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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 4/6/21 through 4/8/21. One complaint was investigated during survey: VA0005132 was substantiated with a significant deficiency, past non compliance. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Quality of Care at a Scope and Severity of isolated, level 4. The census in this 120 certified bed facility was 84 at the time of the survey. The standard survey sample consisted of 2 current resident reviews (Residents # 2 through #3) and 1 closed record reviews (Resident #1). At the end of the findings: After accepting the plan for removal of Immediate Jeopardy from the Administrator, and determining that the Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity level of isolated, level 2.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure an accurate MDS (Minimum data set Assessment) for one of three sample Residents, Resident #1.	F 641		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/30/2021

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The findings included:

Resident #1 was admitted to the facility on 8/10/20 with diagnoses that included but were not limited to paranoid schizophrenia, anoxic brain damage, unspecified dementia without behavioral disturbance, chronic kidney disease stage two, high blood pressure, and history of falling. Resident #1's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/13/21. Resident #1 was coded as being moderately impaired in cognitive function scoring 10 out of 15 on the BIMS (Brief Interview for Mental Status exam).

Review of Resident #1's clinical record revealed that Resident #1 was exhibiting exit seeking behaviors on 3/11/21. The following nursing note was documented: "Patient noted to get up from W/C and go to East wing side door. Alarm sounding and patient redirected to W/C without incident. Patient at door again and ambulated down hallway extremely fast. Redirected back into W/C and UM (unit manager) took patient out in courtyard for a few minutes. Will continue to monitor any further attempts to go towards door. Patient stated when asked where she was going she said, "I'm going outside."

Further review of Resident #1's quarterly MDS with an ARD of 3/13/21, documented the following under Section E. (Behavior): "E0900. Wandering and Frequency. Has the resident wandered?" A "0" (zero) was documented indicating this behavior was not exhibited in the seven day look back period.

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On 4/7/21 at 1:53 p.m., an interview was conducted with OSM (Other Staff Member) #1, the facility social worker. OSM #1 stated that she was responsible for filling out Section E of the MDS assessment. When asked where she gets her information in order to fill out Section E, OSM #1 stated that she will go through the clinical record such as nursing notes etc. for the past 7 days to determine if a resident exhibited any behaviors specified on the MDS. When told OSM #1 about the note dated 3/11/21 of Resident #1 attempting to exit the building and wandering but then the 3/13/21 MDS reflecting no behaviors; OSM #1 stated that 3/11/21 was in the 7 day look back period and should have been reflected on the MDS. OSM #1 stated she would review the MDS and the notes and get back to this writer.

On 4/7/21 at 4:04 p.m., OSM #1 stated that the MDS was coded inaccurately in error.

On 4/8/12 at 12:40 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #1 stated that staff utilized the RAI (Resident Assessment Instrument) Manual when completing the MDS.

Review of the RAI MDS 3.0 manual documents in part, the following:
"SECTION E: BEHAVIOR...Wandering may be a pursuit of exercise or a pleasurable leisure activity, or it may be related to tension, anxiety, agitation, or searching. It is important to assess for reason for wandering. Determine the frequency of its occurrence, and any factors that trigger the behavior or that decrease the episodes. Assess for underlying tension, anxiety, psychosis, drug-induced psychomotor

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F 641	Continued From page 3 restlessness, agitation, or unmet need (e.g., for food, fluids, toileting, exercise, pain relief, sensory or cognitive stimulation, sense of security, companionship) that may be contributing to wandering. Steps for Assessment: 1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period. 2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period. Coding Instructions: -Code 0, behavior not exhibited: if wandering was not exhibited during the 7-day look-back period. Skip to Change in Behavioral or Other Symptoms item (E1100). -Code 1, behavior of this type occurred 1-3 days: if the resident wandered on 1-3 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer Wandering-Impact item (E1000). -Code 2, behavior of this type occurred 4-6 days, but less than daily: if the resident wandered on 4-6 days during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer Wandering-Impact item (E1000). -Code 3, behavior of this type occurred daily: if the resident wandered daily during the 7-day look-back period, regardless of the number of episodes that occurred on any one of those days. Proceed to answer Wandering-Impact item (E1000)."	F 641		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689	Continued From page 4 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 observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure one resident (Resident #1) who had a history of exit seeking behaviors since admission date (8/10/20) and also had exited the facility on 1/23/21 through a non-safety lock door; was free from potential serious harm or death related to an elopement on 3/27/21 at approximately 8:20 p.m. when the resident had fallen on a 4 (four) lane, 55 mph (mile per hour) road. The findings included: Resident #1 was admitted to the facility on 8/10/20 with diagnoses that included but were not limited to paranoid schizophrenia, anoxic brain damage, unspecified dementia without behavioral disturbance, chronic kidney disease stage two, high blood pressure, and history of falling. Resident #1's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/13/21. Resident #1 was coded as being moderately impaired in cognitive function scoring 10 out of 15 on the BIMS (Brief Interview for Mental Status exam).	F 689	Past noncompliance: no plan of correction required.	

