STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 11/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		12/1/15
	This REQUIREMENT is not met as evidenced by: Based on record review and staff, physician, and nurse practitioner interviews, the facility failed to revise the care plan of 1 of 1 sampled cognitively impaired residents (Resident #1), after the resident made a known attempt to leave the building which resulted in placing the resident at risk to continue unsafe exit seeking behavior. The findings included: Resident #1 was admitted to the facility on 5/09/15 from the hospital with diagnoses including cerebrovascular disease, high blood pressure, heart disease, dementia, insomnia, psychosocial behavior problems, psychosis,		F 280 Sanford Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 11/14/15. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/04/2015

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 280

Continued From page 1

unsteady gait, and history of epilepsy.
Review of the resident ' s quarterly care plan dated 8/09/15 addressed the problem of " resident wanders throughout the building/attempts to exit the building and/or is an elopement risk. " The goals stated for this problem were: 1. Resident will remain safe (inside the building except for designated areas outside with staff) & remain free of injuries and 2. Will not present with any episodes of elopement daily over the next review. The interventions listed for this problem included:

1. " Redirect resident as needed. "
2. " Approach resident in calm manner and explain risk if trying to exit. "
3. " MD (medical doctor) & psychological evaluation as needed. "
4. " Monitor for changes in resident mood, behaviors, confusion, etc. (etcetera) and consult with MD (medical doctor) as needed. "
5. " Social Services to evaluate resident. "
6. " Monitor resident for behaviors (attempts at elopement, wandering, etc.) every shift. Record any incidents of elopement in nurse notes. Notify physician of any increased moods or behaviors. "

The quarterly Minimum Data Set (MDS) dated 8/24/15 indicated Resident #1 was severely cognitively impaired and exhibited behavioral symptoms occurring 1 to 3 days of physical and verbal behaviors directed toward others and other behavioral symptoms not directed toward others. The assessment also indicated the resident needed extensive assistance of two person for dressing, hygiene, and transfer and extensive assistance of one person for locomotion. The resident was assessed as ambulatory but balance not steady and only able to stabilize with human assistance. The resident was assessed

F 280

executed to ensure continuing compliance with Federal and State regulatory law.

Corrective Action For Residents Found To Be Affected

The Comprehensive Care Plan for Resident #1 was reviewed by the Social Worker on 11/10/15 and was updated to reflect placement of the Wander Guard bracelet and the placement of the resident in the Wander Guard Unit.

Corrective Action For Residents With The Potential To Be Affected

A one hundred percent chart audit was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers on 11/9/15- 11/13/15 of all residents to determine which residents are identified to be at potential risk for elopement/wandering. All residents that have been identified to be to be at risk for wandering or elopement had their Care Plan reviewed for appropriate interventions by the Care Plan Team 11/9/15 to 11/13/15 and the care plans were updated as necessary.

Measures Put Into Place Or Systemic Changes Made

The Care Plan Team for Resident #1, the Administrative Nursing Team, and the Administrator were in-serviced by the Director of Clinical Services on 11/13/15 regarding how to properly document on the care plan for new onsets of conditions

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F 280	Continued From page 2 to require a wheelchair for safe mobility. The resident was not coded for wandering behavior on the MDS. Nursing Note dated 10/26/15 at 2:27 AM read: " Resident (#1) is up out of bed and room heading toward the exit door on 200 hall, states he is going out to find his brother so they can work on the car. When attempts were made by staff to redirect him back toward his room and away from the exit, he became hostile, threatening, swinging at the staff. He was able to get the door open but was not able to leave the building. Refusing all attempts to return to room or to sit down in w/c (wheelchair) in hall. Med. (medicated) with prn (as needed) Haldol 2.5mg (milligram) and after about 30 minutes he allowed staff to assist him into w/c and stayed within view of staff. " This note was signed by Nurse #1. In an interview on 11/13/15 at 12:25 PM with Nurse #1, who worked with the resident regularly, she acknowledged she was present on 10/26/15 at 2:27 AM when Resident #1 attempted to exit the facility unattended by staff. She stated she was familiar with the residents ' unpredictable behaviors which included aggression toward staff and wandering throughout the facility. Nurse #1 stated that on 10/26/15 it took three staff members to keep Resident # 1 from going out the 200 hall fire door which he had pulled partially open before staff got to him. She stated " he was very confused which was not uncommon for him. He kept stating he wanted to go outside and work on the car. " Nurse #1 noted the residents ' mood and behaviors could change quickly without warning. She further stated the facility administrator and Director of Nursing (DON) had been informed of the attempted elopement on 10/26/15. She did not recall any new interventions being put into place after Resident	F 280	or discontinuing interventions and problems as issues are resolved. Monitoring The Care Plan Team will review two Care Plans weekly for four weeks and eight Care Plans monthly for two more months to ensure the Care Plans are updated with interventions to address new onsets of conditions or discontinuing interventions and problems as issues are resolved. The Director of Nursing will present the results of those reviews to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations.	

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F 280	Continued From page 3	F 280		

#1 attempted to leave the facility on 10/26/15.
In a telephone interview on 11/14/15 at 11:37 AM with Unit Supervisor #1 it was revealed she had been informed by Nurse #1 of Resident #1 ' s attempt to leave the building on 10/26/15 at 2:27 AM. She stated she was called by Nurse #1 who was Resident #1 ' s primary care nurse at around 3:00 AM on 10/26/15 who reported the incident to her. Supervisor # 1 stated she reported the attempted exit from the facility to the Director of Nursing (DON) who gave her no new instructions. She stated the resident ' s care plan was not updated after the elopement attempt. Supervisor #1 stated Resident #1 had demonstrated wandering, anxiety, agitation, and refusal of care since his admission. She stated his behaviors had improved at times with ongoing medication changes but she continued to view him as unpredictable in his behaviors and not easily redirected by staff.
In an interview on 11/14/15 at 10:40 AM with the DON it was revealed she was called by Nurse #1 on 10/26/15 at around 3:00 AM with a report that Resident #1 had opened the 200 Hall exit door and attempted to leave the building unattended. She stated she instructed the staff to administer 2.5mg (milligrams) of Haldol (an antipsychotic). The DON stated she called the administrator, the RP and the resident ' s primary physician and no new orders were given. She further stated that Nurse #1 reported to her that about 30 minutes after the administration of the Haldol, the resident was calm enough to allow staff to return him to his room in his wheelchair. The DON stated she was involved in discussions concerning the resident ' s ongoing safety from wandering or exiting the building but no care interventions were put into place after the 10/26/15 incident. In further interview, the DON stated Resident #1

