the shift change report did not include specifics about the location of Resident #5 nor a report of any new behavior; she just assumed he was in his room. Nurse #2 began the med pass on an adjacent hall and reached the hall of Resident #5 around midnight, but had not yet visualized him during her shift. As nurse #2 progressed down the hall of Resident #5, she stated that her med pass was interrupted with a phone call from the hospital around 12:05 AM on 03/20/14. She was asked by the hospital if Resident #5 was still a Resident in the facility and then advised that he had been brought to the hospital by EMS transport called by the police. The hospital informed nurse #2 that Resident #5 was in good condition and would be transported back to the facility. Nurse #2 stated it was at that point that staff ran to the room of Resident #5 and noted he was not there. Nurse #2 stated Resident #5 was returned to the facility by EMS shortly after 05:00 AM on 03/20/14. The nurse stated she then completed a head-to-toe skin assessment, with no new findings noted, placed a wander guard on the Resident and contacted the DON. On 03/27/14 at 11:04 AM, nurse #1 was interviewed and revealed she completed the Wandering/Elopement Risk Assessment dated 03/05/14 for Resident #5. During the time of the	F 323	done by nursing every shift to observe and ensure all residents are accounted for. This will be reviewed in Risk Management Meeting on a weekly basis and through quarterly QA as needed. (4/21/14) " As a routine practice the Maintenance director or designee will test door alarms daily and reviewed during Weekly Risk Meeting. (4/21/14) " On 3/27/2014 all staff were in-serviced by Director of Nursing, Staff Development Coordinator, Unit Manager and one done by the Regional Vice President of Operations on the following policies and procedures to ensure understanding. New hires will be educated during general orientation. All staff will be in-serviced before returning to work. (3/27/14) 1) Nursing Policy and Procedure #401, Behavioral Assessment/Behavior Monitoring, which states that problematic behavior shall be assessed and monitored. Factors influencing behaviors as well as management interventions shall be evaluated and care planned. Under this policy Residents will be observed by staff on all shifts and immediately report any untoward (untoward meaning unusual behavior) behavior that is observed to a licensed nurse. On 03/28/2014 the facility immediately began in-service on wandering/elopement risk assessment form. Department Heads and Nurse Administration re-in serviced all staff on the Stop and Watch Tool which is utilized by all staff in helping to identify and	

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F 323	Continued From page 8 assessment, nurse #1 stated she reviewed the Resident's medical record to include the hospital records, but found no indication of wandering/elopement behavior in the Resident's medical record, thus interventions were not warranted. Nurse #1 stated she remembered that Resident #5 had a habit of coming out of his room and asking staff to help him locate the bathroom or his room, but because he was easily redirected, this behavior was not noted as wandering or exit seeking. Nurse #1 stated she was a nurse on duty in the facility on 03/19/14 on the 11 PM - 7 AM shift, but was not assigned to care for Resident #5 and did not see him during her shift. On 03/27/14 at 11:24 AM, the DON stated in interview that on admission staff assess a resident's risk for elopement by asking the resident/family, reviewing hospital records, the FL 2 (level of care screening tool) and making observations of the resident. The DON stated the completion of the Wandering/Elopement Risk Assessment was usually completed by the charge nurse or the 11 PM - 7 AM nurse. The DON stated that she spoke to the PoA when Resident #5 was admitted, but no history of wandering/elopement behavior was indicated. The DON further stated that she expected a wander guard to be implemented if there was a history of exit seeking behavior or if a resident expressed a desire to leave the facility. The DON further clarified that if the expressed desire to leave the facility was easily redirected, she would not expect the intervention of a wander guard in all cases, but would expect this intervention if the resident continued to express a desire to leave regardless of whether or not the behavior was easily redirected. The DON stated she would	F 323	communicate changes in patients, even subtle changes and communicate those changes to nursing staff immediately so that appropriate interventions can be put in place. (3/28/14) 2) Policy and Procedure #1539, Safety/Security Systems (Wandering), which states Residents identified as at risk for wandering away from the Center will have the least restrictive monitoring device is in use. This policy gives guidance to initiate safety/security devices as deemed appropriate to minimize the potential for leaving the Center unsupervised. Per this policy complete the appropriate assessments. (3/28/14) 3) Nursing Policy and Procedure #802, Potential Transfer/Discharge Due to Behavior, which states Discharge planning staff, in conjunction with the Administrator and designated nursing staff will evaluate patients who exhibit untoward behaviors. Immediately notify the Administrator, DON or Nursing Supervisor. Proper investigation report will be directed by the Administrator. If there is reason that the patient is a danger to self or others then a review of the medical record with the licensed nurse, CNA and interview with patient/responsible party, to determine what triggers the behavior (i.e. bath time, time of day, room change, loud noise, difficulty hearing/understanding, fear, unfamiliar caregivers, unfamiliar surroundings). (3/28/14) 4) Nursing Policy and Procedure # 1801, Code Orange, which covers the immediate notification of a missing resident, Code Orange will be activated	

