STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. BUILDING _____ B. WING _____	C 10/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

(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 recertification and complaint investigation survey was conducted from 10/8/2018 to 10/11/2018. Immediate Jeopardy was identified at CFR 483.25 at tag F 689 at a scope and severity of J. Immediate Jeopardy began on 09/26/2018 and was removed on 10/11/2018. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		10/31/18

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

Electronically Signed | 10/26/2018

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide dignity for residents by failing to knock or announce themselves before entering residents rooms for 2 of 5 meal pass observations conducted. The findings included: 1. On 10/8/2018 a continuous meal pass observation was conducted on the 800 hall from 11:41 AM to 11:46 AM, during lunch. At 11:41 AM, Nursing Assistant (NA) #3 took a lunch tray from the hall cart and walked into room 802 without knocking or announcing herself to the resident in the room. At 11:43 AM NA #3 took a lunch tray into room 807 without knocking or announcing herself to the resident in the room. At 11:44 NA #3 walked into room 810, empty handed, without knocking or announcing herself to the resident in the room, then walked out and into room 805, empty handed, and without knocking or announcing herself to the resident in	F 550	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F550 1. For effected residents, a corrective action was obtained on 10/08/2018. The CNA who failed to knock prior to entering the resident's room was verbally counseled by the Staff Development Coordinator on knocking on residents doors and asking permission to enter prior to entering a resident's room. 2. Corrective action for residents with	

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F 550	Continued From page 2 the room. At 11:45 AM, NA #3 walked empty handed into Room 804, without knocking or announcing herself to the resident in the room, then left and walked into Room 800 without knocking or announcing herself to the resident in the room. On 10/8/2018 at 11:46AM, an interview was conducted with NA #3 who stated when she entered a resident room, she knocked on the door first and announced herself. NA #3 stated she did not knock or announce herself at this time, because she had already made rounds when she started work at 7:00 AM and she introduced herself to the residents at that time, so they knew who she was already. On 10/10/2018 at 5:24 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she had given an in-service to all staff in July 2018 to knock before entering a resident room. The SDC stated if the door was open they still needed to announce themselves to let the resident know who was coming in. On 10/10/2018 at 4:36 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected staff to knock on the door, introduce themselves and tell the resident why they were there, whether the door was open or closed. 2. An observation was conducted on the 800 hall on 10/10/2018 at 8:44 AM. NA #4 walked into room 801 without knocking or introducing herself and pushed the bedside table to the resident with a meal tray on it.	F 550	the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 10/26/2018, the Staff Development Coordinator completed an audit observing privacy practices for staff knocking on residents doors and asking permission to enter prior to entering. This audit was completed on all skilled halls. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: • All staff must knock on a resident's door prior to entering the room even if the door is open. • All staff must ask permission prior to entering the resident's room. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor procedures for	

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F 550	Continued From page 3 On 10/10/2018 at 12:26 PM, an interview was conducted with NA #4, who stated she had told the resident in Room 801 that she would come back in to feed him earlier. The NA stated she usually knocked on the door if the door was shut, but she hardly ever knocked on a resident's door if it was open. On 10/10/2018 at 5:24 PM, an interview was conducted with the Staff Development Coordinator (SDC). The SDC stated she had given an in-service to all staff in July 2018 to knock before entering a resident room. The SDC stated if the door was open they still needed to announce themselves to let the resident know who was coming in. On 10/10/2018 at 4:36 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected staff to knock on the door, introduce themselves and tell the resident why they were there, whether the door was open or closed.	F 550	resident's rights weekly x 2 weeks then monthly x 3 months using the Residents rights/privacy Quality Assurance monitor. Monitoring will include auditing staff for knocking and asking permission to enter a resident's room prior to entering. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the	F 636		10/31/18

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resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

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F 636	Continued From page 5 (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete an annual resident comprehensive assessment for 1 of 10 residents reviewed (Resident # 1). Findings included: Resident #1 had been admitted on 12/19/11. His diagnoses included dementia, hypertensive heart disease, chronic kidney disease, anemia, diabetes and depression. His most recent Quarterly Minimum Data Set Assessment (MDS) was dated 5/14/18. His last annual comprehensive assessment was dated 8/12/17. On 10/10/18 at 9:43 AM an interview was conducted with MDS nurse #1. She stated Resident #1 should have had an annual MDS/comprehensive assessment completed in August 2018. She stated she was unsure how this had been missed. On 10/10/18 at 10:24 AM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the MDS nurse to complete MDS/comprehensive assessment assignments timely and as assigned and that they would not be late.	F 636	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F636 Comprehensive Assessment and Timing For resident #1, a corrective action was obtained on 10/12/18. On date 10/12/18, an Annual Minimum Data Set assessment was opened for resident #1 with an Assessment Reference Date of 10/12/18 by the Minimum Data Set Nurse. This assessment was completed by the interdisciplinary team on 10/22/18 and was submitted and accepted by state database on 10/25/18 in batch #1134. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 636	Continued From page 6	F 636	All residents have the potential to be affected by the alleged deficient practice. On 10/25/18 the Regional Minimum Data Set Consultant completed 100 % audit of all current residents in the facility in order to validate that all had a comprehensive Minimum Data Set assessment completed within the past 366 days. The results of the audit were: 109 of 109 residents reviewed had a comprehensive Minimum Data Set assessment completed within the past 366 days. Systemic Changes On 10/26/18, the Regional Minimum Data Set Consultant completed an in service training for the facility Minimum Data Set Coordinator including the importance of completing Comprehensive Minimum Data Set assessments within the appropriate timeframes as stated in chapter 2 of the RAI manual. There should be no more than 366 days between the assessment reference dates from one Comprehensive Minimum Data Set assessment to the next. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. On 10/26/18, the Director of Nursing or	

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F 636	Continued From page 7	F 636	Minimum Data Set Nurse will begin auditing the Minimum Data Set Assessment schedule using the quality assurance survey tool entitled "Comprehensive MDS (Minimum Data Set) Completion Date Audit Tool" to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637		10/31/18

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F 637	Continued From page 8 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to perform a Significant Change in Status Assessment (SCSA) for 1 of 1 residents reviewed for hospice care. (Resident #71) Findings included: Resident #71 was admitted to the facility on 8/10/18. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, asthma, muscle weakness, and other sequelae of cerebral infarction. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 coded as an admission assessment revealed she was assessed as severely cognitively impaired. Resident #71 had no moods or behaviors. The MDS indicated that at the time of the assessment, the resident was not receiving hospice services. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice referral. Review of Resident #71's chart revealed on 9/7/18 she began hospice care. Review of Resident #71's Minimum Data Set	F 637	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F637 Comprehensive Assessment after Significant Change For resident #71, a corrective action was obtained on 10/26/18. On 10/25/18, the Regional Minimum Data Set Consultant opened a Significant Change Minimum Data Set Assessment with an Assessment Reference Date of 10/26/18 for Resident #71. The due date for this assessment to be completed on is 11/9/18. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 10/25/18, the Minimum Data Set Consultant completed a 100% audit of all	

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F 637	Continued From page 9 (MDS) assessments revealed no SCSA had been completed. During an interview on 10/10/18 at 8:51 AM MDS Coordinator #1 stated she had just started her position as the MDS Coordinator on 10/8/18 and MDS Coordinator #2's last day was on 10/4/18. She further stated she would have expected MDS Nurse #2 to have performed a SCSA assessment due to hospice election. During an interview on 10/10/18 at 9:57 AM the Director of Nursing stated it was the expectation that a significant change MDS be performed once hospice care was elected and it was not done.	F 637	residents who have been admitted to or discharged from hospice care during the past 90 days to ensure that Significant Change Minimum Data Set assessments have been completed. The audit results are: • 4 residents found to have been admitted to hospice care during the past 90 days. • 1 of the 4 residents was admitted to the facility as a hospice resident; therefore, an Admission Minimum Data Set assessment was completed. • 1 of the 4 residents had already been identified by surveyor as not having a Significant Change Minimum Data Set assessment after being admitted to hospice. This was Resident #71. Significant Change in Status Minimum Data Set Assessment was opened with an Assessment Reference Date of 10/26/18. • 2 of the remaining 4 residents reviewed were found to not have had a Significant Change in Status Minimum Data Set completed after being admitted to hospice care. Significant Change assessments were opened by the Regional Minimum Data Set Consultant for both of these residents on 10/25/18 with Assessment Reference Dates of 10/26/18. Systemic Changes On 10/26/2018, the Minimum Data Set Nurse Consultant in serviced the Minimum Data Set Coordinator on the requirement for and importance of	