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F 280	Continued From page 4 had been care planned for wandering and attempts to exit the building after the 5/19/15 admission assessment. She stated " once the resident was seen by psychiatry and medication was begun his behaviors improved. I did not see documentation in the Nursing Notes or hear discussion in the Interdisciplinary Team meetings to indicate he was showing exit seeking behaviors. " Interview at 10:15 AM on 11/13/15 with facility administrator revealed he had been informed by the DON on 10/26/15 at around 3:00 of Resident #1 ' s attempt to exit the facility on 10/26/15 at 2:27 AM. He was asked to read the nursing note describing the exit attempt on 10/26/15 which was written by Nurse #1. His response to the note was that he did not consider Resident #1 to require additional care plan updates in order to keep him safe from future attempts at exiting the facility. The administrator stated he was in contact with the resident ' s primary care physician and the geriatric specialty Nurse Practitioner who was treating the resident for his moods and behaviors. He stated he felt the resident ' s behavioral medications were effectively controlling his behaviors and additional care plan interventions were not required. He further stated " normally the resident does not attempt to leave the building. " In an interview on 11/13/15 at 12:25 PM restorative aide #1 stated she was not present during the residents attempted exit from the facility on 10/26/15 at 2:25 AM. She stated she had heard about the exit attempt from Nurse #1 the following day on/10/27/15. She stated she and Nurse #1 tried to watch the resident more closely after the incident but no care plan changes were made and no specific orders were given by the facility administration concerning	F 280		

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F 280	Continued From page 5 more frequent monitoring. She stated the resident remained in the same room (203) after the incident on the 200 hall which was not far from the 200 hall exit door. In an interview on 11/13/15 at 1:55 PM with Social Worker #1 and Social Worker #2 it was revealed they were responsible for updating sections C (cognition), D (Mood), and E (Behavior) in the MDS. Both social workers acknowledged they had read the nursing note describing Resident #1 ' s attempt to exit the facility on 10/26/15 at 2:27 AM. They further stated they had discussed the incident with the Interdisciplinary Team including the administrator, DON, nursing supervisors, MDS nurse, and Physician. Both Social Worker #1 and Social Worker #2 stated the consensus of the Interdisciplinary team was that Resident #1 ' s care plan did not require updates to insure his safety from exiting the facility. When asked why they did not update Resident #1 ' s Wandering status on section E of the MDS after his attempt to exit the facility on 10/26/15 at 2:27 AM Social Worker #1 stated " that was up to (the Administrator). When asked if that was part of their responsibility (updating sections C, D, and E of the MDS when required) they stated yes. When asked if the MDS had been updated to reflect Resident #1 ' s wandering attempt on 10/26/15 they stated no. In a telephone interview on 11/14/15 at 12:05 PM with the Geriatric Psychiatry Nurse Practitioner (NP #1) who worked directly with Resident #1 to assist in treatment of his behaviors it was revealed she had treated the resident on a regular basis since shortly after his admission to the facility. She stated she was in contact with the facility during Resident #1 ' s early days of admission and after evaluation she and the psychiatric physician had determined the facility	F 280		

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F 280	Continued From page 6 was capable of caring for the resident and at no risk to other residents. She stated she had been informed of Resident #1 ' s attempt to leave the building on 10/26/15. She stated that after his attempt to leave the building on 10/26/15 she had been under the impression the staff had increased monitoring of the resident ' s location. She further stated she felt increased monitoring was sufficient to maintain the resident ' s safety. She stated she felt medication changes that had been implemented over the past months had been sufficient to control Resident #1 ' s behaviors. NA #1 further stated that over the past 5 months the resident had stabilized with his behaviors and had not exhibited any exit seeking behaviors until the incident on 10/26/15. In a telephone interview on 11/14/15 at 1:27 PM with Resident #1 ' s physician stated he was aware of the resident ' s attempt to leave the building on 10/26/15 and did not recall considering the resident to be a safety or flight risk. He stated " if I had thought the resident needed further interventions to insure his safety I would have written orders for them. " The physician did not recall any concerns with Resident #1 ' s safety or risk of wandering. He stated " I don ' t remember what I did concerning these incidents. " The MD stated " if I had considered sending him to the hospital to be evaluated for behavior and medication management, I would have written an order. "	F 280		
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	F 323		12/1/15

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F 323 Continued From page 7
prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff, physician, and Nurse Practitioner interviews, the facility failed to prevent 1 of 1 sampled cognitively impaired residents (Resident #1), reviewed for wandering behaviors from exiting the facility while unsupervised.
The immediate jeopardy began on 11/07/15 when Resident #1 exited the facility unattended by the facility staff, and was found beside the facility building about 10 feet from a fire exit door. The immediate Jeopardy was removed on 11/14/15 at 3:30 PM when the facility provided an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy (s/s of D). At the time the Immediate Jeopardy (IJ) was removed, the facility was in the process of full implementation and monitoring of the acceptable Credible Allegation (CA). Resident #1 was monitored and evaluated to be safe from exiting the facility while residing in the facility ' s Secured Unit.
The findings included:
Resident #1 was admitted to the facility on 5/09/15 from the hospital with diagnoses including cerebrovascular disease, high blood pressure, heart disease, dementia, insomnia, psychosocial behavior problems, psychosis, unsteady gait, and history of epilepsy.
Review of the resident's quarterly care plan dated 8/09/15 addressed the problem of " resident

F 323

F323

Sanford Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 11/14/15. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.

Corrective action which will be accomplished for those residents found to be affected by the deficient practice:
The resident #1 was put on 15 minute checks/ 24 hours a day immediately upon return into facility on 11/7/15. Resident #1 was placed on one on one observation on 11/9/15 until 8:00 pm at which point a bed was made available in the Wander Guard unit. Wander Guard bracelet was applied to left ankle on 11/9/15 at 8:00pm and checked for sound working order. The Care Plan was updated by Social Worker on 11/10/15 to reflect placement of the Wander Guard bracelet and placement in the Wander Guard Unit.