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Review of Resident #1's clinical record revealed that she was transferred to the facility from another long term care facility on 8/10/20. The following was documented on her "Nursing Admission Report" dated 8/10/20: "Behaviors: sleeps for days, exit seeking...ambulates (ad lib) (spontaneously)..."

Review of a nursing note dated 8/11/20 documented in part, the following: "Exit seeking. Resident has been awake all night, roaming the halls looking for a way out."

Review of Resident #1's admission MDS with an ARD of 8/16/20; documented Resident #1 as being a wanderer in Section E (Behavior). The following was documented: "Behavior of this type occurred 1 to 3 days...Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g. stairs, outside of the facility)? 1. Yes."

A nursing note dated 8/20/20 documented the following: "Wanderguard applied to the left ankle. RP (Responsible Party) and MD (Medical Doctor) made aware via telephone. Resident noted ambulating unassisted and attempting to get out of exit doors, easily redirected but continues to exit seek throughout the day."

Review of Resident #1's elopement care plan dated 8/11/20 documented in part, the following: "(Name of Resident #1) is at risk for elopement r/t (related to) exit seeking behavior...Will not leave facility unattended...Interventions: Activities to keep resident occupied, calmly redirect resident, Engage in conversation and redirect resident from exits as needed (8/20/20), Maintain

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wanderguard in place, Relocate resident to a different area."

Further review of Resident #1's clinical record revealed further exit seeking behaviors on 8/22/20, 8/29/20, and 10/22/20.

Review of Resident #1's 11/18/2020 quarterly elopement assessment documented Resident #1 as having wandering or having exit seeking behaviors.

Review of Resident #1's clinical record revealed that on 12/18/20 the Nurse Practitioner had decreased her Risperdone (1) (antipsychotic) from 1 mg (milligram) BID (Two times daily) to 0.5 BID. The following was documented in part, "She is seen today per staff request for lethargy. Pt has a hx of multiple falls, with no acute injuries. Per staff, she is not herself. She continues to sleep a lot, but does arouse to verbal stimulation and answers questions. She works with therapy, but once in bed will fall back to sleep. Currently up in her w/c, but sleeping. She arouses with stimulation and denies pain and has no complaints except that she's very sleepy. In review of Pt's medication list, noted that she is on Risperdal 1mg BID for paranoid schizophrenia. Will try to cut back on dosage to see if it improves her alertness..."

Review of Resident #1's POS (Physician Order Summary) revealed that Resident #1's Risperdone had been decreased to 0.25 mg BID on 12/24/20. The following nursing note was documented: "(Name of Physician) in facility and informed that resident has sleeping more. Easily aroused and eats her meals. VS (vital signs) have been WNL. New order to decrease Risperdone to

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0.25 MG."

On 1/1/21, Resident #1's exit seeking behaviors had started back up. The following was documented in a nursing note: "Noted patient ambulating in hallway by self, put in W/C. Heard East Wing door alarming, patient was at door stated she was "going home." Patient went to door three times and alarm sounded and door locked and patient brought back to sit in W/C. Patient continues to say she does not live here and is constantly standing up ambulating by self. Patient is post fall from last night. Put patient in MD book to reevaluate due to decrease in Risperdone."

On 1/9/21, the following nursing note was documented: "Patient up in W/C at the nurses station, patient got self out of W/C and walked to the East Wing side door pushing on door and alarm sounded. Redirected patient from area without difficulty and no further attempts made by resident to go towards door today."

A nursing note dated 1/23/21 revealed that Resident #1 had gotten through one of the alarmed doors to the outside. The following was documented: "Alarm sounded. Staff immediately responded. Resident found outside. Resident brought immediately back inside. Head to toe assessment performed. Resident had no injuries."

The following intervention was added to Resident #1's elopement care plan dated after the 1/23/21 incident: "Redirect, head to toe evaluation and monitoring. (1/23/21)."

A nursing note dated 2/11/21 documented the

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following: "Resident is constantly standing and when she stands, she starts running. This is constant and she is watching staff and when they turn their back, she gets up and runs. She is mentioning a bomb going off and if we stand here, it's going to hurt us. Not able to redirect her from this thought and attempted to give her snack that she refused. Melatonin was attempted, she spit it out on the floor. Attempted to give her a drink, but she put it to her lips as if drinking it, then when this nurse turned around, she threw the liquid onto the wall."

