STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675402	A. BUILDING _____ B. WING _____	03/26/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCKWALL NURSING CARE CENTER	206 STORRS ROCKWALL, TX 75087

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement policies and procedures that prohibit neglect for one (Resident #1) of four residents reviewed for elopement risk. 1. The facility failed to have staff present at all times on the male secure unit to supervise and monitor Resident #1. No staff were on the unit on [DATE], when CNA C and LVN B, who were responsible for caring for residents on the secured unit, left to assist residents off the unit. Resident #1 was left unsupervised during the timeframe that he eloped. 2. The facility failed to have a care plan to address Resident #1's exit seeking behaviors with specific interventions to prevent elopement. 3. The facility failed to repair an exit door to the secure unit which had a slight delay in closing. 4. The facility failed to have all entrances/exits monitored to prevent elopements. Two exit/entrance doors did not alarm or alert staff if someone entered or exited unless the person was wearing a wander guard. Resident #1 eloped from the secure unit on [DATE] and was missing for more than seven hours. He was found deceased . Hypothermia was a contributing factor to his cause of death. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could affect the 13 residents, who resided on the male secure unit by placing them at risk for elopement resulting in injuries and/or death. Findings included: 1. Resident #1's MDS assessment, dated [DATE], reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It noted he had severe cognitive impairment with fluctuating behaviors. It noted he needed supervision with ambulation and required assistance with incontinent care. It noted The MDS assessment reflected he received insulin injections. Resident #1's Risk of Elopement/Wandering assessment, dated [DATE], identified the resident as cognitively impaired with pertinent [DIAGNOSES REDACTED]. Resident #1 was able to ambulate independently. Resident #1 wandered aimlessly without purpose. He was a new resident and the family had expressed concern that he would try to leave. The Summary of Review identified the resident as At risk for elopement/wandering as evidenced by: Resident Wandering appropriate interventions have been initiated-Secured Unit. Resident #1's Care Plan, dated [DATE], reflected he was at risk for elopement with a goal of will keep a safe and secure environment for the next 90 days. The approaches were Secured unit and provide a structured environment and daily activities. There were no updates/reviews to the care plan. The Care Plan did not include specific activities or other interventions to prevent elopement. Resident #1's Physician Orders, dated [DATE], revealed the resident required NPH/Regular insulin 10 units in the AM before breakfast and 18 units before dinner. Resident #1's nursing progress notes, dated [DATE], reflected, resident in the unit with exit seeking behavior. Resident #1's nursing progress notes, dated [DATE] at 03:45 AM reflected, resident continues to ambulate throughout secured unit. Exit seeking in (sic) all four doors. Nursing progress note on [DATE] at 12:45 PM reflected, Resident continues to exit seek. Resident attempts to follow the staff out of the exit doors becoming aggressive when redirected. Resident #1's nursing progress note, dated [DATE], reflected, Resident attempted to get out of back door. Then slipped out behind a family member. Resident #1's nursing progress note, dated [DATE] at 9:30 PM, reflected Resident sometimes exhibits exit seeking behavior but redirected as needed. Resident #1's nursing progress notes, dated [DATE] through [DATE], did not reflect exit seeking behaviors. The notes reflected multiple medication changes for other behaviors. Resident #1's nursing progress note, dated [DATE] (Monday) and completed by LVN A reflected at 06:00 AM, CNA told this nurse and ,[DATE] nurse that he could not locate the resident at this time. This nurse and staff went through every room on Secure Unit then this nurse paged a ' Code White ' at this time all staff began searching all rooms in facility and some staff walked the grounds of facility without finding the resident. At 06:10 AM, 911, MD and RP were phoned by this nurse. Search continues with all staff involved inside facility and outside facility. 0705 Police arrived on Sta (Station) 3 where this nurse checks each room on Sta 3 with officers. Resident not located. Staff and officers continue to look for resident at this time. 2. The local Police Report, initiated [DATE], reflected Resident #1 was scheduled to receive insulin at 6:30 AM and the DON reported that might be a problem if Resident #1 was not found by noon. At 1:24 PM he was located behind the bus barn and was deceased . The search team found Resident #1 in a wooded area, which was a vacant lot with overgrown weeds, trees, with a small running creek that was flowing from the recent and steady rains. The report reflected, Near the edge of the creek, I observed an elderly black male wearing a white T-shirt with the name xxx on the left sleeve, an adult diaper, and gray and white slippers. He was lying on his right side facing west. His right arm and hand were beneath him, while his left arm was behind him and appeared to be grasping for a small bush that he was lying back against. His hand was clenched around the small scrub. Also observed was a white and blue print hospital gown lying on the ground in front of him. There were no bruises or abrasions on his hands and legs. There was no substantial mud on his hands or under his fingernails indicating that there were minimal attempts to get up. The absence of lacerations, scrapes and/or bruising was noted as (Resident #1) had been walking in a heavily wooded area and the fact that he was not very muddy or dirty from being in the elements. His shoes were relatively clean as well. I did note that his shoes were on the wrong feet. He exhibited no signs of injury. The temperature was in the mid 40's and moderate steady rain. There were no signs of foul play. The area was not disturbed, and it didn't appear that anyone else had been near him. There was a small, one inch laceration abrasion on his right shin. It looked like it may have only occurred hours earlier. The report also reflected an autopsy was performed and a significant contributing factor to his death was hypothermia . 3. Observation of the male secure unit on [DATE] at 7:45 AM revealed the secure unit was located in the back of the facility. At 8:30 AM, the magnetic door to the secure unit was observed to have no delay in closing. 4. Observations on [DATE] at 7:45 AM, also revealed a nurses ' station was located immediately outside the male secured unit. The nurses ' station served the male and female secure units and general population residents on Hall 300. 5. Review of the staffing schedule for [DATE] to [DATE] as confimed in plan of remoal revealed the following staff were on duty for the night shift (10:00 PM to 6:00 AM): 3LVN; 1 MA, and 7 CNAs for stations 1, station 2 and station 3. 6. Telephone interview with CNA C on [DATE] at 11:20 AM revealed he was the CNA assigned to the male secured unit and the residents on Hall 300 during 10:00 PM to 06:00 AM shift on [DATE] (Sunday) to [DATE] (Monday). He stated he was responsible for a total of 21 residents: 15 on the male secured unit and six residents on Hall 300. He stated every two hours he checked on each resident, provided incontinent care, if needed, and answered their call lights. CNA C revealed he left the male secured unit multiple times during his shift to care for the six residents he was assigned on Hall 300. He stated Resident #1, who resided on the secured unit, was exit seeking. He stated he had tried to get him to go back to bed. He stated he last saw Resident #1 around 5:00 AM. He stated that usually when he left the unit, he reported to the LVN on duty if they were at the desk. He stated LVN B was not at the desk on the morning of [DATE]. He stated when he returned to the secured unit and made his last rounds he was unable to locate Resident #1. He stated he searched all the rooms and then

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

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) notified LVN A and LVN B that he was unable to locate Resident #1. He stated he then continued to search for Resident #1. 7. Interview with LVN B on [DATE] at 07:00 AM revealed Resident #1, was exit seeking. LVN B stated they would try to engage the resident in other activities like watching TV. Interview with LVN B on [DATE] at 07:00 AM revealed he had last seen Resident #1 on the morning of [DATE] between 5:00 AM and 5:15 AM on [DATE] when he gave him medication for GERD. He reported he then left the Secure Unit to give medication on the rest of the 300 Hall. Another interview with LVN B on [DATE] at 2:50 PM reflected CNA C was routinely assigned residents on the 300 Hall. LVN B revealed that he was not at the desk from 5:15 AM until 6:00 AM on [DATE]; he was with residents on the 300 Hall. LVN B also reported he was in and out of the Secure Unit during the 10:00 PM to 6:00 AM shift. They did not have anyone to cover for their absence especially during that time from 5:00 to 6:00 AM because they were making final rounds and providing care for all of the residents. 8. Interview with LVN A on [DATE] at 06:15 AM revealed Resident #1 was exit seeking. LVN A stated they redirected the resident. Redirection depended on the resident and the behavior exhibited. The staff might offer a snack, go for a walk with the resident or engage him in another activity. Interview with LVN A on [DATE] at 06:15 AM revealed she was getting report from the night shift nurse (LVN B) at 6:00 AM on [DATE] when CNA C reported he could not find Resident #1. CNA C reported he had searched all the rooms. LVN A and LVN B also searched the rooms and did not locate the resident. ADON DD had arrived as well as the DON. A Code White was called at 6:20 AM (the facility signal for a missing resident). The entire facility and grounds were searched. When the resident was not located, the police were contacted and the family and the physician were notified. 9. Interview with ADON DD at 06:30 AM on [DATE], revealed she was the Unit Manager for the Secure Unit, and that Resident #1 had a behavior of exit seeking. She stated on the morning of [DATE], she clocked at 6:05 AM and learned Resident #1 was missing. She stated that following a search of the facility, she used her car to search the neighborhood for the next four hours. ADON DD stated that for a resident with exit seeking behavior, they redirected the resident. She stated each residents responded differently to different staff members. Redirection activities might include conversation, walking in a different direction, beverages, snacks, toileting, incontinent care or engaging the resident in an activity. 10. Interview with DON at 7:30 AM on [DATE] revealed he was in the facility at 6:00 AM on [DATE] for an Employee Breakfast when he learned Resident #1 was missing. He stated he participated in the search as well as gathering information. He stated they (the DON, the Administrator and ADON DD) were not certain how Resident #1 eloped. The Unit had two exits. One with an electeomagnetic door with a numeric keypad and a door to the patio with a very loud alarm which required a key to turn off. They believed he must have slipped out by the electromagnetic door after one of the staff and left the facility by the exit near the activity room, which only had an alarm for wander guard devices. He reported there was a slight delay in the door closing by the unit which was eliminated on [DATE] by the alarm company. He also stated that an alarm was installed on the street exit on [DATE] by the same company. DON reported that he was not aware of the staffing during the 10:00 PM to 6:00 AM shift which left secure unit residents unattended for periods of time. 11. During an interview with the Administrator on [DATE] at 10:10 AM, she revealed that on [DATE] at 07:00 AM, they (the Administrator and the DON) began an investigation and notified DADS regarding the elopement of Resident #1. They were uncertain exactly how Resident #1 eloped. She stated there were only two exits on the male secured unit: the entrance/exit doors and a door to a courtyard. She stated that when the door to the courtyard was opened, a loud alarm would activate and and the only way to shut off the alarm, was with a key. She stated the most likely course of elopement was following someone out of the unit via the electro-magnetic doors (entrance/exit doors). She stated It was surmised that Resident #1 left the facility through an exit door near the activity room, which had no alarm. She stated the door had a wander guard system, but Resident #1 did not wear a wander guard device. She stated the reason they surmised this was beacause ADON DD had reported to the DON that Resident #1 had been allowed to accompany his family to the dining room area when his family brought him food. 12. Observations on [DATE] at 8:30 AM, confirmed that upon exiting the male secured unit, that by turning right past the nurses ' station, there were 10 resident rooms on a long corridor, a dining area and an activity room and exit door. Upon opening the exit door, the door had an audible alarm which activated. 