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	165497	A. BUILDING ______ B. WING ______	C 03/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

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F 000	INITIAL COMMENTS Correction date 3-26-20 The following deficiency resulted from investigation of facility self-reported incident #89790-I. Substantiated. See the 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 clinical record review, observation, staff interview, facility record review, and facility policy review, the facility failed to ensure the CCDI (Chronic Confusion and Dementing Illness) unit doors were kept securely locked at all times to prevent the risk of elopement (when a resident leaves the facility without staff knowledge, failed to follow the facility procedures for responding to door alarms to ensure no residents eloped from the facility, and failed to ensure temporary agency staff received training on the elopement procedures for 1 out of 4 residents reviewed for elopement (Resident #4). On 3/4/20 at approximately 5:45 p.m., Resident #4, who resided on the CCDI unit, found walking outside the facility in the parking lot. On 3/10/20 at	F 689		

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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approximately 4:30 p.m. the CCDI North double door exit was not securely locked. At 5:56 p.m., staff responded to the front door alarm and only looked through the window to search for a possible resident, then turned the alarm off without going outside as instructed by the elopement policies and procedures. The facility identified 21 residents that displayed impaired cognition and were independently mobile. The facility reported a census of 50 residents.

Findings include:

According to the annual Minimum Data Set (MDS) assessment tool dated 11/28/19, Resident #4 had diagnoses that included arthritis, osteoporosis, Parkinson's disease, repeated falls, and personal history of healed traumatic fracture. The MDS identified a Brief Interview for Mental Status (BIMS) score of 07 (severe cognitive impairment) with fluctuating signs of inattention and disorganized thinking. The MDS recorded the resident exhibited wandering behavior daily and required supervision of 1 person for transfers, and locomotion off the unit. The MDS documented the resident required supervision with setup assist for walking in room, walking in the corridor and locomotion on the unit. The MDS identified the use of a walker and described the resident as not steady but able to stabilize without staff assistance with moving from seated to standing position, walking, turning around, and surface-to-surface transfers. The MDS documented the resident experienced 2 or more falls without injury and 1 fall with injury since the prior assessment.

The BIMS assessment dated 12/4/19 recorded a score of 04, which indicated the resident

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F 689	Continued From page 2 displayed severe cognitive impairment. The care plan focus area initiated 1/18/18 identified a self-care deficit related to cognitive status and disease processes. The care plan interventions dated 6/28/19 informed staff the resident transferred and ambulated (walked) independently with a walker and was non-compliant with using his walker needing reminders at times. The care plan focus area initiated 1/18/18 identified the resident as at risk for falls related to Parkinson's disease, antipsychotic medication use, unsteady gait, and incontinence. On 11/18/19 the interventions directed staff to assist and guide the resident with sitting in recliner as needed and tolerated due to decrease in judgement. The care plan focus area initiated 6/16/18 identified a potential for elopement (leaving the facility without the knowledge of staff) related to the resident voicing desire to leave the facility. The interventions included: document all attempts to leave the facility in the nurses' notes; redirect the resident if exit seeking; resident unable to leave the facility without staff or family; wander guard check for placement and functioning every shift; and wandering assessment quarterly and as needed. On 3/4/20 the care plan updated interventions to include: unit and dietary staff educated on making sure doors locked upon entering and exiting the locked unit; wander guard alarm check at front door; and all staff education with check outside perimeter and resident head count before turning off front door alarms.	F 689		

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F 689	Continued From page 3 The Pocket Care Plan updated 3/4/20 recorded information pertaining to Resident #4 and directed staff to redirect exit seeking and identified the resident as non-compliant with walker, as well as put himself on the floor to "fix" his walker. The Pocket Care Plan directed staff to remind Resident #4 to walk with flat feet. The Elopement incident report dated 3/4/20 at 6:21 p.m. documented staff found Resident #4 in the parking lot walking toward the building by the Administrator who called the Director of Nursing (DON). When the DON and CNA (Certified Nurse Aide) entered the front lobby, they noted the resident coming in the front door and the wander guard alarmed at that time. Resident #4 walked down the hall and returned to the unit with no issues. The Late Entry Progress Notes created 3/5/20 at 3:11 p.m. by the Administrator documented the following effective 3/4/20 at 5:58 a.m.: On 3/4/20 at 5:58 p.m., the Administrator left in vehicle when an elderly individual was seen walking toward the facility from the far east driveway. Since the Administrator was new and unable to identify the individual at distance, she immediately called the DON as she was still in the building. The Administrator kept watch while parking and by that time had identified the man as a resident of the facility. He proceeded to the door and entered as the DON met him. The Administrator verified the alarms and First Response fob functioned, began to prepare education for staff, and notified the operations director as well as the owner and DIA (Iowa Department of Inspections & Appeals). An investigation was in progress with changes being	F 689		