A note from the nurse practitioner dated 2/12/21 documented in part, the following: "...Per staff, she has been up wandering with increasing agitation and psychosis (stating people are going to shoot her) and has repeatedly tried to elope. She currently receives Risperdone 0.25 mg BID...1. Paranoid Schizophrenia: will increase Risperdal to 0.5 mg BID."

Review of Resident #1's quarterly elopement assessment dated 2/18/21; documented Resident #1 as having wandering or exit seeking behaviors; verbalizing or exhibiting exit seeking behaviors and having a previous history of attempted or actual elopement or unsafe wandering.

Further review of Resident #1's clinical record revealed that Resident #1 continued to exhibit exit seeking behaviors on 3/11/21. The following nursing note was documented: "Patient noted to get up from W/C and go to East wing side door. Alarm sounding and patient redirected to W/C without incident. Patient at door again and ambulated down hallway extremely fast. Redirected back into W/C and UM (unit manager)

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took patient out in courtyard for a few minutes. Will continue to monitor any further attempts to go towards door. Patient stated when asked where she was going she said, "I'm going outside."

Review of Resident #1's care plan revealed that her care plan was reviewed on 3/11/21 but no further interventions were put into place for her exit seeking behaviors.

On 3/27/21, it was revealed that Resident #1 had a true elopement from the facility. The following was documented in a nursing note on 3/28/21: "Received report from offgoing (sic) nurse that resident had an episode of elopement resulting in a fall and was subsequently sent to the ER for evaluation and treatment last night. Returned to the facility with no new orders. Laceration to left corner of the lower lip reported and noted by this writer. Resident has no s/s pain, nonverbal but cooperative. Sitting in wheelchair at nurse's station at this time. Immediate Intervention: Neurochecks initiated and resident being monitored closely at the nurse's station."

Review of Resident #1's ED (Emergency Department) notes dated 3/27/21 documented in part, the following: Time of Arrival 3/27/21 (2054) (8:54 p.m.)...Fall from standing...Abrasion to lip...is a resident of (Name of facility) -chief complaint brought in by EMS (Emergency Medical Services) after the patient escaped (Name of facility) and was found lying in the road on a highway with a speed limit of 55 mph (miles per hour)..."

Review of a facility FRI (Facility Reported Incident) dated 3/27/21 and reported to the

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appropriate state agencies on 3/28/21 at 12:56 a.m. documented in part, the following: "Incident date: 3/27/21...According to CNA (Certified Nursing Assistant) resident got up from w/c and ran down hallway. CNA ran after her, while screaming for help. CNA unable to (sic) stop resident from getting through the doorway resident continue to run toward the street with CNA running behind her, resident stated she tripped and fell car passing, stopped and called 911...Employee action initiated or taken: CNA continue to run after the resident, as she ran throughout the door and toward the street, nurse assess resident (sic), police, and EMT also involved."

Review of the witness statement by the CNA (CNA #3) identified in the above FRI described the events of Resident #1's elopement entirely different from the FRI that was submitted. The following was documented: "On the evening on March 27, I noticed (Name of Resident) walking away from her unit. My self and other staff members kept redirecting patient back to her unit. approximately around 8:30 p.m. we heard an alarm on side door employee entrance. My self and other staff that were around we ran to the door and outside of the facility. that when we saw (Name of Resident #1) laying on the ground. we ran to her and 911 was called immediately. approximately 5 minute (sic) police and EMT arrived and to resident (sic) to emergency room for observation. from (sic) the moment I saw the resident last sitting at the nursing station to the moment I heard the alarm I believe it was between 3 to 5 minutes."

Another witness statement from another CNA (CNA #1) documented in part, the following: "I

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was working after coming off break, while sitting at computer, I heard someone yelling help, help! I went to the door, I notice one staff and a lady from outside say there is a lady laying in the road. I saw over resident (Name of Resident #1) laying down in the road. A stand by called 911."

A statement from LPN (Licensed Practical Nurse) #1, documented the following: "I (Name of LPN #1), was on my cart when I heard (Name of CNA #3) yell (Name of Resident #1) got out. I ran down the hall and out the door where I witnessed (Name of Resident #1) in the street. i (sic) approached the patient the police had already arrived and stated EMS was on the way. The patient had a small injury to her upper lip. She was able to answer questions and stated she was in no pain. EMTs, arrived and patient was transferred into their custody."

