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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of complaint investigations #109238 and #108175. | S 000 | | |
| S3026 SS=D | 26-41-101 (f) (1) Staff Treatment of Residents ANE<br><br>(f)The administrator or operator shall ensure that all of the following requirements are met:<br>(1) No resident shall be subjected to any of the following:<br>(A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion;<br>(B) neglect; or<br>(C) exploitation.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility census totaled 71 residents. Of those, 20 residents resided in the Memory Care Unit and 3 were reviewed for accident hazards. Based on observation, interview and record review the facility failed to ensure 2 of 3 residents remained free of accident hazards when both residents wandered out of or away from staff outside of the Memory Care Unit of the facility. (#1 and #2)<br><br>Findings included:<br><br>- Review of resident #1's FCS (functional capacity screen) dated 5/26/16 revealed the resident had impaired short term memory, impaired decision making and had a risk for falls.<br><br>Review of the resident's Negotiated Service Agreement (NSA - a document developed in collaboration with the resident that described services the resident received) dated 5/31/16 | S3026 | | |

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

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revealed the resident received behavior education and management by the facility. The resident received fall prevention interventions which included a pendant alarm and bathing assistance.

Review of the resident's health service plan revealed:

5/31/16 - The resident ambulated with a 4 wheeled walker in his/her room and within the community.
Facility staff would provide comfort and re-direction if the resident became lost or began looking for the exits.
6/19/16 - The resident had a risk for wandering due to cognition. A discussion would take place at weekly risk meetings for any new/changing behavior.
8/3/16- The resident had a wander guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) placed to his/her right wrist.
12/7/16 - The facility placed a broom in the corner of the dining room so the resident could assist with helping clean up after meals.

Review of the nurse's note dated 12/7/16 at 8:40 PM revealed facility staff discussed the resident in their weekly risk meeting related to his/her wandering score. Facility staff had not observed the resident wandering, though the resident paced the halls of the facility.

Review of nurse's note dated 12/8/16 at 1:14 PM revealed at approximately 6:00 PM on 12/7/16 direct care staff advised the nurse the resident was no longer in the hallway where he/she saw the resident last before the staff member went inside another resident's apartment. When he/she noticed the resident was no longer in the

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hallway, the staff member checked the apartments in resident's immediate vicinity. The staff member checked the assisted living hallway and then alerted other staff to the resident being missing. Other staff on duty went to the area where the resident's wander guard alarm sounded and found the resident looking out the window of the memory care unit stairwell. Facility staff opened the door and the resident advised staff he/she went into the area to look for a broom. Staff re-directed the resident with an activity.

During observations of the area in the memory care unit of the facility (where the resident left the memory care unit) on 12/14/16 revealed two separate doors on the same side of the hallway at the end of the memory care unit farthest away from the main entrance. One door led to the stairwell and a few steps down the other door led to the assisted living area of the facility. Both sets of doors were locked and equipped with wander guards. Once the door to the assisted living hallway (the door the resident exited through) was engaged for 30 seconds, the door opened and an alarm sounded. Once in the hallway of the assisted living area, immediately to the left, there was an unlocked door that led to the stairwell (where the resident was found). To the right of the memory care unit doors were assisted living resident apartments. To re-enter the memory care unit from the assisted living hallway or the stairwell a green button (with instruction) was located adjacent to the doors that had to be pushed to unlock the doors so they could be opened.

During an interview on 12/14/16 at 2:37PM direct care staff A revealed on the evening facility staff found the resident in the stairwell they were

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finishing cleaning up from dinner. He/she heard his/her pager sound, which alerted staff someone opened the door from the memory care unit of the facility to the assisted living hallway. When he/she went to the area he/she heard the door alarm and wander guard alarm sounding. He/she looked through the window on the door and did not see any residents. He/she responded as soon as he/she heard the alarm sound and started to check adjacent resident rooms to where the alarm continued to sound when he/she did not readily see the resident through the window of stairwell door. He/she looked into the hallway multiple times to be sure he/she had not missed seeing the resident. When he/she did not find the resident he/she told the nurse on duty and the other direct care staff the resident went missing. When facility staff returned to the area of the stairwell door they witnessed the resident standing in the stairwell looking through the window on the door that led to the stairwell. The resident had no injury. The resident stated he/she opened the door to look for a broom and apologized for going into the assisted living part of the facility then to the stairwell area of the facility.

During an interview with licensed nursing staff B on 12/14/16 at approximately 2:15 PM revealed the resident had not acted any differently prior to when he/she wandered into the stairwell. He/she was in the conference room located near the nurse's station when direct care staff alerted him/her that the resident was not in the hallway where staff last saw him/her and the door alarm/wander guard sounded. When he/she arrived down the hallway the resident stood just inside the door of the stairwell. The resident had his/her walker. The resident had no injury or concern related to the incident. He/she felt the

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resident could physically open the door from the stairwell, but did not think the resident knew how to push the green button to enter back into memory care section of the facility. The resident stated he/she went into the area to look for a broom. Facility re-directed the resident and he/she had not attempted to go into the area since.

During an interview at 2:21 PM on 12/14/16 with administrative nursing staff C revealed the resident could physically get his/herself back into the memory care area of the facility, but he/she did not know if the resident would use the green button to release the door to let him/herself back into the facility.

During an interview at 2:32 PM on 12/14/16 with administrative nursing staff C revealed he/she reviewed the facility video of the incident and the staff member responded to the sounding alarm immediately, however he/she just looked out the window and did not search outside of the unit immediately for the resident. He/she immediately checked rooms adjacent to the sounding door alarm when he/she did not readily see the resident. Administrative C expected the staff to search the area outside of the door more thoroughly if a door alarm/wander guard sounded.