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F 689	Continued From page 4 made. It was believed another resident who stood near the door playing the Wii game and on other occasions had set the alarm off, had triggered the alarm at the time of the elopement rather than the resident leaving. The facility moved the Wii game. Moved. The Progress Notes dated 3/4/20 at 8:10 p.m. created by Staff C, Licensed Practical Nurse (LPN), documented the DON notified her Resident #4 eloped from the memory unit. Staff C documented she was by the front dining room 400 hall in residents' rooms passing mediation. Staff C wrote she assessed the resident with no concerns identified; Resident #4 smiled and responded the weather was actually very pleasant and also denied pain. The Progress Notes dated 3/5/20 at 2:52 p.m. created by the DON documented Resident #4 found in the parking lot walking toward the building by the Administrator who called her. When the DON and CNA entered the front lobby the resident coming in the front door wearing gray sweatshirt, gray sweatpants, and gripper socks. The DON wrote the wander guard alarmed at that time and Resident #4 walked down the hall and returned to the unit with no issues. The Progress Notes dated 3/8/20 at 8:02 p.m. documented exit seeking behaviors noted as Resident #4 continued to go to the doors, pulling on the doors, or standing and waiting at doors for someone to go in the unit. Resident #4 did not portray a behavior if not let out the door and staff assisted to walk around inside the facility outside of the memory care unit when he got agitated and unable to be redirected.	F 689		

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The Progress Notes dated 3/9/20 at 8:29 p.m. documented Resident #4 continued to stand at the doors waiting for someone to go into the unit with no problems or behaviors. Resident #4 ambulated in halls without his front wheeled walker. Staff encouraged the resident to use the walker.

Facility Investigation

The facility investigation summary dated 3/4/20 completed by the Administrator included the following documentation:

Direct Witness Statements - No staff on duty saw Resident #4 leave the memory unit or the facility. Staff on duty reported the door alarm went off 2 times shortly before they discovered Resident #4 outside. Another resident with a wander guard stood close to the front door in front of the windows. Due to the proximity to the door alarm, when the door opened a wander guard in that area triggered the alarm. The first alarm triggered by that manner with a resident playing the Wii and being too close to the exit. No staff reported turning off the second alarm but the resident playing the Wii remained by the door playing during the series of events.

Resident Statement - Resident #4 interviewed twice. Once responded he took his wife to the hospital but his wife resided in another town. The other interview resident refused to answer as staff stated he was mad they would not let him stand by the exit doors.

Findings - Resident #4 outside with staff supervision; all alarms were in working order;

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Resident #4 wore his wander guard when he returned to the facility; no staff witnessed Resident #4 leave the building; and there had been historic instances when residents knocked on the memory unit doors and other residents outside of the unit opened the doors allowing exit.

Reasonable Conclusion - It was reasonably concluded the memory unit door did not close completely and catch before Resident #4 exited or another resident let him out. Resident #4 had a history of trying to leave through the doors by jerking on them. It was reasonably concluded the staff silenced the alarms when they found another resident with a wander guard playing the Wii game close to the exit and in front of the window. It was believed the beam came through and the alarm activated when the door opened by anyone exiting.

Quality Assurance/Immediate Response - Resident #4 immediately assessed with no injuries found; Resident #4 wander guard checked and working; all door alarms checked and working; all wander guards audited and working; staff re-educated on immediate alarm response protocol; MDS reviewed and MDS training on wandering and elopement; care plan updated; pocket care plan checked for exit seeking notation; Wii game moved to another area not in range of alarm sensor; and continued testing wander guards every shift per protocol.

The Witness Statement form dated 3/4/20 signed by Staff R, CNA, recorded on the 6 a.m. to 2 p.m. shift Resident #4 stood by the exit door except during meal time. After meals, Resident #4 sat for a while then he would go to the exit door, which was normal but that day it was an all-day

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event. Staff R left at 2 p.m. and told the staff coming on to watch Resident #4 as he was ready to bolt.

