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F 000	INITIAL COMMENTS Correction Date: _____ The following deficiency is the result of the investigation of incident #89670-I, completed on February 27 - March 3, 2020. #89670-I was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy and staff interviews the facility failed to ensure that each resident received adequate supervision to prevent elopement for 1 of 7 residents reviewed as identified by the facility at increased risk for elopement, (Resident #1) who exited the facility unsupervised. Which resulted in an immediate jeopardy to resident's health and safety. The facility reported a census of 63 residents. The Minimum Data Set (MDS) assessment dated 1/24/20, for Resident #1 documented diagnoses of Alzheimer's Disease, Cerebrovascular Accident (CVA), Non-Alzheimer's Dementia, anxiety, depression and psychotic disorder. The resident had scored 7 of 15 on a BIMS (Brief Interview for	F 689		

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

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Mental Status) test, which indicated severely impaired cognition. The MDS documented no wandering and supervision with locomotion off the unit.

The Nursing Admit Data Collection tool dated 12/20/19 at 10:00 a.m., documented behavior/cognitive (*) items indicate risk for elopement:
1. Does the resident have a history of any of the following? (check all that apply)
*long term memory loss-checked.
*short term memory loss-checked.

A Social History with an effective date of 12/23/19 at 10:00 a.m., documented psychosocial factors: behaviors with wanders being checked.

A Care Plan, dated as initiated 12/20/19, identified a focus area of resident is at risk for falls related to Alzheimer Dementia with behaviors evidenced by history of falls, resident will not sustain serious injury through the review date. Interventions include: to encourage participation and plan diversional activities that are of resident interest, social activities, coffee group and cards, review as indicated for significant changes in cognition, safety awareness and decision-making capabilities. An initiated date of 2/24/20, established a goal, the resident will not leave facility unattended. Interventions included: check resident every 15 minutes, wandergard used to alert staff to residents movement and to assist staff in monitoring movement.

A Progress Note dated 2/24/20 at 7:45 a.m., documented observed Resident #1 leaving breakfast table without walker, appears slightly

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upset. Facility charge nurse present. This staff member intervened and walker given to resident and asked if could accompany her to room. Resident replied "yes please". Resident ambulated with gait steady with wheeled walker to room with this staff member. Resident mildly upset and crying, encourage resident to take deep breaths and reassured all is okay and husband would be visiting this a.m. Offered drink of water and refused. Resident seemed to accept reassurance from this staff member, and left room. CNA in hallway alerted to resident in room, sitting in recliner and behavior observed.

A Progress Note dated 2/24/20 at 2:42 p.m., noted resident returns to facility from hospital accompanied by husband. Resident is tired at this time, goes to room and rests in bed. Complete head to toe assessment is completed upon return from the hospital. Wandergard bracelet is placed on right side ankle immediately upon return. Care Plan updated to include focus on elopement and15 minute checks are put into place.

An Incident Summary, dated 2/24/20 at 9:00 a.m., and revision dated 2/26/20 at 8:10 a.m., documented at 6:00 a.m., this morning 2/24/20 Resident #1 was in bed sleeping. At approximately 6:45 a.m., Certified Nursing Assistant (CNA) wakes resident up to see if she was ready to get up for the day. Resident said "sure" and proceeded to get out of bed. Resident was already dressed, so staff assisted with set up for brushing teeth and helped comb her hair. Resident in a cheerful mood at this time and was ready for breakfast. Resident then came out to breakfast. At breakfast, resident became upset and was crying. At 7:55 a.m., staff assisted resident back to her room and resident was

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sitting in recliner. At 8:03 a.m. the door alarm on 100 link south door sounds. At 8:04 a.m. staff responds to door alarm and physically checks outside, but does not see anyone. Staff then turned door alarm off. At 9:00 a.m. a phone call received form Resident #1's husband that resident is in the hospital. Upon investigation with County Sheriffs office, a call was received at 8:24 a.m. of elderly woman on the side of the road. A community member was stopped and attempting to assist the resident, and witnessed the resident fall and bump her head. Sheriff arrived on scene right after community member called for an ambulance. Sheriff stated resident appears to be ok, but is disoriented. Resident is transferred to hospital per ambulance for evaluation. Report received from hospital that everything has checked out ok and resident will be retuning to us later today. While resident was out of the building, resident was wearing long pants, shoes, a jacket, and had her red purse. According to the weather report, it was 39 degrees outside at the time. After speaking with the community member who was helping the resident, she had stopped her car to ask the resident if she could help her and offered her a ride. Witness stated resident slowly fell to ground onto her knees and then to her side and bumped her head on the ground. Driver then got out of the car to help. Driver reported the resident was wearing a red jacket and had her purse. When the sheriff stopped on the road to assist them, he asked the resident her name and she was able to state her name. When asked what today's date was, resident was not able to answer correctly. At 2:20 p.m., resident returned to the facility accompanied by her husband. Nurses completed a head to toe assessment and the only thing found was bruising on bilateral knees. During assessment, wandergard bracelet

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was placed on residents ankle and 15 minute checks have been implemented. Nurse stated resident had laughed a couple of times while she was joking with her. Resident #1 rested in bed after completion of assessment.