Review of the follow up to the FRI dated 4/2/21 and sent the the appropriate state agencies at 5:48 p.m., documented in part, the following: " (Name of Resident #1) admitted to (Name of facility) on 8.10.20 and she suffers from ventricular fibrillation, personal history of sudden cardiac arrest, anoxic brain damage, paranoid schizophrenia, chronic kidney disease, diabetes, history of falling, morbid obesity, unspecified dementia. On the night of 3.27.21 (Name of Resident #1) was sitting at the nurse's station in her wheelchair, she was being closely supervised by the staff assigned to her. Per staff, the resident required to be re-directed as she kept getting up and walking in the hallways. Resident is a fall risk and staff applied multiple interventions to ensure her safety to include several diversion activities, and encouragement to return to the unit she was residing in. Resident was complaint with the

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re-direction she received from staff. At approximately 8:30 p.m. the staff heard the side door alarm go off and immediately several staff members including (Name of CNA #1), (Name of CNA #3), (Name of CNA #2) and (Name of LPN #2) rushed to the door and outside the facility. The staff went out and observed her sitting on the ground just off the facility property. The police were called and the resident was sent to the hospital for evaluation and was treated for an abrasion. The resident returned to the facility on 3.28.21. Based on the alarm sounding at the side door we have reasons to believe that (Name of Resident #1) left the facility by pressing on the side door which does open if pressed for longer than 15 seconds. The distance between the side door and the place the resident was found were approximately 400 ft (feet) and this is a resident who is known by all staff to ambulate at a very fast pace at times. As a result of this incident the facility has taken several steps to protect (Name of Resident #1) as well as completed a full audit of the entire facility to ensure no other residents are at risk for elopement. Upon return to the facility (Name of Resident #1) was placed on one to one care, activities department completed an additional assessment called "All about me" where we added several diversion activities including but not limited to supervised ambulation to minimize resident's restlessness, we added temporary alarms on doors and discussed the care plan with the resident and her sister who is her emergency contact Nr. (Number 1). During this meeting we discussed that the resident needed to be in a more secured closed unit related to her dementia and her elopement behaviors. The staff was re-educated on elopement, elopement drills were conducted on all three shifts...The facility has reached out to

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another facility who has a secured dementia unit and the resident was transferred to that facility today 4.2.21."

Further review of Resident #1's elopement care plan revealed updated interventions dated 3/29/21 for "Close Supervision, Medication Review, and Supervised ambulation after dinner."

Review of Resident #1's "Resident Observation/Monitoring Tool", revealed that Resident #1 was placed on one to one supervision from 3/28/21 starting at 7:00 a.m. through 4/1/21. Staff initials were documented on this tool every 15 minutes as well as the resident's status.

A note from the ADON (Assistant Director of Nursing) dated 3/29/21 documented in part, the following: "...additional alarm applied to door exiting unit to provide auditory cue of door opening to staff. Will continue to monitor for effectiveness of interventions...Spoke with resident's sister (Name) via phone...(Name of sister) stated wandering and exit seeking behaviors not new, as resident had demonstrated similar behaviors at previous facility."

A note from the NP (Nurse practitioner) dated 3/29/21 revealed that Resident #1's Risperdone was increased back to 1 mg (milligram) in the evening only.

A note dated 4/1/21 from the Social Worker, documented in part, the following: "Met with resident to discuss transferring to another facility, resident was in agreement with transferring to facility. Called placed to (Name of sister) to discuss that resident was expected (sic) at

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(Name of Nursing Facility) and would be transferring to facility on 4/1/21 (sic) (Discharge date 4/2/21). (Name of sister) was agreeable to transfer stated she just wanted her sister safe..."

Review of the discharge summary dated 4/2/21 documented in part, the following: "Resident has been exit seeking and did exit the facility. Resident will be transferring to another facility for memory care. Family have no questions or concerns at this time. They are happy she is transferring to a locked unit..."

Review of an AD HOC QAPI Action Plan dated 3/29/21 documented the following:
"Problem Statement: Elopement Incident involving resident (Name of Resident #1).
Goal: To ensure resident's safety.
Root causes: Resident's increased risk of elopement due to poor cognition and poor insight into her safety.
Barriers: Insufficient staff to provide one to one care permanently. Doors that are not set up for wanderguard.
Tasks: All about me assessments on high risk residents...Start Date: 3/29/21. Actual Completion Date: 3/29/21.
Close monitoring of resident involved... Start Date: 3/28/21. Resident D/C on 4/2.
Installing additional alarms on all doors furthest from the nurse's station. Start Date: 3/29/21. Actual Completion Date: 3/29/21.
Scheduled Ambulation...Start Date: 3/29/21..."

On 4/6/21, review of the facility's "Elopement Audits" dated 3/30/21 were conducted and revealed that the facility identified four additional residents at risk for elopement. Wanderguards were applied to all four residents with a

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physician's order and care plan updated. It was documented that all four residents were added to an "Elopement Book."

