STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 A complaint investigation survey was conducted from 09/12/17 through 09/14/17. Immediate Jeopardy was identified at: CFR 483.25 at tag F323 at a scope and severity (J) CFR 483.75 at tag F520 at a scope and severity (J) The tags F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 07/25/17 and was removed on 09/14/17. An Partial extended survey was conducted.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
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. (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.	F 323	**Identified Resident** A head to toe assessment was completed for resident # 1 on 7/25/17. 1:1 observations were initiated by the Director of Nursing until 8/1/17 A wanderguard was placed on resident # 1 by the Unit Manager and plan of care updated on 7/26/17 The door codes were changed proactively on 7/27/17 and again proactively on 9/13/17	10/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Raymond Cooper — TITLE: Administrator — (X6) DATE: 10/4/2017

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.

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F 323	Continued From page 1 (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, record review, staff interviews, and law enforcement officer interview, the facility failed to provide supervision to prevent the elopement from the facility of 1 of 5 moderately cognitively impaired residents reviewed for accidents (Resident # 1). On 7/25/17, Resident # 1, unsupervised by staff, exited the facility by wheelchair and traveled approximately 440 feet (146 yards) to a convenience store behind the facility on a sidewalk. Resident #1 was located by law enforcement officer and was returned to the facility with no injuries after an undetermined amount of time outside of the facility. Immediate Jeopardy began on 7/25/17 when Resident #1 exited the facility unsupervised and was found outside by a law enforcement officer on the sidewalk a of a convenience store behind the facility after an undetermined amount of time. The Immediate Jeopardy was lifted on 9/14/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a lower scope and severity level of D (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.	F 323	**Like Residents** Exit seeking evaluations were completed on residents that exit seek by the Director of Nursing and the Unit managers on 7/26/17. **Systemic changes:** Department heads educated all staff (nursing, housekeeping, maintenance, dietary, activities, therapy and administration) regarding behaviors that are indicative of potential changes and exit seeking behaviors and steps to take to prevent unsafe exit from the facility on September 13, 2017. The Administrator and Department Heads educated all staff (nursing, housekeeping, maintenance, dietary, activities, therapy and administration regarding door codes and not to share on September 13, 2017. The education sign in sheets will be filed in Human Resources. Any Full –time or part time employees not educated on September 13, 2017 will be educated by the Department Supervisors prior to working	

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F 323	Continued From page 2 The findings included: Resident #1 was admitted to the facility on 8/22/13 with a readmission date on 7/17/17. The resident's diagnoses included high blood pressure, heart failure, osteoporosis, chronic kidney disease (stage 3), unspecified atrial fibrillation, and below the knee amputation. Review of the care plan dated 7/18/17 revealed focused area "At risk for fall due to limitations secondary to hypertension, congestive heart failure, chronic kidney disease, osteoporosis, hypothyroidism, left below knee amputation". The goal was to minimize the risk for fall. Interventions included to assist with transfer, assist to toilet at bedtime and reinforce need to call for assistance prior to going to the bathroom. Review of the comprehensive readmission Minimum Data Set (MDS) assessment dated 7/24/17 revealed Resident # 1 had adequate hearing, vision, clear speech, and usually made self-understood. Per the MDS, Resident #1 had moderate cognitive impairment with Brief Interview for Mental Status (BIMS) score of 12. Resident #1 was assessed with no signs or symptoms of delirium or psychosis. The resident did not exhibit wandering behavior. The resident was assessed as needing supervision with one person assistance with bed mobility and transfer, limited one person assistance for locomotion on and off unit. The resident was coded as having no functional limitation in range of motion for upper extremities, and impairment on one side for the lower extremities. The resident used a wheelchair as mobility device. Resident #1 was assessed as receiving diuretics 7 out of 7 days in the look back period, and an antidepressant 6	F 323	New hires will be educated by the Department Supervisors or Human Resource Director during orientation. **Monitoring** The Director of Nursing or Unit Managers will audit current residents with exit seeking behaviors to evaluate care plan interventions are effective weekly times four, then monthly times two The Director of Nursing or Unit Manager will audit current residents with change in condition to evaluate exit seeking behaviors weekly times four, then monthly times two The Maintenance Director and Department Heads will conduct missing residents drill weekly times four, then monthly times two. Results of these audits and reviews will be submitted to the facility QAPI committee for review and recommendations as necessary	

