Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6929			**Date:** March 18, 2019
Facility Name: Casa de Paz Healthcare Center		**Survey Dates:** February 6 to February 27, 2019	
Facility Address/City/State/Zip: 2121 W 19th St. Sioux City, IA 51103	**MW/SS**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
58.28(3)e	**481—58.28(135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III) **58.28(3)** *Resident safety.* *e.* Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) **DESCRIPTION:** Based on clinical record review, facility policy review and staff interviews, the facility failed to ensure an intoxicated resident (#5) did not leave the facility without supervision and to an unknown destination of seven total residents reviewed. The facility reported a census of 59 residents. Findings include: The Minimum Data Set (MDS) assessment dated 11/20/18 documented Resident #5's diagnoses included diabetes, seizure disorder, anxiety disorder, depression, and uncomplicated opioid (narcotic) dependence. The assessment documented she had a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact memory and cognition. Resident #5 required supervision with transfers, walking and eating, and the assistance of one staff with dressing, toilet use and personal hygiene. The MDS documented that Resident #5 required daily	**I**	**$ 7500.00 (Held in Suspension)**	**Upon Receipt**

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	insulin, antipsychotic, antidepressant and opioid medications. The 8/28/18 Care Plan showed a focus area of Resident #5's risk for falling related to gait/balance problems, a history of falls, psychoactive drug use, and diagnoses of anemia, anxiety, depression and seizures. The Care Plan also noted that Resident #5 had diabetes, her blood sugars should be checked and medications administered as ordered. An intervention revised on 11/30/18 instructed staff to report all changes in the resident's level of consciousness, sweating, shakiness or sweet smelling breath to the charge nurse. An intervention initiated on 9/26/18 instructed staff to notify Resident #5's family of changes in condition. The care plan did not address her alcohol and drug dependency issues. A Medical Diagnoses list in the resident's electronic health record (EHR) documented her diagnoses also included alcohol abuse, alcohol induced chronic pancreatitis, alcohol dependence, suicidal ideations, sedative, hypnotic or anxiolytic dependence and opioid dependence. The March 2013 revised Clinical Programs Manual related to Elopement Management instructed: The facility is to immediately initiate procedures to locate any resident suspected of elopement. Notification of appropriate parties will comply with state and federal regulations. Elopement is defined as when a resident leaves the premises or a safe area without authorization and/or			

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	necessary supervision. If a resident is identified as cognitively intact, capable of making independent decisions and identified as their own person, has physician authorization and leaves the facility without staff knowledge, the following procedural steps will be taken: Upon return to the facility, the resident will be re-educated on facility procedures of leaving. If the same resident continues to leave without staff knowledge, the interdisciplinary team and physician may individualize the search procedure to address resident patterns. The Procedure: 1. Form a search team. Verify that staff is available to stay with current residents. 2. Notify the supervisor immediately of any suspected elopement. The Supervisor notifies the Administrator and Director of Nursing (DON) if the resident is not immediately located. 3. Search all areas of the facility. 4. Search the facility's immediate grounds and continue to broaden the radius of the outdoor search. Note: Initiate an outdoor search with a second team while the internal search is still underway if there is health threatening weather or a nearby external hazard. 5. Interview staff, other residents and visitors. 6. Notify the family and/or responsible party. 7. Notify the resident's physician. 8. Notify law enforcement and the state agency. The March 2013 revised Clinical Programs Manual related to Elopement Prevention instructed the			

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	following: Elopement is defined as when a resident leaves the premises or a safe area without authorization and/or necessary supervision. The Procedure: 1. Evaluate all residents on admission for risk of elopement: All new admissions that are at risk of elopement will have interventions to put into place immediately until further assessment is complete. Interventions include but are not limited to: a. Environmental modifications to prevent undetected exit (door alarms, wander alerts). b. Increased frequency of resident location rounds. c. Any resident that has a change in condition that places them at risk for elopement. d. Any resident with a history of elopement/wandering in a prior setting. 4. Place the Elopement Risk Alert form in the elopement risk identification notebook and maintain it in an easily accessible location. 5. Develop the Care Plan with input from the interdisciplinary team and the resident and family/responsible party. 6. Initiate individualized interventions to address risk of elopement. 7. Communicate individualized interventions to the caregiving staff, resident and/or family/responsible party. A Health Status Note dated 10/17/18 at 1:55 p.m. documented that a new prescription had been obtained to administer one Hydrocodone/Acetaminophen (Norco) 5 mg/325 mg			

