STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345481	A. BUILDING _____ B. WING _____	C 08/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS NURSING & REHABILITATION CENTER	400 PELT DRIVE FAYETTEVILLE, NC 28301

(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 08/23/18 through 08/25/18. Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/17/18 and was removed on 08/25/18. A partial extended survey was conducted.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and staff interviews, the facility failed to prevent resident to resident abuse in the form of inappropriate touching for one of three residents reviewed for abuse (Resident #3). Resident #2 was observed to have his hand underneath the	F 600	Plan to correct specific deficiency and facts that led to the alleged deficient practice: Resident #3 and Resident #2 observed by staff in main dining area of facility interacting and communicating between	9/10/18

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

Electronically Signed | 09/07/2018

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F 600	Continued From page 1 Resident #3 ' s dress with Resident #2 ' s hand moving up and down near Resident #2 ' s groin area. Resident #3 was assessed by two facility nurses and was found to have tender labia tissue. Findings included: 1a. Resident #3 was admitted to the facility on 2/8/18 with the diagnosis of unspecified dementia without behavior. A review of the quarterly Minimum Data Set dated 7/10/18 revealed the resident had adequate hearing, clear speech, usually understands, and was understood. The resident was unable to complete the cognitive assessment. The resident required extensive assistance for all activities of daily living. The active diagnosis was non-Alzheimer ' s dementia. On 8/23/18 at 4:00 pm Resident #3 was observed sitting in her wheel chair with a private aide present in her room. The private aide had to speak up and face the resident for the resident to hear. The resident was oriented to self with limited orientation to situation. While in Resident #3 ' s room, Resident #2 attempted to enter, and the private aide informed Resident #2 to "get out of here." Resident #2 stated he wanted to talk to the Surveyor. Surveyor exited Resident #3 ' s room and staff escorted Resident #2 away. Both Resident #2 and #3 reside on the same hall. The facility ' s video surveillance (no sound) dated 8/19/18 was reviewed and revealed Resident #3 inappropriately touched Resident #2 as follows: · At 9:58 pm Resident #3 was alone in the (dining room) DR.	F 600	the hours of 8:30 pm and 10:26 pm on 8/19/2018. Staff monitoring frequently and offering to assist resident #3 to retire for the evening, however resident #3 declined assistance to bed when offered, more than 1 time. At approximately 10:26 pm Nursing Assistant #2 rounding to monitor resident #3 observed resident #2 with right hand under dressing gown on top of resident #3's left thigh area. Resident #3 immediately assisted from dining area, by Nursing Assistant #2 and discontinued the interaction with resident #2 upon observing resident #2 with hand located under resident #3's gown on top of her left thigh. Nursing Assistant #2 immediately reported observation and concern to licensed nurse. Licensed nurse immediately to resident #3's room for assessment. Nursing Assistant #2 provided resident #3 with incontinent care, due to noted bowel movement present. Licensed nurse notes following incontinent care of bowel movement resident seemed 'tender' to labia area. Resident #2 immediately placed under direct staff supervision with a ratio of 1:1. 100% of all other residents assessed by licensed staff through an interview process with BIMs scores of >12 regarding inappropriate touching by others with no further concerns reported. Completed 8/24/2018.	

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F 600	Continued From page 2 · At 10:03 Resident #2 returned to the DR near the computer and was observed frequently stroking his own head. · At 10:08 pm Resident #2 placed his scooter to the right of Resident #3 ' s wheel chair parallel. Resident #3 was noted to be fidgeting quickly with the towel that was on her lap. Resident #2 ' s arm can be seen over the right side of his scooter and his forearm and hand are not visible. Resident #3 ' s dress appears to be moving up and down in the center of her dress near her groin. Resident #3 began folding and unfolding the bib towel on her lap nervously during this encounter. Resident #2 ' s hand and arm appeared to be under Resident #3 ' s dress. Resident #3 ' s hand was observed to push at Resident #2 ' s arm. Resident #3 ' s dress continued to move up and down in the center of her lap near her groin and she continued to nervously fold and unfold the towel on her lap and on the right wheel chair arm until staff arrived. Total encounter time of Resident #2 was alone and inappropriately touched Resident #3 in the DR was 18 minutes. · At 10:26 pm Nursing Assistant (NA) #2 arrived to get Resident #3 and quickly wheeled her out of the DR. When Resident #3 was wheeled away from Resident #2 ' s scooter in plain front view of the camera her dress on the right side was up to her upper thigh/groin and the left side of the dress was down below her knee. 1b. Resident #2 was admitted to the facility on 6/28/18 and had the cumulative diagnoses of metabolic encephalopathy and unspecified dementia without behavioral disturbance.	F 600	100% of all other residents with BIMs scores <12 were physically assessed by licensed staff for any signs/symptoms of abuse/neglect/mood changes/behavior changes such as changes in eating/sleeping patterns, with no further concerns noted. Completed 8/24/2018 Procedure for implementing a plan of correction for the alleged deficient practice Resident #2 continued with 1:1 staffing ratio, medical record reviewed by Director of Nursing on 8/20/2018, behavior of inappropriate touching reported to M.D. It was noted by Director of nursing during medical record review, there was a pending urine culture/sensitivity from a urine collected on 8/17/2018 when resident complained of burning upon urination. Results of the 8/17/2018 urinalysis obtained and resident noted with rather significant urinary tract infection, results reported to M.D. with orders received for antibiotic therapy which was initiated 8/20/2018. 1:1 staffing removed once antibiotic therapy initiated however resident remained on close observation with no further behaviors noted. Resident placed back on 1:1 supervision on 8/24/2018 to ensure no further behaviors exhibited; resident #2 was noted to attempt to enter resident #3's room on 8/24/2018 to speak to her while a private care taker was at the bedside, the caretaker requesting resident #2 not speak to resident #3 therefore 1:1 staff ratio re-initiated. Resident remains	