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F 323	Continued From page 3 days out of 7 days during the look back period. Review of an incident report, prepared by the facility, and dated 7/25/17 at 9:30 PM, revealed Resident #1 was brought in the building by a law enforcement officer who indicated that the resident was at "The Store". The incident report also indicated that the resident informed the officer that someone carried him there and left him. On further questioning, Resident #1 could not describe the person who brought him or the mode of transport. Upon arrival to the facility, a complete head to toe assessment was completed and no injuries or bruises were noted. Fifteen minute checks and one to one observation was initiated. Physician (MD) and Responsible Party (RP) were notified at 11:00 PM. Review of the incident statement from the law enforcement officer dated 8/2/17 read in part: "Law Enforcement Officer states that she was in her patrol car and visualized the resident sitting on the sidewalk in front of the store. She states she had observed him for 5 - 10 minutes before approaching him. She walked to him and initiated a conversation. Resident states that he was waiting to be picked up. She states she noticed that the resident was disabled so she offered to buy him something to eat or drink and he declined. Resident eventually gave her a telephone number that she called and spoke to his (family member). The (family member) tells the law enforcement officer that resident is a resident of Manor Care. She states that she pushed the resident's wheelchair to the facility. The front door was locked and a "lady" opened the door for them to come in. The lady directed her (the law enforcement officer) to the left, she (the law enforcement officer) pushed the resident	F 323		

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F 323	Continued From page 4 to the nurse's station and spoke to the nurse. The nurse then took the resident into his room to assess him. The law enforcement officer stated that she never saw anyone with the resident other than the customers that he was speaking with and did not see how the resident got to the store. The law enforcement officer said that the incident occurred around 8:21 PM ". A phone interview was conducted, on 9/13/17 at 8:20 AM, with the law enforcement officer who found the resident on 7/25/17. The officer indicated that she pulled at the store at 8:15 PM on 7/25/17 and noticed Resident # 1 sitting on the concrete sidewalk of the store. The law enforcement officer stated that she approached Resident #1, introduced herself and asked if the resident was hungry or thirsty. She indicated that Resident #1 refused any food or water. She indicated that Resident #1 informed her that someone had left him (the resident) at the store and he was waiting to be picked up. She stated that Resident # 1 provided her with a (family member's) phone number when she inquired about any contact information. The law enforcement officer stated she spoke with the resident's family member who informed her that Resident # 1 resided at Manor Care Nursing Home. The law enforcement officer indicated that she wheeled Resident #1 to the nursing home. She stated that upon reaching the nursing home, she informed a nurse (unsure of her name). The law enforcement officer also stated that the nurse indicated to her that she was about to go to the resident's room for night medications and was not aware the resident was not in his room. The officer indicated that it was around 8:30 PM when she brought Resident #1 to the nursing home.	F 323		

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F 323	Continued From page 5 A phone interview was conducted with Resident #1's family member on 9/12/17 at 4:45 PM. Resident #1's family member indicated that a law enforcement officer had called her on the day of the incident [unsure of the time] and informed her that the resident had given the law enforcement officer her contact number. She stated that the law enforcement officer had informed her that Resident #1 indicated to the law enforcement officer that he was brought to the store by someone and had left him there. She further stated that she informed the law enforcement officer that the resident resided at Manor Care. She stated that the law enforcement officer indicated to her that the resident would be taken back to the facility. She further stated that the resident was able to self-propel his wheelchair. She also stated that the facility had taken precaution to make sure that the incident did not occur again by placing a device on the resident's ankle. She also stated that Resident# 1 had never eloped before and she was not sure why he went outside to the store. Review of investigation statement from the Store clerk dated 7/28/17 revealed Resident #1 had come to the store alone, was sitting outside on the sidewalk and talking to several people coming in and out of the store. The statement also indicated a law enforcement officer came over and started speaking with Resident #1. Later the law enforcement officer pushed the resident's wheelchair and took him back to the facility. The statement also indicated that Resident #1 never entered the store. During an interview with the store clerk on 9/12/17 at 7:50 PM, he stated he observed Resident #1 come down the sidewalk alone. He	F 323		