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F 323	Continued From page 9 expect monitoring on regular rounds for all residents and especially those at risk for wandering/elopement. The DON further revealed that she expected the physician to provide nursing staff with verbal instruction regarding recommendations from their assessments, hand write orders or enter the new order into the computer. The DON also stated that nursing staff should review the physician's progress notes, but recommendations and physician orders should be expressed verbally to staff. The DON reviewed the 03/12/14 physician's progress note regarding the recommendation of a memory care unit for Resident #5 and stated the charge nurse should have reviewed this and brought it to the attention of nurse administration for further evaluation of placement. On 03/27/14 at 11:56 AM, nurse #4 stated in interview that she typically worked with Resident #5 on the 3-11 PM shift. She described Resident #5 as confused, but cooperative. Nurse #4 stated that almost every night he approached the nurse's station around 9:00 PM or 10:00 PM confused, looking for his room, car keys, or the bathroom. Nurse #4 stated this confused behavior increased when Resident #5 was moved to a new room on the same hall. The nurse stated his behavior was easily redirected and not assessed as wandering or exit seeking. The nurse stated that on the evening of 03/19/14, Resident #5 was in his room when she came on shift at 3:00 PM and stayed in his room most of the shift. Nurse #4 stated that around 9:05 PM on 03/19/14, Resident #5 walked from his room to the nurse's desk wearing pajamas and confused about the location of his room; she redirected him to his room, administered medication to him and continued her med pass. Around 9:30 PM on	F 323	throughout the Center. All established search and recover plans will be initiated in full force to locate and secure the resident as quickly as possible. All staff will be pre-assigned and trained on their duties and responsibilities during this critical event. (3/28/14) 5) Nursing Policy and Procedure #1802, Search and Reporting, in the event a resident is reported missing, all available resources will be utilized to search for and find the resident as quickly as possible. Anyone that suspects or realizes that a resident is missing must notify a licensed nurse and/or the Nursing Supervisor immediately. A Nursing Supervisor on duty must immediately initiate a search of the Center and grounds, and at the same time report to the Administrator, the Director of Nursing and Nurse Consultant that the resident is missing. (3/28/14) " Pictures of residents at risk for elopement were added as needed to binders at each nurse□s station and secured behind the receptionist desk. (3/28/14) All new staff will receive education on this binder during general orientation. (ongoing) " Housekeeping will strip and wax hallways in halves to allow passage for walking rounds. This will remain in effect with no end date. (ongoing) How the facility plans to monitor and ensure correction is achieved and sustained. The Administrator/Director of Nursing will present the results of daily and weekly audits to the QA Committee quarterly for a	

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F 323	Continued From page 10 03/19/14, the nurse stated she saw Resident #5 in his room fully dressed, no longer wearing pajamas, but wearing pants, a shirt and shoes and asked NA #2 to encourage Resident #5 to put his pajamas back on. The nurse stated she then went into a supervisor's office, closed the door and began to complete her nurse charting. Nurse #4 then stated that NA #2 told her that Resident #5 was in his room, but refused to put his pajamas back on and she told the NA "okay." Nurse #4 stated she remained in the supervisor's office until she gave report to the oncoming nurse at 11:00 PM. Nurse #4 stated she could not account for the location of Resident #5 after about 9:30 PM on 03/19/14 because she did not conduct walking rounds at the end of shift since the floor was being waxed. Nurse #4 further stated that she was not aware that Resident #5 verbally expressed that he was leaving the facility, but when it was reported to her that Resident #5 refused to put back on his pajamas, she should have gone in to talk to him. The nurse stated she did not because "we see this behavior all the time." Nurse #4 stated Resident #5 did not have a wander guard in place, nor did she assess his change in behavior when she noticed him in his room fully dressed. On 03/27/14 at 12:10 PM, nurse #5 was interviewed and revealed that she cared for Resident #5 on the 7 AM - 3 PM shift. She described Resident #5 as confused, pretty quiet, easily redirected and without a wander guard. Nurse #5 stated that when the physician assessed one of her resident's she reviewed the medical record for any new orders, but did not always review the progress note for recommendations. Nurse #5 reviewed the physician's progress note of 03/12/14 for	F 323	period of at least two quarters for review of continued compliance/revision to plan if needed.	

