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F 000	INITIAL COMMENTS Correction date 3-8-17 The following deficiencies were identified during investigation of complaints #64406-C and #64679-C and facility-reported incident #66353-I . See Code of Federal Regulations (42CFR), Part 483, Subpart B - C.	F 000		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.	F 323		

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

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 323	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy and interviews, the facility failed to provide adequate supervision to protect 2 of 2 residents at risk for elopement. On 2/5/17 Resident #1 eloped from the facility without staff's knowledge and walked a few blocks away. An off duty employee identified Resident #1 and alerted the facility staff. The facility placed a Wander Guard bracelet on the resident approximately a ½ (half) hour before Resident #1 eloped, however the alarm did not activate/sound. Record review and observation revealed Resident #2's Wander Guard bracelet not consistently activating when tested. The findings constitute an immediate jeopardy to residents health and safety. The facility reported a census of 29 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 1/17/17 noted Resident #1 had been admitted on 1/10/17 from another nursing home. The MDS listed anxiety, schizophrenia, and amnesia as diagnoses of Resident #1. The BIMS (brief interview for mental status) assessment indicated Resident #1 had severe cognitive impairment indicated by the score of 4 out of 15. The MDS also noted that Resident #1 walked independently without the use of assistive devices. The Care Plan identified Resident #1 at risk for falls due to psychoactive drug use on 1/10/17, and staff should anticipate and meet his/her needs. The Care Plan revealed Resident #1 at risk for	F 323		

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impaired cognitive functioning, dementia or thought processes related to psychoactive drug use and a diagnosis of schizophrenia.
On 2/5/17 Resident #1's care plan identified he/she at risk for elopement and attempts to go out the door. Staff completed an elopement risk assessment and placed a Wander Guard bracelet to the resident's right wrist.

The initial Elopement/Wandering Evaluation dated 1/10/17 identified Resident #1 as high risk indicated by the score of 11.

A progress note dated 2/5/17 at 1:41 p.m. noted Resident #1 continually talked about the need to go see a friend that lived 3 blocks from Fareway. According to the document, Resident #1 attempted to go out the east door, but staff intervened. An elopement assessment had been completed and a Wander Guard applied to his/her right wrist.

A progress note dated 2/5/17 at 1:45 p.m. noted the frigid temperatures had been discussed with Resident #1 and the facility could assist in trying to arrange a meeting with his/her friend.

The Elopement/Wandering Evaluation dated 2/5/17 identified Resident #1 as high risk indicated by the score of 14.

A progress note dated 2/5/17 at 2:08 p.m. noted as the DON (Director of Nursing) was about to leave the parking lot, an off duty employee was pulling into the parking lot saying Resident #1 had been seen walking down the sidewalk. The DON drove to the location of Resident #1 and the resident got into her vehicle. The note identified the Resident stated he/she intended to walk to a

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friend's house that lived up the street. The DON reminded the resident how they just discussed arranging a meeting to see the friend when Resident #1 said "I know, but I want to see them." The noted revealed the resident wore sweatpants, a sweatshirt, winter coat, shoes, socks and a cap on his/her head. When asked, the resident said he/she exited the facility through the door they use when they go out to smoke.

A progress note dated 2/5/17 at 2:15 p.m. noted the Administrator walked with Resident #1 to the doors; and the Wander Guard alarm sounded each time.

A progress note dated 2/5/17 at 2:26 p.m. noted the outside temperature had been sunny, 31 degrees with 5 miles per hour (mph) winds at the time of elopement.

A progress note dated 2/6/17 at 8:08 p.m. noted Resident #1 attempted to exit the facility (independently) once during the shift and staff intervened.

A progress note dated 2/7/17 at 5:04 a.m. noted Resident #1 had been checked on frequently. The resident had been sleeping on the couch by the birds and [previously] sitting at the table in the south hallway.

A progress note dated 2/8/17 at 11:42 a.m. noted Resident #1 had been pacing the halls.

A progress note dated 2/8/17 at 7:56 p.m. noted Resident #1 attempted to exit the facility twice during the shift. The Wander Guard sounded and staff intervened.

