STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195571	A. BUILDING _____ B. WING _____	**06/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OLD JEFFERSON COMMUNITY CARE CENTER	**8340 BARINGER FOREMAN ROAD. BATON ROUGE, LA 70817**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide adequate supervision for 1 (#6) of 5 residents (#6, #7, #8, #9, and #10) with wandering behaviors and at risk for elopement from a total sample of 10 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). The facility failed to: 1. Re-assess a Resident (#6) for elopement risk after the resident displayed exit-seeking behaviors on [DATE]. 2. Provide adequate supervision to prevent a resident (#6) with severe cognitive impairment from eloping from the facility without staff knowledge of her leaving the facility premises. 3. Monitor the placement of the Wanderguard. 4. Put interventions into place, other than a Wanderguard, after the Resident (#6) attempted to exit the facility numerous times a day. Findings: Review of the facility's policy titled Wandering and Elopement Assessment /Management /Security, Effective date [DATE] included the following: Purpose: To provide guidelines for the identification and management of unsafe wandering of any facility resident while maintain the least restrictive environment for at risk individuals. Policy: All facility residents are assessed for risk behaviors/conditions associated with unsafe wandering/elopement in order to prevent threats to the health, safety and welfare of an individual upon admission, quarterly and with any significant cognitive/physical change that may place the individual at risk for harm due to unsafe wandering/elopement. Facility will maintain procedures to ensure that residents at risk for elopement do not wander away from the facility. Interventions which address/prevent unsafe wandering/elopement will be developed within the resident care plan for at risk residents. In facilities with electronic wander alarm systems, residents assessed to be at risk for unsafe wandering may be placed on the Resident Security System as a measure to reduce the risk of harm from unsafe wandering activities. All staff will receive instruction on wandering/elopement prevention and wander drills protocol/procedures during orientation and annually. Definitions: Elopement - when a resident leaves the facility premises or safe area without supervision or staff's knowledge of departure. Unsafe wandering - random or repetitive locomotion may be goal directed or aimless. Missing Resident: 4. The charge nurse or designee will notify the administrator and DON. Wandering Resident 1. It is the responsibility of all personnel to immediately report to the staff/charge nurse any resident attempting to leave the premises or suspected of being missing. Post-elopement Care 6. Notify regulatory agencies when applicable. 7. A facility assessment/analysis and elopement prevention plan should be immediately instituted once a reportable elopement occurs. Wandering/Elopement Risk Assessment - Management - Prevention 1. Perform an elopement risk assessment for all residents upon admission, quarterly and with any significant cognitive/physical change that may place the individual at risk for wandering/elopement. 2. Document on the risk assessment all physical, emotional, and psychological factors that contribute or apply to unsafe wandering/elopement risk. 4. Develop or review/update the resident specific care plans to address risk factors for wandering/elopement at least quarterly and prn. Include interventions used to manage/prevent elopement/wander risk. 5. Inter-disciplinary team members should document in the resident clinical record behavior changes, and response/reaction to interventions initiated to prevent/control wandering/elopement behaviors. 6. Report any changes/escalation of resident's wandering behaviors to the treating clinician and responsible party. 7. Notify the Administrator, Director of Nursing and facility staff in the event a resident is noted missing from the unit and/or facility. Review of the facility's policy titled Safety and Supervision of Residents included the following: Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Individualized, Resident-Centered Approach to Safety: The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, ensuring that interventions are implemented and documenting interventions. Monitoring the effectiveness of interventions shall include ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new or revised interventions. Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. Resident Risks and Environmental Hazards included: e. Unsafe Wandering RESIDENT #6 Review of Resident #6's clinical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the facility's incident log date [DATE]- [DATE] included the following: Elopement Incidents - Resident #6 - [DATE] at 11:35 a.m. Other incidents- Resident #6 - [DATE] at 2:30 p.m. Review of the facility's incident report dated [DATE] revealed Resident #6 left the premises of the facility and was found by an employee, S8Dietary, standing on the side of the road on a busy two lane highway. She was kicking rocks in the ditch. She said she was trying to go to church. The resident was brought back to the facility by staff. She was assessed by S5RN. She had no injuries. A wander guard was applied. She was given water and returned to her room due to COVID-19 restrictions. Immediate Action Taken: resident was assessed for injury, provided water and had a wander guard placed for safety. She returned to her room due to COVID-19 restrictions. Was she taken to the hospital: No No injuries were observed and she was alert and oriented to person. Family member and physician were notified. Review of facility incident report dated [DATE] revealed, in part, at approximately 2:30 p.m., S9CN brought resident to north side nurse's station. S9CN stated that she and S10CN were in the conference room when they saw resident walking in the outside courtyard area through the window. At that time S9CN went to the entrance door closest to the outside courtyard where resident was seen. Resident #6 then stated I'm so glad you came. I was trying to open the door. Immediate Action Taken: Resident was assessed for injuries, none noted. Resident assisted back to her room. Resident was able to get outside due to her roommate cutting off her Wanderguard. Roommate admitted to doing this. Wanderguard was found in the trash by S4SSD and S1ADM. Scissors removed from room, Resident #6 was given a new Wanderguard and moved to a different room. Resident taken to the hospital: No; no injuries noted Level of consciousness: alert, oriented to person. Predisposing Physiological Factors- Confused and recent change in medications/new, impaired memory, recent change in cognition, recent illness. Predisposing situation factors - active exit seeker. Review of the investigation into Resident #6's elopement ([DATE]) revealed the following: Note text in progress notes dated [DATE] 14:17 (2:17 p.m.) by S2DON: Investigation regarding elopement incident on [DATE] revealed: Resident left the premises of the facility and was found by an employee, S8DS, standing on the side of the road on a local two lane highway. She was kicking rocks in the ditch. Resident #6 said she was trying to go to church. She was brought back to the facility by the staff member. She was assessed by S5RN. She had no injuries. A Wanderguard was applied. She was

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) given water and returned to her room due to COVID-19 restrictions. Resident #6's son was notified. Review of the witness statement dated [DATE] from S8DS revealed the following: On [DATE], after we were done serving lunch to the residents, I left the building. I saw Resident #6 down the street on a local two lane highway. She was standing on the side of the road kicking rocks in the ditch. I stopped to help her. She said she was okay and she wasn't hurt. She was confused and thought she was walking to church. I told her that we needed to go home. I called the nursing home to let them know about the situation. She got in my car and I brought her back to the nursing home. I brought her in the building to the nurses' station. They checked her out and gave her some water. I went back to the kitchen after that. Review of the witness statement dated [DATE] from S13CNA revealed the following: On [DATE], I worked Hall b from 6:00 a.m. - 2:00 p.m. S5RN was the floor nurse. During the shift a Code Blue was announced on the overhead paging system for a resident on Hall a. All available staff, including myself ran to Hall a to check on him. Resident #6 was in her room at that time due to COVID 19 precautions. Review of the Witness statement dated [DATE] from S5RN revealed the following: On [DATE], a Code Blue was called and I ran and assisted. I was in the room during the whole code up until the resident was pronounced expired. Resident #6 was up walking the halls before the code was called. When I returned to the nurse's station another staff member received a phone call from a dietary employee stating that she picked Resident #6 up from down the road. When she returned, Resident #6 was assessed for injuries and given water. At that time, I messaged S2DON to let her know what had happened. I then placed a Wanderguard on Resident #6 and instructed her to please stay in her room for her safety. Resident's son was notified of her getting off of the property. He voiced understanding and was grateful that we were able to get her. Review of the witness statement dated [DATE] from S17WC, revealed the following: I, S17WC, was doing paperwork to have a resident sent out to the ER for a Code Blue while all other staff was in that resident's room where the code was called. Resident #6 must have went out the door during the code. Review of the witness statements dated [DATE] by S9CN revealed the following: On Wednesday [DATE] between the hours of 2:00 p.m. and 2:30 p.m., I was in the conference