On 4/6/21, review of the staff education revealed that all staff including non-nursing departments were educated on the "Elopement Policy" to include assessing ALL residents for the risk of elopement, the elopement book and procedures for a Resident Elopement. Staff were educated on 3/28/21 through 3/29/21. The facility was also able to provide evidence that elopement drills had been conducted on 3/29/21 for all three shifts.

On 4/6/21 at 2:20 p.m., this writer conducted a facility walk through of all exit and alarmed doors with ASM (Administrative Staff Member) #1, the Facility Administrator. The exit door near the facility laundry room (employee entrance and the door Resident #1 had exited) was observed to be alarmed. ASM #1 was able to show this writer that if the push bar was held down for 15 seconds, the door would unlock. While ASM #1 touched the grab bar, the door did a few low beeps, that would not be heard from the nursing station in between the 300 and 400 hall. The alarm did go off once ASM #1 went through this door. This door did not have a wander guard lock system.

On 4/6/21 at 2:21 p.m., the fire door separating the 300 nursing unit from the service hall was observed. An alarm was observed on the door that was functional if the door was physically opened. ASM #1 stated that the fire doors were shut at night once administration left for the day. ASM #1 stated that these were the new alarms that were installed in response to Resident #1's elopement. ASM #1 stated that the alarm used to

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sound like a loud siren when Resident #1 was still in the building. ASM #1 stated that because Resident #1 no longer resides in the facility, the alarm was changed to a loud "Ding Dong" sound. The loud "Ding Dong" sound was observed during observation.

On 4/6/21 at 2:22 p.m., an observation was made of the East Wing Side door. This door lead to the side parking lot. This door had a wanderguard lock system. At 2:23 p.m., ASM #1 asked Resident #2 (One of the residents identified as at risk for elopement) to walk towards the door. Resident #2 had a wanderguard placed to his left ankle. The East Wing side door immediately locked when Resident #2 walked closer to it.

On 4/6/21 at 2:24 p.m. through 2:33 p.m., observation of the rest of the facility doors were conducted. The following was observed:

1) The East Wing back door was an alarmed door with no wanderguard lock system. This door could also unlock after 15 seconds but would alarm once the door was opened.
2) The West Wing side door and back door were alarmed doors with no wanderguard lock system. These doors could also unlock after 15 seconds but would alarm once the door was opened.
3) The Activity Room exit door was an alarmed door with no wanderguard lock system. This door could also unlock after 15 seconds but would alarm once the door was opened.
4) The fire door separating the 100 and 200 nursing unit from the service hall had a newer installed alarm that would go off once the door was opened.
5) The exit door near the facility kitchen (On the service hall) was an alarmed door with no

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wanderguard lock system. This door could also unlock after 15 seconds but would alarm once the door was opened.
6) The front lobby door had a functional wanderguard lock system.

On 4/6/21 at approximately 2:24 p.m., an interview was conducted with ASM #1. When asked why only two doors were equipped to lock for the wanderguard system, ASM #1 stated that she was told by life safety that she could not have every door equipped for the wanderguard system in case of a fire and the firefighters had to get into the building. ASM #1 stated that if a resident with a wanderguard was in front of the doors when firefighters arrived, they would not be able to get the door open.

On 4/6/21 observations of facility revealed no concerns with residents wandering or trying to exit the building.

On 4/6/21 closer observations were made of two of the four "At risk" residents for elopement (Resident #2 and Resident #3). Wanderguards were in place per order and plan of care. There were no concerns related to exit seeking behaviors.

On 4/6/21 at 3:05 p.m., an interview was conducted with CNA #3, the first CNA to find Resident #1 missing. When asked what she could recall about the evening shift of 3/27/21; CNA #3 stated that she remembered hearing the door alarm going off. CNA #3 stated, "The door by the time clock." CNA #3 stated that she was at the nurses station that sits in between the 300 and 400 hall when she heard the alarm. CNA #3 stated that she made her way down the 300 hall

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and instantly knew that (Name of Resident #1) had gotten out. CNA #3 stated that she was yelling (Name of Resident #1) got out as she was running down the 300 hall. When asked why she knew it was Resident #1 who had gotten out, CNA #3 stated that earlier that shift the staff had to continuously redirect the resident who was trying to wander towards the exit doors. CNA #3 stated that as soon as she came out of the alarmed door near the time clock, she heard a lady screaming outside. CNA #3 stated that the lady screaming was a bystander who was yelling "Help, help, help." CNA #3 stated that by the time she got outside, Resident #1 was already laying down in the street. CNA #3 stated, "Everything happened so fast." CNA #3 stated that the bystander had stated that she called EMS. CNA #3 stated when she got outside, EMS was not there yet. CNA #3 stated other staff started coming out behind her. CNA #3 stated that the police had arrived first in response to EMS being called. When asked what time she heard the alarm go off on the exit door, CNA #3 stated that she was not sure, that she did think to look at the time. When asked how much time had past since she had saw the resident last in the facility until she heard the alarm going off, CNA #3 stated that she could not remember. CNA #3 stated she was not Resident #1's assigned aide that night. CNA #3 stated that Resident #1 wandered a lot in the facility and that staff were always trying to redirect her. CNA #3 stated that for the most part, redirection had worked. CNA #3 could not recall if Resident #1 had gotten out of the facility prior to 3/27/21. CNA #3 stated that Resident #1 wore a wanderguard but that not all doors locked for the wanderguard system. When asked what was in place at that moment to ensure other resident did not elope from other exit doors, CNA #3 stated

