State of California - Health and Human Services Agency

Department of Public Health

SECTION 1424 NOTICE

CITATION NUMBER: 94-2330-0011435-F

Date: 05/06/2015 Time: 1290

Type of Visit : Complaint Investig.

YOU ARE HEREBY FOUND IN VIOLATION OF APPLICABLE CALIFORNIA STATUTES AND REGULATIONS OR APPLICABLE FEDERAL STATUTES AND REGULATIONS

Incident/Complaint No.(s) : CA00413475

Licensee Name: Vernon Healthcare Center, LLC

Address: 1037 W. Vernon Avenue Los Angeles, CA 90037

License Number: 970000025 Type of Ownership: Limited Liability Company

Facility Name: VERNON HEALTHCARE CENTER

Address: 1037 W Vernon Ave Los Angeles, CA 90037

Telephone: (323) 232-4895

Facility Type: Skilled Nursing Facility Capacity: 99

Facility ID: 970000050

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS	PENALTY ASSESSMENT $20,000.00 trebled to $60,000.00	DEADLINE FOR COMPLIANCE 5/6/15 5:00 p.m.

F323

CLASS A **CITATION -- PATIENT CARE**

F323 - 42 CFR 483.25 (h)(2). Accidents. The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

On 9/18/14 at 8:15 a.m., an unannounced visit was made to the facility to investigate an entity reported incident regarding an alleged resident to resident abuse that occurred on 8/16/14, when Resident 1 hit Resident 2 in the stomach.

The facility failed to provide adequate supervision to Resident 1 by failing to:

1. Identify the hazards and risks of the resident's wandering behavior.

2. Implement the one-to-one (1:1) monitoring or supervision (an assigned staff supervises and closely watches/monitors a resident at all times) according to the plan of care that was developed to manage the resident's wandering behavior.

Resident 1, who had dementia (loss of brain function that affects memory, thinking, language, judgment, and behavior), was able to wander into the rooms of female residents, Resident 4, 5, 6, and 16, at various times between 4/25/14 and 9/20/14, and was able to enter the room of a male resident with dementia, Resident 3, and hit him on the left eye area of his face two weeks prior to 9/20/14 (exact date undetermined).

Name of Evaluator:
Zosima Gaerlan
HFEN

Evaluator Signature : Zosima Caram Gaerlan, RN

Without admitting guilt, I hereby acknowledge receipt of this SECTION 1424 NOTICE

Signature : Alexis Washington

Name : Alexis Washington

Title : NHA

NOTE: IN ACCORDANCE WITH CALIFORNIA HEALTH AND SAFTEY CODE, FAILURE TO CORRECT VIOLATIONS IS GROUNDS FOR SUSPENSION OR REVOCATION OF YOUR LICENSE

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

The facility placed Resident 1 on 1:1 supervision on 9/8/14 to prevent him from hitting other residents and staff. On 9/18/14, Resident 1 was able to enter inside the room of Resident 5 and 6 by himself. On 9/20/14, Resident 1 was able to enter inside the room of Resident 4 by himself. These female residents, Resident 4, 5, and 6, felt threatened that Resident 1 might hit them. Resident 4 was scared that Resident 1 might do something inappropriate to her.

This failure resulted in psychological harm to the female residents, who felt threatened by Resident 1's behavior, and had the potential to result in physical harm to Resident 1 himself and to other residents.

A review of Resident 1's clinical record indicated the resident was admitted to the facility on 4/25/14, was transferred to the hospital on 8/20/14, and was re-admitted to the facility on 8/24/14 with diagnoses that included dementia and end stage renal (kidney) disease.

According to the quarterly review assessment Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/30/14, Resident 1 was able to make his needs known and was able to understand others usually. He was moderately impaired (decisions poor; cues/supervision required) in cognitive skills for daily decision making, and required limited assistance (resident highly involved in the activity; staff provide guided maneuvering) in walking and during locomotion.

The clinical record indicated Resident 1 was transferred to the hospital on 8/20/14 due to generalized weakness and anemia (the blood lacks healthy red blood cells). Resident 1's history and physical from the hospital, dated 8/20/14, indicated that at the time of the hospital admission, Resident 1 was noted to be severely confused, wandering off out of his room in the hallway with unsteady gait. Another hospital record of consultation, dated 8/1/14, indicated that Resident 1 appeared to wander the hallways without any direction. A progress note, dated 8/22/14, indicated Resident 1 had been wandering the hallways aimlessly. Resident 1 was discharged back to the facility on 8/24/14.

