STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045413	A. Building B. Wing	05/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Health and Rehab	7425 Euper Lane Fort Smith, AR 72903

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 920) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided to prevent elopement, as evidenced by failure to ensure increased supervision was provided during periods of increased exit-seeking behaviors; failure to ensure staff responded promptly to an exit door alarm; and, failure to ensure staff thoroughly checked the area outside the building after a door alarm sounded for 1 (Resident #1) of 6 (Residents #1, #2, #3, #4, #5, and #6) case mix residents who were at risk for elopement. These failed practices resulted in Immediate Jeopardy, which caused, or could have caused serious harm, injury or death to Resident #1, who exited the building at 3:30 a.m., unnoticed by staff and remained outside, alone, for more than 30 minutes, with access to a busy street and wooded area, and had the potential to cause more than minimal harm to 18 residents who were at risk for elopement, according to a list provided by the Director of Nursing (DON) on 5/8/19 at 10:35 a.m. The facility removed the Immediate Jeopardy on 5/5/19, prior to the survey entrance date, when they placed the resident on one-on-one monitoring; however, there were underlying deficient practices that remained uncorrected at the time of the survey. The Administrator was informed of the removed Immediate Jeopardy condition on 5/8/19 at 4:30 p.m. The findings are: Resident #1 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/31/19 documented the resident scored 3 (0-7 indicates severe cognitive impairment) on a Brief Interview for Mental Status (BIMS); exhibited no wandering behaviors; and used a walker to assist with ambulation. a. A physician's orders [REDACTED].Roam Alert on for safety . Check every shift for placement . b. The Care Plan dated 11/16/18 and revised 4/19/19 documented, .Problem . I have impaired cognition and have difficulty communicating . I am at risk for anxiety, restlessness and elopement . Approach / Intervention . Monitor my mood, notify nurse if I am restless, anxious or making attempts to leave facility . Monitor me when my visitors leave . Monitor me when I am ambulating off unit . Roam alert to wrist or ankle for safety . Check every shift for placement . (continued on next page)

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.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. A Resident Locator Alert assessment dated [DATE] documented, .Is Resident ambulatory or self-mobile in wheelchair . Yes . Resident is cognitively impaired, with poor decision-making skills, and / or pertinent diagnosis (e.g. (for example) Dementia, Alzheimer's, Delusions, Hallucinations, [MEDICAL CONDITION]) . Yes . Resident has history (within the last 90 days) of wandering, exit-seeking behavior, or elopement attempts . Yes . Resident making statements that they are leaving, or seeking to find someone or something . Yes . Score . 4 . (A score of 3 or more indicates a need for a locator alert) . d. A Nurse's Note dated 4/1/19 at 10:41 a.m. documented, .on Q (every) 15 min (minutes) checks r/t (related to) trying to leave facility. Has had no behavioral issues and is very pleasant when staff goes to check on him . e. A Nurse's Note dated 4/5/19 at 1:16 p.m. documented, .No further exit-seeking behaviors noted. Resident continues to roam the halls and is easily redirected to activities, meals and toileting . f. A Nurse's Note dated 5/1/19 at 8:33 a.m. documented, .Resident was found increasingly confused this morning, exit-seeking, unsteady gait and diaphoretic. CBG (Capillary Blood Glucose) 160 (after breakfast), BP (Blood Pressure) 122/60, (Temperature) 96.9 ax (axillary), (Heart Rate / Pulse) 86, Respirations 17, and pulse ox (Pulse Oxygenation / saturation) 92%. UTI (Urinary Tract Infection) protocol initiated. Physician notified. New order received STAT (immediate) CMP (Comprehensive Metabolic Panel), CBC (Complete Blood Count), UA (Urinalysis) . g. A Resident Locator Alert assessment dated [DATE] documented, .Is Resident ambulatory or self-mobile in wheelchair . Yes . Resident is cognitively impaired, with poor decision-making skills, and / or pertinent diagnosis (e.g. Dementia, Alzheimer's, Delusions, Hallucinations, [MEDICAL CONDITION]) . Yes . Resident has history (within the last 90 days) of wandering, exit-seeking behavior, or elopement attempts . Yes . Resident making statements that they are leaving, or seeking to find someone or something . Yes .Score . 