Resident Elopement Prevention & Investigation

Presented By: Shelly Maffia MSN, MBA, RN, LNHA, QCP, CHC, CLNC, CPC

Objectives

1. Understand pertinent actions to take to prevent resident elopement
2. Describe best practices for implementing and/or improving internal investigation and documentation practices related to elopements
3. Understand how to apply root cause analysis and the QAPI process when responding to elopement events.
Elopement

- Occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so
- Places at risk of heat/cold exposure, dehydration, medical complications, drowning, or being struck by motor vehicle
- Facility policies must clearly define mechanisms & procedures for assessing/identifying, monitoring, & managing residents at risk for elopement
- Must have care plan interventions for at risk residents to address potential for elopement
- Disaster & emergency preparedness plan should include plan to locate a missing resident


Elopement Prevention

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Individualized Interventions</th>
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<tbody>
<tr>
<td>- Elopement history</td>
<td>- Electronic monitoring/alarm system</td>
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<tr>
<td>- Expresses desire to leave/return home</td>
<td>- Environmental modifications</td>
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<tr>
<td>- Impaired cognition</td>
<td>- Protected list of names &amp; photos of at risk residents</td>
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<tr>
<td>- Adjustment difficulties</td>
<td>- Psychosocial interventions</td>
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<tr>
<td>- Alcohol or drug abuse</td>
<td>- Regular rounds</td>
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<td>- Anxiety</td>
<td>- Structured activities</td>
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<td>- Impaired vision</td>
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<td>- Inability to recognize familiar people, places, objects</td>
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<td>- Psychiatric history</td>
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<td>- Smoking</td>
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Elopement Prevention Facility Practices

- Assessing security of environment
- Door alarms & wander control systems
- External environmental risk factors
- Elopement drills
- Protected list of names, photographs, identifying information for at risk residents

Elopement Management

- IDT review of residents who attempt to leave facility
  - Why and where were they trying to go?
  - Re-evaluate assessments
  - Determine patterns to exit seeking behaviors
  - Review & revise interventions
  - Update plan of care
  - Evaluate & document effectiveness of interventions
Managing Elopement Incident

- Respond to sounding door alarms
- Complete full facility head count if unable to determine reason for sounding alarm
- If resident determined to be missing after head count:
  - Search facility
  - Search facility grounds
  - Interview staff
  - Broaden radius of search
  - Notifications – NHA/DON, family, physician, police, state agency
  - Assess wander protection system
  - Contact emergency rooms
  - Convene emergency team meeting

IJ Elopement Citation Example #1

- Failed to provide adequate supervision to prevent neglect that resulted in IJ when a cognitively intact resident exited facility through front doors, walked down a heavily traveled street, and crossed more than one major intersection late in the evening. Resident was found at his previous residence more than 24 hours later.
  - On admission assessment, resident identified as being high risk for elopement & interventions included Wander guard bracelet & diversional activities. (Wander guard was not applied until 3 days later when resident exhibited exit seeking behaviors)
  - Progress note 9/27 revealed resident was noted as being impulsive and exit-seeking. Was seen with bag of personal items standing near entrance of front door, attempting to exit from locked doors. Staff attempted to redirect. Resident was agitated & expressed desire to leave facility. He spoke with SS, Admin, & DON and informed them that he would not attempt to leave facility & would wait for his brother to pick him up after he has been properly discharged.
  - On 9/27, when making night time medication rounds, resident was not in his room. Search initiated & when resident was not found, ADON was contacted & she called 911. Officers arrived and police report made.
  - Investigation concluded that the resident left the building through the front door while there was an ambulance transferring a resident. Statements document the front alarm was alarming and staff were turning it off because they assumed it was the transportation people that had set the alarm off.
**IJ Elopement Citation Removal Plan-Example #1**

1. Visual signs alerting residents, families and friends were posted at the front door and in patient rooms as a reminder to notify staff when leaving the facility and signing out at the Nurses' Station by 9/28/2021. Visual signs were posted on 9/29/2021 alerting ambulance employees, paramedics, families, and vendors to notify facility personnel immediately if anyone leaves the facility when they are entering or exiting the building. Visual signs alerting staff that door codes are not to be given out to anyone except staff were posted at the alarm panel on 10/1/2021.

2. Cognitive/alert and oriented residents were educated by the Social Services Director or designee on proper Leave of Absence (LOA)/personal outing and were educated on the Against Medical Advice (AMA) procedure by 10/1/2021.