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F 323	Continued From page 8 wanders throughout the building/attempts to exit the building and/or is an elopement risk. " The goals stated for this problem were: 1. Resident will remain safe (inside the building except for designated areas outside with staff) & remain free of injuries and 2. Will not present with any episodes of elopement daily over the next review. The interventions listed for this problem included: 1. " Redirect resident as needed. " 2. " Approach resident in calm manner and explain risk if trying to exit. " 3. " MD (medical doctor) & psychological evaluation as needed. " 4. " Monitor for changes in resident mood, behaviors, confusion, etc. (etcetera) and consult with MD (medical doctor) as needed. " 5. " Social Services to evaluate resident. " 6. " Monitor resident for behaviors (attempts at elopement, wandering, etc.) every shift. Record any incidents of elopement in nurse notes. Notify physician of any increased moods or behaviors. " The quarterly Minimum Data Set (MDS) dated 8/24/15 indicated Resident #1 was severely cognitively impaired and exhibited behavioral symptoms occurring 1 to 3 days of physical and verbal behaviors directed toward others and other behavioral symptoms not directed toward others. The assessment also indicated the resident needed extensive assistance of two person for dressing, hygiene, and transfer and extensive assistance of one person for locomotion. The resident was assessed as ambulatory but balance not steady and only able to stabilize with human assistance. The resident was assessed to require a wheelchair for safe mobility. The resident was not coded for wandering behavior on the MDS. Nursing Note dated 10/26/15 at 2:27 AM read: "	F 323	An audit of each door leading to outside the facility was completed on 11/7/15 by the Director of Nursing to determine if the door is alarmed and if the alarm is in working order. An alarm log was developed by the Administrator on 11/7/15 to be filled out daily by Administrator or Designee to document working order of all working alarms. All facility staff regardless position or title (including licensed staff and nursing assistants) were in-serviced by Director of Nursing and/or Administrative nursing team regarding all staff members are responsible for responding to any alarm sounding in the facility and going outside to check facility grounds when responding to a door alarm on 11/7/15 through 11/13/15. Any facility staffs that were not in serviced on these dates will not be allowed to work until the in-service is completed. Staff member who turned off alarm was in serviced on 11/7/15 regarding thorough checking of surrounding area and outside when they identify a door alarm sounding. How the facility will identify other residents having the potential to be affected by the same deficient practice: A one hundred percent head count was completed on all residents on 11/7/15 by the Weekend Nurse Manager. A one hundred percent chart audit was completed by the Director of Nursing, Assistant Director of Nursing, and Unit	

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F 323	Continued From page 9 Resident (#1) is up out of bed and room heading toward the exit door on 200 hall, states he is going out to find his brother so they can work on the car. When attempts were made by staff to redirect him back toward his room and away from the exit, he became hostile, threatening, swinging at the staff. He was able to get the door open but was not able to leave the building. Refusing all attempts to return to room or to sit down in w/c (wheelchair) in hall. Med. (medicated) with prn (as needed) Haldol 2.5mg (milligram) and after about 30 minutes he allowed staff to assist him into w/c and stayed within view of staff. " This note was signed by Nurse #1. Resident Incident Report for Resident #1 dated 11/07/15 at 2:30 PM stated " resident found outside - back of building, stated he was going to his truck which he had parked out back. " Vital signs were documented: temp (temperature) 97.6, pulse 76, resp. (respirations) 20, B/P (blood pressure) 132/76, pain denied. Vital signs documented were stable. The report indicated the resident ' s Responsible Party (RP) was present and notified at 2:32 PM and the resident's primary physician was notified at 4:00 PM of the incident. The Incident report documented " none apparent " beside the section labeled Type of Injury. The report included an Immediate Post-Incident Action of " keep personal alarm in place/functioning/audible/every 15 minute checks. " The Incident Report documented immediate action as " assessed for injury and assisted back to room. " Nursing Note dated 11/07/15 at 4:56 PM read: " At 2:30 PM - When coming from 300 hall, (Resident #1 ' s family member) asked where her (family member) was as he is not in his room- checked bathroom, therapy room and the dining room where activities were going on - without	F 323	Managers on 11/9/15- 11/13/15 of all residents to determine which residents are identified to be at potential risk for elopement/wandering. All residents that were identified to be at potential risk for wandering/elopements chart were reviewed to identify the need for potential placement in secure/ wandergaurd area. No other residents not already located in Wander Guard hall were identified in requiring the secure/ wander guard area. All facility doors were also checked for properly sounding door alarms by the Administrator for functionality. All doors were functioning properly. All staff in-service was started on 11/7/15 through 11/13/15 by the Nursing Administration regarding elopement policy and procedure, missing resident policy and procedure, policy and procedure on responding and assessing area around door alarms. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The Licensed Nurses will continue to document on the Medication Administration Record/ Treatment Administration Record on each shift on each resident with a wander guard bracelet checking placement and function of the wander guard bracelet. Elopement drills will be completed daily by the ADON/Staff Development Coordinator	

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F 323	Continued From page 10 success - at this time (family member) mentioned hearing an alarm when she came in- while heading outside, housekeeping staff notified us the resident was at the back of the building, where we went immediately - resident stated he went out the end door (201) to go check on his truck - which he stated he had parked at the back of the building - only had on a t-shirt and adult briefs - no injuries noted - assisted back into the building and to his room without incident. " Note was signed by Nurse #1 Review of Resident #1's facility timeline dated 11/13/15 revealed on Saturday, 11/07/15 around 2:00 PM the resident was seen by Nurse #1 sitting in his room on the side of his bed in no acute distress. The next observation of the resident was made by Housekeeper #1 at around 2:30. She stated she observed the resident standing outside the facility about 10 feet from the 200 Hall exit door at that time. Housekeeper #1 stated she left the resident alone outside for about 3 to 4 minutes (her estimate) to go back into the building and get help. Restorative Aide #1 reported that Housekeeper #1 stopped her in the 200 hall at about 2:30 and asked her to come with her to help get Resident #1 back inside. Housekeeper #1 left Restorative aid #1 with the resident while she went back into the facility to find a nurse. Housekeeper #1 estimated it took her about 3 minutes to find Nurse #1 at the nursing station on the 200 hall. Nurse #1 stated she and the resident ' s family member (who stated to Nurse #1 that she had been looking for the resident for about 15 minutes) immediately went out the 200 hall exit door and assisted the resident back into the building in a wheelchair. Nurse #1 stated the resident was back inside the facility in his room with his family member at his side by 2:50 PM. The Resident Incident Report	F 323	for/Nursing Administration for 2 weeks, weekly for 2 weeks and monthly for 2 months via different shifts. Drills will cover responding to alarms and searching for a missing resident. All Door alarms will continue to be checked daily for 2 weeks, weekly for 2 weeks, monthly for 2 months by the Administrator or Designee for proper working status. A list of residents identified to be at risk for elopement utilizing the Elopement Risk Identification Decision Tree continues to be placed at the front of each Elopement book by Social Services to alert the staff nurses as to which residents are at risk/ care planned for risk for elopement. The Social Services Dept. will be responsible for updating and replacing the list and updating the Care Plans and notifying Unit Managers to update Care Cards as changes occur. (This system has been in place for approximately one year.) Elopement Book A elopement risk notebook is kept at each nursing station and front desk with names and pictures of each resident that has been identified to be at risk for elopement. The notebook is updated as admissions occur and a resident has been newly identified as a elopement risk per the Elopement Risk Identification Decision Tree which is completed by the Social Worker. All facility staff has been trained on hire to	