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F 323	Continued From page 6 further stated that Resident # 1 was sitting on the concrete side walk outside the store beside the window and talking to his customers outside the store. He stated that he did not interact much with the resident. He stated he noticed one of his frequent customers spoke to the resident. He indicated after the law enforcement officer spoke with Resident #1, he took the resident back to the facility. The store clerk also indicated that he was unsure of the time, however as it was summer time there was daylight in the evening. Review of the investigation statement from NA #1 dated 7/26/17 revealed Resident # 1 was approached at around 8 PM or so and asked by NA #1 if he wanted a shower. Resident refused indicating he had a meeting to go to and proceeded toward the master hall nursing station. NA #1 indicated that she looked for the resident a little bit later and could not find the resident so NA #1 notified Nurse #1. The nurse was looking for the resident when the law enforcement officer brought the resident in the door. A phone interview was conducted with Nurse Aide (NA) #1 on 9/14/17 at 10:45 AM. NA #1 indicated that she no longer worked in the facility. She stated that she provided care to Resident #1 on the day of the incident. She stated that around 8 PM she had asked the resident if he would like to take a shower. She stated that Resident # 1 refused indicating that he had a meeting to attend. She stated that Resident #1 would go to a poker game in the activity room and she presumed he was going to the game. She stated that activities had poker games in the activity room some evenings. She stated that Resident # 1 was sitting in his wheelchair at the doorway of his room at that time. She stated that while she	F 323		

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was leaving the resident room to attend to another resident, she noticed the resident was wheeling himself to the other end of the hallway towards room 135, opposite direction from the activity room. She also stated that Nurse #1 was in the hallway passing medications at room 126. She further stated that between 8:10 PM and 8:11 PM she had gone to Resident #1's room to ask about the shower again. She indicated that Resident #1 was not in the room and was not in the bathroom. NA# 1 indicated that she informed Nurse #1 about the resident. NA #1 stated that she was on her way towards the dining hall to look for the resident, when she noticed the law enforcement officer bringing in Resident #1. NA#1 stated that the law enforcement officer had informed Nurse #1 that Resident #1 was at the store behind the facility. NA #1 indicated that the nurse took the resident to his room and did a complete assessment. NA #1 also indicated that the front lobby door was locked after 8 PM. She stated that the front door could be opened from the nursing station at the Rehab unit, or a code could be entered at the door. NA # 1 stated that she did not hear any door alarms sound that night.

During an interview with the Activity Director on 9/14/17 at 11 AM, she indicated that Resident #1 would participate in the poker game which was played once or twice a month from 6 PM to 6:30 PM. She further stated that no activities were usually scheduled after 6:30 PM.

Review of the activity calendar for the month of July indicated that no poker activity was conducted on the day of the incident.

Review of the investigation statement from Nurse

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F 323	Continued From page 8 # 1 dated 7/26/17 revealed Nurse #1 (who was taking care of Resident # 1 on the date of the incident) noticed the resident in his wheelchair in the hallway at start of her shift (7 PM - 7 AM) and during medication pass. Nurse # 1 indicated that she became busy with patient care. Resident #1 was wheeled down the hall by a law enforcement officer who stated that the resident was found at the store and resident had informed law enforcement officer that someone had taken him to the store and left him there. Resident was unable to provide more information as to who took him to the store. The law enforcement officer information was documented in the incident report. The resident was assessed and a shower was provided to the resident as it was his scheduled shower day. The front door was checked at around 9:30 PM and it was locked. 15 minutes checks and one to one observation began, and the resident was assisted to bed. A phone interview was conducted on 9/13/17 at 9:10 AM with the nurse (Nurse #1) who was assigned to Resident #1. Nurse #1 indicated that she no longer worked in the facility. Nurse # 1 stated that earlier in the shift (between 7:30PM - 8PM) she noticed Resident #1 sitting in his wheelchair at the nursing station. She indicated that she was passing medications to other residents at that time. She further indicated that 30 minutes later a law enforcement officer came in with the resident. Nurse # 1 stated that when she interviewed Resident #1, resident stated "They took me to the store and now I am back". She indicated that Resident #1 was unable to elaborate on who "they" were, or elaborate further on the incident. Nurse #1 stated that a full body head to toe assessment was done and that no injuries or bruises were noted. Resident #1 did	F 323		

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not appear confused and was his normal self. Nurse #1 indicated that after Resident # 1 was brought back to the facility by the law enforcement officer, Resident #1 was also provided a shower, placed on 15 minutes checks and later one on one observation. Nurse #1 also indicated that no code purple (a code called out in the facility by staff when a resident was missing) was called. However other nurses did a head count as they observed the resident being brought in the facility by a law enforcement officer. Nurse #1 also indicated that the Director of Nursing (DON) was informed sometime later that night (around 3 AM). Nurse #1 indicated that MD and RP were notified. Nurse # 1 further stated that Resident #1 did not exhibit exit seeking behaviors prior to the incident. Nurse #1 stated that she did not hear any door alarms sound that night.

Review of nursing notes dated 7/25/17 at 9:15 PM read in part: "routine medications administered upon resident's return to unit. Assessment completed in the shower no injuries or skin breakdown, tears or discolorations noted. No unusual odors noted. Mannerisms normal for resident. Fifteen (15) minutes checks were started. The resident was assisted to bed and he was resting quietly".