3. The Nurse Managers reviewed/revised/completed 100 percent (%) of facility residents Elopement Risk Assessments by 10/1/2021. Facility residents identified as high risk for elopement plans of care were reviewed and revised as needed by 10/1/2021.

4. A letter was mailed to the Resident Representatives, educating them on the facility’s process for Unplanned LOA and Personal Outing by 10/1/2021.

5. The facility’s Elopement and Wandering Patients Policy was reviewed and revised on 10/1/2021, to include a. Employees should identify the location and respond to an alarm timely b. Upon arrival to location of alarm observe the physical environment both inside and outside for wandering or exit seeking residents. c. Complete a head count on wandering/exit seeking residents to determine location. d. If unable to locate a resident initiate the procedure for locating a missing resident.

**IJ Elopement Citation Removal Plan (#1)**

6. Review of the Abuse Prohibition Plan Policy was conducted on 10/1/2021 by the Regional Director of Operations and the Director of Clinical Education. On duty personnel were educated on the Abuse Prohibition Plan on 10/1/2021 and the off-duty personnel will be educated upon return to work. Newly hired personnel will be educated during their orientation on the Abuse Prohibition Plan.

7. A letter was faxed or mailed to Emergency Medical Services (EMS)/Transport companies to notify staff immediately if a resident leaves the facility without a staff member.

8. The Hospital Transfer Form was updated in the Electronic Health Record on 10/1/2021 to include the observation of EMS staff securing patient in ambulance for transport. Education was provided to the on-duty staff 10/1/2021 and the off-duty staff will be educated upon return to work.

9. The Regional Director of Operations educated the facility Administrator and Director of Nursing on 10/1/2021 on the facility policy and procedure of Abuse Prohibition Plan, Emergency Preparedness, and Elopement and Wandering Patients

10. On 9/29/2021, on duty personnel were educated on responding to any alarms in the building promptly and to do a visual resident observation if a resident exhibited exit seeking behavior or expresses a desire to leave LOA/AMA. On duty staff were educated that door codes were not to be given to anyone except facility staff. The off-duty personnel will be educated upon return to work. Newly hired personnel will be educated during their orientation.
11. The facility arranged to have a vendor on site 9/29/2021 to assess the video surveillance camera operation and provide a quote for replacing/repairing the system. The vendor while on site also assessed the annunciator panel operation/implementation on the south wing of the facility and provided a quote for installation. Quotes were received and approved by Corporate staff on 9/29/2021 and the repairs/installation will begin 10/4/2021.

12. An elopement drill was completed on 10/1/2021 by the Administrator and Director of Nursing.

13. The Medical Director was notified by the Administrator to discuss the Removal Plan of the Immediate Jeopardy and the action plans to provide adequate supervision to prevent a resident, assessed for wandering, from leaving the facility without staff knowledge.

14. The Quality Assurance and Performance Improvement (QAPI) committee met on 10/1/2021 to discuss the Removal Plan of the Immediate Jeopardy to include Resident Education, Responsible Party Education, Staff Education, Emergency Personnel/Visitors/Vendors Education, and reviewed facility policies and procedures to provide adequate supervision to prevent a resident, assessed for wandering, from leaving the facility without staff knowledge.

15. The facility held a Governing Body meeting by a telephone conference on 10/1/2021 to review and approve the facility’s action plan to provide adequate supervision to prevent residents assessed at high risk for elopement, from leaving the facility without staff knowledge.

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**IJ Elopement Citation- Example #2**

- Facility failed to ensure a safe environment to prevent an incident of elopement for 1 Resident reviewed for elopement, wandering behaviors, and safe smoking. The facility's failure resulted in Immediate Jeopardy (IJ) when Resident, a visually impaired resident with short term memory loss walked away from the designated smoking area unsupervised. Resident was found by a Police Officer near an intersection and was returned to the facility approximately 10 minutes later.
**IJ Elopement Citation #3**

- Based on policy review, video camera footage review, medical record review, observation, and interview, the facility failed to provide adequate supervision for a resident with confusion and periods of hallucinations and failed to place and monitor a Wander Guard for function for 2 residents reviewed for wandering behaviors and elopement. Resident #1 exited the facility without staff supervision and knowledge and was found off the facility property, sitting on a concrete block at the entrance into a townhouse community, with a lake across the street. The resident was located approximately 459 feet and 6 inches from the front entrance of the facility, 0.2 of a mile from a busy intersection, and 172 feet from a two-lane busy street that had a 45 miles per hour speed limit. Resident was outside the facility, unsupervised for approximately 39 minutes. The facility's failure resulted in Immediate Jeopardy for Resident #1.IJ was effective 9/30-10/21/21.
  - 9/28/21 Risk for Elopement evaluation revealed resident not at risk for elopement
  - 9/28/21 Baseline care plan revealed mental health needs (panic d/o, concerns with hallucinations & thought process, history substance abuse
  - 9/30/21 video cameras showed resident at front entrance door. She pushed on door & opened with 4-second delay and she exited building and sat on a bench outside for 6 min and then attempted to reenter the building without success. She than ambulated toward parking lot and was no longer seen on video footage.
  - Video showed several staff members exiting facility from 3:57pm-4:26pm, when 2 staff were seen assisting resident back into facility in a wheelchair.

