STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115714	A. BUILDING _____ B. WING _____	**02/20/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHRIDGE HEALTH AND REHABILITATION	**100 MEDICAL CENTER DRIVE COMMERCE, GA 30529**

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 -** Few	**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, clinical record review, staff interview, hospital ER Triage Record review, and facility Follow-Up Report review, the facility failed to prevent neglect by failing to ensure that the WanderGuard system, utilized by facility staff for the supervision of residents at risk for elopement/wandering behavior on the first floor Units B and C, provided alarm coverage which included a set of unlocked doors located in a first floor corridor which was accessible to Unit B and Unit C residents, and which exited the nursing facility into the adjoining hospital. This failure resulted in neglect by allowing the elopement of one (1) Unit B resident (#1), who was at risk for wandering/elopement and who utilized a WanderGuard bracelet, on the total survey sample of fourteen (14) residents. Resident #1, while wearing a WanderGuard bracelet, was able to access this unsecured first-floor corridor on 02/09/2014, pass through the unalarmed corridor doors, exit the nursing facility through this corridor, enter the adjoining hospital and elope. Resident #1 then fell and hit his/her head on pavement, was taken to the hospital emergency room and found to have facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. This resulted in a situation in which the facility's non-compliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing were informed of the immediate jeopardy on February 18, 2014 at 9:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on February 9, 2014 (the date Resident #1 eloped from the facility via a set of unlocked, unalarmed, and unsecured doors located within a corridor which lead from the nursing facility to the adjoining hospital), continued through February 18, 2014, and was removed on February 19, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 18, 2014. During an interview with the Administrator conducted on 02/14/2014 at 11:50 a.m., the Administrator acknowledged Resident #1's nursing facility elopement on 02/09/2014. The Administrator acknowledged that the unlocked corridor doors located in the corridor leading from the nursing facility to the hospital did not have a WanderGuard alarm, and it was thought that Resident #1 had gone through the unalarmed corridor doors, entered the hospital and exited through the front main entrance/exit doors of the hospital. An allegation of jeopardy removal was received on February 19, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 19, 2014, and the facility remained out of compliance at a lower scope and severity of D while the facility completed a process which involved the retraining, via staff in-service, of available nursing staff related to procedural revisions made to ensure adequate supervision for residents at risk of wandering/elopement, but continued to provide in-service training to staff who were initially unavailable for training, as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the monitoring of residents requiring supervision related to the risk of elopement/wandering. Observations were made to assess staffs' performance of care and supervision of these residents. Findings include: Resident #1's Minimum Data Set assessment of 02/06/2014 documented [DIAGNOSES REDACTED]. Section C - Cognitive Patterns recorded a Brief Interview for Mental Status score of six (06), indicating severe cognitive impairment. Section E - Behavior documented that Resident #1 had exhibited wandering behavior, and a 01/31/2014 Physician's Interim Orders form specified a WanderGuard bracelet at all times. A Nurse's Notes (NN) entry of 02/09/2014 for the 7:00 a.m.-7:00 p.m. shift documented that Resident #1 was walking up and down the hallways requiring staff redirection, and that the resident had stated Which way is the way out? I need to get home. The NN documented that at around 3:45 p.m. on 02/09/2014, Resident #1 had been at an activity in the Day Room being assisted by a certified nursing assistant. However, a 02/09/2014, 5:00 p.m. NN documented that a facility nurse received a telephone call from a family member to inform her that Resident #1 had been found with injuries at the roadside, and that Emergency Medical Service (EMS) 911 had been called for hospital transport. The 02/09/2014 hospital ER Triage Record documented that Resident #1 had fallen onto pavement and hit his/her face and forehead. The 02/09/2014 hospital ED Nursing Record (EDNR) documented lacerations/abrasions to Resident #1's face, nose, and forehead, and that the resident had been found by a former neighbor in the highway close to the resident's former home. Resident #1's 02/09/2014 ED Discharge Instructions form documented a laceration repair and injuries which included nasal and right knee patella fractures. A 02/14/2014 facility Follow-Up Report (FR) for Resident #1 documented that Resident #1 was originally admitted to Unit E, a second floor unit, but was moved to first floor Unit B on 02/05/2014 at family request. This FR documented that at 3:45 p.m. on 02/09/2014, Resident #1 was in the Day Room in an activity being assisted by Certified Nursing Assistant (CNA) BB, who left Resident #1 in the Day Room around 4:05 p.m. This FR documented that Resident #1 then left the Day Room and eloped, sustaining a fall before reaching his/her former home located 0.83 mile from the facility. This FR documented Resident #1's hospital transfer after the elopement and fall, and documented treatment for [REDACTED]. During an observation of Unit B conducted on 02/14/2014 at 12:30 p.m. at the end of the B Hall of Unit B, a corridor turned to the right off of B Hall. Within this corridor which was directly accessible from Unit B, observation revealed a set of double doors which were not locked and did not have a WanderGuard alarm. The corridor within which these unalarmed double doors were located, and which originated at the end of the B Hall of nursing facility Unit B, continued into the hospital which adjoined the nursing facility, and terminated at the main entrance/exit doors located at the front of the hospital. A two lane street was observed to run in front of the hospital/nursing facility buildings. Interview with the Administrator conducted on 02/14/2014 at 11:50 a.m. revealed that Resident #1's former home, close to which the resident was found to have fallen after eloping on 02/09/2014, was located on this street which ran directly in front of the hospital/nursing home facilities. During an interview conducted on 02/14/2014 at 12:48 p.m., the DON stated that Resident #1's Unit B room had been located close to the set of unalarmed corridor doors. The DON stated that, based on investigation, the facility determined that on 02/09/2014, Resident #1 had walked down the corridor off of Unit B, passed through the unalarmed corridor doors, continued walking out of the nursing facility and exited out the front door of the hospital. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard alarm bracelets, and despite Resident #1 having severe cognitive impairment and a known history of wandering requiring a WanderGuard bracelet for supervision, the facility neglected Resident #1 by failing to provide supervision, per the resident's WanderGuard device, to address the resident's risk of elopement. Instead, the facility failed to ensure the placement of a WanderGuard alarm on the set of unlocked double doors located in the corridor leading from Unit B, where Resident #1 resided, and continuing into the hospital located adjacent to the nursing facility. This allowed Resident #1, who utilized a WanderGuard bracelet, to exit through these unalarmed, unlocked corridor double doors without the knowledge of nursing facility staff, to exit through the hospital's front entrance/exit doors and elope from the facility, then to gain access to a street where he/she subsequently fell and

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) sustained facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. The immediate jeopardy was determined to have been removed on February 19, 2014, at which time the facility had presented and implemented a credible allegation of jeopardy removal with the following interventions: A. On February 9, 2014, after learning of Resident #1's elopement, the facility conducted a full resident audit to assure the presence of all residents. B. On February 9, 2014, all doors exiting the nursing facility were checked to ensure the proper working order of the WanderGuard alarm system. All existing WanderGuard alarms were functioning properly. C. On February 9, 2014, a procedure was put into place by which a facility employee was placed at the doorway, located in the corridor leading from the nursing facility to the hospital, which was not equipped with a WanderGuard alarm. A scheduled was developed reflecting specific employees who were assigned to be in place at the unalarmed doorway, at specific times and continuously around the clock, until a WanderGuard alarm was installed on the doorway. D. On February 9, 2014, chart audits for all current facility residents were conducted to ensure that all residents who demonstrated a potential for elopement had been accurately identified by the facility. During these chart audits, no new residents were identified to have the potential for elopement. E. On February 9, 2014, Care Plan reviews were conducted for residents assessed to be at risk for elopement to ensure that a comprehensive approach to address this risk was in place. During these Care Plan reviews, no problems were identified. F. On February 9, 2014, in addition to daily WanderGuard bracelet checks completed by the Activities Director which were in place prior to Resident #1's elopement, the facility implemented audits of the door alarms through the preventative maintenance program. The door