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F 000	INITIAL COMMENTS A complaint investigation was conducted from 8/14/19 through 8/15/19. Event ID # VMK111. Past Noncomplaince was identified at: CFR 483.25 at tag F689 at scope and severity (J). F689 constituted Substandard Quality of Care. A partial extended survey was conducted. 1 of 1 allegations was substantiated resulting in a deficiency.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and Physician Assistant interview the facility failed to provide supervision and wander guard placement as ordered by the physician to prevent a resident with severely impaired cognition and exit seeking behaviors, from exiting the facility unsupervised for 1 of 1 residents (Resident #1) reviewed for accidents. Resident #1 was found unsupervised in the facility's parking lot seated in his wheelchair by a visitor approximately 100 feet from a heavily trafficked	F 689	Past noncompliance: no plan of correction required.	8/27/19

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

Electronically Signed | 08/27/2019

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four lane road. Resident #1 was returned to the facility by staff and found to be uninjured.

Findings Included:

Resident #1 was admitted to the facility on 11/30/18. Active diagnoses included: Dementia with behavioral disturbances, Cerebral vascular accident with left side hemiplegia (paralysis), and repeated falls.

Review of a nursing note dated 1/1/19 documented by Nurse #1 revealed Resident #1 was at risk for elopement based upon several verbalizations about going out, home or to the hospital, and unsafe wandering.

A physician's order dated 1/1/19 was initiated for Resident #1 for a wander guard for safety to wheelchair, check for placement and function every shift.

The current plan of care, that was initiated on 1/1/19, revealed Resident #1 was at risk for elopement with goals to include allowing the resident to wander safely within his environment. Interventions included; assessing risk factors, monitoring and reporting changes in behavior, redirection, and a wander guard for safety to wheelchair.

The quarterly Minimum Data Set assessment dated 1/14/19 and a recent quarterly assessment dated 7/8/19 indicated Resident #1 had severely impaired cognition. He required one-person physical assistance with bed mobility, and two-person physical assistance with transfers. He utilized a wheelchair for mobility. He was coded as exhibiting no wandering behaviors, and no

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rejection of care during the seven day look back period on both the 1/14/19 and 7/8/19 assessment.

In an interview with the Occupational Therapist on 8/14/19 at 12:15 PM, she stated Resident #1 was on a restorative program and had repeated falls. She commented the tires on his wheelchair were starting to get worn down and could potentially tip the wheelchair, so a new chair was ordered for safety. She reported that Resident #1 was non ambulatory, his left side was impaired, and stated he was able to propel himself in the wheelchair with his right arm and right leg. She reported that she changed his wheelchair on Friday 7/26/19 the day prior to the incident between 2:30- 2:55 PM. She stated she did not think to check the older wheelchair to see if a wander guard was attached. Following the incident, she reported the therapy department received an in service regarding the elopement policy and the therapists will now check the elopement binder to see if a resident had a wander guard in place and therapy staff will notify the nurse if a resident needs their wander guard replaced.

On Resident #1's Teatment Administraion Record dated 7/26/19 Nurse #5 documented during the 11:00 PM -7:00 AM shift that Resident #1 had a wander guard and documented that the device was checked for placement and functioning. Nurse #5 was unavailable for an interview during the survey.

On Resident #1's TAR dated 7/27/19 Nurse #1 documented during the 7:00 AM- 3:00 PM shift that Resident #1 had a wander guard and documented that the device was checked for placement and functioning.

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In an interview on 8/14/19 at 2:45 PM with Nurse #1 she acknowledged that the nurses were responsible for accurately assessing and documenting on the TAR that the residents wander guards were in place and checked for functioning. She stated it was an oversight that she signed off on the TAR on 7/27/19 during her shift that Resident #1 had a wander guard in place. She reported she thought she saw the wander guard on Resident #1 that day but obviously it was an oversight. She acknowledged that she did receive in service training on elopement procedures, wander guard device checks every shift, and documentation since the incident involving Resident #1

On Resident #1's TAR dated 7/27/19 Nurse #3 documented during the 3:00 PM - 11:00 PM shift that Resident #1 had a wander guard and documented that the device was checked for placement and functioning.

A nursing note written by Nurse #3 on 7/27/19 at 8:09 PM documented that Resident #1 was found in the parking lot. Staff successfully returned the resident back into his room and placed a wander guard to his lower extremity. Resident was responsive with combative behavior.