room when co-worker S10CN stated that she noticed a resident in the outside courtyard area. We both went to the entry located near the courtyard location. When arriving a female resident was standing outside the door. I entered the code and opened the door to let her in and she stated, I'm so glad you came. I was trying to open the door. The female resident was walked to the Northside nurses station and we reported to the nurses the location as to where the resident was found. Review of the witness statement dated [DATE] by S10CN revealed the following: On [DATE] between 2 p.m. and 2:30 p.m., I was in the conference room with S9CN. I was talking on the phone and walked to the window facing the front of the facility. I noticed a resident walking in the courtyard. I then told S9CN that a resident was outside in the courtyard. At this time, S9CN went to the entry door near the courtyard where the resident was located. S9CN returned shortly after with the resident. The resident did not show any signs of injury. She was then walked down the hall to the nurse's station. Review of the witness statement dated [DATE] by S4SSD revealed the following: On [DATE], I assisted S1ADM and S18MRK in searching the resident's room for Resident #6's Wanderguard. The resident's roommate stated she assisted Resident #6 in cutting the Wanderguard strap. She also stated that on a previous date she gave Resident #6 some scissors to remove the strap. On this date, staff members located several scissors which were removed from the room. Staff members were unsuccessful in locating the Wanderguard device, however Resident #6's roommate retrieved the device from the trash can in the bathroom. The roommate was instructed not to assist the resident in removing this safety device. She voiced understanding and stated she would not remove the Wanderguard or give any further assistance/care to Resident #6. Review of a local emergency room s record dated [DATE] revealed Resident #6 was seen for being very anxious. The HPI revealed the resident had escalating mood/behaviors over a 2-week time period and was difficult to redirect. Resident #6 had a Wanderguard and was attempting to elope during the assessment. Review of Resident #6's record from a local behavioral health hospital dated [DATE]-[DATE] revealed the following: [DATE] Resident is very confused. Believes she is [AGE] years old. Stated I have my stuff I need to get as far as my momma's. And she has her stuff and we have been watching you closely. [DATE] placed on elopement precautions. Checking exit doors. [DATE] resident throwing objects at staff when bringing to showers. Has been playing and smearing feces, carrying it in hand and trying to give to staff. [DATE] resident is only orientated to person. Was playing in feces again. [DATE] discharged to nursing home. Diagnoses: [REDACTED]. Discharge medication: Bactrim 1 p.o. bid. Review of the resident's annual MDS dated [DATE] included the following: Section C: Cognitive Patterns- BIMS: 7 (Severe Cognitive Impairment) Section E: Behavioral - Potential indicators of [MEDICAL CONDITION]- None Section G: Functional Status- Locomotion on unit and off unit - Independent. Bed mobility, transfer, dressing, eating, toilet use, personal hygiene- supervision with setup help only. Review of the resident's BIMS score, which was provided by the facility, revealed the following: [DATE]- 12 (moderate impairment) [DATE]- 10 (moderate impairment) [DATE]- 6 (severe cognitive impairment) [DATE]- 7 (severe cognitive impairment) [DATE]- 4 (severe cognitive impairment) Review of the resident's elopement risk assessments from [DATE] until [DATE] revealed the following: [DATE]- 0 [DATE]- 0 [DATE]- 4 [DATE]- 4 In an interview with S1ADM on [DATE] at 8:35 a.m., he stated any score above 0 was a risk for elopement. Review of the resident's care plan included the following: Problem: [DATE]-I am prescribed [MEDICAL CONDITION] medications related to my increased anxiety and agitation. Problem [DATE]-I have a Wander Guard in place (left ankle) due to I have a history of leaving the facility unsupervised, verbally expressed the desire to go home/ looking for mother. [DATE]- I was outside and witnessed attempting to come back inside the facility. Goals: I will not leave facility unattended through the review date. Target date-[DATE] Approaches: I will be redirected/distracted from wandering by offering pleasant diversions, structured activities, food, conversation, television, books that resident prefers. [DATE] Wander Guard applied to Left Extremity. [DATE] Assessed for injuries [DATE]- reapplied wander-guard to Left Lower Extremity. [DATE]-Supervised time outside. Monitor wander-guard placement. [DATE] Problem: I have impaired cognitive function and impaired thought processes regard to [DIAGNOSES REDACTED]. I threw coffee on staff/nurse. Problem: I have depression. I take medication daily to treat my condition. Problem: I am at risk for alteration in my psychosocial well-being related to restriction of