During an interview with Nurse # 2 on 9/12/17 at 7:10 PM, she indicated that she was working on the opposite hallway and did not hear the exit door alarm sound. She further stated that resident was not exit seeking and usually sat in his room doorway in his wheelchair and observed residents and staff. She also indicated that the resident was able to propel his wheelchair throughout the facility.

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F 323	Continued From page 10 During an interview on 9/13/17 at 7:15 PM, NA #2 indicated that she was working on the opposite hallway and did not hear any door alarm sound the day of the incident. She further stated that she had not noticed the resident at all on the day of the incident as she was not assigned to him. Review of nursing notes dated 7/27/17 at 4:01 PM revealed that for the most part, Resident #1 had been alert and verbal until recently. He had a history of being out of bed daily in a self-propelled wheelchair. The resident was pleasant and joked with staff members as he frequently sat near the nurse's station "people watching." He had no psychiatric issues and behaviors have been limited to occasional sexually inappropriate comments towards women. Resident's depression was being managed without medications and he had not exhibited symptoms of mood changes. Resident had declined recently resulting in one hospitalization and one emergency room (ER) visit in the past month related to cardiac issues. The resident appeared to be weaker than normal and noted to sleep more and sit with his head hanging down while in chair. The resident was exit seeking 7/25/2017 and had since received an order for a Wanderguard which had been placed. One on one had continued to this point and will now be discontinued. While residing at the facility, there were no concerns related to exit seeking before the event on 7/25/17. Medical Doctor (MD) evaluated the resident the morning of 7/27/17 due to cognitive decline. MD ordered the discontinuation of Remeron, Neurontin, and Ultram. A CT (a computed tomography - a machine that makes detailed pictures of parts of human body) of the brain was scheduled. The	F 323		

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resident continued to be observed every 15 minutes. No exit seeking behaviors were noted.

Review of the Physician note dated 7/27/17 revealed Resident #1 tried to elope from the facility on 7/25/17 and was found on the sidewalk of the gas station next door. He had been having increasing confusion and disorientation over the last few days. Remeron (a medication prescribed to treat depression) was prescribed to the resident several weeks ago for appetite stimulant and possibly this could have caused an issue. Remeron was discontinued and will be followed up if no improvement or other changes occurred.

Review of Physician note dated 8/1/17 read in part: "Resident unfortunately was found to have elope(d) last week from the facility. He was gone for an undetermined period of time. It was my opinion, after evaluation and inability to find any kind of reversible etiology for his altered mental status, that Remeron was the agent added for appetite stimulant. This has been discontinued. Today patient (resident) states he feels a little better and not as confused. Altered mental status improving. Plan to continue meds as listed with follow if no improvement".

During an interview with the Director of Nursing (DON) on 9/12/17 at 5:15 PM, DON indicated that she was informed about the elopement at 3 AM on 7/26/17. She stated that Nurse #1 was new to the facility and did not know to inform the administrator. The DON stated that Nurse #1 was made aware of the seriousness of the incident when she reported the incident to other nurses. Nurse #1 was made aware that she should call the DON. The DON also stated that there was a part time receptionist in the front lobby who

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MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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worked till 8:30 PM. DON indicated that front door was locked after 8 PM when there was no receptionist in the lobby. The DON further stated that the residents could sit in the front lobby and porch as long as there was a receptionist watching them. She stated that all exit doors were checked weekly by the maintenance personnel. She stated that Resident #1 must have followed some family members exiting the facility and gone out of the building. DON stated that it was her expectation that the staff observe the residents and if any resident was not accounted for then staff should call a Code purple and follow appropriate procedure. She stated that Code purple was announced on the intercom when any resident was not accounted for. She stated that staff was to do a complete head count of all residents under their care at that time and document it, check for missing resident first inside of the facility including but not limited to resident room, closet, and bathrooms. She stated that if the resident was not found in the building, then few staff would check the entire outside perimeter of the building. She stated that the administration was informed immediately. She further stated that it was her expectation that she would be informed immediately if a resident eloped or was not accounted for.

Review of a nursing notes dated 7/26/17 at 2:35 PM revealed the Director of Nursing (DON) was notified of the incident on 7/25/17. The DON gave instructions to provide one on one supervision for Resident #1 until further notice. A Wanderguard was placed on the resident which he was tolerating well.

