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

Received 9/20/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING ____ B. WING ____	C 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO RIVERS HEALTHCARE - NEUSE CAMPUS	1303 HEALTH DRIVE NEW BERN, NC 28560

(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 000	INITIAL COMMENTS The Division of Health Service Regulation, Nursing Home Licensure and Certification Section, conducted a complaint investigation from August 15, 2012 through August 17, 2012. Immediate Jeopardy began in 483.25 on August 11, 2012. It was removed on August 16, 2012 when the facility provided and implemented an credible allegation of compliance.	F 000	F: 323 Submission of this Plan of Correction does not constitute admission of the under-signed that the deficiency was correctly cited or required correction.	
F 323 SS=J	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 observations, record review, and staff interviews, the facility failed to prevent 1 of 1 residents (Resident # 1), who was assessed as being at risk for elopement, from exiting the facility unsupervised. Immediate Jeopardy began on 8/11/12 when Resident # 1 left the facility unsupervised and fell on a main road near the facility. Resident # 1 was transported to the Emergency Room by Emergency Medical Services (EMS). Resident # 1 sustained two lacerations on the face requiring stitches and abrasions on both knees. Resident # 1 also sustained a "new bleed", having suffered a subarachnoid hemorrhage prior to admission to the facility. Resident # 1 exited the facility	F 323	It is the intent of the facility to prevent residents that have been assessed as "at risk for elopement" from exiting the facility un-supervised. On 8/11/12 Resident #1 was placed on "one on one" monitoring when he returned to the facility at around 7:00PM.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Barnett
TITLE: Administrator
(X6) DATE: 9/19/12

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

S.W.

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F 323	Continued From page 1 through a side exit door being used as the main entrance during the renovation of the facility lobby and main entrance. The side exit door was secured by a magnetic lock and required the input of a code number by staff to allow entrance or exit by that door. Immediate Jeopardy was identified on 8/15/12 at 5:12 PM and was removed on 8/16/12 at 7:57 PM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings are: 1. Resident # 1 was admitted to the facility on 7/6/12 with a diagnoses of progressive dementia, functional decline, general debility, and subarachnoid hemorrhage status post a previous fall. A review of the Minimum Data Set (MDS) assessment of 7/13/12 revealed Resident # 1 had severe cognitive impairments and ambulated independently. A review of the Elopement Risk assessments of 7/7/12 and 7/10/12 identified Resident # 1 as being at risk for elopement. A review of the Interdisciplinary (IDT) Progress Notes of 7/10/12 revealed, "Oriented to person only. No safety awareness. Alarm in place. Also has wander guard as he has attempted to open locked door at end of unit." A review of the MD Progress Notes for 7/12/12 revealed, "5. Agitation: mild, trying to leave, wants to go home." "Obs (observation): vss (vital signs stable), heent (head, eyes, ears, nose, throat) wnl (within normal limits), usually pacing in room as to (sic) pacing @ (at) doorways."	F 323	On 8/11/12 at around 3:20PM the magnetic door codes to the key pads were changed by the Maintenance Director. The codes to the key pads will be changed every (2) two weeks on pay days also by the Maintenance Director. On 8/11/12 at approximately 3:30PM a staff member was placed at the temporary entrance/exit and the door will continue to be monitored until the permanent entrance/exit is opened. On 8/11/12 a tool was generated by the Administrator and the Clinical Competence Coordinator to document the breaks and/or meals with relieved coverage documented. All staff was in-serviced on the use of the tool by the Administrator or the CCC on 8/11/12 and 8/12/12.	

