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	145190	A. BUILDING _____ B. WING _____	C 07/14/2015

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F 000	INITIAL COMMENTS Complaint #1563588/IL78424 - F323 Complaint #1563665/IL78506-No deficiency. A partial extended survey was conducted.	F 000		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to implement increased security measures related to escalated exit seeking behaviors for one resident (R1) of eleven residents reviewed for exit seeking behavior. R1 entered a stairwell and was found sitting at the base of the stairs with injuries (closed head injury; hematoma of frontal scalp). The facility door alarm system failed to alert staff that R1 had entered a stairwell. This had the potential to affect 11 at risk residents (R1, R2, R3, R5, R6, R7, R10-R14). This failure resulted in An Immediate Jeopardy. While the Immediate Jeopardy was removed on 7/9/15, the facility remains out of compliance at a severity level of two as the facility is still educating staff in regards to exit seeking, behavior management and one on one monitoring.	F 323		

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

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Department managers will receive training on interdisciplinary care plan development and updating. The facility is implementing a procedure for residents exhibiting new behaviors and/or exit seeking behavior which will be reviewed during morning interdisciplinary team meetings by nursing management and social services.

The findings include:

R1's July 2015 Physician Order Sheet lists diagnoses that includes: Traumatic Brain Injury (TBI), Epilepsy, Grand mal status, Anxiety State, Depressive Disorder and other signs and symptoms involving cognition. The quarterly Minimum Data Set (MDS)dated 5/21/15 identifies R1 with severely impaired cognitive skills for daily decision making. R1 displays inattention, disorganized thinking, physical and verbal behavioral symptoms directed towards others 1-3 days per week. R1 is assessed as wandering on a daily basis. The MDS documents R1 requires extensive assistance of two persons for bed mobility and transfers between surfaces. R1 did not walk during the assessment and is independently mobile via wheelchair. R1 has upper and lower extremity impairment on one side. R1 had two falls with no injury during the assessment period.

R1's Progress Notes dated 7/5/15 at 8:40 am (LPN) E9 documented "Writer heard door alarm sounding. Patient was on north stairwell in wheelchair. Redirected by two other staff members without difficulty. Encourage patient to wait in line to be transported."

On 7/5/15 at 9:57 am E9 documented "Patient

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F 323	Continued From page 2 becoming aggressive with staff making contact with (Certified Nurse Aide) CNA (E12)..Patient pushing on dining room door. Redirected from dining room door. Wheeled back to bedroom. Resident calm after contacting mother." On 7/5/15 at 3:15 pm Registered Nurse (RN) E8 wrote " South elevator alarm is sounding and see pt(patient) enter the elevator and go there and get him out with another nurse aid. Tell pt not to get out and keep monitoring." On 7/5/15 at 3:40 pm E8 documented " keep monitoring pt and see pt wheels (self) around the floor. I give 4 pm meds (medications) for (R4). After the meds given and I get out from the room and immediately go to look for (patient) pt. When I do not see the pt and sent two nurse aides (E6, E7) to look for and at same time I make a head count order through the phone...I hear (E6) call me at north stair door (third floor). I rush there and see a wheelchair lean forward at north entrance and then see the pt is sitting on the stair facing the second floor entrance..the nurse (E5) is assessing the patient..is alert and answers questions...slight skin abrasions noted at right hand and both knees, a red spot with a small skin cut noted at left front head, all extremities movable and help the pt walk down to second floor and put (R1) in (wheelchair) and back to 3rd floor." The progress notes dated 7/5/15 4:20 pm document the physician Z2 was notified and a new order was given to send R1 to the emergency room for evaluation. R1's mother (Z1) was also notified of the transfer. The Hospital Emergency Department	F 323		

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F 323	Continued From page 3 Assessment dated 7/05/15 states "1. Closed head injury without loss of consciousness... 2. Fall down stairs...3. Hematoma of frontal scalp." The 7/6/15 progress notes document R1 returned to the facility at midnight. On 7/6/15 7:21 am progress notes state "resident redirected from south stairwell. Patient pushed door. "... 7:45 am "Resident redirected from south elevator on third floor, Yelling out, " I want my mother, I want to go home." The 7/6/15 10:30 pm progress notes state " Patient is alert and sitting in wheelchair, ..15 minutes checking. pt wheeled himself most of the time but still had 4 times of trying to get in elevator and one time to open south stair door.." On 7/7/15 at 2:15 pm Director of Nurses E2 stated on Sunday 7/5/15 she was notified by Nurse Manager E3 that R1 had gotten into the North Stairwell and they found him sitting on the stairs. They notified the doctor and an order was given to send R1 to the emergency room to be evaluated. E2 stated R1 did not have any major injuries. E2 stated the protocol is if they have a person trying to leave the facility they assign a "1:1 alarm buddy" (staff member) to watch the resident until the behavior subsides and then the 1:1 is discontinued. E2 stated at that time it is not unusual for R1 to try to exit the floor on the elevator and R1 has pushed the stairwell doors open before. E2 stated she had personally witnessed R1 on the stairs on July 1, 2015. E2 heard the north stairwell alarm going off and went to the stairwell where she found R1 inside the stair well standing up out of the wheelchair. E2 stated the staff was able to remove R1 from the stairwell and take R1 back to his room. E2 stated they placed R1 on 1:1 supervision at that time	F 323		

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until the behavior subsided. E2 stated on 7/07/15 at 2:20 pm that R1 is no longer on 1:1 supervision.