The re-admission assessment of Resident 1, dated 8/24/14 at 12:55 p.m., indicated Resident 1 was confused and had poor safety judgment.

According to the Elopement Risk Assessment, dated 8/24/14, Resident 1 was assessed as being at risk for potential elopement from the facility. The assessment indicated the resident was ambulatory with or without a device. There was no risk

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

assessment conducted to identify the hazards and risks of Resident 1's wandering inside the facility or inside other residents' rooms.

The Change of Condition Notes, dated 9/8/14, indicated that Resident 1 was placed on a 1:1 monitoring, to prevent Resident 1 from striking out staff and other residents, after a surveyor informed a staff that Resident 1 hit staff members and Resident 2.

According to the administrator, during an interview on 9/21/14 at 3:50 p.m., a surveyor brought to her attention a CNA note, dated 8/16/14 at 6:30 p.m., which indicated that Resident 1 hit Resident 2 in the stomach and a security staff at the front door. The CNA note indicated Resident 1 also hit CNA 1 with a closed fist four (4) times and twisted the CNA's right arm and right index finger, and Resident 1 continued to wander in and out of other resident's rooms. The administrator stated, during another interview on 9/18/14 at 11:30 a.m., Resident 1 had wandered in the room of Resident 2 and punched Resident 2 in the stomach.

The facility conducted an investigation of the incident that occurred on 8/16/14 and interviews with Resident 4 and 5 on 9/9/14. According to the interview record, Resident 4, an alert female resident, stated that Resident 1 wandered most of the evening. Resident 5, another alert female resident, stated Resident 1 had wandered inside her room at 3 a.m. in the morning and sat at the foot of her bed. Resident 5 stated Resident 1 came in her room, sat on her bed, and fell asleep. Resident 5 stated she had seen Resident 1 put up his fist at the staff when the staff tried to re-direct him and she had also seen Resident 1 strike a staff on two (2) different occasions.

The psychiatrist progress notes, dated 9/10/14, indicated that Resident 1 was confused and disorganized, and wandered into other residents' rooms.

The facility's letter to the Department, dated 9/12/14, indicated it was brought to the administrator's attention on 9/11/14 that Resident 3 had discoloration on his left eye area and the source of the injury was unknown.

During an interview with Resident 13 (the roommate of Resident 3, a cognitively impaired male resident), on 9/20/14 at 1 p.m., the resident stated that during the evening shift at 7 p.m., while he was lying in bed, he saw Resident 1 wandering at the hallway and entering their room. Resident 1 sat on Resident 3's bed while Resident 3 was sleeping. Resident 3 woke up and tried to move his leg to get Resident 1 out of his bed. Resident 13 stated Resident 1 got mad and punched Resident 3 on his left eye

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS

which resulted in the discoloration on the left eye area. Resident 13 stated a female certified nursing assistant (CNA) came inside their room and took Resident 1 out of the room.

The plan of care, dated 9/12/14, indicated that Resident 1 had dementia, had no capacity of making decisions, wanders, confused, resists care, disrobes, and had a history of hitting another resident. The resident goals were to decrease the episodes of wandering and to minimize his risk. One of the interventions was placing the resident on "one-on-one episode" or 1:1 supervision/monitoring. Prior to 9/12/14, the facility did not develop a plan of care to address and manage the resident's behavior of wandering inside other residents' rooms.

The facility's policy and procedure titled, "Wandering & Elopement," dated 1/1/12, indicated that it was the policy of the facility to identify resident at risk for elopement and minimize any possible injury as a result of the elopement. The facility's policy and procedure did not address the procedures to identify the hazards and risks of a wandering behavior, and manage the residents at risk for wandering inside the facility or inside other residents' rooms.

During an interview, on 9/18/14 at 2:40 p.m., CNA 3 stated that Resident 1 wanders into female residents' rooms and everyone knew he is a wanderer and that he wanders into female rooms. CNA 3 stated Resident 1 wandered during the day and night.

During an interview, on 9/20/14 at 10:05 a.m., Licensed Vocational Nurse (LVN) 1 stated since Resident 1 was admitted to the facility, she heard reports that Resident 1 wandered in other residents' rooms.

