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CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

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F 000	INITIAL COMMENTS A Complaint Investigation survey was conducted from 06/13/17 through 06/16/17. Immediate Jeopardy was identified at: 483.25 (tag F323) at a scope and severity of J. Immediate jeopardy began on 06/01/17 when Resident #1 left the facility unattended and without the facility's knowledge. Immediate jeopardy also occurred on 06/05/17 when Resident #1 fell off a wheel chair scale which resulted in a subdural hematoma requiring surgery. Immediate jeopardy was removed on 06/16/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of (D) (No actual harm with potential for more than minimal harm that is not immediate jeopardy.) for monitoring of the revised systems put in place related to supervision to prevent elopements and falls. A partial extended survey was conducted as part of the facility's complaint investigation from 06/13/17 through 06/16/17. Event ID# 23M011.	F 000		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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F 323	Continued From page 1 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to prevent a cognitively impaired resident from exiting the facility without staff supervision (Resident #1) for 1 of 3 sampled residents identified as elopement risks. The facility also failed to remove a wheel chair scale from a common area which resulted in a fall with injury (subdural hematoma which required surgery) for 1 of 3 sampled residents at risk for falls (Resident #1). Immediate jeopardy began on 06/01/17 when Resident #1 left the facility unattended and without the facility's knowledge. Immediate jeopardy also occurred on 06/05/17 when Resident #1 fell off a wheel chair scale which resulted in a subdural hematoma requiring surgery. Immediate jeopardy was removed on 06/16/17 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of	F 323		

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compliance at a lower scope and severity of (D) (No actual harm with potential for more than minimal harm that is not immediate jeopardy.) for monitoring of the revised systems put in place related to supervision to prevent elopements and falls.

The findings included:

Resident #1 was admitted to the facility on 06/06/15 with diagnoses which included dementia with behavioral disturbances and left below the knee amputation.

a) Review of Resident #1's annual Minimum Data Set (MDS) dated 08/11/16 revealed an assessment of severely impaired cognition with rejection of care and wandering behaviors. The MDS indicated Resident #1 was independent in locomotion after set up.

Review of Resident #1's Care Area Assessment (CAA) for behaviors dated 08/28/16 revealed Resident #1 had no exit seeking behavior but wore a wander guard.

Review of Resident #1's quarterly MDS dated 10/06/16 revealed an assessment of severely impaired cognition with rejection of care. The MDS indicated Resident #1 required the physical assistance of one person with locomotion and had no falls.

Review of Resident #1's quarterly MDS dated 01/04/17 revealed an assessment of severely impaired cognition with wandering behavior. The MDS indicated Resident #1 required supervision with independent locomotion and had no falls

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Review of Resident #1's wandering risk assessment dated 03/04/17 revealed documentation of Resident #1's disorientation to person, place and time with a diagnosis of dementia with psychosis and history of wandering. The wandering risk assessment form used by the facility did not contain a section for level of elopement risk.

Review of Resident #1's quarterly MDS dated 04/04/17 revealed an assessment of severely impaired cognition with rejection of care. The MDS indicated Resident #1 required set up help and was independent in locomotion with no falls.

Review of Resident #1's care plan reviewed 04/18/17 revealed identification of elopement risk due to confusion, wandering behavior and independence in wheel chair with the goal of "will not leave facility unattended." Interventions included application and regular function check of a wander guard on the right wrist, diversional activities and monitoring of Resident #1's location.

Review of Resident #1's May 2017 electronic Treatment Administration Record (eTAR) revealed documentation of wander guard placement checks every shift. The eTAR also contained documentation weekly function checks on the evening shift every Wednesday. Nurse #1 documented Resident #1's wander guard functioned on 05/03/17, 05/10/17, 05/17/17, 05/24/17 and on 05/31/17.

Review of a nursing note dated 06/01/17 revealed Resident #1 left the facility without staff knowledge. Nurse #1 documented a visitor was at the front door with Resident #1. Nurse #1

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assessed Resident #1 and notified the physician, the Director of Nursing and Resident #1's family member. Nurse #1 checked Resident #1's wander guard which functioned and replaced it with a new wander guard on the left forearm.