The Witness Statement form dated 3/5/20 signed by Staff S, CNA, recorded she worked the 6 a.m. to 2 p.m. shift on the memory care unit and Resident #4 was frequently an exit seeker. Staff S wrote on 3/4/20 on the day shift, Resident #4 was in the dining room for meals, but all other times he was either by the doors that were locked trying to pry them open with his hands. Staff S documented that was normal behavior for Resident #4 to an extent, but he had increased exit seeking and door pulling brought on by a recent doctors visit when he left the facility on 3/2/20 accompanied by a CNA. Staff S recorded she and Staff R reported to the 2 CNAs coming on the afternoon shift of 2 p.m. to 10 p.m. that they needed to keep a close eye on Resident #4 because of the increased exit seeking behavior.

The hand written statement dated 3/4/20 signed by Staff A, CNA, documented the staff helped the residents to go to the dining rooms, a large dining room and small dining room, at approximately 5:30 p.m. As dietary put food on the tables, the last person helped out of a bathroom to the dining room. Then staff assisted Resident #18 to eat and about 5:50 p.m. as staff assisted dining and monitoring in the large dining room Staff E, CNA from temporary staffing agency, entered the dining room to ask if they were missing anybody. Staff A completed a head count as the DON stood in the dining room.

The hand written, undated, unsigned statement identified as documented by Staff B, CNA from a temporary staffing agency, recorded he went to

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the back door to inform the nurse a resident couldn't chew the meal served. Staff B asked for a different tray and returned to the unit through the back door and continued feeding residents with other residents in the lobby. After finishing the meal, the DON arrived with the resident who had gone out the first door left opened from the kitchen aide. Staff B did a resident count then continued feeding residents.

The hand written statement with an illegible date signed by Staff E documented she heard the alarm go off and ran to the front and the Activity Director had shut it off. The alarm went off a 2nd time and Staff E went up front and shut it off. The alarm went off a 3rd time and Staff E got half way up front and it stopped. The 4th time the alarm went off the DON and Staff E went up front and Resident #4 walking back inside the building. The DON and Staff E helped Resident #4 back to the memory care unit and made sure he was safe.

The hand written statement dated 3/4/20 signed by Staff F, dietary aide, recorded around 5:15 p.m. to 5:30 p.m. he took the memory care cart of food. Staff F placed plates on the table then proceeded to pour drinks. Staff F needed more milk so he ran back to the kitchen to grab another gallon of whole milk and went back down and finished pouring drinks. Staff F then placed milk in fridge and left. When Staff F entered or exited the memory care he pulled or pushed the door closed. About 5:41 p.m. Staff F was in the kitchen getting coffee for main dining room and then went to pour drinks. The agency aide Staff B stopped Staff F and asked him if he was the cook. Staff answered no, she was outside and Staff F proceeded to the dining room.

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Observations

On 3/9/20 at 2:15 p.m. revealed the DIA surveyor opened the front door without pressing a black button and an alarm sounded; no staff answered and the alarm stopped. The Office Manager then appeared in a window and said staff didn't always come to the door as she was usually at the office window.

Observation on 3/9/20 at 2:34 p.m. revealed the North exterior exit door on the back 300 hall opened the alarm box at the door sounded and then the alarm panel sounded at the West nurses station. The alarm had been sounding for two minutes when Staff H, LPN from temporary staffing agency, said she did didn't know the code to turn off the audible alarm box device. Staff H stated she worked at the facility an average of 24 hours a week for about a year and a half. When asked, Staff H responded she received no special training from the facility regarding doors; they just gave her the keys and no specific elopement policy/procedure training. Staff H said she had not been in the facility since 3/4/20 when an elopement occurred. At 2:40 p.m., the DON arrived and responded she did not know the code number to be able to turn off the audible alarm box. Staff C arrived with the code number for the alarm box silencing the alarm and pushed the red reset button on the alarm panel at the West nurses station.

On 3/9/20 at 3:05 p.m., the exterior exit door on the 100 hall was tripped and sounded at the door and at the East nurses' station alarm panel. The DON responded and turned off the audible alarm

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box at the door. Staff D, LPN from temporary staffing agency, and Staff K, CNA from temporary staffing agency, did not know the codes to silence the alarms. Staff K responded she worked at the facility about 1 time a week for the past 3 years. The MDS Coordinator also responded to the door alarm and stated she worked at the facility off and on for 7 years.