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that the facility put alarms on the fire doors that separate the nursing units from the service hall. CNA #3 stated that the fire doors were shut at night and will alarm if the door is opened. CNA #3 stated that since the doors are closer the nursing station, it is easier to hear and see a resident trying to leave through that door. CNA #3 stated that she was also educated on the elopement policy and what to do if a resident goes missing/elopes. CNA #3 denied being short staffed the evening of 3/27/21.

On 4/6/21 at 3:35 p.m., an interview was conducted with CNA #1, another witness to Resident #1's elopement. When asked what she could recall regarding the incident, CNA #1 stated that she was sitting at the nurses station when the door alarm had gone off. CNA #1 stated that CNA #3 went down to check the door. CNA #1 then stated that she heard hollering and could not recall where the hollering was coming from. CNA #1 stated that that was when she ran down the 300 hall. CNA #1 stated that the alarm led her down to the exit door across from the laundry room; the empolyee entrance. CNA #1 stated that she ran outside and saw that the traffic had stopped. CNA #1 stated that she believed she saw Resident #1 sitting in the middle of the road. CNA #1 stated that EMS and the police were there when she got outside but that bystanders were with the resident as well as CNA #3. CNA #1 stated that she heard that an ambulance was coming. CNA #1 stated she had no idea who had called the ambulance. CNA #1 stated that they usually kept Resident #1 at the nurses station for her frequent wandering and exit seeking behavior. CNA #1 stated that Resident #1 walked very well and sometimes walked very fast. CNA #1 stated that the staff would always try to give

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her something to do such as snacks, talking with her etc. CNA #1 stated that Resident #1 wore a wanderguard but that not every door was equipped for the wanderguard safety lock system. CNA #1 stated that directly prior to her elopement that shift, her and other staff had to keep redirecting her to her wheelchair for wandering. CNA #1 stated Resident #1 always had close supervision but was not one to one supervision. CNA #1 could not recall the time she had seen Resident #1 last that shift directly prior to the elopement. CNA #1 stated that she was not sure if the resident got out the building in the past. CNA #1 stated that the facility had added alarms to the fire door leading to the nursing units in response to Resident #1's elopement. CNA #1 denied being short staffed the evening of 3/27/21.

On 4/7/21 at 9:15 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was assigned to Resident #1 on 3/27/21 evening shift and the nurse who was present the first time Resident #1 got out of the facility on 1/23/21. LPN #1 stated that on the evening shift of 3/27/21; she was at the end of the 400 hall passing out medications when she heard CNA #3 scream "(Name of Resident) got out!" LPN #1 stated that she could not hear the door alarm from where she was. LPN #1 stated that CNA #3 was screaming and running at the same time. LPN #1 stated that everyone got up and ran. LPN #1 stated that they all ran down the 300 hall and out of the alarming door at the employee entrance. LPN #1 stated that all that shift, her and the staff had to constantly redirect Resident #1. LPN #1 stated, "I would ask her, Where are you trying to go?" LPN #1 stated that she was trying to keep Resident #1 entertained. LPN #1 stated, "I didn't want to put her in bed; she was a fall risk

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as well. We knew she wouldn't stay in bed. As soon as we couldn't keep our eyes on her, she'd booked it." LPN #1 stated that by the time she got outside, she saw the police had arrived on the scene. LPN #1 stated that Resident #1 was laying in the road with bystanders stopped. LPN #1 stated that it was "Overwhelming." LPN #1 stated that she went out to assess the resident and didn't see any physical injuries. LPN #1 stated that she heard that someone had already called EMS. LPN #1 could not recall the time of events. When asked why Resident #1 was never placed on a continuous one to one supervision, LPN #1 stated, "I don't know. I can only say, just don't have enough staff." LPN #1 stated that they also have other residents with behaviors. LPN #1 could not recall if the staffing was short that evening shift. LPN #1 stated that the facility had added more alarms to the fire doors that she can clearly hear at the end of the 400 hall (hall furthest from fire door). When asked about the first time Resident #1 got out of the facility on 1/23/21; LPN #1 stated that Resident #1 had gotten out of the 400 hall back door. LPN #1 stated that if you press on the door for 15 seconds, the door will unlock. LPN #1 stated that when they heard that alarm go off, everybody got up and ran and immediately got the resident back into the facility. LPN #1 stated that Resident #1 didn't get anywhere, that she was just hanging outside the door. LPN #1 stated that Resident #1 required close supervision and that she would not exit seek every day or every shift, but would have periods where she was "Super active." LPN #1 stated that the physician adjusted Resident #1's medications a few times. LPN #1 stated, "It was difficult."

