STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0479	A. BUILDING _____ B. WING _____	11/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

(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) COMPLETE DATE
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observation, staff and county personnel interviews, and record review, the facility failed to supervise one (1) resident of one (1) who exited the building after exhibiting escalating behaviors of agitation, restlessness and exit seeking and failed to initiate an immediate search according to facility policy. (Resident #1) The findings are: An undated facility policy revealed the following; "should a resident be found to be missing, the resident will be paged to the nursing station three times using the overhead paging system. This shall alert staff to begin an immediate search of the building for that resident which should take no longer than fifteen minutes. Should the resident not be found within fifteen minutes, police and administrator shall be notified. All staff that can be spared shall be dispatched to aid in searching the immediate area." A medical record review revealed Resident #1 was admitted to the facility's adult home care unit on 08/12/09 with diagnoses including mood disorder with psychosis, schizophrenia, and cerebral palsy with left arm weakness. A North Carolina Medicaid Program Long Term Care Services transfer form (FL-2) dated 08/01/09 with a physician signature date of 08/12/09	D 270	The Provider submits this Plan of Action (PoA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiency nor does it constitute an admission that the stated deficiency is accurate. The Provider submits this PoA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	

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D 270	Continued From page 1 recommended rest home level of care post hospitalization. The FL-2 documented inappropriate behavior of wandering, agitation and paranoia at times. The resident's medications included Depakote, Aricept, Abilify and Geodon. A resident assessment and care plan dated 08/09/11 revealed Resident #1 was oriented, cooperative, had adequate memory and normal communication. The care plan documented shower assistance and set-up assistance with each meal. Behaviors were not included in the care plan. Review of nurses' notes on 10/30/2011 at 5:10 p.m. revealed the resident was very restless, agitated and wandering without purpose. On 10/31/11 at 1:00 p.m. nurses' note documented the resident was noted to be very anxious and aimlessly pacing, stating he needed to get a lawyer so he could go home. The physician was notified. No physician orders received. Review of a nurses' note dated 11/1/11 at 2:20 a.m. documented the resident exhibited increased agitation, anxiety, was pacing up and down halls stating "you won't give me my medicine and I have to go home repeatedly." The physician was notified and saw the resident on 11/1/11. Review of the MD progress note documented by the physician assistant on 11/1/11 revealed the resident was calm and cooperative. A nurses' note at 10:20 a.m. documented the resident continued pacing. Review of a nurses' note dated 11/3/11 at 2:30 p.m. the resident continued to pace. The resident stated that he didn't trust the water in the pitcher and he was going to buy his own, now.	D 270	The facility always strives to ensure we follow the Adult Care rules outlined for our Assisted Living beds. Staff members strive to meet the assessed needs, plan of care and current symptoms of each resident. The facility has Assisted Living Policies and Procedures designed to achieve these goals. Realizing no facility is able to 100% prevent a dependant resident from leaving their building without staff observation or knowledge of their departure, makes planning and preventative tools essential. The facility utilizes Risk Assessment tools, Education and Training, a wide variety of Interventions, and Communication as ongoing components to avoid having a resident disappear. Communication with residents' families, their physician(s), and where appropriate other individuals is one of many components covered with ongoing training. Staff member training during orientation and annually thereafter, admission notices, resident counsel meetings, consultant reviews and various other quality assurance measures are other examples of the many components utilized.	

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D 270	Continued From page 2 On 11/6/11, nurses' notes revealed at 9:00 p.m. the resident pacing throughout facility and going into other residents' rooms. Nurses' notes dated 11/7/11 at 11:30 p.m. revealed the resident was up, walking, confused and difficult to redirect. Nurses documented through 11/10/11 the resident's behaviors continued and he was at times, refusing his medications. Resident #1 also refused offers for PRN (as needed) Ativan for anxiety. A physician note dated 11/10/11 indicated the physician was asked to see the resident related to increased behaviors and declining his medications. He assessed that resident with no evidence of hallucinations. He instructed the resident with the importance of taking his medications. If reoccurrence of episodes may give Ativan 0.5 (mg) milligrams up to three times a day PRN for anxiety. Review of Resident # 1's November 2011 MAR (Medication Administration Record) revealed the following: · On 11/08/11 resident refused all medications at 4:30 p.m. and 5:00 p.m. · On 11/09/11 resident refused morning medications then administered by the social worker, evening medications were refused. · On 11/10/11 at 7:30 a.m., resident refused all medications. · Resident #1 was medicated on 11/11/11 at 5:32 a.m. with Ativan 0.5 mg one by mouth for increased anxiety and pacing. Documentation at 6:40 a.m. revealed resident continued to pace throughout the facility. A physician's note on 11/11/11 written by the	D 270	On 11/12/11 a complete and thorough investigation of Resident #1's unplanned departure was done by the Administrator in order to prevent another occurrence as well as to protect other residents. Based on equipment checks, to ensure all equipment was working correctly, system reviews, staff interviews, and resident interviews, it is believed the resident obtained the door code from another resident's family member a day or so prior to 11/12/11. Resident stated he intended to leave without the staff's knowledge by entering the code and leaving the facility when staff members were not looking. His stated purpose in leaving was to go take care of an ex-spouse who resident had recently learned had broken a leg.	