visitation and limited social interaction due to COVID-19. Review of physician progress notes [REDACTED]. Over the past 2 weeks patient's mood and behaviors have escalated such that she is hard to be redirected. Patient continues to ambulate independently and is trying to elope at this time. She has a Wanderguard in place. When staff try to redirect her from the door she tries to pull away. Patient was started on [MEDICATION NAME] last week and the dose was increased with minimal benefit. [MEDICATION NAME] was added and also was increased with minimal benefit. Patient is eating fair but not sleeping. When she does sleep it is because she has ambulated tirelessly around the building. Review of physician progress notes [REDACTED]. While inpatient, patient noted to have labile moods and easily agitated. She was often rambling and confused. She was diagnosed with [REDACTED]. She required frequent medication adjustments due to her poor insight and tangential behavior. She was also noted during her hospitalization to be playing with her feces and smearing in her hand to give to staff. She ultimately adjusted to the multiple medication changes. She did not experience negative side effects. She was diagnosed with [REDACTED]. Patient was discharged back to the facility on [DATE]. Her condition is felt to be stable with medication compliance. She is due for follow-up with the psychiatrist via telehealth on [DATE] at 2:00 p.m. Review of Behavior Notes dated/timed included the following: [DATE] and timed 11:05 a.m. Resident being aggressive toward staff. Yelling and swinging her shoes at staff. Resident unable to be redirected to her room. Attempting to go outside. Resident refusing to go back in her room. Notified S16MD. Gave telephone order to give [MEDICATION NAME] 0.5mg p.o. every day and prn every 6 hours as needed. [DATE] Resident up at 0400 (4:00 a.m.) wandering, shaking facility doors, attempted to exit. Wanderguard noted to Rt. ankle and active. Resident refused to put on shoes or put dentures in mouth. Resident stated that she needed to go check on her mother who was very ill. She began crying, redirection was unsuccessful. Resident continued to pace floors going from exit to exit. Anti-anxiety medication administered per scheduled order. Will report to on coming nurse. Author- S20LPN. Review of the Elopement Risk assessment dated [DATE] 14:56 (2:56 p.m.) revealed the following: Evaluation-Elopement Score: 4.0 (at risk) History of elopement while at home: Yes. History of /or attempted leaving the facility without informing staff: Yes. Verbally expresses the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Wanders: Yes. Wanders aimlessly or non-goal-directed: No. Wandering behavior likely to affect the safety or well-being of self/others: Yes. Wandering behavior likely to affect the privacy of others: No. Recently admitted or readmitted (within past 30 days and has not accepted the situation: No. Clinical suggestions: Staff notified of resident's elopement risk. Identification bracelet utilized, in place. Staff notified of resident's wandering risk. Resident readmitted from behavioral hospital on [DATE]. Resident has a history and is HIGHLY at risk for elopement/wandering related to severe impaired cognition, poor safety awareness, and progressing dementia. Wander Guard in place to left ankle. Review of the Elopement Risk assessment dated [DATE] 08:36 (8:36 a.m.) revealed the following: Evaluation-Elopement Score: 4.0 (at risk) History of elopement while at home: Yes. History of or attempted leaving the

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) facility without informing staff: Yes. Verbally expresses the desire to go home, packed belongings to go home or stayed near an exit door: Yes. Wanders: Yes. Wanders aimlessly or non-goal-directed: No. Wandering behavior likely to affect the safety or well-being of self/others: Yes. Wandering behavior likely to affect the privacy of others: No. Recently admitted or readmitted (within past 30 days and has not accepted the situation: No. Clinical suggestion: Staff notified of resident's elopement risk. Identification bracelet utilized, in place. Staff notified of resident's wandering risk. Resident has a history/highly considered to be at risk for elopement/wandering r/t severely impaired cognition, poor safety awareness, and progressing dementia. Wander Guard in place to left ankle/frequent monitoring of location. Author: S21LPN On [DATE] at 12:30 p.m., an observation and interview was conducted with Resident #6. She was observed walking around in her room without difficulty. A Wanderguard was noted to her left ankle. She invited this surveyor in and asked me to sit and talk with her. She was asked how long she had lived at the facility. She stated, I haven't been here long. There is a lot going on all around. Different diversions for us to pick. But that may not be the proper chemical for me to use, diversion. At one point she touched the Wander Guard and said I need this thing off please. On [DATE] at 10:30 a.m. an observation was performed of Resident #6. She was in her room with the door closed. Signs were noted to the door of her room denoting she was on 14-day quarantine- droplet precautions gown, glove and mask required in the room due to being out of the facility at a Local Behavioral Health On [DATE] at 10:32 am, the resident was noted to open her door and looked into the hall. On [DATE] at 10:34 a.m., an observation was performed of Resident #6. She opened the door to her room and looked into the hall. She saw this surveyor and asked, what do you need from me?' She went back into her room. On [DATE] at 12:50 p.m. an observation was performed of Resident #6. She was ambulating in her room. She attempted to come out into the hallway stating she needed to go the bathroom. On [DATE] at 1:15 p.m., an interview was conducted with S2DON. She was asked to explain when she was notified of the elopement of Resident #6. She stated she was called by S5RN at 11:30 a.m. on [DATE] and notified the resident had eloped, was not harmed and was back in the building. She stated the nurse had checked the resident and she was ok. S5RN had given Resident #6 some water and a Wanderguard was applied. She further explained that when the administrative staff tried to view the video to see what time the resident had left, there was no footage for the last several weeks. She stated at 11:30 a.m. a dietary worker brought the resident back to the facility after finding her on a two lane highway. S2DON was asked about the problem noted in the care plan of the resident outside the facility again on [DATE]. She stated S9CN and S10CN were in the conference room and saw the Resident #6 through the window walking in the courtyard. S9CN went to check and the resident was trying to open the door in get back in. S9CN opened the door for her and let her back in. The Wanderguard was not in place. The residents' roommate was questioned and she admitted to cutting the Wanderguard off at the resident's request. A Wanderguard was found in the trash and scissors were located in the room. The scissors were removed from the room and a new Wanderguard was placed on Resident #6. The roommate was counselled on the danger to the resident by cutting off the Wanderguard. Resident #6 was moved to another room. On [DATE] at 11:43 a.m., an interview was conducted with Resident #6's son. He was asked about his mother's condition. He stated prior to COVID-19, she would go out after every meal to feed the geese. She had a fishing pole and would go fishing in the pond at the nursing home. He stated he would drive up at the nursing home to visit her many times and she would be outside at the pond feeding geese or fishing. He explained since COVID 19 she had not been able to go outside and was expected to stay in her bedroom all day. He said Resident #6 had declined in the last 12 weeks. He stated he took a picture of her 12 weeks ago and one last week and the decline was very obvious. He stated his mother asked about her mother many times. He would always tell her that her mother was doing fine. He stated one time a staff member called from the nursing home and asked him to talk to her because she was upset. She got on the phone with him and she was crying and wanting her mother. He heard the staff tell her that her mother was dead. He said he spoke to the staff and told her not to tell his mother that again. He stated he was aware of an elopement on [DATE]. He said he was told something about the roommate had cut the Wanderguard off and his mother had gotten out of the facility. He was not aware of where she went on [DATE] and not aware of a second time his mother walked out of the door. He was asked if he was aware his mother had left the facility twice. He stated he was not. He was asked if he was aware his mother had walked about a mile from the facility onto a busy two lane highway. He did not know his mother walked down a two lane highway. He was just told she had left the facility property. He stated she probably was going to church because they walked to church every Sunday for [AGE] years. He stated his mother was taken to a local E.R. to have her finger checked and from there was admitted into a Behavioral Health Hospital due to her becoming more confused and combative at sundown. She was in the behavioral hospital for 2 weeks. On [DATE] at 3:10 p.m., a telephone interview was conducted with S5RN. She was asked if she was working on [DATE] when Resident #6 eloped. She stated she was working Hall b. Resident #6 was at the nurse's station that morning when a code was called on another hall in the facility. S5RN left Hall b and went to assist with the code. She was uncertain of the time of the code or when it ended. She stated it lasted about an hour. When she was back at Hall b nurses station after the code someone called and stated they had Resident #6. They had found her down the road and was bringing her back. S5RN was not aware Resident #6 was missing and did not remember what