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for this incident is dated 11/07/15 at 2:30 PM.
An interview was conducted on 11/13/15 at 12:00 PM with Housekeeper #1 who found Resident #1 outside the facility on 11/07/15. Housekeeper #1 stated in her estimation at around 2:30 PM she was walking toward the 200 hall when she heard the exit door alarm going off. She stated that she saw no other staff on the hall. She further stated she opened the door blinds to see if anyone was outside and did not see anyone so she cut the alarm off. She stated she went outside through the laundry room doors which would allow her access back into the building. She further stated she saw Resident #1 leaning against the side of the building about 10 feet from the exit door. She stated he had on a white shirt and a brief. She stated the weather was not very cold and that it was not raining. She described the resident as " looking lost " . She stated she addressed the resident and asked if he was OK and he replied that he was fine. She further stated she did not see any sign of injury or indication of the resident being in distress. Housekeeper #1 stated she went back inside the facility and immediately found a restorative aide (restorative aide #1) on the 200 hall. She stated she and restorative aid #1 went out the laundry doors to be with Resident #1. When asked why she did not bring Resident #1 back into the building herself she stated " he does not like me and I was afraid to try to make him come in. Sometimes he hits the staff. " Housekeeper #1 stated she left the resident and restorative aide #1 outside while she went back into the facility to get his nurse. She stated she found the resident ' s nurse (Nurse #1) near the 200 hall nursing station. She estimated it took her about 2 minutes to enter the building and find the nurse. Housekeeper #1 stated once Nurse #1 was notified she returned to her housekeeping

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be aware of residents identified to be at risk for elopement regarding their whereabouts in the facility, new exit seeking behaviors, increased wandering etc. to report to a nurse immediately for further evaluation regarding need for placement in the Wander Guard Unit or Secure Unit or increased monitoring. The Secure unit is a unit that can only be entered/ exited with key code access. Doors are mag locked at all times. The Wander Guard is secured by securely placing a wander guard bracelet on the resident to be worn 24 hrs. a day. Resident with the wander Guard bracelet is checked each shift for function and placement of bracelet. If a resident wearing a Wander Guard bracelet approaches within 10 feet of an exit door, the door automatically locks. The facility staff has also been trained to immediately report new exit seeking behaviors, increased wandering etc. to report to a nurse immediately for further evaluation regarding need for placement in the Wander Guard Unit or Secure Unit or increased monitoring. If a resident is identified with new exit seeking behaviors and there is not room for placement in the Wander Guard Unit or the Secure Unit, the resident will be placed at minimum on 15 minute checks until alternative placement can be procured.

Monitoring

The Medication Administration Record and Treatment Administration Record of all residents with a Wander Guard

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F 323	Continued From page 12 duties. When housekeeper #1 was questioned if she had ever seen Resident #1 try to exit the building unattended prior to this incident she stated no. In an interview on 11/13/15 at 12:25 PM restorative aide #1 stated as she was walking on the 200 hall at around 2:30 pm on 11/07/15 she was stopped by housekeeper #1 who told her that a resident was outside of the building alone. Restorative aide #1 stated she immediately exited the building through the laundry room doors with housekeeper #1 and went to stand beside Resident #1. She stated she remained with Resident #1, who showed no sign of injury or distress, while housekeeper #1 went to find a nurse. Restorative aide #1 estimated it took about 2 to 3 minutes for Nurse #1 to get outside to the resident. She further stated the nurse instructed her to go inside and get a sheet and wheelchair for the resident which she did immediately. Restorative aide #1 stated she assisted with covering Resident #1 with the sheet and wheeling him back into the building before returning to her own duties. When asked how long it took to get the resident inside once he was pointed out to her by housekeeper #1 she replied " about 4 or 5 minutes. " When asked why she did not just assist the resident inside herself she shook her head and stated " I don ' t mess with him. He will not do what I ask and will fight me if I try to make him do something. " When asked if she had seen Resident #1 attempt to leave the building before this incident, Restorative aid #1 stated " staff keep a close eye on him. He will try to get up out of his wheelchair and I was told by Nurse #1 he tried to leave the building at night a few weeks ago (unsure of date). " In an interview on 11/13/15 at 12:46 PM with the nursing assistant (NA #1), who worked on	F 323	bracelet placed, will be audited by the Director of Nursing daily Monday through Friday and by the Nursing Supervisor on weekends for completion of checking placement and function every shift for four weeks, two times per week for one month, then weekly for one month. The Director of Nursing will follow up as necessary with any staff member failing to document placement and function of the wander guard bracelet. Elopement drills directed by the Nursing Administration Team will be completed weekly on varying shifts for three months to ensure the facility staff follows policy regarding elopements The Director of Nursing will present results of those audits and drills to the Quality Assurance Performance Improvement Committee for three months for review and recommendation.	

