

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/23/2019
NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
(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 000	INITIAL COMMENTS The State Agency (SA) conducted a partial extended survey for Complaint Investigation (CI) MS #15614, from 1/14/19 to 1/23/19. The SA substantiated the complaint for elopement. During the survey it was determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited regulatory deficiencies. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), that began on 12/9/18, when the facility failed to provide adequate assessment and supervision for a confused, demented resident, with a past history of elopement. It is believed Resident #1 exited the building through the 400 hall fire exit door, on 12/9/18 between 8:00 AM and 9:00 AM, and was found 17 steps from the end of the exit ramp, which was 65 steep steps down from the top of the ramp. This exit ramp was greater than six (6) feet tall. Resident #1 was seen from a window by Certified Nursing Assistant (CNA) #1, who immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 and was found with no injury. All staff was responsible to supervise Resident #1 and the other 18 residents at risk for elopement. Resident #1 was on every 30 minute checks from a fall that occurred earlier the morning of 12/9/18. Resident #1 was documented as being observed on these checks for 24 hours. Resident #1 had a history of elopement and was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from doors by asking resident to turn around and assist to move away. The facility	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/01/2019

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 000	Continued From page 1 failed to thoroughly investigate and report the elopement of Resident #1, and failed to ensure appropriate measures were initiated and documented after the elopement occurred, to help prevent further elopement. The failure to provide supervision to ensure Resident #1, a demented resident with a history of elopement, resulted in the resident's elopement from the facility. The failure to supervise, thoroughly investigate, and report the elopement of Resident #1 placed this resident and other demented residents in a situation that was likely to cause serious injury, harm, impairment, or death. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The IJ and SQC existed at: 42 CFR(s) 483.25 (d)(1)(2)-Supervision, F689. 42 CFR(s) 483.12 (c)(1)(4)-Reporting of Alleged Violations, F609. 42 CFR(s) 483.12 (c)(2)- (4)-Investigate/Prevent/Correct Alleged Violation, F610 IJ existed at: 42 CFR(s) 483.21(b)(1)-Develop/Implement Comprehensive Care Plans, F656. The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, and removal of the IJ on 1/19/19. The SA validated the AOC on 1/23/19, and determined the IJ was removed, prior to exit.	F 000			

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F 000	Continued From page 2 Therefore the scope and severity for 42 CFR(s) 483.25(d)(1)(2)-Supervision, F689; 42 CFR(s) 483.21 (b)(1)-Comprehensive Care Plans, F656; 42 CFR(s) 483.12 (c)(1)(4)-Reporting of Alleged Violations, F609, 42 CFR(s) 483.12 (c)(2)-(4)-Investigating, F610, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Additional Tags were cited; F580 and F842.	F 000			
F 580 SS=D	Notify of Changes (Injury/Degrade/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580			3/11/19

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F 580	Continued From page 3 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and policy review, the facility failed to notify the Responsible Party of Resident #1's fall and elopement on 12/9/18 for one (1) of six (6) residents reviewed for notification; Resident #1. Findings Include: Review of the facility's policy titled, "Family	F 580	* Resident #1's family has been notified by the Director of Nursing(DON)on 01/15/19 at 12:30 pm about Resident #1's elopement on 12/09/18. ** All residents are at risk for this same deficient practice. ***All Licensed Practical Nurses(LPN) and		

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F 580	Continued From page 4 Notification Policy", dated 1/1/07, revealed it is the policy of the facility to notify a resident's responsible party or other family members within 24 hours for any accident/incident involving the resident. This policy also noted the facility would document in the nurse's notes the date, time, reason for the notification, the person notified, the person's response if applicable and to be signed by the nurse and the time. Review of the facility's policy titled, "Elopements and Wandering Residents, modified on 4/20/18, revealed the facility would notify the family/authorized representative post elopement of any changes in the physician's orders and be included in changes in the plan of care. This policy also noted documentation in the medical record will include: findings from the nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. Review of the Nurse's Notes, dated 12/9/18 at 6:39 AM, revealed Resident #1 was observed on the floor in the doorway of the room, sitting on her buttocks at 5:45 AM. The Nurse's Notes revealed no documentation of Resident #1 being found outside and unsupervised. Interview with Certified Nursing Assistant (CNA) #1 on 1/14/19 at 12:00 Noon, revealed on the morning of 12/9/18, she observed Resident #1 outside the building and alone in her wheelchair. CNA #1 stated she brought Resident #1 back into the building and confirmed the resident had eloped from the facility. Review of Resident #1's medical record revealed no documented notification to the Responsible	F 580	Registered Nurses (RN) have been in-serviced by QA Nurses beginning on 02/07/19 @ 7am and ending on 03/01/19 at 9am on notifying resident's Responsible Party (RP) on any change in resident status/changes per facility policy and the importance of documenting in the resident's electronic medical record. An Incident Checklist will be kept in the front of the 24 hour report book to be used to list any/all incidents. The checklist will have the following information on it: Incident, Resident Name, Family notification, Physician notification, Incident Report completed, Statements taken and Documented in Chart. Nurses must initial this checklist to show that they have notified the residents Responsible Party and the Physician and document in the electronic medical record that notifications have been done. All nurses have been in-serviced on this checklist beginning on 03/08/19 at 1:30 pm and ending on 03/11/19 at 8:30 am. ****Quality Assurance Licensed Practical nurse(LPN#2) or Registered Nurse(RN#3) will review this checklist on Monday, Wednesday and Friday and audit all incidents for documentation of notification of Responsible Party in the residents electronic medical record. Quality Assurance Licensed Practical Nurse or Registered Nurse will do this weekly for one month, then bi-monthly for one month, then monthly for three months. Audits were started on 02/13/19.		

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F 580	Continued From page 5 Party (RP) or family, of the fall or the elopement for Resident #1 on 12/9/18. Interview on 1/16/19 at 1:40 PM, with Resident #1's RP #1, revealed she was not notified on 12/9/18 of Resident #1's fall or elopement. The RP stated, she was however notified on 1/16/19 by the Director of Nursing (DON) before speaking with the State Agency, after the investigation had begun. In an interview, on 1/16/19 at 3:20 PM, with Resident #1's RP #2 revealed she had not been notified of an elopement or fall on 12/9/18, and stated she visited Resident #1 weekly. Interview with Licensed Practical Nurse (LPN) #1, on 1/18/19 at 11:50 AM, revealed she was instructed by the Director of Nursing (DON) not to notify the family regarding Resident #1's elopement on 12/9/18, and stated, "I knew better". The facility admitted Resident #1 on 2/7/11, with diagnoses including Senile Degeneration of the Brain, Alzheimer's disease, Type II Diabetes Mellitus, Glaucoma and History of Breast Cancer. A Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). Staff assessment identified Resident #1 as severely impaired and never/rarely made decisions.	F 580	The Quality Assurance Nurses will bring their findings to the monthly QA meeting for review and recommendations.		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		3/11/19	

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F 609	Continued From page 6 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to report to the State Agencies (SA)s when Resident #1 exited the facility, unsupervised, on 12/9/18, for one (1) of six (6) residents reviewed for risk of elopement. It is believed Resident #1 exited the building through the 400 hall fire exit door, on 12/9/18, between 8:00 AM and 9:00 AM was found 17 steps from the end of the exit ramp, which was 65 steps down from the top. This exit	F 609	* Resident #1's elopement on 12/09/18 was reported to the State Department of Health by the Director of Nursing and the Attorney Generals office was notified on line by the Administrator on 01/15/19 at 12:30 pm. **All residents are at risk for this deficient practice.		

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F 609	Continued From page 7 ramp was greater than six (6) feet tall. Resident #1 was seen from a window by Certified Nursing Assistant (CNA) #1 and immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 with no injury. There was no documented evidenced that the elopement was reported to the State Agency as required. Resident #1 had a history of elopement and was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from the doors. The facility's failure to report the elopement/lack of supervision for Resident #1 to the State Agencies as required, to ensure corrective actions were taken, placed Resident #1 and other residents at risk for elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/9/18, when Resident #1 exited the building from the 400 hall door unsupervised and was found 17 steps from the end of the exit ramp, which was sixty-five steps down from the top of the ramp. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, with removal of the IJ on 1/19/19. The SA validated the AOC on 1/23/19, and	F 609	*** An in-service education program was conducted by QA nurses beginning on 02/06/19 @ 7am and ending on 03/01/19 @ 9am with all Licensed Practical Nurses(LPN's) and Registered Nurses(RN's) addressing circumstances that require reporting such as injuries of unknown origin, elopement, abuse, neglect, misappropriation of funds, falls with injuries, etc., including appropriate time frames for reporting. Nurses must call the Administrator, Director of Nursing and the Assistant Director of Nursing immediately after any incident involving injuries of unknown origin, falls with injury, Abuse, Neglect, Misappropriation, Exploitation or any incident with an adverse affect for the resident so that it can be reported to the proper agencies within two hours. All other incidents will be brought to the daily Interdisciplinary Team meeting for review for reportable incidents. **** Quality Assurance Registered Nurse (RN) or Licensed Practical Nurse (LPN) will audit residents based on Incident Reports and the Incident Report Checklist. These residents will be assessed and interviewed in addition to reviewing electronic or paper records to ensure that injuries/adverse finding are identified, properly investigated and reported to the appropriate people/State Agencies. They will audit five random residentsd per week for one month, then five residents bi-monthly for one month, then five residents monthly for three		

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F 609	Continued From page 8 determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.12 (c)(1)(4)-Reporting, F609, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility's policy titled, "Abuse, Neglect, or Exploitation Policy", dated 12/1/18, revealed any complaint must be reported to the Administrator and Director of Nursing (DON), as soon as possible, and then reported to State Agencies by phone within 24 hours and in writing within 72 hours. This policy revealed, the report is to include the name, address and phone number of the person making the report, and the name and address of the believed victim. The incident must include details, any observations, any beliefs, date, time, and place the incident occurred. This incident must include any statements related to the incident, and the name of the individual believed to be responsible for the incident. During an interview and observation, on 1/14/19 at 12:00 PM, Certified Nursing Assistant (CNA) #1 stated on the morning of 12/9/18, she observed Resident #1 through the window blinds of room 401, outside and alone in the wheelchair, that was sitting on a grassy area. CNA #1 stated, she immediately went outside and brought Resident #1 inside. CNA #1 used the keypad to unlock the 400 hall fire door exit and walked 65 steps down the ramp and 17 steps from the ramp to where she indicated Resident #1 was located	F 609	months. Audits began on 02/28/19. The Quality Assurance nurses will bring these findings to the Monthly QA meeting for review and recommendations.		