alarms would be checked weekly, on each Tuesday, by the Maintenance Director, and these door alarm checks would be documented via computer data entry. The door alarm test would include a check of the power indicator light to ensure proper function, and also a check for battery condition. A sensor button was to be used to test each door alarm, with the alarm to sound when within six feet of an alarmed doorway. If a door alarm did not initially sound, the test was to be repeated with a different sensor button. Any deviation from full working order found during these weekly door alarm checks would be reported to the Administrator for immediate correction. The Administrator or DON would monitor the results of these weekly door alarm audits, conducted by the Maintenance Director, by reviewing the computer data entered as a result of the door alarm checks weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. The results of these supervisory audits will be submitted to the Quality Assessment/Performance Improvement (QA/PI) Committee for their review. G. On February 9, 2014, the facility contacted the Medical Director to inform him of the elopement of Resident #1. Additionally, a meeting which consisted of some members of the QA/PI Committee, including the Administrator, DON, and Director of Maintenance, was held to review the elopement event and the actions which had been taken by the facility, and to identify any additional actions that were needed. H. On February 15, 2014, the corridor doorway, which lead from the nursing facility to the hospital and which had previously lacked a WanderGuard alarm, was equipped with a WanderGuard alarm. I. On February 18, 2014, the facility continued to provide staff in-service training to facility staff, including licensed nurses, CNAs, and maintenance/housekeeping staff. This in-service training served to both reinforce current facility protocols involving the routine monitoring of residents having WanderGuard bracelet devices and also to provide staff training on newly-implemented protocols related to the facility's WanderGuard alarm system. As of February 18, 2014, 116 of the facility's total 118 employees had received this in-service training. The two (2) remaining staff members, who were on Family and Medical Leave Act leave at the time this in-service training was provided, will received the training upon their return to work. J. On February 18, 2014, the QA/PI Committee met to review the elopement event involving Resident #1, to review the actions taken by the facility as of that date, and to review the monitoring systems put into place as a result of the elopement. The QA/PI Committee will review the results of WanderGuard bracelet monitoring and door alarm audits weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter to ensure ongoing compliance with the systemic measures implemented to correct the identified issue and prevent recurrence. The information will be analyzed by the QA/PI Committee, and subsequent plans of correction will be developed and implemented as needed. This will be an ongoing process. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 19, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On February 9, 2014, the facility implemented a weekly audit of WanderGuard door alarms to be accomplished through the preventative maintenance program by the Maintenance Director. These weekly WanderGuard door alarm audits would check for the proper function of all facility WanderGuard door alarms, and were to be documented via computer data entry. However, these weekly WanderGuard door alarm audits had been initiated only on February 9, 2014, and had occurred only twice prior to the February 20, 2014 exit date of this complaint survey. Therefore, ongoing staff compliance with this newly implemented procedure involving routine, scheduled WanderGuard door alarm monitoring could not be entirely assessed at the time of survey completion, and will thus need future evaluation. Additionally, by February 18, 2014, the facility had completed in-service training for 116 of its 118 facility employees, to include licensed nurses, CNAs, and maintenance/housekeeping staff, regarding both existing and newly-implemented protocols involving the monitoring of residents with WanderGuard bracelets and the WanderGuard alarm system. However, two (2) remaining staff members, who were on leave and had been unavailable for training, will need to receive this training upon returning to work, and this training will thus need future evaluation. Additionally, the QA/PI Committee was to include the review the results of WanderGuard bracelet monitoring and door alarm audits in future meetings, but the Committee had met on On February 18, 2014, only two (2) days prior to the February 20, 2014 exit date of this complaint survey, to begin this process. Thus, the QA/PI Committee's ongoing process of facility procedural oversight could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the D level.
F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility staff interview, hospital ED Nursing Record review, hospital ED Discharge Instructions review, and facility Follow-Up Report review, the facility failed to ensure resident supervision for elopement/wandering behavior, in accordance with the Care Plan which specified WanderGuard bracelet use to address elopement/wandering behavior, by failing to ensure that the WanderGuard system provided protection which included a set of double doors located in one (1) first floor corridor which was accessible to Unit B and Unit C residents, and which exited the nursing facility into an adjoining hospital facility. The failure of the facility to ensure WanderGuard alarm protection on the double doors contained within this unsecured corridor allowed this corridor to serve as an unsecured route of exit for one (1) resident (#1) who eloped through this corridor, and as a potential unsecured route of exit for four (4) additional residents (#5, #11, #12, and #14), whose Care Plans specified the use of WanderGuard bracelets to address known elopement/wandering behavior, on the total survey sample of fourteen (14) residents. Resident #1 subsequently accessed this unsecured corridor on 02/09/2014 without the knowledge of facility staff, exited the facility through the corridor, and eloped through the adjoining hospital. Resident #1 traveled along a street for approximately one-half mile, fell on to the pavement, was taken to the hospital Emergency Department (ED), and was found to have facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. This resulted in a situation in which the facility's non-compliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing were informed of the immediate jeopardy on February 18, 2014 at 9:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on February 9, 2014 (the date Resident #1 eloped from the facility via the unlocked, unalarmed, and unsecured doors located within a corridor which lead from the nursing facility to an adjoining hospital), continued through February 18, 2014, and was removed on February 19, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 18, 2014. During this survey, it was determined that Resident #1, who had a history of [REDACTED]. In addition to Resident #1, Resident #s 5, 11, 12, and 14, who all had cognitive impairment and whose Care Plans all specified the use of WanderGuard bracelets for known elopement/wandering behavior, also resided on Unit B or Unit C, and all had direct access to these unlocked, unalarmed corridor doors which lead directly to the hospital. During an interview conducted on 02/14/2014 at 11:50 a.m., the Administrator acknowledged that the set of unlocked corridor doors located in the corridor leading from the nursing facility into the hospital did not have a WanderGuard alarm. An allegation of jeopardy removal was received on February 19, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 19, 2014, and the facility remained out of compliance at a lower scope and severity of E while the

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) facility completed a process which involved the retraining, via staff in-service, of available nursing staff related to procedural revisions made to ensure adequate supervision for residents at risk of wandering/elopement, but continued to provide in-service training to staff who were initially unavailable for training, as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the monitoring of residents requiring supervision related to the risk of wandering/elopement. Observations were made to assess staffs' performance of care and supervision of these residents. Findings include: During a tour of the facility's first floor conducted on 02/14/2014 at 12:30 p.m., observations were made in first floor Unit B and Unit C. Observation during this tour revealed that the facility utilized a WanderGuard alert system to allow for the supervision of residents at risk for elopement/wandering. A WanderGuard alarm was observed on the nursing facility's main entrance/exit doors located at the front of the facility, and a WanderGuard alarm was observed on doors located at the terminal end of the Unit C front corridor which opened into a corridor of the adjoining hospital facility. However, observation of Unit B revealed a corridor which turned off the end of the B Hall of Unit B and lead into the adjoining hospital facility. This corridor which connected the nursing facility and the hospital was noted to contain a set of double doors which did not have a WanderGuard alarm. These doors were not locked, and opened upon pressing a wall-mounted button. This corridor containing these unalarmed, unlocked doors lead from the nursing facility to the adjoining hospital, continued through the hospital and exited through the hospital's main front entrance/exit doors. During this observation, it was noted that the nursing facility's Unit B and Unit C adjoined, and that residents of both units could travel between units, thus allowing residents of both units to have access to this corridor which exited from Unit B and which contained these unalarmed, unlocked double doors leading into the adjoining hospital. During an interview conducted on 02/14/2014 at 11:50 a.m., the Administrator acknowledged that the double doors located in the corridor leading off of Unit B had no WanderGuard alarm and were not locked. 