FOR ACCEPTABLE
YES ☑ NO ☐
Reviewed By: B Brenown HPSS
Name
Fax ☑
Original ☑
Facility Notified
Name: Beth Mueller HR
Date: 12/31/15
Time: 3:45 pm
Notified By: B Brenown HPSS
Name

PRINTED: 12/09/2015
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. BUILDING _____ B. WING _____	C 12/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND SUBACUTE CENTER	3034 E HERNDON FRESNO, CA 93720

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health-Licensing and Certification during the investigation of an ABBREVIATED SURVEY for Entity Reported Incidents (ERI): CA00446735 Representing the California Department of Public Health-Licensing and Certification: 35737 RN, HFEN. The inspection was limited to the specific incidents investigated and does not represent the findings of a full inspection of the facility. ERI CA00446735: Substantiated, refer to F323 AND F281	F 000	**This plan of correction shall serve as the facility's written credible allegation of compliance.** **AMENDED 12/31/15** 12/18/15 **Preparation and/or execution of this plan of correction does not constitute admission by the provider or the truth of the facts set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the Health and Safety Code Section 1280 and C.F.R.**	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record and administrative document and manufacturer's guideline review, the facility failed to meet professional standards of quality when four of four sampled residents' (Resident 1, 2, 3, 4) Wander Guard transmitter (an alarm system designed to alert staff when a cognitively impaired resident wanders outside alarmed doorways) were not tested for functionality according to the physicians' orders and manufacturer's guidelines. This failure resulted in a fall and injury to	F 28	**F281 Services Provided Meet Professional Standards** Resident 1 admitted to the acute hospital on [redacted] 2015 after a fall. She was readmitted on [redacted]15 at 1700 with a new diagnosis of fractured humerus and UTI. Resident was readmitted with a left arm brace/soft cast and sling. A wander guard was placed on the resident's wrist. The resident has not had any further falls. Resident was assessed upon readmission by Sequoia RN unit manager and it was determined that she no longer required the wander guard upon readmit, as she no longer was able leave the nursing	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Administrator 12-31-15

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 281	Continued From page 1 Resident 1, and had the potential to result in a fall of Resident's 2, 3 and 4's who wore the Wander Guard alarm and were at risk for elopement: Findings: Review of Resident 1's face sheet [document which contains resident specific information] indicated Resident 1 was admitted to the facility on [redacted]14. Resident 1's diagnoses included dementia and a history of falls. Review of Resident 1's Minimum Data Set (MDS- an assessment tool for resident function and cognition ability) assessment, dated [redacted]15, indicated Resident 1 had long and short term memory impairment. Resident 1's nursing progress notes dated [redacted]15 at 10:49 a.m., indicated, "Resident has wandering behavior noted...[Resident 1's physician] notified and order for Wander Guard received..." Review of Resident 1's physician orders dated [redacted]/15, indicated, "Alarm: Wander Guard-related to Dementia-check placement and function q (every) shift..." Resident 1's Treatment Administration Record, dated [redacted]15, and [redacted]/15, indicated, "Alarm: Wander Guard - Check placement and function Q [every] shift...related to Dementia." (memory loss affecting overall mood, behavior and physical function) On [redacted]/15 at 10:55 a.m., Resident 1 was observed asleep in bed with a Wander Guard ankle bracelet on the right ankle.	F 281	station and due to her new medical condition, arm sling, she was not currently able to self propel wheelchair therefore the wander guard order was discontinued. She was reassessed again upon quarterly review by the long term care Manager and it was determined once again that the resident still showed no wandering behaviors that required the wander guard based. This was based on a chart review by the long term care and seeing zero documented attempts in the progress notes by the Licensed Nurses of resident trying to leave Main Lobby doors or sub-acute lobby doors. During the three months between assessments the resident only stayed on her unit and showed no attempts to wheel to the front or side exits or leave out into the exterior patio. Resident is now able to maneuver herself around the nursing station for short distances but has not attempted to exit any of the exterior doors. Resident 1 is under continued assessment for wandering behavior and the need for a wander guard bracelet. Any changes in mobility or behavior will be documented in the Weekly Progress Notes by he License Nurse in the resident's electronic record. If there is a noted improvement that shows the resident is again at risk for wandering, a wander guard will be ordered by the physician and placed on resident.	12/18/15