time the call was. She stated she assessed the resident when she was brought back into the building. The resident was hot and sweating. S5RN explained it was very hot outside. She gave the resident some water and took vital signs. She contacted the S2DON and placed a Wanderguard on the resident. S5RN notified the resident's son and explained to him that the resident had gotten off the facility's property and a Wanderguard was applied. She explained that the resident had Dementia and did not understand that she had to stay in her room due to COVID-19. S5RN stated the resident wandered around the facility a lot and had to be reminded to stay in her room. On [DATE] at 10:48 a.m., an interview was conducted with S11CNA. She stated she had heard that Resident #6 had eloped She was asked how often she checked elopement risk residents. She stated she checked when she arrived for duty to see who was an elopement risk. The kiosk had it on the resident's chart if they are elopement risk. She stated you check them every 2 hrs. When asked how she knew if the Wanderguard was working. She stated there was no way to check the Wanderguard unless the resident was brought near the door. She explained when an elopement code (Code W) was called staff were to go to the front desk and were given assignments. All staff check all over the facility and 2 staff go outside and check around the outside of the building. She stated she had received training on the Wanderguard and on Code W in the past 2 weeks. She explained a Code W is when a resident wanders away from the facility. She stated they had a Code W drill within the last week. S11CNA stated the nurse was responsible for applying the Wanderguard and maintenance checked it to make sure it is working properly. She stated that since COVID no residents were allowed to go outside unsupervised. She stated during a Code Blue all staff usually respond but one was assigned to monitor the unit and stay behind with the residents. She explained Resident #6 walked the building constantly and she walked fast. She stated the resident had to be monitored constantly. She stated the last 2 years Resident #6 had gotten worse with confusion and wandering. On [DATE] at 11:15 a.m., an interview was conducted with S12CNA. She stated she had been working at the facility since August, 2018 and working the Hall b since COVID started. She stated she was off when Resident #6 eloped but she had heard about it. S12CNA explained the nurse informed staff of residents who were an elopement risk at the beginning of the shift and it is in the Kiosk for that resident. She stated the kiosk shows who has a Wanderguard in place. S12CNA stated she was required to see if the Wanderguard was on all the residents with Wanderguards every 2 hours. If the Wanderguard was not on the resident she reported it to the nurse. She explained when the resident with a Wanderguard got close to a door in the facility the door would not open and an alarm would sound. She stated when a resident eloped or was missing, a Code W was called and every one reported to the front desk. Assignments were made when staff gathered at the front nurse's station. She further explained 2 people were assigned to go outside and look all around the outside of the facility. The other staff searched all areas of the building. When asked how she knew who could safely go outside alone, she stated by working with them and knowing the resident. She stated they had in-services on Wanderguard, Elopement, and a drill on Code W within the last 2 weeks. She stated she was required to check the residents every 2 hours and document in the Kiosk. She was asked what activity worked to calm Resident #6. She stated taking her outside for a walk helped. S12CNA stated Resident #6 was a very fast walker. She stated Resident #6's normal activity prior to COVID was sitting in the dining room with her friends, drinking coffee, reading and walking outside by the pond. She stated Resident #6 would go to the pond area and feed the ducks alone. She stated there was never a problem with her doing that in the past. S12CNA explained no resident can go out right now alone. She stated now when someone eloped the code pad by the door sounded off and front desk announced it. On [DATE] at 11:45 a.m., an interview was conducted with S14CNA. She stated she had worked at the facility for 1 month on Hall b. She stated she had heard Resident #6 had eloped. She was asked to explain Resident #6's behaviors since she had worked with her. She stated the resident gets worse after 5 p.m. S14CNA stated Resident #6 tried to exit all the doors and asked for her mother constantly. On [DATE] at 11:55 a.m., an interview was conducted with S7DS. She stated she knew Resident #6. She stated before COVID lockdown that

