F 0323 Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents

Level of harm - Immediate jeopardy

Residents Affected - Few

Based on record review, interview, and observation, the facility failed to adequately assess, care plan and monitor 1 (#7) of 16 sampled residents, for the risk of elopement, which resulted in two elopements out of the facility, and one elopement out of the secured unit, and failed to implement interventions to prevent an elopement for 1 (#17) of 17 sampled and supplemental residents.

Findings include:
1. Resident #7 was admitted to the facility on [DATE], after a fall with a traumatic brain injury.
Review of resident #7's Elopement Risk Assessment, dated 8/1/17, showed The resident is disoriented to place and time but other than that is not an elopement risk.
Review of resident #7's Speech Therapy Note, dated 8/3/17, showed he was found in the facility parking lot.
Review of the Physician Orders, dated 8/3/17, showed a WanderGuard was ordered for resident #7.
During an interview on 9/27/16 at 9:25 a.m., staff member H stated resident #7 had been eloping on 8/3/17, so the facility placed the WanderGuard on his wheelchair.
Review of resident #7's Elopement Report, dated 8/5/17, showed the Wanderguard had been placed on the resident's wheelchair instead of his body, because the facility staff could not find a band. At 8:15 resident was discovered missing with his wheelchair by front door. I called police. CNAs and I went to park, gas station, and bar, and he was not found. At 8:45 police escorted him back into building. He was found at (Facility Name) Clinic. Resident #7 crossed a busy 4-lane road.
Review of resident #7's Nursing Progress Notes, dated 8/15/17, showed he was moved to the locked memory care unit.
During an interview on 9/27/17 at 9:30 a.m., staff member B stated the facility did not have an evaluation for placing residents in the secured unit. It's is an IDT decision.
During an interview on 9/27/17 at 2:30 p.m., staff member Q stated resident #7 packed his bag almost every day, and sat at the locked door. We were told to keep an eye on him.
During an observation on 9/27/17, at 12:20 p.m., resident #7 did not have a WanderGuard on his person.
During an interview on 9/27/17 at 3:40 p.m., staff member D stated resident #7 had followed a food service worker with a food cart, out of the locked unit. The food service worker had not noticed him, but staff member D stated she took him back to the locked unit. This elopement was not documented or investigated.

Review of resident #17's Care Plan, dated 6/13/17, did not include a problem with exit seeking, wandering or elopement.
2. Resident #17 was admitted to the facility on [DATE], related to elopements out of another facility.
Review of resdent #17's Elopement Risk Assessment, dated 5/22/17, showed the resident had a history of [REDACTED].
Review of the State Agency Event Report, dated 5/26/17, showed resident #17 got through the secured unit doors, and went out the front door, during a Fire Drill. A medication nurse was in the parking lot and immediately redirected resident back in facility.
The outcome of the investigation showed All doors were tested and found operational. Staff inserviced on door monitoring during fire drills and elopement procedure. The investigation did not include interventions specific to resident #17, to keep her safe from future elopements.
Review of resident #17's Care Plan, initiated 5/22/17, showed I cannot reliably recognize a dangerous situation. The intervention for safety was I live in a secured unit per my physician's orders [REDACTED]. My continued need for this unit will be evaluated quarterly. It did not include resident-focused interventions for elopements.