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F9999	FINAL OBSERVATIONS Licensure Violation Section 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Based on observation, record review and interview, the facility failed to follow its plan of correction from the 05/24/05 survey by failing to perform 15 minute checks per care plan and failing to orientate and train agency staff on elopement procedure and operations of door alarms. One of nine residents identified with exit seeking behaviors (R1) left the building without staff knowledge or supervision. R1 was returned to the facility by the local police department. Findings include: According to the Current Physician's Order Sheet (POS), R1 was admitted to the facility on 4-18-05 . R1 is 43 years old and has diagnoses that	F9999		

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include: Traumatic Brain Injury (TBI) with explosive outbursts in behaviors, Dementia related to Traumatic Brain Injury, Manic Disorder, Behavior Disorder, Anxiety Disorder and Depressive Disorder.

The 10-18-05 Resident Assessment Instrument (RAI) for R1 documents the following: R1 has short term memory deficit, is moderately impaired for daily decision making and requires supervision and cues. R1 is easily distracted (difficulty paying attention; gets sidetracked) and his mental function varies over the course of the day. R1 ambulates independently.

The facility's 10-30-05 incident report of the elopement (leaving the facility without staff knowledge) of R1 includes the following: R1 was last seen by E3, Certified Nursing Assistant (CNA) approximately 1:45 PM on 10-30-05 lying on his bed as she told him goodbye for the evening. R1 's whereabouts were undetected until approximately 3:00pm when the facility received a phone call from the local Police Department that they were returning R1 to the facility. R1 had been found in the local neighborhood. R1 was returned to the facility by the police at 3:02 PM. R1 was dressed in sweat pants, sweat shirt, socks and shoes. R1 personal electronic monitoring device was intact to R1's right ankle and functional. The temperature was between 58 -60 degrees Fahrenheit and sunny. When R1 was returned a complete body assessment was done. No injuries noted on R1's body , alert and verbally responsive with clear speech. R1 was placed on 1:1 supervision.

According to the facility's incident investigation

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notes dated 11/3/05, Z3 (Police Officer) received a phone call from Z4 (community resident) at 2: 30pm that R1 was in Z4's backyard. Z3 picked up R1 at approximately 2:45 PM from Z4's home . The location where R1 was found measured approximately 7/10th mile west from the facility. R1 would have to walk west from the facility and cross a busy two lane main road. R1 continued to walk west onto a one lane road that both east and west bound traffic drives on, then turned left and entered a housing subdivision and stopped at the home of Z4.

The Nursing Care Plan for R1 dated 5/18/05 documents a problem area of wandering/ elopement. R1's care plan documents that R1 had a previous incident of elopement on 5/14/05 and was returned to the facility by the police. Approaches were for R1 to be monitored every 15 minutes, 1:1 monitoring during episodes of exit seeking behaviors, personal electronic monitoring device on at all times, attempt to redirect when exit seeking , divert resident from doors. Care plan Comment section documents on
5-20-05 facility has a person sitting with resident from 4:00PM to 8:30PM seven days per week, Care Plan Comment section also states that the 1:1 person was discontinued 8-2005. R1's Care Plan was updated on 9-16-05 with the statement that R1 is going home with family on home visits, R1 continues to make attempts to exit seek at times and gets angry during redirection. Activity Care Plan for R1 dated 9/16/05 also identifies R1 to have a "High-risk elopement factor".

The facility's "Elopement Risk Assessment" policy and procedure was reviewed. The policy

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and procedure was issued on 8/29/99 and was revised 12/25/02. It states "A resident's elopement risk will be assessed using the Elopement Risk Assessment (Form #RC14.16.1), upon admission and quarterly thereafter. Residents who have been identified as low, moderate or high risk will be care planned."
Per record review of R1's Elopement Risk Assessment of 11/1/05, R1's Elopement Risk Assessment is still identifying him as a low risk even after two elopements from the facility within 6 months.

R1 resides in the facility's South Building. The facility's South Building is equipped with door alarms at all doors to alert staff if someone exits the facility. There are two alarm systems in place for certain doors within the building. The front entrance lobby door, east entrance kitchen door, smoking exit door and the west entrance door are equipped with personal electronic monitoring alarm system along with the regular door alarms. The remaining entrance/exit doors are equipped only with door alarms. According to the facility incident investigation notes dated 11/3/05 and interview with E12 Maintenance Supervisor on 11/8/05 at 3:55 PM, E12 came to the building on 10/30/05 the date of the incident and checked all door alarms and personal electronic monitoring alarm system. All alarms were in good working condition.