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	tablet every 4 to 6 hours as needed (PRN) to Resident #5. A Health Status Note dated 11/15/18 at 8:05 p.m. documented that after Resident #5 called her surgeon's office, he ordered Resident #5's Norco to be gradually tapered and ultimately discontinued. A Health Status Note dated 12/11/18 at 12:34 p.m. documented that Resident #5 left the facility to see if staff at an urgent care clinic would order different pain medication. At 3:38 p.m. Resident #5 returned from urgent care without new orders. A Health Status Note dated 12/12/18 at 1:08 p.m. documented that Resident #5 returned to the facility with a new order to discontinue any previous order for Norco and to administer Norco 5 mg/325 mg every 6 hours PRN for seven days and a recommendation for counseling. A Health Status Note dated 12/19/18 at 9:02 p.m. documented that Resident #5 felt unhappy when the nurse told her she could not administer the narcotic pain medication she requested because she did not have an order. Resident #5 called the Administrator to voice her concerns. A Health Status Note dated 12/20/18 at 9:48 a.m. documented an order to administer one Norco 5 mg/325 mg every 8 hours PRN until tablets that remained from a previous order were gone, at which time the order should be discontinued.			

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	A Health Status Note dated 12/22/18 at 6:14 p.m. documented that the facility called the on-call doctor in an effort to obtain an order for the anti-anxiety medication Resident #5 requested. The nurse documented receipt of an order to administer one to two Hydroxyzine 25 mg tablets every 6 hours PRN. Health Status Notes dated 12/23/18 recorded that at 1:04 p.m., Resident #5 signed herself out saying she would return once she cashed a check; she left via taxi and returned to the facility at 1:24 p.m. At 2:57 p.m. Resident #5's roommate expressed concern because of the weird noises she heard Resident #5 making. Staff D, LPN (licensed practical nurse) documented Resident #5 told her to leave the room after she attempted to check her blood sugar. At 4:09 p.m. Staff D, entered Resident #5's room when she heard her calling out her children's names. Staff D noted Resident #5 acted differently and the resident permitted her to check her blood sugar. Staff D re-entered Resident #5's room to check her vital signs, at which time she saw Resident #5 finishing a 200 ml (milliliter) bottle of vodka. Staff D received authorization to administer Resident #5's medication from the on-call physician, recorded that Resident #5 is her own responsible party and that she reported the incident to the on-call nurse. A Health Status Note dated 12/23/18 at 9:04 p.m. documented that Staff F, LPN found Resident #5's wheelchair by the front door and could not find Resident #5 in the facility at 8:30 p.m. Staff F			

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	contacted Resident #5's daughter to see if she picked her mother up. Staff F also noted that Resident #5 had not signed out of the facility. Resident #5's daughter told her she had not seen her mother in a month. After further investigation, Staff F documented that another staff member overheard Resident #5 on the phone asking someone whether they were going to come and pick her up. Staff F recorded that another staff member said she saw Resident #5 leaving the facility with a woman (not a resident). When Staff F called again, Resident #5's daughter expressed concern that her mother may go out and get drunk and not return to the facility because she no longer received narcotic pain medication. Staff F wrote that she spoke to Resident #5 about 7:30 p.m., at which time she seemed alert and oriented, and that she notified the Assistant Director of Nursing (ADON). On 12/24/18 at 12:19 a.m. Staff F documented that Resident #5 had not returned to the facility and had not taken her medication prior to leaving. A Health Status Note dated 12/24/18 at 1:45 p.m. documented Resident #5 returned to the facility at 1:10 p.m. in a friend's personal vehicle. Resident #5 appeared to be intoxicated with stumbling, slurred speech, belligerence with staff and clothes soiled with urine and feces. When asked about her whereabouts, Resident #5 stated she had been everywhere. Resident #5 stumbled into her wheelchair, climbed into bed and started yelling she wanted to go to the hospital as she complained of having chest pain. After staff obtained the order, called the ambulance and notified her daughter, Resident #5 refused to go with			