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completing a Significant Change Minimum Data Set assessment for all residents who are either admitted to or discharged from hospice services. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
The Director of Nursing or Minimum Data Set Coordinator will review 5 residents who have been either admitted to or discharged from hospice services during the past 60 days to ensure that a Significant Change in Status Minimum Data Set assessment has been completed as required. This will be done using the quality assurance tool entitled "Significant Change in Status MDS Completion Audit Tool." This audit will be done on weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Dietary Manager and the Administrator.
The title of the person responsible for implementing the acceptable plan of correction;

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F 637	Continued From page 11	F 637	Administrator and /or Director of Nursing.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		10/31/18

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F 656	Continued From page 12 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to update the care plan to reflect a resident's need for supervision outside and hospice status for 1 of 22 resident care plans reviewed. (Resident #71) Findings included: Resident #71 was admitted to the facility on 8/10/18. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, asthma, muscle weakness, and other effects following a cerebral infarction. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 revealed she was assessed as severely cognitively impaired. Resident #71 had no moods or behaviors. She required extensive assistance with bed mobility, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. She was totally dependent on staff for transfers. Resident #71 was always incontinent of bowel and bladder. No restraints or alarms of any kind were used. Review of Resident #71's orders revealed on 9/5/18 she was ordered to have a hospice referral. Review of Resident #71's chart revealed on	F 656	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F656 Develop/Implement Comprehensive Care Plan For resident #71, a corrective action was obtained on 10/9/18. The care plan for Resident #71 was updated to include that she is receiving hospice care. This update was completed by the Minimum Data Set Nurse on 10/9/18. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents who receive hospice services have the potential to be affected by the alleged deficient practice. On 10/25/18, the Minimum Data Set Nurse Consultant conducted a 100% audit on all current residents who are currently receiving	

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F 656	Continued From page 13 9/7/18 she began hospice care. Review of Resident #71's nurse ' s notes revealed there were no nursing notes on 9/26/18. Review of a hospice nurse's note dated 9/27/18 at 1:28 PM revealed Resident #71 was alert and active with no distress noted and no complaints of pain. Blisters were noted on her lower right arm and it was reported to Hospice Nurse #1 that Resident #71 was outside on 9/26/18 and became overheated. Review of a hospice fall report dated 10/2/18 revealed at 10:00 AM Resident #71 sustained a witnessed fall from her wheelchair in the facility parking lot. The contributing factors were noted to be confusion and disorientation. Resident #71 had no apparent injuries and facility staff were informed that Resident #71 was not allowed outside the facility alone. The responsible party was called and informed of the fall. Review of a hospice nurse's note dated 10/2/18 at 10:44 AM revealed Resident #71 sustained a fall out of her wheelchair in the parking lot which was witnessed by a male nursing student. Resident #71 denied pain and no obvious injuries were noted. Resident #71 was brought back to her room where she had a complaint of being thirsty and ice water was given to her. Resident #71's responsible party was called but there was no answer. Resident #71 complained of arm itching and Eucerin cream, a moisturizer, was applied to areas on arms and hands. Review of a hospice nurse's note dated 10/2/18 at 11:36 AM revealed Resident #71's responsible party returned the phone call and was informed	F 656	hospice care in order to ensure that their care plans accurately reflect that they are receiving hospice services. The results of this audit were: 108 residents reviewed for current hospice orders. 7 of 108 residents are currently under hospice care. 5 of 7 residents who are currently receiving hospice services do have a current hospice care plan. 2 of 7 residents who are currently receiving hospice services did not have a hospice care plan. Those 2 residents□ care plans were immediately updated by the Minimum Data Set Nurse Consultant on 10/25/18 to reflect hospice care. Systemic Changes On 10/26/2018, the Minimum Data Set Nurse Consultant in-serviced the facility Minimum Data Set Nurse on the importance of maintaining up to date care plans that are reflective of each resident□s current condition and treatment plans. Emphasis was placed on the importance of ensuring that any resident who is receiving hospice care has a hospice care plan in order to coordinate services and care between facility and hospice staff to best meet resident□s needs.	

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F 656	Continued From page 14 that Resident #71 had fallen and there were no injuries noted or complaints of pain. Review of a health status note dated 10/2/18 at 1:14 PM revealed an interdisciplinary team meeting was held to discuss Resident #71 beginning to exhibit exit seeking behaviors. A group decision was made to apply a wander guard to the resident. Resident #71's responsible party was in the facility and was made aware and agreed with the plan. It was documented she was also aware of the fall the morning of 10/2/18. The Nurse Practitioner as well as Resident #71's physician were notified of the fall and wander guard placement. Review of a nurse's note dated 10/2/18 at 5:00 PM revealed the nurse documented she was informed by a hospice nurse that Resident #71 had fallen while outside. The hospice nurse and a male nursing student got the resident off the ground and brought her back inside. Review of a fall review and follow up dated 10/2/18 at 5:14 PM revealed Resident #71 fell outside of the building attempting to reach over the side of her wheelchair to get something. Review of Resident #71's care plan on 10/8/18 at 12:05 PM revealed she was not care planned for hospice care. Resident #71 was care planned to be an elopement risk and wanderer on 10/4/18. During an interview on 10/8/18 at 12:23 PM Hospice Nurse #2 stated she admitted Resident #71 to hospice. She further stated Hospice Nurse #1 was her primary hospice nurse. Hospice Nurse #2 stated Hospice Nurse #1 had told her someone had let Resident #71 outside the facility	F 656	This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing or Minimum Data Set Nurse will review 5 residents who are currently receiving hospice services to ensure that their care plan reflects hospice care. They will use the quality assurance tool entitled Care Plan Audit Tool. This will be done on a weekly basis for 4 weeks then monthly for 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing.	

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and the resident had fallen into some ants. She further stated the resident's level of functioning was not that great when she admitted Resident #71 to hospice and Hospice Nurse #2 was surprised she had been outside unsupervised and would not have been comfortable with Resident #71 being outside unattended.

During an interview on 10/9/18 at 9:58 AM Hospice Nurse #1 stated Resident #71 was not supposed to go outside unattended. Hospice Nurse #1 stated the responsible party had requested the resident not go outside without supervision because of an incident the week before the fall where she stayed outside too long and got overheated and had blisters on her arm. She further stated other staff in the facility knew not to let Resident #71 outside unattended but the staff member who took Resident #71 outside did not know because she had left Resident #71 outside. Hospice Nurse #1 concluded Nurse #2 was a nurse she could remember knew Resident #71 was not to go outside unsupervised.

During an interview on 10/9/18 at 11:06 AM Nurse #2 stated she was familiar with Resident #71's care. She further stated Resident #71 would think she could do what she used to be able to do. She used to come and go as she pleased but now needed more help and did not understand she needed help. She further stated Resident #71 needed one on one supervision when outside. She further stated she was to be on one on one supervision since her admission in August of 2018. Nurse #2 stated Resident #71 needed to be repositioned in her chair often through the day because she would slump in her chair and was at risk for falls so staff knew she needed supervision when she was outside. She stated there was a

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wandering poster board next to the time clock as well as near the nurse's station, but they had not placed her on that list prior to the fall on 10/2/18. She further stated she did not know why Resident #71 was not on the list prior to 10/2/18 and she had not reported to anyone besides her nurse aides that Resident #71 needed supervision because she thought it was general knowledge.

During an interview on 10/9/18 at 11:47 AM Hospice Nurse Aide #1 stated she had cared for Resident #71 since September 2018 when she was placed on hospice care. She further stated Resident #71 was able to self-propel herself with her feet. She stated she helped a nursing student get her bathed and up for the day on 10/2/18 when she had her fall. She further stated once she was clean and positioned in her chair she went to her next hospice resident and did not see Resident #71 for the rest of the day. The Hospice Nurse Aide further stated ever since Resident #71 had been placed on hospice care she was supposed to have supervision when exiting the locked area of the facility. She further stated this was because Resident #71 tended to slump in her chair and was at risk to falling from her chair, so she needed to be repositioned in her chair often. She further stated Hospice Nurse #1 would inform her which residents required supervision when outside the facility and Resident #71 had always been one who needed supervision when outside.

During an interview on 10/9/18 Nurse Aide #2 stated Resident #71 moved fast and if you don't keep up with her she would disappear. She further stated staff were to keep up with where Resident #71 was because she sometimes sat at the locked door waiting for someone to open it.

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She further stated Resident #71 used to go outside by herself when she was on the assisted living side of the facility but ever since she came to the skilled unit in September 2018 Resident #71 was not to go outside the facility unsupervised by staff. If she wanted to go outside a staff member would need to go outside with her. She further stated she was made aware of this by word of mouth that she was not to go outside the facility unsupervised and she did not report the concern to anyone because everyone already knew. She further stated she did not know anything about her being outside for an extended period of time or getting overheated. She further stated she did know that Resident #71 was not supposed to be outside on her own since sometime in September and sometimes visitors would let her outside and staff would have to bring her back in and educate the visitors.