On 4/7/21 at 12:30 p.m., further interview was

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conducted with ASM #1, the facility administrator. When shown ASM #1 that Resident #1's nursing report sheet dated 8/10/20 documented Resident #1 as having exit seeking behaviors at the previous long term care facility, ASM #1 stated she did not know this information when the resident was admitted. ASM #1 stated that it wasn't until the day after admission that the resident started exhibiting exit seeking behaviors. When asked why Resident #1 was transferred to their facility from another facility, ASM #1 stated that the other facility was trying to make room for their COVID positive residents and Resident #1 was transferred to them. ASM #1 stated that they planned to keep Resident #1 long term care. When asked if she felt the facility could keep a resident like Resident #1 safe; ASM #1 stated, "Just because they (a Resident) have exiting seeking behaviors, doesn't mean can't put interventions in place and keep them safe. We put interventions in place that were working and staff were following. We would have loved to transfer her somewhere else." When asked if the interventions put in place for Resident #1 were effective, if she was able to get out the facility on 3/27/21; ASM #1 stated that staff were closely monitoring the resident and it was only a matter of a "minute or two" that Resident #1 got out. ASM #1 stated that the resident had been in the facility for a long time and that the interventions had worked. When what interventions were put into place after the resident got out of a non-safety lock door on 1/23/21; ASM #1 stated "Literally the patient got out; a minute later staff right after her. Staff responded very well." ASM #1 stated that staff were utilizing the interventions already put into place. ASM #1 stated that her staff also did what they were supposed to do the evening shift of 3/27/21 by responding to the door

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alarm right away. ASM #1 stated that the facility on multiple occasions tried to transfer the resident to another facility with a secured unit but was unsuccessful due to the pandemic. When asked if they attempted to transfer the resident because they didn't feel they could keep her safe, ASM #1 stated it wasn't that the facility could not care for her, but that ideally any wandering/exit seeking resident would benefit on a secured unit.

Review of Resident #1's clinical record failed to evidence any previous attempts to transfer the resident to a secured unit prior to her 3/27/21 elopement.

On 4/7/21 at 2:35 p.m., ASM #1 was made aware for the potential for Immediate Jeopardy Past Non-Compliance related to Resident #1's elopement on 3/27/21. ASM #1 was asked to present any additional information.

On 4/7/21 at 4:20 p.m., ASM #1 was made aware of Immediate Jeopardy Past Non-Compliance. A formal POC (Plan of Correction) was requested.

On 4/7/21 at 5:15 p.m., 5:42 p.m., and on 4/8/21 at 12:00 p.m., the POC was sent to this writer and rejected for minor corrections.

On 4/8/21 at 12:22 p.m., the final POC signed by the facility administrator was accepted. The following was documented as the facility's abatement plan:

"Plan of Correction: Abatement for (Name of Facility) for (Name of Resident #1):

Corrective action for affected resident:
On 3/27/21 at approximately 20:20 (8:20 p.m.)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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staff responded to the door alarm, additional staff were summoned to assist her with the resident. The resident was observed on the street just off the facility ground. Resident reported that she had tripped and fell. 911 called and arrived on scene promptly. Resident was transferred to the hospital for an evaluation. The nurse was able to assess the resident briefly to note a small superficial skin tear to the corner of her lip.
3/27/21 22:56 her physician (Initials) notified of occurrence.
3/27/21 22:57 Emergency contact (Initials) notified of occurrence.
3/28/21 at 7:00 upon her return to facility the nurse on duty conducted a head to toe assessment, initiated neurological checks. Her wanderguard bracelet was in place and functional. The resident displayed no outward signs or symptoms of pain, had no additional injuries, and her neurological checks were without deficits. Facility continued to monitor resident for adverse effects and placed her on 1:1 supervision.
3/27/21 and 3/28/21 an elopement risk assessment was completed on (Name of Resident #1); she continues to be at risk for elopement. Her care plan was reviewed and updated.
3/27/21 the staff on duty were interviewed related to their last interaction with her or last time she had been observed by them. She had last been observed sitting at the nurses' station approximately 5 minutes prior to hearing the alarm sounding.
Resident remained on 1:1 supervision with additional activities of her choice provided until transferred to a secure memory care unit on 4/2/21.