1. Resident #1's Minimum Data Set (MDS) Assessment of 02/06/2014, for an admission of 01/30/2014, documented diagnoses, in Section I - Active Diagnoses, which included [MEDICAL CONDITION] Fibrillation, [MEDICAL CONDITION] Disorder, and Non-Alzheimer's Dementia, and Section C - Cognitive Patterns indicated severe cognitive impairment, with a Brief Interview for Mental Status (BIMS) Summary Score of six (06). Section E - Behavior documented that Resident #1 had exhibited wandering behavior 1 to 3 days during the look-back period. Resident #1's Nursing Admission Care Plan, dated 01/30/2014, identified that the resident was at risk for elopement, and was also at risk for falls. This Nursing Admission Care Plan identified an Approach which specified the use of a WanderGuard alarm to address Resident #1's risk for elopement, with the indicated Goal being that the resident would remain free of injuries and falls. A Nurse's Notes (NN) entry of 02/09/2014 for the 7:00 a.m.-7:00 p.m. shift documented that at around 3:45 p.m., Resident #1 had been seated in the Day Room for an activity. However, a subsequent 02/09/2014, 5:00 p.m. NN documented that Resident #1 had been found at the side of a road by a previous neighbor and was being taken to the hospital. Resident #1's hospital ED (Emergency Department) Nursing Record of 02/09/2014 documented lacerations/abrasions to the face, nose, and forehead, and that the resident had been found by a previous neighbor in the highway outside of the resident's former home. Resident #1's ED Discharge Instructions form of 02/09/2014 documented [DIAGNOSES REDACTED]. A 02/14/2014 facility Follow-Up Report (FR) documented that at 3:45 p.m. on 02/09/2014, Resident #1, who resided on first floor Unit B, had left the facility's Day Room sometime after 4:00 p.m. and eloped, almost reaching his/her former home located 0.83 mile from the nursing facility. This FR documented that the facility believed Resident #1 could have eloped through a set of double doors located in a corridor which lead to the adjoining hospital. As indicated in the 02/14/2014, 12:30 p.m. tour observation referenced above, the corridor which lead off the B Hall of facility Unit B, to which Resident #1 had direct access, contained unlocked double doors which had no WanderGuard alarm, were not locked, and continued into the adjoining hospital facility, passed through the hospital, and exited through the hospital's main entrance/exit doors. During an interview conducted on 02/14/2014 at 11:50 a.m., the Administrator acknowledged these corridor doors off of the Unit B corridor were not locked and did not have a WanderGuard alarm. The Administrator stated that it was thought that on 02/09/2014, Resident #1 walked down the B Hall corridor, passed through the unalarmed double doors, entered into the hospital and eloped through the hospital's front main entrance/exit doors. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, and despite Resident #1 having severe cognitive impairment and a known history of wandering behavior, thereby requiring the use of a WanderGuard bracelet as specified by the Nursing Admission Care Plan, the facility failed to ensure that the unlocked double doors located in the corridor leading from the Unit B hall where Resident #1 resided were equipped with a WanderGuard alarm, to thus ensure WanderGuard bracelet supervision as specified by the Care Plan. Resident #1 then exited the nursing facility through the unalarmed, unlocked corridor double doors and then exited the hospital through the front entrance/exit doors and eloped. Resident #1 then traveled approximately one-half (1/2) mile, fell and sustained facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. Cross refer to F323, example 1, for more information regarding Resident #1. 2. Resident #12's MDS of 11/11/2013 documented diagnoses, in Section I - Active Diagnoses, which included Hypertension and Dementia, and Section C - Cognitive Patterns documented a BIMS Summary Score of seven (7), indicating severe cognitive impairment. Review of Resident #12's Care Plan revealed that the resident resided on Unit B of the facility. An entry on this Care Plan, indicated as a Problem/Need and originally dated 12/31/2013, identified Resident #12 to have wandering behavior. Approaches listed on Resident #12's Care Plan to address this wandering behavior included the use of a WanderGuard bracelet to be applied at all times, and to redirect the resident as indicated. The Goal for these Approaches identified on Resident #12's Care Plan included that the resident would not leave the facility unescorted. However, as indicated in the 02/14/2014, 12:30 p.m. tour observation referenced above, the corridor leading to the adjacent hospital facility, and located at the end of the B Hall of Unit B where Resident #12 resided and to which Resident #12 had direct access, contained double doors which were unlocked and not equipped with a WanderGuard alarm. This corridor continued into the hospital facility and exited through the hospital's main front entrance/exit. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #12, who resided on Unit B, having Dementia and severe cognitive impairment and having been assessed to have a history of wandering behavior, and despite the resident's Care Plan specifying the use of a WanderGuard bracelet and that staff redirect the resident as indicated, the facility failed to ensure that double doors located in the corridor which exited Unit B and lead directly into the adjoining hospital were WanderGuard alarm equipped. By failing to ensure WanderGuard alarm placement on the unlocked double doors contained within this corridor leading from the nursing facility to the hospital, and which served as a direct route of egress from the nursing facility, the facility failed to ensure that the WanderGuard bracelet utilized by Resident #12, as specified by the Care Plan, would allow redirection of the resident as indicated, also as specified by the Care Plan, by alerting staff to wandering/elopement attempts through this unsecured corridor. This presented a wandering risk for Resident #12. Cross refer to F323, example 2, for more information regarding Resident #12. 3. Resident #14's MDS of 01/06/2014 documented diagnoses, in Section I - Active Diagnoses, which included [MEDICAL CONDITION], Hypertension, [MEDICAL CONDITION], Dementia, [MEDICAL CONDITION] Disorder, and a [MEDICAL CONDITION], and Section C - Cognitive Patterns documented severe cognitive impairment, with a BIMS Summary Score of ninety-nine (99). Resident #14's Care Plan identified that the resident resided on Unit C. The Care Plan also identified, as a Problem/Need originally dated 04/18/2013, that Resident #14 was at risk for elopement from the facility. The Care Plan referenced Approaches to address Resident #14's elopement risk which include the use of a WanderGuard bracelet at all times, and for staff to provide redirection as indicated. However, as indicated in the 02/14/2014, 12:30 p.m. tour observation referenced above, Resident #14, who wore a WanderGuard bracelet for elopement-risk and resided on Unit C, had direct access to Unit B, where observation revealed the corridor which lead off of Unit B and contained the double doors which were not locked or equipped with a WanderGuard alarm, and lead to the hospital facility that adjoined the nursing facility, exiting through the hospital's main front entrance/exit. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #14 (who resided on Unit C and had direct access to Unit B) having Dementia and severe cognitive impairment, despite the resident having been assessed to be at risk for elopement, and despite the resident's Care Plan specifying the use of a WanderGuard bracelet for this elopement-risk and that staff redirect the resident as indicated, the facility failed to ensure WanderGuard alarm placement on the unlocked double doors located in the corridor which exited Unit B, lead directly into the adjoining hospital, and allowed nursing facility egress. By failing to ensure WanderGuard alarm placement on these unlocked double doors, the facility failed to ensure that the WanderGuard bracelet utilized by Resident #14, as specified by the Care Plan, would allow redirection as indicated, also as specified by the Care Plan, by alerting staff to elopement attempts through this