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F 323	Continued From page 2 A care plan dated 7/16/12 addressed the risk of elopement with the goal of "Will not elope from health care center (initials of facility). Interventions included: Do not allow resident to leave hcc (health care center) alone without signing out or supervision; approach resident in a warm and positive manner when confused and attempting to leave hcc w/o (without) supervision; maintain locks on doors are in proper working order; keep wander guard bracelet in proper working order; attempt to redirect resident when noted with increase (sic) confusion (activities, toilet, snack, etc...); check wander guard placement q (every) shift; check wander guard functioning daily; notify MD is (sic) warranted. A review of the Nurses Notes, written by Nurse # 1, for 8/11/12 4:00 PM revealed: "(Nursing Assistant/NA # 1), 7-3 CNA (certified nursing assistant), asked me had I seen (Resident # 1). I told her no, not in the last 10 min (minutes). I last saw (Resident # 1) sitting in his bedside chair. She informed me that she had received a call from someone that (Resident # 1) may be on a stretcher on (name of street) in front of the hospital. Immediately she begin (sic) searching the building. I went to my Supervisor (Nurse # 2) RN to inform her of the above info. We got in her car & drove to (hospital). Together we identified (Resident # 1). He was being treated for his injuries. We spoke to him & he spoke to us. Informed his nurse who is (sic) was & to contact us when he is able to be d/c (discharged). Returned to the facility. (Administrator), (Resident # 1's family member) & (name of Resident # 1's attending physician) were notified. Appx. (approximately) 1 PM, I had re-directed Rt. (resident) back down the hallway to his room from the water fountain @ the end of the 100 hall. Sat	F 323	The tool was revised by the Administrator on 8/15/12 and again the staff was in-serviced on the use of the tool by the CCC. Resident #1 was discharged to an Assisted Living Facility with a locked unit on 8/28/12 as arranged by his Family Member/Responsible Party. On 8/12/12 all other residents were assessed or reassessed for wandering behaviors. Any identified resident with wandering behaviors were placed in the "Wandering Program." All identified wandering residents were placed in the "Behavior Management Program" beginning 8/13/12.	

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F 323	Continued From page 3 c (with) Rt. in his room for a few minutes talking (with) him. @ appx. 1:30 PM, Rt was sitting in his room talking (with) his roommate's visitor." During an interview on 8/15/12 at 4:16 PM, Housekeeping Aid (HA) # 1 stated she was the one who called back to the facility asking if the resident was there. HA # 1 stated she had clocked out of the facility at 2:35 PM. When she reached the main road, she saw two paramedics loading someone into an ambulance. HA # 1 stated she thought she recognized the shoes and shorts of the patient, and thought it was Resident # 1. HA # 1 stated she called the facility and talked with (NA # 1), Resident # 1's 7-3 nursing assistant, asking if Resident # 1 was in his room. NA # 1 said Resident # 1 was not in his room. During an interview on 8/15/12 at 3:24 pm, NA # 1 stated, "About 2:20 PM, I saw (Resident # 1) in his room and he said he was okay. I went to do my charting and answered the facility phone. It was (HA # 1) from the 100 hall. She asked me if (Resident # 1) was in his room. I asked her why, she said she saw his shoes on the stretcher. I checked his room and he was not there. I went to find the charge nurse and supervisor, looking for him on the way. I had checked on him 10-15 minutes prior to the phone call and he was in his room." During an interview on 8/15/12 at 4:03 PM, Nurse # 1 stated she was Resident # 1's regular 7-3 nurse on the 100 hall. Nurse # 1 stated, "In the past, (Resident # 1) typically spends most of his time in his room or near it. At 1:00 PM (on 8/11/12), he had been at the water fountain. I walked him back to his room and sat a couple of minutes with him. Between 1:00 PM and 2:20 PM, I looked in his room while I went up and down the hall passing meds and answering	F 323	The resident's care plans were updated appropriately. On 8/11/12 the magnetic door lock codes were changed shortly after 3:00PM. The codes will be changed every 2 weeks on paydays thereafter by the Maintenance Director. Staff was in-serviced on 8/11/12, 8/12/12, on: "Codes –Not to be given to Families/visitors or vendors" by the CCC. A letter was generated and sent related to door codes not being available to anyone but staff was sent to all responsible parties on 8/16/12.	

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F 323	Continued From page 4 callbells, and he was in there. One time he was talking to his roommate's visitor. The last time I saw him was about 2:20 PM. He was sitting in his room and the visitor was gone. I went to another room on a separate hall, and to the nurses station to talk with pharmacy on the phone. I had finished talking with the pharmacy at 2:40 pm when (NA # 1) came and told me she couldn't find the resident. (NA # 1) said she had gotten a call from someone outside the facility asking if the resident was in his room because there was an ambulance on the road loading up someone they thought might be him. The nursing assistant said he was not in his room. While the staff were searching the halls, the supervisor and I went to the hospital to see if it was him. By the time we got to the hospital it was about 2:45 PM. It was him. They were just starting to treat him and we talked to him." During an interview on 8/16/12 at 3:42 PM, Nurse # 2 stated she was the 7-3 Supervisor on 8/11/12. Nurse # 2 stated she had seen Resident # 1 walking on the 100 hall about 20 minutes before being notified he wasn't in the building. Nurse # 2 stated Nurse # 1 reported to her that Resident # 1 was not in his room or on the 100 hall, but may be at the hospital. Nurse # 2 stated she sent staff looking for Resident # 1 inside the facility and on the facility grounds, and she and Nurse # 1 went to the hospital and identified him. Nurse # 2 stated she observed Resident # 1 in the Emergency Room around 2:50 PM. A review of the Emergency Medical Service (EMS) report revealed the dispatch center received a call about the resident on 8/11/12 at 2:32 PM. EMS was enroute at 2:33 PM and reached Resident # 1 at 2:35 PM. The EMS report revealed upon arrival on scene, ""Pt	F 323	The Administrator, DHS, or Maintenance Director will review the Wander Guard Books weekly times 4 weeks then monthly to assure residents pictures and demographics are in the books. Performance Improvement Committee will review the systems monthly and any identified issues will be corrected to maintain compliance.	8/22/12