Observation on 3/9/20 at 3:35 p.m. revealed Resident #4 resided on the CCDI unit. Resident #4 up and down from a chair in the commons area frequently moving about with and without his walker. Resident #4 tinkered with his walker laying it down on the floor at times and handling the screws and such. Resident #4 was able to kneel next to the walker then get up on his own. He was unsteady but able to stabilize himself. Resident #4 then almost speed walked without his walker down the hallway toward the North double door exit. At the North doors, Resident #4 looked through the windows of the door, pulled on the doors, then turned and quickly walked back down the hall in the same manner to the commons area/chairs located at the south end.

Observation on 3/9/20 at 3:41 p.m. revealed 3 possible exits from the CCDI unit. One exterior exit door to the South, one interior double door exit to the East which opened to the 200 hall, and one interior double door exit to the North which opened to the end of 300 hall. Key pads located inside the unit were present at both the East and North double doors which required a key code to unlock the doors to leave the unit. However, both East and North double doors contained a magnetic cross bar on the outside of the doors that only required a person to touch the bar to unlock the doors to gain entry into the unit.

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F 689	Continued From page 11 Observation on 3/9/20 at 4:00 p.m. revealed the wander guard alarm system at the front door checked by Staff D and the alarm functioned properly at all levels. When asked, Staff D reported the wander guard system and the individual residents' wander guard bracelets to be checked every shift. Observation on 3/9/20 at 3:36 p.m. revealed the key code unlocked the North double door exit. When the right door (toward the east as exiting the unit) shut before the left door (toward the west as exiting the unit), the metal strip attached to the right door prevented the left door from fully closing and therefore the magnetic lock did not engage on the left door. No alarms sounded while the door remained unsecured. The key code needed to be reentered to allow the right door to release. Once doors closed in the proper sequence, left then right, the magnetic locks engaged on both doors. Observation 3/10/20 at 5:19 p.m. revealed Staff M, CNA from temporary staffing agency, worked on the CCDI unit with Staff A. Staff M reported the supper meal had not yet been delivered. At 5:31 p.m. the food cart entered the CCDI unit by dietary staff and then at 5:34 p.m. staff exited the East double doors and the door shut completely. At 5:38 p.m. dietary staff left the unit again through the East double doors. At 5:47 p.m. Resident #18 and Resident #19 present in the commons area when the surveyor entered the CCDI unit; no staff present in the area or in the doorway to the 2 dining rooms nor did any staff come out to see who entered the unit. When the doors of the CCDI unit closed, the magnetic connection made a normal to above normal	F 689		

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F 689	Continued From page 12 volume sound clicking into place. Resident #18 and Resident #19 discussed going to supper, ambulated together down the hall to the North double door exit, both pulled and shook the doors, then the 2 residents returned to the commons area. The 2 CNAs assigned to the unit were in the dining room assisting residents with supper with the exit doors not visible from the dining room. At 5:50 p.m., Resident #4 came out of the dining room and ambulated to the commons area where he sat in a chair right next to the East double door exit. Resident #4 stood up and placed his hand on a table to steady himself as he was shaky. At 5:54 p.m. surveyor left the unit and still no staff were present in the commons area and by observation through the windows in the door, no staff came to see who left or entered the unit. Observation revealed no staff were present on the 200 hall of general population. At 5:55 p.m., Staff N, CNA, exited a room on the 100 hall then walked down the hall toward the main facility dining room; no other staff were present in the main commons area by the front door. Two residents in the front commons area played on the Wii game and 1 dietary staff member exited the kitchen and went into the bathroom. At 5:56 p.m., the surveyor opened the front main entrance door and the alarm sounded at the nurses' station alarm panel. Continued observation revealed at 5:57 p.m. Staff O, CNA, entered the facility through the front door and went directly to the time clock room. At 5:58 p.m. Staff D came from the back of the facility, went to the front door, looked out the window of the door to the left and right, then went to the East nurses station alarm panel and turned off the front door alarm pushing the reset button. Staff D did not step outside. Staff D then went to the time clock room and spoke with Staff O.	F 689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QHC WINTERSET NORTH, LLC	411 EAST LANE STREET WINTERSET, IA 50273

(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
F 689	Continued From page 13	F 689		

Observation on 3/11/20 at 10:20 a.m. revealed the facility's Corporate Maintenance Director installed new pull away alarm devices on the CCDI unit doors that would audibly sound off until the magnets realigned; he said this would notify anyone going thru the doors if the doors not shut properly. Observation revealed the alarm did sound if the 2 pieces of the alarm magnets not directly aligned and the alarms did sound when the door improperly shut until it closed properly.