13. Observations on [DATE] at 8:40 AM, of the male secure unit, verified the only other exit door lead to a secured courtyard. Upon opening the exit door, an audible alarm activated. 14. Review of the facility's policies reflected the following: The undated policy to Prohibit the Mistreatment, Neglect and Abuse of Residents and the Misappropriation of Resident Policy noted each resident had the right to be free of neglect and all employees were trained on issues related to facility abuse prohibition policies which covered prevention, identification, and protection. The undated policy regarding Elopement Risk Assessment reflected, The facility will assess all residents for elopement potential to provide a safe and comfortable living environment. Provide Plans of Care which are: --Presented to the IDT --Updated as indicated by resident condition --Contain measures for resident safety. 15. An IJ was identified on [DATE] at 2:25 PM. The Regional Vice President of Clinical Services, Regional Vice President of Operations, Administrator, and DON were notified at that time of the IJ and a Plan of removal was requested. 16. The facility's Plan of Removal was accepted on [DATE]. The plan reflected, Facility Actions taken post event.Elopement/wandering in-service performed [DATE] through [DATE] .with all staff in the building beginning [DATE] and completed [DATE].Every door assessed on [DATE] for proper function .Additional alarms were placed at the Ambulance entrance, an entrance (next to activity room) on the front door, and the Service door. It should be noted that all of these doors had a code alert system where a (wander guard device) bracelet would set off an alarm if resident were to approach the door. In addition the door entering (by activity room) has now been secured and is no longer used (sic) an entrance door, it is now used as an emergency exit only.All residents were re-assessed.and each care plan was reviewed and updated as indicated to reflect current Risk and interventions.Sign in sheets implemented [DATE] at secured unit doors on the inside and outside. Staff members are signing upon entrance and exiting. Visitors are escorted by staff members.Door codes were changed.and are not being shared with family/visitors.Door closure mechanism (sic) was checked and adjusted on the secured unit on [DATE] by (Maintenance Director) from regular time of 6 seconds to 4 seconds to reduce the time the door takes to close automatically .Observation rounds are made several times per shift and performed by charge nurses and CNAs on duty. 17. Observation of entrance and exits to the secure unit on [DATE] between 5:30 AM and 12:00 PM, revealed that staff were signing in and out and verifying that the door closed behind them. 18. Observation of staff on the male secured unit on [DATE] at 5:30 AM revealed one CAN was present. 19. The additional information to the facility's Plan of Removal, was accepted on [DATE] and reflected, On [DATE], staffing was increased on station 3 which includes the 300 hall and the male and female secure units to two aides on each of the female and male sides and two aides on the outside halls, for each of the three shifts 7 days a week 24 hours per day. Facility staffing policy as of [DATE] is that the secure units will always have two aides per side and a dedicated nurse and will never be left unattended, previous policy did not specify number of aides except for female Alzheimer's unit. On [DATE], the facility listed an open position for an additional nurse on each of the three shifts daily for station 3 and the facility is in the process of hiring. A hospitality aide has been hired to provide additional diversional activities. 20. Observation of the male secure unit on [DATE] at 5:15 AM revealed CNA D and CNA EE in the male secure unit. LVN FF was at the nursing station for the 300 Hall. 21. Interview with LVN FF on [DATE] at 5:15 AM revealed she had two CNAs in each of the secure units (male and female) and on the 300 Hall. She reported staffing was safer for the residents and staff. LVN FF also reported they were hiring an additional nurse as well. There were 13 male residents and 15 female residents in the secure unit and 25 residents on the 300 Hall. LVN FF revealed all the locks and doors were checked at the beginning of each shift. Residents were observed at least every hour. 22. Interview with CNA D on [DATE] at 5:25 AM revealed two CNAs had been working every night lately. He stated, It was much better. CNA D stated the intervention redirection for behaviors depended on the resident. The residents were different in ways. When you work with them all the time, you learn what works or the ones where nothing works. I might get them a drink or a snack or walk with them to another part of the unit. 23. Interview with CNA EE at 5:50 AM on [DATE] revealed she had worked in secure units for [AGE] years. She reported she was contracted through a staffing agency and had been oriented to the unit and residents prior to working on the unit. She stated redirection meant changing what was going on so it changed what the resident was doing. 24. Interview with Hospitality Aide FF on [DATE] at 6:00 AM revealed she had previously worked in the Activities Department as an assistant and was now working in the secure unit to assist with providing activities to the male residents. She reported the activities she had initiated so far were exercises, puzzles, walking, going to church in the facility and sing-a-longs. She reported there was varying participation and interest from the residents. 25. Interview with LVN A on [DATE] at 6:10 AM revealed there had been two CNAs on each of the secure units on the 10:00 PM to 6:00 AM shift when she arrived for the 6:00 AM to 2:00 PM shift since [DATE]. 26. Interview with ADON DD on [DATE] at 6:50 AM revealed an increase in staffing to include two licensed nurses for the 300 Hall; one would be dedicated to the secure units. 27. Interview with the DON on [DATE] at 7:30 AM revealed an increase in staffing on the 300 Hall. Each of the three

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) areas: male secure unit, female secure unit and long term care residents, would have two CNAs on each shift and there would be a licensed nurse for the secure units. The CNAs were in place and interview for the licensed nurse was in process. Additionally, a Hospitality Aide with Activity Department experience was added to the male secure unit from 6:00 AM to 2:00 PM. 28. Interview with the Administrator at 08:00 AM on [DATE] revealed the identified staffing changes. The Administrator revealed that the corporate office was developing a policy to reflect the current staff of two CNAs on each unit for each shift as well as the licensed nurse dedicated to the secure units. 29. Staff interviewed on [DATE] between 5:10 AM and 12:00 PM, following acceptance of the plan of removal to verify education and to determine awareness of emergency procedures included: DON, ADON DD, LVN A, LVN B, CNA C, CNA D, CNA E, Hospitality Aide G, CNA F, CNA M, CNA N, LVN O, CNA P, LVN H, CNA I, CNA J, LVN K and LVN L, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, AD W, ADON X, AD Y, LVN Z, ADON AA, LVN BB, CNA CC. All revealed they had received in-service on Code White, elopement residents,, had participated in a Code White drill and taken a proficiency exam on Wednesday, Thursday and/or Friday ([DATE] through [DATE]). 30. On [DATE] at 2:45 PM, the Administrator, DON and RVP were notified the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. 31. Resident Roster, dated [DATE], provided by the Administrator reflected 13 residents on the male secure unit.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit neglect for one (Resident #1) of four residents reviewed for elopement risk. 1. The facility failed to have staff present at all times on the male secure unit to supervise and monitor Resident #1. No staff were on the unit on [DATE], when CNA C and LVN B, who were responsible for caring for residents on the secured unit, left to assist residents off the unit. Resident #1 was left unsupervised during the timeframe that he eloped. 2. The facility failed to have a care plan to address Resident #1's exit seeking behaviors with specific interventions to prevent elopement. 3. The facility failed to repair an exit door to the secure unit which had a slight delay in closing. 4. The facility failed to have all entrances/exits monitored to prevent elopements. Two exit/entrance doors did not alarm or alert staff if someone entered or exited unless the person was wearing a wander guard. Resident #1 eloped from the secure unit on [DATE] and was missing for more than seven hours. He was found deceased . Hypothermia was a contributing factor to his cause of death. An Immediate Threat (IT) was identified on [DATE]. While the IT was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate threat and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could affect the 13 residents, who resided on the male secure unit by placing them at risk for elopement resulting in injuries and/or death. Findings included: 1. Review of the facility's policies reflected the following: The undated policy to Prohibit the Mistreatment, Neglect and Abuse of Residents and the Misappropriation of Resident Policy noted each resident had the right to be free of neglect and all employees were trained on issues related to facility abuse prohibition policies which covered prevention, identification, and protection. The undated policy regarding Elopement Risk Assessment reflected, The facility will assess all residents for elopement potential to provide a safe and comfortable living environment. Provide Plans of Care which are: --Presented to the IDT --Updated as indicated by resident condition --Contain measures for resident safety. 2. Resident #1's MDS assessment, dated [DATE], reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It noted he had severe cognitive impairment with fluctuating behaviors. It noted he needed supervision with ambulation and required assistance with incontinent care. It noted The MDS assessment reflected he received insulin injections. Resident #1's Risk of Elopement/Wandering assessment, dated [DATE], identified the resident as cognitively impaired with pertinent [DIAGNOSES REDACTED]. Resident #1 was able to ambulate independently. Resident #1 wandered aimlessly without purpose. He was a new resident and the family had expressed concern that he would try to leave. The Summary of Review identified the resident as At risk for elopement/wandering as evidenced by: Resident Wandering appropriate interventions have been initiated-Secured Unit. Resident #1's Care Plan, dated [DATE], reflected he was at risk for elopement with a goal of will keep a safe and secure environment for the next 90 days. The approaches were Secured unit and provide a structured environment and daily activities. There were no updates/reviews to the care plan. The Care Plan did not include specific activities or other interventions to prevent elopement. Resident #1's Physician Orders, dated [DATE], revealed the resident required NPH/Regular insulin 10 units in the AM before breakfast and 18 units before dinner. Resident #1's nursing progress notes, dated [DATE], reflected, resident in the unit with exit seeking behavior. Resident #1's nursing progress notes, dated [DATE] at 03:45 AM reflected, resident continues to ambulate throughout secured unit. Exit seeking in (sic) all four doors. Nursing progress note on [DATE] at 12:45 PM reflected, Resident continues to exit seek. Resident attempts to follow the staff out of the exit doors becoming aggressive when redirected. Resident #1's nursing progress note, dated [DATE], reflected, Resident attempted to get out of back door. Then slipped out behind a family member. 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Resident not located. Staff and officers continue to look for resident at this time. 3. The local Police Report, initiated [DATE], reflected Resident #1 was scheduled to receive insulin at 6:30 AM and the DON reported that might be a problem if Resident #1 was not found by noon. At 1:24 PM he was located behind the bus barn and was deceased . The search team found Resident #1 in a wooded area, which was a vacant lot with overgrown weeds, trees, with a small running creek that was flowing from the recent and steady rains. The report reflected, Near the edge of the creek, I observed an elderly black male wearing a white T-shirt with the name xxx on the left sleeve, an adult diaper, and gray and white slippers. He was lying on his right side facing west. His right arm and hand were beneath him, while his left arm was behind him and appeared to be grasping for a small bush that he was lying back against. His hand was clenched around the small scrub. 