On 9/18/14 at 9:15 a.m., during a concurrent interview with Resident 5 and 6, alert female residents who shared the same room, they stated Resident 1 had entered their room several times and had also entered other residents' rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff when the staff tried to get him out of another resident's room.

On 9/18/14 at 9:20 a.m., during an interview, Resident 5 stated there was one incident when Resident 1 climbed on her bed at 3 a.m., sat at the foot of her bed with his legs spread open and facing her, and she had to call staff to get Resident 1 out of her room.

During a concurrent interview, Resident 6 stated Resident 1 had entered her room and

SECTIONS VIOLATED	CLASS AND NATURE OF VIOLATIONS
	ate her food on her bedside table. Resident 6 stated she just allowed Resident 1 to eat her food because she would not fight him. Resident 6 stated she would just ask staff to buy her food because she would not fight Resident 1. On 9/18/14 at 11:30 a.m., during an interview, the administrator stated she was aware that Resident 1 had wandered in the room of Resident 2 and punched Resident 2 in the stomach, but she had no knowledge Resident 1 was wandering inside female residents' rooms. On 9/18/14 at 2:25 p.m., the clinical record of Resident 1 was reviewed with Registered Nurse (RN) 1. RN 1 stated, during a concurrent interview, that Resident 1 was placed on 1:1 supervision and this was a nursing intervention from the plan of care dated 9/12/14. RN 1 stated Resident 1 wandered in the facility but she was not aware he was wandering inside female residents' rooms. On 9/20/14 at 11 a.m., during an interview, Resident 4, an alert female resident, stated Resident 1 had entered her room more than four (4) times in the past and it happened during the day and night. Resident 4 stated there were times that she had to use the call light for the staff to get Resident 1 out of her room and there were times staff followed Resident 1 inside her room to get him out of her room. Resident 4 stated Resident 1 had attempted to climb on her bed a couple of times and she had to use the call light for staff to get him out of her room. Resident 4 also stated her roommate, Resident 16, had said before "Get off my bed" to Resident 1, when Resident 1 tried to climb on Resident 16's bed. During the course of the interview, Resident 4 stated Resident 1 was by himself inside her room "last night," estimating the time it happened as past midnight of 9/20/14. Resident 4 stated she used the call light so staff would go inside her room and get Resident 1 out of her room. Resident 4 stated a female staff entered her room to get Resident 1 out of her room after she pushed her call light. Resident 4 stated Resident 1 walked all the way inside her room without staff beside him. Resident 4 stated she felt scared by the presence of Resident 1 inside her room because she did not know what he (Resident 1) would do next and she had seen Resident 1 hit staff who tried to get him out of the room. Resident 4 stated she felt threatened that Resident 1 might hit her or do something inappropriate to her. Resident 4 stated she had a broken back, she could not lift her right arm, and she could not do anything to defend herself.

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On 9/20/14 at 11:25 a.m., during an interview, CNA 4 stated she was the assigned sitter (1:1 monitor) for Resident 1. CNA 4 stated she did not receive any report from the CNA of the outgoing shift that Resident 1 had wandered inside a female resident's room. CNA 4 stated that if there was anything unusual that occurred during the previous shift, she would get a report from the outgoing sitter. An attempt to interview Resident 1 was conducted after the interview with CNA 4, but Resident 1 did not answer the questions that were asked.

On 9/20/14 at 2 p.m., during an interview, Resident 5 and 6 stated that Resident 1 entered their room by himself last Thursday, 9/18/14, at 8 p.m. and he just stood in front of their closets. Resident 5 and 6 stated they had to call a staff member who was passing by at the hallway to get Resident 1 out of their room. Resident 5 and 6 stated they felt threatened by the presence of Resident 1 inside their room because he might hit them.

The clinical record of Resident 1 was reviewed with the director of nursing (DON) on 9/20/14 at 1:15 p.m. According to the DON, she did not see any documentation that Resident 1 had wandered inside another resident's room. The DON stated that at a minimum, she expected the staff to communicate when a resident wandered inside another resident's room.

The DON stated that conducting an assessment and developing a care plan should be ongoing and could be done anytime. The DON stated the facility did not have a form to use as a tool for assessing and identifying the residents at risk for wandering inside other residents' rooms, and the "Elopement Risk Assessment Form" was the only form/tool the facility had. The DON also stated that Resident 1 did not have a plan of care developed to address his wandering behavior inside another resident's room until 9/12/14.

