STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495108	A. BUILDING ______ B. WING ______	C 03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESAPEAKE HEALTH AND REHABILITATION CENTER	688 KINGSBOROUGH SQUARE CHESAPEAKE, VA 23320

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E 000	Initial Comments An unannounced Medicare/Medicaid abbreviated survey was conducted 03/26/18 through 03/27/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One (1) complaint was investigated during the survey. The census in this 180 certified bed facilty was 165 at the time of the survey. The survey sample consisted of one (1) current Resident review (Resident #1) and one (1) closed record review (Resident #2).	E 000		
F 689 SS=D	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 compliant investigation, clinical record review, and staff interviews, the facility failed to ensure a safe environment and failed to ensure resident's equipment was working properly to prevent an elopement for 1 of 2 residents in the survey sample (Resident #2). The finding included: 1. Resident #2 was admitted to the facility on 02/27/18 and discharged home on 03/16/18. Diagnosis for Resident #2 included but are not	F 689	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 take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged	4/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/12/2018

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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limited to *Dementia and *Depression.

*Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (<https://medlineplus.gov/ency/article/007365.htm >).

*Depression disorder is a chronic (ongoing) type of depression in which a person's moods are regularly low (Mosby's Dictionary Medicine, Nursing & Health Professions 7th edition).

Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date of 3/13/18 coded Resident #2 Brief Interview for Mental Status (BIMS) score of 03 out of a possible score of 15, indicating severe cognitive impairment. The MDS also coded Resident #2 with limited assistance of one with bed mobility, transfers, and limited assistance of two with toilet use. In addition, the MDS coded Resident #2 with limited assistance of one with walking in room, walk in corridor, locomotion on and off the unit.

Resident #2's elopement care plan created on 3/1/18 documented the resident as an elopement risk/wanderer related to resident wandering aimlessly. The goal: the resident's safety will be maintained through the next review date. Some of the intervention/task to manage goal included:

-Wander alert: wanderguard to left ankle
-Identify pattern of wandering: Is wandering

F 689

deficiencies cited have been or will be completed by the dates indicated.

F689

1. Resident #2 was safely discharged from the facility on March 16, 2018.
2. All residents will have a Wandering Risk Assessment completed upon admission, readmission, with a significant change in condition, and quarterly. The alarm system was checked by the service company on March 13, 2018.
Completion date: 4/20/2018
3. Residents identified to be at risk for elopement will have a wanderguard device placed on their ankle or wrist to alert staff of attempts to elope.
Placement of the wanderguard device will be checked every shift. Functioning of the device will be checked weekly on the 7-3 shift. A listing of residents with a device will be kept at each Nursing station and the reception area. Facility-specific orientation for Charge Nurses will include checking placement of a wanderguard alarm every shift and how to check function weekly. Exit doors will be checked every shift. The CNA Assignment Sheet was revised to include a list of residents who wander.
Staff will be educated on:
" Checking placement every shift
" Checking functionality every week by taking the resident to the door
" Documentation of checking placement and functionality
" Accurate completion of Wandering Risk Assessment

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purposeful, aimless or escapist. Is resident looking for something? Does it indicate the need for more exercise?
-Monitor resident's location. Notify the nurse of wandering behavior and attempted divisional interventions.
-Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and book - President prefers.

On 3/12/18, the State Agency recieved a Facility Reported Incident (FRI) a of an elopement with an investigative follow up on 3/14/18.

Review of the clinical record documented that on 3/10/18 at approximately 1:25 p.m., "LPN (License Practical Nurse) #1 received a call from Resident #2's niece stating that the resident was at the credit union and needed to be picked up. The resident was last seen in the dining room eating lunch. Resident noted to have wanderguard on this morning. Niece is going to pick up resident and bring her back to the facility."