In a phone interview on 8/14/19 at 8:45 PM with Nurse #3 who was the nurse assigned to Resident #1 on 7/27/19 he reported that the resident was found outside in the parking lot after dinner on 7/27/19 but couldn't recall the exact time. He reported that it was during his 3-11 PM shift which was a very hectic time especially on weekends and around dinner time when family were visiting, and it was during his med pass. He

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stated that he did not know the resident had managed to get out of the building during that time until he was alerted by staff and did not know how long Resident #1 had been outside unsupervised. He reported that the resident was brought back inside, and vitals were checked, and a full body assessment was completed, and all were within normal limits with no injuries or skin tears and no complaints of pain. The family and the physician were notified of the occurrence. He stated Resident #1 was argumentative because he couldn't be outside. He reported that Resident #1 was found by another nurse earlier that day trying to push on a locked door and stated he did have a history of exit seeking behaviors. After the incident he received an in-service on the elopement policy and procedures including calling the Director of Nursing (DON) and the Administrator immediately if an elopement incident occurred, checking all residents for wander guard placement, checking that all door alarms were working properly, and documentation. Nurse #3 acknowledged that the nurses were to document on the Treatment Administration Record (TAR) that the wander guard was in place and was checked for functioning on every shift.

In a phone interview with Nurse #2 on 8/14/19 at 12:40 PM she reported that she was working on the 100 hall the day of the incident (7/27/19) and a visitor came down the hall and stated she had gone out to her car and saw a resident in the parking lot. Nurse #2 went outside and saw that Resident #1 was in the parking lot attempting to get over a speed bump. She ran out to get him and he planted his feet and started cussing and wouldn't let her push him. She asked the visitor to knock on the emergency door which was the

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closest door to get inside of the building to get more staff to help her. Another nurse came out to help and returned Resident #1 back inside the facility. She stated it was around 7:30 - 7:45 PM and it was not dark outside at that time, and she did not know how long Resident #1 had been outside. Nurse #2 reported Resident #1 had no injuries, and no wander guard was on his wheelchair or on him. The resident told her he was looking for his car. Nurse #2 stated his cognition was very much impaired, and he had tried to open doors but had never made it outside before and stated the emergency doors stay locked and required a code to get in and out of. Nurse #2 reported the facility provided in service training after the incident regarding the elopement policy and reviewed calling the Director of Nursing (DON) and Administrator immediately if a resident exits the building unsupervised, completing an assessment of the resident, checking for wander guard placement, and documenting placement and functioning.

In an interview on 8/14/19 at 12 :51 PM with Nurse Aide # 2, she stated Resident #1 was back and forth from his hallway to the dining room on 7/27/19 the day of the incident. She reported she last saw him before he exited the facility when he rolled himself in his wheelchair to his hallway between 6:50 PM - 7:20 PM. She stated she was not aware of the details of Resident #1 exiting the building unsupervised and was not certain of how long Resident #1 may have been outside. She did not recall if a wander guard was in place. She reported that she was in serviced on the elopement policy which included informing the DON and the Administrator immediately if a resident exits the building unsupervised. She was also in serviced on elopement procedures

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including searching for a resident, checking the notebook which lists all residents with wander guards, and making sure the wander guard device was working properly.

Review of the elopement incident report dated 7/27/19 documented Resident #1 was seen outside of the building in the parking lot. Staff assisted the resident back into the building without any concerns. Immediate action taken included: Nursing staff assisted the resident back into the building, with no injuries observed, and vital signs were within normal limits. The family was notified on 7/27/19 at 8:29 PM. The facility Physician was notified on 7/27/19.

Review of a witness statement dated 7/27/19 by Nurse #4 documented the last time she saw Resident #1 on 7/27/19 was around 5:45 PM when she was at the nurses station and saw him down the hall by room 121. He "jiggled" the exit door; she called him and rolled him up the hallway in his wheelchair. Resident #1 was taken to the dining room for dinner. Nurse #4 was not available for interview during the survey.

An observation was conducted with the DON on 8/14/19 at 2:32 PM of the parking lot at the speed bump where Resident #1 was found unsupervised during the evening of 7/27/19. The speed bump the resident was attempting to roll over in his wheel chair was approximately 2-3 inches high with a gap in the center. A 4-6 inch curb was on both sides of the parking lot where the resident was found. The speed bump was approximately 100 feet from the entrance to the facility's parking lot which was on a high trafficked four lane road which connected to a main thoroughfare with a posted speed limit of 45 miles

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per hour.

According to the National Weather Service computer data base the temperature in Wilmington, NC where the facility is located, on 7/27/19 was 88 degrees Fahrenheit and sunset was recorded at 8:17 PM.

During an observation of Resident #1 on 8/14/19 at 10:30 AM he was observed lying in bed in no acute distress. He was alert and oriented to himself only. A wander guard was in place on his right lower extremity. When asked if he went outside alone recently, he stated he didn ' t know.

In an interview on 8/14/19 at 11:23 AM with Nurse Aide #1 she reported she was not working on 7/27/19 the day of the incident but was assigned to Resident #1 during most of her shifts and was familiar with his care. She did not recall if Resident #1 was wearing his wander guard when she worked with him on 7/26/19 but reported Resident #1 had a wander guard in place for months and had two in place at one time, one on his right leg and one on his wheelchair. She stated he did have exit seeking behaviors such as pushing on doors at times. She stated the resident liked to be outside so the staff including therapy would take him outside to the enclosed courtyard at times during the day. She reported he was non ambulatory, and total dependent care but could propel himself in his wheelchair with minimal difficulty.