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) the resident could go outside alone. Since COVID she had to go out with staff because no one was permitted to go outside alone. She was asked if she had witnessed the resident trying to get out of the facility. She stated she had observed the resident go to the door and push on it but when it wouldn't open. On [DATE] at 12:05 p.m., an interview was conducted with S8DS. She stated she worked in dietary and her shift was 4:30 a.m. to 1:30 p.m.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently by failing to maintain the highest practicable physical, mental and psychosocial well-being for 1 (#6) of 5 residents (#6, #7, #8, #9, and #10) with wandering behaviors from a total sample of 10 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10). The facility failed to: 1. Ensure adequate supervision to prevent a resident (#6) with severe cognitive impairment, from eloping from the facility premises without staff knowledge; 2. Immediately identify and implement actions to ensure residents receive adequate supervision to prevent elopement from the facility; 3. Report an elopement that occurred on 05/03/2020 to the regulating authorities in the required time frame; 4. Initiate an investigation into the elopement of a resident (#6) that occurred on 05/03/2020. Findings: Cross reference F689 Review of the facility's policy titled Wandering and Elopement Assessment /Management /Security, Effective date 04/03/2012 included the following: Purpose: To provide guidelines for the identification and management of unsafe wandering of any facility resident while maintaining the least restrictive environment for at risk individuals. Policy: All facility residents are assessed for risk behaviors/conditions associated with unsafe wandering/elopement in order to prevent threats to the health, safety and welfare of an individual upon admission, quarterly and with any significant cognitive/physical change that may place the individual at risk for harm due to unsafe wandering/elopement. Facility will maintain procedures to ensure that residents at risk for elopement do not wander away from the facility. Interventions which address/prevent unsafe wandering/elopement will be developed within the resident care plan for at risk residents. In facilities with electronic wander alarm systems, residents assessed to be at risk for unsafe wandering may be placed on the Resident Security System as a measure to reduce the risk of harm from unsafe wandering activities. All staff will receive instruction on wandering/elopement prevention and wander drills protocol/procedures during orientation and annually. Definitions: Elopement - when a resident leaves the facility premises or safe area without supervision or staff's knowledge of departure. Unsafe wandering - random or repetitive locomotion may be goal directed or aimless. Missing Resident: 4. The charge nurse or designee will notify the administrator and DON. Wandering Resident 1. It is the responsibility of all personnel to immediately report to the staff/charge nurse any resident attempting to leave the premises or suspected of being missing. Post-elopement Care 6. Notify regulatory agencies when applicable. 7. A facility assessment/analysis and elopement prevention plan should be immediately instituted once a reportable elopement occurs. Wandering/Elopement Risk Assessment - Management - Prevention 1. Perform an elopement risk assessment for all residents upon admission, quarterly and with any significant cognitive/physical change that may place the individual at risk for wandering/elopement. 2. Document on the risk assessment all physical, emotional, and psychological factors that contribute or apply to unsafe wandering/elopement risk. 4. Develop or review/update the resident specific care plans to address risk factors for wandering/elopement at least quarterly and prn. Include interventions used to manage/prevent elopement/wander risk. 5. Inter-disciplinary team members should document in the resident clinical record behavior changes, and response/reaction to interventions initiated to prevent/control wandering/elopement behaviors. 6. Report any changes/escalation of resident's wandering behaviors to the treating clinician and responsible party. 7. Notify the Administrator, Director of Nursing and facility staff in the event a resident is noted missing from the unit and/or facility. Review of the facility's policy titled Safety and Supervision of Residents included the following: Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Individualized, Resident-Centered Approach to Safety: The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks and hazards shall include communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, ensuring that interventions are implemented and documenting interventions. Monitoring the effectiveness of interventions shall include ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed, and evaluating the effectiveness of new or revised interventions. Resident supervision is a core component of the system approach to safety. The type and frequency of resident supervision is determined by the individual resident assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. Resident