Observation on 3/11/20 at 10:30 a.m. revealed 2 random staff in the 200 hallway transporting an unknown resident and they discussed the alarm going off on the CCDI door and how it was new. Discussed 1 to the other they knew Resident #4 eloped the previous week and got all the way to the end of the parking lot down by the apartments and they couldn't believe he didn't fall. They stated Resident #4 always attempting to get out.

Staff Interviews related to Incident #1 - Resident #4 elopement on 3/4/20

On 3/9/20 at 3:52 p.m. the Administrator responded she expected staff to check the wander guard at the front door every shift. The Administrator stated she bought 5 new wander guard bracelets to make sure the facility didn't run out of working bracelets. The Administrator reported she was backing out that night when she saw a man farther down in the driveway by the apartment complex to the east of the facility wearing gripper socks. The Administrator said she called the DON and asked her to come to the door and identify if he was a resident. The Administrator commented she had her eyes on

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F 689	Continued From page 14 him the whole time and the man identified as Resident #4. The Administrator said she called the DON she thought at 5:08 p.m. The Administrator reported Resident #4 went in the facility willingly, the wander guard alarm sounded off, and he did not have his walker with him. The Administrator voiced anyone who would say Resident #4 needed his walker would be lying as he moved very fast without it. The Administrator reported no staff would admit to shutting off the front door alarm. The Administrator explained there was another resident who wore a wander guard bracelet who played the Wii game by the front door that night; the staff believed that resident set off the wander guard alarm frequently. The Administrator said staff moved the TV away from the front door. In a follow-up interview on 3/11/20 at 12:45 p.m. the DON and the Administrator reported supper served at 5:30 p.m. in the CCDI unit. The DON said she received a call from the Administrator at 5:58 p.m. on 3/4/20 about Resident #4 being outside. The DON reported Resident #4 ate part of his supper that night. The DON stated the wander guard at the front door went off 4 times and they thought Resident #4 went outside during those times due to the confusion of another resident having a wander guard positioned by the front door. The DON stated in summary, they did not know how Resident #4 exited the CCDI unit and they could only speculate he left through the front door. The DON reported Resident #4 dressed in gray sweatshirt, gray sweatpants, and gripper socks when he was outside. The DON commented in her investigation she was told: Staff F took food into the unit that night for supper; the Activities Director responded to the 1st wander guard alarm; Staff E responded to the	F 689		

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F 689	Continued From page 15 2nd alarm; the 3rd alarm Staff E halfway up the hall to respond but the alarm turned off so she went back to the dining room; and the 4th alarm Staff E ran to the front and Staff J, Environmental Aide (EA), reported the Activities Director turned off the alarm. On 3/11/20 at 1:05 p.m. Staff E responded she worked at the facility for 1 and ½ years on a full-time basis working day shifts, afternoon shifts, and some overnight shifts. Staff E stated she was not trained before or after the elopement of Resident #4 on the door alarms or elopement facility policies/procedures. Staff E said she just received training that day to make sure residents okay and signed the door alarm/elopement policies as well as receiving her own personal copy of the policies. Staff E recalled working on 3/4/20. Staff E stated she thought the elopement occurred right after supper served, which was served at 5:30 p.m. in the CCDI unit and 6:00 p.m. in the main back dining room, so around 5:45 p.m. to 5:50 p.m. Staff E stated some people served early that night. Staff E recalled she heard the alarm from the front door going off and she ran up front. Staff E stated the Activities Director shut the alarm off. Staff E recalled the 2nd time the alarm sounded she was halfway up the hall when the alarm stopped so she went back. Staff E recalled the 3rd time the alarm went off she ran all the way up to the front door where the wander guard alarm sounding off. Staff E stated she tried to silence the alarm but she was doing it wrong so someone showed her how to do it. Staff E reported a resident with a wander guard thought to be setting off the alarm so they moved her and the TV away from the front door. Staff E responded she was familiar with Resident #4 but she never seen him out.	F 689		