On 9/20/14 at 4:20 p.m., the administrator and the DON were informed that the facility's policy and procedure titled "Wandering & Elopement," dated 1/1/12, that they submitted, only addressed residents at risk for elopement. The administrator and DON could not provide any other policy and procedure that addressed the identification and management of residents at risk for wandering inside the facility, specifically inside other residents' rooms.

A review of the physician's order, dated 9/20/14 and timed at 5:15 p.m., indicated an

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	order to transfer Resident 1 to a hospital for evaluation due to his behavior of being a danger to others secondary to his aggressive behavior. According to the nursing notes, dated 9/20/14, the resident left the facility and was transported to the hospital at 7:15 p.m. A review of Resident 2's clinical record indicated the resident was admitted to the facility on 6/18/14 with diagnoses that included dementia and psychosis (a mental disorder). Resident 2's admission assessment MDS, dated 6/25/14 indicated Resident 2 was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance (resident involved in activity, staff provide weight bearing support) when walking, and required limited assistance (resident involved in activity, staff provide guided maneuvering) in locomotion (how the resident moves between locations). A review of Resident 3's clinical record indicated the resident was re-admitted to the facility on 3/21/14 with admitting diagnoses of dementia. The MDS, 8/13/14, indicated Resident 3 was moderately impaired with his cognitive skills for daily decision making and required extensive assistance with activities of daily living. A review of Resident 4's clinical record indicated the resident was admitted to the facility on 4/21/14 and was re-admitted on 5/2/14 with diagnoses that included hyperlipidemia (high cholesterol) and hypertension (high blood pressure). The admission assessment MDS, dated 5/9/14, indicated was alert and able to make her needs known, unable to walk, needed extensive assistance in bed mobility, dressing, and toilet use, and she was totally dependent on staff for transfers. A review of Resident 5's clinical record indicated the resident was admitted to the facility on 5/5/14 and was re-admitted on 8/27/14 with diagnoses that included congestive heart failure (CHF, a condition that occurs when the heart is unable to pump enough blood to meet the needs of the body's tissues). The quarterly review assessment MDS, dated 8/12/14, the resident was alert and able to make her needs known, and needed supervision in performing activities of daily living. A review of Resident 6's clinical record indicated the resident was admitted to the facility on 2/7/14 and was re-admitted on 6/22/14 with diagnoses that included congestive heart failure (CHF). The admission assessment MDS, dated 6/28/14, indicated the resident was alert and able to make her needs known, needed limited assistance in walking, and required extensive assistance in bed mobility and transfers.

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A review of Resident 13's clinical record indicated the resident was re-admitted to the facility on 3/21/14 with diagnoses that included hypertension (high blood pressure). The MDS, dated 8/6/14, indicated the resident was alert and able to make his needs known.

A review of Resident 16's clinical record indicated the resident was admitted to the facility on 4/8/11 and was re-admitted on 6/29/14 with diagnoses that included dementia. The MDS, dated 8/27/14, indicated the resident's speech was clear, her cognitive skills was moderately impaired, and she needed extensive assistance in activities of daily living.

Therefore, the facility failed to provide adequate supervision to Resident 1 by failing to:

1. Identify the hazards and risks of the resident's wandering behavior.

2. Implement the one-to-one (1:1) monitoring or supervision (an assigned staff supervises and closely watches/monitors a resident at all times) according to the plan of care that was developed to manage the resident's wandering behavior.

This failure presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.

Reviewed & accepted
by 5/6/15

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
PARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055167	A. BUILDING _____ B. WING _____	09/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON HEALTHCARE CENTER	1037 W Vernon Ave, Los Angeles, CA 90037-2415 LOS ANGELES COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit: CLASS A CITATION – PATIENT CARE 94-2330-0011435-F Complaint(s): CA00413475 Representing the Department of Public Health: Surveyor ID # 28070, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. F323 - 42 CFR 483.25 (h)(2). Accidents. The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. On 9/18/14 at 8:15 a.m., an unannounced visit was made to the facility to investigate an entity reported incident regarding an alleged resident to resident abuse that occurred on 8/16/14, when Resident 1 hit Resident 2 in the stomach. The facility failed to provide adequate supervision to Resident 1 by failing to: 1. Identify the hazards and risks of the resident's wandering behavior. 2. Implement the one-to-one (1:1) monitoring or supervision (an assigned staff supervises and closely watches/monitors a resident at all times) according to the plan of care that was developed to		*Vernon Healthcare Center submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Curtis Worden TITLE NHA (X6) DATE 5/6/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 13