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F 323	Continued From page 5 (patient) lying on right side with an abrasion above right eye. Witness stated Pt fell into hwy (highway)." The EMS examination revealed Resident # 1 had bleeding abrasions on the head and both lower legs. Resident # 1 was transported at 2:40 PM and arrived at the hospital at 2:41 PM. A review of the Emergency Room (ER) records for 8/11/12 2:50 PM revealed: "It is noted that pt (patient) has a tracking arm band. (Name of facility) called to inquire if they are missing any residents. Person who answers phone states that they are missing (Resident # 1). Informed nursing home that pt is here in ED (emergency department) after being found lying on (name of road). " Emergency Room records for 8/11/12 2:56 PM revealed: "Patient found lying in street, patient has wonder (sic) off from nursing home. Patient has laceration to ferhead (sic). NH (nursing home) staff arrived shortly after patient and state they have been looking for him." ER records for 8/11/12 2:58 PM revealed Resident # 1 required laceration repair of "a 1.0 cm (centimeter) lac (laceration) of the right eye" requiring two sutures, and another laceration, size not given, over the right eye requiring three sutures. A review of the ER CT (Computed tomography) Scan report dated 8/11/12 revealed: "Scattered areas of petechial hemorrhage. (Petechial refers to small purplish spots on a body surface, such as the skin or a mucous membrane, caused by a minute hemorrhage). Some of the changes in the posterior left parietal lobe (the middle section of the brain) and occipital lobe (the back section of the brain) may be chronic and could be calcification. There is a new petechial hemorrhage in the high right frontal lobe."	F 323		

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F 323	Continued From page 6 A review of the ER Physician's note for 8/11/12 5:55 PM revealed: "Long discussion with the patient's (family member). Informed him that the patient does have a small brain bleed that could possibly become enlarged and could cause death. (Family member) says at this time he wants no further medical treatment and that the patient is DNR (do no resuscitate), comfort care. He is understanding that the patient could possibly die from this bleed." Resident # 1 was discharged to the facility. Observations on 8/15/12 at 1:06 PM revealed Resident # 1 seated in a wheelchair near the nurses station with 1:1 supervision. Resident # 1 was alert and verbal. Resident # 1 had bruising over the right eye with sutures intact. Resident # 1 had healing abrasions on both knees. A personal alarm and a wander guard bracelet were noted. Observations of 8/17/12 at 11:40 AM revealed Resident # 1 ambulating independently in his room with 1:1 supervision. Observation of the 100 hall exit/entrance door on 8/16/12 revealed the door was located on the side of the building and was being used as the main door while the facility lobby and entrance was being renovated. Egress to the lobby entrance was blocked inside the facility, and the lobby entrance door was locked. The 100 hall exit /entrance door opened into a small reception area. The 100 hall began at the right end of the reception area, around a corner to the left. The exit/entrance door was not visible to anyone standing in the 100 hall unless they were about to enter the reception area. The door locked automatically when closed due to a magnetic lock access system. A digital keypad was mounted on the wall beside the door. The door access system required a numeric code to be entered on	F 323		