E4, Certified Nursing Assistant (CNA) on 11/9/05 at 3:30 PM stated that she was walking between two different residents on 10/30/05. " First resident was across the hall from (R1) and the other resident (R4) was located toward the front of West hall. I kept making faces at (R1) and he

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smiled at me this was before
2 PM on 10/30/05. After 2 PM (R1) walked toward the door toward the little dining room on West hall and I took him back to his room, (R1) went to the bathroom and he laid back down in his bed when he was done. (R4) was vomiting and having bad behaviors and I waited for E7, CNA to help me clean (R4) up and I left after 2:30 PM. Before I went into (R4)'s room (R1) was in his room. After leaving (R4's) room I went straight to the time clock and clocked out. One of the CNA's who works third shift told my sister who is a CNA on third shift about the incident with (R1) and my sister told me that it happened on my shift. (R1) had a history of eloping, I was told about it when I first started working about 4 months ago. I knew about the location monitoring sheets and I documented (R1) was in his room on 10/30 05 at 2:30 PM. The facility fired me because they said I falsely documented on the location monitoring sheets about (R1)."

This interview is in conflict with the facility's investigation report date 11/3/05. E1, Assistant Administrator had contacted Z4 who revealed during interview on 10/31/05 the police was contacted on 10/30/05 at
2:30 PM. 11/1/05 interview with Z3, Police Officer stated they received the call approximately 2:30 PM to 2:45 PM. Facility Nurses Notes documents R1 was returned to the facility approximately 3:00 PM.

E10, Certified Nursing Assistant (CNA) on 11/15/05 at 9:28 AM stated that she was working on East wing with E9, Certified Nursing Assistant. " On that day we had two agency nurses Z1 and Z 2 working. They don't know what to do when the

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codes/alarms go off. When the residents go out the smoking door the agency nurses would turn the alarm off. I saw this happen. This is fine because you can see the residents smoke outside. The nurses we had did not know (R1) and I think they might have shut the alarm off. I think this is how(R1) got out because agency nurses did not know him. I was aware of(R1) having a history of eloping. We the CNAs tried to explain to management that it is hard to keep up with someone like (R1). It is hard to hear the alarm while in the resident's rooms. I was not around when(R1) came back. We leave around 2:30 PM and I think he got out when we did rounds. I really believe agency nurses cut the alarm off. West hall E3, CNA went home early and Z1 and Z2 did not know who (R1) was. I just think this is how (R1) got out. When someone goes out smoking doors and the front doors at the same time the alarm show front door and then smoking door. It is drilled in us to go look but not the agency nurses and they will turn the alarm off."

Z1, Licensed Practical Nurse, Agency Nurse on 11/15/05 at 11:20 AM stated that she had worked for the facility before and remembered that (R1) was an elopement risk because he got out of the facility once before. Z1 stated that E1, Assistant Administrator told her to check door alarms during an inservice on 6/30/05. Z1, who worked 10/30/05, stated she did not receive any formal inservice about the policy and procedures of eloping residents. Z1 stated she did not receive any information about an elopement book, that the way she knew who was at risk for elopement was through the nursing report book, where residents will have a BI for Brain Injury next to

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their name and that they are elopement risks. Z1 stated she never received an inservice on the alarm system or the personal electronic monitoring alarm system nor had been told anything about the building. According to Z1 nothing has been brought to her attention about the alarm system other than alarm codes are being changed all the time.

Z2, Registered Nurse, Agency Nurse on 11/15/05 at 11:35 AM stated that she did not receive any inservice in the beginning before she started to work at the facility on 10/30/05. " The night nurse told me that they had alarm system and he pointed out a couple of residents I needed to keep an eye on. (E1, Assistant Administrator) did talk to me on 10/24/05 my first working day half way through the shift while I was passing medications about the elopement book. I do not know how to shut the alarms off. I did not know until I was leaving my second day how to get out of the building without sounding the alarms. They told me to push the green button when I wanted to go outside to pass medications to the smoking residents. I was so busy I really did not have time to mess with the alarms."