The review of the Elopement Incident Report revealed the following:
-Date of Occurrence: 03/10/18 at 12:30 p.m.
-Incident location: Outside.
-Nurse Description: Nurse received phone call from resident's responsible party that her aunt (Resident #2) walked herself to the credit union.
-Patient Description: Patient was trying to go home.
-Immediate Action Taken: Family members picked up resident. When returned, checked vital signs, assessed for injury, checked to see if wanderguard was on and working.
Wanderguard in place to left ankle and red light

F 689

" Reporting confused resident statements that would indicate a desire to leave the facility
" Timely placement of a Wanderguard upon admission when there is documentation that the resident has a history of wandering
Completion date: 4/20/2018
4. Presence of the wanderguard device will be monitored every shift by the Charge Nurse. Functioning will be monitored on a weekly basis by the Charge Nurse bringing the resident to an alarmed door and listening for the alarm to sound or by using the hand-held device. Nursing Management will check function of the alarms by use of the hand-held monitoring device weekly. Checking of exit doors will be monitored by Unit Managers and Supervisors to ensure that the check was completed. Results will be reported to the QAPI Committee for review and recommendation.
Completion date: 4/20/2018

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F 689	Continued From page 3 flashing. Writer replaced wanderguard with a new one that was tested at the doors before application. Started on 15 minute visual checks. -Injuries observed at the time of incident: No injuries observed. -Predisposing situation factors: active exit seeker, ambulating without assist and wanderer. An interview was conducted with LPN #1 on 3/26/18 at approximately 3:20 p.m., who stated, "I saw Resident #2 eating lunch in the dining room and about an hour later I received a phone call from Resident #2's representative stating resident was at the credit union." The LPN said, "The resident's wanderguard was on and blinking red this morning, so I don't know how she could have got out of the facility." The surveyor asked, "What does the blinking light indicate?" The nurse replied, "The wander guard bracelet is working and activated." LPN #1 said she sent Certified Nursing Assistant (CNA) #2 to the credit union to help assist the family with returning the resident back to the facility because she had a good relationship with Resident #2. The LPN said once the resident returned to the facility at 2:41 p.m., a body assessment was completed with no evidence of injury. The LPN also stated that Resident #2 was placed on 15 minutes checks due to her elopement. On 3/27/18 at approximately 8:25 a.m., an interview was conducted with the Director of Nursing (DON) who stated, "I was informed by LPN #1 that Resident #2 had gotten got out of the facility and walked to the credit union. The credit union is 0.4 miles away from the facility. The DON said she was informed that a staff member went to the credit union to assist with returning the resident back to the facility. The surveyor	F 689		

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requested the police report, the DON stated, "A police report was never written but they did come to the facility before the resident arrived and spoke with LPN #1." The DON said she spoke to the resident's representative and informed her she was in the process of investigating Resident #1's elopement.

An interview was conducted with CNA #2 on 3/27/18 at approximately 3:25 p.m., who said she was assigned to Resident #2 that day she got out to the building. I saw her eating lunch in the dining room but after that, I could not tell you anything else. The surveyor asked, "Did you provide Activities of Daily Living (ADL) care that morning," she replied, "No", Resident #2 baths herself but I did notice her wander bracelet to her left ankle."

An interview was conducted with CNA #3 who stated, "I just came back from my break when LPN #1 asked me to go the credit union because Resident #2 got out of the building and the family may need help getting her into the car." The CNA said when she arrived at the credit union there were cops there as well as the resident's family. The CNA said the resident was very aggressive and upset because she wanted to go home and not back the nursing facility. The CNA stated, "The resident got into the car with her family then returned to the facility."

This allegation and findings were addressed with Administration during a briefing on 3/27/18 at approximately 1:00 p.m. The surveyor asked if they knew how or which door Resident #2 eloped through; they all replied, "No." The facility did not present any further information about the findings.

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2. Review of the clinical record on 3/10/8 at approximately 1:25 p.m., revealed, "Received call from resident's niece that resident was at the credit union and needed to be picked up. The resident was last seen in the dining room eating lunch. Resident noted to have wanderguard on this morning. Niece is going to pick up resident and bring her back to the facility." The review of the facility's documentation revealed that Resident #2 was wearing an *Accutech wanderguard device.