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F 609	Continued From page 9 on 12/9/18. CNA #1 stated Resident #1 was still sitting upright in the wheelchair, with the alarm belt in place, when she brought her back into the facility. In an interview on 1/18/19 at 12:30 PM, the Director of Nursing (DON) stated there was no investigation regarding Resident #1 exiting the building, so therefore there was nothing to report. During an interview, on 1/14/19 at 11:18 AM, the facility's Administrator stated Resident #1 was in the sight of staff the whole time while staff was pursuing her on 12/9/18, when she got outside. The Administrator revealed no investigation or reporting was conducted. In a further interview, on 1/14/19 at 11:40 AM, the Administrator stated when talking with Certified Nursing Assistant (CNA) #1 this morning, she learned Resident #1 was outside alone on 12/9/18, and not in sight of employees as previously thought. The Administrator stated, "I made a horrible mistake." In an interview, on 1/14/19 at 2:10 PM, the Administrator stated she was told Resident #1 got out of the building, but staff was with her. The Administrator stated had the occurrence been investigated, then she would have known to report it. The Administrator confirmed she had not reported the elopement for Resident #1 and stated, "I made a big mistake." The facility provided an Acceptable Allegation of Compliance, which included: Resident #1 was admitted on 02/07/11. Resident #1 has the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11,	F 609			

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F 609	Continued From page 10 Resident #1 was originally care planned for Elopement risk. Resident #1 has a history of two (2) prior elopements to 12/09/18. The Elopement care plan was revised on 05/06/16, to include Resident #1's continued risk for elopement. On 12/09/18, at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, seven (7) feet high and five (5) feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 brought Resident #1 back into the facility at approximately 8:30 am with no apparent injuries. Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18, and revealed severe cognitive impairment. The facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. Corrective Actions: 1. LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7 pm on 12/09/18, and was continued on every 30 minute checks until 6:30 am on 12/10/19. 2. LPN #1 reported to the Administrator by	F 609			

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F 609	Continued From page 11 phone, on 12/09/18 at 8:55 am, that Resident #1 exited the building and was brought back in by CNA #1. The Administrator was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19 at 11:45 am, revealed that Resident #1 was not in sight at all times. 3. The Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18 at 9:13 am, of Resident #1 exiting the building supervised. No investigation was initiated at this time. There is no documentation that Resident #1 was assessed upon return to the facility. 4. On 12/09/18 at approximately 10 am, LPN #1 put a sign on the Emergency Exit door. The sign stated, "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". 5. The 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm. There were no specific staff assignments made by LPN #1 to monitor the door. 6. The last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18, by Maintenance personnel, and was noted to be working properly. On 12/09/18 at approximately 11:15 am, the door lock was working properly but the sound for the Emergency Exit door alarm was non-functioning, when checked by Maintenance personnel. The Administrator was notified at 11:30 am, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was	F 609			

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F 609	Continued From page 12 repaired on 12/10/18, by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly. 7. On 12/09/18, after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. On 12/10/18 at 7:00 am, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. During further investigation, on 01/14/19 at approximately 11:45 am, it was determined during interview by the Administrator that CNA #1 did not have Resident #1 in sight at all times. 10. On 01/14/19 at approximately 2:00 pm, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at PM, LPN #2, Administrator, Registered Nurse (RN) #1, RN #2, and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry	F 609			

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F 609	Continued From page 13 Contract Staff, and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. No staff will be allowed to work until they have completed all in-services. 11. Elopement Risk Factors, which are used for assessments, were completed on all 98 residents in the facility on 01/14/19 at 8:00 pm, by LPN # 9. Nineteen residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff; staff is aware, and in-services were conducted on 01/16/19 by LPN #2 that residents are on 15 minute checks. 12. The Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19 at approximately 12:30 pm. No discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 at 3:00 pm, and ending 01/17/19 5:30 pm, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19 at 12:30 pm. Resident #1's Responsible Party was notified on 01/16/19, by the DON at 11:50 am. 14. Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19 at 6:20 pm. Care Plans were reviewed and 19 were updated with current intervention for every 15 minute checks.	F 609			

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F 609	Continued From page 14 15. On 01/14/19 at 6:30 pm, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18, with Resident #1, was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. An Emergency QA meeting was held on 01/16/19 at 12:35 pm, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN #2, and the Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. 17. In-service to all staff was initiated by LPN #2 and RN #2 on 01/16/19 at 3:45 pm, regarding changes to daily door checks. 18. On 01/17/19 at 5:30 pm, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. 19. An Emergency QA meeting was held on 01/18/19 at 11:30 am, regarding Emergency Exit	F 609			

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F 609	Continued From page 15 Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator, and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. In-service to all staff was completed by LPN #2 on 01/18/19 at 11:45 am, regarding changes to the Emergency Exit Door Policy. 21. As of 01/18/19 at 5:00 pm, a total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility. 22. The facility alleges all corrective actions to remove the IJ were completed on 01/18/19, and the IJ removed on 01/19/19. Validation of the Allegation of Compliance included: Based on observation, interviews, record review, the State Agency (SA) validated that Resident #1 was admitted on 02/07/11. Resident #1 had the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1	F 609			

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F 609	Continued From page 16 was originally care planned for Elopement risk. Resident #1 had a history of two (2) elopements prior to 12/09/18. The Elopement care plan was revised on 05/06/16, to include Resident #1's continued risk for elopement. On 12/09/18 at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, 7 feet high and 5 feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 verified by interview that she brought Resident #1 back into the facility at approximately 8:30 am, with no apparent injuries. Record review confirmed Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18 and revealed severe cognitive impairment. Results of record review and interview confirmed the facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. The SA validated the facility's Corrective Actions: 1. The SA validated through interview that LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7:00 pm on 12/09/18, and continued every 30 minute checks until 6:30 am on 12/10/19.	F 609			

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F 609	Continued From page 17 2. The SA validated through interview that LPN #1 reported the elopement of Resident #1 to the Administrator by phone on 12/09/18. Interview with the Administrator confirmed she was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19, revealed that Resident #1 was not in sight at all times. 3. The SA validated through interviews that the Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18, of Resident #1 exiting the building supervised and that no investigation was initiated at this time. 4. The SA validated through observation and interviews that on 12/09/18, LPN #1 put a sign on the Emergency Exit door. The sign stated "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". The sign was observed during survey. 5. The SA validated through staff interviews that the 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm, but no specific staff assignments were made by LPN #1 to monitor the door. 6. The SA validated through interviews and record review that the last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18 by Maintenance personnel and was noted to be working properly, but on 12/09/18, the sound for the Emergency Exit door alarm was non-functioning. Interviews revealed the Administrator was notified, and a repair call was	F 609			

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F 609	Continued From page 18 placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18 by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly. 7. The SA validated through interviews that on 12/09/18 after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. The SA validated through interviews and record review that on 12/10/18, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. The SA validated through interviews that during further investigation on 01/14/19, the Administrator determined that CNA #1 did not have Resident #1 in sight at all times. 10. The SA validated through interviews and record review that on 01/14/19, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at 3:00 pm, LPN #2, Administrator and Registered Nurse (RN) #1, RN #2 and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the	F 609			

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F 609	Continued From page 19 Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. The SA validated through interview and staffing records that no staff have been allowed to work until they have completed all in-services. 11. The SA validated through record reviews and interviews that the Elopement Risk Factors, which are used for assessments, were completed on all 98 residents in the facility on 01/14/19, by LPN # 9 and that 19 residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff and in-services were conducted on 01/16/19 by LPN #2, that residents are on 15 minute checks. 12. The SA validated through interviews and record review that the Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19, and that no discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 and ending 01/17/19, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The SA validated through interviews and record review the facility Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19. Resident #1's Responsible Party	F 609			

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F 609	Continued From page 20 was notified on 01/16/19 by the DON. 14. The SA validated through interviews and record review the Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19. The SA verified Care Plans were updated with current intervention for every 15 minute checks. 15. The SA validated through interviews and record review that on 01/14/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18 with Resident #1 was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. The SA validated through interviews and record reviews an Emergency QA meeting was held on 01/16/19, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN# 2 and Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. The SA validated through record review of the documented daily checks. 17. The SA validated through interviews and record review that in-service to all staff was by	F 609			

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F 609	Continued From page 21 LPN #2 and RN #2 on 01/16/19, regarding changes to daily door checks. 18. The SA validated through interviews and record reviews that on 01/17/19, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. The SA validated no other concerns were noted. 19. The SA validated through interviews and record review that an Emergency QA meeting was held on 01/18/19, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. The SA validated through interviews and record review that an in-service to all staff was completed by LPN #2 on 01/18/19, regarding changes to the Emergency Exit Door Policy. 21. The SA validated through interviews and record reviews as of 01/18/19, total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5)	F 609			

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F 609	Continued From page 22 Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility.	F 609			
F 610 SS=J	22. The SA validated that all corrective actions were completed on 01/18/19, and the IJ removed on 01/19/19. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to investigate when Resident #1 was found outside of the facility, unsupervised on 12/9/19 for one (1) of six (6) residents reviewed at risk for elopement; Resident #1. The facility failed to provide adequate	F 610			3/11/19
			* An investigation was completed on Resident #1's elopement on 12/09/18 by the Administrator, Corporate Nurse, Quality Assurance Licensed Practical Nurse (LPN#2) on 01/18/19. It was determined that Resident #1 who is cognitively impaired, exited the building		

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F 610	Continued From page 23 assessment and supervision for a confused, demented resident, with a past history of elopement. It is believed Resident #1 exited the building through the 400 hall fire exit door and on 12/9/18 between 8:00 AM and 9:00 AM was found 17 steps from the end of the exit ramp that was sixty-five steps down from the top. This exit ramp was greater than six (6) feet tall. Resident #1 was seen from a window by Certified Nursing Assistant (CNA) #1 and immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 with no injury. All staff was responsible to supervise Resident #1 and the other eighteen (18) residents at risk for elopement. Resident #1 was on every 30 minute checks from a fall earlier that morning on 12/9/18 and was documented as being observed on these checks for twenty-four (24) hours. Resident #1 had a history of elopement and was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from doors by asking resident to turn around and assist to move away. The failure to investigate the incident when Resident #1, a demented resident with a history of elopement, was found outside and unsupervised on 12/9/18, placed this resident and other residents in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/9/18, when Resident #1 exited the building from unsupervised and was found 17 steps from the end of the exit ramp of the 400 Hall, that was 65 steps down from the top of the ramp. CNA #1	F 610	unsupervised. ** All residents have the potential to be affected by this deficient practice. ***An in-service education program was conducted by Quality Assurance nurses beginning on 02/07/19 @ 7am and ending on 03/01/19 @ 9am with all Licensed Practical Nurses (LPN's) and Registered Nurses (RN's) on reporting and investigating incidents that involve resident elopements and any incidents with a negative outcome for our residents and their responsibilities related to investigations. All incidents will be fully investigated by the Quality Assurance (QA) Registered Nurse (RN) and Licensed Practical Nurse (LPN). **** Quality Assurance nurses will audit five residents once weekly for one month, bi-monthly for one month and monthly for 3 months. These residents will be assessed and interviewed in addition to reviewing electronic or paper records to ensure elopements/injuries/adverse findings are identified, properly investigated and reported to the appropriate people/State Agencies. Audits began on 02/28/19. The two Quality Assurance nurses will bring these findings to the monthly QA Meeting for review and recommendation.		