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F 600	Continued From page 3 A review of the quarterly Minimum Data Set dated 6/11/18 revealed the resident had adequate hearing, clear speech, and understands and was understood. The cognition was intact, and no behaviors were exhibited. The resident required limited assistance with bathing and dressing, and supervision for transfer and meals. Locomotion was set up only. Active diagnosis was non-Alzheimer ' s dementia. Health note dated 8/20/18 at 11:43 am the resident was diagnosed with a urinary tract infection from culture and antibiotics were ordered. (no mention of behavior change). Nurses ' note dated 8/20/18 late entry for 8/19/18 the resident was placed on 1:1 supervision for allegation of abuse. The resident had unusual behavior (type not provided). Assessment on 8/20/18 revealed the resident had no behaviors and was started on antibiotics 8/20/18. Nurses ' note 8/21/18 late entry: the resident continued on antibiotics. No additional behaviors noted. Interviews of staff reveal no further episodes of inappropriate behaviors no further inappropriate jesters or touching. Will schedule psychiatry evaluation and follow. Psychiatry appointment scheduled for 8/24/2018. The staff will continue to monitor. Plan of care updated 8/20/2018. Nurses ' note dated 8/23/18 late entry: On Monday night, 8/20/18, the resident stayed in his room for the duration of my shift, 11:00 p.m. - 7:00 a.m. He was under constant monitoring during the shift. There was a Certified Nursing Assistant posted on the hall and the medication aide was at the nurse's station. This resident did	F 600	under direct supervision at this time. 100% staff education initiated 8/24/2018 to include supervision of residents, emphasizing to staff to monitor for residents with behaviors that deviate from the norm, such as making sexual advances towards others. This education was initiated by the director of nursing with assistance from the regional staff developer and the regional clinical consultant. Education included: Monitoring for residents who may turn off lighting, residents sitting too closely together, inappropriate touching, and removing cognitively impaired patients from inappropriate settings immediately. All education will completed on or before 9/10/2018 and will include all newly hired associates during the orientation process prior to working independently. The Director of Nursing will ensure all associates receive the education in coordination with the Unit Managers and Administrator. Monitoring Procedure The Director of Nursing and/or Unit Managers will interview 2 non-clinical and 2 clinical staff members weekly regarding their level of understanding related to the 7 types of abuse, those who are able to give consent, signs/symptoms of abuse, and how to report. The monitoring began on 9/4/2018. The Director of Nursing will collect and maintain interviews in the Director of	