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F 323	Continued From page 13 Resident #1's hall on 11/07/14 first shift, it was stated during the time the resident left the building it was revealed NA#1 was newly hired and had been working at the facility for 3 weeks. He stated 11/07/15 was the first day that he worked on his own (unsupervised) and he had 14 residents to care for including Resident #1. NA # 1 stated he was not aware of Resident #1 ' s wandering behaviors or any care planned interventions. NA #1 stated he was aware of Resident #1's behaviors of resisting care and being verbally and physically aggressive toward staff but he was unable to verbalize any interventions (re-approach, ask another staff member to attempt care, etc). NA #1 stated he was in room 204 on the 200 hall providing resident care from approximately 2:15 PM until 2:45 PM which is when Housekeeper #1 found the 200 hall exit door alarming. He estimated he was in room 204 for 30 minutes. NA #1 stated at some point while he was in room 204 he heard an alarm that sounded like the resident " shower call bell. " He stated he completed his resident care and exited the room and no longer heard the bell or alarm. NA #1 stated he was not immediately aware of Resident #1 ' s exit from the facility. He stated Resident #1 had refused his ADL care that morning. He further stated: " he (Resident #1) did not seem to like me and was resistant to my attempts to provide care. I reported this to his nurse (Nurse #1). " NA #1 stated he " had his hands full with other residents " and Nurse #1 provided most of Resident #1's care that day. NA #1 stated the last time he remembered seeing Resident #1 in the facility on 11/07/15 was about 10:00 AM when he saw the resident sitting in his room. NA #1 stated he was busy providing care to other residents and did not check on Resident #1 at a scheduled time. NA #1 stated he was	F 323		

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F 323	Continued From page 14 unable to monitor Resident #1 due to being " overwhelmed " with his assignment. NA #1 was asked when the last time he saw Resident #1 in the building on 11/07/15 and his answer was " I remember seeing him in his room sitting in the wheelchair around 10:00 AM. " NA #1 further stated when he returned to work on Sunday 11/08/15 he was told " someone had to be watching the resident full time. " NA #1 stated he knew he could not watch Resident #1 all of the time while caring for 13 other residents, so he did the best he could. NA #1 reported Resident #1 was much calmer on Sunday and no incidents occurred. NA #1 confirmed Resident #1 was on every 15 minute safety/location checks on Sunday, but stated Nurse #1 did most of the checks. " NA #1 was instructed by a nurse (he did not recall the nurses name), to " check on Resident #1 more frequently. " NA #1 stated he was better able to manage his resident assignment on Sunday. Interview on 11/13/15 at 1:15 PM with Nurse #1 who was assigned to the resident on 11/07/15 when Resident #1 left the building unattended revealed she was in room 303 hanging a tube feeding during the time the exit alarm went off. She stated that after completing the tube feeding at about 2:30 PM she walked toward the 200 hall nursing station where she overheard Housekeeper #1 tell a visitor (Resident #1's RP) " this is his nurse (referring to Resident #1). " Nurse #1 stated she and Resident #1's RP met in the 200 hall and the RP told her Resident #1 was not in his room. Nurse #1 stated she had last seen Resident #1 prior to his exiting the facility on 11/07/15 when she administered his 9:00 AM medications at about 9:15 AM Nurse #1 stated she and the RP went down to the main dining room where activities were ongoing. She stated	F 323		

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F 323	Continued From page 15 the resident was not found in in activities. She further stated she and the RP checked with the PT/OT therapist and Resident #1 was not present there. She stated that while walking back toward the 200 nursing station Resident #1's RP stated she had heard an alarm that sounded different from the call bells. Nurse #1 stated she was going to the phone at the 200 hall nursing station to call a silver alert (an alert code for a missing resident) at about 2:40 PM when she was approached by the housekeeper #1. Nurse #1 stated Housekeeper #1 informed her she had found Resident #1 standing outside the building near the 200 hall exit door unattended. Nurse #1 further stated the housekeeper informed her that a restorative aid (Restorative aide #1) was with the resident and a nurse was needed to assist in getting the resident back inside the building. Nurse #1 stated she and the resident ' s RP immediately went outside to get the resident. She observed he had on a brief and a t-shirt, no shoes or socks. Nurse #1 said she did a quick assessment of the resident while outside and noted he had no injury. She said Resident #1 stated " I went out to check on my truck. " She further stated the resident was wrapped in a sheet and placed in a wheelchair then transported back inside the facility. Nurse #1 stated she did a complete assessment on the resident once he was back in his room and found no sign of injury. She verified vital signs were checked and normal. Nurse #1 estimated the time that the resident was returned to the facility to be at about 2:50 PM. She further stated the resident's RP stayed with him for the next hour. Nurse #1 stated she reported the incident to the Nurse Supervisor (Nurse Supervisor #1) who implemented staff checks on Resident #1's location and safety to be done every 15 minutes.	F 323		

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Nurse #1 ended the interview by stating she recalled an incident a few weeks ago late at night on third shift when Resident #1 went to the 200 Hall door intending to exit the building but she said she was able to stop him from leaving the building during that attempt. She further stated the facility administrator and Director of Nursing (DON) had been informed of the attempted elopement on 10/26/15. She did not recall any new interventions being put into place after Resident #1 attempted to leave the facility on 10/26/15.

In a telephone interview on 11/14/15 at 11:37 AM with Unit Supervisor #1 it was revealed that on 11/07/15 at around 3:00 PM it was reported to her by Nurse #1 that Resident #1 had left the facility unattended by staff between 2:00 and 2:30 PM. She further stated that by the time she was notified of the elopement, Resident #1 had already been assisted back into the facility by Nurse #1. She stated Nurse #1 reported that the resident's vital signs were stable and he showed no sign of injury although he was outside in only a t shirt and briefs. Supervisor #1 stated she went to the resident's room, assessed him herself, and found no injury. She stated the resident was confused but not agitated. Supervisor #1 further stated generally the resident is alert but confused and could be agitated at times. She said Nurse #1 had reported to her earlier in the shift that he was agitated and kept removing his personal alarm (clip on alarm). Supervisor #1 stated that the last time she recalled seeing the resident in the building that afternoon was around 12:30 PM at lunch time. Supervisor #1 verified she called the administrator, the DON, and the resident's primary physician immediately after the incident. She stated per the DON's order's the resident was placed on Q (every) 15 minute checks for

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F 323	Continued From page 17 location and safety. Supervisor #1 stated she was aware of Resident #1's attempt to leave the building on 10/26/15. She stated that in discussions following the incident on 10/26/15 between the administrator, social workers, and nurses it was decided the resident did not require additional care plan interventions for his safety. In an interview on 11/14/15 at 10:40 AM with the Director of Nursing (DON) it was revealed she was called by the first shift supervisor on 11/07/15 (supervisor #1) at about 2:30 PM who reported an incident of Resident #1 being found outside of the building standing against the wall stating he was looking for his truck. The DON stated Supervisor #1 reported the resident was not injured and that he been found by a house keeping staff member. The DON further stated the supervisor had informed her the resident's RP was in the facility when the event took place. The DON stated she contacted the administrator and he agreed the resident should be placed on every 15 minute checks for location and safety. The DON stated she called the supervisor (Supervisor #1) and gave instructions to initiate the every 15 minute safety/location checks. The DON further stated she notified Resident #1's physician of the incident and he gave no new orders. The DON stated she and the administrator had met with the Interdisciplinary Team on Monday 11/09/15 morning and it had been determined Resident #1 would be kept on 15 minute checks until he could be moved to the secured unit. When asked if she had been aware of any other incidents involving the resident attempting to leave the facility she stated " yes I was aware of an attempt by the resident to leave the building on 10/26/15. I discussed the resident's risk of wandering with the administrator. We communicated with the resident's physician and the consensus was that	F 323		