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) unsecured corridor. This presented an elopement risk for Resident #14. Cross refer to F323, example 3, for more information regarding Resident #14. 4. Resident #5's MDS of 11/19/2014 documented diagnoses, in Section I - Active Diagnoses, of [MEDICAL CONDITION], Heart Failure, Hypertension, [MEDICAL CONDITION], Diabetes Mellitus, Arthritis, a history of [MEDICAL CONDITION], and Dementia. Section C - Cognitive Patterns documented that Resident #5 had moderate cognitive impairment, with a BIMS Summary Score of twelve (12). The Care Plan of Resident #5 identified that he/she resided on facility Unit B. Resident #5's Care Plan also identified, as a Problem/Need originally dated 11/20/2013, that the resident had the potential for elopement related to both episodes of confusion with wandering and a history of wandering. This Care Plan identified Approaches to address Resident #5's elopement-risk which included the use of a WanderGuard at all times, and also staff redirection as indicated. However, as indicated in the 02/14/2014, 12:30 p.m. tour observation referenced above, the double doors located within the corridor which lead off of Unit B, where Resident #5 resided, were unlocked and were not equipped with a WanderGuard alarm. This corridor within which these unlocked, unalarmed double doors were located was accessible by Resident #5, lead into the adjoining hospital facility, and exited through the hospital's main front entrance/exit. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #5, who resided on Unit B, having Dementia and cognitive impairment and having been assessed to have the potential for elopement due to confusion and a history of wandering behavior, and despite the resident's Care Plan specifying the use of a WanderGuard bracelet and that staff redirect the resident as indicated, the facility failed to ensure that double doors located in the corridor which exited Unit B and lead directly into the adjoining hospital were WanderGuard alarm-equipped. By failing to ensure WanderGuard alarm placement on the unlocked double doors within this corridor which served as a direct route of egress from the nursing facility, the facility failed to ensure that the WanderGuard bracelet utilized by Resident #5, as specified by the Care Plan, would allow redirection of the resident as indicated, also as specified by the Care Plan, by alerting staff to wandering/elopement attempts through this unsecured corridor. This presented an elopement risk for Resident #5. Cross refer to F323, example 4, for more information regarding Resident #5. 5. Resident #11's MDS assessment of 01/06/2014 documented in Section I - Active [DIAGNOSES REDACTED]. The Care Plan of Resident #11 identified that the resident resided on facility Unit C. The Care Plan also identified, as a Problem/Need originally dated 07/16/2013, that Resident #11 had the potential for wandering behavior, with a history of wandering in the hallways. Care Plan Approaches to address Resident #11's risk for wandering included the use of a WanderGuard bracelet at all times and for staff to redirect the resident as indicated. However, as indicated in the 02/14/2014, 12:30 p.m. tour observation referenced above, Resident #11, who utilized a WanderGuard bracelet and resided on Unit C, had access to the corridor which exited off of Unit B, contained the double doors which were unlocked and were not equipped with a WanderGuard alarm, and which lead from the nursing facility to the adjoining hospital and exited through the hospital's main front entrance/exit. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #11 (who resided on Unit C and had direct access to Unit B) having Dementia/severe cognitive impairment and having been assessed with [REDACTED]. Unit B, lead directly into the adjoining hospital, and allowed nursing facility egress. By failing to ensure WanderGuard alarm placement on these unlocked doors, the facility failed to ensure that the WanderGuard bracelet utilized by Resident #11, as specified by the Care Plan, would allow redirection as indicated, also as specified by the Care Plan, by alerting staff to resident wandering in this unsecured corridor. This represented a wandering risk for Resident #11. Cross refer to F323, example #5, for more information regarding Resident #11. The immediate jeopardy was determined to have been removed on February 19, 2014, at which time the facility had presented and implemented a credible allegation of jeopardy removal with the following interventions: A. On February 9, 2014, after learning of Resident #1's elopement, the facility conducted a full resident audit to assure the presence of all residents. B. On February 9, 2014, all doors exiting the nursing facility were checked to ensure the proper working order of the WanderGuard alarm system. All existing WanderGuard alarms were functioning properly. C. On February 9, 2014, a procedure was put into place by which a facility employee was placed at the doorway, located in the corridor leading from the nursing facility to the hospital, which was not equipped with a WanderGuard alarm. A scheduled was developed reflecting specific employees who were assigned to be in place at the unalarmed doorway, at specific times and continuously around the clock, until a WanderGuard alarm was installed on the doorway. D. On February 9, 2014, chart audits for all current facility residents were conducted to ensure that all residents who demonstrated a potential for elopement had been accurately identified by the facility. During these chart audits, no new residents were identified to have the potential for elopement. E. On February 9, 2014, Care Plan reviews were conducted for residents assessed to be at risk for elopement to ensure that a comprehensive approach to address this risk was in place. During these Care Plan reviews, no problems were identified. F. On February 9, 2014, in addition to daily WanderGuard bracelet checks completed by the Activities Director which were in place prior to Resident #1's elopement, the facility implemented audits of the door alarms through the preventative maintenance program. The door alarms would be checked weekly, on each Tuesday, by the Maintenance Director, and these door alarm checks would be documented via computer data entry. The door alarm test would include a check of the power indicator light to ensure proper function, and also a check for battery condition. A sensor button was to be used to test each door alarm, with the alarm to sound when within six feet of an alarmed doorway. If a door alarm did not initially sound, the test was to be repeated with a different sensor button. Any deviation from full working order found during these weekly door alarm checks would be reported to the Administrator for immediate correction. The Administrator or DON would monitor the results of these weekly door alarm audits, conducted by the Maintenance Director, by reviewing the computer data entered as a result of the door alarm checks weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. The results of these supervisory audits will be submitted to the Quality Assessment/Performance Improvement (QA/PI) Committee for their review. G. On February 9, 2014, the facility contacted the Medical Director to inform him of the elopement of Resident #1. Additionally, a meeting which consisted of some members of the QA/PI Committee, including the Administrator, DON, and Director of Maintenance, was held to review the elopement event and the actions which had been taken by the facility, and to identify any additional actions that were needed. H. On February 15, 2014, the corridor doorway, which lead from the nursing facility to the hospital and which had previously lacked a WanderGuard alarm, was equipped with a WanderGuard alarm. I. On February 18, 2014, the facility continued to provide staff in-service training to facility staff, including licensed nurses, CNAs, and maintenance/housekeeping staff. This in-service training served to both reinforce current facility protocols involving the routine monitoring of residents having WanderGuard bracelet devices and also to provide staff training on newly-implemented protocols related to the facility's WanderGuard alarm system. As of February 18, 2014, 116 of the facility's total 118 employees had received this in-service training. The two (2) remaining staff members, who were on Family and Medical Leave Act leave at the time this in-service training was provided, will received the training upon their return to work. J. On February 18, 2014, the QA/PI Committee met to review the elopement event involving Resident #1, to review the actions taken by the facility as of that date, and to review the monitoring systems put into place as a result of the elopement. The QA/PI Committee will review the results of WanderGuard bracelet monitoring and door alarm audits weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter to ensure ongoing compliance with the systemic measures implemented to correct the identified issue and prevent recurrence. The information will be analyzed by the QA/PI Committee, and subsequent plans of correction will be developed and implemented as needed. This will be an ongoing process. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 19, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On February 9, 2014, the facility implemented a weekly audit of WanderGuard door alarms to be accomplished through the preventative maintenance program by the Maintenance Director. These weekly WanderGuard door alarm audits would check for the proper function of all facility WanderGuard door alarms, and were to be documented via computer data entry. However, these weekly WanderGuard door alarm audits had been initiated only on February 9, 2014, and had occurred only twice prior to the February 20, 2014 exit date of this complaint survey. Therefore, ongoing staff compliance with this newly implemented procedure involving routine, scheduled WanderGuard door alarm monitoring could not be entirely assessed at the time of survey completion, and will thus need future evaluation. Additionally, by February 18, 2014, the facility had completed in-service training for 116 of its 118 facility employees, to include licensed nurses, CNAs, and maintenance/housekeeping staff, regarding both existing and newly-implemented protocols involving the monitoring of residents with WanderGuard bracelets and the WanderGuard alarm system. However, two (2) remaining staff members, who were on leave and had been unavailable for training, will need to receive this training upon returning to work, and this training will thus need future evaluation. Additionally, the QA/PI

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	115714	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHRIDGE HEALTH AND REHABILITATION	100 MEDICAL CENTER DRIVE COMMERCE, GA 30529

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

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F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) Committee was to include the review the results of WanderGuard bracelet monitoring and door alarm audits in future meetings, but the Committee had met on On February 18, 2014, only two (2) days prior to the February 20, 2014 exit date of this complaint survey, to begin this process. Thus, the QA/PI Committee's ongoing process of facility procedural oversight could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the E level.