During an interview on 10/9/18 at 3:50 PM Nurse #3 stated she was familiar with Resident #71's care. She further stated Resident #71 was not to be left outside unsupervised during her shifts. She further stated this was due to her cognitive decline when she moved to the skilled nursing side in August on 2018. She further stated she did not know if other nurse's let her go outside unsupervised on their shifts, and she stated she did not report her concern for Resident #71 being outside unsupervised except to ask visitors or staff to not let her be unsupervised outside.

During an interview on 10/10/18 at 8:08 AM Nurse #2 stated she had told other nurse aides and nurses that Resident #71 was not to go outside unsupervised but had never brought this to the attention of her managers.

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During an interview on 10/10/18 at 8:18 AM Resident #71's Nurse Practitioner stated Resident #71 was in the facility in the assisted living section of the facility. The Nurse Practitioner stated Resident #71 had sustained a gradual decline in status including deterioration of her kidney function. Resident #71 then went to the hospital and came back in August 2018 very debilitated due to her kidney function decline. The Nurse Practitioner spoke with the family and the decision was made to make the resident a hospice resident. She further stated when Resident #71 was in assisted living she was able to make safety decisions, however, once she returned from the hospital in August 2018 she had a very noticeable cognitive decline. She further stated one day Resident #71 went outside in the sun and fell asleep and had gotten a sunburn with some blistering to both forearms, possibly related to kidney failure as well. She further stated following this incident she believed the facility staff supervised Resident #71 more closely when she was outside. The Nurse Practitioner concluded Resident #71 had declined in safety awareness since her hospitalization and she agreed with the placement of the wander guard for safety and for staff to be more cognizant of where she was.

During an interview on 10/10/18 at 8:51 AM MDS Nurse #1 stated she had just started her position as the MDS Coordinator on 10/8/18 and MDS Nurse #2's last day was on 10/4/18. She stated she had worked on the floor for three years in the facility prior to just beginning this new position. MDS Nurse #1 stated previously the care plans were created and updated by MDS Nurse #1. She further stated if there was a change in condition for a resident it would be brought to her attention

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by the floor nurse and then discussed in the interdisciplinary team meeting and updated on the care plan. She further stated if a resident began to have a cognitive or functional decline it was the expectation that the frontline staff would notify the interdisciplinary team to address the decline in documentation and the care plan. She further stated Resident #71 had sustained a severe decline when she came back to the facility from the hospital in August 2018. She further stated Resident #71's safety and cognitive awareness drastically declined following her hospitalization and she was then placed on hospice in September 2018. She further stated if she went outside it was to be with family who would supervise her outside and she was not to be outside by herself. If it was noticed she was going outside by herself the staff would stop her and bring her back on the unit. She further stated she would always sit by the locked door and if a visitor came she would ask them to hold the door for her and would attempt to go out to the front of the facility. She further stated at that time she did not have Resident #71 on her unit and did not know if Nurse #1 had reported the concern of her waiting by the door. She stated it was a general understanding among the frontline nurses and nurse aides Resident #71 was not to be outside unsupervised and she did not know why it was not known by the Director of Nursing, Administrator, or other members of the interdisciplinary team. She stated she did not have Resident #71 once she moved to the 300 hall so she would ask Nurse #2 if Resident #71 was okay to go outside before opening the door and Nurse #2 would tell her no, she had to be supervised outside the facility. She further stated Resident #71 was to be supervised outside the facility since her return from the hospital in August

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F 656	Continued From page 20 2018. She further stated it was the expectation that Nurse #2 and other staff to bring the concern of Resident #71's change in condition, waiting by the door, and decreased safety awareness to the charge nurse, MDS Nurse for care planning, and flagged the chart for the physician. She further stated she would have expected MDS Nurse #2 to have updated the care plan regarding her exit seeking behavior and need for supervision. She further stated Resident #71 should have also been care planned for hospice and it was not done until 10/9/18. During an interview on 10/10/18 at 9:57 AM the Director of Nursing stated it was her expectation if staff saw Resident #71 waiting by the door to go outside, had concerns about the resident ' s safety being outside unsupervised, or saw a decline in cognitive ability they would notify the interdisciplinary team to discuss, address the concern, and implement care plan interventions. She further stated hospice should have also been care planned and it was not.	F 656		
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 observation, record review, staff, hospice staff, and Nurse Practitioner interviews,	F 689	The statements made on this plan of correction are not an admission to and do	10/11/18

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F 689	Continued From page 21 the facility failed to provide supervision to prevent a severely cognitively impaired resident (Resident #71) who displayed wandering behaviors and was known by some staff to require supervision while outside from being outside the facility unsupervised for 1 of 4 residents reviewed for accidents. Immediate Jeopardy began on 9/26/18 when Resident #71 was left outside the facility unsupervised by staff and developed blisters to her right forearm. The resident was brought back inside by a concerned visitor. On 10/2/18 Resident #71 was let outside the facility without supervision in her wheelchair in the facility parking lot where she sustained a fall without injury. The resident was assessed and retrieved by Hospice Nurse #1 and returned to the facility with no physical injuries. Immediate jeopardy was removed on 10/11/18 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #71 was admitted to the facility on 8/10/18. Her active diagnoses included anemia, hypertension, diabetes mellitus, hyperlipidemia, dementia, depression, asthma, and muscle weakness. Review of Resident #71's most recent minimum data set assessment dated 8/17/18 revealed she was assessed as severely cognitively impaired.	F 689	not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Credible Allegation for Supervision to prevent accidents Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 09/26/2018 the resident had been sitting outside on the front porch when a visitor assisted her in the front door and alerted the Unit Manager. This occurred around 1PM. The resident was assisted back to her unit by the Unit Manager and an assessment performed revealing vital signs, SPO2, and blood sugar were within normal limits for this resident. The Unit Manager stated that the resident's skin was warm and dry. No blisters or redness were observed to the residents upper extremities at this time. A report was immediately given to the FNP who then assessed the resident. The FNP stated that the Unit Manager reported to her that the resident had been brought in from outside due to appearing sleepy and was sitting out doors. The Unit Manger took the residents vital signs and reported them to her and they were "well within her normal limits and the resident did not	

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Resident #71 had no moods or behaviors. She required extensive assistance with bed mobility, locomotion on and off unit, dressing, eating, toilet use, and personal hygiene. She was totally dependent on staff for transfers. Resident #71 was always incontinent of bowel and bladder. No restraints or alarms of any kind were used.

Review of Resident #71's care plan dated 8/14/18 revealed she was care planned to be at risk for falls. The interventions included to anticipate and meet her needs as much as possible, criss cross grip strips on floor in her room, educate Resident #71, family, and caregivers about safety reminders and what to do if a fall occurs, encourage her to wear non-skid socks when she was not wearing shoes, observe for possible side effects from medications that may affect balance and gait and report to nurse if Resident #71 had changes in gait or balance, review information on past falls and attempt to determine the cause of falls, record possible root causes, and alter or remove any potential causes if possible.

Review of Resident #71's nurse's notes revealed there were no nursing notes on 9/26/18.

Review of a hospice nurse's note dated 9/27/18 at 1:28 PM revealed Resident #71 was alert and active with no distress noted and no complaints of pain. Blisters were noted on her lower right arm and it was reported to Hospice Nurse #1 that Resident #71 was outside on 9/26/18 and became overheated.

Review of a hospice fall report dated 10/2/18 revealed at 10:00 AM Resident #71 sustained a witnessed fall from her wheelchair in the facility parking lot. The contributing factors were noted to

appear to be in any distress". The FNP states that she was aware of the resident sitting outside alone as she has seen the resident sitting on the front porch frequently and no concerns were seen with this activity. No medical interventions were required due to this event. On 09/27/2018 the Hospice nurse was in the facility to assess the resident and noted blisters on the resident's right arm. The resident was complaining of itching in this area. The hospice nurse directed the hospice aide to apply cream to the area and apply sleeves to prevent the resident from scratching the area and to trim her nails. The hospice nurse states this was completed on 09/27/2018.
On 10/02/2018, the Director of Nursing and the Administrator met and discussed the incident regarding the fall outside and determined the root cause of the incident was that the resident now required supervision while outside.
• Corrective action for the affected resident: On 10/02/2018 the resident was assigned a wander guard bracelet to prevent her from going outside unsupervised due to her safety risk.
On 10/02/2018 the Director of nursing interviewed and assessed the resident for the need of wander guard placement and initiated orders for wander guard placement and monitoring.
On 10/02/2018 at approximately 9:15AM the resident was assisted through the double doors onto the front hall way by the activities assistant. The resident proceeded to go out the front doors to sit on the front porch as per her normal

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be confusion and disorientation. Resident #71 had no apparent injuries and the facility staff were informed that Resident #71 was not allowed outside the facility alone. The responsible party was called and informed of the fall.