*Accutech's Resident Guard wander management systems give Alzheimer's, dementia and other "at-risk" residents the ability to move freely about their facilities while receiving the protection they-and their families-need. This perimeter-based security system puts staff at ease while enabling them to direct their energies toward other critical tasks. Benefits of the system include notification of staff if residents try to leave the facility or wander into restricted areas (http://www.accutechsecurity.com/resident-guard-wander-management).

An interview was conducted with License Practical Nurse (LPN) #1 on 3/26/18 at approximately 3:20 p.m., who stated, "I saw Resident #2 eating lunch in the dining room and about an hour later I received a phone call from Resident #2's representative stating resident was at the credit union." The nurse said, "The resident's wanderguard was on and blinking red this morning, so I don't know how she could have got out of the facility." The surveyor asked, "What does the blinking light indicate?" The nurse replied, "The wander guard bracelet is working and activated." LPN #1 said she sent CNA #2 to the credit union to help assist the family with

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F 689	Continued From page 6 returning the resident back to the facility because she had a good relationship with Resident #2. The LPN said once the resident returned to the facility, an assessment was completed with no evidence of injury. The LPN also stated that Resident #2 was placed on 15 minutes checks due to her elopement. On 3/27/18 at approximately 8:25 a.m., an interview was conducted with the Director of Nursing (DON) who stated, "I was informed by LPN #1 that Resident #2 got out of the facility and walked to the credit union. The credit union is 0.4 miles away from the facility. The DON said she was informed a staff member went to the credit union to assist with returning the resident back to the facility. The DON stated when she came in to start her investigation; she requested the wanderguard bracelet that Resident #2's was wearing at the time she eloped. The wanderguard bracelet was still at the nurses station; blinking red. The DON said she went to the entrance door of the facility, walked through the door but wanderguard did not sound, the doors did not automatically lock, came back inside - walked to the door again and the alarm did not sound; the door did not automatically lock. The DON said she called for the central supply coordinator (CSC) who came up to the DON's office to test the wanderguard bracelet. The DON said she gave the wanderguard bracelet to the central supply coordinator; she walked to the door, the door sounded and the door automatically locked. The DON said she asked the central supply coordinator to come into her office then go back to the front lobby door. The central supply coordinator walked back to the front door, the alarm did not sound and door did not automatically lock. The DON stated, "We are	F 689		

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F 689	Continued From page 7 really unsure which door the Resident #2 eloped from." An interview was conducted with the CSC on 3/27/18 at approximately 9:20 a.m., who said she tested the wanderguard bracelet that Resident #2 was wearing with the DON. "The first time I approached the front entrance door the locked. I was asked by the DON to come into my office and go back the front entrance door again which I did but this time the door did not shut down and lock which is unusual because the first time it automatically locked when the wanderguard device got near the front entrance door." The CSC also stated she checked the wanderguard device that the resident was wearing and it was functioning properly. On 3/27/18 at approximately 9:45 a.m., the DON and surveyor checked the entire exit doors to include the doors that were activated by the wanderguard device. All the doors alarmed and functioned properly. The facility's documentation/record revealed the following: on 3/13/18, Beta Systems of Virginia checked the wanderer control system and found that the system was functional. This allegation and findings were addressed with Administration during a briefing on 3/27/18 at approximately 1:00 p.m. The surveyor asked if they know how or which door Resident #2 eloped through, they all replied, "No." The facility did not present any further information about the findings. The facility's policy: Safety/security Systems (Wandering) (Effective 02/01/15).	F 689		

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F 689	Continued From page 8 Policy: Patients identified as at risk for wandering away from the center will have the least restrictive monitor device in use. Procedure: -Initiate safety/security devices as deemed appropriate to minimize the potential for leaving the Center unsupervised. -Any and all equipment malfunctioning is to be communicated to the Administrator, DON and Maintenance. Repairs are to be initiated immediately. This is a complaint deficiency.	F 689		