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Resident #5 and stated she remembered reviewing the progress note previously, but did not notice the physician's recommendation for placement in a memory care unit. Nurse #5 stated had she noticed that comment, she would have recommended a wander guard for Resident #5 and communicated it to her supervisor for consideration of placement.

On 03/27/14 at 1:46 PM, floor technician #1 was interviewed and stated that he came to work about 9:00 PM on 03/19/14, gathered supplies and began waxing sections of the floor on the 200 hall about 10:30 PM. Floor technician #1 stated he did not see Resident #5 in his room while waxing the floor.

On 03/27/14 at 4:30 PM an observation of the police station revealed it was approximately 0.8 miles away from the facility and across from a 7 lane, 4-way intersection, with a speed limit of 45 miles per hour.

The facility's Administrator, Director of Nursing, Nurse Consultant and Vice President of Clinical Operations were notified of Immediate Jeopardy on 03/27/14 at 4:55 PM for Resident #5. The facility provided a credible allegation of compliance on 03/29/14 at 3:39 PM. The following interventions were put into place by the facility to remove the Immediate Jeopardy.

Credible Allegation of Compliance:
This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations

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constitutes the center's allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated.

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

· On 3/20/2014 Resident # 5 at approximately 12:05 a.m. was reported to be at the hospital. The hospital nurse reported to our facility charge nurse that the Police Department, reported our resident walked to their station and asked for a ride home. The police assisted the resident. They attempted to take him to two different locations. Both of the locations were the incorrect home addresses for the resident. It was at this point the police realized the resident was possibly confused. Emergency Medical Services was called and the resident was transported to the hospital. The resident was evaluated by hospital ED, and it was determined no trauma or injury was experienced by the resident, which was confirmed by facility nurse upon his return.

· Power of Attorney for Resident #5 decided to transfer resident #5 to a different facility on 3/28/14 as previously planned. Resident #5 is no longer in the facility.

· The Resident had a wander guard applied on him upon return to the facility and the Director of Nursing did every 30 minute checks from 0700 a.m. to 0600 p.m. on 03/20/2014.

· On 03/21/2014 resident #5 Wandering and Elopement Risk Assessment was re-evaluated to ensure appropriate interventions were in place.

· All staff was in-serviced on 3/20/2014 for "code orange" including elopement procedures, patient rounding, and responding to alarms.

· On 3/20/14 maintenance director contacted Fire Monitoring Company who performed in

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house testing of all doors and alarms. All door alarms were found to be properly working with no malfunctions (Note: An event history report of the alarm system showed two alarms were signaled on the facility ' s 100 hall. Both were accounted for). As a routine practice the Maintenance directors or designee will test door alarms daily.
· As a routine practice, Housekeeping will strip and wax hallways in halves to allow passage for walking rounds.

How corrective action will be accomplished for those resident having potential to be affected by the same deficient practice:
· The Director of Nursing (DON) arrived at the facility on 3/20/14 and verified that all residents were accounted for.
· As a routine practice, visual rounds and cross shift communication will be done by nursing every shift to observe and ensure all residents are accounted for. This will be reviewed in Risk Management Meeting on a weekly basis and through quarterly QA as needed.
· On 3/20/2014, under the direction of DON, all current residents with a wander guard in place were assessed for placement. All were in place. All staff was in-serviced on 3/20/2014 for "code orange" including elopement procedures, patient rounding, and responding to alarms.
· On 3/20/14 the maintenance director contacted Fire Monitoring Company who performed in house testing of all doors and alarms. All door alarms were found to be properly working. As a routine practice the Maintenance director or designee will test door alarms daily.
· On 03/21/2014 all residents in house on this date, Wandering and Elopement Risk Assessments were re-evaluated and revised as needed by the DON and Registered Nurse