Review of a hospice nurse's note dated 10/2/18 at 10:44 AM revealed Resident #71 sustained a fall out of her wheelchair in the parking lot which was witnessed by a nursing student. Resident #71 denied pain and no obvious injuries were noted. Resident #71 was brought back to her room where she had a complaint of being thirsty and ice water was given to her. Resident #71 responsible party was called but there was no answer. Resident #71 complained of arm itching and cream was applied to areas on arms and hands.

Review of a health status note dated 10/2/18 at 1:14 PM revealed an interdisciplinary team meeting was held to discuss Resident #71 beginning to exhibit exit seeking behaviors. A group decision was made to apply a wander guard to the resident. Resident #71 responsible party was in the facility and was made aware and agreed with the plan. It was documented she was also aware of the fall the morning of 10/2/18. The Nurse Practitioner as well as Resident #71's physician were notified of the fall and wander guard placement.

Review of a nurse's note dated 10/2/18 at 5:00 PM revealed Nurse #2 documented she was informed by a hospice nurse that Resident #71 had fallen while outside. The hospice nurse and a nursing student got the resident off the ground and brought her back inside.

routine. Per the staff interviews conducted including the FNP this was her normal routine up until 10/02/2018. The activity assistant observed the resident still sitting on the front porch at approximately 9:45AM. At approximately 10:15AM the resident was observed leaning over in her wheel chair as to pick something up off the ground and fell out of her wheel chair. The resident did not sustain an injury as a result of this fall. The fall occurred between the canopy and the first handicapped parking spot. The hospice nurse was immediately summoned to assess the resident. After assessment was completed the resident was transported inside and the responsible party and MD were notified by the hospice nurse and the Director of Nursing.
On 10/02/2018 the Director of Nursing and the Administrator met and discussed the incident and determined the root cause of the incident was that the resident now required supervision while outside.
• Corrective action for affected resident:
On 10/02/2018 the resident was assigned a wander guard bracelet to prevent her from going outside unsupervised due to her safety risk.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
An REQ (Review to Ensure Quality) was initiated on 10/05/2018. On 10/05/2018, the Director of Nursing initiated an audit of all current residents and ran a report from Point Click Care of residents' elopement risk scores for the last 3 months to audit for a risk score of moderate or high risk

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F 689	Continued From page 24 Review of a fall review and follow up dated 10/2/18 at 5:14 PM revealed Resident #71 fell outside of the building attempting to reach over the side of her wheelchair to get something. Resident #71 had no complaints of pain and a neurological check was performed which was negative. Review of Resident #71's care plan dated 10/4/18 revealed she was care planned to be an elopement risk and wanderer. The interventions included to assess Resident #71 for fall risk, monitor for fatigue and weight loss. Provide structured activities with toileting, walking inside and outside, and reorientation strategies including signs, pictures and memory boxes. She was care planned to have a wander guard in place. Review of a fall review and follow up dated 10/4/18 at 3:05 AM revealed Resident #71 had no changes in condition following her fall and her neuro checks were negative. Review of weather.com for Mount Olive revealed the high temperature was 88 degrees Fahrenheit and it was cloudy on 9/26/18. On 10/2/18 the high temperature was 85 degrees Fahrenheit and it was sunny. During an interview on 10/8/18 at 12:23 PM Hospice Nurse #2 stated she admitted Resident #71 to hospice care. She further stated Hospice Nurse #1 was her primary hospice nurse. Hospice Nurse #2 stated Hospice Nurse #1 had told her someone had pushed Resident #71 outside the facility and the resident had fallen into some ants. She further stated Resident #71's level of functioning was not good when she admitted Resident #71 and she was surprised	F 689	for elopement. Resident's with a risk score of moderate or high risk for elopement were then reviewed for the following: mobility status when up in their chair or ambulating and if they had a BIMS of 11 or less to determine the need for wander guard placement or supervision when going outside. Residents that had a BIMS of 11 or less and who were independently mobile were reviewed by the Director of Nursing and Nurse Consultant for the need of a wander guard placement or supervision due to potential over exposure when going outside. This was finalized on 10/08/2018. There were no new residents that were identified as needing a wander guard bracelet or supervision while outside. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 10/05/2018 the Staff Development Coordinator, began in-servicing all full time, part time, and as needed staff on resident safety and monitoring. Topics included: All Staff: • Do not forget that frequent monitoring and supervision are needed in order to ensure resident safety. This means that you should be aware of the resident's location. Do not accept the wander guard system as a substitution for resident supervision. • In addition to this, residents not identified as elopement risk should also be monitored for their location. Residents	

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she had been outside unsupervised and would not have been comfortable with Resident #71 being outside unattended.

During observation on 10/9/18 at 8:39 AM Resident #71 was observed in bed. Her right forearm was wrapped in bandages as ordered and no broken skin was visible.

During an interview on 10/9/18 at 9:58 AM Hospice Nurse #1 who was the nurse that responded to Resident #71 fall stated she had gone to Resident #71's room to find Resident #71 and she went to all the halls and could not find her. She further stated she asked Resident #71's nurse and nurse aide where Resident #71 was, and they did not know. She then stated the Activities Director heard her asking for Resident #71 and told Hospice Nurse #1 Resident #71 was outside which was odd because she was not supposed to go outside unattended. Hospice Nurse #1 stated the responsible party had requested the resident not go outside without supervision because of an incident the week before the fall where she stayed outside too long and got overheated. Hospice Nurse #1 stated she noted blisters to Resident #71's forearms and she had Hospice Nurse Aide #1 place cream on Resident #71's arms and wrap them. She stated she asked staff who said it might have been related to her being outside in the sun too long and overheating. She further stated other staff in the facility knew not to let Resident #71 outside unattended but the staff member who took Resident #71 outside did not know because she had left Resident #71 outside. Hospice Nurse #1 stated she then was going outside and heard someone saying, "I need a nurse outside." When she went to the front of the building she saw

that sit on the front porch or out in the courtyards should be monitored for location, hydration, and safety needs. Risk include falls, dehydration, sun burn. Offer fluids, toileting, and rest periods by coming in from outside throughout your shift. Notify the nurse if the resident refuses to come in. Encourage patients who like to sit outdoors for long periods of time to use sunscreen and drink fluids to prevent adverse events. Make routine visits to check on the resident.

10/10/2018: Residents are monitored by nurses and CNA's during routine rounds at all times including while sitting outside. Residents noted sitting for extended times should be 1. Offered fluids (fluids may be obtained from the lobby from the beverage dispenser that is replenished twice a day by the kitchen staff), 2. Sunscreen should be applied as needed to exposed extremities and face of residents sitting for extended periods of time in the sun (sunscreen can be obtained from each nurses cart), 3. Residents should be monitored for clothing appropriate to the season (during warm months residents are not dressed in heavy coats placing them at risk for overheating and during cold months residents are not wearing clothing generally worn during warm months such as shorts that could cause cold exposure concerns such as hypothermia), 4. Signage has been placed in the lobby next to the beverage dispenser alerting visitors and families of the location of sunscreen, how to attain additional fluids,