Review of the facility policy "Hazardous Wandering and Elopement" last revised 9/2016 revealed facility staff would visually check inside and outside the area and/or exit triggering the alarm to determine the reason for the alarm.

The facility failed to ensure resident #1 received adequate supervision to prevent accidents by the failure to physically go outside of the memory

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care area door to search for a resident when the door alarm/wander guard sounded. The resident could not re-enter the memory care portion of the facility related to his/her cognitive status which placed him/her in a dangerous area (bottom of the stairwell).

- Review of resident #2's signed physician orders revealed the following diagnoses: anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), dementia with behaviors (progressive mental disorder characterized by failing memory, confusion), myasthenia gravis (a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal (voluntary) muscles of the body).

Review of the annual functional capacity screen (FCS) dated 9/22/16 revealed the resident had short term memory loss and impaired decision making ability. The resident's long term memory remained intact. The resident required supervision with transfers and walked/mobilized independently. The resident used no assistive devices. The resident usually understood others and could make him/herself understood. The resident believed him/herself capable of increased independence in at least some ADLs (activities of daily living) and had major differences in ADL functioning in morning and evenings. The resident performed daily tasks, but slowly. The resident did not wander.

Review of the Negotiated Service agreement (NSA - document developed in collaboration with the resident that described services the resident received) dated 9/9/16 revealed the facility managed and administered medications and treatments per physician orders. The facility

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monitored and reported changes in mood, behavior, and cognition to the resident's physician. The resident received ongoing education/teaching provided by staff. The resident ambulated without an assistive device. At times he/she needed cuing for transfers. The resident wore a pendent alarm (used to call staff for assistance) provided for safety/wellbeing. The facility invited and prompted the resident to attend activities provided by the community.

Review of the resident's health service plan dated 10/28/16 and updated the following dates revealed:

The facility provided personal care.
The resident received 3 meals a day restaurant style and snacks as needed (PRN).
The resident wore a pendant alarm for safety/well-being and staff assistance.
The resident required a daily reminder for oral care morning, evening and at hour of sleep (HS).
The resident received medication management and staff administered medications as prescribed by his/her physician.
Facility staff monitored for any changes in the resident's mood, behavior or cognition and reported changes to nurse.
6/19/16 -The resident had a wander risk. He/she risked wandering due to his/her cognition. Facility staff had a discussion weekly at risk meetings for new/changed behavior.
11/11/16 - The facility placed a wander guard (bracelet that sets off an alarm when residents wearing one attempt to exit the building without an escort) to the resident's right wrist.

Review of the screening for wandering dated 12/9/16 revealed a score of 14, which indicated the resident had a high risk for elopement.

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| S3026 | Continued From page 7<br><br>Review of the investigation dated 11/11/16 revealed the resident joined a group of independent men/women who exited the facility chapel after a Veteran's Day event. The activity staff realized the resident was not with his/her group and alerted staff to look for the resident.<br><br>Review of the nurse's note dated 11/11/16 at 6:19 PM the facility staff found the resident as he/she ambulated towards the westerly unit following an event in the facility chapel (approximately 475 feet). Facility staff transported the resident back to the memory care unit area of the facility via wheelchair. Staff offered the resident fluids/snack, toileted him/her and helped him/her lay in bed. The resident had a wander guard placed his/her right hand.<br><br>Review of the physician order dated 11/11/16 revealed he/she ordered a wander guard to be placed on the resident and checked every shift.<br><br>During an interview on 12/14/16 at 12:05 PM activity staff Freported staff from the memory care unit dropped the resident off at the activity and left the activity person to watch him/her. He/she revealed another staff member asked him/her leave the presentation to get a scoop from the dietary department. When he/she returned the presentation was over and the resident had left. He/she stated there were other staff in the chapel along with many people when he/she left the resident. When he/she identified the resident left the activity, the activity person went and informed his/her supervisor. He/she then went to the memory care unit to see if another staff member had picked the resident up. All staff started looking for the resident. Staff checked the assisted living portion of the facility, | S3026 | | |

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the bathrooms, and found the resident in the independent living area following a group of residents who lived there.

During an interview on 12/14/16 at 2:43 PM with licensed nursing staff G reported the resident behaved normally on the day he/she exited the chapel with another group of residents. The resident had no wandering or exit seeking behaviors prior to the incident. He/she stated the resident just got caught up in a large group of people and followed a group out thinking he/she was going home. The resident was very happy to be home in his/her own apartment.

During an interview on 12/14/16 at 11:55 AM administrative nurse C reported the memory care unit had 2 residents who attended the Veteran's day event in the Chapel in the main facility. Activity staff F supervised the two residents while attended the activity. Another facility staff member asked the activity staff to retrieve a scoop for the refreshments as they were serving dessert and coffee. There were a lot of people at the event. Other facility staff were present at the activity, but none were specifically assigned to the residents from the memory care unit. The resident was gone when the activity staff returned with the scoop. The resident followed some other residents who were going to the independent living unit. The resident was gone for approximately 10 minutes while staff looked for him/her.

Review of the facility policy " Hazardous Wandering and Elopement " last revised 9/16 revealed staff would be notified of residents who were likely to attempt to leave or get lost within the community. Staff would be instructed on the use of effective interventions to prevent

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| S3026 | Continued From page 9<br>unwitnessed exits.<br><br>The facility failed to ensure resident #2 received adequate supervision to prevent accidents when he/she wandered away from an activity unsupervised by designated staff. | S3026 | | |