| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | N046033 | A. BUILDING: _____ B. WING _____ | C 07/27/2015 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a partial extended complaint investigation #88485.<br><br>Revised and sent on 7/28/15 | S 000 | | |
| S3026 SS=J | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility's assisted living unit census totaled 30 residents with 3 sampled. Based on observation, interview, and record review, the facility failed to provide effective interventions to prevent elopement of 1 of 3 residents sampled (#1). There were 12 residents at risk for elopement. Resident #1 had cognitive deficits, was at risk for falls, and was an elopement risk. This failure to put effective interventions in place for the resident put the resident in immediate jeopardy. Resident #1 was found 1.3 miles from the facility.<br><br>Findings included:<br><br>- Resident #1's Physician ' s Order Sheet (POS) dated 6/9/15 included the diagnosis of mild dementia (progressive mental disorder characterized by failing memory, confusion), falls, | S3026 | | |

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

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advanced osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and cervical (neck bone) fracture.

The physician's telephone order dated 6/10/15 documented new order to add Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and to discontinue diagnosis of mild dementia.

The Functional Capacity Screen dated 4/5/15 documented the resident was independent with walking/mobility, had short term and long term memory loss, impaired decision-making, was a fall risk, was not a wandering risk, and used a walker.

The Brief Interview for Mental Status (BIMS) dated 6/30/15 documented the resident had a score of 6 which indicated severe cognitive impairment.

The Individualized Resident Service Plan (ISP) dated 4/5/15 noted the resident was alert and oriented but with some forgetfulness, was a fall risk, ambulated independently with a rolling walker, and liked to take strolls down the hallway. The plan lacked elopement risk status.

The Wandering/elopement Risk review tools revealed the following:
1/4/15 the resident was at high risk for wandering/elopement.
4/4/15 the resident was at moderate risk for wandering/elopement.
7/15/15 documented the resident had an incident of getting lost, due to dementia, and his/her family was looking for an appropriate facility. The resident had a 24 hour a day caregiver until

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arrangements could be made for a different facility.

The nurse ' s notes documented the following: On 5/16/15 at 2:00 P.M., the resident continued to be confused and agitated. Needing more attention from staff to redirect, he/she will sometimes be too loud of you ask him/her anything, will not have an answer for a simple question you ask him/her. The resident seems to be struggling a lot and difficulty remembering things. Staff monitored, cued and redirected as needed.

On 6/23/15 at 12:45 P.M. noted an off duty staff member called the facility to inform them the resident was walking down the street with his/her walker. Two staff drove to the site, where the resident sat on his/her walker with police and a neighbor present. The resident stated he/she was going to church and took the wrong turn. The unidentified neighbor stated he/she saw the resident sitting on his/her walker and asked if he/she needed help. The resident told the neighbor he/she could not find his/her way home, so the neighbor called the police. The facility staff returned the resident to the facility.

The notarized statement dated 6/24/115 from direct care staff O documented he/she was off duty and observed the resident (off the facility premises) and called the facility.

The undated notarized statement from administrative staff A noted the resident was not at dinner at 12:30 P.M. and looked for the resident. The receptionist saw the resident go outside at 11:45 A.M.. The resident often went outside to sit or walk around the grounds unsupervised. An off duty employee call the

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facility to inform them he/she saw the resident about 1.2 miles from the facility. The facility also received a call from a neighbor who said the resident said he/she was lost and had called the police.

The facility elopement investigation dated 6/23/15 documented an off duty facility employee observed the resident walking a long distance from the community. The facility staff returned the resident to the facility. The investigation lacked documentation on what the resident was wearing at the time of elopement, the temperature, the speed limit, and traffic conditions.
On 7/20/15 at 10:56 A.M. the resident was in his/her room. He/she moved quickly around the room with a steady gait and used a walker.