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F 323	Continued From page 4 A progress note dated 2/13/17 at 7:16 a.m. noted Resident #1 went outside last evening. Alarm sounded. Returned inside with staff without incident. An interview on 3/7/17 at 8:15 a.m. with Staff C, RN, revealed she made the entry on 2/13/17 at 7:16 a.m. that read "Resident #1 went outside last evening; alarm sounded. Returned inside with staff without incident". The RN said the alarm went off so she radioed for everyone to do a head count. She stated that she thought both the Wander Guard alarm and the door alarm sounded, but could not be sure. Staff C said a CNA in the break room radioed back that she saw Resident #1 in the front parking lot. Staff C reported because of his/her location, the RN said she believed the resident exited the front door. The RN said they brought the resident in without incident. Staff C said the resident frequently asked to go out and smoke, but he/she had never attempted to exit. Besides the recent elopement, the RN said she did not know any other elopements. A progress note dated 2/18/17 at 3:47 p.m. noted Resident #1wandered into another resident's room and urinated on the floor. Resident #1 attempted to exit the facility twice at that point in the shift. A progress note dated 2/19/17 at 5:47 p.m. noted the nurse had been in another resident's room when she heard the door alarm and the Wander Guard alarm activate. She looked out the window and saw Resident #1 outside the front door. The nurse ran outside. She told the resident he/she had to let someone know before going outside and The resident replied "Why, the alarm went off	F 323		

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F 323	Continued From page 5 like it was supposed to". A progress note dated 2/20/17 at 7:00 p.m. noted that Resident #1 went outside when he/she saw another staff member out there. Easily redirected back into the facility. An interview on 2/28/17 at 10:40 a.m. with Resident #1 revealed he/she exited the facility through the alarmed door at the end of the east hall, not the "smoking door" the facility thought he/she used. The resident stated it happened about 10:00 a.m. 2. The MDS assessment dated 1/19/17 noted Resident #2 had been admitted on 1/12/17 from another nursing home. The MDS listed dementia, depression, psychotic disorder and tobacco use as diagnoses of Resident #2. The BIMS assessment indicated Resident #2 had severe cognitive impairment indicated by the score of 8 out of 15. The MDS also noted that Resident #2 walked independently without the use of assistive devices. The initial Elopement/Wandering Evaluation dated 1/12/17 identified Resident #2 as low risk indicated by the score of 9. The Care Plan identified Resident #2 as being at risk for falls due to psychoactive drug use on 1/12/17, and staff should anticipate and meet his/her needs. A revision dated 1/18/17 identified Resident #2 as a wanderer at risk for elopement related to impaired safety awareness. A Wander Guard bracelet had been applied to the resident. A progress note dated 1/16/17 at 4:41 p.m. noted	F 323		

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F 323	Continued From page 6 that Resident #2 had a Wander Guard bracelet applied to the right wrist due to continued wandering in the hallways and consistently looking for a cigarette or wanting to go smoke. A progress note dated 2/8/17 at 7:55 p.m. noted that Resident #2 attempted to exit the facility once during the shift. A progress note dated 2/16/17 at 11:03 p.m. and authored by Staff C noted Wander Guard to right wrist. Check every shift for wandering. Alarm does not go off. On 3/7/17 at 8:15 a.m. Staff C, Registered Nurse was asked about the entry made on 2/16/17 at 11:03 p.m. for Resident #2, which read " Check every shift for wandering, WG (Wander Guard) to right wrist, alarm does not go off", she said when the resident walked by the door, the bracelet usually activated the alarm, but this time it did not. The RN said she did not report it. 3. While testing alarms on 2/28/17 at 8:10 a.m. at the end of the east hall where Residents #1 and Resident #2 reside, Staff A, Housekeeper stated the alarm on the door leading outside had been mounted temporarily about a month before because the other one had broken. The alarm sounded only at that location whenever the door opened, unless someone intentionally used the key to disable it. The same key was used to silence the alarm if it had been activated. The key had been kept above a frame mounted on the wall. The alarm had been mounted right above the door, and the switch was accessible to anyone that wanted to use it. A switch on the alarm could be manually changed to delay the activation for 15 seconds after the door opened.	F 323		

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F 323	Continued From page 7 Observation showed a door leading into the break room at the opposite end of the east hall had been equipped with a door alarm. The alarm could be disabled by pushing a button (located about 3 feet from the floor) so the alarm would not sound once the door opened. Observation inside the break room, showed a door that led outside had been equipped with an alarm mounted at the top of the door. The alarm sounded only at that location anytime the door opened, and shut off as soon as the door closed with the automatic closer. At a later time, the surveyor asked Staff F, CNA to activate the alarm inside the break room as the surveyor stood in the nearby hallway to listen for the alarm. The door alarm could barely be heard when standing next to the door that led into the break room from the hallway. A South Hall exit door that led outside had been equipped with an alarm that sounded at that location only. While testing alarms with Staff A present during an observation on 2/28/17 at 10:22 a.m., the Wander Guard alarm failed to activate when Resident #2 walked through the door. Resident #2 had been wearing a winter coat and had on a Wander Guard bracelet. As a follow up, Resident #2 walked through the door again wearing the same coat and this time the alarm activated. Staff A said she did not understand why it failed the first time. Interviews: An interview on 2/28/17 at 12:00 p.m. with Staff D, Laundry, revealed she had gotten off work about 10:00 a.m. on 2/5/17. She said she had driven by the facility about 1:00 p.m. or 1:30 p.m. that afternoon and saw Resident #1 about ½	F 323		

