

Legal Issues



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Implement Safety Measures to Avoid Resident Elopements

A nursing facility must ensure that its resident environment remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. These Medicare/Medicaid certification requirements, found at F323 of the State Operations Manual, are frequently cited by the State Agencies for a variety of “unavoidable” resident accidents.

One frequent resident accident/safety citation relates to resident elopement, which is often cited at the immediate jeopardy level. Many elopements occur and are cited across the country each year, and some result in significant injury or death. Prevention of accidents related to wandering and exit seeking is vital to implement on a consistent basis to avoid the regulatory and litigation risks that are a result of a resident elopement.

An unsafe elopement occurs when a resident leaves the premises without authorization and supervision. Residents with confusion or dementia are among those who are not safe being out of the facility without authorization.

Data Tag F323 requires facilities to proactively undertake numerous actions relating to a safe environment and accident prevention for each facility resident. The required processes include:

- ▶ Identifying hazards and risks.
- ▶ Evaluating and analyzing the identified hazards and risks.
- ▶ Implementing interventions to reduce hazards and risks.
- ▶ Monitoring for effectiveness and modifying interventions as necessary (SOM, Appendix PP, F323).

Accident prevention and risk reduction include many areas of concern for facilities, such as the risk of elopement for residents at an increased risk of wandering and exit seeking.

Case Ruling

A recent Health and Human Services Departmental Appeals Board (DAB) case highlights the importance of ensuring that appropriate safety measures are in place and are being effectively monitored to prevent elopements. The DAB hears the formal appeals of certified facilities when they challenge survey citations and the resulting sanctions imposed related to the survey process. The August 2014 DAB decision in the case filed by Methodist Health and Rehabilitation Center against the Centers for Medicare & Medicaid Services upheld noncompliance deficiencies issued at F323 citing multiple resident elopements over several months in 2013.

The administrative law judge (ALJ) determined that the facility failed to:

1) comprehensively investigate the causes of the elopements, 2) determine the actual causation allowing the residents to exit the facility undetected, and 3) follow its internal anti-elopement policies and procedures resulting in gaps in the facility’s safety measures.

If residents are successfully exit-seeking, the facility’s interventions will likely be determined to be ineffective in a survey by the state agency.

These alleged gaps allowed a 94-year-old resident with dementia to elope on two separate occasions within a month. The facility was cited for failing to thoroughly investigate the cause of the resident’s exit. The resident was able to leave in both instances undetected, which placed her at risk of harm when unsupervised outdoors. The resident had been deemed an increased risk for elopement, and was wearing an electronic bracelet designed to alarm when exiting through a door equipped with a sensor. However, on both occasions, the alarm failed to sound when the resident silently exited the building alone and without staff knowledge. Fortunately, the resident did not have any significant injuries as a result of the two elopements.

Unfortunately, within 3 months, another resident eloped from the building. An 87-year-old resident with dementia eloped similarly exited without triggering an alarm. The facility took action by placing tape over the door until the maintenance supervisor could arrive the next day and reactivate the alarm. During the investigation, a door sensor indicated that the door had been opened, but no audible alarm had sounded.

The ALJ cited a failure to thoroughly investigate the cause of the elopements when the facility assumed that a contractor had disabled the alarm, and so determined that the facility failed to take reasonable measures to protect the residents at risk of elopement. The ALJ’s decision stated that something caused the alarm system to be defeated and, whether it was human error or a failure of the equipment, it did not matter because the facility did not fully investigate. Additionally, the ALJ stated that the facility failed to make effective systemic changes to correct the alarm system after

each of the three elopements. The immediate jeopardy citation and the imposed civil money penalty of \$3,150/day for 29 days and \$150/day for another 15 days were upheld.

This case highlights the importance of a facility’s ongoing culture of safety that includes consistent and effective measures to prevent elopement that are consistently implemented by all facility staff members. Some considerations when reviewing safety measures to prevent elopements include:

- ▶ The DAB and regulators have an unstated presumption that all elopements are preventable, as a facility knows there are wandering residents and some of those residents will have exit-seeking behaviors. In other words, elopement is a known risk that must be prevented. If residents are wandering and successfully exit-seeking, the facility’s interventions that are in place will likely be determined to be ineffective in a survey by the state agency.
- ▶ Assessing a resident at admission for a risk of elopement, coupled with periodic reassessments, can reduce the risk.
- ▶ Increased monitoring for new residents is a good practice, as the environment is new to the resident and the staff is unaware of the resident’s daily patterns of activity and capabilities.
- ▶ A comprehensive elopement prevention program with ongoing education for all facility staff should be implemented.
- ▶ Periodically conduct elopement drills to ensure that the staff is knowledgeable about the elopement policies and procedures.
- ▶ Door alarms and other equipment-based systems must be routinely

monitored and documented for proper function. If systems are damaged or inoperable, other interventions must be undertaken to maintain the residents’ safety until the systems are effectively repaired.

- ▶ Elopements consistently are cited at the immediate jeopardy level across the country, and incur significant civil money penalties.
- ▶ Actual harm or injury to a resident is not necessary for an immediate jeopardy citation to be issued or upheld.
- ▶ The duty to protect residents includes protection from foreseeable risks outside of the building. A known dementia resident will be unsafe outside of the building without supervision.
- ▶ Care planning alone is not an effective action plan. The planned interventions must be consistently implemented.
- ▶ Supervision must be “adequate” to meet the residents’ needs. Each resident may need different types and amounts of supervision based on the identified needs, goals, plan of care, and current standards of practice.
- ▶ Reasonable interventions must be implemented to prevent elopement, as this is a foreseeable risk.

Monitoring Is Vital

Elopement prevention is an important component of a facility’s overall safety program. Nursing facilities work on a daily basis to maintain a safe environment for their residents through implementation of numerous safety and accident prevention measures. These measures include people-based interventions, such as diligent observation of residents at increased risk of accidents, and equipment-based interventions, such as electronic door alarms and delayed egress systems. Daily monitoring of the staff interventions and the equipment-based systems are vital to maintain a safe and secure environment. An ineffective or incomplete elopement prevention program places residents at significant risk of injury or death, and also places facilities at risk of immediate jeopardy citations and civil negligence lawsuits.

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This column is not to be substituted for legal advice. The writer, JANET K. FELDKAMP, practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, OH. You can comment on this and other columns at www.caringfortheages.com, under “Views.”