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, clinical record review, EMS Prehospital Care Report Summary review, hospital Record of Admission report review, hospital ER Triage Record review, hospital ED Nursing Record review, nursing facility Follow-Up Report review, Weather.com report review, MapQuest.com report review, hospital staff interview, and nursing facility staff interview, the facility failed to ensure that the WanderGuard alarm system, utilized by the facility to alert staff of attempts by residents having wandering/elopement behavior to exit the facility, included alarm coverage for a set of unlocked double doors contained in one (1) first floor corridor which was accessible to Unit B and Unit C residents, and which exited the nursing facility into the adjoining hospital facility. The facility's failure to ensure WanderGuard alarm protection on these unlocked doors located in this corridor leading from the nursing facility into the hospital thus allowed this corridor to serve as a route of elopement for one (1) resident (#1) who utilized a WanderGuard bracelet for wandering/exit-seeking behavior and eloped through these unlocked/unalarmed doors, and as a potential route of elopement for four (4) additional residents (#5, #11, #12, and #14) on the survey sample with known elopement/wandering behavior, all of whom utilized WanderGuard bracelets and had access to this unsecured nursing home/hospital corridor, on the total survey sample of fourteen (14) residents. Resident #1 accessed this unsecured corridor on 02/09/2014, exited the nursing facility through this corridor via these unalarmed and unlocked doors, and eloped through the adjoining hospital. Resident #1 then traveled along a street for a distance of approximately one-half mile, fell hitting his/her head on the pavement, was taken to the hospital Emergency Department (ED), and was found to have sustained facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. This resulted in a situation in which the facility's non-compliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing were informed of the immediate jeopardy on February 18, 2014 at 9:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on February 9, 2014 (the date Resident #1 eloped from the facility via the set of unlocked, unalarmed, and unsecured doors located within the corridor which lead from the nursing facility to the adjoining hospital) continued through February 18, 2014, and was removed on February 19, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 18, 2014. During this survey, it was determined that the facility failed to ensure supervision of Resident #1, who had a history of [REDACTED]. On 02/09/2014, Resident #1 eloped from the facility, traveled a distance of approximately one-half mile, and sustained a fall resulting in facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. On 02/05/2014, prior to this elopement incident of 02/09/2014, Resident #1 had been transferred to Unit B located on the nursing facility's first floor after having been admitted to Unit E located on the second floor upon original facility admission. However, a Unit B corridor directly connected with, and lead into, a corridor of the hospital which adjoined the nursing facility, and double doors within this corridor were not equipped with a WanderGuard alarm and were not locked. During an interview with the Administrator conducted on 02/14/2014 at 11:50 a.m., when questioned about Resident #1's 02/09/2014 nursing facility elopement, the Administrator acknowledged that Resident #1's Unit B room had been located in close proximity to the unlocked corridor doors which were located in the corridor leading into the hospital and which did not have a WanderGuard alarm. The Administrator stated it was thought that Resident #1 had passed through the unalarmed corridor double doors into the hospital and exited through the front main entrance/exit doors of the hospital. In addition to Resident #1, four (4) more sampled residents (#5, #11, #12, and #14) who had cognitive impairment and utilized WanderGuard bracelets for known elopement/wandering/exit-seeking behavior, also resided either on Unit B or Unit C, both of which allowed direct access to this set of unlocked, unalarmed corridor doors which lead into the hospital. An allegation of jeopardy removal was received on February 19, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 19, 2014, and the facility remained out of compliance at a lower scope and severity of E while the facility completed a process which involved the retraining, via staff in-service, of available nursing staff related to procedural revisions made to ensure adequate supervision for residents at risk of wandering/elopement, but continued to provide in-service training to staff who were initially unavailable for training, as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the monitoring of residents requiring supervision related to the risk of wandering/elopement. Observations were made to assess staffs' performance of care and supervision of these residents. Findings include: 1. Record review for Resident #1 revealed a 5-day PPS Minimum Data Set (MDS) Assessment having an Assessment Reference Date of 02/06/2014 which documented a facility Entry Date of 01/30/2014. Section I - Active [DIAGNOSES REDACTED].#1 had [DIAGNOSES REDACTED]. Section C - Cognitive Patterns documented that Resident #1 had a Brief Interview for Mental Status (BIMS) Summary Score of 06, indicating that the resident had severe impairment in cognition. Section G - Functional Status indicated that Resident #1 was independent with walking, and Section E - Behavior documented that the resident had exhibited wandering behavior 1 to 3 days during the look-back period, and that this wandering placed the resident at significant risk of getting to a potentially dangerous place (e.g., outside of the facility). Review of Resident #1's admission physician's orders [REDACTED]. A Physician's Interim Orders form dated 01/31/2014 specified that Resident #1 was to wear a WanderGuard bracelet at all times. The 01/30/2014 admission physician's orders [REDACTED].#1 referenced above also documented that upon facility admission, Resident #1 was admitted to a room on Unit E (one of the facility's second floor units utilized for the placement of residents at risk for elopement). However, a Nurse's Notes (NN) entry of 02/05/2014 at 4:40 p.m. documented that Resident #1 had been transferred to Unit B (a first floor, ground-level unit) per the family's request. A NN entry of 02/06/2014 of the 7:00 a.m.-7:00 p.m. shift for Resident #1 documented that the resident was alert but with confusion, and that the resident had been pacing in the hall and going into other residents' rooms. This NN also documented that Resident #1 had approached the C Hall doors twice that shift, and that staff had to redirect the resident. A NN entry of 02/07/2014 of the 7:00 p.m.-7:00 a.m. shift for Resident #1 documented that the resident had been walking up and down the hall, and a twenty-four hour summary assessment sheet of 02/07/2014 for Resident #1 documented that the resident had exhibited wandering behavior on both the day and night shifts. A NN entry of 02/08/2014 of the 7:00 a.m.-7:00 p.m. shift for Resident #1 documented that the resident remained confused, was looking to go home, and stating that someone was coming to get her. This NN also documented that Resident #1's family would visit, but that the resident would wander after the family left. A twenty-four hour shift summary assessment of 02/08/2014 for Resident #1 documented that the resident had exhibited wandering behavior on the day shift of that date. A NN entry of 02/09/2014 of the 7:00 a.m.-7:00 p.m. shift for Resident #1 documented that the resident continued to show confusion and was following staff around from room-to-room. This NN documented that Resident #1 was walking up and down the hallways, and that staff would redirect him/her as he/she got to the end of the hallways. This NN also documented that Resident #1 had stated Which way is the way out? I need to get home. The NN documented that at around 3:45 p.m. on 02/09/2014, Resident #1 had been given drawing material and Crayons by Licensed Practical Nurse (LPN) AA and seated in the Day Room for an activity, and that moments later, a certified nursing assistant was noted assisting Resident #1 with the activity while seated at the table in the Day Room. However, a NN entry of 02/09/2014, timed at 5:00 p.m., for Resident #1 documented that the nurse received a telephone call from a family member of Resident #1 to inform the nurse that the resident had been found at the roadside, and in close proximity to a local lake, by a previous neighbor, who had noted injuries and called Emergency Medical Service (EMS) 911. The family member informed the nurse that Resident #1 was being taken to the hospital emergency room . In this NN, the nurse referenced the resident's use of a WanderGuard bracelet and indicated that it was unknown how the resident had eloped from the building. A NN entry of 02/09/2014, timed at 5:10 p.m., for Resident #1 documented that the nurse copied the necessary paperwork from the resident's nursing facility medical record and walked the paperwork over to the hospital (which was located adjacent to the nursing home and connected to the nursing home via a shared corridor).

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) The nurse documented in this NN that once she arrived in the hospital ER, she was informed by an Emergency Medical Technician that he had cut a WanderGuard bracelet off of Resident #1. The EMS Prehospital Care Report Summary for Resident #1 documented that on 02/09/2014 at 4:40 p.m., EMS had received a telephone call regarding Resident #1. This EMS Report Summary documented that EMS staff responded and found Resident #1 to have walked from the nursing home to her prior private home and to have fallen face-first to the roadway. This EMS Summary documented a hematoma to Resident #1's forehead and a contusion with laceration to the nose, and further documented the resident's hospital transport. Review of the hospital Record of Admission for Resident #1 revealed a hospital admission date of [DATE], with an Admitting [DIAGNOSES REDACTED]. The ER Triage Record for Resident #1 documented, in the Assessment section, a Chief Complaint of the resident having fallen onto pavement and having hit his/her face and forehead approximately thirty (30) minutes prior to hospital arrival. The hospital ED Nursing Record (EDNR) for Resident #1 contained an entry, dated 02/09/2014 and timed at 5:10 p.m., which documented the resident's hospital ED nursing assessment. This EDNR entry documented that Resident #1 stated he/she had fallen and hit his/her face. The EDNR entry also documented that lacerations and abrasions were noted to Resident #1's face, bridge of the nose, and forehead. The EDNR entry further documented that Resident #1 had been found by a previous next-door neighbor, who had found the resident in the highway and on the ground outside of the resident's former home (the place of dwelling prior to nursing home admission). A subsequent EDNR entry for Resident #1, dated 02/09/2014 and timed at 8:20 p.m., documented that Resident #1 had been discharged to home from the hospital with family members. The ED Discharge Instructions form for Resident #1 documented an ED discharge date of [DATE], and documented ED [DIAGNOSES REDACTED]. During an interview with hospital ED Registered Nurse (RN) CC conducted on 02/18/2014 at 1:15 p.m., RN CC stated that he was working in the hospital's ED on the evening of 02/09/2014 when Resident #1 was brought to the ED for treatment of [REDACTED].