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. Except for nursing homes, the findings 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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	manage the resident's wandering behavior. Resident 1, who had dementia (loss of brain function that affects memory, thinking, language, judgment, and behavior), was able to wander into the rooms of female residents, Resident 4, 5, 6, and 16, at various times between 4/25/14 and 9/20/14, and was able to enter the room of a male resident with dementia, Resident 3, and hit him on the left eye area of his face two weeks prior to 9/20/14 (exact date undetermined). The facility placed Resident 1 on 1:1 supervision on 9/8/14 to prevent him from hitting other residents and staff. On 9/18/14, Resident 1 was able to enter inside the room of Resident 5 and 6 by himself. On 9/20/14, Resident 1 was able to enter inside the room of Resident 4 by himself. These female residents, Resident 4, 5, and 6, felt threatened that Resident 1 might hit them. Resident 4 was scared that Resident 1 might do something inappropriate to her. This failure resulted in psychological harm to the female residents, who felt threatened by Resident 1's behavior, and had the potential to result in physical harm to Resident 1 himself and to other residents. A review of Resident 1's clinical record indicated the resident was admitted to the facility on 4/25/14, was transferred to the hospital on 8/20/14, and was re-admitted to the facility on 8/24/14 with diagnoses that included dementia and end stage renal (kidney) disease.	F 323	**What corrective action(s) will be accomplished for the resident(s) affected by the deficient practice?** On 9/20/14 at approx. 515pm the doctor of Residents Resident 1 and Resident 2 was notified of these residents risk for wandering into other resident's rooms and the facility's limited ability to manage their behavior. The Physician order was subsequently received to transfer both residents to another facility. Resident 1 was discharged to Brothman Medical Center at around 7:30pm. The responsible party was informed and was in agreement. Resident 2 was discharged to So. California Hollywood at around 6:30pm. The responsible party was informed and was in agreement.	09/20/14 09/20/14

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	According to the quarterly review assessment Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/30/14, Resident 1 was able to make his needs known and was able to understand others usually. He was moderately impaired (decisions poor; cues/supervision required) in cognitive skills for daily decision making, and required limited assistance (resident highly involved in the activity; staff provide guided maneuvering) in walking and during locomotion. The clinical record indicated Resident 1 was transferred to the hospital on 8/20/14 due to generalized weakness and anemia (the blood lacks healthy red blood cells). Resident 1's history and physical from the hospital, dated 8/20/14, indicated that at the time of the hospital admission, Resident 1 was noted to be severely confused, wandering off out of his room in the hallway with unsteady gait. Another hospital record of consultation, dated 8/1/14, indicated that Resident 1 appeared to wander the hallways without any direction. A progress note, dated 8/22/14, indicated Resident 1 had been wandering the hallways aimlessly. Resident 1 was discharged back to the facility on 8/24/14. The re-admission assessment of Resident 1, dated 8/24/14 at 12:55 p.m., indicated Resident 1 was confused and had poor safety judgment. According to the Elopement Risk Assessment, dated 8/24/14, Resident 1 was assessed as being		**How will another resident or other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken** On 9/20/14, other residents will be assessed by the Licensed Nurses for the risk of wandering. There were no other residents identified at risk for wandering. What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur? 1. An In-service was initiated on 3-11 Staff by the DSD, DNS and the QA Nurse regarding the facility's newly drafted policy and procedures for wandering residents with special emphasis on the screening, assessment, monitoring and escalation of plan of care of those at risk for wandering. This in-service will be continued to be given to other shift until the facility staff are all done. 2. Residents upon admission, re-admission, quarterly, annually and as needed will be assessed by the Licensed Nurse using the Wandering assessment tool. Residents at risk for wandering will be identified by wearing a green band.	09/20/14 09/20/14 Ongoing

