STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	C 06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 6/12/19 to 6/13/19. The survey was prompted by complaint intake WY00002848. The following common abbreviations are used through this document: CNA; Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, policy and procedure review, and review of facility incident reports, the facility failed to ensure resident safety for 1 of 1 sample residents (#1) who eloped from the facility. This failure resulted in past non-compliance at actual harm to resident #1 who left the facility and fell which resulted in a subdural hematoma, head laceration, and rib fractures. Corrective measures were implemented by the facility prior to the	F 689	Past noncompliance: no plan of correction required.	6/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2019

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survey and compliance was determined to be met on 6/8/19. The findings were:

1. Review of the 4/8/19 admission MDS assessment showed resident #1 had diagnoses which included cerebrovascular accident or transient ischemic attack and had a brief interview of mental status (BIMS) score of 14/15 (cognitively intact). Further review showed the resident required limited assistance of 1 person for transfer, walking in room and corridor, and locomotion on and off the unit, and wandering was not coded. Review of the "Cognitive Loss" care plan last revised on 5/3/19 showed the resident was at risk for cognitive impairment and staff were to anticipate needs and observe for non-verbal cues, orient as needed to person, place, and time, introduce themselves and what they did at the facility, explain what they intended to do while providing care, anticipate the resident's needs, and observe for non-verbal cues.

2. Review of a radiology report dated 6/2/19 and timed 9:51 AM showed "...Exam: Chest, abdomen, and pelvis CT [Computed tomography] with intravenous contrast...acute mildly displaced left posterior 6th rib fracture. Acute nondisplaced left posterior 7th, 8th, and 9th rib fractures. Acute nondisplaced left anterior left 6th and 7th rib fractures..." Review of a dated 6/2/19 and timed 8:38 AM showed "...Exam: Head CT without intravenous contrast...Moderate acute right cerebral hemisphere subdural hemorrahage...Small subacute or chronic subdural hemorrhage adjacent to the left frontal and temporal lobes..." Review of the emergency room note dated 6/2/19 and timed 10:59 AM showed "...Patient is being seen for Head Injury,

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with and onset UNK [unknown] hours ago...It appears the pt [patient] went outside either last night or in the early morning hours and fell hitting [his/her] head. [S/he] has abrasions on most of [his/her] bony joints from what appears an attempt to drag [him/herself] on the ground...Problem List...Laceration without foreign body of scalp...Disposition/Plan...The subdural bleed does not appear to be causing too much MS difficulties other than what we have witnessed so far. The eliquis has me worried that the bleed may continue and pt's [patient's] status may deteriorate...The PNA [pneumonia] was a surprise and the likely cause of [his/her] nocturnal wandering and confusion...Rib fracture are an element of the pt's [patient's] pain, but have no complications at the moment..." The following concerns were identified:

a. Review of a facility incident report dated 6/2/19 and timed 7:10 AM showed the resident was found on the ground outside "between the church [and] NH [nursing home]" near the cement walk. The facility staff called 911 to have the resident sent to the emergency department related to a "head wound."

b. Review of a "Communication Log" entry dated 6/2/19 and timed 7:10 AM showed "I had finished getting another resident up when I opened the curtains in room 109 and saw a resident laying outside on the lawn and sidewalk. Got the nurse and another CNA went out to find [resident's name], called 911 got blankets and a pad to stop the bleeding."

c. Review of the facility's investigation summary dated 6/7/19 showed "On 6/2/19 at 5:40 a.m. [resident's name] was in another resident's room. [resident's name] was redirected back to [his/her] room by staff, and resident sat in [his/her] chair in [his/her] room. At 6:30 a.m. CNA

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went into [resident's name]'s room and set out clothing for [him/her] to begin dressing [him/herself] for the day...CNA was assisting this other resident at 7:05 a.m. While with this other resident, CNA opened room curtains and saw [resident's name] lying outside, at 7:10 a.m. CNA immediately alerted another CNA and LPN. All three of these staff members responded to assist [resident's name] outside. LPN called 911. Staff did not move resident but did apply pressure to bleeding head wound and covered resident with warm blankets. [Resident's name] was transferred to ER via ambulance. Resident injuries include subdural hematoma (collection of blood outside the brain caused by severe head injuries), scalp laceration, multiple rib fractures, and sacral fractures...Findings conclude the alarm to the emergency exit the resident used to get out of the building was not on. Findings conclude that the resident did demonstrate confusion prior to the incident."

d. Observation on 6/12/19 at 4:25 PM showed the emergency exit outside room 114 was shut and latched. There was no visible indication the door was armed with an alarm.