4 . (A score of 3 or more indicates a need for a locator alert) . h. A Urinalysis laboratory report dated 5/3/19 at 10:24 a.m. documented no infection and a culture was not indicated. i. A Nurse's Note dated 5/5/19 at 8:12 a.m. and written / signed by the Director of Nursing (DON) documented, .Received call from the Administrator that staff reported to her that resident had wandered out of the Care Center and entered the Assisted Living Facility next door. He was pleasant and cooperative, stating that he was 'looking for a ride to the drugstore.' Resident was assessed by Charge Nurse with no negative findings. Physician and family notified. All are in agreement that evaluation by geri-psych (Geriatric Psychiatric Facility / Provider) is indicated at this time . j. The Office of Long Term Care (OLTC) Incident and Accident Report, Division of Medical Services (DMS) form 7734, dated 5/5/19 documented, .On 5/5/19 at 4:00 a.m., resident wandered out of the building and entered the campus Assisted Living next door. Assisted Living staff notified Charge Nurse (Licensed Practical Nurse (LPN) #1) at (facility name) and she, (LPN #1), and (Certified Nursing Assistant (CNA) #3) went to walk him back to his room. He was pleasant and cooperative. Resident stated that, 'I need a ride to the drug store.' Resident was assessed by (LPN #1) with no negative findings. Resident was placed on Q (every) 15 checks. Consulted with family and physician and both agree that geri-psych (Geriatric Psychiatric Facility / Provider) consult is indicated at this time. Resident placed on 1:1 (one-on-one monitoring) pending placement . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	k. On 5/7/19 at 3:20 p.m., the facility doors were checked with the Maintenance Director for proper functioning. The door at the end of the West Long Hall was checked, and the alarm was noted to be at a low volume. The surveyor walked to the Nurse's station at the other end of the hall. LPN #2, who was sitting at the Nurse's Station, was asked if she could hear a door alarm. She stated, No. LPN #3 was standing by the Nurse's Station and was asked if she could hear a door alarm. She stated, No. CNA #7 was standing by the Nurse's Station and was asked if he could hear a door alarm. He stated, No. The distance from the West Long Hall exit door to the Nurse's Station was measured by the Maintenance Director as 118.8 feet. l. On 5/8/19 at 6:55 a.m., CNA #1, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked if she was familiar with Resident #1. She stated, I know who you are talking about. One night I walked the halls with him for like 2 hours because he wanted to go home. His wife and kids were waiting for him out in the car, he thought. She was asked if he wore a Roam Alert bracelet. She stated, I think he did. In the last few days, he came down to the end of West Hall and was shaking on the doors. She was asked if he had ever gotten out before. She stated, Not that I know of. m. On 5/8/19 at 7:05 a.m., the Maintenance Director measured the distance from the door the resident exited from to the door he entered at the Assisted Living facility. The distance was 432 feet. n. On 5/8/19 at 7:10 a.m., CNA #2, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked if she knew Resident #1. She stated, Yes. He roams a lot at night. Just walking. He is sometimes looking for his parents or his car. Every once in a while, he'll go to the doors and try to get out. She was asked how he got out of the building on the morning of 5/5/19. She stated, I guess he held down the door long enough for it to open. She was asked what the facility should do to keep residents like that from getting out of the building. She stated, I guess pay attention to the Roam Alerts on the computer or check on the residents more than every 2 hours. She was asked what she would do if she heard a door alarm. She stated, I go check it. I will open the door and see if there's anyone outside. Then, turn the alarm off. o. On 5/8/19 at 8:38 a.m., LPN #1, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked if she was familiar with Resident #1. She stated, Yes. I was his nurse last weekend. He's confused. He walks around. He's pleasant. I was not aware he was an exit-seeker until Saturday night. Sometime early in the shift, maybe between 12 to 1 (12:00 a.m. to 1:00 a.m.), the front door alarm went off. So, I went to it, and there was an aide; I think it was (CNA #3), and (Resident #1). He was trying to go out the front door. He said he needed to go get groceries. We redirected him and, he went to his room and laid down. When staff made their next round, he was still in bed. She was asked if supervision was increased for him since he was observed