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D 270	Continued From page 3 physician's assistant (PA) revealed the resident was again seen for increased behaviors and inability to sit for more than "three to five minutes" during their conversation. The PA assessment on this date included increased obsessive behavior. During the conversation, the resident stated he was "home sick" and had been in the facility a long time. During this visit, the PA referred the resident to the psychiatrist for an evaluation. On 11/11/11 starting at 11:20 p.m., LN#1 (licensed nurse) documented the resident was pacing the halls. Attempts to redirect the resident at that time were successful. On 11/12/11 at 1:30 a.m. LN #1 documented "exit seeking." The resident was observed making several attempts to exit the front door without success. On 11/12/11 at 2:40 a.m. LN #1 documented "exit seeking." She further stated the resident was found sitting outside on the activity porch. When asked why he was outside, the resident responded he had been released by the physician's assistant. According to the note, staff attempted to redirect resident, telling him the time of day and the "danger of exiting the building." The note further revealed Ativan 0.5 mg one by mouth was given for anxiety/aggressive behavior. Review of the nurses' note dated 11/12/11 at 6:00 a.m. written by LN #1 indicated she last saw the resident at approximately 3:45 a.m. He was resting in bed with his eyes closed. This note also documented "full staff is searching for resident at present." Documentation did not include notification of family, administrator or sheriff's department.	D 270	On 11/12/11 the following steps were immediately carried out. ▪ Resident #1's physician was consulted for input with plan of care revisions and prevention plan. ▪ The resident's risk assessment was updated to reflect the resident's unplanned exit from the facility and the increased risk potential for the resident attempting another unplanned leave. ▪ The resident's care instructions were revised to reflect the unplanned leave and prevention plan developed. ▪ The resident's care changes and prevention plan were discussed with resident and the responsible party. ▪ 1:1 supervision was implemented from 11/11/11 to 11/14/11. ▪ Resident was transferred to a hospital geri-psych unit for evaluation and medication assessment on 11/14/11. ▪ The administrator and unit nurse responsible for resident's care instructed the care staff on the new prevention plan, revised plan of care and additional supervision interventions. ▪ The Administrator changed immediately the key pad code for the doors.	

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D 270	Continued From page 4 On 11/12/11 at 6:45 a.m. LN #1 documented the sheriff's department placed a call to notify the facility that Resident #1 was found. The physician was notified and the resident was sent to the hospital Emergency Department (ED) for evaluation. Review of the ED report dated 11/12/11 revealed the resident was evaluated post transport by the Emergency Medical Services. He was dressed in multiple layers of clothing and had a laceration on his forehead. A Computerized Topography (CT) scan was negative. The resident refused sutures. Steri-strips were applied and Resident #1 was released back to the facility. Review of the facility incident report dated 11/12/11 stated the resident was given an Ativan (medication for anxiety/aggressive behavior) at 2:45 a.m. "Unable to locate resident at approximately 6:00 a.m. Sheriff's Dept called facility to inform us the resident had been found." The last notation on the incident report was the resident was placed on one to one monitoring starting with his return to the facility from the ED and was sent out to the gero-psychiatric hospital unit for evaluation on 11/14/11. The resident's assessment and care plan was updated on 11/21/11 to indicate wandering behavior with history of elopement, redirect resident away from exterior doors and do not give resident door codes. During an interview on 11/22/11 at 2:00 p.m., NA#1 stated she had taken care of Resident #1 prior to his elopement from the facility on 11/12/11. She revealed the resident was constantly walking and seldom in his room. He sometimes said that he wanted to go home but	D 270	▪ Signs were posted at the entrance and at all keypads reminding families and visitors to not give door codes to residents or allow a resident to leave unsupervised. ▪ Staff re-training was conducted by the Administrator with staff working 11/12/11 regarding the Missing Resident Policy and signs of a resident at risk for exiting the facility without staff observation or knowledge of their departure. and ▪ Charge nurses instructed subsequent shifts staff on the prevention plan, changes and the re-training materials at the beginning their shift. Additional steps were implemented to reduce the risk of visitors or families giving door codes to residents to include, but not limited to: ▪ On 11/12/11 signs were posted at the entrance and at all keypads reminding families and visitors to not give door codes to residents or allow a resident to exit unsupervised. ▪ A reminder notice was mailed with the December statements, reminding families and their visitors of the importance of following safety precautions by not giving door codes to residents or allowing residents to exit the facility as they enter or leave.	