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	the paramedics after they arrived at 1:15 p.m. The nurse notified Resident #5's daughter again and assured her they would monitor Resident #5 for any distress from detoxing from (not having) alcohol. Further assessment revealed that Resident #5 complained of severe lower back pain and of being very tired. Health Status Notes dated 12/26/18 at 6:03 p.m. documented Resident #5 said she wanted something different for anxiety at 4:15 p.m. Staff D wrote that she left a message with the resident's doctor and the physician's nurse called back saying the resident's request may not be addressed that day because of so few staff members in the clinic. Staff D informed Resident #5 they may not get a call until the next day. Resident #5 signed herself out at 5:20 p.m. and said she was leaving with a church friend. At 7:51 p.m., Staff B, LPN documented that Resident #5 had alcohol to drink and was currently in her room yelling and talking to people that were not there. Staff B recorded the resident's roommate expressed concern and asked if anything could be done for the resident. Staff B planned to call the on-call doctor about the resident's condition (however, interview with Staff B revealed she never called the doctor as planned). At 11:32 p.m., Staff B documented Resident #5 was still inebriated, threatened staff and called them vulgar names. Staff B wrote she found an empty bottle of vodka in the resident's garbage can. Health Status Notes dated 12/27/18 recorded that at 5:34 a.m. Resident #5 requested to take a walk			

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	outside of the building. The nurse explained that residents are not allowed to just go out for a walk. Resident #5 then re-approached her and requested to go to the hospital, but the resident refused assessment. When asked if she had an immediate need, Resident #5 told the nurse she was having an anxiety attack and in immediate need of care. The nurse initiated calls to obtain an order and to notify the on-call nurse, at which time Resident #5 yelled uncontrollably and demanded to be let out to walk to the hospital. The nurse called an emergency ambulance and it came and took Resident #5 to the hospital. The nurse notified the physician, the Administrator and the on-call nurse and documented Resident #5 as her own responsible party. A Health Status Note dated 12/27/18 at 5:55 a.m. documented hospital staff called to inform facility staff that Resident #5 refused their assistance and was going to leave the hospital and walk to her daughter's house. Resident #5 told hospital staff she would return to the facility by noon that day. Resident #5 eloped from the hospital at 5:50 a.m. The nurse also noted that Resident #5 was her own responsible person. A document dated 12/27/18 at 10:00 a.m. recorded an interview the DON (Director of Nursing) and Assistant DON conducted with Staff B before they ultimately terminated her related to a series of events that occurred during her 6:00 p.m. to 6:00 a.m. shift on 12/26/18. The events involved multiple residents, which included Resident #5. Staff B stated that she had no idea Resident #5 was intoxicated until the end			

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	of her shift. However; Staff B documented at 7:51 p.m. that the resident had alcohol to drink and yelled at people not in her room. The Staff B documented that the on-call would be notified, but failed to notify the physician. Staff B documented at 11:21 p.m. that Resident #5 refused medications and was still inebriated; still nobody was notified. When asked, Staff B stated she did not call because she did not feel as though it to be an emergent situation. When asked about conflicting information between what she said and what she documented, Staff B said she did not visually see Resident #5 drinking alcohol and did not see the bottle until morning. However; Staff B documented at 11:32 p.m. that an empty bottle of vodka was in the resident's trash can. Staff B did not give any additional explanation about the incident. An interview on 2/6/19 at 3:45 p.m. with Staff D revealed she knew Resident #5 had a history of substance abuse so she wanted to let the ADON know about the 12/23/18 incident. Staff D said Resident #5 could sign herself out since she was responsible for herself, but she wanted to check to make sure in light of the circumstances. Staff D stated the on-call nurse told her to keep a close eye on Resident #5 once she returned from cashing her check. Staff D said that although Resident #5 returned, they did not think she would because she had not been getting Norco anymore. Facility staff wondered if Resident #5 left to find something as a substitute for Norco, which she did. Resident #5 went to her room once she returned after cashing her check. Resident #5's roommate reported she heard Resident #5 making strange			