Review of a nurse practitioner's (NP) note dated 06/02/17 revealed documentation of a physical assessment. The NP documented a bruise on Resident #1's left thumb and no injuries. The NP documented Resident #1 self-propelled in a wheel chair with no changes in motor function or alertness.

Telephone interview with Resident #1's family member on 06/13/17 at 11:45 AM revealed the family member visited Resident #1 on 06/01/17. The family member explained she left Resident #1 in the room and left the facility at approximately 5:30 PM to obtain clothing for Resident #1. The family member reported she informed Nurse #1 of her departure and expected return to the facility. The family member explained she received a call from the facility approximately 30 minutes later when she was driving back to the facility. Resident #1's family member reported she stayed that evening (06/01/17) with Resident #1 to make certain he was alright. Resident #1's family member met the next day (06/02/17) with the Director of Nursing and Administrator and agreed to the plan of daily wander guard function checks for Resident #1.

Telephone interview with Nurse Aide (NA) #3 on 06/13/17 at 12:42 PM revealed Resident #1 wandered independently in a wheel chair. NA #3 reported she worked on 06/01/17 and did not hear an alarm sound.

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F 323	Continued From page 5 Observation on 06/13/17 at 2:30 PM revealed a high pitched, shrill alarm sounded which could be heard at the end of the nursing unit. Interview with NA #4 on 06/13/17 at 2:31 PM revealed the shrill alarm signaled the front door opened with a wander guard resident nearby. NA #4 explained Resident #1 wandered independently in a wheel chair throughout the facility. Interview with Nurse #1 on 06/13/17 at 3:02 PM revealed Resident #1 used a wheel chair independently with a wander guard on the wrist. Nurse #1 reported she checked Resident #1's wander guard for placement each shift. Nurse #1 explained she checked Resident #1's wander guard for alarm and door lock function at the front door every Wednesday. Nurse #1 reported Resident #1's wander guard alarmed on 06/01/17 at approximately 5:00 PM when the pharmacy delivered medications. Nurse #1 explained Resident #1 was in lobby with her at the time of medication delivery and the wander guard alarmed when the front door opened. Nurse #1 reported she was not aware that Resident #1's family member left the facility. Nurse #1 explained Resident #1's family member visited frequently and always informed her when leaving. Nurse #1 reported Resident #1 would be distracted with conversation when the family member left to prevent Resident #1 from becoming upset. Continued interview with Nurse #1 revealed she was in the front lobby's restroom at approximately 6:00 PM when the front door alarm sounded. Nurse #1 reported a visitor, who was not known	F 323		

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to her, was with Resident #1 at the front door. Resident #1's wander guard alarmed when the visitor opened the door. Nurse #1 explained she checked Resident #1's wander guard for function and it worked. Nurse #1 explained she did not have the opportunity to interview the unknown visitor because she immediately assessed Resident #1 for injury. Nurse #1 reported the unknown visitor stated Resident #1 was "on the road." Nurse #1 did not know if the visitor meant the front entrance driveway into the facility's campus, the front circular driveways or the street address road. The visitor left during the assessment. Nurse #1 reported she notified Resident #1's physician, family member and the Director of Nursing. Nurse #1 replaced Resident #1's wander guard with a new one and implemented visual checks every 15 minutes.

Interview with Nurse Aide (NA) #1 on 06/13/17 at 3:25 PM revealed she saw Resident #1 seated in a wheel chair on the nursing unit approximately 15 minutes before the alarm sounded which would be approximately at 5:45 PM on 06/01/17. NA #1 explained Resident #1 used the wheel chair independently and wandered throughout the facility. NA #1 reported she checked Resident #1 on a regular basis throughout the shift since Resident #1's admission to the facility.

Interview with NA #5 on 06/13/17 at 4:36 PM revealed Resident #1 wandered independently in a wheel chair on 06/01/17. NA #5 reported she did not hear an alarm sound until Resident #1 returned and Nurse #1 responded. NA #5 reported she did not know Resident #1's family member left the facility on 06/01/17.