by herself and other staff exit-seeking that shift. She stated, I told staff to keep an eye on him. She was asked if she implemented a set schedule of checks, like every 15-minute checks. She stated, No. She was asked what happened next. She stated, The next thing I know, I'm on North (North Hall) and the phone rings, and it's the Assisted Living facility telling me he was over there. Me and (CNA #3) went to get him. She was asked how he got out of the building. She stated, That's what I wanted to know. But I found out later that the volume on my computer was down. I didn't know it. It would have alerted me that he triggered a door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	p. On 5/8/18 at 8:58 a.m., Registered Nurse (RN) #1 was asked if she was familiar with Resident #1. She stated, Yes. He's very confused but easily redirected. He's very sweet. She was asked if he was considered to be at risk for elopement. She stated, Yes, he was at risk. He's ambulatory. He likes to walk the halls. He had a Roam Alert bracelet on. I placed it on him when he was admitted because I asked a family member if he needed it, and they said, 'Yes.' He doesn't try to leave every day, but he was having a bit more confusion like Thursday or Friday. His lab work was negative. She was asked how the facility should have prevented him from getting outside the building. She stated, The alarm should have gone off so staff should have checked to see why. She was asked what staff would do to check that. She stated, They should see if the door is open, and the computer should show them where the resident last was. There should be an audible and visual alert that shows you where he last was. If a resident with a bracelet gets close enough to trigger the system, it will alert. Staff should go outside and check if a door alarm is going off. She was asked if she felt supervision should be increased when there is a resident who is displaying obvious exit-seeking behaviors. She stated, We have Q (every) 15-minute check forms at the desk for the nurses to use if needed. I'm not sure why that wasn't done. She was asked if she felt it was okay for staff to silence a door alarm without going outside to check for residents. She stated, I don't think that's okay. She was asked if she was aware of the volume being down on LPN #1's laptop at the time of the elopement on 5/5/19. She stated, No, I was not aware of that. q. On 5/8/19 at 9:10 a.m., video footage of the elopement was reviewed. The video showed the resident approach the smoke area door at 3:24 a.m. He pressed on the door for a few seconds, but then walked away because the door did not open; however, he had triggered the alarm and the door opening sequence which caused the door to unlock 15 seconds later. At 3:30 a.m., the resident came back to the door, pushed on it and it opened. He walked outside. CNA #5 approached the door and was observed swiping his badge to silence the door alarm at 3:35 a.m., 11 minutes after the door alarm was activated. He did not go outside to search the area. An outside camera showed the resident walking along a sidewalk behind the nursing home at 3:47 a.m. The resident eventually was able to get into the Assisted Living facility at approximately 3:58 a.m., 34 minutes after he initially went outside. r. On 5/8/19 at 9:44 a.m., CNA #3, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked if she was familiar with Resident #1. She stated, Yes. I was one of his CNAs. I went with the nurse to get him that morning. He's very confused. Laid back. That night, all night, he thought his family was there to take him to the drug store. He's not like that every night, but when he is, it's a one-track mind. He was pushing on all the doors. We watched him try to get out the front door several times that shift. She was asked if he had ever eloped before. She stated, Not that I know of. She was asked how he got out that morning. She stated, If you push long enough, by default, the doors automatically unlock after pushing on it. She was asked if she was told to increase his supervision that shift, such as doing every 15-minute checks, since he was actively exit-seeking much of the shift. She stated, No. I was not told to do Q (every) 15-minute checks or anything like that, but I've been a CNA for a long time, so I just know. She was asked what she would do if she heard a door alarm. She stated, I see if someone is trying to go out, and then go out to look. s. On 5/8/19 at 10:25 a.m., CNA #4, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked if she was familiar with Resident #1. She stated, Yes. He walks down North Hall a lot. He likes to go to the exit and try to get out. He does it often, but not every day. Sometimes he will push on the door. Sometimes he will just look out and say he's looking for his wife. I didn't see him at all that night. When we got done with our second rounds, (LPN #1) got a call telling her one of the residents was over there in Assisted Living . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	t. On 5/8/19 at 11:08 a.m., CNA #5, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked about Resident #1. He stated, He was asleep for most of the shift. I was on the Front Hall, but went to Northwest for a little while. He was asked if the resident is a wanderer. He stated, Yeah, he wanders around the building, but on 11:00 p.m. to 7:00 a.m. he's usually sleeping. He was asked if he, at some point, went and silenced a door alarm at the break / smoking area door. He stated, Yes. I don't remember when it was, but I was walking and heard the alarm and went and swiped my badge to silence it. That door alarm goes off all the time. He was asked why the door alarm goes off all the time. He stated, I don't know. When you come through it, you can swipe to come in or out, and after you leave the door, it'll go off again. He was asked if he had reported that to anyone. He stated, No. I have not. He was asked if he went outside and checked the area when he silenced the door alarm. He stated, No. He was asked, why not and stated, Because of that door sometimes just going off. He was asked if it had ever occurred to him that a resident might have gone out that door. He stated, No. He was asked if this elopement incident had triggered him to tell someone, like the DON, that there was a problem with the door. He stated, No, but it probably should have. He was asked if he knew of any other doors that had problems with functioning properly. He stated, Not that I know of. u. On 5/8/19 at 11:30 a.m., CNA #6, who worked the 11:00 p.m. to 7:00 a.m. shift on 5/4/19 to 5/5/19, was asked if she was familiar with Resident #1. She stated, Yes. He sometimes comes to West and tries to get out our door, or he sits in the Day Room. She was asked if she remembered seeing him last Saturday night. She stated, I don't remember seeing him. Some nights he's there, some not. She was asked if he was an elopement risk. She stated, Probably. He's confused and he tries to get out the door. It was either Saturday or Sunday when he tried to get out the door. She was asked if she was aware of any problems with any of the doors functioning properly. She stated, No. v. The facility's policy titled Wandering or Elopement, provided by the Director of Nursing on 5/8/19, documented, .Purpose: To provide guidelines to follow to help create a safe environment for residents who are at risk for 'unsafe wandering' or elopement . Scope of Responsibility: . All facility staff . Definition: . Elopement is defined as slipping away secretly, running away, leaving without accompaniment or knowledge of the staff . Elopement occurs when a resident leaves the premises or a safe area without authorization and / or any necessary supervision to do so . Procedure: Upon admission an assessment will be completed to identify risks . Reassessment will be completed on a quarterly basis, with a significant change in condition, and PRN (as needed) . For residents identified at risk: A Roam Alert Device will be placed on residents with a score of 3 or more on the Elopement Risk Assessment . Care Plan will address the Roam Alert and other interventions to promote a safe environment and reduce unsafe wandering . The Roam Alert device will be checked for placement every shift and documented by the Charge Nurse in the Treatment Record (TAR} and the nursing assistant in the E-Care . A battery check for the Roam Alert device will be made monthly as well as PRN . documentation of battery function will be made in the E-Care . Technical difficulties or malfunctions will be reported to (Name) . If Roam Alert System is not functioning, institute q (every) 15 minute visual checks on all resident with a Roam Alert device . If doors are not secure post a staff member at each malfunctioning door until repaired . All facility staff will assist residents with redirection when they observe unsafe wandering or exit seeking behavior . Documentation will be made in the EMR (Electronic Medical Record) utilizing the Behavior Documentation assessment . w. The facility removed the Immediate Jeopardy and reduced the scope and severity to E on 5/5/19, prior to the survey entrance date, by implementing the following, according to a list provided by the DON on 5/8/19 at 8:58 a.m.: (continued on next page)

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