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F 610	Continued From page 24 returned Resident #1 back into the building. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, and the IJ removed on 1/19/19. The SA validated the AOC on 1/23/19, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.12 (c)(2)-(4), F610, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled, "Abuse, Neglect, or Exploitation Policy", dated 12/1/18, revealed any complaint must be reported to the Administrator and Director of Nursing (DON), as soon as possible, and then reported to State Agencies by phone within 24 hours and in writing within 72 hours. Any report of abuse, neglect or exploitation will be investigated by the Administrator/Director of Nursing/Social Services/Quality Assurance (QA) Committee and Facility Security. Investigation shall include but is not limited to questioning the resident involved when appropriate, questioning all staff members, with written statements to be taken as quickly as possible.	F 610			

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F 610	Continued From page 25 During an interview and observation, on 1/14/19 at 12:00 PM, Certified Nursing Assistant (CNA) #1 stated on the morning of 12/9/18, she observed Resident #1 through the window blinds of room 401, outside in her wheelchair, by herself and immediately went and got her back inside the facility. CNA #1 exited the fire door located on the 400 Hall and walked 65 steps down the ramp and 17 steps from the ramp to where she indicated Resident #1 was located on 12/9/18. CNA #1 stated Resident #1 was still sitting upright in the wheelchair, with the alarm belt in place, when she brought her back into the facility. In an interview, on 1/14/19 at 11:18 AM, the Administrator stated initially it was thought that Resident #1 was in sight of staff the whole time, with staff pursuing her on 12/9/18, when she got outside. The Administrator confirmed, no investigation was conducted for the elopement of Resident #1. In an interview, on 1/14/19 at 11:40 AM, the Administrator stated CNA confirmed in an interview (1/14/19) that Resident #1 was outside alone on 12/9/18, and not in sight of employees as previously thought. The Administrator stated, "I made a horrible mistake." During an interview, on 1/14/19 at 2:10 PM, the Administrator stated she was told that Resident #1 got out, but staff was with her. The Administrator stated the occurrence should have been investigated, then she would have known to report it. The Administrator confirmed the elopement of Resident #1 was not investigated or reported and stated, "I made a big mistake."	F 610			

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F 610	Continued From page 26 Interview with the Director of Nursing (DON), on 1/14/19 at 10:55 AM, revealed an investigation was initiated when Resident #1 eloped in December and a head count of all residents were conducted. The DON also stated there was a staff member assigned to each door until the door could be checked after Resident #1 eloped. The DON confirmed the investigation was not documented and was not thorough. Interview on 1/18/19 at 12:30 PM, with the DON, revealed on 12/9/18, she was instructed by the Administrator to go to the facility and conduct a head count and to place staff at all doors, with the focus on the 400 Hall door, because the door wasn't shutting or something, not alarming. On the next day (12/10/18), the DON revealed an investigation was initiated, but was told by the Administrator to stop because Resident #1 was in sight of staff at all times. The DON stated, if an investigation had been completed, it would have revealed Resident #1 had got outside alone and unsupervised. Record review revealed the facility failed to initiated an investigation of Resident #1's elopement on 12/9/18, until 1/14/19, after the Administrator was notified by the State Agency (SA). The facility admitted Resident #1 on 2/7/11, with diagnoses including Type II Diabetes Mellitus, Alzheimer's Disease, Senile Degeneration of the Brain, Glaucoma and History of Breast Cancer. A review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental	F 610			

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F 610	Continued From page 27 Status (BIMS). Staff assessment identified Resident #1 as severely impaired and never/rarely made decisions. The facility provided an Acceptable Allegation of Compliance, which included: Resident #1 was admitted on 02/07/11. Resident #1 has the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1 was originally care planned for Elopement risk. Resident #1 has a history of two (2) prior elopements to 12/09/18. The Elopement care plan was revised on 05/06/16, to include Resident #1's continued risk for elopement. On 12/09/18, at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, seven (7) feet high and five (5) feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 brought Resident #1 back into the facility at approximately 8:30 am with no apparent injuries. Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18, and revealed severe cognitive impairment. The facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18.	F 610			

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F 610	Continued From page 28 The facility failed to report Resident #1's elopement to the required State Agencies. Corrective Actions: - LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7 pm on 12/09/18, and was continued on every 30 minute checks until 6:30 am on 12/10/19. - LPN #1 reported to the Administrator by phone, on 12/09/18 at 8:55 am, that Resident #1 exited the building and was brought back in by CNA #1. The Administrator was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19 at 11:45 am, revealed that Resident #1 was not in sight at all times. - The Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18 at 9:13 am, of Resident #1 exiting the building supervised. No investigation was initiated at this time. There is no documentation that Resident #1 was assessed upon return to the facility. - On 12/09/18 at approximately 10 am, LPN #1 put a sign on the Emergency Exit door. The sign stated, "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". - The 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm. There were no specific staff assignments made by LPN #1 to monitor the door.	F 610			

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F 610	Continued From page 29 6. The last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18, by Maintenance personnel, and was noted to be working properly. On 12/09/18 at approximately 11:15 am, the door lock was working properly but the sound for the Emergency Exit door alarm was non-functioning, when checked by Maintenance personnel. The Administrator was notified at 11:30 am, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18, by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly. 7. On 12/09/18, after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. On 12/10/18 at 7:00 am, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. During further investigation, on 01/14/19 at approximately 11:45 am, it was determined during interview by the Administrator that CNA #1 did not have Resident #1 in sight at all times. 10. On 01/14/19 at approximately 2:00 pm, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at PM, LPN #2, Administrator, Registered Nurse (RN) #1, RN #2, and RN #3 began in-servicing all staff on the	F 610			

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F 610	Continued From page 30 following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. No staff will be allowed to work until they have completed all in-services. 11. Elopement Risk Factors, which are used for assessments, were completed on all 98 residents in the facility on 01/14/19 at 8:00 pm, by LPN # 9. Nineteen residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff; staff is aware, and in-services were conducted on 01/16/19 by LPN #2 that residents are on 15 minute checks. 12. The Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19 at approximately 12:30 pm. No discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 at 3:00 pm, and ending 01/17/19 5:30 pm, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The Administrator notified the Attorney General's office of Resident #1's elopement and	F 610			

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F 610	Continued From page 31 the DON called Resident #1's elopement in to the State Department of Health on 01/15/19 at 12:30 pm. Resident #1's Responsible Party was notified on 01/16/19, by the DON at 11:50 am. 14. Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19 at 6:20 pm. Care Plans were reviewed and 19 were updated with current intervention for every 15 minute checks. 15. On 01/14/19 at 6:30 pm, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18, with Resident #1, was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. An Emergency QA meeting was held on 01/16/19 at 12:35 pm, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN #2, and the Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. 17. In-service to all staff was initiated by LPN #2 and RN #2 on 01/16/19 at 3:45 pm, regarding changes to daily door checks.	F 610			

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F 610	Continued From page 32 18. On 01/17/19 at 5:30 pm, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. 19. An Emergency QA meeting was held on 01/18/19 at 11:30 am, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator, and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. In-service to all staff was completed by LPN #2 on 01/18/19 at 11:45 am, regarding changes to the Emergency Exit Door Policy. 21. As of 01/18/19 at 5:00 pm, a total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility. 22. The facility alleges all corrective actions to remove the IJ were completed on 01/18/19, and	F 610			

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F 610	Continued From page 33 the IJ removed on 01/19/19. Validation of the Allegation of Compliance included: Based on observation, interviews, record review, the State Agency (SA) validated that Resident #1 was admitted on 02/07/11. Resident #1 had the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1 was originally care planned for Elopement risk. Resident #1 had a history of two (2) elopements prior to 12/09/18. The Elopement care plan was revised on 05/06/16, to include Resident #1's continued risk for elopement. On 12/09/18 at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, 7 feet high and 5 feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 verified by interview that she brought Resident #1 back into the facility at approximately 8:30 am, with no apparent injuries. Record review confirmed Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18 and revealed severe cognitive impairment. Results of record review and interview confirmed the facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1	F 610			

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F 610	Continued From page 34 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. The SA validated the facility's Corrective Actions: 1. The SA validated through interview that LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7:00 pm on 12/09/18, and continued every 30 minute checks until 6:30 am on 12/10/19. 2. The SA validated through interview that LPN #1 reported the elopement of Resident #1 to the Administrator by phone on 12/09/18. Interview with the Administrator confirmed she was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19, revealed that Resident #1 was not in sight at all times. 3. The SA validated through interviews that the Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18, of Resident #1 exiting the building supervised and that no investigation was initiated at this time. 4. The SA validated through observation and interviews that on 12/09/18, LPN #1 put a sign on the Emergency Exit door. The sign stated "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". The sign was observed during survey. 5. The SA validated through staff interviews that the 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm, but no specific staff assignments were made by LPN #1 to	F 610			

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F 610	Continued From page 35 monitor the door. 6. The SA validated through interviews and record review that the last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18 by Maintenance personnel and was noted to be working properly, but on 12/09/18, the sound for the Emergency Exit door alarm was non-functioning. Interviews revealed the Administrator was notified, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18 by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly. 7. The SA validated through interviews that on 12/09/18 after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. The SA validated through interviews and record review that on 12/10/18, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. The SA validated through interviews that during further investigation on 01/14/19, the Administrator determined that CNA #1 did not have Resident #1 in sight at all times. 10. The SA validated through interviews and record review that on 01/14/19, the Corporate	F 610			

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F 610	Continued From page 36 Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at 3:00 pm, LPN #2, Administrator and Registered Nurse (RN) #1, RN #2 and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. The SA validated through interview and staffing records that no staff have been allowed to work until they have completed all in-services. 11. The SA validated through record reviews and interviews that the Elopement Risk Factors, which are used for assessments, were completed on all 98 residents in the facility on 01/14/19, by LPN # 9 and that 19 residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff and in-services were conducted on 01/16/19 by LPN #2, that residents are on 15 minute checks. 12. The SA validated through interviews and record review that the Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19, and that no discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on	F 610			

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F 610	Continued From page 37 01/16/19 and ending 01/17/19, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The SA validated through interviews and record review the facility Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19. Resident #1's Responsible Party was notified on 01/16/19 by the DON. 14. The SA validated through interviews and record review the Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19. The SA verified Care Plans were updated with current intervention for every 15 minute checks. 15. The SA validated through interviews and record review that on 01/14/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18 with Resident #1 was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. The SA validated through interviews and record reviews an Emergency QA meeting was held on 01/16/19, regarding door alarm checks.	F 610			

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F 610	Continued From page 38 In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN# 2 and Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. The SA validated through record review of the documented daily checks. 17. The SA validated through interviews and record review that in-service to all staff was by LPN #2 and RN #2 on 01/16/19, regarding changes to daily door checks. 18. The SA validated through interviews and record reviews that on 01/17/19, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. The SA validated no other concerns were noted. 19. The SA validated through interviews and record review that an Emergency QA meeting was held on 01/18/19, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel.	F 610			

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F 610	Continued From page 39 20. The SA validated through interviews and record review that an in-service to all staff was completed by LPN #2 on 01/18/19, regarding changes to the Emergency Exit Door Policy. 21. The SA validated through interviews and record reviews as of 01/18/19, total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility. 22. The SA validated that all corrective actions were completed on 01/18/19, and the IJ removed on 01/19/19.	F 610			
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656			3/11/19

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F 656	Continued From page 40 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to follow the plan of care for elopement for Resident #1 for one (1) of six (6) residents reviewed for elopement; Resident #1. Resident #1 had been assessed and care planned for the risk of elopement, with a past history of elopement. It is believed Resident #1 exited the building through the 400 hall fire exit door on 12/9/18 between 8:00 AM and 9:00 AM. The resident was found 17 steps from the end of the exit ramp that was 65 steps down from the top. This exit ramp was greater than six (6) feet tall. Resident #1 was seen from a window by	F 656	* Resident #1's Care Plan was revised on 01/14/19 by Licensed Practical Nurse (LPN)#9 to indicate Resident #1 exited the building on 12/09/18 and was outside the building without staff assistance. Resident #1. was returned to the building by staff with no injuries noted. Resident on 15 minute visual monitoring. Emergency Exit door closed to all traffic. ** All residents at risk for elopement have the potential to be affected by this deficient practice.		