Interview with NA # 6 on 06/13/17 at 4:45 PM

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revealed Resident #1 wandered independently in a wheel chair on 06/01/17. NA #6 reported she did not hear an alarm sound until Resident #1 returned and Nurse #1 responded.

Interview with the maintenance director on 06/13/17 at 4:57 PM revealed the facility's wander guard system functioned, he checked it daily 5 days a week, and the wander guard battery lasted 3 years. The maintenance director explained the front door automatically locked when a resident with a wander guard approached within 9 feet. If someone opened the door during the hours of 6:30 AM and 9:30 PM when the front door was unlocked, then an alarm would sound if a wander guard resident was within 9 feet. The maintenance director reported he repaired a mag lock on 05/17/17 with the vendor on site that same day to ensure the locks and system operated. There was no problem. The maintenance director explained he checked the system after Resident #1's elopement and found no problems. The maintenance director explained he contacted the wander guard company by telephone and email to make certain he checked the system thoroughly.

Interview with the Director of Nursing (DON) on 06/14/17 at 8:52 AM revealed only licensed nurses and the front office staff could silence the alarm. The DON reported Nurse #1 notified her of Resident #1's elopement on 06/01/17. The DON reported she directed Nurse #1 to replace Resident #1's wander guard as a precaution and implement frequent checks. The DON explained all residents with wander guards were checked for function and no problem identified. The DON reported she interviewed all evening staff on duty on 06/01/17 and no staff member heard an alarm

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sound until Resident #1 was at the front door with the unknown visitor. The DON explained the alarm could only be turned off physically with a badge.

Observation on 06/14/17 at 3:30 PM revealed the facility's campus consisted of a driveway from the main road into a parking lot. The main road was a two-lane street with a speed limit of 35 miles per hour in a residential area. Three private single homes faced and used the facility's driveway for egress. The parking lot extended to the front of the facility which consisted of 2 circular driveways under a portico. A sidewalk bordered the circular driveway and parking lots. The distance from the front door to the driveway into the parking lot was approximately 100 yards and the distance from the front door to the street was approximately 133 yards.

The immediate jeopardy was identified on 06/15/17. The facility administrator was notified of the immediate jeopardy on 06/15/17 at 10:50 AM.

The facility provided an acceptable credible allegation of compliance which included:

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 6/1/17 Resident # 1, who had a wander guard initiated on 6/7/15 - was observed before dinner at the facility's front door and it locked preventing him from leaving. Resident #1 was re-directed to dining room by nursing assistant. After dinner, a family member of Resident #1 visited the resident. Approximately 15 minutes after she had

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F 323	Continued From page 9 left the facility's front door alarmed. At approximately 6:00 PM a visitor was with Resident #1 at the facility's outside front entrance and stated the resident had fallen near the road. Initial nurse assessment revealed no injury. Resident said he was following his daughter when asked why he left the building. The resident's wander guard was checked for function near the front door by his charge nurse. When the door was closed and wander guard was two feet away from door it locked. A new wander guard was placed on Resident #1's left forearm. On 06/01/17 Resident #1's family member and the on call MD were informed of the resident's unsupervised exit from the facility and his statement. Family member returned to the facility and stayed with him until approximately 10:30 PM. Charge nurse initiated frequent checks ranging from 15 minutes to an hour. They were initiated at approximately 6:30 PM and concluded approximately 10:00 AM the following day. On 6/2/17 Resident #1 Wandering and Elopement Risk Assessment was re-evaluated to ensure appropriate interventions were in place by the Director of Nursing (DON). DON and administrator also met with the resident's concerned party/family member and discussed the care plan. New intervention was added to the Kardex for nursing assistants to validate the function of the resident's wander guard daily. Function checks were located on the Medication Administration Record (MAR) for nursing to validate weekly. Nurse practitioner assessment completed on 6/2/17 revealed a bruise to the left thumb. On 06/05/17 Resident #1 experienced a fall in the facility and was transferred to a hospital and remains in the hospital as of 06/16/17. How corrective action will be accomplished for	F 323		