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F 600	Continued From page 4 not come out of his room or interact with any residents at any time during this shift. On 8/23/18 at 3:45 pm an interview was conducted with Resident #2 who was oriented to self, situation, and time. Resident #2 was able to remember and state to provide detail of 8/19/18 in the dining room when Resident #3 was present. Resident #2 stated that he was in the dining room listening to music on the computer. Resident #3 was there. Resident #2 stated that was the first time he had touched Resident #3 (Resident #2 was smiling). Resident #2 commented that many of his friends in the facility had died or were sick and not able to visit with him. Resident #2 did not comment on what the facility staff said to him about Resident #3. On 8/23/18 at 4:00 pm an interview was conducted with Resident #3 ' s private aide who stated she was aware of an altercation between Resident #2 and Resident #3. The private aide stated that Resident #3 was a religious person and would not consent to sexual relations in a public place with a man she does not know. The private aide stated that the resident had dementia and was not able to consent to sexual relations. The resident was frequently confused and not oriented to her surroundings. On 8/23/18 at 4:30 pm an interview was conducted with NA #2 who stated on 8/19/18 at approximately 10:25 pm the NA entered the DR to retrieve Resident #3 to help her get to bed. NA #2 stated upon entry to the DR and walking near to Residents #2 and #3 that were next to each other, NA #2 observed Resident #2 with his hand and forearm under the dress of Resident #3 and her dress moving up and down near her groin.	F 600	Nursing office and the results of all interviews and observation during daily rounding to the weekly QA committee to ensure corrective action for trends or ongoing concerns is initiated immediately by ensuring 1:1 staffing ratio for those residents who exhibit inappropriate behavior and the staffing level will continue until interdisciplinary team, ie. clinicians, physician, Nursing Assistants, etc. provide assessment that deems resident appropriate to interact with general resident population. The monitoring will be reviewed by the weekly QA committee for a minimum of 3 months and will continue until no longer deemed necessary.	

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F 600	Continued From page 5	F 600		

When Resident #2 saw NA #2, he moved his hand down to the resident ' s sock and touched it. NA #2 noted that Resident #3 had brown matter on his fingers and nails that resembled stool. NA #2 stated that Resident #3 looked nervous and was fidgeting with her towel bib which was unusual. NA #2 stated that she immediately took the resident to her assigned nurse, Nurse #2, and informed her of what she observed. Nurse #1 was also informed of NA #2 ' s observation for a second witness. NA #2 stated that Nurse #s 1 and 2 took Resident #3 to her room to assess her. NA #2 was directed to find Resident #2 and to supervise him. NA #2 found Resident #2 in the hall bathroom washing his hands of brown matter. NA #2 asked Resident #2 what he was washing, and he stated nothing. NA #2 supervised Resident #2 for the remainder of the shift.

On 8/23/18 at 5:55 pm an interview was conducted with Nurse #1 who stated she was informed by NA #2 that Resident #2 had his hand moving up and under the dressing and inside the undergarment of Resident #3. NA #2 also stated that she thought Resident #2 had penetrated Resident #3 ' s private with his hand. Nurse #1 stated that she and Nurse #2 assessed Resident #3 who had stool in her undergarment. After incontinence care Nurse #2 assessed that Resident #3 was tender upon touch of her labia with no other injury noted. Nurse #1 stated that Resident #3 could not give consent to sexual contact due to cognitive deficit and was not able to make decisions due to a cognitive deficit.

On 8/24/18 at 6:30 pm an interview was conducted with the DON who stated Resident #3 ' s resident representative was informed of the inappropriate touching on 8/20/18 after the DON

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F 600	Continued From page 6	F 600		

had the opportunity to review the video recording and speak to staff.

On 8/24/18 at 6:30 pm an interview was conducted with the DON who stated Resident #2 had his first psychiatry evaluation yesterday and was placed on an anti-depressant after the death of his son. Psychiatry was to follow. On 8/23/18 a second counseling was done by the DON with Resident #3 which was more successful than the first counseling on 8/20/18. The resident was more receptive and made some of the same comments to the DON that he made during surveyor interview, except he did not admit inappropriately touching the resident. Resident #2 commented they were friends and he knew the family (of Resident #3). Documentation was provided of the counseling. The DON stated that she now understood a resident with a cognitive deficit cannot give sexual consent and informed Resident #2 that touching was not permitted and what he did not wrong. Resident #3 was supervised 1:1 for 24 hours and is currently continuously staff supervised throughout the facility for his interaction with all residents.

During the course of the survey Resident #2 was observed to have free movement in his scooter throughout the facility. He was not observed communicating with Resident #3.

On 8/24/18 at 6:30 pm an interview was conducted with the DON. The DON stated that she now understood a resident with a cognitive deficit cannot give sexual consent and informed Resident #2 that touching was not permitted and what he did not wrong. Resident #3 was supervised 1:1 for 24 hours and is currently continuously staff supervised throughout the

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F 600	Continued From page 7	F 600		

facility for his interaction with all residents. She stated Resident #3 ' s resident representative was informed of the inappropriate touching on 8/20/18 after the DON had the opportunity to review the video recording and speak to staff.

On 8/24/18 at 6:45 pm an interview was conducted with the Administrator who stated that he was aware of the altercation between Residents #2 and #3. The DON was handling the facility investigation and staff education and the 24 hour and 5-day report to the State.