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F 656	Continued From page 41 Certified Nursing Assistant (CNA) #1 and immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 with no injury. Due to a history of prior elopement, Resident #1 was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from doors by asking the resident to turn around and assist to move away. The failure to implement the care plan to have secured exit doors and supervision for residents with a known history of elopement, placed this and other residents at risk for elopement in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) that began on 12/9/18, when Resident #1, a cognitively impaired resident, exited the building, believed to be from the 400 hall door, unsupervised. Resident #1 and was found at the bottom of the exit ramp, approximately 65 steps from the top of the ramp and approximately 17 steps from the end of the exit ramp. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, and the IJ removed on 1/19/19. The SA validated the AOC on 1/23/19, and determined the IJ was removed prior to exit.	F 656	Care Plans for 19 residents at risk for elopement were reviewed and updated as necessary by Licensed Practical Nurse (LPN)#9 on 01/14/19 at 6:20pm. *** All Licensed Practical Nurses (LPN's) and Registered Nurses(RN's) have been in-serviced by the two Quality Assurance nurses beginning on 02/07/19 at 7am, ending on 03/01/19 at 9am on following and updating the Care Plan and where the Care Plan is located. Care Plans are located at the nurse's station in a purple binder. Care Plans will be updated as needed. All Certified Nursing Assistants (CNA's) have been in-serviced on 03/08/19 at 1:20pm on the importance of following the Care Plan. Certified Nursing Assistant Care Plans are kept in a binder at the nurses station. Resident #1's Care Plan has been updated on 03/07/19 to give resident a basket of laundry to fold on active days and to be taken for walks in the courtyard with supervision. Activity Director will chart in Activity Notes each time activity occurs. **** Quality Assurance Licensed Practical Nurse (LPN#2) will check Resident #1's electronic medical record weekly for documentation that activity has occurred. This will be done for 3 months. Quality Assurance Registered Nurse (RN)#4 or Licensed Practical Nurse (LPN)		

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F 656	Continued From page 42 Therefore, the scope and severity for 42 CFR(s) 483.21 (b)(1)-Develop/Implement Comprehensive Care Plan, F656, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: A review of the facility's policy titled, "Elopements and Wandering Residents, modified on 4/20/18, documented the purpose of the policy is to ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Review of the facility's policy titled, "Documentation of Elopement Policy", dated 11/5/09, revealed care planning will be done on the incident and any and all measures/approaches to prevent recurrence. Review of Resident #1's care plan, revealed the resident was at risk for elopement with an onset date of 2/7/11, upon admission. The facility identified Resident #1 as a potential for elopement related to impaired cognition, history of wandering at home and packing up to leave. The listed approaches included to ensure doors are tightly closed and to check doors and systems per protocol. This care plan also listed an approach to direct resident away from doors, and to tell the resident to turn around or assist	F 656	#2 will audit five residents at risk for elopement by observation of staff to ensure care plan is being followed once weekly for one month, bi-monthly for one month and once monthly for three months. Audits began on 02/28/19. The two Quality Assurance Nurses will bring these findings to the monthly QA Meeting for review and recommendations.		

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F 656	Continued From page 43 resident to move away from the door. Review of Resident #1's, "Risk Factors for Elopement" assessment, dated 11/7/18, documented Resident #1 had a score of 14. This assessment indicated a score above ten (10) was a high risk for elopement. In an interview and observation, with Certified Nursing Assistant (CNA) #1, on 1/14/19 at 12:00 PM, she stated on the morning of 12/9/18, she observed Resident #1 through the window blinds of room 401, outside and alone in the wheelchair, which was sitting upright on the grass. The Surveyor and CNA #1 walked 65 steps down the ramp and 17 steps from the ramp to where the CNA indicated Resident #1 was located on 12/9/18. CNA #1 stated Resident #1 was still sitting upright in the wheelchair, with the alarm belt in place, when she brought her back into the facility and reported to the nurse. CNA #1 confirmed Resident #1 did not have enough supervision on 12/9/18, to prevent her from eloping from the facility. CNA #1 stated she was not assigned to Resident #1 on 12/9/18, but stated it was everyone's responsibility to watch all residents at risk for elopement. CNA #1 stated she was aware that Resident #1 was at risk for elopement, and that information is located in the care plan. CNA #1 was asked if the care plan for Resident #1 was followed if she was found outside that far away from the building, and unsupervised, and she responded, "I guess not." In an interview, on 1/18/19 at 11:50 AM, Licensed Practical Nurse (LPN) #1 revealed she was on duty 12/9/18, when Resident #1 eloped. LPN #1 stated, she was notified that CNA #1 saw Resident #1 go outside, and she went out and got	F 656			

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F 656	Continued From page 44 her. LPN #1 stated, the Administrator was notified, and then was told that CNA #1 did not see Resident #1 go outside, but that Resident #1 was already outside when she was seen out the window. LPN #1 stated she was instructed by the DON not to document the elopement in the Nurses Notes, or to notify the family, or obtain statements. LPN #1 stated the elopement occurred after breakfast between 8:00 AM and 9:00 AM, then stated, "Nobody was actually at the Nurses Station when it happened." LPN #1 stated Registered Nurse (RN) #4 was the supervisor that day and checked Resident #1 out for injuries when Resident #1 was returned to the building. In an interview with RN #4, on 1/18/19 at 12:20 PM, she revealed on 12/9/18, she was working as the RN Supervisor, when she heard CNA #1 scream and say that Resident #1 was outside and started running outside. RN #4 reported, that she put the code in the 400 hall door, and exited the building toward where Resident #1 was located outside. RN #4 stated, she observed Resident #1 sitting upright in the wheelchair, stating that she was going home. RN #4 stated, staff assisted Resident #1 inside. RN #4 stated, she received a phone call from the DON to watch the 400 hall door, and to put a note on the door that no staff was allowed to use it. RN #4 stated she had to enter the code to open the 400 hall door, but did not remember hearing an alarm. In an interview, on 1/16/19 at 4:40 PM, LPN #10 stated the purpose of the resident care plan is to have a guide for all resident care and is resident centered. LPN #10 stated if a resident had a care plan for elopement and that resident got outside with no staff present, then the care plan for that resident was not followed. LPN #10 stated there	F 656			

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F 656	Continued From page 45 was no documentation of Resident #1's elopement on 12/9/18, so we can't attest the care plan was followed. In an interview, on 1/16/19 at 4:50 PM, LPN # 9 revealed the resident's care plan is an individual working care plan based on the needs, wants and sometimes the diagnosis of a resident. LPN #9 stated if a resident is care planned for an elopement risk and they get outside, unsupervised, then somebody was not watching them per the care plan. The facility admitted Resident #1 on 2/7/11, with diagnoses including Alzheimer's disease, Senile Degeneration of the Brain, Type II Diabetes Mellitus, Glaucoma and History of Breast Cancer. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). Staff assessment identified Resident #1 as severely impaired and never/rarely made decisions.	F 656			
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:	F 689			3/11/19

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F 689	Continued From page 46 Based on observations, record review, interviews, and policy review, the facility failed to provide adequate assessment and supervision for a confused, demented resident, Resident #1, with a past history of elopement for one (1) of six (6) residents reviewed for risk of elopement; Resident #1. It is believed Resident #1 exited the building through the 400 hall fire exit door on 12/9/18 between 8:00 AM and 9:00 AM. The resident was found 17 steps from the end of the exit ramp that was 65 steps down from the top, and greater than six (6) feet in height. Resident #1 was observed from a window inside the facility, by Certified Nursing Assistant (CNA) #1, who immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 with no injury. All staff was responsible to supervise Resident #1 and the other 18 residents at risk for elopement. Resident #1 was on every 30 minute checks from a fall earlier that morning on 12/9/18, and was documented as being observed on these checks for twenty-four (24) hours. Resident #1 had a history of elopement and was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from doors, by asking resident to turn around and assist to move away. The failure to provide supervision to Resident #1, a demented resident with a history of elopement, resulted in the resident's elopement from the facility and placed this resident and other demented residents with a risk of elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an	F 689	* Resident #1 was returned to the building by Certified Nursing Assistant (CNA) #1 on 12/09/18 at 8:30am and was assessed by Licensed Practical Nurse (LPN) #1. No injuries were noted. ** 19 cognitively impaired residents at risk for elopement have the potential to be affected by this deficient practice. There have been no elopements since 12/09/18. *** An education in-service was conducted by the two Quality Assurance Nurses beginning on 02/18/19 at 7 am and ending on 03/01/19 at 9am on the policy and procedure for accidents and supervision for all staff. Also included in this training was head counts will be done three times daily, and that Maintenance will check the doors daily for proper functionality. All staff were also in-serviced on elopement drills. Elopement drills will be conducted by the Administrator, Director of Nursing and Assistant Director of Nursing. Elopement drills began on 02/28/19 at 3:10 pm. The key card reader on the Emergency Exit door on the 400 has been deactivated and no longer acts as an employee entrance/exit. Emergency Exits now have a five second delay for locking instead of a fifteen second delay. Door codes have been changed and only the following people have codes: Administrator, Director of Nursing, Assistant Director of Nursing, Corporate Nurse, Assistant Administrator		

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F 689	Continued From page 47 Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/9/18, when Resident #1 exited the building unsupervised and was found in her wheelchair, 17 steps from the end of the exit ramp that was 65 steps down from the top of the ramp. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, and removal of the IJ on 1/19/19. The SA validated the AOC on 1/23/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s) 483.25 (d)(1)(2)-Supervision, F689, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility's policy titled, "Elopements and Wandering Residents, modified on 4/20/18, revealed the purpose of the policy is to ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. This policy revealed the facility is equipped with door	F 689	and Maintenance Supervisor. All Emergency Exits will be checked daily by Maintenance Personnel to ensure they are in proper working order. A locking system was ordered on 03/01/19 for the doors leading to the patient care area. This will include a push button entry and a keypad exit. **** The two Quality Assurance Nurses will audit the elopement drills by collecting the in-service sheets once per shift per month for three months, once per shift per quarter for three months. Audits began on 02/28/19. The Quality Assurance Nurses will audit door alarm check book once daily for seven days, two days bi-weekly for three months and once weekly for three months. Audits began on 02/28/19. The Quality Assurance Nurses will bring these findings to the monthly Quality Assurance meeting for review and recommendations.		