During an observation on 9/12/17 at 12 Noon, Resident #1 was observed sitting in a wheelchair

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in his room. Resident #1 indicated he was waiting for his lunch tray. Resident # 1 refused to talk about the incident on 7/25/17.

During an observation on 9/12/17 at 3 PM, Resident #1 was observed sitting in a wheelchair near his room doorway and was watching staff and other residents. The observation revealed the resident had a Wanderguard to his right leg and had a below the knee amputation on the left side. Resident # 1 refused to be interviewed.

During an observation of all the exit doors from the hallway on 9/12/17 at 10:00 AM, the observation revealed all exit doors including the front door had a signage that state "Push until alarm sounds. Door can be opened in 15 seconds". There was a code pad near the doors. Employee exit door in the main hallway had a code pad on it. The door was closed and opened only with a code. The observation of the front door revealed that the front door consisted of 2 doors that were closed and needed to be pushed open. The observation also revealed that the doors had to be held to be kept open and would close when released.

On 9/12/17 at 12:35 PM the alarm system of an exit door in the hallway was observed. The observation revealed that the door needed to be pushed hard for 15 seconds to open. It was also observed that while the door was pushed, the alarm sounded in the building. The alarm could be deactivated when the door closed properly and a code was entered on the code pad near the door. It was also observed that the door needed a code to open without the alarm. However, if the door was kept open for 15 seconds the alarm activated and the door needed to be closed to

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F 323	Continued From page 14 deactivate the alarm. On 9/12/17 at 12:45 PM, an observation of the dirty utility room door opposite to Resident # 1's room revealed the door had a code pad and opened only with a code. The observation revealed that when the door was opened and released, the door slammed shut immediately. The observation also revealed a door on the other side of the room had no code, but had a lever (handle). When the lever was lowered, the door opened to the loading hallway. The door was heavy and needed to be held to be kept open. The door had a key pad for code on the other side of the loading hallway. The loading hallway had an exit door that led to the employee parking lot. The door had no code. The door had a Wanderguard alert system placed. During an interview with the maintenance personnel on 9/12/17 at 5:30 PM, he indicated that the front entrance door automatically locked around 8:05 PM and automatically unlocked after 8:05 AM. He stated that the door needed a code to be opened during that time, if not the alarm was activated. He stated that when a resident with a Wanderguard approached the front door, the door would automatically be locked and the alarm would sound. He also stated that the door and alarms were tested and recorded weekly in Tactical Enterprising logistical System (TELS) report. During an interview with the evening receptionist on 9/12/17 at 6:49 PM, she indicated that she usually worked from 5 PM - 8:30 PM on the weekdays. She indicated that from 8:05 PM to around after 8:00 AM the front door was automatically locked and needed a code to open	F 323		

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the door. She stated that she made sure no resident was sitting in the lobby or on the front porch before the end of her shift. She also indicated that on the day of the incident she did not see the resident near the front lobby.

A walk to the store was completed on 9/12/17 at around 1:45 PM. The walkway around the building was well maintained and had no broken ground areas. The walkway passed through the entrance of employee parking lot and then crossed an open area with some trees and bushes towards the employee parking before reaching the store. The distance between the facility entrance and the store was approximately 400 - 450 feet. The street, usually had light traffic movement.

Review of the official weather report for 7/27/17 revealed 93 degrees Fahrenheit recorded for high and 73 degrees Fahrenheit recorded for low temperatures. Weather report also indicated some clouds with no rain.

On 9/14/17 at 11:50 AM, Corporate Personnel demonstrated the operation of the monitor at the front door from the rehab nursing station. The monitor displayed the picture of the person outside the front door. The monitor had an intercom that can be used to communicate with the person outside the facility. The monitor also had a key button that could open the locked front door. The corporate personnel indicated that this operation was done when the front door was locked at night (after 8 PM) and family member/ visitor needed to visit a resident after 8 PM. The corporate personnel indicated that the staff see who was at the front door at night before the door was opened.

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F 323	Continued From page 16 The Administrator, DON, corporate personnel were notified of Immediate Jeopardy on 9/13/17 at 4:28 PM. On 9/14/17 at 4:42 PM the facility provided the following credible allegation of compliance: The facility Quality Assessment and Assurance committee met on September 13, 2017 and implemented an internal plan of correction due to concerns identified through the complaint process and QA identification. On July 25, 2017 Resident #1 exited the facility at approximately between the hours of 8pm and 8:21pm. The resident was last seen at approximately 8pm when he was offered a shower and refused and was seen sitting at nursing station. At approximately between 8pm and 8:21pm, according to staff statements, they started looking for resident. When search was initiated Resident #1 was returned to center by police officer. The resident returned to his room and was reevaluated and a head to toe skin assessment was completed and care plan was updated on 7/26/2017. Resident #1 did not have any injuries upon assessment which is documented in progress notes on 7/25/2017. Investigation was initiated on 7/26/2017 and an internal plan of correction was developed on 7/26/2017 proactively to ensure wanderguard monitoring and door alarm system function and monitoring was in continued compliance. This included like residents that are at risk for elopement was in place and in compliance. During the investigation the root cause was identified as the resident exhibited a change in	F 323		