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	at risk for potential elopement from the facility. The assessment indicated the resident was ambulatory with or without a device. There was no risk assessment conducted to identify the hazards and risks of Resident 1's wandering inside the facility or inside other residents' rooms. The Change of Condition Notes, dated 9/8/14, indicated that Resident 1 was placed on a 1:1 monitoring, to prevent Resident 1 from striking out staff and other residents, after a surveyor informed a staff that Resident 1 hit staff members and Resident 2. According to the administrator, during an interview on 9/21/14 at 3:50 p.m., a surveyor brought to her attention a CNA note, dated 8/16/14 at 6:30 p.m., which indicated that Resident 1 hit Resident 2 in the stomach and a security staff at the front door. The CNA note indicated Resident 1 also hit CNA 1 with a closed fist four (4) times and twisted the CNA's right arm and right index finger, and Resident 1 continued to wander in and out of other resident's rooms. The administrator stated, during another interview on 9/18/14 at 11:30 a.m., Resident 1 had wandered in the room of Resident 2 and punched Resident 2 in the stomach. The facility conducted an investigation of the incident that occurred on 8/16/14 and interviews with Resident 4 and 5 on 9/9/14. According to the interview record, Resident 4, an alert female resident, stated that Resident 1 wandered most of the evening. Resident 5, another alert female resident, stated Resident 1 had wandered inside	F 323	Those residents who can remove the green band will have a green special needs sheet by the head of the bed. 3. Residents determined to be risk of wandering shall be referred to IDT for further assessment and escalation of their plan of care. 4. If the facility is unable to effectively control a resident's wandering behavior, the IDT will consider and developed a plan for placement of the resident to another more secured facility. 5. Signs in the facility will be posted as a reminder to staff concerning the meaning of the green ID. **A description of the monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, evaluated for effectiveness, integrated into the quality assurance program** 1. Department Managers, when making observation rounds, will report to the IDT, for further assessment, any resident who in their observations may be an candidate for inclusion in the list	09/20/14 Ongoing

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	her room at 3 a.m. in the morning and sat at the foot of her bed. Resident 5 stated Resident 1 came in her room, sat on her bed, and fell asleep. Resident 5 stated she had seen Resident 1 put up his fist at the staff when the staff tried to re-direct him and she had also seen Resident 1 strike a staff on two (2) different occasions. The psychiatrist progress notes, dated 9/10/14, indicated that Resident 1 was confused and disorganized, and wandered into other residents' rooms. The facility's letter to the Department, dated 9/12/14, indicated it was brought to the administrator's attention on 9/11/14 that Resident 3 had discoloration on his left eye area and the source of the injury was unknown. During an interview with Resident 13 (the roommate of Resident 3, a cognitively impaired male resident), on 9/20/14 at 1 p.m., the resident stated that during the evening shift at 7 p.m., while he was lying in bed, he saw Resident 1 wandering at the hallway and entering their room. Resident 1 sat on Resident 3's bed while Resident 3 was sleeping. Resident 3 woke up and tried to move his leg to get Resident 1 out of his bed. Resident 13 stated Resident 1 got mad and punched Resident 3 on his left eye which resulted in the discoloration on the left eye area. Resident 13 stated a female certified nursing assistant (CNA) came inside their room and took Resident 1 out of the room. The plan of care, dated 9/12/14, indicated that	F 323	2. The Department Managers will also ask residents if there are other residents wandering in their room during observation rounds. 3. The RN supervisor will monitor placement of ID green band/green special needs sheet on residents who are at risk for wandering. 4. The MRD will conduct an audit of residents wandering assessment on admission, re-admission, quarterly, annually and as needed for completion. 5. The DNS/designee will do 3 random resident wandering assessments in the next 3 months to ensure compliance. 6. The Administrator will report compliance to the new wandering policy to the monthly QAA committee for further recommendations and suggestions.	Ongoing Ongoing Ongoing Ongoing Monthly

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	055167	A. BUILDING _____ B. WING _____	09/21/2014