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F 323	Continued From page 10 those residents having potential to be affected by the same deficient practice: As a routine practice, visual rounds and cross shift communication will be done by nursing every shift to observe and ensure all residents are accounted for. Orders are placed on the MAR for documentation of location of wander guard on resident's body every shift and function of wander guard weekly. The resident's nurse will be responsible for checking and documenting the location of the resident's wander guard on their body every shift and the function of the wander guard weekly. Care plans are updated to include location of wander guard and serial number of device. This will be reviewed in Risk Management Meeting on a weekly basis and through quarterly Quality Assurance (QA) meeting as needed. All facility staff were in-serviced beginning on 6/13/17 for Policy #1902 - Missing resident - and "code orange" including elopement procedures, patient rounding, and responding to alarms. Education was provided by DON, unit managers, and unit coordinator. New hires will be educated during general orientation. All staff will be in-serviced before returning to work. Beginning on 6/13/17, as per policy, the Maintenance director or designee will continue to test door alarms daily and results of checks will be documented in our maintenance software program. The alarm monitoring company will be contacted if any issues are identified. On 6/13/17, all 7 residents in-house on this date with wander guards had their Wandering and Elopement Risk Assessments and care plans re-evaluated and revised as needed by the DON and Regional Nurse Consultant. All wander guards were checked by DON for function and all	F 323		

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were working appropriately. Administrator, DON, Regional Nurse Consultant, and Maintenance Director were unable to re-create the scenario of door not alarming with a wander guard in place. On 6/13/17, the maintenance director contacted an Alarm Monitoring Company who performed in house testing of all facility doors and alarms on 6/15/17 and they were also unable to re-create this scenario of door not alarming with a wander guard in place. The system is working as designed.

b) Review of Resident #1's quarterly Minimum Data Set (MDS) dated 04/04/17 revealed an assessment of severely impaired cognition with rejection of care. The MDS indicated Resident #1 required set up help and was independent in locomotion and had no falls.

Review of Resident #1's care plan revised 03/29/17 revealed a risk for falls related to gait/balance problems and unawareness of safety needs. Interventions included to keep the environment free of trip hazards.

Review of a nurse note dated 06/05/17 at 5:00 PM revealed Nurse #1 documented Resident #1 fell backward in a wheel chair onto the floor. Nurse #1 documented Resident #1's back of the head swelled and Resident #1 remained alert and confused. Resident #1's blood pressure measured 148/81 millimeters of mercury, heart rate measured 80 with a respiratory rate of 20. Resident #1's oxygen saturation rate measured 96% on room air. Resident #1's pupils were equal and reactive to light. Nurse #1 notified the physician and transferred Resident #1 to the hospital.

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Review of Resident #1's fall assessment dated 06/05/17 revealed Nurse #1 documented the intervention to prevent recurrence was to not leave the wheel chair scale unattended.

Review of Resident #1's emergency room admission dated 06/05/17 revealed a diagnosis of left acute subdural hematoma without loss of consciousness. Review of a neurosurgical operative note dated 06/06/17 revealed Resident #1 underwent a left craniotomy for evacuation of the subdural hematoma.

Telephone interview with Nurse Aide (NA) #3, who cared for Resident #1 on the day shift, on 06/13/17 at 12:42 PM revealed Resident #1 used a wheel chair independently and wandered in the facility on 06/05/17.

Interview with Nurse #1 on 06/13/17 at 3:02 PM revealed she witnessed Resident #1's fall. Nurse #1 explained she was at the medication cart approximately 6 to 7 feet away when Resident #1 rolled up the ramp to the wheel chair scale. Nurse #1 reported Resident #1 fell backwards when the wheel chair reached the top of the ramp incline. Nurse #1 explained she could not reach Resident #1 in time to prevent the fall. Nurse #1 explained the wheel chair scale was placed in front of the nursing desk with both ramps lowered. Nurse #1 reported the wheel chair was usually stored in the alcove but was placed in front of the nursing desk when the nurse aides weighed residents. Nurse #1 reported she transferred Resident #1 to the hospital.

Interview with Nurse Aide (NA) #1 on 06/13/17 at 3:25 PM revealed Resident #1 used his wheel chair independently and wandered in the facility.

