Woodmere Rehab & Health Care Center, Inc

Deficiency Details, Complaint Survey, December 1, 2011

PFI: 0539
Regional Office: MARO--Long Island sub-office

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F323 483.25(h): FACILITY IS FREE OF ACCIDENT HAZARDS

Scope: Pattern

Severity: Immediate Jeopardy

Substandard Quality of Care

Corrected Date: December 29, 2011

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.

Citation date: December 1, 2011

Based on observation, record review and staff interviews during an abbreviated and partial extended survey it was determined that the facility failed to ensure that each resident assessed and identified at risk for elopement/wandering was provided adequate supervision, and monitoring to protect the health and safety of the residents. The facility failed to ensure there was a system in place to safeguard residents at risk for elopement and wandering during a facility outing. The facility's failure to communicate to facility staff that a number of residents on the outing required supervision due to their risk for elopement and wandering resulted in a resident's undetected elopement. Specifically, one (Resident #1) of 6 residents reviewed with a history of wandering and was planned for 30 minutes visual monitoring attended a facility outing and successfully eloped undetected by the facility's staff and was not located until a call was received four days later from a hospital in another county stating that Resident #1 had been found unresponsive and later pronounced dead at the hospital.

This resulted in actual harm to Resident #1 that is Immediate Jeopardy, Substandard Quality of Care and potential for serious harm to Residents (#2, #3, #4, #5, and #6)who have been assessed as at -risk for elopement/wandering and are taken out on facility outings.

Complaint Number: NY00109157

The finding is:

Resident #1 was 55 years old and admitted to the facility on 3/22/11 with diagnoses including Rhabdomyolysis, Diabetes Mellitus, Hypertension and Cognitive Disorder Not Otherwise Specified.

The Minimum Data Set 3.0 (an assessment tool) dated 9/11/11 documented Resident #1's cognition as severely impaired.

The Wandering Risk Scale dated 3/22/11 and updated 9/20/11 documented that
Resident #1 was assessed to be at low risk for wandering.

The Comprehensive Care Plan dated 3/23/11 and updated 9/20/11 documented that Resident #1 was low risk for wandering and utilized a wander guard to left ankle due to ambulatory status and diagnosis of mild dementia.

The Certified Nursing Assistant Assignment/Accountability Record dated November 2011 documented that Resident #1 wore a wander guard to his left ankle and did not include 30 minute monitoring.

The Policy and Procedure for Out of Facility Trips dated 7/07 documented that the Director of Recreation will

determine the necessary staff/resident ratio to properly supervise and monitor the residents, according to the individual needs of the residents and assign the staff accordingly.

The Policy and Procedure for Wandering Risk Protocol Scale dated 6/08 documented (on admission) all residents will be assessed by a nurse to determine his or her risk for harm due to wandering by utilizing 'Wandering Risk Scale' ...Residents that score in the high risk range or as per discretion by the Licensed Nurse, a wander guard will be placed on those residents."

The Policy and Procedure for Prevention of Elopement (PPPE) dated 10/08 documented the risk factors for elopement including, but not limited to, a resident who has a history of wandering/elopement. The PPPE further documented "if a resident is assessed to be at risk for elopement ...a wander guard device is put on the resident and the resident is placed on every 30 minutes monitoring ...All staff ...are to be made knowledgeable of residents at risk for elopement and be prepared to intervene."

The facility's Investigative Summary dated 11/25/11 documented that there were 19 residents who went to an inter-generational trip at a local school on 11/22/11. Resident #1 was noted missing during a headcount by staff at 12:20 PM. Based on the risk assessments since admission, Resident #1 was not at risk for elopement, low risk for wandering and a wander guard was provided to the resident upon admission as a preventive measure. Adequate staff was provided, the resident's plan of care and facility policy were followed, however, due to the fact that the school cafeteria was full of students, school staff, residents and facility staff when the incident occurred, the resident left the cafeteria unnoticed by the staff.

The 30 Minute Frequent Check Sheets from 3/22/11 to 11/22/11, documented that Resident #1 was being monitored for his whereabouts every 30 minutes .

The Wanderguard/Elopement List dated 11/22/11 documented Resident #1's wander guard.