E7,Certified Nursing Assistant, stated on 11/9/05 at 2:55 PM that she was standing at the nurses station when R1 returned through the front door. E7 stated that she did not hear the alarm go off when R1 walked through the doors with E5,CNA on 10/30/05 at 3:00 PM who also witnessed that the alarm did not sound. E7 stated that she walked over to R1 and walked him back through the entrance doors to ensure that R1 personal electronic monitoring device was working properly and the alarm did sound when she and

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F9999	Continued From page 18 R1 came back through the doors. E5, Certified Nursing Assistant verified during interview on 11/9/05 at 3:13 PM that she was the one who brought R1 back into the building when the police had dropped him off and R1's personal electronic monitoring device did not sound when they walked through the door. E5 also stated she was present when E7,CNA walked back through the doors with R1 to check that his personal electronic monitoring device did work. E5 stated it did activate the alarm system when they came back through the doors. R1 stated on 11/8/05 at 2:50 PM that he did not know what door he went out of, it might of been the kitchen door, but he was not sure. He stated he crossed the street where there was no traffic. He was asked if he knew what to do when he came to a busy street. R1 stated "I went to a construction zone and talked with the guys working there. They said traffic was busy for about another half hour then their foreman will come out and stop the traffic then people can cross the street." When asked how he returned to the facility, R1 stated "I walked back to the facility by myself." When asked about the police returning him to the facility, R1 stated he did not know that the police brought him back and that he walked right into the facility. When asked if the door he went out alarmed, R1 stated he knew the doors had alarms and they made an irritating noise when you leave. When asked about his personal electronic monitoring alarm bracelet, he responded that he has a bracelet but he left it at home although he lifted up his right foot and pointed to his bracelet. R1 stated when he comes back into the facility he makes that	F9999		

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irritating noise when he walks through the front door. When asked when he left the building he stated he thought it was right after lunch because he wanted to get something to drink. Upon completion of interview with R1, E2 (Director of Brain Trauma Injury Unit) who was present during the interview was asked if there had been construction going on 10/30/05. E2 stated no construction has been taking place to her knowledge. Incident date was on 10/30/05 which was a Sunday and construction crews usually do not work on Sundays.

E2, (Director of Brain Trauma Injury Unit) on 11/9 /05 at 9:30 AM stated that R1 was alert but confused at times. R1 will forget to go to the bathroom and you will have to remind him or he will soil himself. R1 is unsafe outside. "When I left the building for the day on 10/30/05 he was in his room. When (R1) came to us he was high risk for elopement. His file from his past placement told us he was at risk for elopement. (R1) has left the building before either in May or June of this year. When (R1) eloped from the building we assigned a 1:1 with him at that time."

E3, (Certified Nursing Assistant on Brain Injury Unit) on 11/9/05 at 9:52 AM stated "With the BI (Brain Injury) that(R1) has, it would be scary for him to be by himself outside because he would not know what to do or where to go. I would not consider him safe being outside by himself. (R1) is easily agitated. (R1) is at risk for elopement, he requires supervision all the time this is why he has the location monitoring sheets, we do checks every 15 minutes for his whereabouts. On the day of the incident I came in at 5:30am and I got off at 1:30pm on Sundays. Me and E4 (Certified

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F9999	Continued From page 20 Nursing Assistant) started rounds at 1:00pm. I checked my people the Brain Injury residents and I helped E4 with her residents. I saw (R1) at 1:30 pm , he was lying on his bed by the door and I told him I was leaving and he told me to take care ."	F9999		

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F 366	Continued From page 15 fact not listed as described by R9. During observation of the noon meal in the South building on 2-1-06 showed that the tray cards do not have likes and dislikes entered on the cards with the exception of some beverages for most of the residents. The only other entries listed were diet restrictions for foods to limit or foods to add to the tray. Three residents had dislikes listed on the 61 tray identification cards reviewed.	F 366		
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS 300.1210b)3)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	F9999		

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F9999	Continued From page 16 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview, and record review, the facility failed to ensure that resident equipment brought in from home was free of accident hazards for one of one sampled residents using her own bed (R1). Staff failed to conduct a safety assessment of R1's bed and attachments prior to resident use, thus failing to identify a space between the frame, mattress and siderail which could entrap R1. Staff failed to reassess R1's bed safety in relation to individual behaviors after falls.	F9999		

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The findings include:

1. According to the current Physicians Order Sheet (POS) and Physician Progress Notes dated February 2006, R1 is a 91 year old resident admitted to the facility on 2/16/05, with diagnoses which included severe Parkinson's Disease, severe Dyskinesia with involuntary movements and resting tremors of the hands and feet, Osteoporosis, Glaucoma, and Degenerative Joint Disease.