e. Interview with LPN #1 on 6/12/19 at 4:59 PM revealed on the day resident #1 fell outside, 2 CNAs ran past the medication room while she was inside and said someone was on the ground outside. The LPN went outside and resident #1 was on the ground with his/her head partially on the cement and his/her body on the grass. The resident had "severe bleeding" from his/her head. CNA #1 held pressure on the wound and LPN #1 ran to the emergency room to notify them of the situation and obtain warm blankets. Further interview revealed the resident was positioned on his/her right side, facing downward and she could see abrasions on the resident's knee; however,

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she did not perform a skin assessment due to the resident's head injury. She was unsure how the resident got outside and stated s/he did not normally try to leave the building. LPN #1 confirmed the resident did not wear a wanderguard bracelet and the nurses unlock the doors in the morning. She was not sure how the emergency exit alarm was turned off.

f. Interview with CNA #2 on 6/12/19 at 5:31 PM revealed she had never seen the emergency exit left unlocked and she had never seen anyone open the door. Further interview revealed on 6/1/19 resident #1 was "not [him/herself]," had been wandering, and had asked about going out the emergency exit. The CNA revealed she reported the resident's increased confusion to the nurse at that time.

g. Interview with CNA #3 on 6/12/19 at 5:38 PM revealed she was not aware of the emergency door being unarmed and confirmed resident #1 had never tried to leave the facility prior to 6/2/19. She revealed the resident had increased confusion for "4 or 5 days" prior to the incident.

h. Interview with CNA #4 on 6/12/19 at 5:43 PM revealed she was not aware of a time when the emergency exit was not alarmed and confirmed resident #1 had been confused on the Friday prior to his/her fall.

i. Interview with CNA #1 on 6/13/19 at 8:47 AM revealed she was in room 109 assisting a resident on 6/2/19. When she opened the curtains, the CNA saw a body on the ground outside and did not know who it was. The person was lying on the sidewalk and lawn. The CNA, another CNA, and the nurse ran outside. The CNA revealed the resident was resident #1 and his/her body was cold and s/he was non-responsive. The CNA threw her cell phone to

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the nurse to call 911 and ran inside to get a blanket and a pad to apply compression to the wound. The nurse called 911 and then went to the emergency room for a heated blanket. The CNA revealed she was talking to the resident and the resident was moving his/her eyes. When the nurse returned they put heated blankets on the resident and continued to hold pressure until the ambulance arrived. The CNA confirmed the resident was not dressed and was lying with his/her head on the cement and body on the lawn. The CNA revealed she thought the resident exited the facility through the emergency exit and had last observed the resident at 6:30 AM in his/her room. Further interview revealed the emergency exit must be "manually set" and the night nurse checked to make sure. The CNA confirmed the resident had not wandered before and the resident had demonstrated "possible confusion" for "about a week" prior to the incident.

j. Observation on 6/13/19 at 9:10 AM showed the area where the resident was observed on the ground, located away from the building on the south side. There was a sidewalk which curved around the lawn and connected the emergency exits. The lawn had bare spots with uneven areas of dirt which were different heights. Interview with CNA #1 at that time revealed the resident was lying on his/her right side, facing the highway and had a laceration on the left side of his/her forehead.

k. Interview with CNA #5 on 6/13/19 at 9:20 AM revealed she was assisting a resident in room 111 and opened the room's curtains at 7 AM. The CNA did not observe resident #1 outside at that time. She confirmed the alarm did not sound while providing assistance in room 111.

l. Interview with the DON, administrator, and social services director on 6/13/19 at 9:40 AM

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revealed the social services director was notified the resident had exited the west hall fire exit, fell, and was sent to emergency room. The DON indicated he was notified the resident received a laceration to his/her forehead. It was confirmed that the resident had not attempted to leave the facility prior to the incident. The administrator revealed the alarms were not activated at the time of the incident and the LPN on duty had to reactivate it after the resident was found outside. Further interview revealed the facility's alarm system had different modes and the system "must not have been" in the correct mode. The administrator revealed immediate training on the alarm system was performed on the day of the incident, the policy was updated, a 24 hours checklist was implemented for staff to verify the emergency exit doors were locked and alarmed, and nurses were to verify each shift.

m. Observation on 6/13/19 at 9:55 AM showed the emergency exit was locked and the alarm system was activated. Further observation showed the instructions for arming the system were posted with an hourly verification near the alarm panel and it had been signed off by staff.

n. Review of the training documentation showed training was performed and signed by staff on 6/5/19, 6/6/19, 6/7/19, 6/8/19, and 6/10/19.

m. Review of the policy titled "Door Alarm Activation" with and "issue date" of 6/2/19 showed "...System needs to armed at all times. Day shift The alarm system needs to be armed with doors 01 and 02 bypassed (front door and patio door). Night Shift At 9:15pm [sic] the system needs armed with none of the doors bypassed. At 5:00am [sic] the system needs armed with doors 01 and 02 bypassed (front door and patio)..." The policy also included instructions on how to set the

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F 689	Continued From page 7 alarm system.	F 689		