An undated list of residents (provided by the Director of Recreation) documented 19 residents attending the Thanksgiving Luncheon on 11/22/11. Five of the nineteen residents were on the Wanderguard/Elopement List.

The Elopement Risk Assessment dated 9/20/11 documented that Resident #1 was not at risk for elopement.

The Medical Progress Notes dated 10/31/11 documented that Resident #1 did not have capacity to make decisions regarding medical care, discharge and finances due to dementia.

The Physician's Orders for Monitoring dated 11/14/11 documented wander guard to left ankle, check for placement and skin integrity every shift.

The Nursing Progress Notes (NPN) dated 11/22/11 at 12:30 PM, documented that the recreation staff who went out with the residents called the unit to inform that Resident #1 was missing from the group. The nursing supervisor was informed.

The NPN dated 11/23/11 documented that, on 11/22/11 at approximately 12:30 PM, Resident #1 could not be located in the school cafeteria. An immediate search was conducted in the entire school as well as its neighboring areas. The resident's sister, police precinct and hospitals were informed.

The Medical Progress Notes dated 11/24/11 documented that on 11/22/11, during a recreational trip, Resident #1 "was missed and never found - search is in progress ...history of mild dementia ...Patient was following commands and was never on one to one observation. His elopement score was low. I do not think that patient's health or life is in any immediate danger at this time. Search for patient to be continued."

The Fire Department of New York (FDNY) Prehospital Care Report dated 11/25/11 at 7:04 AM documented that the resident was found in another county face down on the side walk, pulseless, frozen body, unresponsive, unable to open mouth, unable to be intubated. The resident was taken to the hospital.

The Hospital Emergency Physician Record dated 11/25/11 at 7:15 AM documented that the resident was brought to the Emergency Room, where intubation was tried but failed because the resident's mouth was unable to be opened due to rigor. The resident was very cold (72 degrees Fahrenheit). Anesthesia and tracheostomy team called. Anesthesia intubated the resident and the resident was placed on external warmer and warm saline infusion.

The Office of Chief Medical Examiner Report documented that the resident was found in the street by EMS (Emergency Medical Services). The resident was pronounced dead on 11/26/11 at 8:55 AM due to cardiac arrest and hypothermia.

An interview was conducted with a Recreation Aide (RA #1) on 11/28/11 at 12:33 PM. RA #1 stated that, on 11/22/11 at approximately 11:00 AM, a number of residents assembled in the lobby area on unit 1 South. RA #1 stated that although she could not recall the number of residents, a headcount of residents going on the trip was taken and the residents and recreation staff left the facility to walk to a local school for a holiday meal outing . RA #1 stated she escorted Resident #1 in a group of other residents from the facility to the local school. RA #1 recalled Resident #1 being among a headcount at 12:10 PM at the school, but when RA #1 did another headcount at 12:20 PM, Resident #1 could not be found. RA #1 stated that she immediately told RA #2 and started to search inside and outside the school but could not locate the resident. RA #1 stated that she thought Resident #1 had been seated at one of two tables in the front of the school cafeteria but could not be sure as to which table. RA #1 stated that she was not specifically assigned to Resident #1 because no one (staff) has any specific assignments. RA #1 knew of four residents on unit 2 South (Resident #1's unit) that went out on the trip because RA #1 does activities on that unit. RA #1 stated that she did not know whether or not Resident #1 wore a wander guard. She had a list of residents on the trip but the list did not say anything about the residents except their names. RA #1 stated that she always knew Resident #1 and did not know of any residents at risk for wandering on the trip.She also stated that no one told her about wandering and elopement regarding the residents on the outing.

An interview was conducted with the 11/22/11 assigned 7:00 AM to 3:00 PM Certified Nursing Assistant (CNA #1) on 11/28/11 at 1:17 PM, she floats throughout the facility and was only assigned to Resident #1 on 11/22/11. CNA #1 stated that she recalled Resident #1 as being pretty independent, doing everything for himself, but did not talk very much. CNA #1 stated that she had to write down where the resident was every 30 minutes but CNA #1 did not know why she had to do this and whether or not Resident #1 wore a wander guard.

An interview was conducted with Resident #1's daily assigned 7:00 AM to 3:00 PM CNA #2 on 11/28/11 at 1:50 PM. CNA #2 stated that he has been taking care of Resident #1 for the past three months and knew Resident #1 wore a wander guard and CNA #2 had to make sure he knew where the resident was every 30 minutes. Resident #1 could do a lot for himself but needed help to remember to do things.