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	noises. Staff D then talked to the ADON and they felt the resident was on something. Resident #5 initially refused to let her check her blood sugar, but eventually agreed. Staff D went back into Resident #5's room to check her vital signs, at which time she saw the resident take the final chug from a bottle of vodka. Staff D said she suspected that Resident #5 obtained the vodka from a drive through liquor store down the road when she left to cash her check and the resident had a significant history of alcohol abuse. Resident #5 seemed to abstain from alcohol because she seemed content as long as she had access to Norco. The LPN said Resident #5 left AMA (against medical advice) last summer, wound up in the hospital after abusing substances and re-admitted to the facility after hospitalization. Staff D said that although she was only involved in the 12/23/18 drinking incident, but she believed it happened more than once. On 2/11/19 at 11:15 a.m. Staff D stated she did not really know how big of a bottle she saw Resident #5 drinking, despite documenting 200 ml. Staff D said the resident was really drunk. During interview on 2/7/19 at 8:15 a.m. with Staff F stated that her shift started at 6:00 p.m. on 12/23/18. Staff F said that although she had not been assigned as Resident #5's Nurse, she would have assumed responsibility for her after 10:00 p.m. Staff F remembered seeing Resident #5 at about 7:30 p.m. and the resident did not seem to be intoxicated. Resident #5 might have come up and greeted Staff F. The LPN said she would have referred Resident #5 to her Nurse if she asked for medication. Staff F recalled			

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	someone identified an unoccupied wheelchair by the front door as Resident #5's. Staff F said they searched the building and could not locate her. Staff F said the nurse assigned to Resident #5 from 6:00 p.m. to 10:00 p.m. said she heard the resident on the phone asking someone to come and pick her up and someone else told her they saw Resident #5 leave with a woman who did not reside at the facility so they did not search outside. Staff F called the resident's daughter when they could not locate her, who did not know her mother left or where she might have gone, and the facility's on-call person, the ADON. Staff F said nobody told her Resident #5 had been seen intoxicated after finishing the last drink from a bottle of vodka that day. She remembered being told about an incident, but she did not recall it being that day. Staff F spoke with Resident #5's daughter throughout the night about locating her mother and she left it up to the ADON once she notified her. Another nurse had been assigned to Resident #5 at the time she left the building, but she did exactly what she would have done if she was assigned to her. Staff F said she did not know if the facility informed Resident #5's daughter her mother was intoxicated after finishing a bottle of vodka. Staff F said she did not know if they implemented frequent checks after they saw her drinking and would not have known until she assumed responsibility for her at 10:00 p.m. Staff F definitely would have called the physician and monitored Resident #5 very closely if she found Resident #5 chugging the last of a bottle of vodka. An interview on 2/7/19 at 9:15 a.m. with Staff I, LPN			

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	revealed that she assessed Resident #5 when she returned to the facility on 12/24/18 after being gone all night. Staff I stated Resident #5 was very intoxicated and covered in feces; the resident went to lie down. Resident #5 complained of chest pain so she obtained an order to send her to ER. Once the ambulance arrived, Resident #5 refused to go with them. Staff I said she did not know how Resident #5 got back to the facility, she only saw her walk in the door. Staff I stated she did not know Resident #5's history because she only worked at the facility for a short while. Staff I said Resident #5 had been upset recently because physicians refused to prescribe narcotics to her. As a result, Staff I said Resident #5 left and got drunk. An interview on 2/7/19 at 9:40 with Staff C, RN, when asked about her observations of Resident #5 on the evening of 12/23/18 as her nurse, she did not recall the specific events of the evening. An interview on 2/11/19 at 12:15 p.m. with Staff G, RN revealed that she came to work on 12/27/18 at 5:00 a.m. Staff G saw Resident #5 in the front foyer and she smelled alcohol on the resident. Resident #5 was very intoxicated, slurring her words and swearing at the nurse and a CNA, and the resident wanted to leave the building on foot. She said they kept telling her it would dangerous for her to leave because of being very cold outside. Staff G said Staff B had been assigned as the resident's nurse that night, but another nurse was dealing with Resident #5 when she arrived for work. Staff G stated another nurse obtained an order to send the Resident to ER. Staff G said she			

