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S9999	Final Observations Licensure Violations: 610a) 300.1010h) 300.1010i) 300.1030a)3) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)1)2)3)9)10) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest	S9999		

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decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

Section 300.1030 Medical Emergencies

a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as:

3) Traumatic injuries (for example, fractures, burns, and lacerations).

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest

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practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), 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.

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S9999	Continued From page 3 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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	S9999		

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S9999	Continued From page 4 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. 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a).) 10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation , interview and record review the facility failed to supervise and implement interventions to prevent one resident (R1) from falling from a 3rd floor window out of three residents reviewed for wandering behavior and supervision. This failure resulted in R1 entering the 3rd floor Dementia unit unlocked/unattended oxygen room and exiting the 3rd floor window. R1 was found face down on the concrete pavement . R1 was pronounced dead at the hospital.	S9999		

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Finding include:

Document review reveals R1 is an 80 year old male with a diagnosis including Depression , Anxiety, Panic Disorder and Dementia. R1 was admitted to the facility 10/01/13. R1 was housed on the 3rd floor in the locked dementia care unit. (The nurse station Pathways unit) . R1 used a wheelchair but could walk with unsteady gait. Nurse Note 10/2/, R1 expressed that he wanted a taxi to go home. Physician Order 10/2/13 documents a departure alert system was placed on R1. Medicare Daily Documentation (undated) R1 "wanders on or off unit." Pre-Admission Clinical Assessment 9/6/13 documents "increased confusion at sundown." Nurse Note 10/1/13 "had sitter watching resident all night." Time Card for private sitter company documents R1 had a sitter for 3 nights in a row, 10/2/13 through 10/4/13. Nurse Note 10/2/13 6:30pm, R1 "wants to go home, wants to call for a taxi." Nurse Note 10/4/13, R1 "attempted to wander around the unit. Kept redirected by staff." Nurse Note 10/5/13 5am, R1's wife notifies E10(Nurse) that she is going home, "watch the resident." 5:15am, E10 called Z1(Physician) for a sedative due to "extreme agitation." R1 threw a remote control at E10, and twisted another nurse's arm. Local Fire Department Report 10/5/13 documents "Arrived to find (R1) lying in the courtyard below an open window...found (R1) on the ground in the courtyard outside their office approximately 7:43am." Emergency Department Records 10/5/13 document "(R1) presents after jumping from 3rd story at nursing home. Patient last seen at 7am, found down by nursing home at 7:43am.

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Patient pronounced dead in emergency department at 8:30am." Interim Care Plan 10/2/13 documents the use of a departure alert system. No Minimum Data Set available due to R1 only residing at the facility for 4 days prior to death.
Initial investigation report states on 10/5/13 at approximately 7:35AM R1 was found outside on the ground near the building in the supine position . A third floor window above the resident was open. Cardiopulmonary Resuscitation was initiated by staff. 911 was called. R1 expired after arrival at the hospital. Final Investigation Report 10/11/13 documents "The allegation of neglect was substantiated for (E10) for not making (E3) aware of (R1)'s change in condition and need for constant 1:1 care."
R1s clinical record review revealed the following observations. R1s Occupational Therapy Assessment dated 10/2/13 documents Suicidal Ideation. R1s Physical Therapy Assessment dated 10/2/13 documents "Suicidal Ideation (was on a psychiatric unit)."
The facility was entered on 10/6/13. The 3rd floor was toured with E9 (Alzheimer Unit Director). The 3rd floor is a locked unit (Pathway Unit). A keypad code is required to exit the doors from the floor. The "Oxygen/Crash Cart" room was observed next to the nurse station. At time of observation a small slide lock was temporarily installed on the door approximately 5 feet from the floor. The door was missing the lock latch assembly. Signs posted on the exterior side show "Crash Cart , CPR mask , Oxygen Room , Please keep this door closed". The inside of the room has a window. This window is three feet from the floor. The window has two glass panels approximately two by four feet in size. One panel swings outward by use of a crank handle. The crank handle and mechanism to open the window

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were missing. A small metal bracket was installed on the window with two screws preventing it from opening. Two locking levers to the opening glass panel were secured. There is an employee bathroom with a separate door in this room. The O2/Crash cart room was also used as a locker room for employees. E9 (Alzheimer Unit Director) 10/6/13 10AM stated the police removed the window latch mechanism after the incident. The small slide lock was installed on the room door after the incident. The room was normally open and there was no lock latch assembly on the door. The door could not be locked.

The following staff that had direct contact with R1 , before the incident , were interviewed during the investigation.
E10 (Registered Nurse) 1:15 PM 10/08/13 stated she works from 7 PM to 7AM. I received report from E4 (Registered Nurse) at the beginning of my shift (10/5/13) that R1 needs 1:1 supervision because he doesn't sleep at night and gets out of bed. R1 was wearing a departure alert system because he was a high risk for elopement and did not want to stay at the facility. R1s wife will be staying with him for the night. R1 was on sleeping pills and psychotropic medication. At 8PM I gave R1 his medications , his wife was sitting there. At 2AM wife got me and stated R1 would not sleep and he needed more sleep medication. I gave R1 Halcion .25 by mouth. At 4:30AM I saw R1 in his room with wife. She was putting on his socks.She told me he slept for two hours. At 5 AM R1s wife told E11 (Certified Nurses Aid) she was going home and to watch the resident. After she left R1 was already standing up. I tried to get him to sit down but he threw the recliner chair remote control at me. He kept standing up and resisting. I called E11 for assistance. We put him in the wheelchair