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F 689	Continued From page 26 Resident #71 laying against the curb in the handicapped parking spot across the parking lot drive through and a Nursing Student was with Resident #71 and was brushing ants off her. She stated the Nursing Student was in his car in the parking lot and observed Resident #71 sustain a fall in the parking lot. She further stated the nursing student told her she was trying to pick something up off the parking lot and had tumbled out of the chair and he responded to her immediately. She stated Resident #71 did not hit her head. Hospice Nurse #1 stated she assessed Resident #71 and there were no signs of injuries, but ants were crawling on her which she and the nursing student brushed off Resident #71. She further stated the reason Resident #71 was not to be left outside unattended was because she would not know to come back in and had poor safety awareness. She further stated Nurse #2 who had Resident #71 on 10/2/18 knew Resident #71 was not to be outside alone. Hospice Nurse #1 concluded Resident #71 was able to self-propel herself in her wheelchair and must have wheeled herself to the other side of the parking lot near the curb where she sustained her fall. During an interview on 10/9/18 at 11:06 AM Nurse #2 stated she was familiar with Resident #71's care. She further stated Resident #71 would think she could do what she used to be able to do. Resident #71 used to come and go in the facility as she pleased when she was in assisted living, but now needed more help and did not understand that. She further stated Resident #71 needed one on one supervision when outside. Nurse #2 stated Resident #71 was to be on one on one supervision since August of 2018. She further stated on 10/2/18 one of the nursing	F 689	and who to contact if concerns arise regarding residents sitting on the front porch. • Residents at risk for elopement are identified by this facility by placing a picture of the resident in an Elopement Risk notebook that is located at each nurse's station, receptionist desk, and a poster at the time clock. It is each employee's responsibility to review this notebook at the beginning of each shift so that you are familiar with residents who are at risk. The Director of Nursing is responsible for ensuring the elopement risk notebooks and poster are up to date. • If a resident begins to exhibit exit seeking behaviors such as sitting for long periods of time at the doors, trying to open exit doors, exhibits anxiousness about leaving or expecting a family member to arrive, and other activities that involve trying to leave the facility or verbalizing that they want to leave or are going to leave. Notify the Nurse immediately. Redirect the resident by encouraging them to participate in activities that they enjoy or meeting physical needs such as toileting or hunger/thirst. Assess for evidence of pain and address as indicated. The care plan/kardex is a good resource for additional interventions. • Once the resident starts exhibiting exit seeking behavior, if the interventions are not effective in redirecting the behavior, then one-on-one should be initiated and you should call the Administrator or DON when this occurs. The MD, RP, DON, &	

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students found Resident #71 in the parking lot. Resident #71 had eaten her breakfast, got up in her chair, and was out in the hall. Nurse #2 further stated she did not take Resident #71 outside and instead, Resident #71 scooted to the locked door where the Activities Director opened the door for her while she was heading to stand up meeting. Nurse #2 stated Resident #71 then must have proceeded to go out the front door. She further stated the Activities director did not know she was not allowed to go outside on her own and needed another person to sit with her. Nurse #2 stated Resident #71 needed to be repositioned in her chair often through the day because she would slump in her chair and was at risk for falls. She further stated she spoken with the Activities Director and educated her. She further stated the Administrator had also educated staff to not allow Resident #71 outside unattended since her return in August 2018. She further stated there was a wandering poster board next to the time clock as well as near the nurse ' s station. She further stated they had not placed her on that list prior to the fall on 10/2/18 but did not know why she had not been placed on the list.

During an interview on 10/9/18 at 11:29 AM the Activities Director stated she was on her way to the standup meeting which started at 9:15 AM and Resident #71 was right behind her as she went through the door and she held the door for Resident #71 to go out of the locked area of the facility. The Activities Director stated she then went to the conference room door on that hall and went in as Resident #71 was heading to the front door. The Activities Director further stated at that time she was not aware Resident #71 was not to leave the facility unattended by staff. She stated

Administrator should be notified of the exit seeking behavior for further interventions.
- If new exit seeking behavior is noted, check the resident's vital signs and assess for a change in condition. Notify MD of the findings.
- Changes in condition that could affect a resident's safety include: new or worsening: confusion, behavioral changes, level of cognition, or mood changes. If you notice any of these changes in your resident notify the nurse for assessment and MD notification if indicated.
- If the resident does not have a wander guard band on, then initiate one. Additional wander guard bands are located in the top drawer of desk in EMAR back up computer office at end of 400 hall beside nurses station.
- The CNA's check placement of the wander bracelet q shift and this is documented on the electronic charting in POC. If the bracelet is not found on the resident, immediately notify the nurse for a replacement.
- Function of wander guards is completed by the 11-7 shift nurse. This check is documented on the eMAR.
- If an elopements occurs, complete an incident report with notification of MD and RP. You must also immediately notify the Administrator or Director of Nursing.
- Any time an exit door alarm sounds or a squeal box alarms, then a staff member must immediately physically go to that door and check to see if a resident has exited or attempted to exit before resetting the alarm.

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F 689	Continued From page 28 after Resident #71 had her fall in the parking lot, Nurse #2 came and informed her Resident #71 was not to leave the locked area unattended by staff. She further stated sometimes the staff send an email to all staff informing them of who could not be outside the locked area unattended and other times the staff verbally inform her of who cannot leave the locked area unattended. She further stated the only reason she held the door open for Resident #71 on 10/2/18 was because she was unaware Resident #71 was to be under supervision when outside the locked area of the facility. She stated either no one told her, she missed the email, or no email was sent. During an interview on 10/9/18 at 11:47 AM Hospice Nurse Aide #1 stated she had cared for Resident #71 since September 2018 when she was placed on hospice care. She further stated Resident #71 was able to self-propel herself with her feet. She further stated she helped a nursing student get Resident #71 bathed and up for the day on 10/2/18 when she had her fall. She further stated once she was clean and positioned in her chair she went to her next hospice resident and did not see Resident #71 for the rest of the day. Hospice Nurse #1 further stated she was told about Resident #71's fall the next day on 10/3/18. The Hospice Nurse Aide further stated ever since Resident #71 had been placed on hospice care she was supposed to have supervision when exiting the locked area of the facility. She further stated the supervision was needed because Resident #71 tended to slump in her chair and was at risk to falling from her chair, so she needed to be repositioned in her chair often. She further stated the Hospice Nurse #1 would inform her which residents required supervision when outside the facility and Resident #71 had always	F 689	• At no time can a staff member disable an exit door/wander guard system alarm without the knowledge and approval of the Administrator or DON. All Staff: Wander guard system We have a wander guard system that will alarm if a resident is trying to leave the facility. This system will alarm when a resident comes through the double doors on the front hall way and after they move past the first conference room door before nearing the second conference room door. IF AN ALARM SOUNDS • Staff should quickly respond to the location and determine the cause of the alarm. • If it is possible that a resident has left the facility then implement the missing person procedure. • Complete an incident report for QA follow up. • EMERGENCY SWITCH o There is an emergency switch that is covered at each door. This is only to be used in the case of emergency. o There is an alarmed cover over this switch. WHEN THE SYSTEM MAY NOT WORK • The system shuts down anytime the fire alarm is sounded. During this time, all at risk residents should be monitored and exit doors checked to ensure residents do not exit during the fire alarm. All doors	

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been one who needed supervision when outside.

During an interview on 10/9/18 at 1:56 PM the Director of Nursing stated she had not been aware Resident #71 had been outside the previous week on 9/26/18 and overheated until after Resident #71's fall on 10/2/18. She further stated no staff members brought the concern to her attention that Resident #71 had been outside and gotten over heated or had a decline safety awareness. She further stated sitting outside was not anything unusual for Resident #71 and she had not implemented any one on one care and no concerns had been brought to her by staff prior to the fall that Resident #71's Responsible Party and hospice did not want Resident #71 outside unsupervised until they had a meeting after the fall. During the meeting following Resident #71's fall on 10/2/18 staff then did inform the Director of Nursing about the concern of the family and Nurse #2 informed the Director of Nursing that Resident #71's responsible party had wanted Resident #71 to not be outside unattended. She further stated if a family member shared a concern with a staff member it was her expectation that the staff member brings that concern to the administrative staff to follow up on. She further stated Nurse #2 did not bring the concern to the administrative staff and should have. The Director of Nursing concluded to her knowledge, Resident #71 had been in the facility for a long time in assisted living and had recently been placed in the skilled nursing unit following her hospitalization, but she had always been let outside unsupervised.

During an interview on 10/9/18 at 2:16 PM the Administrator stated Resident #71 had been having some changes recently and he felt it would

should be checked to make sure that they lock back after the fire alarm is finished. The charge nurses responsible for that area should check. Main doors and employee entrance should be checked by the 100 hall nurse for all 3 shifts.

- If a resident stands (the alarm will be sounding) at the door for more than 20 seconds and applies pressure the door will release. If a resident is seen standing at the door they should be redirected.
- Any time the system is not functioning properly the administrator and maintenance director should be immediately notified.

For Nurses
When completing the risk assessment UDA:

- Risk assessments are completed on all new admissions and readmissions and quarterly reviews. Once the UDA is completed review the score by clicking on the score beside the completed assessment. If the Skilled resident scores moderate (5-10) or high (11 or higher) for elopement risk then apply a wander guard bracelet and enter batch orders for bracelet function and placement checks. The bracelet must remain in place until reviewed by the DON and QOL team.
- During the daily Clinical meeting review, the DON will ensure that with each newly identified resident at risk for elopement that the resident's picture is placed in each Elopement Risk notebook within 72 hours of identification.