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F 281	Continued From page 2 On [redacted]15 at 11:35 a.m., during an interview, LN 1 stated he did not have a device to test the Wander Guard. On [redacted]15 at 11:40 a.m., during an observation and concurrent interview, Licensed Nurse (LN) 1 pointed to the main entrance and a side entrance to the building equipped with the Wander Guard alarm (door alarm operates by monitoring motion through a doorway or hallway). LN 1 stated, "These are the only two doors that have Wander Guard alarms." Facility map indicated there were a total of 11 exits. LN 1 did not know why the exit doors were not equipped with the Wander Guard alarm. On [redacted]15 at 12 p.m., during an interview, LN 2 stated Wander Guard testing was done on the night shift. LN 2 stated she had worked on the night shift and had never checked the functioning of the Wander Guard alarm. On [redacted]15 at 2:50 p.m., during an interview, LN 3 stated, the nurses had no way to check the Wander Guard alarm system other than walking the residents who wore the alarms through the doors which were set up for the alarm system. On [redacted]15 at 4 p.m., during an interview, a Central Supply (CS) worker stated he had not used a transmitter tester to verify the Wander Guard worked properly. The CS staff stated, "The box [transmitter tester- used to check Wander Guard function] broke back in March and we haven't replaced it, I guess we forgot." On [redacted]15 at 4:05 p.m., during an interview, CS removed the transmitter from Resident 1's ankle	F 281	Residents 2, and 3 have not experienced any harm, but have had their wander guards checked every shift to ensure proper placement to residents' person by assigned Licensed Nurse on the electronic Treatment Record. Resident 4 was discharged from the facility on [redacted]/15. Other residents potentially at risk will be identified through one or more of the following: IDT clinical assessment, history gathering of previous wandering behaviors from the family, interviewing staff on all shifts that care for resident, documented evidence in the progress note of residents wandering by Licensed nurses and utilization of the wandering risk assessment tool. All residents (Residents 2 and 3) who have orders for a wander guard have had their wander guard bracelets tested and continue to be checked for proper functioning each week. (Exhibit C) Facility purchased Wander Guard transmitter test boxes on [redacted]15 (Exhibit D). The transmitters will be stored in the medication cart, for those nursing stations that have resident(s) who use a wander guard. An additional transmitter is available in central supply. The Director of Central Supply has identified the process for testing the	12/18/15

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F 281	Continued From page 3 in order to demonstrate how to test the Wander Guard. CS walked through the main entrance while holding Resident 1's Wander Guard in his hand; this triggered an audible alarm. CS stated he was following manufacturer guidelines in testing the Wander Guard transmitter. On [redacted]/15 at 4:10 p.m., during an interview, LN 4 stated, "I don't know what a Wander Guard is." LN 4 was unable to identify the Wander Guard on Resident 1's right ankle. On [redacted]15 at 4:45 p.m., during an interview, the Administrator (Adm) stated, "There is no way the nurse is going to be bringing the resident to the door to check that the Wander Guard works." Adm stated she was not aware that the transmitter tester had been broken since [redacted] 2015. On [redacted]15 at 10:45 a.m., during an interview, LN 5 stated, she checked the Wander Guard was around Resident 1's ankle and did not know anything about testing the Wander Guard. LN 5 stated, "Once in a while, I take Resident 1 to the front entrance to check [the Wander Guard] but not every day." On [redacted]15 at 3:45 p.m., during an interview, the Staff Development Assistant (DSDA) stated Wander Guards were tested by taking the resident with a Wander Guard transmitter through the door ways that triggered the Wander Guard alarm to sound. On [redacted]15 at 4 p.m., during an interview, DSDA stated there had not been any staff training on how to test functionality of the Wander Guard.	F 281	transmitter through review of the manufacturer's guideline (Exhibit E). The guidelines state as follows: • Transmitters in use must be tested weekly • Test the operation of Transmitters in use weekly using the transmitter tester • Visually inspect transmitters in use weekly for damage or loose parts • Verify on a weekly basis that the warranty expiration date stamped on transmitters in use has not expired. If the warranty period has expired, discard and replace the transmitter immediately • The facility will keep records of test and transmitter inspection • Never take a resident to a door to test their transmitter The Director of Central Supply/designee will test and document the Wander Guard system weekly according to the manufacturer's recommendations in the elopement wandering resident process binder located at each station. The Central Supply Director will be responsible for this weekly test as he is the one to distribute the initial wander guards and initiate the log in the elopement binder. The doors were adjusted on [redacted]15 by the maintenance director to close slowly, allowing more time for the alarm to sound.	12/18/15