#1 was wearing a long-sleeve shirt, jogging pants, and shoes when he/she presented at the hospital ED for treatment. Review of Weather.com revealed that the exterior environmental temperature for the Commerce, Georgia area, in which the nursing facility was located, registered at 59 degrees Fahrenheit on 02/09/2014 at 4:55 p.m., the date and approximate time of Resident #1's elopement from the facility. A facility Follow-Up Report (FR) dated 02/14/2014 referenced Resident #1 and documented the facility's investigation into Resident #1's 02/09/2014 elopement. This facility FR documented, in the Background section, that after Resident #1's original facility admission to Unit E (on the facility's second floor) where residents considered to be at risk for elopement were housed, the resident was moved from Unit E to Unit B (on the facility's first floor) on 02/05/2014 at the request of the resident's family. The Review of Initial Report section of this FR documented that on 02/09/2014 at 5:00 p.m., the facility received a telephone call from a family member informing facility staff that Resident #1 had left the facility. Further review of the FR revealed, in the Details of Investigation/Chronology of Events section, that at 3:45 p.m. on 02/09/2014, Resident #1 had been placed in the Day Room for an activity by LPN AA, and that Certified Nursing Assistant (CNA) BB had assisted Resident #1 in the Day Room from 4:00 p.m. until 4:05 p.m. CNA BB then left Resident #1 to assist other residents in preparing for dinner. This FR documented that sometime after 4:00 p.m. on 02/09/2014, Resident #1 left the Day Room and headed toward his/her former home. The FR documented that Resident#1 almost reached his/her former home, located 0.83 mile from the nursing facility, but sustained a fall prior to arriving. This FR documented that at 5:00 p.m., the facility received a telephone call from the family of Resident #1 informing facility staff of the resident's elopement and hospital transfer, and that upon Resident #1's arrival at the hospital after the elopement and fall, the resident was treated for [REDACTED]. This FR documented that later in the evening of 02/09/2014 at 8:20 p.m., Resident #1 left the hospital in the company of a family member and went home, not returning to the nursing facility. The Summary/Conclusion section of the FR, which chronicled the facility's investigation into Resident #1's elopement and fall with injuries on 02/09/2014 as referenced above, documented the facility had concluded that it was unknown how Resident #1 was able to elope from the facility undetected. This section of the FR further documented that it was believed that Resident #1 could have eloped through the set of double doors located in a corridor which went past the facility's kitchen and eventually lead to the adjoining hospital's main entrance/exit. During an observation conducted on 02/14/2014 at 12:30 p.m., accompanied by the facility's Administrator, a tour of the entire facility was conducted, to include the former Unit B room where Resident #1 had resided prior to the 02/09/2014 elopement. Resident #1's former room was observed to be at the end of the B Hall of Unit B. Approximately ten (10) feet from Resident #1's former room, and at the end of the B Hall of Unit B, a corridor turned to the right. After the right turn, this corridor extended a distance of approximately twenty (20) feet, at which point a set of double doors was encountered. These double doors were observed to be unalarmed, and were observed to open after activation via a wall-mounted button located on an adjacent wall and in close proximity to the double doors. These doors were not locked, and opened when the wall-mounted button was pressed. Upon passing through this set of unlocked double doors, the corridor continued for a distance of approximately twenty (20) feet, then turned right and continued for a distance of approximately another eighty (80) feet, passing through the adjoining hospital facility and exiting through the hospital's main entrance/exit doors, which were unlocked, unalarmed, and located at the front of the hospital. Upon exit through the hospital's front main entrance/exit doors, the hospital's front parking lot was located directly in front of the entrance/exit doors. The hospital parking lot then adjoined a two lane street which ran in front of the hospital and nursing facility buildings. During an interview with the Administrator conducted on 02/14/2014 at 11:50 a.m., the Administrator stated that Resident #1's former home, where the resident had resided prior to nursing facility admission, was located on the street which was adjacent to the hospital parking lot, at a distance of 0.83 mile (Source: MapQuest.com) from the nursing facility/hospital. The Administrator further stated that it was on this street, and in close proximity to Resident #1's former home, that Resident #1 was found to have fallen and sustained injuries after having eloped from the nursing facility on 02/09/2014. During the 02/14/2014, 12:30 p.m. nursing facility tour referenced above, observations made of the facility's first floor units (both of Unit B where Resident #1 had resided and Unit C) revealed a WanderGuard alarm on the entrance/exit doors located at the nursing facility's main entrance at the front of the facility. Additionally, observation in Unit C's front corridor revealed WanderGuard-alarmed doors located at the terminal end of Unit C's front corridor which opened into a corridor of the adjoining hospital facility. However, as referenced above, the double doors which were located in the corridor leading off of Unit B and continuing into the adjoining hospital facility, and through which Resident #1 exited Unit B and eloped on 02/09/2014, did not have a WanderGuard alarm and were not locked. During this observation, it was noted that Unit B was contiguous to Unit C, allowing residents of both Unit B and Unit C to move freely between units, and thus allowing residents of both units access to the Unit B corridor, ultimately leading to the hospital, in which the unlocked double doors were not equipped with a WanderGuard alarm. During the 02/14/2014, 11:50 a.m. interview with the Administrator referenced above, the Administrator was questioned regarding Resident #1's 02/09/2014 nursing facility elopement. During this interview, the Administrator stated that Resident #1's room, located on the B Hall of Unit B, was located in close proximity to the set of corridor doors which were not locked, which did not have a WanderGuard alarm, and which were located in the corridor leading past the kitchen area and then into the hospital. The Administrator stated that on 02/09/2014 at approximately 4:00 p.m., Resident #1 had been observed by staff while participating in an activity in the Day Room. The Administrator stated that it was thought that Resident #1 left the Day Room shortly after 4:00 p.m. to return to his/her room, but then continued to walk down the B Hall corridor, passed through the unalarmed corridor double doors, entered into the hospital corridor, and exited the hospital through the hospital's front main entrance/exit doors. The Administrator stated it was thought that Resident #1, upon exiting the hospital, walked across the front parking lot, went to the street in front of the hospital, made a left onto the street, walked approximately one-half (1/2) mile, and was found by a former neighbor to be lying face down in a ditch by the street. The Administrator acknowledged that Resident #1's prior home was located approximately 0.83 mile from the nursing facility/hospital on the street where he/she was found to have fallen after the 02/09/2014 elopement from the nursing facility. The Administrator further stated that after Resident #1's elopement, all facility doors having WanderGuard alarms were checked and were found to be functioning properly, but acknowledged that the corridor doors through which it was though Resident #1 had passed (and then eloped through the hospital's main entrance/exit) did not have a WanderGuard alarm. During an interview with the DON conducted on 02/14/2014 at 12:48 p.m., the DON stated that on 02/09/2014, after Resident #1 eloped from the facility, the Maintenance Supervisor had tested all existing WanderGuard-alarmed exit doors and had found them to be working properly. However, the DON stated that Resident #1's former room was located close to the end of the B Unit corridor and close to the set of unalarmed corridor doors at the end of the corridor. The DON stated that, based on the Maintenance Supervisor's finding that all existing WanderGuard-alarmed doors were functioning correctly on 02/09/2014, the facility determined that Resident #1 had walked down the Unit B corridor upon which his/her room was located, but then the unalarmed corridor doors allowed

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 6) the resident to continue walking down the corridor out of the nursing facility and to exit out the front doors of the hospital. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #1 having severe cognitive impairment and a known history wandering behavior requiring the use of a WanderGuard bracelet, despite Resident #1 being observed on multiple occasions to continue exhibiting both wandering behavior and exit-seeking behavior, the facility transferred Resident #1 on 02/05/2014 from Unit E (a second floor unit for which the exit was WanderGuard alarm protected) to Unit B (a first floor unit which allowed access to a set of unsecured, unlocked corridor doors which did not have a WanderGuard alarm and which lead to the hospital.) Resident #1 then exited through the unalarmed, unlocked corridor double doors while wearing a WanderGuard bracelet but without the knowledge of nursing facility staff, gained access to the hospital corridor, exited the hospital through the hospital's front entrance/exit doors, and eloped from the facility. The facility thus failed to ensure supervision of Resident #1 related to his/her risk for elopement/wandering, via the use of the WanderGuard bracelet as ordered by the physician, by failing to ensure the placement of a WanderGuard alarm on the unlocked corridor doors contained within the corridor which exited off of Unit B where Resident #1 resided, allowing the resident to exit through these doors undetected by staff and to elope. After Resident #1 eloped, he/she then traveled approximately one-half (1/2) mile toward his/her former home, fell , and sustained facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. In addition to Resident #1 referenced above, four (4) additional sampled residents (#5, #11, #12, and #14) utilized WanderGuard bracelets for elopement and/or wandering behaviors and resided on either Unit B or Unit C of the facility's first floor. As documented in the 02/14/2014, 12:30 p.m. observation of Unit B and Unit C referenced above, these units were contiguous, therefore allowing Residents #5, #11, #12, and #14 to move freely between these units. However, as also documented in the 02/14/2014, 12:30 p.m. Unit B and Unit C observation referenced above, the unlocked double doors located in the facility corridor which lead off of Unit B, into the adjoining hospital facility, and ultimately allowing exit through the hospital's main front entrance/exit doors, were neither locked nor WanderGuard alarm-equipped. This placed Residents #5, #11, #12, and #14 (who all had wandering and/or elopement behaviors requiring WanderGuard bracelet use and who all had access to these unlocked/unalarmed corridor doors) at risk for elopement, as evidenced by the following: 2. Record review for Resident #12 revealed a Quarterly MDS having an Assessment Referenced Date of 11/11/2013 which documented in Section I - Active [DIAGNOSES REDACTED]. Section C - Cognitive Patterns of this MDS documented that Resident #12 had a BIMS Summary Score of 7, indicating that the resident had severe cognitive impairment. Section G - Functional Status documented that Resident #12 utilized a walker and wheelchair as mobility devices, and Section J - Health Conditions documented that the resident had a history of [REDACTED].