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	Resident 1 had dementia, had no capacity of making decisions, wanders, confused, resists care, disrobes, and had a history of hitting another resident. The resident goals were to decrease the episodes of wandering and to minimize his risk. One of the interventions was placing the resident on "one-on-one episode" or 1:1 supervision/monitoring. Prior to 9/12/14, the facility did not develop a plan of care to address and manage the resident's behavior of wandering inside other residents' rooms. The facility's policy and procedure titled, "Wandering & Elopement," dated 1/1/12, indicated that it was the policy of the facility to identify resident at risk for elopement and minimize any possible injury as a result of the elopement. The facility's policy and procedure did not address the procedures to identify the hazards and risks of a wandering behavior, and manage the residents at risk for wandering inside the facility or inside other residents' rooms. During an interview, on 9/18/14 at 2:40 p.m., CNA 3 stated that Resident 1 wanders into female residents' rooms and everyone knew he is a wanderer and that he wanders into female rooms. CNA 3 stated Resident 1 wandered during the day and night. During an interview, on 9/20/14 at 10:05 a.m., Licensed Vocational Nurse (LVN) 1 stated since Resident 1 was admitted to the facility, she heard reports that Resident 1 wandered in other residents' rooms.			

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	On 9/18/14 at 9:15 a.m., during a concurrent interview with Resident 5 and 6, alert female residents who shared the same room, they stated Resident 1 had entered their room several times and had also entered other residents' rooms. Resident 5 and 6 stated Resident 1 became combative by hitting staff when the staff tried to get him out of another resident's room. On 9/18/14 at 9:20 a.m., during an interview, Resident 5 stated there was one incident when Resident 1 climbed on her bed at 3 a.m., sat at the foot of her bed with his legs spread open and facing her, and she had to call staff to get Resident 1 out of her room. During a concurrent interview, Resident 6 stated Resident 1 had entered her room and ate her food on her bedside table. Resident 6 stated she just allowed Resident 1 to eat her food because she would not fight him. Resident 6 stated she would just ask staff to buy her food because she would not fight Resident 1. On 9/18/14 at 11:30 a.m., during an interview, the administrator stated she was aware that Resident 1 had wandered in the room of Resident 2 and punched Resident 2 in the stomach, but she had no knowledge Resident 1 was wandering inside female residents' rooms. On 9/18/14 at 2:25 p.m., the clinical record of Resident 1 was reviewed with Registered Nurse (RN) 1. RN 1 stated, during a concurrent interview, that Resident 1 was placed on 1:1 supervision and			

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	this was a nursing intervention from the plan of care dated 9/12/14. RN 1 stated Resident 1 wandered in the facility but she was not aware he was wandering inside female residents' rooms. On 9/20/14 at 11 a.m., during an interview, Resident 4, an alert female resident, stated Resident 1 had entered her room more than four (4) times in the past and it happened during the day and night. Resident 4 stated there were times that she had to use the call light for the staff to get Resident 1 out of her room and there were times staff followed Resident 1 inside her room to get him out of her room. Resident 4 stated Resident 1 had attempted to climb on her bed a couple of times and she had to use the call light for staff to get him out of her room. Resident 4 also stated her roommate, Resident 16, had said before "Get off my bed" to Resident 1, when Resident 1 tried to climb on Resident 16's bed. During the course of the interview, Resident 4 stated Resident 1 was by himself inside her room "last night," estimating the time it happened as past midnight of 9/20/14. Resident 4 stated she used the call light so staff would go inside her room and get Resident 1 out of her room. Resident 4 stated a female staff entered her room to get Resident 1 out of her room after she pushed her call light. Resident 4 stated Resident 1 walked all the way inside her room without staff beside him. Resident 4 stated she felt scared by the presence of Resident 1 inside her room because she did not know what he (Resident 1) would do			

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	next and she had seen Resident 1 hit staff who tried to get him out of the room. Resident 4 stated she felt threatened that Resident 1 might hit her or do something inappropriate to her. Resident 4 stated she had a broken back, she could not lift her right arm, and she could not do anything to defend herself. On 9/20/14 at 11:25 a.m., during an interview, CNA 4 stated she was the assigned sitter (1:1 monitor) for Resident 1. CNA 4 stated she did not receive any report from the CNA of the outgoing shift that Resident 1 had wandered inside a female resident's room. CNA 4 stated that if there was anything unusual that occurred during the previous shift, she would get a report from the outgoing sitter. An attempt to interview Resident 1 was conducted after the interview with CNA 4, but Resident 1 did not answer the questions that were asked. On 9/20/14 at 2 p.m., during an interview, Resident 5 and 6 stated that Resident 1 entered their room by himself last Thursday, 9/18/14, at 8 p.m. and he just stood in front of their closets. Resident 5 and 6 stated they had to call a staff member who was passing by at the hallway to get Resident 1 out of their room. Resident 5 and 6 stated they felt threatened by the presence of Resident 1 inside their room because he might hit them. The clinical record of Resident 1 was reviewed with the director of nursing (DON) on 9/20/14 at 1:15 p.m. According to the DON, she did not see any documentation that Resident 1 had wandered inside another resident's room. The DON stated			