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F 323	Continued From page 17 condition on the day of the event that he exited the facility. The facility could not identify which door Resident #1 exited, however it was determined based on staff interviews conducted on 7/26/2017 that no alarm was heard or silenced. Maintenance director checked all doors on 7/27/2017 and found none disarmed and all were working properly. Furthermore, the maintenance director went to each door to check system and found wanderguard system had no malfunction identified and was in working order. Current doors alarm and releases after 15 seconds of constant pressure as per Life Safety guidelines. Investigation found no issues in this area and doors and alarms functioning correctly requiring no outside intervention. Resident #1's care plan was updated to prevent reoccurrence. The facility's internal proactive plan of correction did not address like residents as this was considered isolated and not a systemic failure. However a plan of correction has been updated to include the following to address like residents who may experience a change in condition to ensure staff is prepared proactively to respond and prevent a reoccurrence or like incident. Immediate Corrective Action " The Director of Nursing/ Unit Manager/ Maintenance director inserviced all staff on all shifts on code purple drills which was initiated on 7/26/2017 and completed on 7/27/2017 " Exit seeking evaluations were completed on residents who wear wanderguards and this was completed on 7/26/2017 " Log book documentation was in place for door alarms and wanderguards systems. The documentation reflects monitoring was completed	F 323		

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F 323	Continued From page 18 on 7/25/2017 and has occurred weekly. " Investigation of Resident #1 exiting the facility was completed on 7/27/2017 " An Ad Hoc committee which included payroll, business office manager, unit manager's, social service director, admissions director, dietician, food service director, MDS, director of rehab, DON, Maintenance director, Administrator, and Housekeeping supervisor held 9/13/2017 to address additional plan of correction " The facility will continue to monitor the wander guard system through our current Maintenance system which is checked weekly for functionality. " The Identified Resident care plan and interventions were updated at the time of the incident and plan has been effective in preventing reoccurrence. The care plan included but not limited to the following: o Allow to wander inside the facility and redirect as needed o Check alert bracelet (Wanderguard bracelet) q shift and function q day o Escort to and from dining room and activities o wander guard bracelet o frequent checks of patient location o Provide directional cues to include name on Resident #1's door to assist him with location of room " Department heads will educate starting 9/13/2017 facility staff (Nursing, Dietary, Housekeeping, Activities, Therapy, Administration) on the LOA (Leave Of Absence) policy and the Administrator will send on 9/14/17 a form letter to families to ensure all understand the LOA policy components. This is not a new policy and education is being done proactively for residents who leave the facility with or without family via doctor's orders. This policy is not	F 323		

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F 323	Continued From page 19 relevant to the incident that occurred on 7/25/2017 but is being done proactively. " Department Heads will educate starting 9/13/2017 facility staff (Nursing, Dietary, Housekeeping, Activities, Therapy, Administration) on behaviors that are indicative of potential changes and exit seeking behavior and steps to take to prevent unsafe exit from the facility. " Door codes were changed by Maintenance Director proactively on 7/27/2017 and will be changed again proactively 9/13/17 " Administrator or designee will educate facility staff starting on 9/13/2017 (Nursing, Dietary, Housekeeping, Activities, Therapy, Administration) not to share door codes proactively " The Medical Director was notified on 9/13/2017 of citation and plan of correction that has been developed. " Inservices started on 9/13/2017 and will continue until all staff is inserviced. This will be accomplished by staff that has not been educated will be educated before they start their shift ongoing until completed. An employee roster list was established and as people complete their inservicing they are highlighted off so facility clear system to manage completion of training. New hires will be inserviced as part of their orientation process. " Any staff that has not been educated will be educated before they start their shift ongoing with new hires as well. The credible allegation was validated on 9/14/17 at 8:00 PM. The survey team confirmed the completion of wandering assessments for all resident with a potential for elopement. The MDS and care plans were verified for updates for	F 323		