An Emergency Room Report, dated 2/24/20 at 9:00 a.m., documented patient arrived via ambulance. Patient had fallen in front of the Sheriffs department and had eloped from the Nursing Home. Patient is currently a resident there for dementia. Impression, knee contusion, fall, and contusion of head. It is reassuring that there is no immediate life-threatening condition found during patients examination.

A Nursing Admit-Readmit Data Collection tool dated 2/24/20 at 2:20 p.m., documented 1. behavior/cognitive (*) items indicate risk for elopement:
*long term memory loss-checked.
*short term memory loss-checked.
*resident may be at risk for elopement-checked.
Focus-the resident has potential for elopement related to diagnosis of Alzheimer/Dementia evidenced by recent elopement-checked
Goal- Resident will not leave the facility unattended
2. All skin observations: right front knee bruising 3.5 centimeters by 2.0 centimeter.

A Communication to the Physician by facsimile, dated and signed by the physician on 2/24/20, documented concern: Resident had an elopement episode this a.m.. Okay to apply wandergard alarm to decrease risk of further episodes. Physician responded: Good idea, not sure how she got out.

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Review of the Policy and Procedure for Alarms: Bed, Chair and Door dated 12/19, documented the policy is the center will ensure that a system is in place for all bed, chair and door alarms and these alarms are in proper working order. Alarms will be installed and placed according to the manufacturers instructions: All staff will be responsible for physically checking on the resident when an alarm goes off.

Review of the Resident Elopement with no date, documented: In the event of a Resident Elopement: Elopement is defined as "a resident who has impaired decision-making ability, leaves the facility with-out the knowledge or authorization of staff, regardless of injury".
1. Notify the Administrator, Director of Nursing, and Charge Nurse immediately
2. Mobilize staff to begin a search. Begin an organized, assigned street search and dependent upon staffing, send at least one person from each hall to search. "THE CHARGE NURSE MUST STAY IN THE BUILDING."
3. If the resident cannot be located within a reasonable amount of time, the Charge Nurse will notify the police to assist with the search.
4. In all cases, family will be notified of the incident.
5. Notify the physician.
6. Complete the incident report in point click care as well as paper investigation sheet. When completing the sheet, be sure to include the following:
*Any injuries the resident sustained.
*Weather conditions at the time of the elopement, raining, snowing, evening, daylight, temperature, etc.
*Corrective action that was taken.
7. Notify DIA with in 24 hours.

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Review of the Policy and Procedure for Elopement dated 4/16, stated purpose is to:
*Asses and identify residents at risk for elopement.
*To clearly define the mechanisms and procedures for monitoring and managing residents at risk for elopement.
*To provide a system of documentation for the prevention of, and in an event of, elopement.
*To minimize risk for elopement through individualized interventions.
*To provide staff members with education on elopement at orientation and at least annually.
*To identify a plan in the event of resident elopement.
*To provide protection for residents at risk for elopement.
Policy included:
*The location will be responsible for maintain a system that clearly defines the mechanisms and procedures for monitoring and managing residents at risk for elopement. These include identifying environmental hazards and residents risks: evaluating/analyzing hazards and risk: implementing interventions; and monitoring/modifying interventions as needed.
*All residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed. Each location will put measures in place to minimize the risk of elopement that are individualized to resident needs and identified on the care plan. When an elopement occurs, immediate efforts to locate the resident will be taken. All occurrences will be documented and all follow-up required by state and federal regulations will occur.
*Careplan team members should consider the following when assessing risk for elopement:

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*wandering behavior- the movement may be goal-directed (the person appears to be searching for something such as an exit) or may be non-goal directed or aimless. Non-goal directed wandering requires a response a manner that addresses both safety issues and a evaluation to identify root causes to the degree possible. Moving about the location aimlessly may indicate that the resident is frustrated, anxious, bored, hungry or depressed. Unsafe wandering and elopement can be associated with falls and related injuries.

*History of elopement

*Cognitive impairment

*Attempts to leave location

*Residents who are new admits to location

*Recent alteration in residents mental status without a history of previous cognitive impairment to include memory loss, decrease awareness and disturbances in judgement, reasoning and perception.

During interview on 3/2/20 at 11:30 a.m., Staff A, Certified Nursing Assistant, (CNA) stated on 2/24/20 she was scheduled to work the 300 hallway for which is not her normal hall, usually she works the 200 hallway so she was frazzled that they had switched her assignment. Staff A said that about 8:00 a.m., Staff A was in room 321 doing cares when the door alarm sound that was right next to room 321, Staff A couldn't stop what she was doing to get the door alarm. Staff A said about 8:03 a.m., went out of the room and went down the 300 hallway and then 100 hallway to see if any staff or visitors came in through the southeast door. Staff A stated she didn't see anyone that she didn't recognize so she went to the southeast door and proceeded to look out the windows, didn't see anyone, and then proceeded

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to punch in the code to silence the alarm. Staff A failed to announce anything over the walkie because Staff A didn't think it was a resident. Staff A proceeded to work on the 300 hallway when about 9:00 a.m., the facility director came over the walkie asked if anyone had seen Resident #1, that the husband had called the Director of Nursing and said the resident was in the emergency room at the hospital and the resident had walked out of the building and was found along the side of the road. Staff A commented she was in room 307 when the page came over the walkie. Staff A responded to the facility Director of Nursing and stated the door alarm was sounding on the south east side of the facility but when I looked out the windows I didn't see anyone so I went and silenced the door alarm. Staff A admitted they heard the southeast door alarm but when looked outside didn't see anything or anyone so Staff A punched in the code to silence the door alarm off. Staff A admitted they didn't go out the door and look around the facility, Staff A went back to taking care of residents.