Physician's orders will be initiated by the hall nurse who completes the Risk UDA that identifies the resident at risk for

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F 689	Continued From page 30 be best for the wander guard to be placed following the fall on 10/2/18. He further stated the week before the fall Resident #71 had been outside for an extended period and a guest was concerned she was too warm. He further stated he was not aware of the blisters to the resident's right arm until after the fall on 10/2/18 but Resident #71 was very lethargic when she came inside on the day someone was concerned she overheated. He further stated from that point he spoke with staff to be sure they were aware of her location for safety precautions. He further stated Resident #71 had been outside every day since she had been in the facility for years and because her cognition was decreasing he wanted staff to be aware of where she was. He further stated no staff had brought to his attention that Resident #71's responsible party had requested Resident #71 not be left outside unsupervised. The Administrator also stated he was not aware that front line nurses and nurse aides had not been allowing Resident #71 to go outside unsupervised and thought it had always been her routine to go outside. He further stated if a family member brought a request such as supervision while outside to their attention, it was his expectation that the staff member bring this concern to the administration's attention to be addressed in the interdisciplinary team meetings. He further stated he had provided education verbally to staff to ensure they were aware of where Resident #71 was and if she was outside following the incident where the visitor was concerned about her overheating. He further stated it was his expectation Resident #71's nurse and nurse aide would have known Resident #71's location on 10/2/18 when the hospice nurse was asking where her location was. He further stated following the fall on 10/2/18 he met with the	F 689	elopement when the score is generated. Conclusion • Remember to monitor all residents for location and safety needs on routine visits. • When exit seeking behavior is noted, try to redirect the resident. If the resident is not redirectable, then initiate one on one and notify the Administrator and initiate a wander guard band. Assess for a change in condition and notify the R/P and MD. If you have questions or need clarification please contact your nurse manager/Director of Nursing. Resources Please provide supporting resources including: • Resident safety and health program and Liberty Elopement Policy and Procedure On 10/05/2018 the Nurse Consultant educated the Director of Nursing on reviewing residents with a moderate and high score for risk of elopement daily Monday through Friday in the Clinical quality of life meeting for the need of wander guard placement or supervision. When a risk assessment is completed on a resident on admission, quarterly, and with significant changes the elopement risk score will populate to the point click care dashboard for review. If the resident is independently mobile and has a BIMS score of 11 or less then the resident is to be reviewed for the need of a wander	

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responsible party and she shared with him she had spoken to an unnamed staff member that she wanted Resident #71 to have supervision while outside. He further stated this was the first time he had heard this concern and the conclusion was to place a wander guard on Resident #71 following the fall on 10/2/18.

During an interview on 10/9/18 Nurse Aide #1 stated Resident #71 moved fast since she came to the 300 hall and if she did not keep up with Resident #71 she would disappear. She further stated staff were to keep up with where Resident #71 was. The nurse aide stated Resident #71 used to go outside by herself when she was on the assisted living side of the facility. She further stated since she came to the skilled unit at some point in September 2018 Resident #71 was not to go outside the facility unsupervised by staff. If Resident #71 wanted to go outside a staff member would need to go outside with her. She further stated she was made aware of this by word of mouth that Resident #71 was not to go outside the facility unsupervised. She further stated she did not know anything about her being outside for an extended period of time or getting overheated. She concluded she did know, however, Resident #71 was not supposed to be outside on her own since sometime in September and sometimes visitors would let her outside and staff would have to bring her back in and educate the visitors.

During an interview on 10/9/18 at 3:50 PM Nurse #3 stated she was familiar with Resident #71's care. She further stated Resident #71 was not to be left outside unsupervised during her shifts. She further stated this was due to her cognitive decline when she moved to the skilled nursing

guard placement and or supervision when going outside.
The Staff Development Coordinator will ensure that any employee who has not received this training by 10/09/2018 will not be allowed to work until the training is completed. As of 10/09/2018 approximately 50% of employees have received this training. This in-service included the following topics:
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
The Director of Nursing or Staff Development Coordinator will complete the Quality Assurance (QA) for resident safety daily Monday thru Friday times 2 weeks then monthly x three months: monitoring will include observing residents sitting outside for safety concerns such as overheating, incontinence care, safety issues. In addition to this a quality assurance monitor will be completed to review residents with a newly completed risk assessment to audit the elopement risk score for appropriate interventions. This monitor will be completed by the Nurse consultant on 5 residents weekly for 2 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate.
Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager.

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F 689	Continued From page 32 side in August on 2018. She further stated she did not know what other did on their shifts, and she stated she did not report her concern for Resident #71 being outside unsupervised except to ask visitors or staff to not let her be unsupervised outside. During an interview on 10/9/18 at 4:24 PM the Administrator stated he did not have any documentation regarding the incident on 9/26/18 when the resident was brought in by a visitor and was lethargic and there was a concern she was warm. During observation on 10/9/18 at 5:35 PM the distance Resident #71 traveled from the entrance to the area she sustained a witnessed fall was measured with the Plant Operations Supervisor to be 68 feet. During an interview on 10/10/18 at 8:08 AM Nurse #2 stated some time prior to Resident #71's fall on 10/2/18, Unit Manager #1 had brought Resident #71 in the facility from outside because she had overheated, and her arms were very warm. Unit Manager #1 placed Resident #71 by the nurse station and told Nurse #2 that Resident #71 had gotten over heated. She stated Resident #71's Nurse Practitioner and Nurse #2 did an assessment of Resident #71. She further stated Resident #71 sat in her chair for a while and then had placed her in her room. Resident #71 was lethargic and not as active as she had been in the morning. Nurse #2 further stated she had told other nurse aides and nurses that Resident #71 was not to go outside unsupervised but had never brought this to the attention of her managers.	F 689	The administrator is responsible for assuring the implementation of the credible allegation. Completion date 10/10/2018	

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During an interview on 10/10/18 at 8:18 AM Resident #71's Nurse Practitioner stated Resident #71 was in the facility in the assisted living section of the facility for a long time. The Nurse Practitioner stated she saw Resident #71 much more than the physician and was very familiar with Resident #71. The Nurse Practitioner stated Resident #71 had sustained a gradual decline in status with a huge bump in deterioration of her kidney function. Resident #71 then went to the hospital and came back in August 2018 very debilitated due to her kidney function decline. The Nurse Practitioner spoke with the family and the decision was made to make the resident a hospice resident. She further stated when Resident #71 was in assisted living she was able to make safety decisions, however, once she returned from the hospital in August 2018 she had a very noticeable cognitive decline. She further stated one day Resident #71 went outside in the sun and fell asleep and had gotten a sunburn with some blistering to both forearms, possibly related to kidney failure as well. She stated she did not document this assessment anywhere because hospice usually documented on Resident #71. She further stated following this incident she believed the facility staff supervised Resident #71 more closely when she was outside. She further stated she then visited Resident #71 on 10/1/18 and her blisters had opened and were itchy. She further stated she had ordered cetirizine for the itching. The Nurse Practitioner concluded Resident #71 had declined in safety awareness since her hospitalization and she agreed with the placement of the wander guard for safety and for staff to be more cognizant of where she was.

During an interview on 10/10/18 at 8:51 AM MDS

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Nurse #1 stated if there was a change in condition for a resident it would be brought to MDS Nurse #2's attention by the floor nurse and then discussed in the interdisciplinary team meeting and updated on the care plan. She further stated if a resident began to have a cognitive or functional decline it was the expectation that the frontline staff would notify the interdisciplinary team to address the decline in documentation and the care plan. She further stated Resident #71 had sustained a severe decline when she came back to the facility from the hospital in August 2018. She further stated Resident #71's safety and cognitive awareness drastically declined following her hospitalization and she was then placed on hospice in September 2018. She further stated if Resident #71 went outside it was supposed to be with family who would supervise her outside and Resident #71 was not to be outside by herself. If it was noticed she was going outside by herself the staff would stop her and bring her back on the unit. She further stated Resident #71 would always sit by the locked door and if a visitor came she would ask them to hold the door for her and would attempt to go out to the front of the facility. She further stated she cared for Resident #71 when she first came back from the hospital on the 100 hall and Resident #71 hardly got out of bed during that time. She further stated once she moved to the 300 hall Resident #71 began getting up and out of bed. She stated it was around the beginning of September 2018 when Resident #71 became more active and at that time MDS Nurse #1 did not have Resident #71 on her unit and did not know if Nurse #2 had reported the concern of her waiting by the door. MDS Nurse #1 stated it was a general understanding among the frontline nurses and nurse aides Resident #71 was not to

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be outside unsupervised and she did not know why it was not known by the Director of Nursing, Administrator, or other members of the interdisciplinary team. She stated she did not have Resident #71 once she moved to the 300 hall so she would ask Nurse #2 if Resident #71 was okay to go outside before opening the door and Nurse #2 would tell her no, Resident #71 had to be supervised outside the facility. She further stated Resident #71 was to be supervised outside the facility since her return from the hospital in August 2018. MDS Nurse #1 further stated it was the expectation that Nurse #2 bring the concern of Resident #71's change in condition, waiting by the door, and decreased safety awareness to the charge nurse, MDS Nurse for care planning, and flagged the chart for the physician.