On 8/25/18 at 12:15 pm an interview was conducted with NA #3 who stated she had worked at the facility for a year and was very familiar with Resident #2. The inappropriate touching was a new behavior. NA #3 stated that when she entered the dining room (DR) some of the lights were out. She checked both residents and there was nothing wrong. The lights were sometimes turned off to watch a movie on television (TV) in the DR. The TV was playing at the time she checked the DR and did not think anything was wrong with the lighting. There were always two emergency lights on in the back of the DR. The two residents knew each other and have talked many times before in various places of the facility. Resident #2 was known by this staff member for almost a year and has not had any of this type of behavior before. The management did educate and set up a plan for the resident to be watched throughout the facility for his interactions with all residents after the incident. The resident was care planned for behaviors and Resident #2 was monitored for his communication/interaction with all residents. Resident #2 was currently under close observation.

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, video surveillance recording review, and resident and staff interviews, the facility failed to maintain a safe environment for a cognitively impaired, wandering resident for one of three residents reviewed for accidents (Resident #1). Resident #1 had an expired wander guard bracelet which did not trigger-lock the exit door and the resident was able to exit the facility unsupervised. Immediate jeopardy (IJ) began on 8/17/18 when Resident #1 exited the facility unsupervised, was missing for 40 minutes, and was found in a heavily wooded area adjacent to the facility property. The IJ was removed on 8/25/18 when the facility implemented a credible allegation of IJ removal. The facility will remain out of compliance at a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service. Findings included: Resident #1 was admitted on 8/15/18 with the cumulative diagnoses of dementia with Lewy	F 689	Plan to correct specific deficiency and facts that led to the alleged deficient practice: The resident was admitted to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement; therefore wanderguard bracelet was initiated and added to the patient□s plan of care. He has the diagnosis of Lewy Body Dementia. On August 17th 2018 at 12:37 pm, resident # 1 went out the back door and walked across the parking lot to the wooded area adjacent to the facility. He said he was looking for his wife. The resident was found in the woods around 1:40 pm. The resident was assessed by the nurse upon entering the facility on August 17, 2018 and the MD and RP were notified of the event. There were minor scratches noted to resident□s legs. 1:1 was initiated for this resident to ensure his safety. 1:1 was maintained 24 hours a day from 8/17/18 immediately upon return to the facility until 8/20/18 at 11 PM.	9/10/18

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F 689	Continued From page 9 bodies, dementia with other diseases, behavioral disturbances, auditory and visual hallucinations, diabetes, and depression. The 5-day, in-progress Minimum Data Set (MDS) dated 8/20/18 for Resident #1 was reviewed and revealed an assessment of adequate hearing, clear speech, was understood and sometimes understands. Cognition was severely impaired. His mood was little interest in doing things and there were no behaviors. The remaining assessments were not completed. The resident participated in the assessment. The resident ' s care plan was updated on 8/17/18 to reflect wandering behaviors. An elopement incident report dated 8/17/18 was completed. The elopement was within the first 72 hours of admission and the resident ' s wander guard (WG) [radio emitter bracelet that locks or alarms the exit door when approached] was expired. Resident #1 ' s 8/17/18 elopement was observed on 8/23/18 of the facility ' s surveillance video camera numbers 7, 19, 25, 26, 27, and 31 which record the resident halls and exit doors. The video recording had no sound. On 8/17/18 at 12:26 pm the resident was observed fully dressed in sneakers, wearing a baseball cap, looking around on the sloped hall that has exit doors to the two gated courtyards with an entry door that enters at the end of hall 500 with a facility exit door (door has a wander guard alarm). At 12:31 pm the resident was observed to enter	F 689	Investigation completed and found that the wanderguard placed on the resident was expired therefore interdisciplinary team members concluded with the placement of an active non-expired wanderguard, all other wander management systems were functioning, therefore wander management system would keep resident sufficiently monitored. Upon return to the facility on 8/17/18, resident□s wanderguard was immediately replaced by the Director of Nursing with a current wanderguard (i.e. one not expired). An REQ (Review to Ensure Quality) was initiated on 08.17.18. The wanderguard was found to be not be working correctly because it was expired, expiration date was noted to be 3/2018. Expired wanderguard bracelet was found to be the root cause for the deficient practice. The wanderguard bracelets for this particular wandering monitoring management system have an expiration date or □life□ of approximately 3 years, unfortunately the wanderguard bracelet placed on this patient expired 3/2017; the licensed nurse who applied the watchmate bracelet was not aware of the expiration date when she applied the wanderguard bracelet to the patient. The licensed nurse had not received education that the wanderguards had expiration dates. The wanderguard was retrieved from a locked cart located at the nursing station of the 300/400 hall area, located central within the facility.	