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F 323	Continued From page 7 the keypad to unlock the release bar across the door. The door could not be opened by pulling on the handle from the outside, or by pushing on the release bar from the inside, unless the door code had been entered first. Observations of the facility on 8/16/12 revealed the facility was located 0.1 mile from a main boulevard intersection, next to the hospital. According to the EMS report of 8/11/12, Resident # 1 was found lying in front of the hospital. During an interview on 8/15/12 2:00 PM, the Administrator stated the 100 hall exit/entrance door was monitored by reception staff in the reception area Monday - Friday 8:30 AM - 5:00 PM, and by the evening receptionist from 4:00 PM - 8:00 PM. On the weekends, the door was monitored by the Floor Tech (FT) assigned to that end of the 100 hall from 7:00 AM - 10:00 AM. Administrative staff monitored the door from 10:00 AM - 2:00 pm. A Floor Tech was resumed monitoring the door from 2:00 pm - 10:00 PM. No one was assigned to the door after 10:00 PM. The Administrator stated that unless a wanderer knew the code, there was no way they could get out. The Administrator stated they had not figured out who had opened the door and let Resident # 1 walk out with them. The Administrator stated staff knew not to give the door code to visitors or family members, but felt it was possible long term residents / family members could have known the code. An observation on 8/15/12 of the door monitoring tool utilized since 8/11/12 revealed the form was not completely filled out and did not indicate when staff monitoring the exit / entrance door on the 100 hall took breaks, returned from breaks, or who relieved them, or whether the door was being monitored during breaks.	F 323		

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F 323	Continued From page 8 The Administrator was notified of the Immediate Jeopardy on 8/15/12 at 5:15 PM. The facility provided a credible allegation of compliance on 8/16/12 at 6:43 PM, The allegation of compliance indicated: Immediate Actions: 1. A Nursing Assistant was with the resident at 2:20 pm in the facility. 2. Resident went out the temporary entrance door, which had a functioning mag lock in place, sometime between 2:20 - 2:30pm. The facility assumed a visitor let him out due to fact the mag (magnetic) locks were functioning properly and the resident did not know the code. 3. Resident ambulated 0.1 miles to the business sign where (the main boulevard and the facility road) meet. 4. Resident fell while stepping off the curb onto the boulevard. 5. Emergency Medical Services (EMS) received a call at 2:32 pm, EMS services responded at 2:35pm. 6. He was transported to the medical center by EMS at 2:40 pm. 7. The resident was signed into the medical center at 2:48 pm, noted to have a laceration to his upper right forehead, received two 5-0 sutures, above right eye three 5-0 sutures placed. 8. The Residents Family Member requested Resident be sent back to the nursing facility. ER diagnosis: Small Subarachnoid hemorrhage, trauma, head laceration, fall (accidental). 9. Resident was returned to facility around 7:00 pm on 8/11/12 and placed on 1:1 observation from 8/11/12 through 8/16/12. At which time no further exit seeking behaviors have been identified since 8/11/12. The 1:1 supervision was provided by the nursing staff (Licensed Nurses	F 323		

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F 323	Continued From page 9 and Certified Nursing Assistants) 24 hours a day 7 days per week beginning 8/11/12. The nursing staff providing 1:1 was relieved for breaks by another staff member (Department Managers, housekeepers). 10. Nursing staff monitored neuro checks on resident for 48 hours after fall. The staff began neuro checks at 7:00 pm on 8/11/12 and continued every four hours X 5, then every eight hours X 3. 11. The facility placed a staff member to monitor the temporary entrance/exit door on 8/11/12 at 2:30 pm. The temporary entrance/exit door will be monitored until the permanent entrance / exit is opened, then the temporary door will be monitored by the management system for that door as well as all other exit doors. The staff member monitoring the door is relieved for breaks by another staff member. During the weekdays the receptionist monitors the temporary entrance door from 8:30 am -8:00 pm, the floor tech monitors from 8:00 pm - 11:00 pm, then the nursing staff monitor from 11:00 pm - 8:30 am. During the weekends the Floor tech monitors the door from 7:00 am - 10:00 am, the administrative manager on duty from 10:00 am - 2:00 pm, then housekeeping from 2:00 pm - 10:00 pm, then nursing staff from 10:00 pm - 7:00 am. The staff monitoring the door remains at the reception area with direct visualization of the door, their responsibilities include watching the door, letting visitors in and out of the facility and answering the phone. 12. The monitoring form being utilized 8/11/12 identified the date, employee time they began monitoring the door, time out for breaks and the employee relieving the assigned employee for break, (the employee monitoring the door request	F 323		