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F 281	Continued From page 4 On [redacted]15 at 12:15 p.m., during an interview, LN 7 stated when she tested the Wander Guard transmitter with a newly acquired tester, she expected to hear one beep and see a green light to signal once; if it was working properly. On [redacted]15 at 3:20 p.m., during an interview, LN 8 was asked to demonstrate the process of conducting a Wander Guard transmitter test for Resident 2's Wander Guard. LN 8 pressed the side button on the transmitter tester which she placed on top of Resident 2's Wander Guard transmitter. LN 8 pressed the button to test the wander guard transmitter. After she heard the first beep and visualized the green light signal she released the button. On [redacted]15 at 3:30 p.m., during an interview, LN 6 was asked to demonstrate the process of conducting a Wander Guard transmitter test on Resident 3. LN 6 stated, "I am not one hundred percent certain how to conduct the transmitter test." Review of Resident 2's face sheet indicated Resident 2 was admitted on [redacted]15. Resident 2's Care Plan dated [redacted]15, indicated, "The resident is an elopement risk..." An intervention on the Care Plan indicated, "Wander guard to right ankle." Resident 2's physician order dated [redacted]15 indicated, "Wander Guard: Check function every day and evening shift." Resident 2's Wandering Risk Assessment dated [redacted]15, indicated Resident 2 had a diagnosis of Early Dementia and a history of wandering behaviors. Clinical record reviewed indicated Resident 3 was admitted on [redacted]/15. Resident 3's "Order Summary Report," dated [redacted] 2015, contained	F 281	Licensed and unlicensed staff were in-serviced on [redacted]15, [redacted]15 and [redacted]/15 by the Director of Staff Development on the topic of patient safety including the purpose and function of wander guards per the manufacturer's guidelines (Exhibit F). Licensed and unlicensed staff were in-serviced again to the wander guard system and assessment of residents who display wandering behaviors by Director of Staff Development and Chief Compliance Officer on [redacted]15 (Exhibit G). A make-up in-service is scheduled for [redacted]15 (Exhibit H) with the Director of Staff Development. Licensed nurses who identify damage to the wander guard bracelet will replace the bracelet. Alarmed doors that malfunction identified by maintenance will be repaired immediately. Until the doors are repaired, a staff member will be assigned to monitor the door at all times.	12/18/15