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D 270	Continued From page 5 nothing more specific. About two weeks prior to the incident, she observed the resident pushing on the handle of an exit door but he could not open it. He then left the door. NA#1 stated she told the staff on the 100 hall to watch him, but could not recall whom she told. Telephone interview with LN #1 on 11/22/11 at 7:00 p.m. revealed she had cared for Resident #1 during the evening of 11/11/11 and night of 11/12/11. She stated during that evening the resident's agitation began to escalate. At approximately 12:00 a.m. to 1:00 a.m. the resident was observed attempting to leave the building. He was pushing the handle and trying to punch the key pad to open the door. She further stated on two occasions during this time frame, she found the resident sitting on the porch outside of the activity room. LN #1 indicated she redirected the resident into the building and at 2:30 a.m. she medicated the resident with Ativan. LN #1 stated that she checked on the resident at 3:40 a.m. and found him lying in bed with his eyes closed. At approximately 5:50 a.m., LN #1 noted the resident was not in his room. She went to the nurses' station and could not find him. She returned to his room and "really started looking for him at 6:00 a.m." She concluded the facility was notified by the sheriff's department at approximately 6:30 a.m. the resident had been found approximately two miles from the facility. During a telephone interview on 11/22/11 at 2:45 p.m., the county dispatcher revealed he received an anonymous phone call on 11/12/11 at 6:20 a.m. He stated the caller told him an elderly man with a cane was seen walking down the highway near a local restaurant, and might need a ride somewhere. The dispatcher further stated he called the sheriff's department with this	D 270	▪ Social Worker will stress safety information that was already in the admission packet. Resident safety and door code precautions were already discussed during the admission process. Resident #1 was re-admitted to the facility on 11/21/11 following hospital mental health care and medication changes. 1:1 supervision was implemented until the effects of hospitalization, mental health care received and medication changes could be evaluated. Resident was readmitted to hospital's geri-psych unit on 11/22/11. The Maintenance Director on 11/14/11 re-changed all door codes. The Director of Nursing conducted additional training on 11/14/11 and 11/17/11 on how to recognize the signs of a resident at risk for elopement and the Missing Resident policy and Procedures. Part-time staff members not available were required to read the information prior to working their next scheduled shift.	

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FORM APPROVED

Division of Health Service Regulation

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D 270	Continued From page 6 information at 6:24 a.m. A telephone interview with the sheriff's department officer on 11/22/11 at 3:00 p.m. revealed Resident #1 was found on 11/12/11 at 6:30 a.m. lying in a ditch with his pants pulled down below his knees. He stated the resident had cuts on his forehead, his glasses were broken and resident's goatee was icy. The deputy stated he helped Resident #1 to get up. He put him in the patrol car and turned up the heat. He asked the resident where he lived and he answered "up the hill." The resident also stated he was trying to go "home to (the next community northeast of the facility)." The deputy transported the resident to the EMS station and notified the facility. He was told by staff that they were trying to find the resident. Observation on 11/22/11 at 2:35 p.m. of the area in which the resident was found revealed the road was two lanes with narrow shoulder access. The posted speed limit was 45 miles per hour. The area was two miles from the facility on a rural, winding road. According to the internet site (Weather Underground) the recorded temperature for that location on 11/12/11 between 4:00 a.m. and 6:30 a.m. ranged between 25 to 27 degrees Fahrenheit. During an interview on 11/23/11 at 10:45 a.m., the administrator stated she was not notified that Resident #1 was missing until 7:00 a.m. She further stated that staff should have contacted her earlier. When asked, she stated the psychiatric consult was ordered but the Psychiatrist was unavailable during that time to complete the evaluation of the resident.	D 270	As part of the QAA process, Nursing Administration reviewed all Adult Care residents' Potential Risk Assessment to insure any recent behavior changes were reflected. No updates were needed. The Potential Risk Assessment tool will be reviewed and updated quarterly or upon a significant change. As part of the QAA process, the Maintenance Director will continue to regularly check equipment to ensure it is working correctly and to change door codes quarterly or more frequently if required. As part of the QAA process, the Quality Assurance Nurse will monitor staff skills and reactions regarding their re-training on spotting signs of a resident at increased risk to exit and how to respond to wandering behavior changes and exit seeking residents. The QAA Nurse's observation will occur throughout December, January and February with follow-up training if necessary. Reports of the staff observations will be made monthly to the Administrator and QAA Committee. Completion Date ~~11/14/11~~ 11/24/11	