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block west of Fareway on Bluff Street. She said the resident had on a brown corduroy coat, sweat pants, stocking cap and shoes. To ensure the resident's identity, she turned around and drove past him/her again. According to Staff D, she drove to the facility and told the DON. Staff D said they each drove separate vehicles, and she left when she saw the resident get into the DON's van.

According to Staff D, whenever she had a problem with a Wander Guard not being activated by a bracelet, she told the DON or the Administrator. Staff D said that sometimes she takes residents out to smoke at 8:00 a.m. to help the CNAs (certified nursing assistant). She said the alarms have not always gone off.

Staff D said she believed one of two things caused the alarm to fail. According to her, either heavy winter coats or another person walking between a resident's bracelet and the alarm acted as a barrier. Staff D said now nurses roll up the resident's coat sleeves to prevent the coat from obstructing the signal. Staff D said she did not trust the alarm system as 100% reliable. She said she always made sure to keep her eyes on the residents.

An interview on 2/28/17 at 2:20 p.m. with Staff B, LPN (Licensed Practical Nurse) revealed the facility put the Wander Guard bracelet on Resident #1 the morning he/she eloped. According to the LPN, Resident #1 talked about wanting to visit a friend in Cherokee since he/she had been admitted to the facility. Staff B said they tried to appease him/her by saying they would arrange that sometime. After telling him/her the prior, he/she went about his/her routine of walking around the facility. Staff B said the resident continued to talk about visiting his/her friend. The

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F 323	Continued From page 9 LPN said at some point that afternoon before he/she eloped, he/she came to the nurse's station and asked her a couple of questions. She referred him/her to the DON's office because of the nature of the question. Staff B said Resident #1 left the nurse's station and headed towards the DON's office and then did not see him/her again until the resident returned to the facility with the DON after the elopement. Staff B said she saw the resident headed toward the DON's office, so she assumed he/she went there. The LPN said shortly after she saw him/her, the DON approached her and said she was leaving for the day. Staff B stated she called the DON a few minutes after she left because she had a question. Once Staff B asked the question, the DON told her that should be the least of her worries. The DON asked Staff B if she knew the location of Resident #1. Staff B said she told the DON she had just seen the resident and sent him/her to her office before she left the building. The DON informed Staff B Resident #1 was down by the school and she would be bringing him/her back. Staff B said they returned minutes later. Staff B said this was the first time she heard of problems with alarms not being activated by resident's that wore bracelets. An interview on 3/1/17 at 8:30 a.m. with Staff E (Registered Nurse), RN revealed she worked as an aide from 6 a.m. to 2 p.m. the day Resident #1 eloped [2/5/17]. According to Staff E, the resident had been asking to walk downtown between 10:00 a.m. and 1:00 p.m. Staff E said she told him/her it was cold outside and suggested calling his/her friend instead. Staff E said she tried to utilize interventions in an effort to redirect him/her. She said she tried an activity, having him/her up by the nurses' station to watch a	F 323		

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movie. She said he/she constantly paced the halls looking for his/her room. Staff E said she believed Resident #1 actually forgot where his/her room was located. She said she assessed him/her every day since the elopement. She said they use a box (a small electronic device) to check his/her Wander Guard bracelet every shift. The RN said a green light comes on when it functions properly and a red light comes on if not. The nurse said they replace it if the red light comes on or when it reaches its expiration date. The housekeeper uses the same box to check the alarms at the doors. According to the RN, Resident #1 pushed the button to disable the door alarm at the smoking door and walked out the 1st glass door, but not through the 2nd door to the outside. He/She was easily redirected back inside. Since he/she demonstrated the ability to disable the door alarm and expressed an interest in walking somewhere, the RN told the DON they needed to apply a bracelet. The RN said she took him/her into the DON's office and assessed whether or not the bracelet should be applied. The results indicated he/she needed a bracelet. The RN said she informed Staff B, the on duty nurse. The RN said Staff B was busy, so she did it herself. Staff E activated the bracelet, and used the box to verify that it worked properly. Staff E said she did not check the bracelet against the Wander Guard alarm. The RN said that shortly after Resident #1 had been admitted; he/she tried to push the door open to go out. She said he/she had been used to going out to smoke anytime he/she wanted at the facility he/she came from. She said it has been difficult for Resident #1 and #2 to adjust to smoking at specified times only. According to the RN, the resident's bracelet activated the alarm to sound when he/she returned after eloping. The RN said she checked