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the resident did not require extra care plan interventions. "
Nursing Note dated 11/07/15 at 6:08 PM read: "Medicated x 2 this shift for increased agitation at 9 am for cursing at unseen visitor and increased anxiety about the work he needed to be doing - med was effective. Resident calmed down, was compliant with care, no further cursing. Then med again at 5:52 PM with po (by mouth) Haldol for wanting to go check on his car and arguing with his brother-in-law (no one present). Remains on q (every) 15 min. checks for location. Personal alarm in place/functioning/audible." Note was signed by Nurse #1.
Resident #1's care plan for wandering and behaviors was updated 11/07/15 when a handwritten note was added to the behaviors care plan, stating " 15 min checks - NSG " (nursing). On 11/09/15 a handwritten note was added to the behaviors care plan stating " moved to Wander guard unit. " On 11/10/15 additional interventions were added to Resident #1 ' s care plan for wandering. The new interventions included: Assign staff to account for resident whereabouts at all times; Note which exits resident favors for elopement from facility; Alert staff working near those areas; Place monitoring device on resident that sounds alarms when resident leaves building; place resident in area where constant observation is possible; alert staff to resident's wandering behavior.
Nursing Note dated 11/08/15 at 3:00 AM read: "Resident (#1) is in bed sleeping at this time. Resident is cooperative with staff regarding taking medications and incontinence care. Bed remains in lowest position, floor mat in place, personal safety alarm in use and functioning properly. Call bell within reach. Continue monitoring." Note was signed by Nurse #2.

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F 323	Continued From page 19 Nursing Note dated 11/08/15 9:03 AM read: "Resident (#1) remains on q (every) 15 min checks for location and safety. Spoke with RP about moving him to a room on 400 hall (Wander Guard Secured Unit) and applying wander guard (ankle alarm system) to ensure further safety. RP did not give consent at this time for the room change. Stated she wanted a meeting with Administrative staff Monday AM and to check out the 400 hall he (Resident #1) would be moved to prior to giving consent. Reiterating informed her staff would continue with the 15 minute checks Q (every) day." Note was written by Nurse #3. Nursing Note dated 11/08/15 at 11:07 AM read: "Alert, oriented to self only. Resident is up in w/c (wheelchair) in dining room at this time. No exit seeking behaviors so far this shift. Resident has made no attempts to get out of chair." Note continues and concludes with " Continues on q (every) 15 minute checks for location." Note was signed by Nurse #1. Nursing Note dated 11/09/15 7:26 PM read: " Resident continues to attempt to leave building stating " he is going to go take care of that cardboard. " Demonstrating verbal and combative behaviors with female staff during times of increased anxiety. PRN (as needed) administration at (4:00 PM) during stated time of increased anxiety. Informed from management that (RP) would be coming tonight to approve transfer to 400 hall (Secured Unit) or take resident home with her. Expected time of visit between (7:00 PM) and (10:00 PM). Will continue to monitor." Note was signed by Nurse #4. Social Worker Note dated 11/10/15 at 10:22 AM, written by Social Worker #2, read: " Resident has had several exit seeking behaviors within the last several weeks with the last documentation being	F 323		

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F 323	Continued From page 20 11/07/15." Note was signed by the facility Social Worker #1. Nursing Note dated 11/10/15 at 10:36 AM resident moved to room 403A (Secured Unit) per staff request, family informed by staff. Note was signed by Social Worker #2. Nursing Note dated 11/10/15 5:09 PM read: " Spoke with (Resident #1's RP) at this time and made her aware that a room change had been made to resident and that a wander guard (ankle security alarm) has been put into place at this time. Will continue to monitor resident at this time. " Note was signed by Nurse #5. In an interview on 11/13/15 at 1:40 PM with Social Worker #1 it was revealed that on admission a Risk Assessment dated 5/19/15 had evaluated the resident as an elopement risk. Social Worker #1 stated the resident had been care planned for wandering and attempts to exit the building after the 5/19/15 assessment. She stated "once the resident was seen by psychiatry and medication was begun his behaviors improved. I did not see documentation in the Nursing Notes or hear discussion in the Interdisciplinary Team meetings to indicate he was showing exit seeking behaviors. When asked if she was aware of Resident #1's attempt to exit the building on 10/26/15 she stated yes. She said: " I did not get involved in making determinations about whether he was safe in the unsecured part of the facility that is up to (the administrator)." She further stated she was involved in communicating with the resident's RP to convey the need to move him to a secured location after he left the facility unattended on 11/07/15. In an interview on 11/13/15 at 1:55 PM with Social Worker #2, who wrote a Social Worker Note dated 11/10/15 which stated "Resident has had several exit seeking behaviors within the last few	F 323		

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SANFORD HEALTH & REHABILITATION CO	**2702 FARRELL ROAD SANFORD, NC 27330**

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F 323	Continued From page 21 weeks the last documented episode being 11/07/15." When asked about the documentation of " exit seeking behaviors within the last few weeks " in her own note, she stated: " that was a typing error, the note should have been corrected to state days where it states weeks." When asked about her role in evaluating the resident for Wandering and elopement risk as outlined in the Resident's care planned intervention of "Social Services to evaluate resident" she stated she read the nursing notes and monitored the resident. In an interview by telephone on 11/13/15 at 2:30 PM Nurse #2 stated she had worked with Resident #1 about once a week and stated she had not observed the resident trying to exit the building. She stated the nursing staff "have to watch him (Resident #1) closely because he can become confused and agitated at times." She verified she was aware of the every 15 minute safety/location checks the resident was ordered to be on until he was secured in the Wander Guard Unit. In a telephone interview on 11/14/15 at 12:05 PM with the Geriatric Psychiatry Nurse Practitioner (NP #1) who worked directly with Resident #1 to assist in treatment of his behaviors it was revealed she had treated the resident on a regular basis since shortly after his admission to the facility. She stated she was in contact with the facility during Resident #1's early days of admission and after evaluation she and the psychiatric physician had determined the facility was capable of caring for the resident and at no risk to other residents. She stated she had been informed of Resident #1's attempt to leave the building on 10/26/15 and of his most recent exit of the facility on 11/07/15. She stated that after his attempt to leave the building on 10/26/15 she had	F 323		