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	heard about Resident #5 being intoxicated after being caught with a bottle of vodka a few days before and that Resident #5 should not be able to leave the building without supervision if she is intoxicated. Staff G stated instead, staff should notify the doctor and the resident should be monitored at least every 15 minutes when she is intoxicated. Staff G believed Resident #5 tried to self-medicate after doctors refused to prescribe narcotics to her and knew she had a problem with Norco. During an interview on 2/11/19 at 1:05 p.m. with Staff B, she stated the facility fired her, partly because of an incident involving Resident #5 on 12/26/18. Staff B worked the 6:00 p.m. to 6:00 a.m. shift that day and Resident #5 apparently had a lot of behaviors that started on the previous shift. Staff B said Resident #5 told the nurse on the previous shift that she wanted something for anxiety. Staff B said Staff D told her they called the doctor and he refused to prescribe anything for Resident #5's anxiety, which caused the resident to get upset. Staff D told them the resident planned to go to church to take care of her anxiety in her own way. Although the alternative use of the term "church" was not familiar to Staff B, she said other staff members knew Resident #5 actually meant going to the liquor store rather than church. Staff D told her Resident #5 signed herself out and left the facility. After report, Staff B saw Resident #5 walking in the front door, offering it must have either been a short church service or she didn't go very far. Staff B remembered someone told her they were supposed to be checking on Resident #5 every 15 minutes, but she did not see			

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	Resident #5 again until medication pass sometime between 7:30 and 8:30 p.m. Staff B heard someone swearing. Resident #5's roommate approached her and said it was Resident #5 she heard. Staff B figured Resident #5 still felt upset about not getting something for anxiety. After giving the roommate her medication, Staff B entered Resident #5's room and saw her sitting in her chair with her eyes closed and her arms across her chest. Resident #5 did not answer her when she called her name or when asked if she wanted her medication, so Staff B left the room. Resident #5 had a history of declining things and would let them know when she was ready at a later time. Staff B sent a Certified Nursing Aid (CNA) into Resident #5's room later when she heard the Resident yelling again. Staff B said it seemed apparent that Resident #5 did not want to communicate with her because she had been in there more than one time and the resident kept her eyes closed and did not say anything. When Staff B saw a CNA carrying garbage out of Resident #5's room she saw an empty bottle of vodka, but did not know the size bottle (guessing it to be the size of her hand). The resident's roommate said Resident #5 talked to people that were not there and from outside the room, Staff B overheard what sounded like Resident #5 yelling and arguing with someone. Staff B said she tried to assess her but Resident #5 turned completely away from her and shut her eyes. Resident #5 said she just wanted to go to sleep when the nurse asked her what she needed. Staff B stated she did not smell alcohol on the resident, so she could not account for her behavior. Despite documenting that she would, Staff B said she never called the doctor.			

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Facility Administrator Date

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Iowa Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number: 6929				**Date:** March 18, 2019
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	An interview on 2/12/19 at 11:40 a.m. with the ADON revealed that Staff D notified her about mid-morning on 12/23/18 that Resident #5 was going to cash a check and be right back. Staff D expressed concern about Resident #5 leaving and wondered if she should be allowed to go. According to the ADON, Resident #5 had a history of leaving AMA, but she made her own decisions as her own Power of Attorney (POA). The ADON said she authorized Resident #5 to leave. The ADON said she received another call saying the resident returned safely about 10 or 15 minutes later and she then told Staff D to keep an eye on Resident #5 because of her history of alcohol abuse and leaving AMA. The ADON received a call from Staff F later that evening saying that Resident #5 left with a heavyset woman after a CNA opened the door for her. The ADON said the CNA reported that Resident #5 said she would be back later. The ADON told Staff F to let her know when she returned. The ADON said got a very late call saying Resident #5 had not returned yet, sometime after 10:00 p.m. The ADON told Staff F to call her as soon as the resident returned and she would call the Administrator to let her know. The ADON said she called the Administrator as soon as she got off the phone with Staff F. According to the ADON, the Administrator said they should keep reaching out to see if they could find her if Resident #5 left AMA. The ADON said nobody mentioned to her that Resident #5 left AMA. Therefore, the ADON said she did not know if the resident just went out for the night. The ADON said the nurse took the liberty of documenting that she spoke to the ADON about			