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	495258	A. BUILDING _____ B. WING _____	C 04/08/2021

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How will with facility identify other like residents that have the potential to be affected and what corrective action will be done.
3/27/21 the nurse on duty completed an immediate head count; all residents were accounted for.
3/27/21 current wander guards in use where checked to ensure place and functional; all of which were.
3/27/21 facility exit doors were checked to ensure they are secure and alarm as designed; no adverse findings.
3/29/21 at 08:30 additional alarms were added to the doors by the Maint. (Maintenance Director).
Elopement risk assessments completed on current residents by the ADON on 3/30/21; no new findings.
A review of residents determined to be at risk according to the elopement risk assessment was conducted to ensure orders and care planned interventions are appropriate; no additional findings. This review began on 3/28/21 and was completed on 3/30/21 by the DON/designee.
All residents on admission have an elopement assessment completed to determine risk.

What will you do to prevent this from reoccurring or what systemic change will you implement:
100 % (percent) of staff were re-educated by the Administrator or designee on the Elopement policy and procedure, the alarms added to the doors, as well as additional interventions put in place for this resident. Education began on 3/27/21 and concluded on 3/29/21.
Elopement drills were conducted on each shift on 3/29/21 by the Administrator or designee; staff responded appropriately.
A review of the elopement binder was completed on 3/28/21 by the SS (social services) designee;

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no adverse findings.
Ad hoc QAPI meeting conducted 3/29/21.

How will you monitor and maintain ongoing compliance
Administrator or designee to complete and audit of the facility door logs 5 times per week for 4 weeks then monthly times 2. Audits to include doors being checked daily for function and alarm. Results to be forwarded to the facility QAPI committee for further review and recommendations.
Elopement Drills will be conducted on varying weekly for 4 weeks then monthly for 2 months; will resume regular schedule thereafter. Results to be forwarded to the QAPI committee for further review and recommendations.
Will continue to audit residents at for elopement to ensure interventions are appropriate and in place. Audits will be completed every week on residents at risk for elopement for 4 weeks then monthly for 2 months. Results will be forwarded to the QAPI committee for further review and recommendations.

Date of compliance: 3/30/21."

Review of the thirty day maintenance logs for March and April 2021, revealed audits of all door alarms were conducted on a daily basis.

Further review of the elopement drills revealed a second elopement drill was conducted on 4/8/21.

Further review of the Elopement Audits revealed a second elopement audit was conducted on 4/7/21 on all four residents initially identified as being at risk for elopement.

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Review of the "Elopement books" that were located at both the East and West nursing stations and at the receptionist desk contained the following information:
- All four residents that were identified as high risk for Elopement.
-All four residents face sheets and pictures.
-The Elopement policy.

On 4/6/21 through 4/8/21, interviews with staff were conducted to verify education regarding the elopement policy. There were no concerns related to staff education.

No further information was presented prior to exit.

Facility policy titled, "Elopement/Unauthorized Absence Policy" documents the following: "The facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner. Procedure: Assessment: 1. All residents will be assessed for the risk of elopement using the (Name) Elopement Assessment on admission, quarterly and as needed. 2. When the (Name) elopement assessment is a score 4 or higher, the resident is identified as "at risk for elopement."
3. Resident's identified at risk will have interventions promptly implemented to provide resident's safety.
4. Residents identified at risk will have their picture and facesheet placed in a binder that is kept in an area accessible by staff.
Resident elopement/unauthorized procedure:
1. Upon determining that a resident cannot be

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F 689	Continued From page 28 located a headcount will be conducted. If resident is still missing "Code Green" using the resident's name, room number, and unit name will be announced...Announce three times. 2. The clinical supervisor or designee will notify the Administrator, the Director of Nursing, and the attending physician. 3. The highest ranking staff members becomes the "Team Leader" and coordinates the search effort. 4. The Team leader or designee will maintain accurate documentation during the search process. 5. A floor plan will be used to ensure a thorough search of the interior. 6. If the resident is not located on the premises, the Team Leader will direct staff to conduct an external search. Team leader or designee will notify the family/legal representative and inquire as to potential whereabouts. 7. If the resident is not located in a reasonable period of time, based on resident's physical/mental condition and environment factors, the Administrator or designee will notify the local emergency response agencies... Actions when resident is located: 1. Page: "Code Green Clear" three times. 2. Examine the resident and record findings in the chart. 3. Notify family/legal representative. 4. Administer any missed/late medications per physician's order ... 5. Initiate prompt interventions to prevent further exit seeking..." COMPLAINT DEFICIENCY	F 689		