#12's Care Plan identified that he/she resided on Unit B, and that he/she had a history of [REDACTED]. An Interdisciplinary Progress Notes (IPN) entry of 02/14/14 at 2:00 p.m. for Resident #12 documented that the resident was rolling himself/herself in the wheelchair, going to the C Hall and trying to go home. However, the 02/14/2014, 12:30 p.m. observation referenced above revealed that, even though Resident #12 resided on Unit B and required a WanderGuard bracelet, the resident had access to the double doors, which were neither locked nor WanderGuard alarm protected, located within the corridor exiting Unit B and then exiting through the adjoining hospital's main front entrance/exit doors. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #12 (who resided on Unit B) having severe cognitive impairment, despite the resident having been assessed to have a history of wandering behavior and continuing to exhibit exit-seeking behavior thereby requiring the use of a WanderGuard bracelet, and despite the resident being ambulatory via wheelchair and walker, the facility failed to ensure that the WanderGuard system, intended to prevent resident elopement, included a WanderGuard alarm on the unlocked double doors in the nursing facility corridor which exited Unit B (upon which Resident #12 resided) and lead into an unsecured corridor in the hospital. The facility thus failed to ensure adequate supervision, via the WanderGuard bracelet, for Resident #12, who was at risk for wandering/elopement and who required the use of the WanderGuard bracelet for this risk. 3. Record review for Resident #14 revealed a Quarterly MDS assessment having an Assessment Reference Date of 01/06/2014 which documented in Section I - Active [DIAGNOSES REDACTED]. Section C - Cognitive Patterns documented that Resident #14 had a BIMS Summary Score of 99, indicating that the resident had severe cognitive impairment, and documented that the resident had both short-term and long-term memory problems. Section G - Functional Status documented that Resident #14 required only supervision/limited assistance with locomotion, and that the resident utilized a wheelchair as a mobility device. Resident #14's Care Plan identified the resident to be at risk for elopement, and specified the use of a WanderGuard bracelet. An Interdisciplinary Progress Notes (IPN) entry of 02/08/2014 at 11:00 a.m. for Resident #14 documented that the resident resided on Unit C (located on the facility's first floor and adjacent to Unit B), and that the resident was noted to be following other residents into their rooms, requiring redirection. A later IPN of 02/08/2014 at 3:00 p.m. documented that Resident #14 continued going into other residents' rooms, and that Resident #14 was following a resident down the hallway. An IPN of 02/13/2014 at 2:30 p.m. for Resident #14 documented that Resident #14 had again gone into another resident's room. However, the 02/14/2014, 12:30 p.m. observation referenced above revealed that, even though Resident #14 required the use of a WanderGuard bracelet for a risk of elopement and resided on Unit C, the resident also had access to Unit B and thus had access to the double doors, which were neither locked nor WanderGuard alarm protected, located within the corridor which exited Unit B and then exited the adjoining hospital's main front entrance/exit doors. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #14 (who resided on Unit C) having severe cognitive impairment and having been assessed to be at risk for elopement requiring the use of a WanderGuard bracelet, and despite the resident being ambulatory via a wheelchair and continuing to exhibit wandering behavior, the facility failed to ensure that the WanderGuard alert system, intended to prevent resident elopement, included the placement of a WanderGuard alarm on the set of unlocked double doors in the nursing facility corridor which exited Unit B (to which Resident #14 had access) and lead into a corridor in the hospital adjacent to the nursing facility. The facility thus failed to ensure adequate supervision, via the WanderGuard bracelet, for Resident #14 who was at risk for elopement and who required the use of the WanderGuard bracelet for this risk. 4. Record review for Resident #5 revealed an Annual MDS assessment having an Assessment Reference Date of 11/19/2014 which documented in Section I - Active [DIAGNOSES REDACTED]. Section C - Cognitive Patterns of this MDS documented that Resident #5 had a BIMS Summary Score of 12, indicating that the resident had moderate cognitive impairment. Section G - Functional Status documented that Resident #5 utilized a walker and a wheelchair as mobility devices, and required the limited assistance with walking in the room and in the corridor of his/her unit, but was totally dependent on staff for locomotion off of the unit. Resident #5's Care Plan identified that the resident had the potential for elopement, and that the resident required the use of a WanderGuard bracelet. Further record review for Resident #5 revealed a NN entry of 11/17/2013 for the 7:00 a.m.-7:00 p.m. shift which documented that the resident resided on Unit B, and documented that the resident propelled himself/herself utilizing a wheelchair. However, the 02/14/2014, 12:30 p.m. observation referenced above revealed that, even though Resident #5 resided on Unit B and required a WanderGuard bracelet for the risk of elopement, the resident had access to the double doors which were not locked or WanderGuard alarm equipped, and were located in the corridor which exited Unit B and then exited through the hospital's front entrance/exit. Based on the above, despite the facility's system for supervision of residents at risk of wandering/elopement involving the use of WanderGuard bracelets, despite Resident #5 (who resided on Unit B) having cognitive impairment and having been assessed to be at risk for elopement and requiring the use of a WanderGuard bracelet, the facility failed to ensure that the WanderGuard alert system, intended to prevent resident elopement, included a WanderGuard alarm on the unlocked double doors in the corridor which exited Unit B and lead into a corridor in the hospital adjacent to the nursing f
F 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on observation, record review, and staff interview, the facility failed to ensure oversight by, and the involvement of, the Quality Assessment/Performance Improvement (QA/PI) Committee in the formulation and implementation of a corrective action plan developed in response to resident elopement. This corrective action plan was developed regarding the elopement of one (1) resident (#1) who resided on Unit B, had wandering/elopement behavior, and utilized a WanderGuard bracelet, of five (5) sampled Unit B and Unit C residents (#1, #5, #11, #12, and #14) with known elopement/wandering behavior who

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	115714	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHRIDGE HEALTH AND REHABILITATION	100 MEDICAL CENTER DRIVE COMMERCE, GA 30529

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

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) utilized WanderGuard bracelets, on the total survey sample of fourteen (14) residents. Resident #1, who utilized a WanderGuard bracelet to address wandering behavior and resided on Unit B, eloped through unlocked double doors which had no WanderGuard alarm and which were located in a corridor leading from facility Unit B into the adjoining hospital. Facility administrative staff developed a corrective action plan in response to Resident #1's elopement to address this failure of the WanderGuard alert system to protect Resident #1, and the additional residents of Units B and C who were at risk for elopement/wandering, from eloping through these unlocked and unalarmed corridor doors. However, this corrective action plan was developed and implemented prior to QA/PI Committee review, analysis and evaluation. This resulted in a situation in which the facility's non-compliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the immediate jeopardy on February 18, 2014 at 9:30 a.m. The non-compliance related to the immediate jeopardy was identified to have existed on February 9, 2014 (the date Resident #1 eloped from the facility via the set of unlocked, unalarmed, and unsecured doors located within the corridor which lead from the nursing facility to the adjoining hospital) continued through February 18, 2014, and was removed on February 19, 2014. The facility implemented a credible allegation of jeopardy removal related to the immediate jeopardy on February 18, 2014. During an interview with the Administrator conducted on 02/14/2014 at 11:50 a.m., the Administrator acknowledged Resident #1's 02/09/2014 nursing facility elopement, and that a plan of action had been developed by facility management staff in response to the resident's elopement. However, the Administrator further acknowledged that at the time of this 02/14/2014 interview, the QA/PI Committee had not met to review and analyze this plan of action which had been developed by facility management staff. An allegation of jeopardy removal was received on February 19, 2014. Based on the corrective plans which had been developed and implemented by the facility, the immediacy of the deficient practice was determined to have been removed on February 19, 2014, and the facility remained out of compliance at a lower scope and severity of E while the facility completed a process which involved the retraining, via staff in-service, of available nursing staff related to procedural revisions made to ensure adequate supervision for residents at risk of wandering/elopement, but continued to provide in-service training to staff who were