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F 689	Continued From page 10 the gated-locked court yard from the long-sloped hall that leads to hall 500 with a facility exit door. At 12:37 pm the resident re-entered the building into hall 500 from another door in the court yard that is near the facility exit door. At 12:37 pm the resident walked through hall 500 ' s facility exit door. The door did not lock. The resident was observed to run across the pavement into the nearby woods. At 1:06 pm 4-5 staff members were observed to be looking in all rooms from cameras 25, 29, 31. At 1:09 pm a staff member was observed to exit the building looking around the facility grounds. At 1:16 pm staff used camera recordings to view the resident ' s activity (per Maintenance Manager who is responsible). At 1:30 pm the Director of Nursing (DON) was observed on recording to enter the woods across the pavement from hall 500 ' s facility exit door. At 1:31 pm five staff members were observed on recording to enter the woods behind the DON with 2 more staff immediately behind them. At 1:40 pm the resident was recorded walking back from the woods with staff. Timeframe 12:37 pm leaves building and 1:40 pm resident walked back to the building with staff. On 8/23/18 at 9:45 am an observation was done of Resident #1 in his room. The resident was sitting on his bed and was observed to ambulate	F 689	The cart was audited to ensure no other expired wanderguard bracelets, as was all other storage carts located within the facility, nursing stations, desk, offices, central supply units, and maintenance shop. All audits of these areas were complete by close of business on Friday, August 17, 2018. Director of nursing ensured all audits were sufficiently completed. Procedure for implementing a plan of correction for the alleged deficient practice On 08.17.18, the Unit Manager and the scheduler, checked 100% of all the other residents with wander guards in use residing within the facility which include 6 total skilled residents, there were no other wander guards found expired and all were functioning properly. The wander guard bracelets were checked by utilizing the manufacturer (wanderguard checker□); when placed directly beside the wanderguard the transmitter will beep repetitively and a light turns green located on the □checker□. On 08.17.18, the Director of Nursing began in-servicing all nurses on the following: " Elopement Prevention and Maintenance with Wanderguard alarm systems. o All resident will be assessed on admission and quarterly for elopement risk. o Residents found at risk shall be	

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	345481	A. BUILDING _____ B. WING _____	C 08/25/2018

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F 689	Continued From page 11 independently and steadily. There was a sitter in the room with 1:1 supervision. The resident had minor scratches to his arms and legs that were healing. The resident walked to the front door with staff and the wander guard triggered the door to lock. The door would not open until the resident stepped 10 feet away from the door. The door was opened by an oncoming visitor who had a resident with him wearing a wander guard and the alarm sounded. On 8/23/18 at 10:15 am an interview was conducted with the Maintenance Manager (MM) who stated that there was an elopement on 8/17/18. The staff could not find Resident #1 in the building so the MM provided the facility camera recording and the resident was observed to exit out of the main rehabilitation exit door on Hall 500. The wander guard did not alarm. On the film the resident was seen exiting to the gated courtyard on the long main hall that leads to hall 500 and re-entered onto hall 500 nearest to the hall 500 exit door (which bypasses the nursing station) and exited the building. While in the building, the resident was video recorded looking around for staff before he eloped. The resident was seen on camera running into the woods. Five staff members looked for the resident who was found in the woods next to the facility. The resident had minor scratches from the brush. The resident had to be coaxed and led by his hand to return to the facility. MM checked the wander guard and it was not working, it had expired. The door was checked with a working wander guard and it locked. The exit doors that have alarms and wander guard locking mechanisms are checked weekly and found to be working.	F 689	identified by staff in the care plan and care guides. o Transmitter bracelets (wanderguard) will be attached to wrist or ankle after being checked for expiration date and tested to make sure they were functioning properly. " Return demonstration of how to find expiration date to ensure that it is not expired on the wander guard device and how to check to ensure it is working. " All nursing staff (RN, LPN, Nurse Aide) to be trained prior to being allowed to work, this includes full time, part time and PRN employees. " This will also be added to the facility new hire orientation. Education began on 8/17/18 and 100% of employees will be re-educated on or before 9/10/2018 to include new hires which will be educated during the orientation process. Employees will not be permitted to work until they have received this education. The Maintenance Director added alarming boxes 8/25/2018 before 12:00 pm to the exit doors which lead to the patio area or any other exit area with the potential that have on/off switches for exterior gates with keypads and/or the doors are found to be otherwise not monitored. The alarming boxes will alert the staff anytime the doors exiting to the patio or gated areas are opened. All doors and alarms are checked daily by maintenance director or managers on duty. However, on 8/23/18 the	