According to the most current Minimum Data Set (MDS) assessment dated 12/12/05, R1 has no memory or cognitive impairment. The assessment shows that R1 requires one assist to complete most Activities of Daily Living (ADLs) such as transferring, dressing, hygiene and ambulation in room. According to this MDS, R1 is unable to maintain standing balance without physical help and has an unsteady gait. On the February 2006 POS, the Physician has ordered a soft waist restraint when up in wheelchair due to Parkinson's and as a reminder not to reach for things from the wheelchair. The Physician also ordered 1/2 side rails up x 2 to aid with bed mobility.

On 2/8/06 at 12:00 noon, E1, the Administrator stated, R1 "brought her own bed with her on admission, which included the bed frame, mattress and two half side rails." E1 also stated that R1 brought her own bed linens, which E1 described as "very smooth," and her own "silky" nightgowns. Observation on 2/7/2006 at 9:30 a. m. showed that R1's bed has a hand crank at the foot of the bed for height adjustment and a hand held electric remote to raise and lower the head

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F9999	Continued From page 18 of the bed. Interview with Z1, R1's daughter, on 2/8/06 at 2: 40 p.m., found that the bed had been used since 1990. Z1 stated that the trapeze had been added, but that the side rails came with the bed. Z1 also said that she had tried to upgrade the side rails but was unsuccessful. According to the Accident and Incident Log dated November 2005, R1 fell on 11/06/05 and again on 11/12/05. The nurses notes dated 11/6/05 at 7:20 a.m. state, "Resident slid from (wheelchair) to floor reaching for wash cloth landed on right knee, hit (right) side of face on door causing glasses frame to hit (right) cheek and above (right) eye causing a small red area at each place ...." The nurses notes dated 11/12/05 at 7:30 p. m. staff have written, "Housekeeper found resident on floor....Resident was on the floor with wheelchair tipped up with resident's feet on pedals. Asked if (R1) hit her head, she said 'Yes on the floor'. Resident was lying on right hip and complained of pain." The Current Care plan dated 12/16/05 identifies that R1....."Resident (at) risk for falls (due to) Parkinson's disease, Osteoporosis. Resident (frequently) leans forward to pick up items on floor . Res. frequently makes attempts to get out of bed and wheelchair despite repeated instructions to wait/seek help..... 11/6/05 Reaching for wash cloth. Slid out of (wheelchair) - Did (not) use reachers.....11/12/05 (Resident) again leaning forward in chair to (pick up) item and fell out of (wheelchair)..." On 2/7/06 at approximately 10:30 a.m., E1,	F9999		

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	145753	A. BUILDING _____ B. WING _____	C 02/16/2006

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F9999	Continued From page 19 Administrator, stated that (R1) was placed on every 15 minute checks starting on 11/12/05. In the nurses notes dated 12/8/05 at 10:35 p.m., staff have written, "Resident found leaning forward in (wheelchair) with wheels off ground." On the Care Plan an entry dated 12/16/05 states, "Res. with new order for lap Buddy when in wheelchair..." During discussion with E1, the Administrator on 2/8/06 at 3:25 p.m., it was confirmed that although staff have assessed the need for R1 to have additional monitoring to prevent further falls from the wheelchair on 11/16 /05, and on 12/16/05 obtained an order for a lap buddy restraint, the assessment did not include any fall prevention assessment if R1 displayed the "reaching behaviors" from the bed. In the nurses notes dated 1/9/06 at 7:05 a.m., E 12, Licensed Practical Nurse (LPN), wrote "While walking past (resident) room (R1) was noted to have her neck wedged between her side rail and the mattress, unresponsive, skin color ashen. Received assist to remove (R1) from side rail. Neck stabilized and immediately started resuscitation procedure per other nurse on duty." During interview with E12, LPN, on 2/08/06 at 10: 10 a.m., E12 stated, "I was leaving to clock out and looked into (R1's) room. At first I saw the resident hanging from the side rail - she looked dead. After calling for help - I went to the resident and noted that (R1's) body was resting on the floor. Her airway was restricted from the side rail. (R1's) head was twisted at an angle with the side rail located up and under the left side of the chin (3 to 4 inches approximately) cutting off her airway. (R1) was totally unresponsive and upon the initial assessment (R	F9999		