On 7/20/15 at 7:50 A.M. administrative staff B stated a staff member sat at the front desk from 7:00 A.M. until the doors were alarmed at 8:00 P.M., then a security guard would monitor the doors until morning. Resident #1 was in the elopement book but he/she went outside unsupervised but always came back

On 7/20/15 at 10:56 A.M. the resident stated he/she went out of the facility to take a walk and could not remember where he/she was walking. The resident could not remember which door he/she went out. He/she did not tell the staff when he/she would go out of the building. Staff were always at the front door and they would say hello and talk to him/her. During the interview the resident had trouble answering questions and at times changed the subject mid-sentence.

On 7/20/15 at 11:53 A.M. the resident ' s family member stated the day the resident left the building and was found away from the facility. The

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| S3026 | Continued From page 4<br>family member had been a patient in facilities skilled unit and was being discharged the day resident #1 was found away from the facility. He/she thought his/her parent went looking for him/her and got lost. The resident went on walks to where the family member worked in the shopping area next to the facility. The staff told the resident not to go off the property after he/she had a fall a few years ago and the resident had not left the property unsupervised since then that he/she knew of. The resident did have times when he/she was confused.<br><br>On 7/20/15 at 2:00 P.M. administrative nursing staff D stated the resident walked independently with a walker and had a history of walking over to the shopping center where his/her family member worked. The resident took walks and he/she knew where he/she was going. The day the resident eloped he/she was concerned about his/her family member and turned the wrong way out of the facility and continued to walk. A neighbor was walking and asked the resident if he/she needed help. The resident told the neighbor he/she was lost so the neighbor called the police. An off duty staff member called the facility to report the resident was off facility property. The resident was not in the elopement book because he/she had permission to walk the grounds unsupervised. The facility did not know the resident was missing.<br><br>On 7/20/15 at 3:14 P.M. direct care staff P stated the resident was an elopement risk. If the resident went outside the staff did 2 hours check on general rounds. If a resident was missing he/she would look in the sign-out book to make sure the resident wasn ' t signed out, then would tell the nurse and look for the resident. | S3026 | | |

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| S3026 | Continued From page 5<br><br>The path the resident took out of the facility was unknown. The facility staff found the resident over one mile away. The most direct route out of the front door included a 4 lane street with heavy traffic, with a sidewalk next to the street, with a speed limit of 35 miles per hour (MPH); and a 2 lane road with a speed limit of 35 mph, where staff found the resident. The total distance was 1.3 miles from the facility.<br><br>According to Wunderground.com on Tuesday, June 23, 2015 at 11:53 A.M. the temperature was 77 degrees, at 12:53 P.M. the temperature was 79 degrees with overcast skies.<br><br>The facility ' s Wandering and Elopement Safety Program (AL) policy, revised 10/26/11, noted the facility provided a system to identify residents at risk for unsafe wandering and elopement. A service/support plan must be developed immediately, and reviewed with staff if the resident is determined to be at risk, the resident ' s current photo would be located at the front reception desk and in the medication book.<br><br>The facility failed to provide adequate supervision to this cognitively impaired resident who was at risk for falls. The resident exited the facility without staff and was found 1.3 miles from the facility on a busy street: this placed this resident in Immediate Jeopardy.<br><br>The immediate Jeopardy was abated on 7/21/15 after the facility completed elopement risks assessments on all assisted living residents, updated assisted living resident ' s service plans, placed pictures of residents at risk in the elopement book at the receptionist ' s desks, hallway exit doors are alarmed 24 hours a day, the front desk is monitored by staff from 6:00 | S3026 | | |

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| S3026 | Continued From page 6<br>A.M. until 9:00 P.M. and intermittently by security throughout the night, resident identified at risk for elopement who exit the building will be monitored by visual sight of staff, all the assisted living staff were in-serviced on the wandering an elopement safety program, and residents will sign out when they exit the building.<br>The deficiency remains at a scope and severity of a " D " . | S3026 | | |