During an interview on 10/10/18 at 12:40 PM Unit Manager #1 stated approximately two weeks ago she was returning to the facility from her lunch break with Unit Manager #2 who was Resident #71's unit manager. She further stated they were coming into the front of the building around 1 PM and a visitor was bringing Resident #71 inside from outside and said that Resident #71 didn't seem like herself and asked them to help her get Resident #71 inside. Unit Manager #1 stated they took her to unit 2 where Nurse #2 and Resident #71's Nurse Practitioner were. Unit Manager #1 stated she took Resident #71's vital signs, oxygen blood levels, and blood sugars because Resident #71 was diabetic. Unit Manager #1 stated she did not recall any vital signs being abnormal at that time or her blood sugar being abnormal. She further stated she did not do a skin assessment on Resident #71 at that time. She stated if anyone had ever told her Resident #71 was not supposed to be outside or needed to be

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supervised it would have been alarming because she thought Resident #71 could go outside unsupervised. She further stated a staff member was not outside with Resident #71 on the day she was brought in by a concerned visitor, however other residents and visitors were outside with Resident #71. She further stated Resident #71 would sit at the locked door and wait for someone to open the door and let her go outside. She further stated after her fall outside on 10/2/18 she was aware Resident #71 needed supervision, however prior to 10/2/18 no staff, family members, or hospice staff had informed her they did not want Resident #71 outside unsupervised.

During an interview on 10/2/18 at 2:02 PM Hospice Nurse Aide #1 stated when Hospice Nurse #1 told her about the blisters to Resident #71's arms Hospice Nurse #1 asked her to place cream to Resident #71's blisters and wrap them. She further stated this happened about two weeks ago but did not remember the date. She stated when she first observed Resident #71's forearms it looked like a sun burn because her skin was peeling, and Resident #71 was scratching at it. She stated she placed the cream on Resident #71's forearms and wrapped them. She further stated now the left arm had appeared to heal and they were currently only wrapping the right forearm.

During an interview on 10/10/18 at 2:14 PM Unit Manager #2 stated she was coming back from lunch around 1 PM with Unit Manager #1 and when she came into the building she was stopped by a family member as Unit Manager #1 continued. Someone stopped Unit Manager #1 and mentioned something to her about Resident #71 and Unit Manager #1 took Resident #71 back

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in to the facility. Unit Manager #2 stated Unit Manager #1 pushed Resident #71 to Nurse #2 and reported to Nurse #2 she had been stopped and that there was a concern about Resident #71's health. She further stated Unit Manager #1 and Nurse #2 did an assessment on Resident #71 and everything seemed okay. Unit Manager #2 further stated at that time to her knowledge no skin assessment was done. She further stated she did not know when the blisters to Resident #71 were first identified but they were brought to her attention on 10/4/18. Unit Manager #2 stated it was brought to her attention because on 9/29/18 Resident #71's nurse had documented a new skin issue in their documentation. She further stated she was not aware of any blisters to Resident #71's left arm that Hospice Nurse #1 and Hospice Nurse Aide #1 wrapped on 9/27/18. She further stated when Resident #71 was on the assisted living side she was able to self-propel. Resident #71 then returned from the hospital to the skilled unit on 100 hall but was not as active. Unit Manager #2 further since Resident #71 went to the 300 hall on 9/1/18 she began to self-propel herself in her chair again. She further stated Resident #71 had always had a routine of going outside and sitting under the car port when she was in assisted living. She further stated prior to 10/2/18 she would have opened the door and let the resident go outside unsupervised. Unit Manager #2 stated no staff, family members, or hospice staff had brought to her attention their concerns with Resident #71 going outside unsupervised by staff. She further stated it was her expectation that if any staff had such concerns they would report to her and she could begin the process of implementing a plan and updating the care plan.

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During an interview on 10/10/18 at 5:25 PM the Director of Nursing stated Resident #71 had no new formal risk assessment or elopement risk assessment since her admission on 8/10/18 when she was on the 100 hall.

During an interview on 10/11/18 at 10:30 AM Nurse Aide #1 stated Resident #71 came to the 300 hall in September of 2018. She further stated since that time Resident #71 was not to go outside the locked area of the facility unsupervised by staff per her nurses.

The Administrator and DON were notified of the immediate jeopardy on 10/9/18 at 4:35 PM. On 10/10/18 at 4:30 AM the facility provided the following credible allegation of compliance for immediate jeopardy removal:

"Credible Allegation for Supervision to prevent accidents
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
On 09/26/2018 the resident had been sitting outside on the front porch when a visitor assisted her in the front door and alerted the Unit Manager. This occurred around 1PM. The resident was assisted back to her unit by the Unit Manager and an assessment performed revealing vital signs, SPO2, and blood sugar were within normal limits for this resident. The Unit Manager stated that the resident ' s skin was warm and dry. No blisters or redness were observed to the residents upper extremities at this time. A report was immediately given to the FNP who then assessed the resident. The FNP stated that the Unit Manager reported to her that the resident had been brought in from outside

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due to appearing sleepy and was sitting out doors. The Unit Manger took the residents vital signs and reported them to her and they were "well within her normal limits and the resident did not appear to be in any distress". The FNP states that she was aware of the resident sitting outside alone as she has seen the resident sitting on the front porch frequently and no concerns were seen with this activity. No medical interventions were required due to this event. On 09/27/2018 the Hospice nurse was in the facility to assess the resident and noted blisters on the resident ' s right arm. The resident was complaining of itching in this area. The hospice nurse directed the hospice aide to apply cream to the area and apply sleeves to prevent the resident from scratching the area and to trim her nails. The hospice nurse states this was completed on 09/27/2018.
On 10/02/2018, the Director of Nursing and the Administrator met and discussed the incident regarding the fall outside and determined the root cause of the incident was that the resident now required supervision while outside.
· Corrective action for the affected resident: On 10/02/2018 the resident was assigned a wander guard bracelet to prevent her from going outside unsupervised due to her safety risk.
On 10/02/2018 the Director of nursing interviewed and assessed the resident for the need of wander guard placement and initiated orders for wander guard placement and monitoring.
On 10/02/2018 at approximately 9:15AM the resident was assisted through the double doors onto the front hall way by the activities assistant. The resident proceeded to go out the front doors to sit on the front porch as per her normal routine. Per the staff interviews conducted including the FNP this was her normal routine up until

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10/02/2018. The activity assistant observed the resident still sitting on the front porch at approximately 9:45AM. At approximately 10:15AM the resident was observed leaning over in her wheel chair as to pick something up off the ground and fell out of her wheel chair. The resident did not sustain an injury as a result of this fall. The fall occurred between the canopy and the first handicapped parking spot. The hospice nurse was immediately summoned to assess the resident. After assessment was completed the resident was transported inside and the responsible party and MD were notified by the hospice nurse and the Director of Nursing. On 10/02/2018 the Director of Nursing and the Administrator met and discussed the incident and determined the root cause of the incident was that the resident now required supervision while outside.

· Corrective action for affected resident: On 10/02/2018 the resident was assigned a wander guard bracelet to prevent her from going outside unsupervised due to her safety risk.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

An REQ (Review to Ensure Quality) was initiated on 10/05/2018. On 10/05/2018, the Director of Nursing initiated an audit of all current residents and ran a report from Point Click Care of residents ' elopement risk scores for the last 3 months to audit for a risk score of moderate or high risk for elopement. Resident ' s with a risk score of moderate or high risk for elopement were then reviewed for the following: mobility status when up in their chair or ambulating and if they had a BIMS of 11 or less to determine the need for wander guard placement or supervision when going outside. Residents that had a BIMS

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of 11 or less and who were independently mobile were reviewed by the Director of Nursing and Nurse Consultant for the need of a wander guard placement or supervision due to potential over exposure when going outside. This was finalized on 10/08/2018. There were no new residents that were identified as needing a wander guard bracelet or supervision while outside.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
On 10/05/2018 the Staff Development Coordinator, began in-servicing all full time, part time, and as needed staff on resident safety and monitoring. Topics included:
All Staff:
· Do not forget that frequent monitoring and supervision are needed in order to ensure resident safety. This means that you should be aware of the resident ' s location. Do not accept the wander guard system as a substitution for resident supervision.
· In addition to this, residents not identified as elopement risk should also be monitored for their location. Residents that sit on the front porch or out in the courtyards should be monitored for location, hydration, and safety needs. Risk include falls, dehydration, sun burn. Offer fluids, toileting, and rest periods by coming in from outside throughout your shift. Notify the nurse if the resident refuses to come in. Encourage patients who like to sit outdoors for long periods of time to use sunscreen and drink fluids to prevent adverse events. Make routine visits to check on the resident.