An interview was conducted with RA #2 on 11/28/11 at 2:04 PM. RA #2 stated that on 11/22/11, the recreation staff left the facility through the back door of unit 1 South with residents to go for a Thanksgiving lunch at the local school. RA #2 stated that the staff walked with the residents to the school. RA #2 stated that she has been working at the facility for about ten years and RA #2 has an idea of residents' behaviors. RA #2 stated that, based on her knowledge, she tries to keep an eye on residents. RA #2 stated that the recreation staff usually tries to watch out for the residents they know, but there are no specific assignments on trips. RA #2 stated that "sometimes you may have one or two residents from your floor and other times five or six." RA #2 stated that the school cafeteria was chaotic and congested because there were a lot of students from the school mixed in with the residents. RA #2 stated that she did not know if Resident #1 wore a wander guard and did not think any resident was at risk for elopement. RA #2 stated that she was not told of any resident who needed to be watched any differently or about wandering and elopement regarding the residents on the outing..

An interview was conducted with RA #3 on 11/28/11 at 2:13 PM. RA #3 stated that she really only knows the residents on the 3rd floor of the facility where she works and was not sure if she knew Resident #1. RA #3 stated that when she goes on trips with residents, she is supposed to pay attention to all residents and is not assigned to any one in particular. RA #3 stated that she was not told of any specific behaviors regarding any of the residents on the trip and did not know if any residents might have been at risk for elopement or wandering.

An interview was conducted with RA #4 on 11/28/11 at 2:18 PM. RA #4 stated that she went on the trip with the residents on 11/22/11 and was helping to push a resident, who was in a wheelchair. RA #4 stated that she had to veer away from the group while walking from the facility to the school because the side walks had cracks over which RA #4 could not push the wheelchair. Once she arrived at the school, RA #4 had to keep an eye on residents. RA#4 further stated that there were many people at the school and it was very hard to do. RA #4 stated that she did not know if any resident on the trip wore a wander guard, but she didn't think so and no one told her about wandering and elopement regarding the residents on the outing.

An interview was conducted with RA #5 on 11/28/11 at 2:34 PM. RA #5 stated that she was not really assigned to anyone on the trip and was just watching over the residents as they walked from the facility to the school. RA #5 was not aware that Resident #1 had escaped because RA #5 had to leave the school and return to the facility to get another resident who had been added to the list. RA #5 stated that when she returned to the school, Resident #1 was gone already. No one told her about wandering and elopement

regarding the residents on the outing.

An interview was conducted with the Licensed Master Social Worker (LMSW) on 11/29/11 at 9:55 AM. The LMSW stated that she has assessed Resident #1' s cognition a few times since the resident's admission to the facility. Resident #1 was alert and oriented to person and has consistently scored as severely impaired on the BIMS (Brief Interview for Mental Status). The LMSW stated that care planning for a resident with wandering and/or elopement behaviors is done by the nursing department.

An interview was conducted with the 7:00 AM to 3:00 PM 2 South unit charge Registered Nurse (RN) on 11/29/11 at 11:15 AM. The RN stated that Resident #1 had been pacing and wandering the hallway when he first came into the facility. Resident #1 lived at the end of the hall and, due to his independent ambulatory status a wander guard was placed on the resident as a precautionary measure and placed on 30 minute monitoring. Per facility policy, any resident with a wander guard must be monitored. The RN stated that she did assess Resident #1 twice since his admission to the facility and did not take into account the resident's history of wandering upon admission, which would have changed the assessment to make the resident at risk for wandering and elopement. The RN stated that, on 11/22/11, the recreation department had a list of residents who were being taken on a trip to a local school. The RN stated there was no discussion with or report given to recreation regarding any resident who might be at risk to wander. The RN stated there have been trips such as this one in the past and the RN did not recall having a discussion regarding residents' behaviors prior to the trips.