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F 323	Continued From page 10 to be relieved for a break by calling the nursing and request coverage) also signs in and out, then the assigned employee signs back in. This form accounts for all minutes of the day and identifies who was monitoring the door twenty four hours a day. Identification of others: 1. 100% of the residents had an elopement risk assessments completed on 8/13/12, eleven residents currently had wander guards and one new resident was identified during the completion of the elopement risk assessments. The elopement risk assessments will be completed quarterly by Licensed Nursing staff 2. Residents identified as " at risk " for elopement had their care plans reviewed and updated as indicated on 8/13/12. 3. The wander guard books were reviewed to ensure the residents had current demographic and updated pictures as indicated on 8/13/12. 4. Demographic sheets that state the resident height, weight, hair color and eye color was added to the wander guard book on 8/13/12. The wander guard books are maintained at each nurses ' station and at the receptionist desk. 5. All staff education was started on 8/11/12 related to not propping doors open for any reason. This education continues until 100% of the staff has been completed. Staff will receive this education on their next scheduled day to work. 6. All Staff education was started on 8/13/12 related to not distributing the door security codes to any visitor. This education will continue until 100% of the staff has been completed. Staff will receive this education on their next schedule day to work. 7. Facility Staff were reeducated starting on	F 323		

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
	345357	A. BUILDING ______ B. WING ______	C 08/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWO RIVERS HEALTHCARE - NEUSE CAMPUS	1303 HEALTH DRIVE NEW BERN, NC 28560

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F 323	Continued From page 11 8/15/12 on the door monitoring tool which identifies the time the assigned staff started monitoring the door, when they left the area and who relieved them. 8. A letter explaining that the door codes will not be made available to anyone but staff, for the safety of the residents was mailed to family members / responsible parties on 8/16/12. The door codes were changed on 8/11/12 at approximately 3:30 pm. 9. The Maintenance Director checked all exit doors mag locks to ensure they are locking on 8/11/12 and has continued to check all mag lock doors daily to ensure the mag locks are functioning properly since 8/11/12, the maintenance director will continue to check the mag logs on all the doors ongoing. The mag lock doors include the doors at the end of the hallways on 100 hall, 300 hall, and 400 hall. Testing the doors include pushing on them to open without punching the code to release the mag lock. 10. The Wander guarded door will be monitored daily by taking the wander guard checker to the wander guarded door to ensure it locks down. This will continue daily and ongoing. The Residents with wander guard bracelets have their bracelets checked daily by the Maintenance department and/or nursing department by utilizing a wander guard checker that lights up to identify that the wander guard bracelet / door is functioning as indicated by the yellow light. The wander guard bracelet check is documented on the door alarm device daily testing report form. System changes: 1. The Wander guarded door will be monitored daily by taking the wander guard checker to the wander guarded door to ensure it locks down. This will continue daily and is ongoing. The	F 323		

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F 323	Continued From page 12 Residents with wander guard bracelets have their bracelets checked daily by the Maintenance department and/or nursing department by utilizing a wander guard checker that lights up to identify that the wander guard bracelet/door is functioning as indicated by the yellow light. The wander guard bracelet check is documented on the door alarm device daily testing report form. 2. Education to new staff members on " Not providing the families and/or visitors the codes to the doors " will be provided during staff orientation upon hire by the Clinical Competent Coordinator, beginning 8/12/12. 3. Education related to not propping any door open will be provided during staff orientation upon hire by the Clinical Competency Coordinator, beginning 8/11/12. 4. The Administrator / Director of Health Services and/or Director of Maintenance will review the Wander Guard Books weekly for 4 weeks then monthly thereafter to ensure the residents picture and demographic sheet is maintained in the book, beginning 8/13/12. 5. Families will be notified on admission that the door codes will not be given to family members and/or any visitor for the safety of the residents by the Admissions Director, Social Service Director and/or Administrator, beginning 8/13/12. 6. The Administrator will review the exit door monitoring tool signature log daily for one week then weekly for four weekly them monthly thereafter to ensure the form identifies all times are accounted for, beginning 8/12/12. 7. The Maintenance Director will change the door codes bi-weekly for three months then monthly thereafter or as directed by the performance improvement committee, beginning 8/11/12. Monitoring	F 323		

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F 323	Continued From page 13 Interventions were integrated into QA on 8/13/12. 1. The monitoring of the exit door monitoring tool will be taken to the performance committee meeting by the Administrator monthly for review and recommendations. 2. The percentage of staff educated related to not propping doors open will be taken to the Performance Improvement committee by the Administrator and/or Director of Health Services monthly to ensure 100% of employees who have worked have completed the education. 3. The percentage of employees educated on NOT providing the door codes to visitors will be taken to the Performance Improvement committee by the Administrator and/or Director of Health Services monthly to ensure 100% of employees who have worked have completed the education. 4. The percentage of staff related to education for the exit door monitoring tool will be taken to performance improvement by the Administrator monthly to ensure 100% of employees who have worked have completed the education.	F 323		