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LICENSING & CERTIFICATION

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F 281	Continued From page 5 an order initiated on [redacted]15 indicating, "Check placement of wander guard every shift for resident history of wandering." Resident 3's Elopement Risk Assessment, dated [redacted]15, indicated Resident 3 was independent in mobility by ambulation [walking], wheelchair...Resident 3 had desire to exit facility...Resident 3 had confusion...Plan was to implement Wander guard." Resident 3's Care Plan, dated [redacted]15, indicated, "The resident is an elopement risk/wanderer [as evidenced by] history of attempt to leave facility...CNA (Certified Nursing Assistant) to monitor placement and function of wander guard daily." Clinical record review indicated Resident 4 was admitted on [redacted]15. Resident 4 had an admitting diagnosis of Dementia. Resident 4's Treatment Administration Record, dated [redacted]15-[redacted]15, indicated, "Alarm Wander Guard-Check placement and function Q shift. The facility policy and procedure titled, "Resident Elopement and Wandering" dated [redacted]15, indicated, "Facility administration and staff recognize that elopement poses a real danger to certain residents...functional alarm systems will be implemented in order to maintain the resident's safety...Apply Wander Guard bracelet to the resident wrist or wheelchair if the resident refuses to wear the bracelet or removes the bracelet...Placement and function of the Wander Guard should be checked at the start of each shift..." Review of manufacturers guidelines titled, "Wandering Management Transmitter User Guide" dated 6/12/14, indicated, "Users must read this Guide before using the Product." Under	F 281	The Director of Central Supply began testing each resident's alarm bracelet with the transmitter tester, following the manufacturer's guidelines, on [redacted]15 (Exhibit C). Beginning [redacted]15 the doors alarmed with the wander guard will also be tested weekly using a test bracelet (Exhibit I) by the Central Supply Director/Designee tests of the bracelets and doors will continue on a weekly basis by Central Supply Director/Designee. Ongoing all tests will be recorded by the Central Supply designee on the respective log. The Administrator/designee will provide oversight on all logs monthly (exhibit C and I) to ensure compliance. Quality Assurance report of the improper use and function of the Wander Guard system will be reported to the QA&A committee by the Administrator and/or Central Supply Director/designee on a quarterly basis. The facility will be in substantial compliance no later than December 18, 2015. RECEIVED DEC 31 2015	12/18/15

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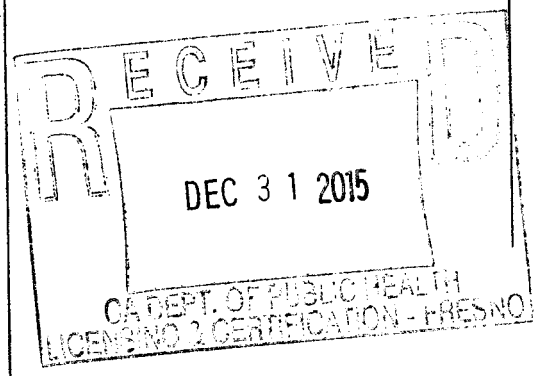
F 281	Continued From page 6 Required Transmitter Testing it indicated, "You must test these transmitters prior to use to verify proper operation...Test the operation of the transmitter using the Transmitter Tester...The device beeps once when you initially press the button...While holding the button in, the indicator light flashes and a tone sound once per second, wait for at least 3 flashes of the indicator light and 3 tones from the transmitter tester to verify that the transmitter is functioning correctly...Required weekly testing for transmitters in use on residents...All steps are mandatory. Note: Transmitters in use must be tested at least weekly...Test the operation of transmitters in use weekly using the transmitter tester ...Verify on a weekly basis that the warranty expiration date stamped on transmitters in use has not expired...Your facility must keep records of test and transmitter inspection. NOTE: Never take a resident to a door to test their transmitter..."	F 281		12/18/15
F 323 SS=G	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 staff interview, clinical record and administrative document review, the facility failed to identify environmental hazards and failed to provide supervision to prevent an accident for	F 323	**F323 Free of Accident Hazards /Supervision/Devices** Resident 1 admitted to the acute hospital on [redacted]/2015 after a fall. She was readmitted on [redacted]15 at 1700 with a new diagnosis of fractured humerus and UTI. Resident was readmitted with a left arm brace/soft cast and sling. A wander guard was placed on the resident's wrist. The resident has not had any further falls. Resident was assessed upon readmission by Sequoia RN unit manager and it was determined that she no longer requires the wander guard as she no longer leaves the nursing station and due to her new medical condition, arm sling, she was not currently able to self propel wheelchair. She	