An interview was conducted with the Attending Physician (AP) on 11/29/11 at 11:45 AM. The AP stated that Resident #1 came to the facility with a history of delirium and severe dementia but the AP was never notified about the resident's pacing. The AP stated that wandering and elopement are pretty close to each other and the AP cannot say with certainty that Resident #1 was not an elopement risk. Regarding the Physician's Orders for a wander guard for Resident #1, the AP stated that he is not attentive to ancillary orders and he (AP) stated that he did not think Resident #1 was on 30 minute monitoring.
The AP further stated that he is also the Medical Director (MD) for the facility and having conferred with Administration, he has reviewed policies, but has not made changes regarding policies on wander guard, prevention of elopement and out of facility trips.

An interview was conducted with the Director of Recreation (DR) on 11/29/11 at 1:39 PM. The DR stated his staff developed a list of residents who wanted to go on trips and who were the most appropriate residents and residents who have not out in the past. The staff's lists are formulated into one list which must be given final approval by the Director of Nursing. The DR stated that, on the day of any particular trip, the list is given to the charge nurse on each nursing unit and the DR would expect to be made aware of any resident who might need to be more closely monitored. The DR stated that on 11/22/11, no staff member told him of any resident who was at risk for wandering or elopement. He was not aware of any resident on the 11/22/11 trip who had a history of wandering. The DR stated that he does receive a Wanderguard/Elopement List regularly and routes the list to his staff but could not identify if any of the residents on the 11/22/11 trip were on the list. The DR further stated that he did not attend the outing on 11/22/11 but believes that he provided the recreation staff with specific assignments to individual residents. The DR stated that these assignments were provided in written form but "I probably threw it out."

An interview was conducted with the 3:00 PM to 11:00 PM Registered Nurse Supervisor (RNS) on 11/29/11 at 2:03 PM. The RNS stated that he assessed Resident #1 for wandering and elopement on the day the resident was admitted to the facility. The RNS stated that, although there was no known history from the hospital regarding wandering, Resident #1 was pacing up and down the hall. Resident #1's ambulatory status was independent and his room was by the exit door, so the RNS felt it was prudent to put a wander guard on Resident #1 because Resident #1 "could easily blend in." The RNS stated that due to the resident's wander guard, Resident #1 was also placed on 30 minute monitoring. Any resident who has a wander guard is placed on 30 minute monitoring "to know their whereabouts in case they try to elope. If a resident had any times of wandering in the facility, then this is still his history and would be on the assessments." The RNS stated that he did not do any of Resident #1's assessments for wandering and elopement since the resident's admission but the history "should have been on the assessment."

An interview was conducted with the Director of Nursing (DON) on 11/30/11 at 12:35 PM. The DON stated that when Resident #1 was found to be missing from the outing, a full search of the neighborhood and police contact was made. Four days later the DON spoke with a hospital in Brooklyn and was made aware that Resident #1 had been found unresponsive on the street by EMS. The DON stated that she went to the hospital where the DON identified Resident #1's body. Resident #1 had died but the hospital would not provide the DON with any further information regarding the resident. The DON stated that she is acting as the In-Service Coordinator. There is no specific guideline to follow when residents go out on a facility trip. The DON stated

that the DR should disseminate the Wanderguard/Elopement List to the recreation staff and the recreation staff should know their residents. The DON further stated that Resident #1 was on the Wanderguard/Elopement List on 11/22/11 and was being monitored every 30 minutes because all residents with wander guards are monitored in this way. The DON did not believe that Resident #1 was at risk for wandering or elopement and referred to the resident's assessments. Upon further inquiry, the DON stated that any resident with a history inclusive of wandering at any time would be at risk for elopement. The DON stated that as a result of the investigation of Resident #1's elopement, the facility concluded that the resident went undetected due to the high activity level at the school. All recreation staff were given disciplinary action for same. The DON was unable to state what the recreation staff should have done.

An interview was conducted with the Administrator on 11/30/11 at 2:14 PM. The Administrator stated that he was advised of Resident #1's elopement at 12:30 PM on 11/22/11 and took immediate efforts at searching for the resident involving the police and hospitals but was not able to locate the resident. The Administrator stated that, sometime afterwards, he was told by staff that it was chaotic at the school and no staff saw how Resident #1 left the school cafeteria. The Administrator stated that there should be a designated leader to give out assignments to staff when residents are taken out on a trip and a process of going over with the nurse how much supervision is needed before the trip occurs.

415.12(h)(1)(2)