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	that at a minimum, she expected the staff to communicate when a resident wandered inside another resident's room. The DON stated that conducting an assessment and developing a care plan should be ongoing and could be done anytime. The DON stated the facility did not have a form to use as a tool for assessing and identifying the residents at risk for wandering inside other residents' rooms, and the "Elopement Risk Assessment Form" was the only form/tool the facility had. The DON also stated that Resident 1 did not have a plan of care developed to address his wandering behavior inside another resident's room until 9/12/14. On 9/20/14 at 4:20 p.m., the administrator and the DON were informed that the facility's policy and procedure titled "Wandering & Elopement," dated 1/1/12, that they submitted, only addressed residents at risk for elopement. The administrator and DON could not provide any other policy and procedure that addressed the identification and management of residents at risk for wandering inside the facility, specifically inside other residents' rooms. A review of the physician's order, dated 9/20/14 and timed at 5:15 p.m., indicated an order to transfer Resident 1 to a hospital for evaluation due to his behavior of being a danger to others secondary to his aggressive behavior. According to the nursing notes, dated 9/20/14, the resident left the facility and was transported to the			

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	hospital at 7:15 p.m. A review of Resident 2's clinical record indicated the resident was admitted to the facility on 6/18/14 with diagnoses that included dementia and psychosis (a mental disorder). Resident 2's admission assessment MDS, dated 6/25/14 indicated Resident 2 was moderately impaired in cognitive skills for daily decision-making, needed extensive assistance (resident involved in activity, staff provide weight bearing support) when walking, and required limited assistance (resident involved in activity, staff provide guided maneuvering) in locomotion (how the resident moves between locations). A review of Resident 3's clinical record indicated the resident was re-admitted to the facility on 3/21/14 with admitting diagnoses of dementia. The MDS, 8/13/14, indicated Resident 3 was moderately impaired with his cognitive skills for daily decision making and required extensive assistance with activities of daily living. A review of Resident 4's clinical record indicated the resident was admitted to the facility on 4/21/14 and was re-admitted on 5/2/14 with diagnoses that included hyperlipidemia (high cholesterol) and hypertension (high blood pressure). The admission assessment MDS, dated 5/9/14, indicated was alert and able to make her needs known, unable to walk, needed extensive assistance in bed mobility, dressing, and toilet use, and she was totally dependent on staff for transfers.			

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	A review of Resident 5's clinical record indicated the resident was admitted to the facility on 5/5/14 and was re-admitted on 8/27/14 with diagnoses that included congestive heart failure (CHF, a condition that occurs when the heart is unable to pump enough blood to meet the needs of the body's tissues). The quarterly review assessment MDS, dated 8/12/14, the resident was alert and able to make her needs known, and needed supervision in performing activities of daily living. A review of Resident 6's clinical record indicated the resident was admitted to the facility on 2/7/14 and was re-admitted on 6/22/14 with diagnoses that included congestive heart failure (CHF). The admission assessment MDS, dated 6/28/14, indicated the resident was alert and able to make her needs known, needed limited assistance in walking, and required extensive assistance in bed mobility and transfers. A review of Resident 13's clinical record indicated the resident was re-admitted to the facility on 3/21/14 with diagnoses that included hypertension (high blood pressure). The MDS, dated 8/6/14, indicated the resident was alert and able to make his needs known. A review of Resident 16's clinical record indicated the resident was admitted to the facility on 4/8/11 and was re-admitted on 6/29/14 with diagnoses that included dementia. The MDS, dated 8/27/14, indicated the resident's speech was clear, her cognitive skills was moderately impaired, and she needed extensive assistance in activities of daily			

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	living. Therefore, the facility failed to provide adequate supervision to Resident 1 by failing to: 1. Identify the hazards and risks of the resident's wandering behavior. 2. Implement the one-to-one (1:1) monitoring or supervision (an assigned staff supervises and closely watches/monitors a resident at all times) according to the plan of care that was developed to manage the resident's wandering behavior. This failure presented either an imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.			