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1) was not breathing. The weight from (R1's) neck/chin on the bed rail prevented us from lowering the side rail. In order to let down the side rail, you need to raise the side rail about an inch to release it - so that it would lower. No other beds on the North building are like this. By this time the other nurse (E6, LPN) arrived...I pushed the mattress in and up and (E6, LPN), cleared (R1's) neck and lowered her to the floor." E12, went on to explain, "The resident's mattress had a foam topper on it and was positioned about 4 1/2 inches from the side rail. The side rail was attached to the side of the bed securely, but the side rail 'gives' easily. The side rails came with the bed from home." E12 said, "(R1) wore silky pajamas and had very smooth sheets. E12, LPN, also stated, "When I found the resident at 7: 05 a.m., the head of the bed was approximately at a 30 degree angle."

During interview with E6, LPN on 2/7/06 at 10:15 a.m., E6 stated, "the other nurse yelled for help. I got there and E12, LPN, lifted up the mattress to get (R1's) head out. I checked and found a faint pulse and gave (R1) a few rescue breaths. (R1) was blue. (R1's) chin was resting on the lower rail - the back of the head was resting on the frame, body was laying on the floor, (R1's) shoulder was resting against the back of the bed frame. (R1) was at an angle. Staff phoned 911..." E6 also stated, "(R1) has had her own bed since admission, (with) silk sheets and night gowns.

During interview with R1 on 02/07/06 at 9:30 a.m. , R1 stated, "I was turning off my television when I dropped the remote. I leaned over the bed to pick it up off of the floor when I slid out of bed and got caught in the side rail. I'm lucky that the

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nurse saw me I was just about gone." Later that day 02/07/06 at 3:50 p.m., R1 stated, " I was going head first trying to reach a little further but my head got in the way. I reached to get the remote. Then I turned over and my legs fell out of the bed."

The hospital Admission Record dated 01/09/06 ,shows that R1 was admitted with a diagnosis of Acute Cerebral Vascular Accident (CVA) with Right Hemiplegia status post Respiratory Arrest. The hospital "Discharge Summary,"dated 01/11/ 06, showed the "Discharge Diagnosis (es): 1. Status post respiratory arrest now stable. 2. Recent fall or slip with neck trauma." The discharge summary also included the "Hospital Course: Patient is a 91 year-old white female ... who was admitted because of a slip or a fall from her bed and she was found hanging by her neck from her bed rail with her body on the floor. She had respiratory arrest and had to be resuscitated by (emergency personnel) prior to transport to the hospital. (R1) will be discharged to (the facility) today (1/11/06)."

During interview with E10, Environmental Supervisor on 2/7/06 at approximately 3:45 p.m., she stated, "The normal procedure is that Maintenance checks equipment and fills out a form - that resident equipment such as walkers and lamps brought in from home meet safety/ maintenance regulations." E10 also said, "(R1's) family took the mattress home....I do not know if (R1's) bed has had a safety/maintenance check since the incident. (E11)\, Supervisor of Maintenance, would do this type of check." E10 explained, "Nursing writes on the Maintenance Log Sheet if a new resident is admitted and a

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check of personal equipment needs to be done." Review of the Maintenance Work Request Log Sheet for the North Building showed that from January 2005 to 2/8/06, there has not been any documentation of R1's admission or a request to check personal equipment.

During interview with E11, Maintenance Supervisor, on 2/7/06 at 4:10 p.m., he stated "I knew (R1) had her own bed. I did not check (R1 's) bed for safety. I haven't checked the bed since (R1) fell."

Interview with E1, Administrator, on 2/8/06 at approximately 12:00 noon, E1 stated that there had been "no check of (R1's) bed since admission. The Maintenance Supervisor, (E11) did not know that he was supposed to be doing that, but he does now."

During this same interview with E1 at 12:00 noon on 2/08/06, she stated that she examined the bed after the incident. "The problem was not with the bed, but with the side rails. One side rail was pulled out a little bit so it didn't meet flush with the mattress. I reenacted the event, with the mattress and with the body weight, it left enough room between the mattress and the rail for the resident's head to get caught."

The "Preventative Maintenance Program-Annual Inspections" Policy states, "10. Inspect all electrical equipment for bad wiring and proper operations. a. Check all residents' equipment, record, and tag."

(A)