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F 689	Continued From page 48 locks/alarms to help avoid elopements but are not a replacement for necessary supervision. This policy defines elopement to occur when a resident leaves the premises or a safe area without authorization and/or necessary supervision. Review of the facility's policy titled, "Documentation of Elopement Policy", dated 11/5/09, revealed an elopement is considered to be when a resident, (confused or alert), wanders past the facility exit without staff knowledge. A review of Resident #1's, "Risk Factors for Elopement" assessment, dated 11/7/18, documented Resident #1 had a score of 14. This assessment noted a score above ten (10) indicated a high risk for elopement. Review of Resident #1's cumulative Physician's orders for January 2019, revealed an order for a Wanderguard Bracelet with an order date of 5/19/16, related to elopement risk. Review of Resident #1's care plan, revealed the resident was at risk for elopement, with an onset date of 2/7/11, upon admission. The facility identified Resident #1 as a potential for elopement related to impaired cognition, history of wandering at home and packing up to leave. A review of the care plan dated for 8/2/18, revealed Resident #1 remained an elopement risk with approaches to ensure doors are tightly closed and to check doors and system per protocol. An additional approach was listed to direct resident away from doors-ask resident to turn around and assist to move away. Interview and observation with Certified Nursing	F 689			

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F 689	Continued From page 49 Assistant (CNA) #1, on 1/14/19 at 12:00 PM, revealed on the morning of 12/9/18, she observed Resident #1 through the window blinds of room 401. Resident #1 was outside and alone in the wheelchair, which was sitting on the grass. CNA #1 stated, she immediately went outside and brought Resident #1 inside. CNA #1 and the Surveyor, using the keypad to unlock the 400 hall fire door exit, walked 65 steps down the ramp and 17 steps from the ramp to where she indicated Resident #1 was located on 12/9/18. CNA #1 stated, Resident #1 was still sitting upright in the wheelchair, with the alarm belt in place, when she brought her back into the facility. CNA #1 confirmed, Resident #1 did not have enough supervision on 12/9/18, to prevent her from eloping from the facility. CNA #1 stated, she was not assigned to Resident #1 on 12/9/18, but stated that it was everyone's responsibility to watch all residents at risk for elopement. In an interview, with the Administrator, on 1/14/19 at 11:18 AM, she stated no investigation was conducted because Resident #1 was in sight of staff the whole time with staff pursuing her on 12/9/18, when she got outside. Further interview with the Administrator, on 1/14/19 at 11:40 AM, revealed when she talked to CNA #1 this morning, she learned Resident #1 was outside alone on 12/9/18, and not in sight of employees as previously thought. The Administrator stated, "I made a horrible mistake." Interview with the Director of Nursing (DON), on 1/14/19 at 10:55 AM, confirmed Resident #1 did go outside unsupervised on 12/9/18, and an investigation was initiated, but not completed. The DON stated that a head count of all the residents was conducted and staff members were	F 689			

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F 689	Continued From page 50 assigned to each door until the doors could be checked after Resident #1 eloped. In an interview, on 1/18/19 at 11:50 AM, Licensed Practical Nurse (LPN) #1 stated that she was on duty 12/9/18, when Resident #1 eloped. LPN #1 stated she was notified that CNA #1 saw Resident #1 go outside and that she went out and got her. LPN #1 stated the Administrator was notified about the elopement and was told that CNA #1 did not see Resident #1 go outside, but that Resident #1 was already outside when the CNA saw her out the window. LPN #1 stated, she was instructed by the DON not to document Resident #1's elopement in the Nurses Notes, not to notify the family, and not to obtain statements. LPN #1 stated the elopement occurred after breakfast, between 8:00 AM and 9:00 AM, and stated, "Nobody was actually at the Nurses Station when it happened." LPN #1 stated Registered Nurse (RN) #4 assessed Resident #1 with no injury when CNA #1 returned the resident to the building. An interview with RN #4, on 1/18/19 at 12:20 PM, revealed on 12/9/18, she was working as the RN Supervisor. She stated she heard CNA #1 scream and say that Resident #1 was outside and started running outside the building. RN #4 stated, she put the code in the 400 hall door, and exited the building toward where Resident #1 was outside. RN #4 stated, she observed Resident #1 was sitting upright in the wheelchair, stating that she was going home. RN #4 stated staff got Resident #1 inside and CNA #1 then told her she saw Resident #1 through the blinds of the window from room 401. RN #4 stated she obtained Resident #1's vital signs and checked her over, and didn't see any injuries. RN #4 stated she	F 689			

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F 689	Continued From page 51 received a phone call from the DON, to watch the 400 hall door and to put a note on the door that no staff was allowed to use it. RN #4 stated she had to enter the code to open the 400 hall door, but did not remember hearing an alarm. RN #4 stated, she did not remember that Resident #1 had a fall earlier that day, but this event occurred around 8:00 AM to 8:30 AM. RN #4 confirmed a head count of all other residents was completed and everyone was accounted for. Interview on 1/18/19 at 12:30 PM, with the DON, revealed she was called to the facility on 12/9/18, and was instructed by the Administrator via phone, to conduct a head count and to place staff at all doors, with the focus on the 400 Hall door, because the door wasn't shutting or something not alarming. The next day (12/10/18), the DON stated an investigation was initiated, but was told by the Administrator to stop because Resident #1 was in sight of staff at all times. The DON stated that if an investigation had been completed, it would have revealed Resident #1 had gotten outside alone. During an interview, on 1/18/19 at 11:36 AM, the Maintenance Director stated on 12/9/18, when at the facility fixing a leak in the ceiling, he was notified the back door was not working properly. He stated the alarm was not working and was instructed by the Administrator, by phone, to notify the security company. An interview, on 1/18/19 at 11:40 AM, with Contract Vender #1 of the security company, revealed he was unsure of the exact date in December, but he came and repaired the circuit card for the back door, because it was not working properly at the time. Contract Vender #1	F 689			

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F 689	Continued From page 52 stated, "The only reason to replace that card is if the door is not locking properly, the magnetic part and sounding, they both go together." An interview with the Medical Director, on 1/15/19 at 10:55 AM, confirmed he was recently a part of the Quality Assurance (QA) committee meeting, where the elopement, care plan, reporting and investigating policies were discussed, with no changes made at that time. The Medical Director confirmed, the alarm on the 400 hall door was repaired and a sign was posted that employees would no longer be allowed to use the door as an exit. The facility admitted Resident #1, on 2/7/11, with diagnoses including Alzheimer's Disease, Senile Degeneration of the Brain, Type II Diabetes Mellitus, Glaucoma and History of Breast Cancer. A review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). Staff assessment identified Resident #1 as severely impaired and never/rarely made decisions. The facility provided an Acceptable Allegation of Compliance, which included: Resident #1 was admitted on 02/07/11. Resident #1 has the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1 was originally care planned for Elopement risk. Resident #1 has a history of two (2) prior elopements to 12/09/18. The Elopement care plan was revised on 05/06/16, to include	F 689			

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F 689	Continued From page 53 Resident #1's continued risk for elopement. On 12/09/18, at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, seven (7) feet high and five (5) feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 brought Resident #1 back into the facility at approximately 8:30 am with no apparent injuries. Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18, and revealed severe cognitive impairment. The facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. Corrective Actions: 1. LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7 pm on 12/09/18, and was continued on every 30 minute checks until 6:30 am on 12/10/19. 2. LPN #1 reported to the Administrator by phone, on 12/09/18 at 8:55 am, that Resident #1 exited the building and was brought back in by CNA #1. The Administrator was told that Resident #1 was in line of sight at all times, but further	F 689			

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F 689	Continued From page 54 investigation on 01/14/19 at 11:45 am, revealed that Resident #1 was not in sight at all times. 3. The Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18 at 9:13 am, of Resident #1 exiting the building supervised. No investigation was initiated at this time. There is no documentation that Resident #1 was assessed upon return to the facility. 4. On 12/09/18 at approximately 10 am, LPN #1 put a sign on the Emergency Exit door. The sign stated, "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". 5. The 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm. There were no specific staff assignments made by LPN #1 to monitor the door. 6. The last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18, by Maintenance personnel, and was noted to be working properly. On 12/09/18 at approximately 11:15 am, the door lock was working properly but the sound for the Emergency Exit door alarm was non-functioning, when checked by Maintenance personnel. The Administrator was notified at 11:30 am, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18, by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly.	F 689			

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F 689	Continued From page 55 7. On 12/09/18, after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. On 12/10/18 at 7:00 am, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. During further investigation, on 01/14/19 at approximately 11:45 am, it was determined during interview by the Administrator that CNA #1 did not have Resident #1 in sight at all times. 10. On 01/14/19 at approximately 2:00 pm, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at PM, LPN #2, Administrator, Registered Nurse (RN) #1, RN #2, and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. No staff will be allowed to work until they have completed all in-services.	F 689			

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F 689	Continued From page 56 11. Elopement Risk Factors, which are used for assessments, were completed on all 98 residents in the facility on 01/14/19 at 8:00 pm, by LPN # 9. Nineteen residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff; staff is aware, and in-services were conducted on 01/16/19 by LPN #2 that residents are on 15 minute checks. 12. The Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19 at approximately 12:30 pm. No discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 at 3:00 pm, and ending 01/17/19 5:30 pm, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19 at 12:30 pm. Resident #1's Responsible Party was notified on 01/16/19, by the DON at 11:50 am. 14. Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19 at 6:20 pm. Care Plans were reviewed and 19 were updated with current intervention for every 15 minute checks. 15. On 01/14/19 at 6:30 pm, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in	F 689			

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F 689	Continued From page 57 attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18, with Resident #1, was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. An Emergency QA meeting was held on 01/16/19 at 12:35 pm, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN #2, and the Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. 17. In-service to all staff was initiated by LPN #2 and RN #2 on 01/16/19 at 3:45 pm, regarding changes to daily door checks. 18. On 01/17/19 at 5:30 pm, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. 19. An Emergency QA meeting was held on 01/18/19 at 11:30 am, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator, and Corporate Nurse. A change was made to the Emergency Exit Door Alarm	F 689			

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F 689	Continued From page 58 System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. In-service to all staff was completed by LPN #2 on 01/18/19 at 11:45 am, regarding changes to the Emergency Exit Door Policy. 21. As of 01/18/19 at 5:00 pm, a total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility. 22. The facility alleges all corrective actions to remove the IJ were completed on 01/18/19, and the IJ removed on 01/19/19. Validation of the Allegation of Compliance included: Based on observation, interviews, record review, the State Agency (SA) validated that Resident #1 was admitted on 02/07/11. Resident #1 had the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1 was originally care planned for Elopement risk. Resident #1 had a history of two (2) elopements prior to 12/09/18. The Elopement care plan was revised on 05/06/16, to include Resident #1's	F 689			

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F 689	Continued From page 59 continued risk for elopement. On 12/09/18 at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, 7 feet high and 5 feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 verified by interview that she brought Resident #1 back into the facility at approximately 8:30 am, with no apparent injuries. Record review confirmed Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18 and revealed severe cognitive impairment. Results of record review and interview confirmed the facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. The SA validated the facility's Corrective Actions: 1. The SA validated through interview that LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7:00 pm on 12/09/18, and continued every 30 minute checks until 6:30 am on 12/10/19. 2. The SA validated through interview that LPN #1 reported the elopement of Resident #1 to the Administrator by phone on 12/09/18. Interview	F 689			

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F 689	Continued From page 60 with the Administrator confirmed she was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19, revealed that Resident #1 was not in sight at all times. 3. The SA validated through interviews that the Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18, of Resident #1 exiting the building supervised and that no investigation was initiated at this time. 4. The SA validated through observation and interviews that on 12/09/18, LPN #1 put a sign on the Emergency Exit door. The sign stated "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". The sign was observed during survey. 5. The SA validated through staff interviews that the 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm, but no specific staff assignments were made by LPN #1 to monitor the door. 6. The SA validated through interviews and record review that the last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18 by Maintenance personnel and was noted to be working properly, but on 12/09/18, the sound for the Emergency Exit door alarm was non-functioning. Interviews revealed the Administrator was notified, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18 by the alarm company (Proper Name), and all Emergency Exit doors were checked by	F 689			

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F 689	Continued From page 61 the alarm company and found to be working properly. 7. The SA validated through interviews that on 12/09/18 after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. The SA validated through interviews and record review that on 12/10/18, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. The SA validated through interviews that during further investigation on 01/14/19, the Administrator determined that CNA #1 did not have Resident #1 in sight at all times. 10. The SA validated through interviews and record review that on 01/14/19, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at 3:00 pm, LPN #2, Administrator and Registered Nurse (RN) #1, RN #2 and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5)	F 689			