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F 689	Continued From page 16 Staff E said the unit doors always shut as far as she knew and she knew the kitchen person Staff F went back to the unit but not normally go thru there. Staff E recalled she was on the west hall when the DON had her go with her as the Administrator reported a resident in the facility parking lot. Staff E stated as she got to the front door Resident #4 walked back into the facility and the Administrator said he was just on the sidewalk at the end of the parking lot. Staff E stated Resident #4 did not say anything to her and thought he was care planned for walker. Staff E stated the DON directed her to go to the CCDI unit staff and ask them if they were missing anyone. Staff E stated Staff A and Staff B on the unit and both in the dining rooms feeding residents; they did not know Resident #4 not in the unit. Staff E recalled Staff B asked how Resident #4 got out and stated it was a bit hard when no nurse was back there during the meal to supervise. Staff E explained the nurse couldn't be in the unit at mealtime as the nurse had to pass pills and it was not the nurse's responsibility as the CNAs should know where the residents were at all times. Staff E stated the CNAs shouldn't let residents wander during mealtimes. Staff E commented Resident #4 always tried to get out of the unit. Staff E responded she didn't know the unit doors could close improperly and voiced the doors clicked when shut. Staff E reported when she walked into the front commons area to respond to the wander guard alarms no staff present in the front commons area as everyone had gone down to assist feeding in the main dining room. On 3/11/20 at 1:17 p.m. the Activities Director recalled working on 3/4/20 and stated that was the day the therapy dog visited the facility. The	F 689		

#1a

April 17, 2020

QHC Winterset North, LLC
411 E Lane St
Winterset, IA 50273

Provider #165497

Incident #89790

F689

This plan of correction constitutes our credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the federal and state laws.

F 689-
Winterset Care Center North reasonably ensures:
(1) The resident environment remains free of accident hazards as is possible and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents. Which includes providing adequate supervision for residents at risk for wandering, ensuring the CCDI unit doors close appropriately, and all staff have been trained, including agency personnel, to follow the facility protocol on operating/responding to door alarms.

1. Corrective actions for R#4:
   On 3/4/2020 R#4 escorted to CCDI Unit by DON.
   On 3/4/2020 R#4 was assessed for physical wellbeing.
   On 3/42020 R#4's wandering device was checked and working.
   On 3/4/2020 15 min checks resumed for R#4.
   On 3/4/2020 staff on duty notified of R#4 elopement and potential to exit again.
   On 3/4/2020 physician, family, owner, and operations all notified. Administrator and DON active in the elopement.
   On 3/5/2020 R#5 MDS and care plan updated for elopement potential.

2. All residents in the facility with confusion, potential to wander and impaired ambulation could possibly be affected. Specifically the residents in the CCDI Unit are at highest risk.
   Corrective actions for all residents:
   - On 3/4/2020 all wandering devices were checked,
   - On 3/4/2 all door alarms were checked and functioning.
   - On 3/5/2020 the metal strip on the exit door was reversed to ensure the door closes properly and not stay ajar.
   - On 3/11/2020 Corporate maintenance installed magnetic alarms on the door that remain activated until the doors are safely closed.
   - On 3/11/2020 the elopement and door alarm policies were revised and staff re-education began. The policies were emailed to all staffing agencies used by the facility for their staff education to review prior to next working shift. The policies state a staff and two if

available will exit outside and look for potential eloping residents until found or all residents are accounted for inside. The alarm will remain on until there is at least one staff member outside searching.

- On 3/11/2020 door alarm and elopement policies were added to the CNA and nursing orientation check list.
- On 3/11/2020 A door alarm drill was implemented once a week times twelve weeks, two times monthly times three months and monthly ongoing. The drill log records staff responses per policy requirements.
- Revised 15 minute check record to fill gap.

3. Training completed:
   - On 3/4/2020 all staff were educated on proper response to door alarms and ongoing for future staff educated, agency personnel and new hires
   - On 3/5/2020 staff education began on the wander device system from the manufacturer.
   - On 3/5/2020 MDS Coordinator re-educated on coding MDS accurately and care planning wandering residents with the correct interventions.
   - On 3/11/2020 the elopement and door alarm policies were revised and staff re-education began. Staffing agencies notified by email all agency staff would need to read and sign new policies at next shift.The policies state a staff and two if available will exit outside and look for potential eloping residents until found or all residents are accounted for inside. The alarm will remain on until there is at least one staff member outside searching.
   - On 4/03/2020 and ongoing revised door alarm and elopement policies reviewed at facility all staff meeting and absent staff required to review individually.

4. Compliance auditing:
   - The Administrator or designee will complete audits weekly, which includes providing adequate supervision for residents at risk for wandering, ensuring the CCDI unit doors close appropriately, and all staff have been trained, including agency personnel, to follow the facility protocol on operating/responding to door alarms times 12 weeks then 2 times a month for 3 months with compliance reviewed quarterly by the Quality Assurance Committee.

5. Compliance Date: April 8, 2020