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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) He stated he last saw Resident #1 around 5:00 AM. He stated that usually when he left the unit, he reported to the LVN on duty if they were at the desk. He stated LVN B was not at the desk on the morning of [DATE]. He stated when he returned to the secured unit and made his last rounds he was unable to locate Resident #1. He stated he searched all the rooms and then notified LVN A and LVN B that he was unable to locate Resident #1. He stated he then continued to search for Resident #1. 9. Interview with LVN B on [DATE] at 07:00 AM revealed Resident #1, was exit seeking. LVN B stated they would try to engage the resident in other activities like watching TV. Interview with LVN B on [DATE] at 07:00 AM revealed he had last seen Resident #1 on the morning of [DATE] between 5:00 AM and 5:15 AM on [DATE] when he gave him medication for GERD. He reported he then left the Secure Unit to give medication on the rest of the 300 Hall. Another interview with LVN B on [DATE] at 2:50 PM reflected CNA C was routinely assigned residents on the 300 Hall. LVN B revealed that he was not at the desk from 5:15 AM until 6:00 AM on [DATE]; he was with residents on the 300 Hall. LVN B also reported he was in and out of the Secure Unit during the 10:00 PM to 6:00 AM shift. They did not have anyone to cover for their absence especially during that time from 5:00 to 6:00 AM because they were making final rounds and providing care for all of the residents. 10. Interview with LVN A on [DATE] at 06:15 AM revealed Resident #1 was exit seeking. LVN A stated they redirected the resident. Redirection depended on the resident and the behavior exhibited. The staff might offer a snack, go for a walk with the resident or engage him in another activity. Interview with LVN A on [DATE] at 06:15 AM revealed she was getting report from the night shift nurse (LVN B) at 6:00 AM on [DATE] when CNA C reported he could not find Resident #1. CNA C reported he had searched all the rooms. LVN A and LVN B also searched the rooms and did not locate the resident. ADON DD had arrived as well as the DON. A Code White was called at 6:20 AM (the facility signal for a missing resident). The entire facility and grounds were searched. When the resident was not located, the police were contacted and the family and the physician were notified. 11. Interview with ADON DD at 06:30 AM on [DATE], revealed she was the Unit Manager for the Secure Unit, and that Resident #1 had a behavior of exit seeking. She stated on the morning of [DATE], she clocked at 6:05 AM and learned Resident #1 was missing. She stated that following a search of the facility, she used her car to search the neighborhood for the next four hours. ADON DD stated that for a resident with exit seeking behavior, they redirected the resident. She stated each residents responded differently to different staff members. Redirection activities might include conversation, walking in a different direction, beverages, snacks, toileting, incontinent care or engaging the resident in an activity. 12. Interview with DON at 7:30 AM on [DATE] revealed he was in the facility at 6:00 AM on [DATE] for an Employee Breakfast when he learned Resident #1 was missing. He stated he participated in the search as well as gathering information. He stated they (the DON, the Administrator and ADON DD) were not certain how Resident #1 eloped. The Unit had two exits. One with an electeomagnetic door with a numeric keypad and a door to the patio with a very loud alarm which required a key to turn off. They believed he must have slipped out by the electromagnetic door after one of the staff and left the facility by the exit near the activity room, which only had an alarm for wander guard devices. He reported there was a slight delay in the door closing by the unit which was eliminated on [DATE] by the alarm company. He also stated that an alarm was installed on the street exit on [DATE] by the same company. DON reported that he was not aware of the staffing during the 10:00 PM to 6:00 AM shift which left secure unit residents unattended for periods of time. 13. During an interview with the Administrator on [DATE] at 10:10 AM, she revealed that on [DATE] at 07:00 AM, they (the Administrator and the DON) began an investigation and notified DADS regarding the elopement of Resident #1. They were uncertain exactly how Resident #1 eloped. She stated there were only two exits on the male secured unit: the entrance/exit doors and a door to a courtyard. She stated that when the door to the courtyard was opened, a loud alarm would activate and and the only way to shut off the alarm, was with a key. She stated the most likely course of elopement was following someone out of the unit via the electro-magnetic doors (entrance/exit doors). She stated It was surmised that Resident #1 left the facility through an exit door near the activity room, which had no alarm. She stated the door had a wander guard system, but Resident #1 did not wear a wander guard device. She stated the reason they surmised this was beacause ADON DD had reported to the DON that Resident #1 had been allowed to accompany his family to the dining room area when his family brought him food. 14. Observations on [DATE] at 8:30 AM, confirmed that upon exiting the male secured unit, that by turning right past the nurses ' station, there were 10 resident rooms on a long corridor, a dining area and an activity room and exit door. Upon opening the exit door, the door had an audible alarm which activated. 15. Observations on [DATE] at 8:40 AM, of the male secure unit, verified the only other exit door lead to a secured courtyard. Upon opening the exit door, an audible alarm activated. 16. An IT was identified on [DATE] at 2:25 PM. The Regional Vice President of Clinical Services, Regional Vice President of Operations, Administrator, and DON were notified at that time of the IJ and a Plan of removal was requested. 17. The facility's Plan of Removal was accepted on [DATE]. The plan reflected, Facility Actions taken post event.Elopement/wandering in-service performed [DATE] through [DATE] .with all staff in the building beginning [DATE] and completed [DATE].Every door assessed on [DATE] for proper function .Additional alarms were placed at the Ambulance entrance, an entrance (next to activity room) on the front door, and the Service door. It should be noted that all of these doors had a code alert system where a (wander guard device) bracelet would set off an alarm if resident were to approach the door. In addition the door entering (by activity room) has now been secured and is no longer used (sic) an entrance door, it is now used as an emergency exit only.All residents were re-assessed.and each care plan was reviewed and updated as indicated to reflect current Risk and interventions.Sign in sheets implemented [DATE] at secured unit doors on the inside and outside. Staff members are signing upon entrance and exiting. Visitors are escorted by staff members.Door codes were changed.and are not being shared with family/visitors.Door closure mechanism (sic) was checked and adjusted on the secured unit on [DATE] by (Maintenance Director) from regular time of 6 seconds to 4 seconds to reduce the time the door takes to close automatically .Observation rounds are made several times per shift and performed by charge nurses and CNAs on duty. 18. Observation of entrance and exits to the secure unit on [DATE] between 5:30 AM and 12:00 PM, revealed that staff were signing in and out and verifying that the door closed behind them. 19. Observation of staff on the male secured unit on [DATE] at 5:30 AM revealed one CAN was present. 20. The additional information to the facility's Plan of Removal, was accepted on [DATE] and reflected, On [DATE], staffing was increased on station 3 which includes the 300 hall and the male and female secure units to two aides on each of the female and male sides and two aides on the outside halls, for each of the three shifts 7 days a week 24 hours per day. Facility staffing policy as of [DATE] is that the secure units will always have two aides per side and a dedicated nurse and will never be left unattended, previous policy did not specify number of aides except for female Alzheimer's unit. On [DATE], the facility listed an open position for an additional nurse on each of the three shifts daily for station 3 and the facility is in the process of hiring. A hospitality aide has been hired to provide additional diversional activities. 21. Observation of the male secure unit on [DATE] at 5:15 AM revealed CNA D and CNA EE in the male secure unit. LVN FF was at the nursing station for the 300 Hall. 22. Interview with LVN FF on [DATE] at 5:15 AM revealed she had two CNAs in each of the secure units (male and female) and on the 300 Hall. She reported staffing was safer for the residents and staff. LVN FF also reported they were hiring an additional nurse as well. There were 13 male residents and 15 female residents in the secure unit and 25 residents on the 300 Hall. LVN FF revealed all the locks and doors were checked at the beginning of each shift. Residents were observed at least every hour. 23. Interview with CNA D on [DATE] at 5:25 AM revealed two CNAs had been working every night lately. He stated, It was much better. CNA D stated the intervention redirection for behaviors depended on the resident. The residents were different in ways. When you work with them all the time, you learn what works or the ones where nothing works. I might get them a drink or a snack or walk with them to another part of the unit. 24. Interview with CNA EE at 5:50 AM on [DATE] revealed she had worked in secure units for [AGE] years. She reported she was contracted through a staffing agency and had been oriented to the unit and residents prior to working on the unit. She stated redirection meant changing what was going on so it changed what the resident was doing. 25. Interview with Hospitality Aide FF on [DATE] at 6:00 AM revealed she had previously worked in the Activities Department as an assistant and was now working in the secure unit to assist with providing activities to the male residents. She reported the activities she had initiated so far were exercises, puzzles, walking, going to church in the facility and sing-a-longs. She reported there was varying participation and interest from the residents. 26. Interview with LVN A on [DATE] at 6:10 AM revealed there had been two CNAs on each of the secure units on the 10:00 PM to 6:00 AM shift when she arrived for the 6:00 AM to 2:00 PM shift since [DATE]. 27. Interview with ADON DD on [DATE] at 6:50 AM revealed an increase in staffing to include two licensed nurses for the 300 Hall; one would be dedicated to the secure units. The DON was interviewing applicants for that position. There were also two CNAs for the male secure unit, the female secure unit and the long term residents for each of the shifts and a Hospitality aide for the 6:00 to 2:00 PM shift. 28. Interview with the DON on [DATE] at 7:30 AM revealed an increase in staffing on the 300 Hall. Each of the three areas: male secure unit, female secure unit and long term care residents, would have two CNAs on each shift and there would be a

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	675402	A. BUILDING _____ B. WING _____	03/26/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCKWALL NURSING CARE CENTER	206 STORRS ROCKWALL, TX 75087

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) licensed nurse for the secure units. The CNAs were in place and interview for the licensed nurse was in process. Additionally, a Hospitality Aide with Activity Department experience was added to the male secure unit from 6:00 AM to 2:00 PM. 29. Interview with the Administrator at 08:00 AM on [DATE] revealed the identified staffing changes. The Administrator revealed that the corporate office was developing a policy to reflect the current staff of two CNAs on each unit for each shift as well as the licensed nurse dedicated to the secure units. 30. Staff interviewed on [DATE] between 5:10 AM and 12:00 PM, following acceptance of the plan of removal to verify education and to determine awareness of emergency procedures included: DON, ADON DD, LVN A, LVN B, CNA C, CNA D, CNA E, Hospitality Aide G, CNA F, CNA M, CNA N, LVN O, CNA P, LVN H, CNA I, CNA J, LVN K and LVN L, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, AD W, ADON X, AD Y, LVN Z, ADON AA, LVN BB, CNA CC. All revealed they had received in-service on Code White, elopement residents,, had participated in a Code White drill and taken a proficiency exam on Wednesday, Thursday and/or Friday ([DATE] through [DATE]). 31. On [DATE] at 2:45 PM, the Administrator, DON and RVP were notified the IT was removed. While the IT was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate threat and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. 32. Resident Roster, dated [DATE], provided by the Administrator reflected 13 residents on the male secure unit.