Risks and Environmental Hazards included: e. Unsafe Wandering On 06/26/2020 at 10:05 a.m., an interview was conducted with S2DON. She explained that on 05/03/2020 the resident was found on a two lane Highway by S8DS. She said the resident was brought back to the facility and assessed by S5RN. She stated a Wanderguard was applied to Resident #6's right lower extremity. She stated S5RN called S2DON at 11:35 a.m. and S1ADM was notified by S2DON per text upon knowledge of the elopement. S2DON stated the MD and the Resident's son were notified. S2DON said following the 05/03/2020 elopement, the only intervention implemented for Resident #6 was the Wanderguard. S2DON stated she did not know how long the resident was gone from the facility. She stated the facility's video footage was reviewed to assist with confirming a time the resident had eloped from the facility however there was nothing on it for the prior two weeks; therefore, she had not been able to pin down the exact time the resident left the facility. S2DON stated staff at the facility did not know Resident #6 had eloped until she was returned to the facility. She was asked if she was aware of the resident attempting to get out of the facility on 04/21/2020. She stated she was not and no new interventions were put into place after Resident #6 attempt to get out of the facility on 04/21/2020. S2DON stated it would have been beneficial to complete an Elopement Risk Assessment following the resident's increase of exit seeking behaviors on 04/21/2020. S2DON explained the staff that usually completed the Elopement Risk Assessment were not at work therefore she would have been the one to complete it and she did not complete one. S2DON verified that following Resident #6 elopements from the facility on 05/03/2020 and 05/27/2020, there was not an increase in supervision or an increase in staff. S2DON stated the following interventions were put into place after the 05/03/2020 elopement of Resident #6 occurred: 05/03/2020- Wander Guard; 06/11/2020- SIMS was completed, investigation was conducted, and Elopement Risk Assessments were completed for everyone in the building, Education was provided to the facility's staff along with Wander drills, in which the staff responded as if a resident had eloped; 06/12/2020- Monitoring for Wanderguard by the nurse every shift on MAR; 06/15/2020- CNA's monitoring for Wanderguards on Kiosk started, and the front door was locked. S2DON stated S1ADM was responsible for completing the SIMS report S2DON stated the SIMS report was completed on 06/11/2020 and the investigation was started on 06/11/2020. She stated the training and education was started on 06/11/2020. No training or drills were completed prior to 06/11/2020. S2DON stated S1ADM was responsible for completing the SIMS report. She further stated she and S1ADM were responsible for the investigation. S2DON stated the investigation into the resident's elopement incidents were not started until 06/11/2020 because the facility had 45 plus residents with COVID. She said, We just lost track of it. It was not on our radar. On 06/26/2020 at 12:45 p.m., an interview was conducted with S1ADM. He was asked to explain what happened on 05/03/2020. He stated he received a text that Resident #6 had eloped and was returned to the facility. He stated no one contacted him when she left because no one knew she was gone. He said he was contacted when she returned. He stated the nurse assessed her and applied a Wanderguard to her leg. He was asked if any other interventions were put into place at that time. S1ADM stated nothing else was put into place. He stated on 05/27/2020, S9CN brought the resident to the front nurse's station. He, S4DDS, and S18MRK were standing and talking when S9CN brought the resident up to them. S9CN said she had seen her outside and let her in. There was no Wanderguard on the resident. Resident #6 was moved to another with a resident who stays in bed and would not assist with cutting off the Wanderguard. S1ADM was asked if any other interventions were put into place other than reapplying the Wanderguard. S1ADM stated the resident was sent out to theER on [DATE] due to increased agitation, walking the facility, testing the doors, and throwing hot coffee on a nurse. The resident was admitted to a behavior health hospital for medication adjustments. No training or drills were completed until 06/11/2020. She returned from that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195571	A. BUILDING _____ B. WING _____	**06/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) to the facility on [DATE]. When asked about completing the investigation and implementing intervention following each of the Resident #6's elopements, he stated he and S2DON just dropped the ball. He stated he is aware of the timelines that are required for completion of the SIMS and the start of the investigative process but he did not meet those timelines. He stated, looking back he should have increased supervision on Resident #6.