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**IJ Elopement Citation Removal Plan (#3)**

1. NP notified on 9/30/21 at 4:55pm that resident exited facility. A one-time dose of Lorazepam ordered for server agitation & resident was placed on 1:1 monitoring until she was calm & allowed Wander Guard bracelet to be placed on her.
2. Elopement Risk assessment updated on 9/30 to indicate resident was elopement risk and care plan was updated
3. At 530pm on 9/30, brother notified of resident wanting to go home & he informed staff he would pick her up next morning to take home. Resident was discharged home 10/1.
4. Facility initiated successful elopement drill on night shift on 10/19 & day shift on 10/20. Drills will be conducted q shift weekly for 4 weeks, then monthly for 2 months, then quarterly.
5. On 10/19/21, elopement risk assessment completed for all residents in facility
6. Initiated staff education regarding building security, missing residents, & elopement prevention on 9/30-10/1. Initiated re-education on 10/19 & no one allowed to work until education completed.
7. On 10/19 Maintenance completed check of all exit doors to ensure they alarmed when panic bar pressed. Will check all exit doors weekly for 4 weeks, then monthly.
8. Elopement books reviewed & updated on 9/30 to ensure all residents at risk for elopement were identified & care plans updated.
9. Placed photos of elopement risk residents in easy view of receptionist desk to aid in identification & monitoring of at-risk residents on 10/19
10. Receptionists educated 9/30 to stress improving vigilance of monitoring residents in front lobby.
**IJ Elopement Citation – Example #4**

- Based on policy review, video camera footage review, weather website review, medical record review, observation, and interview, the facility failed to provide a safe, secure environment, and adequate supervision for a vulnerable confused resident with exit seeking behaviors for 1 sampled resident. (Resident #1) reviewed for elopement/wandering and exit seeking behaviors. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy when Resident #1, a vulnerable confused resident wandered out of the COVID Unit, wandered throughout the facility, pulled the fire alarm, and exited the facility unsupervised. Resident #1 was found by staff in an unlocked staff member's car. The vehicle where Resident #1 was located was parked approximately 78 feet from the front entrance of the facility.
  - Resident brought back in facility within minutes, when staff found him rummaging through a car. He was wearing t-shirt, pants, & slippers & it was 25°F outside.

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**IJ Elopement Citation Corrective Action Plan (#4)**

1. 100% elopement risk assessment audit completed 1/7-1/8.
2. 100% medical record reviewed completed 1/7-1/8, observing for confused patients with any exit seeking behaviors.
3. Staff education on elopement & exit seeking behaviors initiated 1/7 & no staff were allowed to work until education completed.
4. A fire alarm pull station cover was ordered on 1/8 and installed on 1/11 to reduce risk of confused patients pulling the alarm.
5. On 1/8 and AdHoc QAPI meeting conducted to discuss incident.
6. On 1/8, 100% wander guard audit completed.
7. Doors of COVID unit will be checked by staff at beginning & end of each shift.
8. Form developed to indicate new admissions name & room number that will be placed at all nurse stations.
### IJ Elopement Citation – Example #5

- The facility's failure to provide supervision and ensure a safe environment resulted in Immediate Jeopardy when a cognitively impaired, vulnerable resident, exited the facility unsupervised through the North Hall Door unsupervised, and was found approximately 5-6 minutes later, sitting in a chair at a picnic table on the back patio, 13 feet from the door of the facility, and 134 feet from the driveway in front of the nursing home.
  - Resident BIMS =4. Exhibited 1-3 days of wandering in look-back period of last MDS. Identified as moderate risk for elopement.
  - Multiple exit attempts documented in progress notes. On 3/21, after having exit seeking attempts that day, she was later found sitting on back patio drinking beverage. Staff were unaware she was outside. Placed on 1:1 supervision. Annual survey team was there for annual & investigated.