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F 323	Continued From page 7 one of three residents (Resident 1) when Resident 1 fell and sustained a fractured arm after exiting through an outside door that failed to alert staff when exited by Resident 1. This failure resulted in an injury to Resident 1's left humerus (upper arm) which caused Resident 1 pain and a decline in physical function. Findings: Resident 1's face sheet [document which contains resident specific information] indicated Resident 1 was admitted to the facility on [redacted]14. Resident 1's diagnoses included Dementia (cognitive impairment) and a history of falls. Resident 1's Minimum Data Set (MDS- an assessment tool used to identify physical and cognitive abilities) assessment dated [redacted]15, indicated Resident 1 had long and short term memory impairment. Resident 1's "Fall Risk Assessment" dated [redacted]15, indicated, Resident 1 had a score of 18 which revealed the resident was at a high risk for falls. The assessment revealed Resident 1 had a history of multiple falls, was frequently disoriented, and required staff assistance with transfer, and had a decrease in muscle coordination. Review of Resident 1's physician orders dated [redacted]15, indicated, "Alarm: Wander Guard (An alarm system providing notification to staff when residents try to leave the facility or wander into restricted areas)-related to Dementia-check placement and function q (every) shift...	F 323	was reassessed again upon quarterly review by the long term care Manager and it was determined once again that the resident continued to no longer exhibits wandering behaviors that required the wander guard based on zero documented attempts in the progress notes by the Licensed Nurses of resident trying to leave Main Lobby doors or sub-acute lobby doors. Resident is currently able to maneuver herself around the nursing station for short distances but has not attempted to exit any of the exterior doors. Resident 1 is under continued assessment for wandering behavior and the need for a wander guard bracelet. Any changes in mobility or behavior will be documented in the Weekly Progress Notes by he License Nurse in the resident's electronic record. If there is a noted improvement that shows the resident is again at risk for wandering, a wander guard will be ordered by the physician and placed on resident. Any resident that required a wander guard or had a tendency to go outside independently or unsupervised prior to [redacted]15 would have been at risk for the deficient practice. No other residents have wandered outside of the facility without proper supervision. Audible alarms were installed on all courtyard entry doors on City Square on [redacted]15 by the Maintenance Director (Exhibit J). A licensed nurse was assigned to sit at the nursing station, monitoring the alarm system throughout each shift until the facility contracted gardener leveled the flower beds on [redacted]15 to prevent reoccurrence (Exhibit K).	[redacted]