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F 689	Continued From page 12 On 8/23/18 at 10:30 am an observation was done of the MM ' s evaluation of all facility exit doors. Hall 100 ' s emergency exit door that was required to alarm when opened was shut off and did not alarm. The MM used a key to turn the alarm on and it tested okay. On 8/24/18 at 9:40 am an interview was conducted with Nurse #1 who was assigned to Resident #1 on 8/17/18 day shift. Nurse #1 had worked at the facility for approximately 20 years and was very familiar with the facility policy. Nurse #1 stated she noticed Resident #1 was missing on 8/17/18 at approximately 12:45 pm. The resident had recently been to therapy and was sitting in a chair at the nurses ' station. Nurse #1 looked on hall 400 to find the resident and he was not found so the DON was notified, and a code PINK was called. Code PINK is where all the rooms in the facility are checked and the surveillance cameras are observed to evaluate for exiting activity. Nurse #1 stated she does not remember the time the resident was identified on camera recording when he left the building through hall 500 exit door. Nurse #1 stated that the resident was found in the woods adjacent to the facility. When the resident was first seen he proceeded to run. The resident was gone (missing) for approximately 20 - 30 minutes. The resident was assessed, and no injury was found. The resident ' s wander guard was not operating. Nurse #1 also stated that Resident #2 was admitted the day before he eloped and had a wander guard placed. Nurse #1 stated she had not known that the resident was a wanderer. The wander guards were checked every night shift with a testing device and there was a listing of all	F 689	maintenance director had been interrupted during his monitoring of the devices, he would have completed the audit prior to end of day, however, when the surveyor accompanied by the Maintenance Director arrived at the door to the 100 hall exit it was found to be turned to the off position . The 100 hall alarming box was immediately turned to the on postion by the maintenance director and found to be functioning once engaged to the on position. The DON/SDC initiated re-education 8/23/2018 of all staff regarding the alarming boxes to ensure boxes are not turned off following door opening/closing. The licensed nursing staff will monitor each exit door with alarming boxes installed every shift during licensed nurse walking rounds to validate alarming boxes are turned to the on position and functioning. All education is being completed by licensed personnel and will be completed prior to employees working their next scheduled shifts until 100% complete and will be added to the new orientation hires to be completed prior to working independently. All education regarding the alarming boxes will be completed on or before 9/10/2018. The facility updated all physician orders 8/24/2018 for resident□s with wanderguard placement to include the expiration date within the body of the order. The physician orders states to check for placement, function, and expiration date each shift; with the current expiration date listed within the body of	

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F 689	Continued From page 13 residents with wander guards at each nurses ' station. Nurse #1 stated she did not know if the resident ' s wander guard was tested the night of 8/16/17. On 8/24/18 at 10:18 am an interview was conducted with the occupational therapist (OT) #1 who stated on 8/17/18 she worked with Resident #2 in the therapy room. The resident was cooperative and did not state he did not want to be here or wanted to leave. The resident was intermittently confused and was able to communicate. Hallucinations were noted and then rationale conversation. When the physical therapy session was completed the resident was placed at hall 400 nurses ' station at 12:20 pm. The nurse was given report. OT #1 stated she then went to lunch. The resident was wearing shoes at the time. On 8/24/18 at 10:35 am an interview was conducted with Nursing Assistant (NA) #1 who was assigned to Resident #1 on 8/17/18 on day shift. The resident was newly admitted and was supervised due to potential for wandering. On 8/17/18 the resident received a shower at approximately 10:00 am. The resident was cooperative and did not verbalize that he wanted to leave or not be at the facility. NA #1 stated the last time she saw Resident #1 he was sitting at the nurses ' station. NA #1 stated that she noticed Resident #1 was missing around 12:20 to 12:30 pm when the trays were brought to the hall. The resident can walk around the facility independently. All rooms were immediately checked, and a code PINK was called because the resident was not found. The family was called to determine if the resident left with the family, and he had not. The grounds outside the	F 689	the order for additional communication and awareness. The licensed nurse will be responsible to ensure the wander transmitter is checked for proper function, placement, and expiration date each shift; after verifying, the licensed nurse will then initial as validation the process was completed in the electronic medication administration record. Monitoring Procedure The Director of Nursing and/or Nurse Manager will monitor residents with wander guard bracelets to ensure their daily bracelet check has been completed by the licensed nurses to ensure placement, function, and expiration date. The licensed nurse will use the wanderguard checking device each shift for each wanderguard to ensure the device is in place, functioning, and not expired. This will be accomplished by reviewing the MAR/TAR to validate the documentation by the licensed nurse in the daily clinical meeting for all residents with wanderguard orders. The DON and/or nurse manager will review the orders and documentation compliance for 2 residents per day in the clinical meeting for those residents that have a wander guard bracelet. This will be completed daily for 2 weeks and then weekly for 3 months or until resolved by the Quality Assurance Committee. If inconsistencies are identified, the staff member will be reeducated on checking the wander guard bracelet per the MD order in PCC. This monitoring was initiated on 8.23.18.	