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D 270	Continued From page 7 Interview with LN #2 on 11/23/11 at 11:00 a.m. revealed he worked the night of the incident with Resident #1 but was not assigned to that hall. The last time he saw the resident was at 2:00 a.m. when he was in the day room. He did not see him after that time. LN #2 further stated he was not made aware the resident had been exit seeking earlier in the evening. Interview at 11/23/11 at 12:15 p.m. with NA #3 who worked the evening of 11/11/11 revealed Resident #1 was "confused and not himself." She stated the resident told her he wanted to go home "to his dad." She further stated she notified the Medication Technician (Med Tech) on that unit of the resident's statements. Interview with the Med Tech on 11/23/11 at 1:15 p.m. revealed she did not recall being told this information by NA #3, but did remember the resident's behavior of pacing and refusing medications was escalating. During this interview, the Med Tech also indicated she had received no additional education related updates on elopement. Telephone interview with NA #2 on 11/23/11 at 1:50 p.m. revealed he worked on the night of 11/12/11 and last saw the resident in the day room across from the activity room at 4:00 a.m. He had not been made aware the resident had been exit seeking or found outside earlier in the evening. Interview with the ADON on 11/23/11 at 2:30 p.m. revealed she had been manager on call on 11/12/11 but had not been notified that Resident #1 was missing.	D 270		

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D 270	Continued From page 8 Review of nurses' notes dated 11/21/11 at 5:00 p.m. revealed the resident was readmitted to the facility and placed on one to one supervision. Observation on 11/22/11 at 11:20 a.m. revealed Resident #1 appeared very anxious and was speaking very loudly. The resident picked up his cane and personal belongings and exited the room. Staff was accompanying the resident. Review of physician progress notes dated 11/22/11 revealed Resident #1 returned to the facility with no significant improvement. The resident was not easily directed and went to the front door "to go home." Nurses' note documented the resident was discharged back to the psych unit on 11/22/11 at 12:45 p.m. The administrator was notified of the Type A-2 State Licensure Rule violation on 11/23/11 at 9:15 a.m. The following allegation of compliance to correct the violation was accepted on 11/23/11 at 4:00 p.m.: Elderberry Health Care Allegation of Compliance Resident #1 was last observed in his bed at approximately 3:45 am on 11/12/11. At approximately 5:50 am, resident was noted to be missing. All staff were notified and search was begun. At approximately 6:20 am, Madison County Sherriff's Department notified facility by phone that resident was with them. Sherriff's Department notified EMS. Resident was then transported by Madison County EMS Mission Hospital Emergency Department for evaluation. A telephone message was left for Resident #1's	D 270		

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D 270	Continued From page 9 daughter (legal guardian) at approximately 7 am and Administrator was notified at that time. The Administrator proceeded to Mission Hospital Emergency Department. Resident was discharged from ED and returned to facility by Administrator at approximately 12 noon on 11/12/11. Resident reported to me during ride back to building that he was going to see his ex-wife because she had surgery and needed him. He did promise me that he would not leave the facility and would have staff call me if he needed to go somewhere. Upon arrival at the facility, resident was cooperative and returned to his room. Administrator changed exit code on front door and on side entrance. Resident was placed on acuity and observed carefully. Resident was subsequently placed on 1 on 1 observation which was continued until his discharge to Park Ridge Hospital's Gero-Psychiatric Unit on Monday, 11/14. On 11/14 and 11/17, Administrator and the Director of Nursing conducted in-services with staff re. Policy and Procedures for Elopement. Staff will not be permitted to work until in-serviced on elopement is completed. Education was provided regarding the signs and how to recognize a resident at risk for elopement. Procedure for who to notify and when to notify was also explained. Notice was sent in Nov. Statements to family members reminding them to not give any resident the door code. On Monday, 11/14, facility psychologist was notified of incident and an evaluation requested. On 11/14 resident noted to be suffering hallucinations and delusions and some confusion. Following discussion with facility physician, facility staff and guardian, arrangements were made for resident to be discharged to Park Ridge Hospital's	D 270		

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D 270	Continued From page 10 Gero-Psychiatric unit for evaluation, treatment and possible medication adjustment. Resident was subsequently admitted to Park Ridge Hospital on Monday 11/14. On 11/21/11 Maintenance Director changed the door codes on all the doors in the facility. Resident #1 was discharged back to Elderberry Health Care on Monday, 11/21 in the afternoon. Resident was placed on acuity and was monitored for behaviors with 1:1 observation. On Tuesday, 11/22/11, resident was noted to be once again exit-seeking and suffering hallucinations. Guardian was notified and resident was returned to Park Ridge at approximately noon and was readmitted at that time. All adult care home residents were reviewed for elopement risk on 11/14/11. Elopement risks and procedures will be monitored in Quality Assurance meetings monthly. Quality Assurance nurse will conduct interviews with staff to ensure they are knowledgeable with identifying elopement behaviors and the facility procedure for elopement. Quality Assurance nurse will report findings to Administrator and Quality Assurance committee monthly and on-going. Administrator will review reports and conduct in-services as needed. All new employees will be trained on the policy and procedure for elopement.	D 270		