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F 323	Continued From page 8 Resident 1's plan of care (POC) dated [redacted]14 indicated, "The resident is high risk for falls [related to] unaware of safety needs, confusion, gait balance problems; ...The resident will not sustain serious injury...staff to anticipate and meet the resident needs..." Resident 1's nursing progress notes dated [redacted]5 indicated, "...CNA [Certified Nursing Assistant] reported to writer...patient is laying on the ground outside...Resident was laying on her side, resident had vomited...Resident was observed, with an abrasion on her right forehead, pain to left arm with softball size lump noted. Called to ambulance... resident sent to hospital..." On [redacted]15 at 10:55 a.m., during an observation, Resident 1 was in bed asleep with a soft cast and a sling present on the left arm. On [redacted]15 at 11:20 a.m., during an interview, Licensed Nurse (LN) 1 stated Resident 1 required more assistance in activities of daily living (ADL's). LN 1 stated prior to Resident 1's fall and fracture, Resident 1 required extensive assistance (staff provide weight bearing support) with her ADL's and was able to propel around in the wheel chair. LN 1 stated Resident 1 now required maximum assistance (full staff performance) which required the assistance of two persons with ADL's. On [redacted]15 at 12:00 p.m., during an observation, LN 2 walked to the outside patio to indicate the location of where Resident 1 had fallen. LN 2 stated Resident 1 had gone outside in her wheelchair on [redacted]15 when the wheel of the chair tipped over the edge of the side walk, and the wheelchair and Resident 1 fell to the ground.	F 323	Facility purchased Wander Guard transmitter test boxes on [redacted]15 (Exhibit D). The transmitters will be stored in the medication cart, for those nursing stations that have resident(s) who use a wander guard. An additional transmitter is available in central supply. The Director of Central Supply has identified the process for testing the transmitter through review of the manufacturer's guideline. The Director of Central Supply will test and document the Wander Guard system weekly according to the manufacturer's recommendations (Exhibit E). All tests will be documented on the proper log Central Supply Director/designee (Exhibits C and I). The wander guard system will be tested weekly ongoing. The doors to the courtyards were adjusted on [redacted]15 by the maintenance director to close slowly, allowing more time for the alarm to sound.	12/18/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPLETION DATE
F 323	Continued From page 9 An empty flower bed was unlevel, the ground lower than the sidewalk, was present alongside one side of the side walk. On the surface of the dirt three sprinkler heads protruded creating a trip and fall hazard. On [redacted]15 at 12:20 p.m., during an observation, the call light system displayed an alert to staff by signaling a light over each resident room and by sending an audible signal to the nursing station each time a call button was pressed. There was no light above the patio door exit to alert staff visually when Resident 1 exited the door. On [redacted]15 at 12:25 p.m., during an interview, LN 2 stated, "There were no noise making alarms (an alarm triggering the attention of staff) at the doors during the day of [Resident 1's] fall." LN 2 stated the door to the patio was not set to alarm as a response to a wander guard alarm when a resident wearing an alarm exited the door. On [redacted]15 at 12:35 p.m., during an interview, CNA 1 stated at approximately 2:10 p.m., she was notified by another CNA that someone was in the outside patio on the ground. CNA 1 stated, "We ran outside and we found [Resident 1], on the floor." CNA 1 stated she and another CNA ran back inside to call for help leaving the resident alone on the ground. CNA 1 could not explain how Resident 1 had gotten unassisted. CNA 1 stated "Residents like [Resident 1] are not allowed to be outside on their own." CNA stated Resident 1 needed supervision because of her diagnoses of dementia and unsafe wandering. On [redacted]15 at 1:00 p.m., during an interview, LN 9 stated she was the nurse in charge on the day of Resident 1's fall. LN 9 stated, "It was around	F 323	The Maintenance Director/Designee will be responsible for the safety check of the facility grounds. He will monitor the courtyards monthly to ensure that walkways are level with the ground. Ongoing. All inspections will be documented on the maintenance safety log and repairs will be made as necessary (Exhibit L). Licensed and unlicensed staff were in-serviced on [redacted]15, [redacted]/15 and [redacted]/15 by the Director of Staff Development on the topic of patient safety including the purpose and function of wander guards per the manufacturer's guidelines (Exhibit F). Licensed and unlicensed staff were in-serviced again to the wander guard system and assessment of residents who display wandering behaviors by the Director of Staff Development and Chief Compliance Officer on [redacted]15 (Exhibit G). A make-up in-service is scheduled for 12/18/15 (Exhibit H) with the Director of Staff Development. Licensed nurses who identify damage to the wander guard bracelet will replace the bracelet. Alarmed doors that malfunction identified by maintenance will be repaired immediately. Until the doors are repaired, a staff member will be assigned to monitor the door at all times.	1/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. BUILDING _____ B. WING _____	C 12/04/2015