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F 689	Continued From page 14 building were also checked concurrently with room check. NA #1 stated that about 10 minutes into the search, the video recordings were observed which revealed the resident had exited the building into the woods and an outside search in the woods was started. The resident was found. The resident was missing for approximately 20 minutes. The resident was assessed by the nurse and was found to have no injury. The resident was provided water because he was sweating. The resident was placed on an every 10-minute watch for the day and evening shift. The resident ' s wander guard was not working and was replaced with a tested/working wander guard. On 8/23/18 at 5:00 pm an interview was conducted with the DON who stated Resident #1 was placed on 10-minute checks for 24 hours. The DON stated that the process for wander guard check was changed on 8/17/18 to document its presence and the expiration date. The root cause analysis for the elopement was a non-working wander guard. On 8/23/18 at 5:15 pm an interview was conducted with the Corporate Nursing Consultant who stated and provided the non-working wander guard which was dated 3/17 and expired. The Administrator, Corporate Nurse Consultant and Director of Nursing were notified of the Immediate Jeopardy on 8/24/18 at 2:54 pm. The facility provided an acceptable credible allegation for immediate jeopardy removal on 8/25/18 which included the following: Plan to correct specific deficiency and facts that	F 689	The Director of Nursing will print a monthly report from the electronic health record of all residents with orders for wanderguard monitoring, any resident with a bracelet found to have an expiration date within the following 60 days will have a new wanderguard applied with an updated expiration date. Order will be updated to coincide with new wanderguard placement. All newly admitted residents who are assessed to require a wander management transmitter, will have orders reviewed during the daily clinical quality reviews by the Director of Nursing and/or Unit Manager to ensure the orders include the expiration dates of the transmitters effective 8/24/2018. All expired wander management transmitters will be discarded by licensed personnel when removed from use. Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator. The Director of Nursing and the licensed Administrator will be responsible for implementing and monitoring of all interventions and monitoring.	

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F 689	Continued From page 15 led to the alleged deficient practice The resident was admitted to the facility on August 15th 2018, with risk assessment completed on admission and deemed to be a moderate risk for elopement; therefore wanderguard bracelet was initiated and added to the patient ' s plan of care. He has the diagnosis of Lewy Body Dementia. On August 17th 2018 at 12:37 pm, resident # 1 went out the back door and walked across the parking lot to the wooded area adjacent to the facility. He said he was looking for his wife. The resident was found in the woods around 1:40 pm. The resident was assessed by the nurse upon entering the facility on August 17, 2018 and the MD and RP were notified of the event. There were minor scratches noted to resident ' s legs. 1:1 was initiated for this resident to ensure his safety. 1:1 was maintained 24 hours a day from 8/17/18 immediately upon return to the facility until 8/20/18 at 11 PM. Investigation completed and found that the wanderguard placed on the resident was expired therefore interdisciplinary team members concluded with the placement of an active non-expired wanderguard, all other wander management systems were functioning, therefore wander management system would keep resident sufficiently monitored. Upon return to the facility on 8/17/18, resident ' s wanderguard was immediately replaced by the Director of Nursing with a current wanderguard (i.e. one not expired). An REQ (Review to Ensure Quality) was initiated on 08.17.18. The wanderguard was found to be not be working correctly because it was expired, expiration date was noted to be 3/2018.	F 689		

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Expired wanderguard bracelet was found to be the root cause for the deficient practice. The wanderguard bracelets for this particular wandering monitoring management system have an expiration date or ' life ' of approximately 3 years, unfortunately the wanderguard bracelet placed on this patient expired 3/2017; the licensed nurse who applied the watchmate bracelet was not aware of the expiration date when she applied the wanderguard bracelet to the patient. The licensed nurse had not received education that the wanderguards had expiration dates. The wanderguard was retrieved from a locked cart located at the nursing station of the 300/400 hall area, located central within the facility.

The cart was audited to ensure no other expired wanderguard bracelets, as was all other storage carts located within the facility, nursing stations, desk, offices, central supply units, and maintenance shop. All audits of these areas were complete by close of business on Friday, August 17, 2018. Director of nursing ensured all audits were sufficiently completed.