F 0279 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to develop a care plan that described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #1) of four residents reviewed for neglect. The facility failed to have an individualized care plan to address Resident #1's exit seeking behaviors. Resident #1, who was a high risk for elopement, had a history of [REDACTED]. The care plan did not include what activities or distractions to provide Resident #1 when he was exit seeking. Resident #1 eloped from the secure unit on [DATE] and was missing for more than seven hours. He was found deceased . The cause of death was arterial sclerotic and hypertensive cardiovascular disease in conjunction with Alzheimer's dementia and diabetes and a contributing factor was hypothermia. An Immediate Threat (IT) was identified on [DATE]. While the IT was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate threat and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could affect the 13 residents, who resided on the male secure unit by placing them at risk for elopement resulting in injuries and/or death. Findings included: 1. Resident #1's MDS assessment, dated [DATE], reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It noted he had severe cognitive impairment with fluctuating behaviors. It noted he needed supervision with ambulation and required assistance with incontinent care. It noted The MDS assessment reflected he received insulin injections. Resident #1's Risk of Elopement/Wandering assessment, dated [DATE], identified the resident as cognitively impaired with pertinent [DIAGNOSES REDACTED]. Resident #1 was able to ambulate independently. Resident #1 wandered aimlessly without purpose. He was a new resident and the family had expressed concern that he would try to leave. The Summary of Review identified the resident as At risk for elopement/wandering as evidenced by: Resident Wandering appropriate interventions have been initiated-Secured Unit. Resident #1's Care Plan, dated [DATE], reflected he was at risk for elopement with a goal of will keep a safe and secure environment for the next 90 days. The approaches were Secured unit and provide a structured environment and daily activities. There were no updates/reviews to the care plan. The Care Plan did not include specific activities or other interventions to prevent elopement. Resident #1's Physician Orders, dated [DATE], revealed the resident required NPH/Regular insulin 10 units in the AM before breakfast and 18 units before dinner. Resident #1's nursing progress notes, dated [DATE], reflected, resident in the unit with exit seeking behavior. Resident #1's nursing progress notes, dated [DATE] at 03:45 AM reflected, resident continues to ambulate throughout secured unit. Exit seeking in (sic) all four doors. Nursing progress note on [DATE] at 12:45 PM reflected, Resident continues to exit seek. Resident attempts to follow the staff out of the exit doors becoming aggressive when redirected. Resident #1's nursing progress note, dated [DATE], reflected, Resident attempted to get out of back door. Then slipped out behind a family member. Resident #1's nursing progress note, dated [DATE] at 9:30 PM, reflected Resident sometimes exhibits exit seeking behavior but redirected as needed. Resident #1's nursing progress notes, dated [DATE] through [DATE], did not reflect exit seeking behaviors. The notes reflected multiple medication changes for other behaviors. Resident #1's nursing progress note, dated [DATE] (Monday) and completed by LVN A reflected at 06:00 AM, CNA told this nurse and ,[DATE] nurse that he could not locate the resident at this time. This nurse and staff went through every room on Secure Unit then this nurse paged a ' Code White ' at this time all staff began searching all rooms in facility and some staff walked the grounds of facility without finding the resident. At 06:10 AM, 911, MD and RP were phoned by this nurse. Search continues with all staff involved inside facility and outside facility. 0705 Police arrived on Sta (Station) 3 where this nurse checks each room on Sta 3 with officers. Resident not located. Staff and officers continue to look for resident at this time. 2. The local Police Report, initiated [DATE], reflected Resident #1 was scheduled to receive insulin at 6:30 AM and the DON reported that might be a problem if Resident #1 was not found by noon. At 1:24 PM he was located behind the bus barn and was deceased . The search team found Resident #1 in a wooded area, which was a vacant lot with overgrown weeds, trees, with a small running creek that was flowing from the recent and steady rains. The report reflected, Near the edge of the creek, I observed an elderly black male wearing a white T-shirt with the name xxx on the left sleeve, an adult diaper, and gray and white slippers. He was lying on his right side facing west. His right arm and hand were beneath him, while his left arm was behind him and appeared to be grasping for a small bush that he was lying back against. His hand was clenched around the small scrub. Also observed was a white and blue print hospital gown lying on the ground in front of him. There were no bruises or abrasions on his hands and legs. There was no substantial mud on his hands or under his fingernails indicating that there were minimal attempts to get up. The absence of lacerations, scrapes and/or bruising was noted as (Resident #1) had been walking in a heavily wooded area and the fact that he was not very muddy or dirty from being in the elements. His shoes were relatively clean as well. I did note that his shoes were on the wrong feet. He exhibited no signs of injury. The temperature was in the mid 40's and moderate steady rain. There were no signs of foul play. The area was not disturbed, and it didn't appear that anyone else had been near him. There was a small, one inch laceration abrasion on his right shin. It looked like it may have only occurred hours earlier. The report also reflected an autopsy was performed and a significant contributing factor to his death was hypothermia . 3. Observation of the male secure unit on [DATE] at 7:45 AM revealed the secure unit was located in the back of the facility. At 8:30 AM, the magnetic door to the secure unit was observed to have no delay in closing. 4. Observations on [DATE] at 7:45 AM, also revealed a nurses ' station was located immediately outside the male secured unit. The nurses ' station served the male and female secure units and general population residents on Hall 300. 5. Review of the staffing schedule for [DATE] to [DATE] as confirmed in plan of removal revealed the following staff were on duty for the night shift (10:00 PM to 6:00 AM): 3 LVN; 1 MA, and 7 CNAs for stations 1, station 2 and station 3. 6. Telephone interview with CNA C on [DATE] at 11:20 AM revealed he was the CNA assigned to the male secured unit and the residents on Hall 300 during 10:00 PM to 06:00 AM shift on [DATE] (Sunday) to [DATE] (Monday). He stated he was responsible for a total of 21 residents: 15 on the male secured unit and six residents on Hall 300. He stated every two hours he checked on each resident, provided incontinent care, if needed, and answered their call lights. CNA C revealed he left the male secured unit multiple times during his shift to care for the six residents he was assigned on Hall 300. He stated Resident #1, who resided on the secured unit, was exit seeking. He stated he had tried to get him to go back to bed. He stated he last saw Resident #1 around 5:00 AM. He stated that usually when he left the unit, he reported to the LVN on duty if they were at the desk. He stated LVN B was not at the desk on the morning of [DATE]. He stated when he returned to the secured unit and made his last rounds he was unable to locate Resident #1. He stated he searched all the rooms and then notified LVN A and LVN B that he was unable to locate Resident #1. He stated he then continued to search for Resident #1. 7. Interview with LVN B on [DATE] at 07:00 AM revealed Resident #1, was exit seeking. LVN B stated they would try to engage the resident in other activities like watching TV. Interview with LVN B on [DATE] at 07:00 AM revealed he had last seen Resident #1 on the morning of [DATE] between 5:00 AM and 5:15 AM on [DATE] when he gave him medication for GERD. He reported he then left the Secure Unit to give medication on the rest of the 300 Hall. Another interview with LVN B on [DATE] at 2:50 PM reflected CNA C was routinely assigned residents on the 300 Hall. LVN B revealed that he was not at the

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F 0279 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) desk from 5:15 AM until 6:00 AM on [DATE]; he was with residents on the 300 Hall. LVN B also reported he was in and out of the Secure Unit during the 10:00 PM to 6:00 AM shift. They did not have anyone to cover for their absence especially during that time from 5:00 to 6:00 AM because they were making final rounds and providing care for all of the residents. 8. Interview with LVN A on [DATE] at 06:15 AM revealed Resident #1 was exit seeking. LVN A stated they redirected the resident. Redirection depended on the resident and the behavior exhibited. The staff might offer a snack, go for a walk with the resident or engage him in another activity. Interview with LVN A on [DATE] at 06:15 AM revealed she was getting report from the night shift nurse (LVN B) at 6:00 AM on [DATE] when CNA C reported he could not find Resident #1. CNA C reported he had searched all the rooms. LVN A and LVN B also searched the rooms and did not locate the resident. ADON DD had arrived as well as the DON. A Code White was called at 6:20 AM (the facility signal for a missing resident). The entire facility and grounds were searched. When the resident was not located, the police were contacted and the family and the physician were notified. 9. Interview with ADON DD at 06:30 AM on [DATE], revealed she was the Unit Manager for the Secure Unit, and that Resident #1 had a behavior of exit seeking. She stated on the morning of [DATE], she clocked at 6:05 AM and learned Resident #1 was missing. She stated that following a search of the facility, she used her car to search the neighborhood for the next four hours. ADON DD stated that for a resident with exit seeking behavior, they redirected the resident. She stated each residents responded differently to different staff members. Redirection activities might include conversation, walking in a different direction, beverages, snacks, toileting, incontinent care or engaging the resident in an activity. 10. Interview with DON at 7:30 AM on [DATE] revealed he was in the facility at 6:00 AM on [DATE] for an Employee Breakfast when he learned Resident #1 was missing. He stated he participated in the search as well as gathering information. He stated they (the DON, the Administrator and ADON DD) were not certain how Resident #1 eloped. The Unit had two exits. One with an electeomagnetic door with a numeric keypad and a door to the patio with a very loud alarm which required a key to turn off. They believed he must have slipped out by the electromagnetic door after one of the staff and left the facility by the exit near the activity room, which only had an alarm for wander guard devices. He reported there was a slight delay in the door closing by the unit which was eliminated on [DATE] by the alarm company. He also stated that an alarm was installed on the street exit on [DATE] by the same company. DON reported that he was not aware of the staffing during the 10:00 PM to 6:00 AM shift which left secure unit residents unattended for periods of time. 11. During an interview with the Administrator on [DATE] at 10:10 AM, she revealed that on [DATE] at 07:00 AM, they (the Administrator and the DON) began an investigation and notified DADS regarding the elopement of Resident #1. They were uncertain exactly how Resident #1 eloped. She stated there were only two exits on the male secured unit: the entrance/exit doors and a door to a courtyard. She stated that when the door to the courtyard was opened, a loud alarm would activate and and the only way to shut off the alarm, was with a key. She stated the most likely course of elopement was following someone out of the unit via the electro-magnetic doors (entrance/exit doors). 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Review of the facility's policies reflected the following: The undated policy to Prohibit the Mistreatment, Neglect and Abuse of Residents and the Misappropriation of Resident Policy noted each resident had the right to be free of neglect and all employees were trained on issues related to facility abuse prohibition policies which covered prevention, identification, and protection. The undated policy regarding Elopement Risk Assessment reflected, The facility will assess all residents for elopement potential to provide a safe and comfortable living environment. Provide Plans of Care which are: --Presented to the IDT --Updated as indicated by resident condition --Contain measures for resident safety. 15. An IJ was identified on [DATE] at 2:25 PM. The Regional Vice President of Clinical Services, Regional Vice President of Operations, Administrator, and DON were notified at that time of the IJ and a Plan of removal was requested. 16. The facility's Plan of Removal was accepted on [DATE]. The plan reflected, Facility Actions taken post event.Elopement/wandering in-service performed [DATE] through [DATE] .with all staff in the building beginning [DATE] and completed [DATE].Every door assessed on [DATE] for proper function .Additional alarms were placed at the Ambulance entrance, an entrance (next to activity room) on the front door, and the Service door. It should be noted that all of these doors had a code alert system where a (wander guard device) bracelet would set off an alarm if resident were to approach the door. In addition the door entering (by activity room) has now been secured and is no longer used (sic) an entrance door, it is now used as an emergency exit only.All residents were re-assessed.and each care plan was reviewed and updated as indicated to reflect current Risk and interventions.Sign in sheets implemented [DATE] at secured unit doors on the inside and outside. 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LVN FF was at the nursing station for the 300 Hall. 21. Interview with LVN FF on [DATE] at 5:15 AM revealed she had two CNAs in each of the secure units (male and female) and on the 300 Hall. She reported staffing was safer for the residents and staff. LVN FF also reported they were hiring an additional nurse as well. There were 13 male residents and 15 female residents in the secure unit and 25 residents on the 300 Hall. LVN FF revealed all the locks and doors were checked at the beginning of each shift. Residents were observed at least every hour. 22. Interview with CNA D on [DATE] at 5:25 AM revealed two CNAs had been working every night lately. He stated, It was much better. CNA D stated the intervention redirection for behaviors depended on the resident. The residents were different in ways. When you work with them all the time, you learn what works or the ones where nothing works. I might get them a drink or a snack or walk with them to another part of the unit. 23. Interview with CNA EE at 5:50 AM on [DATE] revealed she had worked in secure units for [AGE] years. She reported she was contracted through a staffing agency and had been oriented to the unit and residents prior to working on the unit. She stated redirection meant changing what was going on so it changed what the resident was doing. 24. Interview with Hospitality Aide FF on [DATE] at 6:00 AM revealed she had previously worked in the Activities Department as an assistant and was now working in the secure unit to assist with providing activities to the male residents. She reported the activities she had initiated so far were exercises, puzzles, walking, going to church in the facility and sing-a-longs. She reported there was varying participation and interest from the residents. 25. Interview with LVN A on [DATE] at 6:10 AM revealed there had been two CNAs on each of the secure units on the 10:00 PM to 6:00 AM shift when she arrived for the 6:00 AM to 2:00 PM shift since [DATE]. 26. Interview with ADON DD on [DATE] at 6:50 AM revealed an increase in staffing to include two licensed nurses for the 300 Hall; one would be dedicated to the secure units. 27. Interview with the DON on [DATE] at 7:30 AM revealed an increase in staffing on the 300 Hall. Each of the three areas: male secure unit, female secure unit and long term care residents, would have two CNAs on each shift and there would be a licensed nurse for the secure units. The CNAs were in place and interview for the licensed nurse was in process. Additionally, a Hospitality Aide with Activity Department experience was added to the male secure unit from 6:00 AM to 2:00 PM. 28. Interview with the Administrator at 08:00 AM on [DATE] revealed the identified staffing changes. The Administrator revealed that the corporate office was developing a policy to reflect the current staff of two CNAs on each unit for each shift as well as the licensed nurse dedicated to the secure units. 29. Staff interviewed on [DATE] between 5:10 AM and