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it with the box again, and it tested OK. The RN said Resident #1 had a big dark green or brown heavy coat on when he/she walked in. She stated he/she also had on long pants, a shirt, socks, shoes and a baseball hat. She said the cap did not cover his/her ears. The RN said the admitting nurse does the initial elopement evaluation. According to the RN, every new admission should be evaluated. She stated that a good nurse should apply a bracelet when a newly admitted resident fails the elopement assessment.

An interview on 2/28/17 at 1:10 p.m. with the Maintenance Supervisor revealed he found a broken wire on the far east door so he replaced it with a temporary alarm a couple weeks ago. He stated the alarm sounded just at that location, nowhere else in the building. He worked at the facility for about a year and the break room alarm system was configured the way it currently is. The Maintenance Supervisor reported he checked the schematic and figured out whoever wired the Wander Guard alarm at the smoking door had 3 wires in the wrong place. He believed that explained why the alarm failed on occasion

An interview on 2/28/17 at 8:05 a.m. and subsequent interviews with the DON revealed what she knew about Resident #1's elopement and the facility's alarm system. The DON said Resident #1 had been seen pushing the button to silence door alarms. The DON reported they made the decision to put a Wander Guard bracelet on him/her shortly before he/she eloped [on 2/5/17].
According to the DON, the resident exited the "smoking" door on the east hall where Residents #1 and #2 reside. The DON stated apparently Resident #1 had pushed the button to silence the

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F 323	Continued From page 12 door alarm, and the Wander Guard bracelet he/she wore had not activated the Wander Guard alarm when he/she exited because the resident had been wearing a corduroy coat that apparently acted as a barrier that caused the alarm to fail. The DON said she had not known Resident #1 eloped until an off duty employee pulled into the parking lot as she was about to leave for the day. She said Staff D, Laundry Aide informed her she had seen the resident walking on the sidewalk, about 1 ½ blocks near the Fareway. The DON said she drove to Resident #1 and he/she got into her vehicle. She said once she returned Resident #1 to the facility, they checked the Wander Guard alarm and bracelet he/she had on and it did not sound while he/she had his/her coat on. The DON stated but the alarm did sound when the resident was not wearing his/her coat. The DON said they had maintenance change the sensitivity on the alarm to compensate for the heavy coat. She said they did an initial elopement assessment when the resident was admitted from another facility. The DON said he/she scored an 11, which indicated a medium to high risk of elopement. When asked why Resident #1 did not wear a Wander Guard bracelet with a score of 11 and Resident #2 did with a score of 9, she stated up until that point, they used discretion on an individual basis according to their observations and not necessarily based on scores. She said Resident #2 demonstrated behaviors that warranted a more immediate need for a bracelet. During another interview, the DON stated the records that followed Resident #1 from the facility where he/she previously resided were incomplete and she did not know if the resident had a history of eloping. The DON stated she did not have any observations or knowledge that warranted the	F 323		

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	165428	A. BUILDING _____ B. WING _____	C 03/07/2017

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F 323	Continued From page 13 decision to apply a Wander Guard (WG) bracelet to the resident. This surveyor also informed the DON that interviews also confirmed that the Wander Guard alarm on the "smoking" door had failed on other occasions before Resident #1 eloped. The DON said nobody shared that information with her before the day he/she eloped. She said she expected staff to relay that type of information. A document titled Code Alert System Quote for a new alarm system had been written for the facility on 11/8/16 and expired on 12/23/16. A document titled Code Alert System Quote for a new alarm system had been written for the facility on 3/1/17 and will expire on 3/31/17. An interview on 2/28/17 at 10:45 a.m. with the Administrator revealed she expected the Wander Guard alarm system to work 100% of the time. She said she had consulted the appropriate people to inquire about updating the whole alarm system. She said Wander Guard had been contacted about a replacement part last October or November, at which time they had been informed the facility's system would become obsolete. According to the Administrator, they asked for a quote at that time. She stated after Resident #1 eloped on 2/5/17, the system's sensitivity had been adjusted when they realized the alarm failed to activate. The Administrator said she thought they resolved the problem by making that adjustment, and did not need to upgrade the system yet. On 3/1/17 the Administrator said they ordered a new alarm system that will be installed within 5 business days.	F 323		