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F 323	Continued From page 20 residents with potential for elopement. The updated "missing resident" wandering/elopement notebook was verified. The survey team also verified the Treatment Administration Record (TAR) for monitoring of placement and functionality of wanderguard on every shift daily for residents with Wanderguard. Resident #1 had a medical procedure and was not in the facility at the time of verification to determine if the Wanderguard was in place, however other residents with Wanderguards were observed and their Wanderguards were in place and functioning. The alarms on all the exit doors were tested and were confirmed to be working properly. Wanderguard was tested near the front door to ensure the front door was locked when the Wanderguard was near the door. The observation revealed that the front door was locked and alarm activated. The alarm was deactivated with a code. Staff were interviewed to verified education on the Code purple [Missing resident] and procedure to follow when the missing resident code was announced.	F 323		
F 520 SS=J	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee;	F 520		

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

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F 520	Continued From page 21 (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, law enforcement officer interview, and the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 2/03/17 recertification survey to correct a deficiency in the area of accidents (F323), which was subsequently recited on 9/14/17 on this complaint	F 520	**Identified Resident** No residents were identified. **Like Residents** Director of Nursing determined that all residents have the potential to be affected by this practice. **Systemic Changes** The Quality Assurance Consultant educated the leadership team regarding the QAA process on September 14, 2017. Department heads educated all staff (nursing, housekeeping, maintenance, dietary, activities, therapy and administration) regarding the QAPI process on September 14, 2017. The education sign in sheets will be filed in Human Resources. Any Full –time or part time employees not educated on September 14, 2017 will be educated by the Department Supervisors prior to working.	10/6/17

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F 520	Continued From page 22 investigation. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program. Immediate Jeopardy began on 7/25/17 when Resident #1 exited the facility unsupervised and was found outside, after an undetermined amount of time, by a law enforcement officer on the sidewalk at a convenience store behind the facility. The Immediate Jeopardy was removed on 9/14/17 when the facility's acceptable credible allegation of compliance was verified. The facility will remain out of compliance at a lower scope and severity level of D (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 Included: This tag is cross referenced to F 323 - Based on observations, record review, staff interviews, and law enforcement officer interview, the facility failed to provide supervision to prevent the elopement from the facility for 1 of 5 moderately cognitively impaired residents reviewed for accidents (Resident # 1). On 7/25/17 Resident # 1, unsupervised by staff, exited the facility by wheelchair and traveled approximately 440 feet (146 yards) to a convenience store behind the facility on a sidewalk. Resident #1 was located by a law enforcement officer and was returned to the facility with no injuries after an undetermined amount of time outside of the facility.	F 520	New hires will be educated by the Department Supervisors or Human Resource Director during orientation. **Monitoring** The Quality Assurance consultant (assigned by corporate), Regional Director of Operations and or The Senior Administrator conduct random audits weekly times four, then monthly times six to validate compliance with the Quality Assurance Program which will include review of the facility self - identification, documentation and internal plan of corrections. Administrator will review compliance for the QAA process monthly times three then quarterly thereafter. Results of the reviews will be submitted to the QAA committee for further recommendations as appropriate.	

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F 520	Continued From page 23 During the recertification survey of 2/03/17, the facility was cited at F323 for failure to maintain a safe environment by allowing one sampled resident using oxygen via portal tank adjacent to another resident who was actively smoking. On the current complaint survey of 9/14/17 the facility was cited at F323 for failure to provide supervision to prevent elopement from the facility of a moderately cognitively impaired reviewed for accidents. An interview with the Administrator on 9/14/17 at 7:45 PM revealed the facility had a Quality Assurance and Performance Improvement (QAPI) program in place. Administrator indicated that the QAA committee consisted of himself, Director of Nursing, Minimum Data Set coordinator, Medical Director, Business Office Manager, Dietary Manager, All Department heads and the Admissions Coordinator. He indicated that team met during daily stand up meeting, monthly reviews and quarterly assessment. He indicated that the team discussed on-going issues, has an audit program, tracked and trended the problem and planned training and education process based on the trends. The Administrator, DON, corporate personnel were notified of Immediate Jeopardy on 9/13/17 at 4:28 PM. On 9/14/17 at 4:42 PM the facility provided the following credible allegation of compliance: The facility Quality Assessment and Assurance committee met on September 13, 2017 and implemented an internal plan of correction due to concerns identified through the complaint process and QA identification. On 9/13/2017 facility was notified that areas of	F 520		