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F 689	Continued From page 62 Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. The SA validated through interview and staffing records that no staff have been allowed to work until they have completed all in-services. 11. The SA validated through record reviews and interviews that the Elopement Risk Factors, which are used for assessments, were completed on all 98 residents in the facility on 01/14/19, by LPN # 9 and that 19 residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff and in-services were conducted on 01/16/19 by LPN #2, that residents are on 15 minute checks. 12. The SA validated through interviews and record review that the Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19, and that no discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 and ending 01/17/19, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The SA validated through interviews and record review the facility Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19. Resident #1's Responsible Party was notified on 01/16/19 by the DON. 14. The SA validated through interviews and record review the Care Plans for residents at risk	F 689			

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F 689	Continued From page 63 for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19. The SA verified Care Plans were updated with current intervention for every 15 minute checks. 15. The SA validated through interviews and record review that on 01/14/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18 with Resident #1 was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. The SA validated through interviews and record reviews an Emergency QA meeting was held on 01/16/19, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN# 2 and Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. The SA validated through record review of the documented daily checks. 17. The SA validated through interviews and record review that in-service to all staff was by LPN #2 and RN #2 on 01/16/19, regarding changes to daily door checks. 18. The SA validated through interviews and	F 689			

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F 689	Continued From page 64 record reviews that on 01/17/19, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. The SA validated no other concerns were noted. 19. The SA validated through interviews and record review that an Emergency QA meeting was held on 01/18/19, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. The SA validated through interviews and record review that an in-service to all staff was completed by LPN #2 on 01/18/19, regarding changes to the Emergency Exit Door Policy. 21. The SA validated through interviews and record reviews as of 01/18/19, total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility.	F 689			

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F 689	Continued From page 65	F 689			
F 842 SS=D	22. The SA validated that all corrective actions were completed on 01/18/19, and the IJ removed on 01/19/19. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F 842		3/11/19	

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F 842	Continued From page 66 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and policy review, the facility failed to document an elopement in Resident #1's medical record for one (1) of six (6) resident records reviewed; Resident #1.	F 842	* Resident #1's elopement was documented in electronic medical record by the Director of Nursing on 01/16/19 at 2:46pm.		

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
(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 842	Continued From page 67 Findings include: Review of the facility's policy titled, "Medical Records-Documentation Policy", dated 7/21/09, revealed the facility would maintain complete and accurate medical records to include any injuries received in the facility and any unusual happenings to the resident. This policy also noted, nurses on all shifts will document anytime a problem or unusual incident occurs to a resident. Review of the facility's policy titled, "Elopements and Wandering Residents", modified on 4/20/18, revealed documentation in the medical record will include: findings from the nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable. Review of the facility's policy titled, "Documentation of Elopement Policy", dated 11/5/09, revealed the facility would document in the resident's medical record, the date, time, what occurred, results of the body audit, vital signs, the notification of all parties, the outcome and the nurse's signature. Record review of the Nurse's Notes from 12/9/18, revealed no documentation of Resident #1 being found outside and unsupervised. There was also no documentation of the responsible party or family notification of the elopement for 12/9/18. Interview and observation with Certified Nursing Assistant (CNA) #1, on 1/14/19 at 12:00 PM, revealed on the morning of 12/9/18, she observed Resident #1 unsupervised and outside the facility.	F 842	** All residents are at risk for this deficient practice. *** An education in-service program was conducted by Quality Assurance Nurses beginning on 02/07/19 at 7am and ending on 03/01/19 at 9 am for all Licensed Practical Nurses (LPN's) and Registered Nurses (RN's) on complete documentation in resident's electronic medical record concerning any issue that pertains to the resident. An Incident Checklist will be kept in the front of the 24 hour report book to be used to list any/all incidents. The checklist will have the following information on it: Incident, Resident Name, Family notification, Physician notification, Incident Report completed, Statements taken and Documented in Chart. Nurses must initial this checklist to show that they have documented any incident in the electronic medical record. All nurses have been in-serviced on this checklist beginning on 03/08/19 at 1:30 pm and ending on 03/11/19 at 8:30 am. ****The two Quality Assurance Nurses will audit five residents electronic medical record for complete documentation once weekly for one month, once bi-monthly for one month and once monthly for three months. The two Quality Assurance Nurses will bring these findings to the monthly Quality Assurance Meeting for review and		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 842	Continued From page 68 CNA #1 stated she brought resident #1 back into the building. CNA #1 acknowledged Resident #1 had eloped from the facility. In an interview, on 1/18/19 at 11:50 AM, Licensed Practical Nurse (LPN) #1 stated that she was on duty 12/9/18, when Resident #1 eloped. LPN #1 stated, she was instructed by the DON not to document Resident #1's elopement in the Nurses Notes, not to notify the family, and not to obtain statements. LPN #1 stated the elopement occurred after breakfast, between 8:00 AM and 9:00 AM. She stated, "I knew better." An interview with RN #4, on 1/18/19 at 12:20 PM, revealed on 12/9/18, she was working as the RN Supervisor and confirmed Resident #1 had eloped and was brought back to the facility. She confirmed there was no documentation in the record of the elopement. When RN #4 was asked why there was no documentation, she responded, "I should have, I don't know." In an interview, on 1/16/19 at 4:40 PM, with LPN #10, she stated there was no documentation regarding the incident when Resident #1 eloped from the facility on 12/9/18. The facility admitted Resident #1 on 2/7/11 with diagnoses of Type II Diabetes Mellitus, Alzheimer's Disease, Senile Degeneration of the Brain, Glaucoma and History of Breast Cancer. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). The staff assessment identified Resident #1 as severely impaired and	F 842	recommendations.		

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F 842	Continued From page 69 never/rarely made decisions.	F 842			

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M 000	Initial Comments The State Agency (SA) conducted a partial extended survey for Complaint Investigation (CI) MS #15614, from 1/14/19 to 1/23/19. The SA substantiated the complaint for elopement. During the survey it was determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for the Institutions for Aged and Infirm with statutes cited at M640. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care that began on 12/9/18, when the facility failed to provide adequate assessment and supervision for a confused, demented resident, with a past history of elopement. It is believed Resident #1 exited the building through the 400 hall fire exit door, on 12/9/18, between 8:00 AM and 9:00 AM, and was found 17 steps from the end of the exit ramp. The exit ramp was 65 steep steps down from the top. This exit ramp was greater than six (6) feet tall. Resident #1 was seen from a window by Certified Nursing Assistant (CNA) #1, who immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 and was found with no injury. All staff was responsible to supervise Resident #1 and the other 18 residents at risk for elopement. Resident #1 was on every 30 minute checks from a fall that occurred earlier the morning of 12/9/18. Resident #1 was documented as being observed on these checks for twenty-four (24) hours. Resident #1 had a history of elopement and was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from doors by asking resident to turn around and assist to move away.	M 000		

Mississippi State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/01/19

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M 000	Continued From page 1 The failure to provide supervision to ensure Resident #1, a demented resident with a history of elopement, resulted in the resident's elopement from the facility and placed this resident and other demented residents at risk for elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The IJ and SQC existed at: M640-Accidents The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, and removal of the IJ on 1/19/19. The SA validated the AOC on 1/23/19, and determined the IJ was removed, prior to exit. Therefore the scope and severity for M640 was lowered from a "Level IV" to a scope and severity of a "Level II", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. An additional Tag was cited at M735. The facility held a license for 105 beds, with a census of 97.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents' environment remains as free of accident hazards as possible, and adequate	M 640		3/11/19

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M 640	Continued From page 2 supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV Based on observations, record review, interviews, and policy review, the facility failed to provide adequate assessment and supervision for a confused, demented resident, Resident #1, with a past history of elopement for one (1) of six (6) residents reviewed for risk of elopement; Resident #1. It is believed Resident #1 exited the building through the 400 hall fire exit door on 12/9/18 between 8:00 AM and 9:00 AM. The resident was found 17 steps from the end of the exit ramp that was 65 steps down from the top, and greater than six (6) feet in height. Resident #1 was observed from a window inside the facility, by Certified Nursing Assistant (CNA) #1, who immediately went outside and returned Resident #1 into the building. Resident #1 was assessed by Licensed Practical Nurse (LPN) #1 with no injury. All staff was responsible to supervise Resident #1 and the other 18 residents at risk for elopement. Resident #1 was on every 30 minute checks from a fall earlier that morning on 12/9/18, and was documented as being observed on these checks for twenty-four (24) hours. Resident #1 had a history of elopement and was care planned to ensure doors are tightly closed and to check doors and systems per protocol, and to direct Resident #1 away from doors, by asking resident to turn around and assist to move away. The failure to provide supervision to Resident #1, a demented resident with a history of elopement,	M 640	* Resident #1 was returned to the building by Certified Nursing Assistant (CNA) #1 on 12/09/18 at 8:30am and was assessed by Licensed Practical Nurse (LPN) #1. No injuries were noted. ** 19 cognitively impaired residents at risk for elopement have the potential to be affected by this deficient practice. There have been no elopements since 12/09/18. *** An education in-service was conducted by the two Quality Assurance Nurses beginning on 02/18/19 at 7 am and ending on 03/01/19 at 9am on the policy and procedure for accidents and supervision for all staff. Also included in this training was head counts will be done three times daily, and that Maintenance will check the doors daily for proper functionality. All staff were also in-serviced on elopement drills. Elopement drills will be conducted by the Administrator, Director of Nursing and Assistant Director of Nursing. Elopement drills began on 02/28/19 at 3:10 pm. The key card reader on the Emergency Exit door on the 400 has been deactivated and no longer acts as an employee entrance/exit. Emergency Exits now have a five second delay for locking instead of a fifteen second delay. Door codes have been	

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M 640	Continued From page 3 resulted in the resident's elopement from the facility and placed this resident and other demented residents with a risk of elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/9/18, when Resident #1 exited the building unsupervised and was found in her wheelchair, 17 steps from the end of the exit ramp that was 65 steps down from the top of the ramp. On 1/14/19 at 2:20 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 1/22/19, in which the facility alleged all corrective actions were completed on 1/18/19, and removal of the IJ on 1/19/19. The SA validated the AOC on 1/23/19, and determined the IJ was removed prior to exit. Therefore, the scope and severity for M640 was lowered from a "Level IV" to a scope and severity of a "Level II", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility's policy titled, "Elopements and Wandering Residents, modified on 4/20/18, revealed the purpose of the policy is to ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate	M 640	changed and only the following people have codes: Administrator, Director of Nursing, Assistant Director of Nursing, Corporate Nurse, Assistant Administrator and Maintenance Supervisor. All Emergency Exits will be checked daily by Maintenance Personnel to ensure they are in proper working order. A locking system was ordered on 03/01/19 for the doors leading to the patient care area. This will include a push button entry and a keypad exit. **** The two Quality Assurance Nurses will audit the elopement drills by collecting the in-service sheets once per shift per month for three months, once per shift per quarter for three months. Audits began on 02/28/19. The Quality Assurance Nurses will audit door alarm check book once daily for seven days, two days bi-weekly for three months and once weekly for three months. Audits began on 02/28/19. The Quality Assurance Nurses will bring these findings to the monthly Quality Assurance meeting for review and recommendations.	