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F 323	Continued From page 22 been under the impression the staff had increased monitoring of the resident's location. She further stated she felt increased monitoring was sufficient to maintain the resident's safety. NP #1 stated she was surprised to hear that Resident #1 had exited the building without supervision on 11/07/15. She stated she felt medication changes that had been implemented over the past months had been sufficient to control Resident #1's behaviors. NA #1 further stated that over the past 5 months the resident had stabilized with his behaviors and had not exhibited any exit seeking behaviors until the incident on 10/26/15. In a telephone interview on 11/14/15 at 1:27 PM with Resident #1's physician stated he was aware of the resident ' s attempt to leave the building on 10/26/15 and did not recall considering the resident to be a safety or flight risk. He stated " if I had thought the resident needed further interventions to insure his safety I would have written orders for them. " The physician did not recall any concerns with Resident #1's safety or risk of wandering. He stated " I don ' t remember what I did concerning these incidents. " The MD stated " if I had considered sending him to the hospital to be evaluated for behavior and medication management, I would have written an order." Interview, observation and tour of facility at 10:15 AM on 11/13/15 with facility administrator revealed the location of Resident #1's room (#403) on 11/07/15. Room #403 was observed to be midway between the 200 hall nursing station and the 200 hall fire exit door. The fire exit door was about 20 feet from room 203 ' s door. The facility administrator opened the 200 hall exit door and pointed out the area where Resident # 1 was found standing outside of the facility on 11/07/15	F 323		

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F 323	Continued From page 23	F 323		

which was next to the back side of the building approximately 10 feet from the 200 hall exit door. The area where the resident was found was grassy, on the back side of the building, and surrounded on 2 sides by building wings. It was noted that the 200 hall exit door alarmed properly when opened. The administrator stated he was informed of the 11/07/15 incident involving Resident #1 leaving the building by Nurse Supervisor #1 around 2:45 PM on 11/07/15. He stated he instructed Supervisor #1 to inform Resident #1's physician and initiate every 15 minute safety/location checks on Resident #1 immediately. He further stated the resident remained on the 15 minute checks until 11/09/15 at 8:00 PM when he was moved to a room on the facility ' s secured unit. The administrator stated the resident would have been moved sooner but his RP did not want him moved. He stated the resident's RP stated she would rather take the resident home than have him moved to the unit. He further stated the RP was given until 11/09/15 at 8:00 PM to come to the facility and pick him up. He stated she did not take the resident home so he was moved to the secured unit for his safety. He stated the resident's RP was notified prior to the resident's relocation.
Observation was made on 11/13/15 at 10:35 AM of the secured unit. The facility administrator was present during the observation. Observation of the unit revealed it was secured by double doors that opened onto the interior of the building next to the 200 nursing station. Resident #1 was observed in room 403 resting in bed with a bed alarm in place. The resident was observed to be confused but showed no sign of agitation or aggressive behaviors. It was noted the resident had a wander guard bracelet in place on his left ankle. The facility administrator explained the

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F 323	Continued From page 24 ankle bracelet functioned by triggering the unit exit doors to lock when it came within 10 feet of the doors. The unit exit doors were tested with a wander guard ankle bracelet and found to lock when the bracelet came within 10 feet of the door sensor. The administrator stated that residents in the secured unit were required to wear the ankle alarm bracelet 24 hours per day except when ADL care or skin assessments required its removal. He stated staff were required to remain with any resident while their ankle alarm was not in place. He further stated the residents in the secured unit were assessed every shift by the primary care nurse to ensure their ankle alarm bracelet was in place. In a continuation of the interview on 11/13/15 at 11:50 AM with facility administrator he was asked why additional interventions were not care planned for Resident #1 after the resident ' s attempt to leave the facility which was documented in nursing notes on 10/26/15 at 2:27 AM. His reply was that he was aware of the incident but felt the resident was safe without adding additional interventions. He further stated normally the resident did not attempt to leave the building. In an additional interview on 11/14/15 at 2:05 PM with the facility administrator it was revealed that he was aware of Resident #1's attempt to exit the facility unsupervised on 10/26/15, was aware of the physical and verbal behaviors the resident directed toward staff at times, and was aware that no new care planned interventions had been put in place after the resident attempted to leave the facility on 10/26/15. He stated he did not consider additional interventions to be needed at that time. The administrator further acknowledged the resident had left the facility unattended on 11/07/15 around 2:30 PM. He	F 323		

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F 323	Continued From page 25 stated: " He (Resident #1) will need to remain in the Wander Guard Unit in order to insure his safety from exiting the building. The Administrator was notified of the Immediate Jeopardy on 11/13/15 at 5:45 PM. The facility provided the following Credible Allegation on 1/14/15 at 2:30 PM. Corrective action which will be accomplished for those residents found to be affected by the deficient practice: The resident #1 was put on 15 minute checks/ 24 hours a day immediately upon return into facility on 11/7/15. Resident #1 was placed on one on one observation on 11/9/15 until 8:00 pm at which point a bed was made available in the Wander Guard unit. Wander Guard bracelet was applied to left ankle on 11/9/15 at 8:00pm and checked for sound working order. The Care Plan was updated by Social Worker on 11/10/15 to reflect placement of the Wander Guard bracelet and placement in the Wander Guard Unit. An audit of each door leading to outside the facility was completed on 11/7/15 by the Director of Nursing to determine if the door is alarmed and if the alarm is in working order. An alarm log was developed by the Administrator on 11/7/15 to be filled out daily by Administrator or Designee to document working order of all working alarms. All facility staff regardless position or title (including licensed staff and nursing assistants) were in-serviced by Director of Nursing and/or Administrative nursing team regarding all staff members are responsible for responding to any alarm sounding in the facility and going outside to check facility grounds when responding to a door alarm on 11/7/15 through 11/13/15. Staff member who turned off alarm was in serviced on 11/7/15 regarding thorough checking of surrounding area and outside when they	F 323		