During interview on 2/27/20 at 9:50 a.m., the facility Director of Nursing stated on 2/24/20 at 8:03 a.m., the southeast door on the 200 hallway had alarmed, staff at 8:04 a.m., went and responded to the door alarm, peeked their head out of the door and didn't see anyone so silenced the door alarm and continued with their daily duties. The Director of Nursing was told a community member had driven by Resident #1 on 4th Avenue and saw that the resident looked lost, so the community member stopped to assist Resident #1 to see if she needed help, in the process of visiting with the resident, the community member saw the resident go down on

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her knees and bump her head on the curb, by that time the sheriff came by (the sheriff office is south of the facility) and asked the resident who she was, 911 was called and the resident was taken to the local hospital for an evaluation, the residents husband called the facility at 9:00 a.m., stating that the hospital had called to notify him the resident was at the emergency room, they are running test and when/if the tests come back ok, they will be discharging her back to the facility. At 2:00 p.m., the Director of Nursing received a phone call from the husband that the test results came back and no injuries were found and labs were ok so Resident #1 will be coming back to the facility. A wandergaurd was placed around the residents left ankle and 15 minute checks have been initiated. All staff got re-educated on responding to the door alarms and not to silence them until they know for sure that all the residents are accounted for, re-educated on missing/elopement residents and signed off that they understand what they need to do.

During interview on 2/27/20 at 11:02 a.m., the town sheriff said he was coming to work, around 8:20 a.m., on 2/24/20, he was heading north, (the speed limit going north said 35 miles per hour) he came up over the hill and noticed a lady was on the ground about 4 feet off the highway lying on her back on the west side of the highway. He assisted the community member by staying with the lady on the ground while the lady from the community got a blanket out from her car. The community member called 911 to dispatch the ambulance to the scene. The sheriff stated he was really glad that she didn't get hit, due to this can be a very busy highway. He said there was no walker with her and that she did have long

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pants on, coat and a purse, the day was sunny and not breezy. He went on to say she was pretty lucky that she didn't fall and get hurt worse, like a head injury, or sustain a fracture.

During interview on 3/3/20 at 9:05 a.m., the community member said she was driving south on 14th Avenue when she noticed a lady in a jacket carrying her purse on the right side of the road, past the sheriff department. She pulled up along side of the lady and asked her if she needed a ride, the lady looked at her puzzled so she pulled up in front of the lady on the right side of the road, got out and walked to the back of her car and as she was approaching her she went down on both knees and then leaned to the left and fell onto the ground and bumped the side of her head on the pavement. She went ahead and called 911 not sure who the lady was or where she came from. This happened around 8:15 a.m., on 2/24/20, about that time the sheriff came over the hill heading north and stopped on the east side of the road, and came over to assist with the lady. The sheriff asked the lady questions on who she was and where she lived and she was not able to answer any of those questions that were asked. I explained to the sheriff that I had called 911. He stayed with the lady on the shoulder while I went to my car to get a blanket out to cover her, it was sunny but the wind was cool. The ambulance came, not sure what time, loaded her up on a cot and took off, so I got back into my car and proceeded to go south and do my errands.

Observation on 3/2/20 at 4:15 p.m., revealed the speed limit sign on 14th Ave SE, coming north stated 25 miles per hour, as you approach the hill and proceed to go over the hill the speed limit

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sign stated 35 miles per hour, as you go north off of Highway 3 onto 14th Ave SE, the speed limit stated 35 miles per hour, as you come up and go over the hill, still heading south the speed limit drops to 25 miles per hour.

The distance from where the resident left the facility through the southeast door to the area where the resident was found was approximately 500 surveyor steps, for which the resident crossed a field with rough and rugged grass, a curb outside of the facility and a driveway with pot holes.

The National Weather Service Forecast Office for 2/24/20, documented the temperature at 39 degrees Fahrenheit, with the wind out of the east northeast at 10.5 miles per hour

During an environmental tour on 2/27/20 at 9:30 a.m., facility Director of Nursing and Business Office Manger went around to all the door alarms and they all sounded and staff responded quickly to the alarms.

The facility abated the immediate jeopardy on February 24, 2020 by educating all staff that each and every time a door alarm goes off all staff, irregardless of position or department is expected to respond to the alarm and determine why the alarm went off. The immediate area outside the door which is sounding must be checked to ensure no resident is out there. If no immediate known reason why the alarm sounded, a head count must be done to ensure all residents are present and accounted for.