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	Resident #5 leaving AMA. According to the ADON, she believed she told the nurse to call the doctor for authorization to administer her medication since she had been drinking alcohol. The ADON said if she faced the same situation as Staff F, she would have monitored the resident frequently, assessed and re-assessed the resident if she knew she was intoxicated. The ADON said she did not personally observe Resident #5 to determine if she was intoxicated. Between the time staff saw Resident #5 drinking and the time they discovered her missing, the ADON said it would be hard to say that enough time lapsed for her to be sober enough to leave the facility safely. And it's a fine line because she had been told staff can't stop anyone from leaving. The ADON said if she knew the resident was stumbling over drunk before she left, she would have contacted the doctor immediately to know what to do. The ADON said she never faced a similar situation. When asked, the ADON said she did not know if she would have called the police under those circumstances. The ADON said she would follow the direction of upper management. An interview on 2/12/19 at 12:15 p.m. with the Administrator revealed that although she did not know exactly when they notified her of Resident #5 being missing on 12/23/18; she knew nobody called her during the night after their discovery. The Administrator said she would have expected them to call her and the DON. Staff should have also called the hospital and the police since they found Resident #5 intoxicated before she went missing. The stated the facility was responsible for the resident's safety. If Resident #5			

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	drank a bottle of vodka, it should have been assumed that she was no longer capable of making rational decisions. A subsequent interview on 2/12/19 at 2:30 p.m. with the ADON revealed that she spoke to the Administrator the morning after Staff F discovered Resident #5 missing. The ADON said she told the Administrator about Staff D's concern about the resident leaving the facility with her history of substance abuse. A subsequent interview on 2/12/19 at 3:00 p.m. with the Administrator revealed that she found a text that she sent to the ADON on 12/24/18 at 9:09 a.m. She said she first talked to the DON and ADON about it on 12/24/18. The Administrator considered the text her evidence that the ADON notified her about the incident at some point before the time and date of the text. The Administrator's text informed the ADON that she spoke to their Corporate Nurse Consultant; who asked them to contact the hospitals to see if Resident #5 happened to be there. They were also supposed to contact the police and to inform they wanted to know the status of Resident #5's welfare if police had any interaction with her. According to the Nurse Consultant's instructions, the facility needed to document they contacted each hospital and the police to do a wellness check. The documentation should have also stated that Resident #5 had not been admitted to the hospital and police would do a wellness check if they had contact with her. The Administrator could not find documentation to verify that those things were done. The Administrator			

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	said she would have called the Nurse Consultant sooner if the ADON reported Resident #5 as still missing when she first realized it. A subsequent interview on 2/12/19 at 3:15 p.m. with the ADON revealed clarification about what Staff D told her in the mid-afternoon of 12/23/18. The ADON said Staff D told her she saw Resident #5 take the last swig out of a bottle of alcohol. According to the ADON, Staff D did not see her drink the whole bottle. The ADON said she told Staff D to assess Resident #5, take a full set of vital signs and notify the doctor to see if she could receive her medications without any interactions with the alcohol. The ADON said she also told Staff D to check the resident frequently. The ADON also clarified she obtained Staff F's call on 12/23/18 at about 8:35 p.m. Staff F told her they saw Resident #5's wheelchair at the front door. The ADON said Staff F's interviews revealed that Staff J, CNA overheard Resident #5 speak to someone on the phone earlier trying to get a ride. Staff J also said she opened the door and saw Resident #5 leaving with a woman who did not live at the facility. There had been recent discussions about Resident #5 leaving AMA in light of the physicians refusing to prescribe narcotics to her. An interview on 2/19/19 at 12:05 p.m. with Staff J, CNA stated she went in Resident #5's room on 12/23/18 at about 2:00 p.m. at the start of her shift. After a while, the resident's roommate came out of their room expressing concern about Resident #5 acting weird. Staff J entered the room and asked Resident #5 some questions, which she did not			