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and wheeled him to the nurses station. I asked E12 (Certified Nurse Aid) and E13 (Certified Nurse Aid) to watch R1. I called E14 (Nurse Night shift supervisor) and told him we have a situation on the unit . R1 was agitated. At 5:15AM E14 told me to call the doctor. I called Z1 (Physician) . Z1 ordered Haldol 2 Milligram intramuscularly to be given for severe agitation. During this time R1 twisted E14's arm. He refused to sit down and continued hitting staff. I called R1s wife and told her R1 was a danger to himself. I told her R1 needed 1:1 supervision immediately. R1s wife said her son would be there at 6:30AM to watch R1. R1 was at the nurses station from 5AM to 6:45AM. The son never showed up. At 6:45AM E11 took R1 back to his room . At 7AM I saw E3 (Certified Nurse Aid) walking R1 towards the nursing station. At 7:35AM I gave a report to E4 (Nurse) on R1. At 7:35AM E5(Certified Nurse Aid) came to the nurses station panicking and stated someone was on the ground. I thought a resident fell on the floor. E4(Nurse) , E12(Certified Nurse Aid) , E15(Nurse) and myself were in the nurses station giving shift change reports. The overhead pager sounded code blue. E5 pointed to the window in the 'O2 " room next to the nurses station. We looked in the room. The window was open more that halfway. Normally the window is closed. The handcrank that opens the window was not there. There was someone on the ground outside.
E3 (Certified Nurse Aid) 2:35PM 10/6/13 stated the following. This was the first time I was R1s caregiver. In the morning 10/5/13 at 7AM I saw E11(Certified Nurse Aid) . He was trying to put R1 in bed. E11 assigned me to care for R1 at this time. I took R1 for a walk . We walked to the nurses station . There was 4 to 5 nurses in the nurse station behind the glass and closed door

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having a meeting. One nurse (unidentified by interviewee) told me to take R1 to his room so he could get a blood draw. Z2 (Outside service nurse phlebotomist) and I took R1 to his room and sat him in his chair. I left R1 with Z2. I went to the next room to get the resident ready for breakfast. I assumed Z2 would get me when she was finished. When I was in room I saw R1 in the hallway by himself. I put R1 back in his room on the recliner chair and told him to wait until I was finished, and I left R1 alone in the room. I proceeded to take the resident to the dining room. I then heard E6 (Certified Nurse Aid) scream a resident fell out the window. The O2 / Crash cart room is always open and unlocked. We use the bathroom in this room. It is also a locker room for staff belongings.
Z2 (outside service phlebotomist) 2:45PM 10/8/13 stated the following. On 10/5/13 at 7 AM I arrived at the facility on the 3rd floor to draw blood from two residents. At this time R1 was standing at the nurses station . There were other staff (unidentified by Z2) at the nurses station. E3(Certified Nurse Aid) and I took R1 to his room (310) . E3 left the room. I had to ask R1 several times to sit down in his chair while I drew blood from his right arm. I left his room approximately 7AM after drawing his blood . He was standing and rearranging pillows on his wheelchair. I thought he would be ok so I went to draw blood in a different room. E3 was already in room with that resident. When I was finished I saw R1 in another residents room across the corridor. I told E3 that was next to me that R1 was across the hall. The certified nurse aid went to get R1 and escorted him back to his room. E3 was in room with R1 when I left the area.
E5 (Certified Nurse Aid) 2:05PM 10/6/13 stated the following. I was walking in the hallway (time not identified by E5) when I noticed an empty

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wheelchair at the O2/Crashcart room doorway. I opened the door and saw the window was wide open. The wind was blowing in the room. The window screen was on the floor . E6s (Certified Nurse Aid) lunch bag was scattered on the floor. E6 came into the room with me. We looked out the window. We saw a resident on the ground. Staff were standing around the resident.
E6 (Certified Nurse Aid) 1:45PM 10/06/13 stated it was almost time for breakfast . There was a wheelchair in the nurses station. E5 (Certified Nurse Aid) went to the O2 /Crashcart room . She told me my lunchbox and its contents was on the floor. I went into the room and started to pick up my lunch. The window screen was on top of the contents of my lunchbox. The window was open. There was a crank on the window . I looked out the window and saw staff around a resident on the ground.
On 10/8/13 at 9:45am, E1(Administrator) stated that the facility does not have a policy on how to conduct 1:1 supervision.
Z1 (Physician) 3PM 10/8/13 stated the following. The facility is expected to provide 1:1 supervision if the resident is able to get off of the floor. He was not supervised since he was found outside the building. 1:1 supervision means supervision 100 percent of the time. The facility made the decision for 1:1 supervision since they provided R1 with a sitter for three nights before the incident. R1 clearly needed 1:1 supervision. R1s situation fell through the cracks and had a bad outcome.
E9 (Nurse/Director of the Alzheimer's unit) 9:25AM 10/9/13 stated the facility staff have no formal training in 1:1 supervision. We know we have to provide 1:1 supervision if there is harmful behavior or wandering. R1 was considered a wanderer since he was looking for a taxi to go home.

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S9999	Continued From page 11 E2 (Director Of Nursing) 3:45PM 10/9/13 stated if we know in advance that we need 1:1 supervision we have an outside provider send a sitter to be with the resident. R1 had a private sitter for three days (10/2,3,4th). The family wanted to give the 1:1 supervision . If the family leaves the resident we will either get the outside provider or have staff fill in for the 1:1 supervision. Wanderguard Process Policy "The decision to utilize a (departure alert device) for a particular resident will be based on, but not limited to the following: the specific exit seeking behavior of the resident and/or verbalized intent to leave the unit or facility. Devices may be utilized in one of two ways: a secondary security to the delayed egress system of the unit or to address exit seeking behavior." The facility does not have a policy for instructing staff on how to perform 1:1 supervision of a resident. (A)	S9999		