There were no progress notes for 7/1/15, 2015 in R1's chart about R1 being found in the stairwell or that any 1:1 monitoring was being conducted. The 7/1-7/6 progress notes also make no mention of any 1:1 alarm buddy assignment after R1's attempts to leave the unit.

On 7/08/15 at 12:45 pm E2 stated she did not document the incident in the progress notes and E2 did not know why the nurse had not documented the 7/1/15 incident and interventions in R1's record.

On 7/8/15 at 1:00 pm E2 provided a written statement that E2 had heard the alarm on 7/01/15 at 1:45 pm and had observed a wheelchair inside the north stairwell landing and saw (R1) was standing on the landing about three steps down. E2 wrote she called for assistance and they walked (R1) back up the stairs and put (R1) in the wheelchair. E2 had written "(R1) was just standing and he was holding onto the stairwell with his right hand. " E2 wrote "When asked (7/01/15 approximately 1:45 pm) what (R1) was doing (R1) responded (R1) wasn't sure."

Registered Nurse (RN) E5 confirmed on 7/7/15 at 4:40 pm that E5 was working on the second floor and assessed R1 on 7/5/15 after being notified that R1 had fallen in the stairwell. E5 found the wheelchair at the top of the third floor landing and R1 was sitting at the top of the stairs on the second floor landing. E5 stated that R1 stated that he had fallen on the stairs. E5 stated R1 became really agitated and was yelling that (R1)

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didn't want to be there and to leave (R1) alone. R1 had an area on forehead and lip that E5 showed to RN E8 who came down from the third floor and took over R1's assessment.

Certified Nurse Aide (CNA) E6 confirmed on 7/08/15 at 10:00 am that E6 was working on the third floor 2-10 pm shift on 7/5/15. E6 stated earlier in the shift, R1 really wanted to talk to his mother and they assisted R1 to dial the number, with no answer. E6 said R1 was upset and went to the elevators twice. E6 left R1 with Registered Nurse (RN) E8 to answer call lights and was in a resident room when Nurse E8 asked if E6 had seen R1. E6 started looking for R1 and went to the North Stairwell door window and saw R1's wheelchair tipped forward at the top of the stairs on the landing. E6 saw R1 sitting at the top of the second set of stairs facing the second floor landing. E6 had not heard any stairwell door alarm sound.

On 7/8/15 at 11:15 pm CNA E7 stated E7 had come to work on 7/5/15 at 2:30 pm and was assigned to R1. E7 stated she was informed during report that R1 was having a bad day and R1 had been trying to get out of the dining room exit door earlier. E7 stated "All the staff have to keep an eye on (R1) because no one is assigned to do one to one monitoring of R1 any more. E7 stated "Somedays (R1) just wants Mom and will do anything to talk to her." E7 had last seen R1 at the Nurses Station by R1's room. E7 stated about ten minutes later Nurse (E8) was looking for R1. E7 had not heard any door alarm sound so E7 went down the North elevator. E7 stated as the elevator passed the second floor she could hear a staff calling for help stating the R1 was on the stairs. E7 stated R1's wheelchair was at the

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top of the third floor landing, the wheels were locked and the chair was tipped forward. E7 stated it looked like R1 had slid out of the wheelchair as the chair pad was on the stairs towards the bottom of the landing. E7 stated "We always listen for the alarms and we did not hear anything."

On 7/8/15 at 1:15 pm Licensed Practical Nurse (LPN) E9 stated she was working on 7/5/15 on the day shift. R1 was in the North Stairwell landing with the wheelchair. R1 had pushed open the door and R1 was found in the wheelchair on the landing and had not gotten to the stairs. E9 stated they did not implement 1:1 supervision of R1 after the incident. E9 stated "We all keep an eye on (R1) that's all we can do, we have several residents with (electronic monitoring bracelets) on the floor.. all you have to do is push on the stairwell door and it opens there are no locks, just an alarm that sounds different from the elevator alarm." E9 stated she did give report to second shift to watch (R1) because "(R1) was on the move."

The exit seeking profile book on 7/7/15 contained information for 10 residents (R1, R2, R3, R5, R6, R10-14) assessed at risk of exit seeking. R1's resident information profile did not include any information about repeated exit seeking attempts via stairwells and elevator. The facility added R7 to the list of at risk residents on 7/8/15 after an attempt to exit on the elevator.