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F 0279 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) 12:00 PM, following acceptance of the plan of removal to verify education and to determine awareness of emergency procedures included: DON, ADON DD, LVN A, LVN B, CNA C, CNA D, CNA E, Hospitality Aide G, CNA F, CNA M, CNA N, LVN O, CNA P, LVN H, CNA I, CNA J, LVN K and LVN L, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, AD W, ADON X, AD Y, LVN Z, ADON AA, LVN BB, CNA CC. All revealed they had received in-service on Code White, elopement residents,, had participated in a Code White drill and taken a proficiency exam on Wednesday, Thursday and/or Friday ([DATE] through [DATE]). 30. On [DATE] at 2:45 PM, the Administrator, DON and RVP were notified the IT was removed. While the IT was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate threat and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. 31. Resident Roster, dated [DATE], provided by the Administrator reflected 13 residents on the male secure unit.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of four residents reviewed for accidents and supervision. 1. The facility failed to have staff present at all times on the male secure unit to supervise and monitor Resident #1. No staff were on the unit on [DATE], when CNA C and LVN B, who were responsible for caring for residents on the secured unit, left to assist residents off the unit. Resident #1 was left unsupervised during the timeframe that he eloped. 2. The facility failed to have a care plan to address Resident #1's exit seeking behaviors with specific interventions to prevent elopement. 3. The facility failed to repair an exit door to the secure unit which had a slight delay in closing. 4. The facility failed to have all entrances/exits monitored to prevent elopements. Two exit/entrance doors did not alarm or alert staff if someone entered or exited unless the person was wearing a wander guard. Resident #1 eloped from the secure unit on [DATE] and was missing for more than seven hours. He was found deceased . Hypothermia was a contributing factor to his cause of death. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could affect the 13 residents, who resided on the male secure unit by placing them at risk for elopement resulting in injuries and/or death. Findings included: 1. Resident #1's MDS assessment, dated [DATE], reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It noted he had severe cognitive impairment with fluctuating behaviors. It noted he needed supervision with ambulation and required assistance with incontinent care. It noted The MDS assessment reflected he received insulin injections. Resident #1's Risk of Elopement/Wandering assessment, dated [DATE], identified the resident as cognitively impaired with pertinent [DIAGNOSES REDACTED]. Resident #1 was able to ambulate independently. Resident #1 wandered aimlessly without purpose. He was a new resident and the family had expressed concern that he would try to leave. The Summary of Review identified the resident as At risk for elopement/wandering as evidenced by: Resident Wandering appropriate interventions have been initiated-Secured Unit. Resident #1's Care Plan, dated [DATE], reflected he was at risk for elopement with a goal of will keep a safe and secure environment for the next 90 days. The approaches were Secured unit and provide a structured environment and daily activities. There were no updates/reviews to the care plan. The Care Plan did not include specific activities or other interventions to prevent elopement. Resident #1's Physician Orders, dated [DATE], revealed the resident required NPH/Regular insulin 10 units in the AM before breakfast and 18 units before dinner. Resident #1's nursing progress notes, dated [DATE], reflected, resident in the unit with exit seeking behavior. Resident #1's nursing progress notes, dated [DATE] at 03:45 AM reflected, resident continues to ambulate throughout secured unit. Exit seeking in (sic) all four doors. Nursing progress note on [DATE] at 12:45 PM reflected, Resident continues to exit seek. Resident attempts to follow the staff out of the exit doors becoming aggressive when redirected. Resident #1's nursing progress note, dated [DATE], reflected, Resident attempted to get out of back door. Then slipped out behind a family member. Resident #1's nursing progress note, dated [DATE] at 9:30 PM, reflected Resident sometimes exhibits exit seeking behavior but redirected as needed. Resident #1's nursing progress notes, dated [DATE] through [DATE], did not reflect exit seeking behaviors. The notes reflected multiple medication changes for other behaviors. Resident #1's nursing progress note, dated [DATE] (Monday) and completed by LVN A reflected at 06:00 AM, CNA told this nurse and ,[DATE] nurse that he could not locate the resident at this time. This nurse and staff went through every room on Secure Unit then this nurse paged a ' Code White ' at this time all staff began searching all rooms in facility and some staff walked the grounds of facility without finding the resident. At 06:10 AM, 911, MD and RP were phoned by this nurse. Search continues with all staff involved inside facility and outside facility. 0705 Police arrived on Sta (Station) 3 where this nurse checks each room on Sta 3 with officers. Resident not located. Staff and officers continue to look for resident at this time. 2. The local Police Report, initiated [DATE], reflected Resident #1 was scheduled to receive insulin at 6:30 AM and the DON reported that might be a problem if Resident #1 was not found by noon. At 1:24 PM he was located behind the bus barn and was deceased . The search team found Resident #1 in a wooded area, which was a vacant lot with overgrown weeds, trees, with a small running creek that was flowing from the recent and steady rains. The report reflected, Near the edge of the creek, I observed an elderly black male wearing a white T-shirt with the name xxx on the left sleeve, an adult diaper, and gray and white slippers. He was lying on his right side facing west. His right arm and hand were beneath him, while his left arm was behind him and appeared to be grasping for a small bush that he was lying back against. His hand was clenched around the small scrub. Also observed was a white and blue print hospital gown lying on the ground in front of him. There were no bruises or abrasions on his hands and legs. There was no substantial mud on his hands or under his fingernails indicating that there were minimal attempts to get up. The absence of lacerations, scrapes and/or bruising was noted as (Resident #1) had been walking in a heavily wooded area and the fact that he was not very muddy or dirty from being in the elements. His shoes were relatively clean as well. I did note that his shoes were on the wrong feet. He exhibited no signs of injury. The temperature was in the mid 40's and moderate steady rain. There were no signs of foul play. The area was not disturbed, and it didn't appear that anyone else had been near him. There was a small, one inch laceration abrasion on his right shin. It looked like it may have only occurred hours earlier. The report also reflected an autopsy was performed and a significant contributing factor to his death was hypothermia . 3. Observation of the male secure unit on [DATE] at 7:45 AM revealed the secure unit was located in the back of the facility. At 8:30 AM, the magnetic door to the secure unit was observed to have no delay in closing. 4. Observations on [DATE] at 7:45 AM, also revealed a nurses ' station was located immediately outside the male secured unit. The nurses ' station served the male and female secure units and general population residents on Hall 300. 5. Review of the staffing schedule for [DATE] to [DATE] as confimed in plan of remoal revealed the following staff were on duty for the night shift (10:00 PM to 6:00 AM): 3 LVN, 1 MA, and 7 CNAs for stations 1, station 2 and station 3. 6. Telephone interview with CNA C on [DATE] at 11:20 AM revealed he was the CNA assigned to the male secured unit and the residents on Hall 300 during 10:00 PM to 06:00 AM shift on [DATE] (Sunday) to [DATE] (Monday). He stated he was responsible for a total of 21 residents: 15 on the male secured unit and six residents on Hall 300. He stated every two hours he checked on each resident, provided incontinent care, if needed, and answered their call lights. CNA C revealed he left the male secured unit multiple times during his shift to care for the six residents he was assigned on Hall 300. He stated Resident #1, who resided on the secured unit, was exit seeking. He stated he had tried to get him to go back to bed. He stated he last saw Resident #1 around 5:00 AM. He stated that usually when he left the unit, he reported to the LVN on duty if they were at the desk. He stated LVN B was not at the desk on the morning of [DATE]. He stated when he returned to the secured unit and made his last rounds he was unable to locate Resident #1. He stated he searched all the rooms and then notified LVN A and LVN B that he was unable to locate Resident #1. He stated he then continued to search for Resident #1. 7. Interview with LVN B on [DATE] at 07:00 AM revealed Resident #1, was exit seeking. LVN B stated they would try to engage the resident in other activities like watching TV. Interview with LVN B on [DATE] at 07:00 AM revealed he had last seen Resident #1 on the morning of [DATE] between 5:00 AM and 5:15 AM on [DATE] when he gave him medication for GERD. He reported he then left the Secure Unit to give medication on the rest of the 300 Hall. Another interview with LVN B on [DATE] at 2:50 PM reflected CNA C was routinely assigned residents on the 300 Hall. LVN B revealed that he was not at the desk from 5:15 AM until 6:00 AM on [DATE]; he was with residents on the 300 Hall. LVN B also reported he was in and out of the Secure Unit during the 10:00 PM to 6:00 AM shift. They did not have anyone to cover for their absence especially during

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) that time from 5:00 to 6:00 AM because they were making final rounds and providing care for all of the residents. 8. Interview with LVN A on [DATE] at 06:15 AM revealed Resident #1 was exit seeking. LVN A stated they redirected the resident. Redirection depended on the resident and the behavior exhibited. The staff might offer a snack, go for a walk with the resident or engage him in another activity. Interview with LVN A on [DATE] at 06:15 AM revealed she was getting report from the night shift nurse (LVN B) at 6:00 AM on [DATE] when CNA C reported he could not find Resident #1. CNA C reported he had searched all the rooms. LVN A and LVN B also searched the rooms and did not locate the resident. ADON DD had arrived as well as the DON. A Code White was called at 6:20 AM (the facility signal for a missing resident). The entire facility and grounds were searched. When the resident was not located, the police were contacted and the family and the physician were notified. 9. Interview with ADON DD at 06:30 AM on [DATE], revealed she was the Unit Manager for the Secure Unit, and that Resident #1 had a behavior of exit seeking. She stated on the morning of [DATE], she clocked at 6:05 AM and learned Resident #1 was missing. She stated that following a search of the facility, she used her car to search the neighborhood for the next four hours. ADON DD stated that for a resident with exit seeking behavior, they redirected the resident. She stated each residents responded differently to different staff members. Redirection activities might include conversation, walking in a different direction, beverages, snacks, toileting, incontinent care or engaging the resident in an activity. 10. Interview with DON at 7:30 AM on [DATE] revealed he was in the facility at 6:00 AM on [DATE] for an Employee Breakfast when he learned Resident #1 was missing. He stated he participated in the search as well as gathering information. He stated they (the DON, the Administrator and ADON DD) were not certain how Resident #1 eloped. The Unit had two exits. One with an electeomagnetic door with a numeric keypad and a door to the patio with a very loud alarm which required a key to turn off. They believed he must have slipped out by the electromagnetic door after one of the staff and left the facility by the exit near the activity room, which only had an alarm for wander guard devices. He reported there was a slight delay in the door closing by the unit which was eliminated on [DATE] by the alarm company. He also stated that an alarm was installed on the street exit on [DATE] by the same company. DON reported that he was not aware of the staffing during the 10:00 PM to 6:00 AM shift which left secure unit residents unattended for periods of time. 11. During an interview with the Administrator on [DATE] at 10:10 AM, she revealed that on [DATE] at 07:00 AM, they (the Administrator and the DON) began an investigation and notified DADS regarding the elopement of Resident #1. They were uncertain exactly how Resident #1 eloped. She stated there were only two exits on the male secured unit: the entrance/exit doors and a door to a courtyard. She stated that when the door to the courtyard was opened, a loud alarm would activate and and the only way to shut off the alarm, was with a key. She stated the most likely course of elopement was following someone out of the unit via the electro-magnetic doors (entrance/exit doors). She stated It was surmised that Resident #1 left the facility through an exit door near the activity room, which had no alarm. She stated the door had a wander guard system, but Resident #1 did not wear a wander guard device. She stated the reason they surmised this was beacause ADON DD had reported to the DON that Resident #1 had been allowed to accompany his family to the dining room area when his family brought him food. 12. Observations on [DATE] at 8:30 AM, confirmed that upon exiting the male secured unit, that by turning right past the nurses ' station, there were 10 resident rooms on a long corridor, a dining area and an activity room and exit door. Upon opening the exit door, the door had an audible alarm which activated. 