In an interview on 8/14/19 at 2:15 PM with the facility's physician assistant, she reported that Resident #1 did exhibit exit seeking behaviors. She stated the wander guard device was ordered in January 2019 due to the resident verbalizing

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exit seeking behaviors and the order for placement on his wheelchair was due to him "picking" at the device. She reported that she was notified of the incident on 7/27/19 and the wander guard is now placed on his lower leg for safety.

In an interview on 8/14/19 at 11:40 AM with the Administrator and the Director of Nursing (DON) present, the administrator acknowledged that Resident #1 did exit the building unsupervised on 7/27/19. She reported that occupational therapy gave him a new wheelchair recently without placing his wander guard on the new chair. She stated that Resident #1 did not have a wander guard device on his leg or on his wheelchair on 7/27/19. She reported on the day of the incident the front door did not alarm because the resident did not have a wander guard on. A visitor came in the facility and notified the nurse that a resident was outside in the parking lot. The nurse assisted Resident #1 back inside of the building and he had no injuries. She stated Resident #1 was a very busy person and wandered safely around the building and went outside to the courtyard with supervision at times. She reported that the wander guard had been placed on Resident #1 in January 2019 due to him verbalizing exit seeking behaviors. She stated he had not exited the building unsupervised prior to the 7/27/19 incident. She reported that the resident would pick at the wander guard bracelet when it was on his lower leg and an order was written to place the device on his wheelchair however following the incident on 7/27/19 they changed the order for the wander guard to be placed on his lower leg. After the incident on 7/27/19 the Administrator reported that all wander guard bracelets for all residents were monitored and checked for functioning. She stated the nurses were

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responsible for checking placement and using the wander guard device meter to check for proper functioning on every shift.

In a follow up interview with the Administrator on 8/15/19 at 12:40 PM she acknowledged staff failed to have a wander guard in place on Resident #1 on 7/26/19 and 7/27/19. She stated the nurses should have assessed the resident for wander guard placement and checked the device for proper functioning every shift and documented placement on the TAR. Her expectation was that staff were supervising residents and assessing for wander guard placement at least every shift. She stated staff should follow all precautions in order to maintain the safety of the residents.

The facility's corrective action plan dated 7/28/19 was as follows:

1.An investigation was initiated on 7/28/19 to determine the root cause regarding Resident #1 ' s elopement incident. It was determined Resident #1 did not have his wander guard in place on 7/27/19 due to the occupational therapist changed his wheelchair on 7/26/19 and did not replace the wandering device which was ordered to be placed on the resident's wheelchair.

The Administrator provided statements from staff that were working on 7/27/19. The DON and Administrator completed in services and provided education to all staff regarding the elopement policy including; announcing a code green (elopement), notifying the Administrator and DON immediately, searching all areas, actions to take when the resident was located, and conducting elopement drills.

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The corrective actions for the affected resident included: Resident #1 was returned to a secure environment with help from the staff and upon assessment the nurse applied the wander guard device to his leg. The family was notified on 7/27/19 at 8:29 PM and the physician was notified on 7/27/19.

The corrective action for residents with the potential to be affected included: any resident who had been assessed as needing a wander guard had the potential to be affected. All devices were checked on all residents for placement and function on 7/28/19. A 100% audit of all residents was conducted on 7/30/19 to identify elopement risk. Elopement drills were conducted on 7/29/19 through 7/30/19 for all shifts which included practice scenarios.

2. Measures implemented to assure the deficient practice would not reoccur included: a) education was provided to all nursing staff regarding the elopement policy, checking wander guard placement every shift, and alerting administration and the DON of all elopement attempts whether successful or not, which was completed on 7/29/19. b) the elopement policy was reviewed with all staff on 7/29/19. c) occupational therapy staff was in-serviced on the elopement policy on 7/30/19.

3. Ongoing compliance with the plan of action will be monitored and maintained by: a) nurses will check all residents for wander guard placement each shift and for function nightly. c) wander guard placement will be verified and documented weekly for twelve weeks by the DON or designee and discussed during the weekly resident review.

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F 689	Continued From page 11 The Don will report the results of the monitoring to the monthly QA (Quality Assurance) committee for review and recommendations for twelve weeks beginning 7/30/19. As part of the validation process on 8/15/19 the plan of correction was reviewed which included dates and content of the in services that were conducted, review of the audits initiated, and copies of the facility elopement policy. During the investigation, interviews were conducted with nursing staff to ensure their understanding and knowledge of assessing for wander guard placement. Seven staff members were interviewed regarding Inservice training and knowledge of the elopement policy. Observations were conducted during the investigation of all residents with wander guards and placement and functioning were verified. The facility 's correction date of 7/30/19 was verified.	F 689		