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(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
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NA #1 reported she assisted Resident #1 into the wheel chair on 06/05/17 when she came on duty at 3:00 PM. NA #1 explained NA #2 was weighing all residents in the facility at the time of Resident #1's fall. NA #1 reported the wheel chair scale was placed in front of the nursing station with the ramps down.

Interview with NA #2 on 06/13/17 at 3:30 PM revealed he volunteered to obtain resident weights on 06/05/17 with permission from the unit coordinator. NA #2 explained he moved the wheel chair scale in front of the nursing station and lowered the ramps on each side at approximately 3:30 to 4:00 PM. NA #2 reported he transported residents to the scale from the resident rooms and the other nursing unit. NA #2 reported he stopped transporting residents to the wheel chair scale for approximately 10 minutes to assist transporting residents to the dining room for the dinner meal. NA #2 reported he did not return the wheel chair scale to the alcove or place the ramps in the up position.

Observation of the metal wheel chair scale with the maintenance director on 06/14/17 at 9:01 AM revealed the wheel chair scale measured 54 inches by 29 inches with the two ramps in the down position. The incline of each ramp was approximately 35 degrees.

Telephone interview with the unit coordinator on 06/14/17 at 9:06 AM revealed NA #2 placed the wheel chair scale in front of the nursing station on 06/05/17. The unit coordinator explained the wheel chair scale was always placed in front of the nursing station while in use. The unit coordinator reported the scale was unattended for the time it took to transport residents to the scale

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 06/16/2017

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which would be less than 2 minutes. The unit coordinator was aware NA #2 left wheel chair scale unattended to assist with transportation to the dining room.

Interview with the Director of Nursing (DON) on 06/14/17 at 9:31 AM revealed after Resident #1's fall from the wheel chair scale, she directed staff not to leave the wheel chair scale unattended with the ramps down. The DON explained the wheel chair scales were stored in an alcove when not in use.

The immediate jeopardy was identified on 06/15/17. The facility administrator was notified of the immediate jeopardy at 10:50 AM.

The facility provided an acceptable credible allegation of compliance which included:

How the corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 6/5/17 at approximately 6:00 PM Resident # 1 was observed by a staff nurse. One of the facility's wheelchair scales was near the nursing station with its ramp lowered. Resident #1 was observed to roll himself onto the scale's ramp in his wheelchair and leaned backwards once he arrived at the top of incline and fell backwards hitting his head on the floor. Resident was evaluated by Director of Nursing (DON) and orders were obtained to send to the Emergency Room (ER) for evaluation. Resident #1 has not returned to facility since his fall of 6/5/17 and remains in the hospital.

How corrective action will be accomplished for

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F 323	Continued From page 15 those residents having potential to be affected by the same deficient practice: Facility identified ambulatory and self-propelled wheelchair residents as potentially being affected by deficient practice. Root cause analysis of Resident #1's fall on 06/05/17 was performed by DON and revealed that on 6/05/17 a nursing assistant was using one of the facility's wheel chair scales to obtain resident weights at the nursing station and stepped away to take the resident to the dining room. The nursing assistant left the scale's ramp in the down position, which allowed Resident #1 to wheel his wheel chair across the scale's ramp surface and fall backwards. Staffing in-service began on 6/13/17 for new storage procedures for wheelchair scale for all staff. In-service is conducted by DON, unit manager, and unit coordinator. Staff were directed the wheel chair scale's ramp is to be closed when it is not in use. All staff have been in-serviced to include proper storage of all equipment when not in use and to identify any environmental safety concerns. New staff hires will be educated during general orientation. All staff will be in-serviced before being allowed to return to work. Nursing assistant that was using the scale on 6/5/17 has been given one-on-one education on proper storage of wheelchair ramps when not in use. The immediate jeopardy was removed on 06/16/17 at 11:30 AM following observations of staff supervision of residents identified as at risk of elopement and the function of the wander guard system. Observations revealed resident areas were free from environmental hazards.	F 323		

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F 323	Continued From page 16 Staff interviews revealed receipt of training related to elopement and fall prevention. Documentation was reviewed regarding staff training related to resident supervision, fall prevention and freedom from environmental hazards.	F 323		