Procedure for implementing a plan of correction for the alleged deficient practice

On 08.17.18, the Unit Manager and the scheduler, checked 100% of all the other residents with wander guards in use residing within the facility which include 6 total skilled residents, there were no other wander guards found expired and all were functioning properly. The wander guard bracelets were checked by utilizing the manufacturer (wanderguard checker '); when placed directly beside the wanderguard the transmitter will beep repetitively and a light

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F 689	Continued From page 17 turns green located on the ' checker ' . On 08.17.18, the Director of Nursing began in-servicing all nurses on the following: · Elopement Prevention and Maintenance with Wanderguard alarm systems. o All resident will be assessed on admission and quarterly for elopement risk. o Residents found at risk shall be identified by staff in the care plan and care guides. o Transmitter bracelets (wanderguard) will be attached to wrist or ankle after being checked for expiration date and tested to make sure they were functioning properly. · Return demonstration of how to find expiration date to ensure that it is not expired on the wander guard device and how to check to ensure it is working. · All nursing staff (RN, LPN, Nurse Aide) to be trained prior to being allowed to work, this includes full time, part time and PRN employees. · This will also be added to the facility new hire orientation. Education began on 8/17/18 and was completed on 8/22/18 except for four employees that only work on the weekend or on vacation. These employees will not be allowed to work until they have received this education. The Director of Nursing will ensure that this education occurs prior to the employee working again. The Maintenance Director will add alarming boxes on 8/25/2018 before 12:00 pm to the exit doors which lead to the patio area or any other exit area with the potential that have on/off switches for exterior gates with keypads and/or the doors are found to be otherwise not	F 689		

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monitored. The alarming boxes will alert the staff anytime the doors exiting to the patio or gated areas are opened.

All doors and alarms are checked daily by maintenance director or managers on duty. However, on 8/23/18 the maintenance director had been interrupted during his monitoring of the devices, he would have completed the audit prior to end of day, however, when the surveyor accompanied by the Maintenance Director arrived at the door to the 100 hall exit it was found to be turned to the off position . The 100 hall alarming box was immediately turned to the on postion by the maintenance director and found to be functioning once engaged to the on position. The facility initiated re-education 8/23/2018 of all staff regarding the alarming boxes to ensure boxes are not turned off following door opening/closing. The facility will monitor each exit door with alarming boxes installed every shift during licensed nurse walking rounds to validate alarming boxes are turned to the "on" position and functioning. All education is being completed by licensed personnel and will be completed prior to employees working their next scheduled shifts until 100% complete and will be added to the new orientation hires to be completed prior to working independently.

The facility updated all physician orders 8/24/2018 for resident ' s with wanderguard placement to include the expiration date within the body of the order. The physician orders states to check for placement, function, and expiration date each shift; with the current expiration date listed within the body of the order for additional communication and awareness. The licensed nurse will be responsible to ensure

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the wander transmitter is checked for proper function, placement, and expiration date each shift; after verifying, the licensed nurse will then initial as validation the process was completed in the electronic medication administration record.

Monitoring Procedure

The Director of Nursing and/or Nurse Manager will monitor residents with wander guard bracelets to ensure their daily bracelet check has been completed by the licensed nurses to ensure placement, function, and expiration date. The licensed nurse will use the wanderguard checking device each shift for each wanderguard to ensure the device is in place, functioning, and not expired. This will be accomplished by reviewing the MAR/TAR to validate the documentation by the licensed nurse in the daily clinical meeting for all residents with wanderguard orders. The DON and/or nurse manager will review the orders and documentation compliance for 2 residents per day in the clinical meeting for those residents that have a wander guard bracelet. This will be completed daily for 2 weeks and then weekly for 3 months or until resolved by the Quality Assurance Committee. If inconsistencies are identified, the staff member will be reeducated on checking the wander guard bracelet per the MD order in PCC. This monitoring was initiated on 8.23.18.

The Director of Nursing will print a monthly report from the electronic health record of all residents with orders for wanderguard monitoring, any resident with a bracelet found to have an expiration date within the following 60 days will have a new wanderguard applied with an updated expiration date. Order will be updated to coincide

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with new wanderguard placement.

All newly admitted residents who are assessed to require a wander management transmitter, will have orders reviewed during the daily clinical quality reviews by the Director of Nursing and/or Unit Manager to ensure the orders include the expiration dates of the transmitters effective 8/24/2018.

All expired wander management transmitters will be discarded by licensed personnel when removed from use.
Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.

The Director of Nursing and the licensed Administrator will be responsible for implementing the credible allegation.

Immediate Jeopardy removal date: 8/25/18

Validation:
Immediate Jeopardy (IJ) was removed on 8/25/18 at 2:45 pm when validation was completed of the credible allegation for IJ removal as evidenced by interviews of two licensed nurses, two nursing assistants, one housekeeper, and the Maintenance Manager for evidence of in-service completion and a review of the new elopement process policy and evaluation and new documentation requirement of the wander guard bracelet presence, expiration date, and working

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