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAKEVIEW NURSING CENTER

**16411 ROBINSON ROAD
GULFPORT, MS 39503**

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M 640	Continued From page 4 supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. This policy revealed the facility is equipped with door locks/alarms to help avoid elopements but are not a replacement for necessary supervision. This policy defines elopement to occur when a resident leaves the premises or a safe area without authorization and/or necessary supervision. Review of the facility's policy titled, "Documentation of Elopement Policy", dated 11/5/09, revealed an elopement is considered to be when a resident, (confused or alert), wanders past the facility exit without staff knowledge. A review of Resident #1's, "Risk Factors for Elopement" assessment, dated 11/7/18, documented Resident #1 had a score of 14. This assessment noted a score above ten (10) indicated a high risk for elopement. Review of Resident #1's cumulative Physician's orders for January 2019, revealed an order for a Wanderguard Bracelet with an order date of 5/19/16, related to elopement risk. Review of Resident #1's care plan, revealed the resident was at risk for elopement, with an onset date of 2/7/11, upon admission. The facility identified Resident #1 as a potential for elopement related to impaired cognition, history of wandering at home and packing up to leave. A review of the care plan dated for 8/2/18, revealed Resident #1 remained an elopement risk with approaches to ensure doors are tightly closed and to check doors and system per protocol. An additional approach was listed to direct resident	M 640		

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M 640	Continued From page 5 away from doors-ask resident to turn around and assist to move away. Interview and observation with Certified Nursing Assistant (CNA) #1, on 1/14/19 at 12:00 PM, revealed on the morning of 12/9/18, she observed Resident #1 through the window blinds of room 401. Resident #1 was outside and alone in the wheelchair, which was sitting on the grass. CNA #1 stated, she immediately went outside and brought Resident #1 inside. CNA #1 and the Surveyor, using the keypad to unlock the 400 hall fire door exit, walked 65 steps down the ramp and 17 steps from the ramp to where she indicated Resident #1 was located on 12/9/18. CNA #1 stated, Resident #1 was still sitting upright in the wheelchair, with the alarm belt in place, when she brought her back into the facility. CNA #1 confirmed, Resident #1 did not have enough supervision on 12/9/18, to prevent her from eloping from the facility. CNA #1 stated, she was not assigned to Resident #1 on 12/9/18, but stated that it was everyone's responsibility to watch all residents at risk for elopement. In an interview, with the Administrator, on 1/14/19 at 11:18 AM, she stated no investigation was conducted because Resident #1 was in sight of staff the whole time with staff pursuing her on 12/9/18, when she got outside. Further interview with the Administrator, on 1/14/19 at 11:40 AM, revealed when she talked to CNA #1 this morning, she learned Resident #1 was outside alone on 12/9/18, and not in sight of employees as previously thought. The Administrator stated, "I made a horrible mistake." Interview with the Director of Nursing (DON), on 1/14/19 at 10:55 AM, confirmed Resident #1 did go outside unsupervised on 12/9/18, and an	M 640		

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M 640	Continued From page 6 investigation was initiated, but not completed. The DON stated that a head count of all the residents was conducted and staff members were assigned to each door until the doors could be checked after Resident #1 eloped. In an interview, on 1/18/19 at 11:50 AM, Licensed Practical Nurse (LPN) #1 stated that she was on duty 12/9/18, when Resident #1 eloped. LPN #1 stated she was notified that CNA #1 saw Resident #1 go outside and that she went out and got her. LPN #1 stated the Administrator was notified about the elopement and was told that CNA #1 did not see Resident #1 go outside, but that Resident #1 was already outside when the CNA saw her out the window. LPN #1 stated, she was instructed by the DON not to document Resident #1's elopement in the Nurses Notes, not to notify the family, and not to obtain statements. LPN #1 stated the elopement occurred after breakfast, between 8:00 AM and 9:00 AM, and stated, "Nobody was actually at the Nurses Station when it happened." LPN #1 stated Registered Nurse (RN) #4 assessed Resident #1 with no injury when CNA #1 returned the resident to the building. An interview with RN #4, on 1/18/19 at 12:20 PM, revealed on 12/9/18, she was working as the RN Supervisor. She stated she heard CNA #1 scream and say that Resident #1 was outside and started running outside the building. RN #4 stated, she put the code in the 400 hall door, and exited the building toward where Resident #1 was outside. RN #4 stated, she observed Resident #1 was sitting upright in the wheelchair, stating that she was going home. RN #4 stated staff got Resident #1 inside and CNA #1 then told her she saw Resident #1 through the blinds of the window from room 401. RN #4 stated she obtained	M 640		

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M 640	Continued From page 7 Resident #1's vital signs and checked her over, and didn't see any injuries. RN #4 stated she received a phone call from the DON, to watch the 400 hall door and to put a note on the door that no staff was allowed to use it. RN #4 stated she had to enter the code to open the 400 hall door, but did not remember hearing an alarm. RN #4 stated, she did not remember that Resident #1 had a fall earlier that day, but this event occurred around 8:00 AM to 8:30 AM. RN #4 confirmed a head count of all other residents was completed and everyone was accounted for. Interview on 1/18/19 at 12:30 PM, with the DON, revealed she was called to the facility on 12/9/18, and was instructed by the Administrator via phone, to conduct a head count and to place staff at all doors, with the focus on the 400 Hall door, because the door wasn't shutting or something not alarming. The next day (12/10/18), the DON stated an investigation was initiated, but was told by the Administrator to stop because Resident #1 was in sight of staff at all times. The DON stated that if an investigation had been completed, it would have revealed Resident #1 had gotten outside alone. During an interview, on 1/18/19 at 11:36 AM, the Maintenance Director stated on 12/9/18, when at the facility fixing a leak in the ceiling, he was notified the back door was not working properly. He stated the alarm was not working and was instructed by the Administrator, by phone, to notify the security company. An interview, on 1/18/19 at 11:40 AM, with Contract Vender #1 of the security company, revealed he was unsure of the exact date in December, but he came and repaired the circuit card for the back door, because it was not	M 640		

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M 640	Continued From page 8 working properly at the time. Contract Vender #1 stated, "The only reason to replace that card is if the door is not locking properly, the magnetic part and sounding, they both go together." An interview with the Medical Director, on 1/15/19 at 10:55 AM, confirmed he was recently a part of the Quality Assurance (QA) committee meeting, where the elopement, care plan, reporting and investigating policies were discussed, with no changes made at that time. The Medical Director confirmed, the alarm on the 400 hall door was repaired and a sign was posted that employees would no longer be allowed to use the door as an exit. The facility admitted Resident #1, on 2/7/11, with diagnoses including Alzheimer's Disease, Senile Degeneration of the Brain, Type II Diabetes Mellitus, Glaucoma and History of Breast Cancer. A review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). Staff assessment identified Resident #1 as severely impaired and never/rarely made decisions. The facility provided an Acceptable Allegation of Compliance, which included: Resident #1 was admitted on 02/07/11. Resident #1 has the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1 was originally care planned for Elopement risk. Resident #1 has a history of two (2) prior elopements to 12/09/18. The Elopement care plan was revised on 05/06/16, to include	M 640		

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
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M 640	Continued From page 9 Resident #1's continued risk for elopement. On 12/09/18, at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, seven (7) feet high and five (5) feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 brought Resident #1 back into the facility at approximately 8:30 am with no apparent injuries. Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18, and revealed severe cognitive impairment. The facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. Corrective Actions: 1. LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7 pm on 12/09/18, and was continued on every 30 minute checks until 6:30 am on 12/10/19. 2. LPN #1 reported to the Administrator by phone, on 12/09/18 at 8:55 am, that Resident #1 exited the building and was brought back in by CNA #1. The Administrator was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19 at 11:45 am, revealed	M 640			

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M 640	Continued From page 10 that Resident #1 was not in sight at all times. 3. The Administrator notified the Corporate Nurse and the Director of Nursing (DON) on 12/09/18 at 9:13 am, of Resident #1 exiting the building supervised. No investigation was initiated at this time. There is no documentation that Resident #1 was assessed upon return to the facility. 4. On 12/09/18 at approximately 10 am, LPN #1 put a sign on the Emergency Exit door. The sign stated, "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". 5. The 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm. There were no specific staff assignments made by LPN #1 to monitor the door. 6. The last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18, by Maintenance personnel, and was noted to be working properly. On 12/09/18 at approximately 11:15 am, the door lock was working properly but the sound for the Emergency Exit door alarm was non-functioning, when checked by Maintenance personnel. The Administrator was notified at 11:30 am, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18, by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly. 7. On 12/09/18, after Resident #1 was returned	M 640		

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STREET ADDRESS, CITY, STATE, ZIP CODE

LAKEVIEW NURSING CENTER

**16411 ROBINSON ROAD
GULFPORT, MS 39503**

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M 640	Continued From page 11 to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building. 8. On 12/10/18 at 7:00 am, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. During further investigation, on 01/14/19 at approximately 11:45 am, it was determined during interview by the Administrator that CNA #1 did not have Resident #1 in sight at all times. 10. On 01/14/19 at approximately 2:00 pm, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at PM, LPN #2, Administrator, Registered Nurse (RN) #1, RN #2, and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. No staff will be allowed to work until they have completed all in-services. 11. Elopement Risk Factors, which are used for assessments, were completed on all 98 residents	M 640		

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M 640	Continued From page 12 in the facility on 01/14/19 at 8:00 pm, by LPN # 9. Nineteen residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff; staff is aware, and in-services were conducted on 01/16/19 by LPN #2 that residents are on 15 minute checks. 12. The Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19 at approximately 12:30 pm. No discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 at 3:00 pm, and ending 01/17/19 5:30 pm, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19 at 12:30 pm. Resident #1's Responsible Party was notified on 01/16/19, by the DON at 11:50 am. 14. Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19 at 6:20 pm. Care Plans were reviewed and 19 were updated with current intervention for every 15 minute checks. 15. On 01/14/19 at 6:30 pm, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18, with Resident #1, was discussed. Policies and procedures were reviewed:	M 640		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAKEVIEW NURSING CENTER

**16411 ROBINSON ROAD
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M 640	Continued From page 13 Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. An Emergency QA meeting was held on 01/16/19 at 12:35 pm, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN #2, and the Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. 17. In-service to all staff was initiated by LPN #2 and RN #2 on 01/16/19 at 3:45 pm, regarding changes to daily door checks. 18. On 01/17/19 at 5:30 pm, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. 19. An Emergency QA meeting was held on 01/18/19 at 11:30 am, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator, and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON,	M 640		

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M 640	Continued From page 14 ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. In-service to all staff was completed by LPN #2 on 01/18/19 at 11:45 am, regarding changes to the Emergency Exit Door Policy. 21. As of 01/18/19 at 5:00 pm, a total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff, and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility. 22. The facility alleges all corrective actions to remove the IJ were completed on 01/18/19, and the IJ removed on 01/19/19. Validation of the Allegation of Compliance included: Based on observation, interviews, record review, the State Agency (SA) validated that Resident #1 was admitted on 02/07/11. Resident #1 had the following diagnoses: Syncope and collapse, Senile Degeneration of the Brain, Diabetes, and Alzheimer's disease. On 02/07/11, Resident #1 was originally care planned for Elopement risk. Resident #1 had a history of two (2) elopements prior to 12/09/18. The Elopement care plan was revised on 05/06/16, to include Resident #1's continued risk for elopement. On 12/09/18 at approximately 8:00 am, Resident #1, who is cognitively impaired and wheelchair bound, exited the building unsupervised. Resident #1 was located approximately 17 walking steps from the end of the ramp in a grassy area located outside	M 640		