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F 323	Continued From page 26 identify a door alarm sounding. How the facility will identify other residents having the potential to be affected by the same deficient practice: A one hundred percent head count was completed on all residents on 11/7/15 by the Weekend Nurse Manager. A one hundred percent chart audit was completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers on 11/9/15- 11/13/15 of all residents to determine which residents are identified to be at potential risk for elopement/wandering. All residents that were identified to be at potential risk for wandering/elopements chart were reviewed to identify the need for potential placement in secure/ wander guard area. No other residents not already located in Wander Guard hall were identified in requiring the secure/ wander guard area. All facility doors were also checked for properly sounding door alarms by the Administrator for functionality. All doors were functioning properly. All staff in-service was started on 11/7/15 through 11/13/15 by the Nursing Administration regarding elopement policy and procedure, missing resident policy and procedure, policy and procedure on responding and assessing area around door alarms. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. Elopement drills will be completed daily by the ADON/Staff Development Coordinator for/Nursing Administration for 2 weeks, weekly for 2 weeks and monthly for 2 months via different shifts. Drills will cover responding to alarms and searching for a missing resident.	F 323		

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F 323	Continued From page 27 All Door alarms will continue to be checked daily for 2 weeks, weekly for 2 weeks, monthly for 2 months by the Administrator or Designee for proper working status. A list of residents identified to be at risk for elopement utilizing the Elopement Risk Identification Decision Tree continues to be placed at the front of each Elopement book by Social Services to alert the staff nurses as to which residents are at risk/ care planned for risk for elopement. The Social Services Dept. will be responsible for updating and replacing the list and updating the Care Plans and notifying Unit Managers to update Care Cards as changes occur. (This system has been in place for approximately one year.) Elopement Book An elopement risk notebook is kept at each nursing station and front desk with names and pictures of each resident that has been identified to be at risk for elopement. The notebook is updated as admissions occur and a resident has been newly identified as an elopement risk per the Elopement Risk Identification Decision Tree which is completed by the Social Worker. All facility staff has been trained on hire to be aware of residents identified to be at risk for elopement regarding their whereabouts in the facility, new exit seeking behaviors, increased wandering etc. to report to a nurse immediately for further evaluation regarding need for placement in the Wander Guard Unit or Secure Unit or increased monitoring. The Secure unit is a unit that can only be entered/ exited with key code access. Doors are mag locked at all times. The Wander Guard is secured by securely placing a wander guard bracelet on the resident to be worn 24 hrs. a day. Resident with the wander Guard bracelet is checked each shift for	F 323		

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F 323	Continued From page 28 function and placement of bracelet. If a resident wearing a Wander Guard bracelet approaches within 10 feet of an exit door, the door automatically locks. The facility staff has also been trained to immediately report new exit seeking behaviors, increased wandering etc. to report to a nurse immediately for further evaluation regarding need for placement in the Wander Guard Unit or Secure Unit or increased monitoring. If a resident is identified with new exit seeking behaviors and there is not room for placement in the Wander Guard Unit or the Secure Unit, the resident will be placed at minimum on 15 minute checks until alternative placement can be procured. On 11/14/15 at 3:30 PM verification of the Credible Allegation was evidenced by: interview of all staff related to their being able to identify residents at risk for elopement and verifying staff understood how to identify, report, and monitor residents at risk for wandering. Secured areas were checked to insure doors alarmed properly. The Wander Guard Unit was checked to insure guard bracelets were in place on 100% of resident in the unit and the unit staff were educated on need to test alarms every shift. It was also verified that the Elopement Notebook was present at each nursing station and the front desk and that staff understood how to use the notebook to identify residents who required more frequent monitoring. Social Workers were interviewed to insure they were trained to do the risk assessments on residents and to insure the notebook is updated as admissions occur and as residents are newly identified as an elopement risk per the Elopement Risk Identification Decision Tree which is completed by the Social Worker.	F 323		

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F 356	Continued From page 29	F 356		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately post nurse staffing information. Findings included:	F 356	F356 Disclaimer Clause:	12/1/15

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F 356	Continued From page 30 The Daily Staffing Form and Daily Nursing Assignment sheets were reviewed for 11/1/15 through 11/13/15. The Daily Staffing Forms indicated the facility had five registered nurses (RN) working from 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM. The Daily Assignment sheets reflected one to two RN ' s. In an interview on 11/14/15 at 9:45 AM, the director of nursing (DON) verified the DON and the Minimum Data Set (MDS) nurses was not to be counted in the daily staffing hours. She stated Monday through Friday, the treatment nurse was the RN coverage while the weekend supervisor met the weekend RN requirement. In an interview on 11/14/15 at 10:10 AM, the staffing coordinator stated she did not complete the Daily Staffing Form but rather she completed the Nursing Assignment sheets. She stated the receptionist completed the Daily Staffing Form and there was no coordination between what she puts out for the daily staffing and what was posted for the facility staffing hours. In an interview on 11/14/15 at 2:04 PM, the receptionist stated she had been in her position since August of this year and was trained by the previous receptionist. She stated she was aware that the facility had to have one RN each day but she did not realize the numbers were inaccurate. In an interview on 11/14/15 at 2:47 PM, the administrator stated he thought the computer program auto populated the licensed practical nurses (LPN) hours into the box for the RN hours. He stated the information provided was misleading regarding the actual hours per day of resident care.	F 356	Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective Action For Residents Found To Be Affected No resident was identified to be affected by the deficient practice. Corrective Action For Residents With The Potential To Be Affected No resident was identified to potentially be affected by the deficient practice. Measures Put Into Place Or Systemic Changes Made The format for posting staffing hours on The Daily Staffing Form was changed by the Administrator on 11/14/15 and the Daily Staffing Form was reposted at that time. Any facility staff that may be responsible for posting the Daily Staffing form was in-serviced by the Administrator on 11/14/15 regarding how to calculate the staffing hours for the licensed nurses and the nursing assistants according to	

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F 356	Continued From page 31	F 356	the actual hours per day of resident care. The receptionist will be responsible for posting the Daily Staffing Form. The Staffing Coordinator will provide the daily staffing sheet to the receptionist to reference scheduled staff for accuracy of the Daily Staffing Form. Any facility staff that may be responsible for posting the Daily Staffing form will be in-serviced by the Administrator regarding how to calculate the staffing hours for the licensed nurses and the nursing assistants according to the actual hours per day of resident care prior to allowing them to post the Daily Staffing form. Monitoring The Administrator or Designee will audit the Daily Staffing form daily for one week, then weekly for three weeks, and then monthly for two months to ensure the staffing hours are calculated correctly.	

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F 356	Continued From page 32	F 356	The Administrator will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations.	