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F 323	Continued From page 10 2 p.m., one CNA came to me and told me [Resident 1] was on the floor." LN 9 stated Resident 1 was found on her right side, and the resident stated to LN 9 she had a broken arm and was in pain. LN 9 stated Resident 1 "can not be outside, she needs to have supervision." LN 9 stated there were no alarms at the door to alert her of Resident 1's exiting through the patio doors. LN 9 confirmed Resident 1's fall was avoidable. On [redacted]15 at 2:10 p.m., during an interview, the Director of Staff Development (DSD) stated there were no alarms triggered at the door because, there were no alarms at the doors prior to Resident 1's fall. On [redacted]15 at 3:15 p.m., during an interview, the Maintenance Director (MD) stated he was responsible for the safety check of the facility grounds. The MD stated he was part of a safety committee, and stated, "I am responsible for my team of 12 members, we identify things or potential risks that can affect the safety of all in the building." The MD stated there had never been any discussion regarding the unleveled ground surface on the outside patio. On [redacted]15 at 3:20 p.m., during an observation and concurrent interview on the outside patio, the MD measured the unleveled ground along one side of the side walk where Resident 1 had fallen. There were three measurements taken along side the sidewalk, first measurement was the location where Resident 1 had fallen; it measured a drop of three and half inches from the cemented walkway to the ground. A second area measured a two inch drop from the sidewalk to the ground, and the third area measured a four	F 323	Residents who display wandering behaviors will be assessed by the licensed nurse using the wander risk assessment tool and visual evidence of residents' wandering towards Main lobby doors and sub-acute lobby doors. Wander guard will be applied by licensed nurses with a physician's order to those residents' who are assessed as being at risk for wandering. Licensed nurses will check the placement of the wander guard bracelet every shift. The Administrator/designee will provide oversight on logs and ensure log binders are at the nurses stations on a monthly basis (exhibit C and I) to ensure compliance. Quality Assurance report of the improper use and function of the Wander Guard system will be reported to the QA&A committee by the Administrator and/or Central Supply Director/designee on a quarterly basis. The facility will be in substantial compliance no later than December 18, 2015.	12/18/15

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F 323	Continued From page 11 inch drop from the side walk to the ground. The MD stated, "Yes, I agree the ground is unleveled." On [redacted]/15 at 11:45 a.m., during an interview, the Minimum Data Set Coordinator (MDSC) stated Resident 1 had a significant change in overall function following her fall and fracture. MDSC stated, " [Resident 1] has had noted decline in several areas, she declined in transfers, locomotion on unit and off unit, dressing, eating, toilet use, and bathing." On [redacted]15 at 12:00 p.m., during an interview, The MD stated he had not done "anything" to the area on the patio that was unlevel. On [redacted]15 at 12:10 p.m., during an observation and concurrent interview with the Administrator (Adm) and the Operations Regional Director (ORD), a recording of Resident 1's fall from [redacted]15 was viewed. The recording revealed a date of [redacted]15 at 1:19 p.m. Resident 1 was observed sitting in her wheel chair in the hallway which led to the exit patio doors. LN 9 was observed standing in front of a medication cart in the hallway close to a doorway in which the hallway led to the exit out to the patio. LN 9 was seen going into a resident room at this time. Resident 1 was wheeling in the wheelchair toward the exit patio door at 1:20 p.m. The video recorded Resident 1's fall outside at 1:22 p.m. On 11/12/15 at 1:40 p.m., during an interview, the DON stated Resident 1 had sustained a fall on [redacted]15 because the ground was unlevel. Resident 1's POC dated [redacted]/15, indicated, "The resident is an elopement risk/wanderer [as evidenced by] Resident wanders aimlessly,	F 323		12/18/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 12 Disoriented to place..." The document indicated a goal, "The resident will not leave facility unattended...The residents safety will be maintained..." POC interventions indicated, "Assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities...Wander Alert when up in chair to alert staff of whereabout." Resident 1's X- Ray report dated [redacted]15 at 4:51 p.m., indicated, "There is a left humerus helical (spiral) midshaft (mid way between the end of a long bone) fracture...Extensive soft tissue swelling." The facility administrative document titled, "Job description Maintenance Supervisor" undated, indicated, "...The primary purpose of your position is to assist...day to day activities of the Maintenance Department in accordance with current Federal, State and local standards...to assure that our facility is maintained in a safe and comfortable manner..." The facility policy and procedure titled, "Fall Prevention Program" dated 12/1/2011 indicated, "...To identify residents who are at risk of falling and prevent accidents by providing an environment that is free from hazards...all residents will receive adequate supervision and assistive devices to prevent accidents..."	F 323		12/18/15