13. Observations on [DATE] at 8:40 AM, of the male secure unit, verified the only other exit door lead to a secured courtyard. Upon opening the exit door, an audible alarm activated. 14. Review of the facility's policies reflected the following: The undated policy to Prohibit the Mistreatment, Neglect and Abuse of Residents and the Misappropriation of Resident Policy noted each resident had the right to be free of neglect and all employees were trained on issues related to facility abuse prohibition policies which covered prevention, identification, and protection. The undated policy regarding Elopement Risk Assessment reflected, The facility will assess all residents for elopement potential to provide a safe and comfortable living environment. Provide Plans of Care which are: --Presented to the IDT --Updated as indicated by resident condition --Contain measures for resident safety. 15. An IJ was identified on [DATE] at 2:25 PM. The Regional Vice President of Clinical Services, Regional Vice President of Operations, Administrator, and DON were notified at that time of the IJ and a Plan of removal was requested. 16. The facility's Plan of Removal was accepted on [DATE]. The plan reflected, Facility Actions taken post event.Elopement/wandering in-service performed [DATE] through [DATE] .with all staff in the building beginning [DATE] and completed [DATE].Every door assessed on [DATE] for proper function .Additional alarms were placed at the Ambulance entrance, an entrance (next to activity room) on the front door, and the Service door. It should be noted that all of these doors had a code alert system where a (wander guard device) bracelet would set off an alarm if resident were to approach the door. In addition the door entering (by activity room) has now been secured and is no longer used (sic) an entrance door, it is now used as an emergency exit only.All residents were re-assessed.and each care plan was reviewed and updated as indicated to reflect current Risk and interventions.Sign in sheets implemented [DATE] at secured unit doors on the inside and outside. Staff members are signing upon entrance and exiting. Visitors are escorted by staff members.Door codes were changed.and are not being shared with family/visitors.Door closure mechanism (sic) was checked and adjusted on the secured unit on [DATE] by (Maintenance Director) from regular time of 6 seconds to 4 seconds to reduce the time the door takes to close automatically .Observation rounds are made several times per shift and performed by charge nurses and CNAs on duty. 17. Observation of entrance and exits to the secure unit on [DATE] between 5:30 AM and 12:00 PM, revealed that staff were signing in and out and verifying that the door closed behind them. 18. Observation of staff on the male secured unit on [DATE] at 5:30 AM revealed one CAN was present. 19. The additional information to the facility's Plan of Removal, was accepted on [DATE] and reflected, On [DATE], staffing was increased on station 3 which includes the 300 hall and the male and female secure units to two aides on each of the female and male sides and two aides on the outside halls, for each of the three shifts 7 days a week 24 hours per day. Facility staffing policy as of [DATE] is that the secure units will always have two aides per side and a dedicated nurse and will never be left unattended, previous policy did not specify number of aides except for female Alzheimer's unit. On [DATE], the facility listed an open position for an additional nurse on each of the three shifts daily for station 3 and the facility is in the process of hiring. A hospitality aide has been hired to provide additional diversional activities. 20. Observation of the male secure unit on [DATE] at 5:15 AM revealed CNA D and CNA EE in the male secure unit. LVN FF was at the nursing station for the 300 Hall. 21. Interview with LVN FF on [DATE] at 5:15 AM revealed she had two CNAs in each of the secure units (male and female) and on the 300 Hall. She reported staffing was safer for the residents and staff. LVN FF also reported they were hiring an additional nurse as well. There were 13 male residents and 15 female residents in the secure unit and 25 residents on the 300 Hall. LVN FF revealed all the locks and doors were checked at the beginning of each shift. Residents were observed at least every hour. 22. Interview with CNA D on [DATE] at 5:25 AM revealed two CNAs had been working every night lately. He stated, It was much better. CNA D stated the intervention redirection for behaviors depended on the resident. The residents were different in ways. When you work with them all the time, you learn what works or the ones where nothing works. I might get them a drink or a snack or walk with them to another part of the unit. 23. Interview with CNA EE at 5:50 AM on [DATE] revealed she had worked in secure units for [AGE] years. She reported she was contracted through a staffing agency and had been oriented to the unit and residents prior to working on the unit. She stated redirection meant changing what was going on so it changed what the resident was doing. 24. Interview with Hospitality Aide FF on [DATE] at 6:00 AM revealed she had previously worked in the Activities Department as an assistant and was now working in the secure unit to assist with providing activities to the male residents. She reported the activities she had initiated so far were exercises, puzzles, walking, going to church in the facility and sing-a-longs. She reported there was varying participation and interest from the residents. 25. Interview with LVN A on [DATE] at 6:10 AM revealed there had been two CNAs on each of the secure units on the 10:00 PM to 6:00 AM shift when she arrived for the 6:00 AM to 2:00 PM shift since [DATE]. 26. Interview with ADON DD on [DATE] at 6:50 AM revealed an increase in staffing to include two licensed nurses for the 300 Hall; one would be dedicated to the secure units. 27. Interview with the DON on [DATE] at 7:30 AM revealed an increase in staffing on the 300 Hall. Each of the three areas: male secure unit, female secure unit and long term care residents, would have two CNAs on each shift and there would be a licensed nurse for the secure units. The CNAs were in place and interview for the licensed nurse was in process. Additionally, a Hospitality Aide with Activity Department experience was added to the male secure unit from 6:00 AM to 2:00 PM. 28. Interview with the Administrator at 08:00 AM on [DATE] revealed the identified staffing changes. The Administrator revealed that the corporate office was developing a policy to reflect the current staff of two CNAs on each unit for each shift as well as the licensed nurse dedicated to the secure units. 29. Staff interviewed on [DATE] between 5:10 AM and 12:00 PM, following acceptance of the plan of removal to verify education and to determine awareness of emergency procedures included: DON, ADON DD, LVN A, LVN B, CNA C, CNA D, CNA E, Hospitality Aide G, CNA F, CNA M, CNA N, LVN O, CNA

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 8) P, LVN H, CNA I, CNA J, LVN K and LVN L, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, AD W, ADON X, AD Y, LVN Z, ADON AA, LVN BB, CNA CC. All revealed they had received in-service on Code White, elopement residents,, had participated in a Code White drill and taken a proficiency exam on Wednesday, Thursday and/or Friday ([DATE] through [DATE]). 30. On [DATE] at 2:45 PM, the Administrator, DON and RVP were notified the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. 31. Resident Roster, dated [DATE], provided by the Administrator reflected 13 residents on the male secure unit.
F 0353 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessment and individual plans of care for one (Resident #1) of four residents reviewed for elopement risk. The facility failed to have staff present at all times on the male secure unit to supervise and monitor residents on the 10:00 PM to 6:00 AM shift. CNA C and LVN B, who were responsible for residents residing on the male secured unit, left the unit unsupervised when Resident #1 eloped. Resident #1 eloped from the male secure unit on [DATE] and was missing for more than seven hours. He was found deceased . The cause of death was arterial sclerotic and hypertensive cardiovascular disease in conjunction with Alzheimer's dementia and diabetes and a contributing factor was hypothermia. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could affect the 13 residents, who resided on the male secure unit by placing them at risk for elopement resulting in injuries and/or death. Findings included: 1. Resident #1's MDS assessment, dated [DATE], reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It noted he had severe cognitive impairment with fluctuating behaviors. It noted he needed supervision with ambulation and required assistance with incontinent care. It noted The MDS assessment reflected he received insulin injections. Resident #1's Risk of Elopement/Wandering assessment, dated [DATE], identified the resident as cognitively impaired with pertinent [DIAGNOSES REDACTED]. Resident #1 was able to ambulate independently. Resident #1 wandered aimlessly without purpose. He was a new resident and the family had expressed concern that he would try to leave. The Summary of Review identified the resident as At risk for elopement/wandering as evidenced by: Resident Wandering appropriate interventions have been initiated-Secured Unit. Resident #1's Care Plan, dated [DATE], reflected he was at risk for elopement with a goal of will keep a safe and secure environment for the next 90 days. The approaches were Secured unit and provide a structured environment and daily activities. There were no updates/reviews to the care plan. The Care Plan did not include specific activities or other interventions to prevent elopement. Resident #1's Physician Orders, dated [DATE], revealed the resident required NPH/Regular insulin 10 units in the AM before breakfast and 18 units before dinner. Resident #1's nursing progress notes, dated [DATE], reflected, resident in the unit with exit seeking behavior. Resident #1's nursing progress notes, dated [DATE] at 03:45 AM reflected, resident continues to ambulate throughout secured unit. Exit seeking in (sic) all four doors. Nursing progress note on [DATE] at 12:45 PM reflected, Resident continues to exit seek. Resident attempts to follow the staff out of the exit doors becoming aggressive when redirected. Resident #1's nursing progress note, dated [DATE], reflected, Resident attempted to get out of back door. Then slipped out behind a family member. Resident #1's nursing progress note, dated [DATE] at 9:30 PM, reflected Resident sometimes exhibits exit seeking behavior but redirected as needed. Resident #1's nursing progress notes, dated [DATE] through [DATE], did not reflect exit seeking behaviors. The notes reflected multiple medication changes for other behaviors. Resident #1's nursing progress note, dated [DATE] (Monday) and completed by LVN A reflected at 06:00 AM, CNA told this nurse and ,[DATE] nurse that he could not locate the resident at this time. This nurse and staff went through every room on Secure Unit then this nurse paged a ' Code White ' at this time all staff began searching all rooms in facility and some staff walked the grounds of facility without finding the resident. At 06:10 AM, 911, MD and RP were phoned by this nurse. Search continues with all staff involved inside facility and outside facility. 0705 Police arrived on Sta (Station) 3 where this nurse checks each room on Sta 3 with officers. Resident not located. Staff and officers continue to look for resident at this time. 2. The local Police Report, initiated [DATE], reflected Resident #1 was scheduled to receive insulin at 6:30 AM and the DON reported that might be a problem if Resident #1 was not found by noon. At 1:24 PM he was located behind the bus barn and was deceased . The search team found Resident #1 in a wooded area, which was a vacant lot with overgrown weeds, trees, with a small running creek that was flowing from the recent and steady rains. The report reflected, Near the edge of the creek, I observed an elderly black male wearing a white T-shirt with the name xxx on the left sleeve, an adult diaper, and gray and white slippers. He was lying on his right side facing west. His right arm and hand were beneath him, while his left arm was behind him and appeared to be grasping for a small bush that he was lying back against. His hand was clenched around the small scrub. Also observed was a white and blue print hospital gown lying on the ground in front of him. There were no bruises or abrasions on his hands and legs. There was no substantial mud on his hands or under his fingernails indicating that there were minimal attempts to get up. The absence of lacerations, scrapes and/or bruising was noted as (Resident #1) had been walking in a heavily wooded area and the fact that he was not very muddy or dirty from being in the elements. His shoes were relatively clean as well. I did note that his shoes were on the wrong feet. He exhibited no signs of injury. The temperature was in the mid 40's and moderate steady rain. There were no signs of foul play. The area was not disturbed, and it didn't appear that anyone else had been near him. There was a small, one inch laceration abrasion on his right shin. It looked like it may have only occurred hours earlier. The report also reflected an autopsy was performed and a significant contributing factor to his death was hypothermia . 3. Observation of the male secure unit on [DATE] at 7:45 AM revealed the secure unit was located in the back of the facility. At 8:30 AM, the magnetic door to the secure unit was observed to have no delay in closing. 4. Observations on [DATE] at 7:45 AM, also revealed a nurses ' station was located immediately outside the male secured unit. The nurses ' station served the male and female secure units and general population residents on Hall 300. 