On 7/7/15 at 1:45 pm the third floor north stairwell door was opened without putting in the bypass code. The door alarm sounded. The door opened onto a landing that was approximately 8-10 feet to the edge of a set of nine stairs that led to another

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landing and set of nine stairs to the second floor floor stairwell door. The stairwell is at the north end of the third floor not visible from the nurses station. There were two additional stairwell doors on the south end of the third floor that are also equipped in the same manner.

Maintenance Director E4 stated on 7/7/15 at 1:45 pm the doors to the stairwells on the second and third floor are alarmed with a door alarm but is not equipped with an electronic monitoring system or any magnetic lock system. E4 stated "I was asked to come in on Sunday morning (7/5/15) to change the egress code for the Dining Room Exit door because (R1) was trying to open the door. "

On 7/08/15 at 12:00 pm E4 stated he was not aware that R1 had gotten into the North Stairwell with out the door alarming. E4 was not informed or called in on 7/5/15 to check the alarms or change the bypass codes on the third floor stairwells. E4 checked all the doors including the stairwell doors during his routine check on Monday 7/6/15 and stated the alarms were functioning properly.

On 7/07/15 at 2:00 pm R1 was sitting in a wheelchair in the first floor lounge with Z1 (family). R1 was noted to have a 1/4 inch scabbed cut on his left forehead. There was no bruising around the area.

On 7/8/15 at 9:00 am R1 was asked about the fall in the stairwell. R1 denied getting in the stairwell or having a fall. R1 denied knowing how to put in an alarm code to enter the stairwell. R1 showed a scrape on his hand and stated did not know how the scrape got there.

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F 323	Continued From page 8 R1's Care Plan dated 4/15/15 states "Wandering/Pacing related to:TBI (Traumatic Brain Injury), cognitive impairment, (electronic monitoring device) applied. Goal: Will wander only within certain boundaries. Interventions allow to wander in hallway on 3rd floor only. Redirect as needed..reassess daily for need for 1:1..Resident will be monitored frequently after 1:1 is completed. " R1's 4/15/15 Care Plan states "Elopement risk (impulsiveness, mobility, easily confused/disoriented, history of elopement, cognitive loss r/t traumatic brain injury) related to:cognitive impairment." The approaches included activities that could be offered to R1 to redirect or engage resident. There was no intervention of increased supervision during exit seeking behaviors. R1's Care Plan did not address R1's repeated attempts to leave the third floor via the elevator or stairwells, the fall in the stairwell or any new interventions to prevent R1 from entering the stairwells without staff knowledge. The facility Wandering Practice Guide dated 4/2008 states "Safe Wandering Interventions..Reassess patients with exit seeking/unsafe wandering behaviors regularly..During periods of agitation or increased frequency of behaviors the following interventions can be helpful in managing behaviors like exit seeking/unsafe wandering and may include, but are not limited to: one to one supervision; "an alarm buddy", supervised walking, activities based on patients personal preference.." The Immediate Jeopardy situation was identified on 7/9/15. The Immediate Jeopardy was	F 323		

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determined to have begun on 7/1/15 when R1 exhibited an escalation of deliberate exit seeking behaviors including trying to leave the floor via the stairwells and staff failed to implement supervision measures to prevent R1 from entering the stairwell which put R1 at immediate risk of fall related injuries. R1 was evaluated at the hospital and returned to the facility on 7/6/15. R1 continued to exhibit exit seeking behavior on 7/7/15 again trying to enter the stairwell, yet continuous supervision of R1 was not implemented until 7/7/15 at 8:55 pm.

E1, Administrator was informed of the Immediate Jeopardy on 7/9/15 at 2:40pm.

The surveyors confirmed through observation, interview and record review that the facility took the following actions to remove the Immediate Jeopardy:

1. The facility obtained physician orders to sent R1 to the Emergency Room for evaluation following the incident of 7/5/15. This was completed by E8, RN.

2. E1, Administrator confirmed that nursing staff placed R1 on indefinite one to one supervision on 7/7/15 at 8:55 pm.

3. The facility reevaluated all at risk residents for exit seeking (R1, R2, R3, R5, R6, R7, and R10-14) and chart audits were done to insure the plan of care, exit seeking assessments, physician's orders and interventions were in place on 7/8-7/9/15 to prevent further risk to residents. The resident exit seeking profile book was updated to reflect the changes. This was completed by Administrator E1, Nursing

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F 323	Continued From page 10 Supervisor E3 and Corporate Nurse. 4. The exit door alarms were evaluated by an outside alarm company on 7/8/15 to ensure correct functioning of alarms and locking devices. Door alarm drills were conducted and staff was educated related to exit seeking and behavior management and 1:1 supervision plan for R1. This was completed by Director of Nurses E2 and Corporate Nurse Educator.	F 323		