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M 640	Continued From page 15 the 400 hall emergency exit. Due to the location of Resident #1, it is believed that Resident #1 exited through the 400 Hall Emergency Exit door. The exit ramp measures 153 feet long, 7 feet high and 5 feet wide with a handrail the entire way (approximately 65 steps). Certified Nursing Assistant (CNA) #1 verified by interview that she brought Resident #1 back into the facility at approximately 8:30 am, with no apparent injuries. Record review confirmed Resident #1's last Brief Interview for Mental Status (BIMS) was conducted on 10/10/18 and revealed severe cognitive impairment. Results of record review and interview confirmed the facility failed to investigate Resident #1's elopement and failed to document an assessment and interventions after Resident #1 exited the building unsupervised on 12/09/18. The facility failed to report Resident #1's elopement to the required State Agencies. The SA validated the facility's Corrective Actions: 1. The SA validated through interview that LPN #1 kept Resident #1 in her line of sight for the remainder of her shift which ended at 7:00 pm on 12/09/18, and continued every 30 minute checks until 6:30 am on 12/10/19. 2. The SA validated through interview that LPN #1 reported the elopement of Resident #1 to the Administrator by phone on 12/09/18. Interview with the Administrator confirmed she was told that Resident #1 was in line of sight at all times, but further investigation on 01/14/19, revealed that Resident #1 was not in sight at all times. 3. The SA validated through interviews that the Administrator notified the Corporate Nurse and	M 640		

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M 640	Continued From page 16 the Director of Nursing (DON) on 12/09/18, of Resident #1 exiting the building supervised and that no investigation was initiated at this time. 4. The SA validated through observation and interviews that on 12/09/18, LPN #1 put a sign on the Emergency Exit door. The sign stated "This is an Emergency Exit Only. Employees must use Employee Exit at the rear of the building". The sign was observed during survey. 5. The SA validated through staff interviews that the 400 Hall Emergency Exit door was visually monitored from approximately 10:00 am on 12/09/18, by nursing staff, until repairs were made on 12/10/18 at 12:00 pm, but no specific staff assignments were made by LPN #1 to monitor the door. 6. The SA validated through interviews and record review that the last check of the Emergency Exit door alarm system prior to Resident #1's elopement was on 12/07/18 by Maintenance personnel and was noted to be working properly, but on 12/09/18, the sound for the Emergency Exit door alarm was non-functioning. Interviews revealed the Administrator was notified, and a repair call was placed to the alarm company at this time. The Emergency Exit door alarm was repaired on 12/10/18 by the alarm company (Proper Name), and all Emergency Exit doors were checked by the alarm company and found to be working properly. 7. The SA validated through interviews that on 12/09/18 after Resident #1 was returned to the building, LPN #1 initiated a resident head count. The census was 92. The head count revealed all 92 residents were in the building.	M 640			

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M 640	Continued From page 17 8. The SA validated through interviews and record review that on 12/10/18, 400 and 500 hall nursing staff were in-serviced by the Assistant Director of Nursing (ADON) on the 400 hall Emergency Exit Door; the employees must use employee entrance, not the 400 hall Emergency Exit. 9. The SA validated through interviews that during further investigation on 01/14/19, the Administrator determined that CNA #1 did not have Resident #1 in sight at all times. 10. The SA validated through interviews and record review that on 01/14/19, the Corporate Nurse educated the Administrator and DON on proper investigating and reporting. Beginning on 01/14/19 at 3:00 pm, LPN #2, Administrator and Registered Nurse (RN) #1, RN #2 and RN #3 began in-servicing all staff on the following policies: Abuse/Neglect and Exploitation, Reporting incidents, Emergency Exit Door Alarm System, to include alarm checks that are done Monday through Friday by Maintenance personnel, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. A total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel. This was completed by 6:00 pm on 01/15/19. The SA validated through interview and staffing records that no staff have been allowed to work until they have completed all in-services. 11. The SA validated through record reviews and interviews that the Elopement Risk Factors, which	M 640		

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M 640	Continued From page 18 are used for assessments, were completed on all 98 residents in the facility on 01/14/19, by LPN # 9 and that 19 residents were identified as being at risk for elopement: Resident #1, and Resident #3 through Resident #20. All 19 residents were placed on every 15 minute checks by nursing staff and in-services were conducted on 01/16/19 by LPN #2, that residents are on 15 minute checks. 12. The SA validated through interviews and record review that the Elopement risk book was reviewed for accuracy by LPN #2 on 1/14/19, and that no discrepancies were noted. All staff were in-serviced on the Elopement Book beginning on 01/16/19 and ending 01/17/19, by LPN #2 and RN #2 to ensure they are aware of the Elopement book, where it is located and what residents are at risk for elopement. 13. The SA validated through interviews and record review the facility Administrator notified the Attorney General's office of Resident #1's elopement and the DON called Resident #1's elopement in to the State Department of Health on 01/15/19. Resident #1's Responsible Party was notified on 01/16/19 by the DON. 14. The SA validated through interviews and record review the Care Plans for residents at risk for elopement were reviewed and updated as necessary by LPN #9 on 01/14/19. The SA verified Care Plans were updated with current intervention for every 15 minute checks. 15. The SA validated through interviews and record review that on 01/14/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, DON, Administrator, QA Nurse, and Minimum Data Set(MDS) Nurse in	M 640			

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M 640	Continued From page 19 attendance. Medical Director attended by phone. The elopement that occurred on Sunday, 12/09/18 with Resident #1 was discussed. Policies and procedures were reviewed: Abuse/Neglect and Exploitation, Investigating and Reporting policy, Emergency Exit Door Alarm System, Elopement and Wandering Resident, Following Care Plan and the non-use of the Emergency Exit by the 400 hall Nurse's Station. No revisions were made. 16. The SA validated through interviews and record reviews an Emergency QA meeting was held on 01/16/19, regarding door alarm checks. In attendance were the Medical Director, Administrator, DON, Maintenance Supervisor, LPN# 2 and Assistant Administrator. A change was made to the Emergency Exit Door Alarm System Policy to include the doors will be checked on a daily basis by Maintenance personnel. The SA validated through record review of the documented daily checks. 17. The SA validated through interviews and record review that in-service to all staff was by LPN #2 and RN #2 on 01/16/19, regarding changes to daily door checks. 18. The SA validated through interviews and record reviews that on 01/17/19, LPN #2 reviewed 82 incident reports from 12/01/18 to 01/17/19, to ensure thorough investigation and reporting requirements were met, and brought her findings to the QA interdisciplinary team. There were no other concerns for reporting or investigating identified. The SA validated no other concerns were noted. 19. The SA validated through interviews and record review that an Emergency QA meeting	M 640			

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M 640	Continued From page 20 was held on 01/18/19, regarding Emergency Exit Door Policy. In attendance were the Medical Director, Administrator, DON, LPN# 2, Assistant Administrator and Corporate Nurse. A change was made to the Emergency Exit Door Alarm System Policy. The doors now have a five (5) second delay in locking instead of a 15 second delay. Codes have been changed and only the following staff has access: The Administrator, Assistant Administrator, Corporate Nurse, DON, ADON and Maintenance Supervisor. Changes included the Emergency Exit doors are checked and documented daily by Maintenance personnel. 20. The SA validated through interviews and record review that an in-service to all staff was completed by LPN #2 on 01/18/19, regarding changes to the Emergency Exit Door Policy. 21. The SA validated through interviews and record reviews as of 01/18/19, total of 155 employees: 15 RN's, 36 LPN's, 54 CNA's, seven (7) Activity Aides, Activity Director, 14 dietary staff, three (3) Maintenance, five (5) Administrative staff, 13 Housekeeping/Laundry Contract Staff and seven (7) contract therapy personnel were in-serviced on the policy and or policy changes made by the facility. 22. The SA validated that all corrective actions were completed on 01/18/19, and the IJ removed on 01/19/19.	M 640			
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards	M 735			3/11/19

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M 735	Continued From page 21 and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following	M 735			

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M 735	Continued From page 22 discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on observations, record review, interviews, and policy review, the facility failed to document an elopement in Resident #1's medical record for one (1) of six (6) resident records reviewed; Resident #1. Findings include: Review of the facility's policy titled, "Medical Records-Documentation Policy", dated 7/21/09, revealed the facility would maintain complete and accurate medical records to include any injuries received in the facility and any unusual happenings to the resident. This policy also noted, nurses on all shifts will document anytime a problem or unusual incident occurs to a resident. Review of the facility's policy titled, "Elopements and Wandering Residents", modified on 4/20/18, revealed documentation in the medical record will include: findings from the nursing and social service assessments, physician/family notification, care plan discussions, and consultant notes as applicable.	M 735	* Resident #1's elopement was documented in electronic medical record by the Director of Nursing on 01/16/19 at 2:46pm. ** All residents are at risk for this deficient practice. *** An education in-service program was conducted by Quality Assurance Nurses beginning on 02/07/19 at 7am and ending on 03/01/19 at 9 am for all Licensed Practical Nurses (LPN's) and Registered Nurses (RN's) on complete documentation in resident's electronic medical record concerning any issue that pertains to the resident. An Incident Checklist will be kept in the front of the 24 hour report book to be used to list any/all incidents. The checklist will have the following information on it: Incident, Resident Name, Family notification, Physician notification, Incident Report completed, Statements taken and Documented in Chart. Nurses must initial this checklist to show that they have documented any incident in the electronic	

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M 735	Continued From page 23 Review of the facility's policy titled, "Documentation of Elopement Policy", dated 11/5/09, revealed the facility would document in the resident's medical record, the date, time, what occurred, results of the body audit, vital signs, the notification of all parties, the outcome and the nurse's signature. Record review of the Nurse's Notes from 12/9/18, revealed no documentation of Resident #1 being found outside and unsupervised. There was also no documentation of the responsible party or family notification of the elopement for 12/9/18. Interview and observation with Certified Nursing Assistant (CNA) #1, on 1/14/19 at 12:00 PM, revealed on the morning of 12/9/18, she observed Resident #1 unsupervised and outside the facility. CNA #1 stated she brought resident #1 back into the building. CNA #1 acknowledged Resident #1 had eloped from the facility. In an interview, on 1/18/19 at 11:50 AM, Licensed Practical Nurse (LPN) #1 stated that she was on duty 12/9/18, when Resident #1 eloped. LPN #1 stated, she was instructed by the DON not to document Resident #1's elopement in the Nurses Notes, not to notify the family, and not to obtain statements. LPN #1 stated the elopement occurred after breakfast, between 8:00 AM and 9:00 AM. She stated, "I knew better." An interview with RN #4, on 1/18/19 at 12:20 PM, revealed on 12/9/18, she was working as the RN Supervisor and confirmed Resident #1 had eloped and was brought back to the facility. She confirmed there was no documentation in the record of the elopement. When RN #4 was asked why there was no documentation, she responded, "I should have, I don't know."	M 735	medical record. All nurses have been in-serviced on this checklist beginning on 03/08/19 at 1:30 pm and ending on 03/11/19 at 8:30 am. ****The two Quality Assurance Nurses will audit five residents electronic medical record for complete documentation once weekly for one month, once bi-monthly for one month and once monthly for three months. The two Quality Assurance Nurses will bring these findings to the monthly Quality Assurance Meeting for review and recommendations.	

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M 735	Continued From page 24 In an interview, on 1/16/19 at 4:40 PM, with LPN #10, she stated there was no documentation regarding the incident when Resident #1 eloped from the facility on 12/9/18. The facility admitted Resident #1 on 2/7/11 with diagnoses of Type II Diabetes Mellitus, Alzheimer's Disease, Senile Degeneration of the Brain, Glaucoma and History of Breast Cancer. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/18, revealed Resident #1 was unable to complete the Brief Interview for Mental Status (BIMS). The staff assessment identified Resident #1 as severely impaired and never/rarely made decisions.	M 735		