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F 323	Continued From page 14 Minimum Data Set (MDS) Coordinator. · On 03/27/2014 all residents in house on this date, Wandering and Elopement Risk Assessments were re-evaluated by the DON and Registered Nurse Minimum Data Set (MDS) Coordinator. A facility employee was posted in the front lobby by the door to monitor for any attempts by any resident to exit the facility until all wander-guards were checked and in place. · 03/27/2014 Initially at 05:00 p.m. every 15 minute visual checks were completed on residents that could be at risk based on Wandering Assessment and then at 1100 p.m. an employee was posted at the front door until 2:45 a.m. when all wander-guards were verified to be in place. · On 3/27/2014 all staff were in-serviced by Director of Nursing, Staff Development Coordinator, Unit Manager and one done by the Regional Vice President of Operations on the following policies and procedures to ensure understanding. New hires will be educated during general orientation. All staff will be in-serviced before returning to work. 1) Nursing Policy and Procedure #401, Behavioral Assessment/Behavior Monitoring, which states that problematic behavior shall be assessed and monitored. Factors influencing behaviors as well as management interventions shall be evaluated and care planned. Under this policy Residents will be observed by staff on all shifts and during visual rounds every shift. Staff will immediately report any untoward (untoward meaning unusual behavior) behavior that is observed to a licensed nurse. Department Heads and Nurse Administration immediately re-in serviced all staff on 03/28/14 on the Stop and Watch Tool which is utilized by all staff in helping to identify and communicate changes in patients	F 323		

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to the licensed nurse, even subtle changes, and communicate those changes to nursing staff immediately so that appropriate interventions can be put in place. On 03/28/2014 the facility also began in-service for all staff on wandering/elopement risk assessment form which specifies the behavior of residents at risk for elopement. The form provides the licensed nurse with multiple interventions for residents at risk of elopement including the use of wander guards, frequent monitoring, use of diversion, among others.

2) Policy and Procedure #1539, Safety/Security Systems (Wandering), which states Residents identified as at risk for wandering away from the Center will have the least restrictive monitoring device is in use. This policy gives guidance to initiate safety/security devices as deemed appropriate to minimize the potential for leaving the Center unsupervised. Per this policy complete the appropriate assessments.

3) Nursing Policy and Procedure #802, Potential Transfer/Discharge Due to Behavior, which states Discharge planning staff, in conjunction with the Administrator and designated nursing staff will evaluate patients who exhibit untoward behaviors. Immediately notify the Administrator, DON or Nursing Supervisor. Proper investigation report will be directed by the Administrator. If there is reason that the patient is a danger to self or others then a review of the medical record with the licensed nurse, CNA and interview with patient/responsible party, to determine what triggers the behavior (i.e. bath time, time of day, room change, loud noise, difficulty hearing/understanding, fear, unfamiliar caregivers, unfamiliar surroundings).

4) Nursing Policy and Procedure # 1801, Code Orange, which covers the immediate notification

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of a missing resident, Code Orange will be activated throughout the Center. All established search and recover plans will be initiated in full force to locate and secure the resident as quickly as possible. All staff will be pre-assigned and trained on their duties and responsibilities during this critical event.

5) Nursing Policy and Procedure #1802, Search and Reporting, in the event a resident is reported missing, all available resources will be utilized to search for and find the resident as quickly as possible. Anyone that suspects or realizes that a resident is missing must notify a licensed nurse and/or the Nursing Supervisor immediately. A Nursing Supervisor on duty must immediately initiate a search of the Center and grounds, and at the same time report to the Administrator, the Director of Nursing and Nurse Consultant that the resident is missing.

· On 3/27/2014 Risk Meeting held consisting of Interdepartmental team members, RN Nurse Consultant, Director of Nursing, Minimum Data Set RN and RN Unit Manager and all in-house resident Wandering Assessments reviewed and updated as needed.

· Wander risk care plans were updated to include appropriate interventions. Pictures of residents at risk for elopement were added as needed to binders at each nurse ' s station and secured behind the receptionist desk. All new staff will receive education on this binder during general orientation.

· Housekeeping will strip and wax hallways in halves to allow passage for walking rounds. This will remain in effect with no end date.

· On March 29, 2014, Director of Nursing contacted Medical Director and attending physician and instructed that orders, recommendations and progress notes be flagged

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F 323	Continued From page 17 so that nurses can address orders, recommendations or progress notes as needed. Immediate jeopardy was removed on 03/29/14 at 3:39 PM when interviews with nursing staff revealed they were in-serviced to conduct visual walking rounds each shift. Additionally, interviews with nurses revealed they were in-serviced to immediately re-evaluate and assess a resident with changes in behavior consistent with an increased risk for wandering/elopement and to immediately implement interventions as needed. Interviews with nurses also revealed they were in-serviced to review/process any flagged physician progress notes with orders/recommendations. Interviews with nurse aides and housekeeping staff revealed they were in-serviced on how to recognize even subtle changes in behavior that would place a resident at increased risk for wandering/elopement and to immediately report this behavior to a nurse. These interviews also revealed they were in-serviced on the use of the facility's Stop and Watch tool for documenting changes in behavior and reporting this behavior to a nurse.	F 323		