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	respond to, but Resident #5 said she was in pain. Staff J stated she could not smell alcohol, but she did not get very close to the resident. Staff J thought maybe the resident had low blood sugar so she reported it to Staff D. Resident #5 told Staff D to get away from her when she went to check on her. Staff J said she continued on with her duties. Staff J said she heard about 3:00 or 4:00 p.m. that Resident #5 had been drinking. Staff J asked another staff member what they knew about Resident #5's condition and they realized she had been drinking once they found an empty bottle. Staff J next saw Resident #5 around 7:00 or 8:00 p.m. by the front door. Resident #5 called her over to let her out the door; the resident did not ask, but said she was leaving with a visitor. Staff J said she entered the code for them to leave. Staff J thought Resident #5 already signed out, but realized she had not when the nurses were looking for her an hour or two later. Staff J learned Resident #5 left without signing out. She did not know if Resident #5 got in a car or if she walked away, and Resident #5 did not slur her words or stumble on her way out the door. The CNA said she seemed sober, but she acted really mean. Staff J said she could not smell alcohol on her at that time either. Staff J stated she knew Resident #5 should not leave before signing out, but she did not realize the resident had not signed out. Staff J said she never knew Resident #5 had a history of substance abuse. An interview on 2/20 at 9:40 a.m. with Staff A, RN revealed that Staff D brought an empty liquor bottle out of a resident's room on 12/23/18 at about 4:00 p.m.			

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	and showed it to her. Staff A estimated the size of the bottle as about 6" (inches) tall, 4" wide and about 1" to 1 ½" thick. Staff A said she knew Resident #5 wanted to leave earlier in the day to go cash a check. She and Staff D told Resident #5 there were not any banks open. Staff A said she did not see Resident #5 outside of her room after Staff D showed her the empty bottle, not even in the dining room when she did medication pass. An interview on 2/20/19 at 1:10 p.m. with Staff H, CNA revealed that she did not know Resident #5 had a history of substance abuse. Staff H said she heard about Resident #5 leaving one night after she had been drinking. Nobody told her to monitor the resident closely in the preceding days before 12/23/18. Staff H said that although they had assigned halls, they assist residents wherever they're needed. A subsequent interview on 2/20/18 at 1:40 p.m. with Staff A revealed she knew Resident #5 had a history of substance abuse. Staff A said Resident #5 always asked for pain medication and believed Resident #5 had diagnoses related to substance abuse too. Staff A said nobody told her to monitor Resident #5 carefully because of no longer receiving pain medication in the days that preceded the 12/23/18 incident. An interview on 2/20/19 at 2:30 p.m. with Staff E, CNA revealed that she worked with Resident #5 a lot and realized she had a history of substance abuse. Resident #5 brought alcohol back to the facility and came back drunk a couple of times. Staff E			

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	remembered a night they found Resident #5 drunk in her room. Staff E said the resident yelled, screamed and got really mean. Staff E said she also knew Resident #5 had a dependency issue with prescribed narcotics. Staff E said Resident #5 always argued and yelled at the nurses about needing her pills. Staff E recalled multiple incidents sometime between mid-December and mid-January. She remembered the night Resident #5 left the facility after she got caught drinking in her room. Staff E said they found an empty bottle. Staff E said she did not remember if the resident signed herself out or just left without telling someone. According to the CNA, every resident is supposed to tell someone before they leave. Staff E said she would ask a resident if they signed out yet if they asked her to let them out. Staff E said she did not see anyone visiting Resident #5 that night. Staff E recalled another time when Resident #5 came back drunk after saying she was going to church. When asked, Staff E said she did not know that Resident #5 had no longer been getting Norco in the days that preceded the alcohol related incidents. The CNA said nobody informed her to check on Resident #5 frequently. She said it would have been nice to know that she was not getting narcotics so that we could have kept a better eye on her. According to Staff E, CNAs are around the residents more than anyone and they need to know what is going on. The incident detailed above resulted in an Immediate Jeopardy (IJ) for facility residents. The facility abated the IJ situation on 2/21/19 through a combination of staff education on the needs of residents with histories			

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	of substance abuse, when to initiate assessment of said residents and when to identify abuse allegations or the need for close supervision.			

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