initially unavailable for training, as they reported to work. In-service materials and records were reviewed. Interviews were conducted with staff to ensure they were knowledgeable about the monitoring of residents requiring supervision related to the risk of wandering/elopement. Observations were made to assess staffs' performance of care and supervision of these residents. Findings include: Cross refer to F323. Based on observation, clinical record review, and staff interview, the facility failed to ensure that the WanderGuard alarm system included alarm coverage for unlocked double doors located in a first floor corridor which was accessible to residents having elopement/wandering behavior of Unit B and Unit C and which exited the nursing facility into the adjoining hospital. The failure allowed this unlocked and unsecured corridor to serve as a route of elopement, or potential route of elopement, for five (5) residents who utilized WanderGuard bracelets for elopement/wandering behavior (#1, #5, #11, #12, and #14), on the survey sample of fourteen (14) residents. Resident #1 exited the nursing facility through this corridor on 02/09/2014, eloped through the adjoining hospital, traveled along a street for a distance of approximately one-half mile, then fell , was transferred to the hospital, and had sustained facial abrasions, a nasal laceration requiring sutures, a nasal fracture, and a fractured right knee cap. An interview was conducted with the Administrator and DON on 02/20/2014 at 11:30 a.m. related to the facility's QA/PI Committee. During this interview, the Administrator was questioned regarding the QA/PI Committee's involvement in the oversight and evaluation of the facility's system for monitoring residents at risk for elopement/wandering, and of the Committee's involvement in the formulation of corrective actions which were developed and implemented as a result of Resident #1's 02/09/2014 elopement. The Administrator presented a written response to the questions posed during this 02/20/2014, 11:30 a.m. interview. In this written response, the Administrator documented that, prior to the elopement incident of 02/09/2014 involving Resident #1, the WanderGuard system had not been presented to the QA/PI Committee as it had not been identified as an issue that needed to be addressed. The Administrator documented that on the night of 02/09/2014, after Resident #1 eloped, the Administrator, DON, and Director of Maintenance met and developed a corrective action plan. However, the Administrator documented that there had been no meeting of the QA/PI Committee related to the 02/09/2014 elopement of Resident #1 until 02/18/2014, and acknowledged that it was not until that date (some nine (9) days after the incident involving Resident #1's elopement and injury) that the QA/PI Committee had conducted an analysis of the elopement of Resident #1, and had reviewed and evaluated the corrective actions, which included procedural changes and staff in-service training, which had been developed and put into place by the Administrator, DON, and Director of Maintenance. No evidence was presented by the facility to indicate that the QA/PI Committee had been involved in the formulation of the corrective action plan, developed and put into place by management staff as a result of the 02/09/2014 elopement of Resident #1, to evaluate the effectiveness of the corrective actions in assuring the supervision of residents at risk for elopement. Instead, this corrective action plan was developed and implemented in the absence of input by the QA/PI Committee, and without oversight by the Committee, prior to plan implementation. By the time the QA/PI Committee met on 02/18/2014 to review the plan of action, originally developed on 02/09/2014 by facility management staff and which involved procedural modifications related to the facility's WanderGuard alert system, 116 of the facility's 118 employees (as documented in the facility's credible allegation of jeopardy removal) had already received inservice training regarding these procedural changes. The immediate jeopardy was determined to have been removed on February 19, 2014, at which time the facility had presented and implemented a credible allegation of jeopardy removal with the following interventions: A. On February 9, 2014, after learning of Resident #1's elopement, the facility conducted a full resident audit to assure the presence of all residents. B. On February 9, 2014, all doors exiting the nursing facility were checked to ensure the proper working order of the WanderGuard alarm system. All existing WanderGuard alarms were functioning properly. C. On February 9, 2014, a procedure was put into place by which a facility employee was placed at the doorway, located in the corridor leading from the nursing facility to the hospital, which was not equipped with a WanderGuard alarm. A scheduled was developed reflecting specific employees who were assigned to be in place at the unalarmed doorway, at specific times and continuously around the clock, until a WanderGuard alarm was installed on the doorway. D. On February 9, 2014, chart audits for all current facility residents were conducted to ensure that all residents who demonstrated a potential for elopement had been accurately identified by the facility. During these chart audits, no new residents were identified to have the potential for elopement. E. On February 9, 2014, Care Plan reviews were conducted for residents assessed to be at risk for elopement to ensure that a comprehensive approach to address this risk was in place. During these Care Plan reviews, no problems were identified. F. On February 9, 2014, in addition to daily WanderGuard bracelet checks completed by the Activities Director which were in place prior to Resident #1's elopement, the facility implemented audits of the door alarms through the preventative maintenance program. The door alarms would be checked weekly, on each Tuesday, by the Maintenance Director, and these door alarm checks would be documented via computer data entry. The door alarm test would include a check of the power indicator light to ensure proper function, and also a check for battery condition. A sensor button was to be used to test each door alarm, with the alarm to sound when within six feet of an alarmed doorway. If a door alarm did not initially sound, the test was to be repeated with a different sensor button. Any deviation from full working order found during these weekly door alarm checks would be reported to the Administrator for immediate correction. The Administrator or DON would monitor the results of these weekly door alarm audits, conducted by the Maintenance Director, by reviewing the computer data entered as a result of the door alarm checks weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter. The results of these supervisory audits will be submitted to the Quality Assessment/Performance Improvement (QA/PI) Committee for their review. G. On February 9, 2014, the facility contacted the Medical Director to inform him of the elopement of Resident #1. Additionally, a meeting which consisted of some members of the QA/PI Committee, including the Administrator, DON, and Director of Maintenance, was held to review the elopement event and the actions which had been taken by the facility, and to identify any additional actions that were needed. H. On February 15, 2014, the corridor doorway, which lead from the nursing facility to the hospital and which had previously lacked a WanderGuard alarm, was equipped with a WanderGuard alarm. I. On February 18, 2014, the facility continued to provide staff in-service training to facility staff, including licensed nurses, CNAs, and maintenance/housekeeping staff. This in-service training served to both reinforce current facility protocols involving the routine monitoring of residents having WanderGuard bracelet devices and also to provide staff training on newly-implemented protocols related to the facility's WanderGuard alarm system. As of February 18, 2014, 116 of the facility's total 118 employees had received this in-service training. The two (2) remaining staff members, who were on Family and Medical Leave Act leave at the time this in-service training was provided, will received the training upon their return to work. J. On

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) February 18, 2014, the QA/PI Committee met to review the elopement event involving Resident #1, to review the actions taken by the facility as of that date, and to review the monitoring systems put into place as a result of the elopement. The QA/PI Committee will review the results of WanderGuard bracelet monitoring and door alarm audits weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter to ensure ongoing compliance with the systemic measures implemented to correct the identified issue and prevent recurrence. The information will be analyzed by the QA/PI Committee, and subsequent plans of correction will be developed and implemented as needed. This will be an ongoing process. Based on these corrective actions which had been developed and implemented by the facility as outlined above, the immediacy of the deficient practice was removed on February 19, 2014. However, the effectiveness of the corrective action plans could not be fully assessed to ensure ongoing application and completion. On February 9, 2014, the facility implemented a weekly audit of WanderGuard door alarms to be accomplished through the preventative maintenance program by the Maintenance Director. These weekly WanderGuard door alarm audits would check for the proper function of all facility WanderGuard door alarms, and were to be documented via computer data entry. However, these weekly WanderGuard door alarm audits had been initiated only on February 9, 2014, and had occurred only twice prior to the February 20, 2014 exit date of this complaint survey. Therefore, ongoing staff compliance with this newly implemented procedure involving routine, scheduled WanderGuard door alarm monitoring could not be entirely assessed at the time of survey completion, and will thus need future evaluation. Additionally, by February 18, 2014, the facility had completed in-service training for 116 of its 118 facility employees, to include licensed nurses, CNAs, and maintenance/housekeeping staff, regarding both existing and newly-implemented protocols involving the monitoring of residents with WanderGuard bracelets and the WanderGuard alarm system. However, two (2) remaining staff members, who were on leave and had been unavailable for training, will need to receive this training upon returning to work, and this training will thus need future evaluation. Additionally, the QA/PI Committee was to include the review the results of WanderGuard bracelet monitoring and door alarm audits in future meetings, but the Committee had met on On February 18, 2014, only two (2) days prior to the February 20, 2014 exit date of this complaint survey, to begin this process. Thus, the QA/PI Committee's ongoing process of facility procedural oversight could not be evaluated at the time of survey completion. Therefore, the non-compliance continues, but the scope and severity is reduced to the E level.