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F 323	Continued From page 14 The facility revised their Elopement Policy on 2/17/ and instructed staff to complete an assessment of wandering residents. The policy indicated residents with a history of behaviors, including wandering, will be obtained prior to admission. The policy noted that an alarm bracelet may be placed on the resident to audibly alert staff of attempts by the resident to exit [the building]. The protocol indicated an alarm bracelet may be used for residents that had been considered at higher risk based on previous elopements. The policy indicated staff would implement frequent checks/monitoring as appropriate. The policy indicated residents with an exacerbation of wandering or exit seeking behaviors that continue, staff will provide 1:1 supervision until the physician can assess the resident for causes and or alternative placement is determined. The policy indicated when a door alarms are de-activated or turned off, staff will perform immediate head count to ensure all residents are accounted for and [notify] the unit nurse will/DON/Administrator will investigate how the door alarm de-activated. The facility abated the IJ on February 28, 2017 when they completed the following: a). Replaced Wander Guard bracelets for all residents (two). b). The Wander Guard system will be tested daily per shift by the charge nurse (or designee) to validate the equipment is consistently functioning as intended. c). Secondary alarms were purchased and placed on all [exit] doors.	F 323		

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F 323	Continued From page 15 d). Doors with codes to disable were replacement with alarm has been purchased and installed with the key maintained at the nurse's station. e). All residents identified at risk for elopement continue to be checked every 30 minutes and document on the observation flow sheet. f). The Wander Guard equipment, including bracket and detections units at the door will be checked every shift by the Charge Nurse with bracelet documentation complete on the TAR (Treatment Administration Record) and door checks documented on the flow sheet. g). All residents at risk for wandering or elopement will be frequently checked with documentation noted on the flow sheet. h). The facility re-assess residents' at risk for elopement/wandering for implementation of Wander Guards as needed. All staff were educated on the use and management of the Wander Guard equipment to minimize the elopement risk and maximize resident safety (all information listed above). The training consisted of new door alarms, frequent checks, door checks and the Wander Guard policy. Staff were trained on 2/28/17, and continued training on 3/1/17. These actions lowered the scope and severity of the IJ to a "D" level with the need for ongoing monitoring to maintain residents safety. The facility purchased a wandering management system to replace the current system entirely. On	F 323		

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F 323	Continued From page 16 3/10/17 the facility informed DIA the new system was now in place.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review and staff interview, facility failed to utilize sanitary techniques while handling food during breakfast service for 1 out of 1 kitchen. The facility reported a census of 29 residents. Findings include:	F 371		

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F 371	Continued From page 17 Observation on on 2/28/17 at 6:50 a.m. revealed that during breakfast service, Staff G, Dietary Aid handled a paper and pen and touched her hair net four times while using the same gloved hands to slice an onion. Staff G then handled the paper breakfast order forms, touched her hair net repeatedly and removed the glasses off of her face, before she used the same gloved hands to remove of 14 slices of bread from the wrapper and toasted, buttered, cut and plated them to be served various different residents. Next Staff G handled an unpeeled banana as she cut it in half and plated 2 premade pancakes before she handed a clean hair net to the Dietary Manager with the same gloved hands. She changed her right glove at 7:30 a.m. Staff G then touched the microwave button and her hair net repeatedly before she changed both gloves at 7:35 a.m. Staff G then handled the pancakes with her gloved hands, placed them in the microwave and touched her hairnet. She removed the pancakes from the microwave with the same gloved hands and plated them. Next she unwrapped and handled a slice of cheese, 3 pieces of bacon directly out of the pan before she toasted, buttered and cut 2 more slices of bread and with the same gloved hands. The facility's undated Guidelines for Food Handling policy directed that food will be handled in a manner that minimizes the risk of contamination. Proper utensils such as tissue, spatula, tongs or single use gloves will be used for food handling. If gloves are used, proper use needs to be followed; like washing hands before and after wearing or changing gloves; changing gloves whenever there is a change in activity, the type of food being worked with or whenever	F 371		

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F 371	Continued From page 18 leaving your workstation. Also change gloves after sneezing, coughing or touching hair or face with gloved hands. An interview on 3/1/17 at 10:30 a.m. with the Dietary Manager revealed that he had previously spoken to Staff G about washing her hands and changing gloves frequently. The Dietary Manager stated he would rather have her use bare hands and utensils than have the false sense that gloved hands are bullet proof.	F 371		