5. Review of the staffing schedule for [DATE] to [DATE] as confirmed in plan of removal revealed the following staff were on duty for the night shift (10:00 PM to 6:00 AM): 3 LVN; 1 MA, and 7 CNAs for stations 1, station 2 and station 3. 6. Telephone interview with CNA C on [DATE] at 11:20 AM revealed he was the CNA assigned to the male secured unit and the residents on Hall 300 during 10:00 PM to 06:00 AM shift on [DATE] (Sunday) to [DATE] (Monday). He stated he was responsible for a total of 21 residents: 15 on the male secured unit and six residents on Hall 300. He stated every two hours he checked on each resident, provided incontinent care, if needed, and answered their call lights. CNA C revealed he left the male secured unit multiple times during his shift to care for the six residents he was assigned on Hall 300. He stated Resident #1, who resided on the secured unit, was exit seeking. He stated he had tried to get him to go back to bed. He stated he last saw Resident #1 around 5:00 AM. He stated that usually when he left the unit, he reported to the LVN on duty if they were at the desk. He stated LVN B was not at the desk on the morning of [DATE]. He stated when he returned to the secured unit and made his last rounds he was unable to locate Resident #1. He stated he searched all the rooms and then notified LVN A and LVN B that he was unable to locate Resident #1. He stated he then continued to search for Resident #1. 7. Interview with LVN B on [DATE] at 07:00 AM revealed Resident #1, was exit seeking. LVN B stated they would try to engage the resident in other activities like watching TV. Interview with LVN B on [DATE] at 07:00 AM revealed he had last seen Resident #1 on the morning of [DATE] between 5:00 AM and 5:15 AM on [DATE] when he gave him medication for GERD. He reported he then left the Secure Unit to give medication on the rest of the 300 Hall. Another interview with LVN B on [DATE] at 2:50 PM reflected CNA C was routinely assigned residents on the 300 Hall. LVN B revealed that he was not at the desk from 5:15 AM until 6:00 AM on [DATE]; he was with residents on the 300 Hall. LVN B also reported he was in and out of the Secure Unit during the 10:00 PM to 6:00 AM shift. They did not have anyone to cover for their absence especially during that time from 5:00 to 6:00 AM because they were making final rounds and providing care for all of the residents. 8. Interview with LVN A on [DATE] at 06:15 AM revealed Resident #1 was exit seeking. LVN A stated they redirected the resident. Redirection depended on the resident and the behavior exhibited. The staff might offer a snack, go for a walk with the resident or engage him in another activity. Interview with LVN A on [DATE] at 06:15 AM revealed she was getting report from the night shift nurse (LVN B) at 6:00 AM on [DATE] when CNA C

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F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) reported he could not find Resident #1. CNA C reported he had searched all the rooms. LVN A and LVN B also searched the rooms and did not locate the resident. ADON DD had arrived as well as the DON. A Code White was called at 6:20 AM (the facility signal for a missing resident). The entire facility and grounds were searched. When the resident was not located, the police were contacted and the family and the physician were notified. 9. Interview with ADON DD at 06:30 AM on [DATE], revealed she was the Unit Manager for the Secure Unit, and that Resident #1 had a behavior of exit seeking. She stated on the morning of [DATE], she clocked at 6:05 AM and learned Resident #1 was missing. She stated that following a search of the facility, she used her car to search the neighborhood for the next four hours. ADON DD stated that for a resident with exit seeking behavior, they redirected the resident. She stated each residents responded differently to different staff members. Redirection activities might include conversation, walking in a different direction, beverages, snacks, toileting, incontinent care or engaging the resident in an activity. 10. Interview with DON at 7:30 AM on [DATE] revealed he was in the facility at 6:00 AM on [DATE] for an Employee Breakfast when he learned Resident #1 was missing. He stated he participated in the search as well as gathering information. He stated they (the DON, the Administrator and ADON DD) were not certain how Resident #1 eloped. The Unit had two exits. One with an electeomagnetic door with a numeric keypad and a door to the patio with a very loud alarm which required a key to turn off. They believed he must have slipped out by the electromagnetic door after one of the staff and left the facility by the exit near the activity room, which only had an alarm for wander guard devices. He reported there was a slight delay in the door closing by the unit which was eliminated on [DATE] by the alarm company. He also stated that an alarm was installed on the street exit on [DATE] by the same company. DON reported that he was not aware of the staffing during the 10:00 PM to 6:00 AM shift which left secure unit residents unattended for periods of time. 11. During an interview with the Administrator on [DATE] at 10:10 AM, she revealed that on [DATE] at 07:00 AM, they (the Administrator and the DON) began an investigation and notified DADS regarding the elopement of Resident #1. They were uncertain exactly how Resident #1 eloped. She stated there were only two exits on the male secured unit: the entrance/exit doors and a door to a courtyard. She stated that when the door to the courtyard was opened, a loud alarm would activate and and the only way to shut off the alarm, was with a key. She stated the most likely course of elopement was following someone out of the unit via the electro-magnetic doors (entrance/exit doors). She stated It was surmised that Resident #1 left the facility through an exit door near the activity room, which had no alarm. She stated the door had a wander guard system, but Resident #1 did not wear a wander guard device. She stated the reason they surmised this was beacause ADON DD had reported to the DON that Resident #1 had been allowed to accompany his family to the dining room area when his family brought him food. 12. Observations on [DATE] at 8:30 AM, confirmed that upon exiting the male secured unit, that by turning right past the nurses ' station, there were 10 resident rooms on a long corridor, a dining area and an activity room and exit door. Upon opening the exit door, the door had an audible alarm which activated. 13. Observations on [DATE] at 8:40 AM, of the male secure unit, verified the only other exit door lead to a secured courtyard. Upon opening the exit door, an audible alarm activated. 14. Review of the facility's policies reflected the following: The undated policy to Prohibit the Mistreatment, Neglect and Abuse of Residents and the Misappropriation of Resident Policy noted each resident had the right to be free of neglect and all employees were trained on issues related to facility abuse prohibition policies which covered prevention, identification, and protection. The undated policy regarding Elopement Risk Assessment reflected, The facility will assess all residents for elopement potential to provide a safe and comfortable living environment. Provide Plans of Care which are: --Presented to the IDT --Updated as indicated by resident condition --Contain measures for resident safety. 15. An IJ was identified on [DATE] at 2:25 PM. The Regional Vice President of Clinical Services, Regional Vice President of Operations, Administrator, and DON were notified at that time of the IJ and a Plan of removal was requested. 16. The facility's Plan of Removal was accepted on [DATE]. The plan reflected, Facility Actions taken post event.Elopement/wandering in-service performed [DATE] through [DATE] .with all staff in the building beginning [DATE] and completed [DATE].Every door assessed on [DATE] for proper function .Additional alarms were placed at the Ambulance entrance, an entrance (next to activity room) on the front door, and the Service door. It should be noted that all of these doors had a code alert system where a (wander guard device) bracelet would set off an alarm if resident were to approach the door. In addition the door entering (by activity room) has now been secured and is no longer used (sic) an entrance door, it is now used as an emergency exit only.All residents were re-assessed.and each care plan was reviewed and updated as indicated to reflect current Risk and interventions.Sign in sheets implemented [DATE] at secured unit doors on the inside and outside. Staff members are signing upon entrance and exiting. Visitors are escorted by staff members.Door codes were changed.and are not being shared with family/visitors.Door closure mechanism (sic) was checked and adjusted on the secured unit on [DATE] by (Maintenance Director) from regular time of 6 seconds to 4 seconds to reduce the time the door takes to close automatically .Observation rounds are made several times per shift and performed by charge nurses and CNAs on duty. 17. Observation of entrance and exits to the secure unit on [DATE] between 5:30 AM and 12:00 PM, revealed that staff were signing in and out and verifying that the door closed behind them. 18. Observation of staff on the male secured unit on [DATE] at 5:30 AM revealed one CAN was present. 19. The additional information to the facility's Plan of Removal, was accepted on [DATE] and reflected, On [DATE], staffing was increased on station 3 which includes the 300 hall and the male and female secure units to two aides on each of the female and male sides and two aides on the outside halls, for each of the three shifts 7 days a week 24 hours per day. Facility staffing policy as of [DATE] is that the secure units will always have two aides per side and a dedicated nurse and will never be left unattended, previous policy did not specify number of aides except for female Alzheimer's unit. On [DATE], the facility listed an open position for an additional nurse on each of the three shifts daily for station 3 and the facility is in the process of hiring. A hospitality aide has been hired to provide additional diversional activities. 20. Observation of the male secure unit on [DATE] at 5:15 AM revealed CNA D and CNA EE in the male secure unit. LVN FF was at the nursing station for the 300 Hall. 21. Interview with LVN FF on [DATE] at 5:15 AM revealed she had two CNAs in each of the secure units (male and female) and on the 300 Hall. She reported staffing was safer for the residents and staff. LVN FF also reported they were hiring an additional nurse as well. There were 13 male residents and 15 female residents in the secure unit and 25 residents on the 300 Hall. LVN FF revealed all the locks and doors were checked at the beginning of each shift. Residents were observed at least every hour. 22. Interview with CNA D on [DATE] at 5:25 AM revealed two CNAs had been working every night lately. He stated, It was much better. CNA D stated the intervention redirection for behaviors depended on the resident. The residents were different in ways. When you work with them all the time, you learn what works or the ones where nothing works. I might get them a drink or a snack or walk with them to another part of the unit. 23. Interview with CNA EE at 5:50 AM on [DATE] revealed she had worked in secure units for [AGE] years. She reported she was contracted through a staffing agency and had been oriented to the unit and residents prior to working on the unit. She stated redirection meant changing what was going on so it changed what the resident was doing. 24. Interview with Hospitality Aide FF on [DATE] at 6:00 AM revealed she had previously worked in the Activities Department as an assistant and was now working in the secure unit to assist with providing activities to the male residents. She reported the activities she had initiated so far were exercises, puzzles, walking, going to church in the facility and sing-a-longs. She reported there was varying participation and interest from the residents. 25. Interview with LVN A on [DATE] at 6:10 AM revealed there had been two CNAs on each of the secure units on the 10:00 PM to 6:00 AM shift when she arrived for the 6:00 AM to 2:00 PM shift since [DATE]. 26. Interview with ADON DD on [DATE] at 6:50 AM revealed an increase in staffing to include two licensed nurses for the 300 Hall; one would be dedicated to the secure units. 27. Interview with the DON on [DATE] at 7:30 AM revealed an increase in staffing on the 300 Hall. Each of the three areas: male secure unit, female secure unit and long term care residents, would have two CNAs on each shift and there would be a licensed nurse for the secure units. The CNAs were in place and interview for the licensed nurse was in process. Additionally, a Hospitality Aide with Activity Department experience was added to the male secure unit from 6:00 AM to 2:00 PM. 28. Interview with the Administrator at 08:00 AM on [DATE] revealed the identified staffing changes. The Administrator revealed that the corporate office was developing a policy to reflect the current staff of two CNAs on each unit for each shift as well as the licensed nurse dedicated to the secure units. 29. Staff interviewed on [DATE] between 5:10 AM and 12:00 PM, following acceptance of the plan of removal to verify education and to determine awareness of emergency procedures included: DON, ADON DD, LVN A, LVN B, CNA C, CNA D, CNA E, Hospitality Aide G, CNA F, CNA M, CNA N, LVN O, CNA P, LVN H, CNA I, CNA J, LVN K and LVN L, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, AD W, ADON X, AD Y, LVN Z, ADON AA, LVN BB, CNA CC. All revealed they had received in-service on Code White, elopement residents,, had participated in a Code White drill and taken a proficiency exam on Wednesday, Thursday and/or Friday ([DATE] through [DATE]). 30. On [DATE] at 2:45 PM, the Administrator, DON and RVP were notified the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate

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F 0353 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. 31. Resident Roster, dated [DATE], provided by the Administrator reflected 13 residents on the male secure unit.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of one (Resident #1) of 13 residents located in the male secured unit. 1. The Administrator failed to implement the facility's Abuse Prohibition Protocol and Elopement Policy. 2. The DON failed to adequately staff the male secured unit with exit seeking male residents residing on the unit. Resident #1 eloped from the secure unit on [DATE] and was missing for more than seven hours. He was found deceased . The cause of death was arterial sclerotic and hypertensive cardiovascular disease in conjunction with Alzheimer ' s dementia and diabetes and a contributing factor was hypothermia. An Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. These failures could affect the 13 residents, who resided on the male secure unit by placing them at risk for elopement resulting in injuries and/or death. Findings included: 1. Resident #1's MDS assessment, dated [DATE], reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. It noted he had severe cognitive impairment with fluctuating behaviors. It noted he needed supervision with ambulation and required assistance with incontinent care. It noted The MDS assessment reflected he received insulin injections. Resident #1's Risk of Elopement/Wandering assessment, dated [DATE], identified the resident as cognitively impaired with pertinent [DIAGNOSES REDACTED]. Resident #1 was able to ambulate independently. Resident #1 wandered aimlessly without purpose. He was a new resident and the family had expressed concern that he would try to leave. The Summary of Review identified the resident as At risk for elopement/wandering as evidenced by: Resident Wandering appropriate interventions have been initiated-Secured Unit. Resident #1's Care Plan, dated [DATE], reflected he was at risk for elopement with a goal of will keep a safe and secure environment for the next 90 days. The approaches were Secured unit and provide a structured environment and daily activities. There were no updates/reviews to the care plan. The Care Plan did not include specific activities or other interventions to prevent elopement. Resident #1's Physician Orders, dated [DATE], revealed the resident required NPH/Regular insulin 10 units in the AM before breakfast and 18 units before dinner. Resident #1's nursing progress notes, dated [DATE], reflected, resident in the unit with exit seeking behavior. Resident #1's nursing progress notes, dated [DATE] at 03:45 AM reflected, resident continues to ambulate throughout secured unit. Exit seeking in (sic) all four doors. Nursing progress note on [DATE] at 12:45 PM reflected, Resident continues to exit seek. Resident attempts to follow the staff out of the exit doors becoming aggressive when redirected. Resident #1's nursing progress note, dated [DATE], reflected, Resident attempted to get out of back door. Then slipped out behind a family member. Resident #1's nursing progress note, dated [DATE] at 9:30 PM, reflected Resident sometimes exhibits exit seeking behavior but redirected as needed. Resident #1's nursing progress notes, dated [DATE] through [DATE], did not reflect exit seeking behaviors. The notes reflected multiple medication changes for other behaviors. Resident #1's nursing progress note, dated [DATE] (Monday) and completed by LVN A reflected at 06:00 AM, CNA told this nurse and ,[DATE] nurse that he could not locate the resident at this time. This nurse and staff went through every room on Secure Unit then this nurse paged a ' Code White ' at this time all staff began searching all rooms in facility and some staff walked the grounds of facility without finding the resident. At 06:10 AM, 911, MD and RP were phoned by this nurse. Search continues with all staff involved inside facility and outside facility. 0705 Police arrived on Sta (Station) 3 where this nurse checks each room on Sta 3 with officers. Resident not located. Staff and officers continue to look for resident at this time. 2. The local Police Report, initiated [DATE], reflected Resident #1 was scheduled to receive insulin at 6:30 AM and the DON reported that might be a problem if Resident #1 was not found by noon. At 1:24 PM he was located behind the bus barn and was deceased . The search team found Resident #1 in a wooded area, which was a vacant lot with overgrown weeds, trees, with a small running creek that was flowing from the recent and steady rains. The report reflected, Near the edge of the creek, I observed an elderly black male wearing a white T-shirt with the name xxx on the left sleeve, an adult diaper, and gray and white slippers. He was lying on his right side facing west. His right arm and hand were beneath him, while his left arm was behind him and appeared to be grasping for a small bush that he was lying back against. His hand was clenched around the small scrub. Also observed was a white and blue print hospital gown lying on the ground in front of him. There were no bruises or abrasions on his hands and legs. There was no substantial mud on his hands or under his fingernails indicating that there were minimal attempts to get up. The absence of lacerations, scrapes and/or bruising was noted as (Resident #1) had been walking in a heavily wooded area and the fact that he was not very muddy or dirty from being in the elements. His shoes were relatively clean as well. I did note that his shoes were on the wrong feet. He exhibited no signs of injury. The temperature was in the mid 40's and moderate steady rain. There were no signs of foul play. The area was not disturbed, and it didn't appear that anyone else had been near him. There was a small, one inch laceration abrasion on his right shin. It looked like it may have only occurred hours earlier. 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He stated when he returned to the secured unit and made his last rounds he was unable to locate Resident #1. He stated he searched all the rooms and then notified LVN A and LVN B that he was unable to locate Resident #1. He stated he then continued to search for Resident #1. 7. Interview with LVN B on [DATE] at 07:00 AM revealed Resident #1, was exit seeking. LVN B stated they would try to engage the resident in other activities like watching TV. Interview with LVN B on [DATE] at 07:00 AM revealed he had last seen Resident #1 on the morning of [DATE] between 5:00 AM and 5:15 AM on [DATE] when he gave him medication for GERD. He reported he then left the Secure Unit to give medication on the rest of the 300 Hall. Another interview with LVN B on [DATE] at 2:50 PM reflected CNA C was routinely assigned residents on the 300 Hall. LVN B revealed that he was not at the desk from 5:15 AM until 6:00 AM on [DATE]; he was with residents on the 300 Hall. LVN B also reported he was in and out of the Secure Unit during the 10:00 PM to 6:00 AM shift. They did not have anyone to cover for their absence especially during that time from 5:00 to 6:00 AM because they were making final rounds and providing care for all of the residents. 8. Interview with LVN A on [DATE] at 06:15 AM revealed Resident #1 was exit seeking. LVN A stated they redirected the resident. Redirection depended on the resident and the behavior exhibited. The staff might offer a snack, go for a walk with the resident or engage him in another activity. Interview with LVN A on [DATE] at 06:15 AM revealed she was getting report from the night shift nurse (LVN B) at 6:00 AM on [DATE] when CNA C reported he could not find Resident #1. CNA C reported he had searched all the rooms. LVN A and LVN B also searched the rooms and did not locate the resident. ADON DD had arrived as well as the DON. A Code White was called at 6:20 AM (the facility signal for a missing resident). The entire facility and grounds were searched. When the resident was not located, the police were contacted and the family and the physician were notified. 9. Interview with ADON DD at 06:30 AM on [DATE], revealed she was the Unit Manager for the Secure Unit, and that Resident #1 had a behavior of exit seeking. She stated on the morning of [DATE], she clocked at 6:05 AM and learned Resident #1 was missing. She stated that following a search of the facility, she used her car to search the neighborhood for the next four hours. ADON DD stated that for a resident with exit seeking behavior, they redirected the resident. She stated each residents responded differently to different staff

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Observations on [DATE] at 8:40 AM, of the male secure unit, verified the only other exit door lead to a secured courtyard. Upon opening the exit door, an audible alarm activated. 14. Review of the facility's policies reflected the following: The undated policy to Prohibit the Mistreatment, Neglect and Abuse of Residents and the Misappropriation of Resident Policy noted each resident had the right to be free of neglect and all employees were trained on issues related to facility abuse prohibition policies which covered prevention, identification, and protection. The undated policy regarding Elopement Risk Assessment reflected, The facility will assess all residents for elopement potential to provide a safe and comfortable living environment. Provide Plans of Care which are: --Presented to the IDT --Updated as indicated by resident condition --Contain measures for resident safety. 15. An IJ was identified on [DATE] at 2:25 PM. The Regional Vice President of Clinical Services, Regional Vice President of Operations, Administrator, and DON were notified at that time of the IJ and a Plan of removal was requested. 16. The facility's Plan of Removal was accepted on [DATE]. The plan reflected, Facility Actions taken post event.Elopement/wandering in-service performed [DATE] through [DATE] .with all staff in the building beginning [DATE] and completed [DATE].Every door assessed on [DATE] for proper function .Additional alarms were placed at the Ambulance entrance, an entrance (next to activity room) on the front door, and the Service door. It should be noted that all of these doors had a code alert system where a (wander guard device) bracelet would set off an alarm if resident were to approach the door. In addition the door entering (by activity room) has now been secured and is no longer used (sic) an entrance door, it is now used as an emergency exit only.All residents were re-assessed.and each care plan was reviewed and updated as indicated to reflect current Risk and interventions.Sign in sheets implemented [DATE] at secured unit doors on the inside and outside. Staff members are signing upon entrance and exiting. Visitors are escorted by staff members.Door codes were changed.and are not being shared with family/visitors.Door closure mechanism (sic) was checked and adjusted on the secured unit on [DATE] by (Maintenance Director) from regular time of 6 seconds to 4 seconds to reduce the time the door takes to close automatically .Observation rounds are made several times per shift and performed by charge nurses and CNAs on duty. 17. Observation of entrance and exits to the secure unit on [DATE] between 5:30 AM and 12:00 PM, revealed that staff were signing in and out and verifying that the door closed behind them. 18. Observation of staff on the male secured unit on [DATE] at 5:30 AM revealed one CAN was present. 19. The additional information to the facility's Plan of Removal, was accepted on [DATE] and reflected, On [DATE], staffing was increased on station 3 which includes the 300 hall and the male and female secure units to two aides on each of the female and male sides and two aides on the outside halls, for each of the three shifts 7 days a week 24 hours per day. Facility staffing policy as of [DATE] is that the secure units will always have two aides per side and a dedicated nurse and will never be left unattended, previous policy did not specify number of aides except for female Alzheimer's unit. On [DATE], the facility listed an open position for an additional nurse on each of the three shifts daily for station 3 and the facility is in the process of hiring. A hospitality aide has been hired to provide additional diversional activities. 20. Observation of the male secure unit on [DATE] at 5:15 AM revealed CNA D and CNA EE in the male secure unit. LVN FF was at the nursing station for the 300 Hall. 21. Interview with LVN FF on [DATE] at 5:15 AM revealed she had two CNAs in each of the secure units (male and female) and on the 300 Hall. She reported staffing was safer for the residents and staff. LVN FF also reported they were hiring an additional nurse as well. There were 13 male residents and 15 female residents in the secure unit and 25 residents on the 300 Hall. LVN FF revealed all the locks and doors were checked at the beginning of each shift. Residents were observed at least every hour. 22. Interview with CNA D on [DATE] at 5:25 AM revealed two CNAs had been working every night lately. He stated, It was much better. CNA D stated the intervention redirection for behaviors depended on the resident. The residents were different in ways. When you work with them all the time, you learn what works or the ones where nothing works. I might get them a drink or a snack or walk with them to another part of the unit. 23. Interview with CNA EE at 5:50 AM on [DATE] revealed she had worked in secure units for [AGE] years. She reported she was contracted through a staffing agency and had been oriented to the unit and residents prior to working on the unit. She stated redirection meant changing what was going on so it changed what the resident was doing. 24. Interview with Hospitality Aide FF on [DATE] at 6:00 AM revealed she had previously worked in the Activities Department as an assistant and was now working in the secure unit to assist with providing activities to the male residents. She reported the activities she had initiated so far were exercises, puzzles, walking, going to church in the facility and sing-a-longs. She reported there was varying participation and interest from the residents. 25. Interview with LVN A on [DATE] at 6:10 AM revealed there had been two CNAs on each of the secure units on the 10:00 PM to 6:00 AM shift when she arrived for the 6:00 AM to 2:00 PM shift since [DATE]. 26. Interview with ADON DD on [DATE] at 6:50 AM revealed an increase in staffing to include two licensed nurses for the 300 Hall; one would be dedicated to the secure units. 27. Interview with the DON on [DATE] at 7:30 AM revealed an increase in staffing on the 300 Hall. Each of the three areas: male secure unit, female secure unit and long term care residents, would have two CNAs on each shift and there would be a licensed nurse for the secure units. The CNAs were in place and interview for the licensed nurse was in process. Additionally, a Hospitality Aide with Activity Department experience was added to the male secure unit from 6:00 AM to 2:00 PM. 28. Interview with the Administrator at 08:00 AM on [DATE] revealed the identified staffing changes. The Administrator revealed that the corporate office was developing a policy to reflect the current staff of two CNAs on each unit for each shift as well as the licensed nurse dedicated to the secure units. 29. Staff interviewed on [DATE] between 5:10 AM and 12:00 PM, following acceptance of the plan of removal to verify education and to determine awareness of emergency procedures included: DON, ADON DD, LVN A, LVN B, CNA C, CNA D, CNA E, Hospitality Aide G, CNA F, CNA M, CNA N, LVN O, CNA P, LVN H, CNA I, CNA J, LVN K and LVN L, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, AD W, ADON X, AD Y, LVN Z, ADON AA, LVN BB, CNA CC. All revealed they had received in-service on Code White, elopement residents,, had participated in a Code White drill and taken a proficiency exam on Wednesday, Thursday and/or Friday ([DATE] through [DATE]). 30. On [DATE] at 2:45 PM, the Administrator, DON and RVP were notified the IJ was removed. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that is not immediate jeopardy and a scope of pattern because the facility was continuing to in-service staff and was monitoring the effectiveness of the Plan of Removal. 31. Resident Roster, dated [DATE], provided by the Administrator reflected 13 residents on the male secure unit.