### IJ Elopement Citation Example #6

- Resident was missing, unsupervised and away from facility for approximately 2 hours. Staff was not aware of resident was missing until he was discovered walking down the road by staff coming to work. Resident was soaking wet & shaking when found. Facility investigation concluded he exited through a side door when door did not lock after staff exited the door. Resident was immediately placed on 1:1 supervision.
  - Resident had been in facility for 2 years & had severely impaired cognition
  - Identified to be at risk r/t wandering & confusion
  - He was care planned for staff to place a wandering device on resident as applicable, check placement every shift, check function daily, place my demographic sheet and picture in the elopement notebook, redirect resident away from doorways and engage me in diversional activities, and wander bracelet related to wandering and exit seeking behavior. Nurse to check placement and function every shift including skin check under bracelet right wrist.
### Corrective Actions Taken (#6)

1. 7:50am assisted back into facility & assessed by licensed nurse with no injuries found. Facility initiated investigation
2. 7:55am RN completed a head count on all residents to ensure everyone was accounted for with no issues identified
3. Between 7:50-7:55am maintenance director completed a 100% audit of all doors & windows in facility. All windows were locked with security devices in place. All doors were functioning properly. All locked doors were unlocked & reset to assure they were working properly. Doors with alarms were active & reset to assure proper function
4. 8am nurse completed audit with the order listings of current wander bracelets to assure they were in place & reviewed MAR, care plans & Kardex to assure they were current & up to date
5. 8:15am DON & ADON initiated in-services on Wander policy & elopement and not staff were permitted to work until completion of in-service
6. 9:30am wander guard bracelet drill was initiated with no staff allowed to work until completion
7. 9:54am state agency was notified and investigation was completed the same day
8. 10am new keypad on side door was replaced by maintenance
9. 10:45am a technician from the wander system checked all Access Control System doors & determined that all doors locked securely & all codes worked correctly
10. At 3pm an AD-Hoc QA meeting was conducted

### IJ Elopement Citation Example #7

- Resident last seen at 8pm and found at 10:06pm- was missing unsupervised & away from facility for 92 minutes. Facility was not aware of resident’s absence until they made rounds & resident was not in building. Staff went to look for resident & found her in a parked car one street over behind the facility trying to start a car. The police were called. Immediate investigation revealed she exited through the exit door on hall when door opened after being pressed on for 10 seconds. Resident immediately placed on 1:1 when returned to facility
  - Facility had 2 residents who wander. Staff heard exit door alarm go off at 8pm & saw one of the wandering residents at the door & redirected the resident away from the door. 30 minutes later, they noticed the other wandering resident was missing.
Corrective Actions Taken #7

1. Resident assessed & had no injuries & was placed on 1:1 supervision upon returning to center. Through RCA, facility determined how resident was able to leave unsupervised. Facility reviewed their wandering/missing resident policy, educated staff on the policy, & held a QA meeting. Facility removed the delayed egress from 3 exit doors (exit doors still unlock in event that fire monitoring system alarms)

2. NHA, police, medical director, responsible party, & survey agency all notified immediately or within 2 hours of event

3. Upon resident return, head to toe body audit completed on resident & head count of all residents completed. Maintenance Director performed checks on all exterior doors & windows within one hour of resident return

4. At 9am next morning wandering risk observations completed on all residents, with no newly identified resident wandering risk. Resident wandering list located at nurse’s station & each ancillary department was updated.

5. At 9am, several foot rounds, around center, were made to determine resident’s path. At 10am, completed removal of egress from 3 exterior doors & exit stopper alarms were added to 2 doors & new latches added to courtyard gates. At 11am ad-hoc QAPI meeting held

6. On date of incident in-servicing began on Wandering/missing resident, abuse, & door alarm policies and no staff worked until in-service completed

Elopement Drill

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<tr>
<th>Date of Drill</th>
<th>Start Time</th>
<th>End Time</th>
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<tbody>
<tr>
<td>CHECK EACH ITEM YES OR NO</td>
<td>YES NO</td>
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ELOPEMENT DRILL CHECKLIST

- did staff verify if the missing resident was on exit or closed out?
- did staff search with facility for missing resident?
- was the charge nurse notified of missing resident?
- was the staff member designated to complete a Missing Resident Request Form?
- did the staff member provide all required steps to the request form?

RESIDENT INFORMATION
- was the resident identified by a nurse when found?
- did the resident receive any medical treatment?
- was the resident identified as a missing resident?
- did the staff member provide all required steps to the request form?

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References

• CMS Appendix PP

Questions?

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