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F 520	Continued From page 24 concern would be cited as an Immediate Jeopardy. On July 25, 2017, Resident # 1 exited the facility at approximately between the hours of 8pm and 8:21pm. The resident was last seen at approximately 8pm when he was offered a shower and refused and was seen sitting at nursing station. At approximately between 8pm and 8:21pm, according to staff statements, they started looking for resident. When search was initiated Resident # 1 was returned to center by a law enforcement officer. The resident returned to his room and was reevaluated and a head to toe skin assessment was completed and care plan was updated on 7/26/2017. Resident #1 did not have any injuries upon assessment which is documented in the progress notes on 7/25/2017. Investigation was initiated on 7/26/2017 and an internal plan of correction was developed on 7/26/2017 proactively to ensure wanderguard monitoring and door alarm system function and monitoring was in continued compliance. This included like residents that are at risk for elopement was in place and in compliance. During the investigation the root cause was identified as the resident exhibited a change in condition on the day of the event that he exited the facility. The facility could not identify which door Resident # 1 exited, however it was determined, based on staff interviews conducted on 7/26/2017, that no alarm was heard or silenced. Maintenance director checked all doors on 7/27/2017 and found none disarmed and all were working properly. Furthermore, the maintenance director went to each door to check system and found wanderguard system had no malfunction identified and was in working order. Current doors alarm and release after 15 seconds of constant pressure as per Life Safety	F 520		

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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
F 520	Continued From page 25 guidelines. Investigation found no issues in this area and doors and alarms were functioning correctly requiring no outside intervention. Resident #1's care plan was updated to prevent reoccurrence. The facility's internal proactive plan of correction did not address like residents as this was considered isolated and not a systemic failure. The facility has routine quality assurance meetings which include the Administrator, Director of Nursing, Medical Director and Department Heads. The facility quality assurance committee met on 7/26/2017 related to Resident #1 and developed an internal plan of correction. However a plan of correction has been updated to include the following to address our quality assurance process which will include additional monitoring by non-facility personnel to facilitate continuous quality improvement and give guidance to try to prevent adverse incidents. Immediate Corrective Action " An Adhoc meeting will be held on 9/14/2017 which will include the Administrator, Director of Nursing, Activities, Therapy, Maintenance, and housekeeping to discuss additional plan of correction for our quality assurance program " The Administrator will notify the Medical Director on 9/14/2017 on new area of concern and plan of correction to address quality assurance process " The Department heads and quality assurance consultant will inservice all staff on all shifts on the quality assurance process and how to bring any concerns to the committee for review and consideration " Inservices started on 9/14/2017 and will continue until all staff is inserviced. This will be accomplished by staff that has not been educated will be educated before they start their shift	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 09/14/2017

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F 520	Continued From page 26 ongoing until completed. An employee roster list was established and as people complete their inservicing they are highlighted off so facility has a clear system to manage completion of training. New hires will be inserviced as part of their orientation process. " The Quality assurance consultant (assigned by corporate), Regional Director of Operations and or Senior Administrator will conduct monthly random audits weekly for 4 weeks and then monthly for 6 months to validate compliance with the Quality Assurance program which will include review of facility's self-identification, documentation and internal plan of corrections. " Data collected by audits will be taken to QA for further review and recommendation. The Administrator is responsible for attaining and maintaining compliance, and will do this by submitting findings of audits and validation to the Quality Assurance Committee for further review and recommendations as needed, monthly times 6 months and as indicated thereafter. The credible allegation was validated on 9/14/17 at 8:00 PM. The survey team confirmed through interviews with the Administrator and all department heads for the QAPI program. Administrator indicated that the Medical director was informed of F520. Administrator stated that the Quality assurance consultant (assigned by corporate), Regional Director of Operations and or Senior Administrator will conduct random audits weekly for 4 weeks and then monthly for 6 months to validate compliance with Quality Assurance (QA) program. The survey team also validated the credible allegation for F323 with confirmation of the completion of wandering assessments for all resident with a potential for	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 520	Continued From page 27 elopement. The MDS and care plans were verified for updates for residents with potential for elopement. The updated "missing resident" wandering/elopement notebook was verified. The survey team also verified the Treatment Administration Record (TAR) for monitoring of placement and functionality of Wanderguard on every shift daily for residents with Wanderguard. Resident #1 had a medical procedure and was not in the facility at the time of verification to determine if the Wanderguard was in place, however other residents with Wanderguards were observed and their Wanderguards were in place and functioning. The alarms on all the exit doors were tested and were confirmed to be working properly. Wanderguard was tested near the front door to ensure the front door was locked when the Wanderguard was near the door. The observation revealed that the front door was locked and alarm activated. The alarm was deactivated with a code. Staff were interviewed to verify education on the Code purple [Missing resident] and procedure to follow when the missing resident code was announced.	F 520		