10/10/2018: Residents are monitored by nurses and CNA ' s during routine rounds at all times including while sitting outside. Residents noted

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sitting for extended times should be 1. Offered fluids (fluids may be obtained from the lobby from the beverage dispenser that is replenished twice a day by the kitchen staff), 2. Sunscreen should be applied as needed to exposed extremities and face of residents sitting for extended periods of time in the sun (sunscreen can be obtained from each nurses cart), 3. Residents should be monitored for clothing appropriate to the season (during warm months residents are not dressed in heavy coats placing them at risk for overheating and during cold months residents are not wearing clothing generally worn during warm months such as shorts that could cause cold exposure concerns such as hypothermia), 4. Signage has been placed in the lobby next to the beverage dispenser alerting visitors and families of the location of sunscreen, how to attain additional fluids, and who to contact if concerns arise regarding residents sitting on the front porch.

· Residents at risk for elopement are identified by this facility by placing a picture of the resident in an Elopement Risk notebook that is located at each nurse ' s station, receptionist desk, and a poster at the time clock. It is each employee ' s responsibility to review this notebook at the beginning of each shift so that you are familiar with residents who are at risk.
The Director of Nursing is responsible for ensuring the elopement risk notebooks and poster are up to date.
· If a resident begins to exhibit exit seeking behaviors such as sitting for long periods of time at the doors, trying to open exit doors, exhibits anxiousness about leaving or expecting a family member to arrive, and other activities that involve trying to leave the facility or verbalizing that they want to leave or are going to leave. Notify the

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Nurse immediately. Redirect the resident by encouraging them to participate in activities that they enjoy or meeting physical needs such as toileting or hunger/thirst. Assess for evidence of pain and address as indicated. The care plan/kardex is a good resource for additional interventions.

· Once the resident starts exhibiting exit seeking behavior, if the interventions are not effective in redirecting the behavior, then one-on-one should be initiated and you should call the Administrator or DON when this occurs. The MD, RP, DON, & Administrator should be notified of the exit seeking behavior for further interventions.

· If new exit seeking behavior is noted, check the resident ' s vital signs and assess for a change in condition. Notify MD of the findings.

· Changes in condition that could affect a resident ' s safety include: new or worsening: confusion, behavioral changes, level of cognition, or mood changes. If you notice any of these changes in your resident notify the nurse for assessment and MD notification if indicated.

· If the resident does not have a wander guard band on, then initiate one. Additional wander guard bands are located in the top drawer of desk in EMAR back up computer office at end of 400 hall beside nurses station.

· The CNA ' s check placement of the wander bracelet q shift and this is documented on the electronic charting in POC. If the bracelet is not found on the resident, immediately notify the nurse for a replacement.

· Function of wander guards is completed by the 11-7 shift nurse. This check is documented on the eMAR.

· If an elopements occurs, complete an incident report with notification of MD and RP.

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You must also immediately notify the Administrator or Director of Nursing.

· Any time an exit door alarm sounds or a squeal box alarms, then a staff member must immediately physically go to that door and check to see if a resident has exited or attempted to exit before resetting the alarm.

· At no time can a staff member disable an exit door/wander guard system alarm without the knowledge and approval of the Administrator or DON.

All Staff:
Wander guard system
We have a wander guard system that will alarm if a resident is trying to leave the facility. This system will alarm when a resident comes through the double doors on the front hall way and after they move past the first conference room door before nearing the second conference room door.

IF AN ALARM SOUNDS

· Staff should quickly respond to the location and determine the cause of the alarm.

· If it is possible that a resident has left the facility then implement the missing person procedure.

· Complete an incident report for QA follow up.

· EMERGENCY SWITCH

o There is an emergency switch that is covered at each door. This is only to be used in the case of emergency.

o There is an alarmed cover over this switch.

WHEN THE SYSTEM MAY NOT WORK

· The system shuts down anytime the fire alarm is sounded. During this time, all at risk

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residents should be monitored and exit doors checked to ensure residents do not exit during the fire alarm. All doors should be checked to make sure that they lock back after the fire alarm is finished. The charge nurses responsible for that area should check. Main doors and employee entrance should be checked by the 100 hall nurse for all 3 shifts.

· If a resident stands (the alarm will be sounding) at the door for more than 20 seconds and applies pressure the door will release. If a resident is seen standing at the door they should be redirected.

· Any time the system is not functioning properly the administrator and maintenance director should be immediately notified.

For Nurses

When completing the risk assessment UDA:

· Risk assessments are completed on all new admissions and readmissions and quarterly reviews. Once the UDA is completed review the score by clicking on the score beside the completed assessment. If the Skilled resident scores moderate (5-10) or high (11 or higher) for elopement risk then apply a wander guard bracelet and enter batch orders for bracelet function and placement checks. The bracelet must remain in place until reviewed by the DON and QOL team.

· During the daily Clinical meeting review, the DON will ensure that with each newly identified resident at risk for elopement that the resident ' s picture is placed in each Elopement Risk notebook within 72 hours of identification. Physician ' s orders will be initiated by the hall nurse who completes the Risk UDA that identifies the resident at risk for elopement when the score is generated.

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Conclusion

· Remember to monitor all residents for location and safety needs on routine visits.

· When exit seeking behavior is noted, try to redirect the resident. If the resident is not redirectable, then initiate one on one and notify the Administrator and initiate a wander guard band. Assess for a change in condition and notify the R/P and MD.

If you have questions or need clarification please contact your nurse manager/Director of Nursing.

Resources

Please provide supporting resources including:

· Resident safety and health program and Liberty Elopement Policy and Procedure

On 10/05/2018 the Nurse Consultant educated the Director of Nursing on reviewing residents with a moderate and high score for risk of elopement daily Monday through Friday in the Clinical quality of life meeting for the need of wander guard placement or supervision. When a risk assessment is completed on a resident on admission, quarterly, and with significant changes the elopement risk score will populate to the point click care dashboard for review. If the resident is independently mobile and has a BIMS score of 11 or less then the resident is to be reviewed for the need of a wander guard placement and or supervision when going outside.

The Staff Development Coordinator will ensure that any employee who has not received this training by 10/09/2018 will not be allowed to work until the training is completed. As of 10/09/2018 approximately 50% of employees have received this training. This in-service included the following topics:

Indicate how the facility plans to monitor its

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F 689	Continued From page 47 performance to make sure that solutions are sustained. The Director of Nursing or Staff Development Coordinator will complete the Quality Assurance (QA) for resident safety daily Monday thru Friday times 2 weeks then monthly x three months: monitoring will include observing residents sitting outside for safety concerns such as overheating, incontinence care, safety issues. In addition to this a quality assurance monitor will be completed to review residents with a newly completed risk assessment to audit the elopement risk score for appropriate interventions. This monitor will be completed by the Nurse consultant on 5 residents weekly for 2 weeks then monthly for 3 months. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. The administrator is responsible for assuring the implementation of the credible allegation. Completion date 10/10/2018" The credible allegation for Immediate Jeopardy removal was validated on 10/11/18 at 11:09 AM, which removed the Immediate Jeopardy on 10/10/18, as evidenced by staff interviews, in-service record reviews, and observation. The in services included information on, elopement risk assessments and how to complete them, identification of residents who are at risk for elopement, and what actions to take if a resident appears to be at risk for elopement.	F 689		
F 690	Bowel/Bladder Incontinence, Catheter, UTI	F 690		10/31/18

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F 690 SS=D	Continued From page 48 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and	F 690	The statements made on this plan of	

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F 690	Continued From page 49 record review the facility failed to keep a urinary catheter bag from coming in contact with the floor for 1 of 2 residents reviewed for catheter care. (Resident #23) Findings included: Resident #23 was admitted to the facility on 9/28/12. His active diagnoses included hypertension, benign prostatic hyperplasia, and neurogenetic bladder. Review of Resident #23's most recent minimum data set assessment dated 7/23/18 revealed Resident #23 was assessed as modified independence with decision making and had no moods or behaviors. The resident required extensive assistance with bed mobility, eating, and toilet use. Resident #23 was totally dependent on staff for dressing and personal hygiene. The resident was assessed to have an indwelling catheter. Review of Resident #23's care plan dated 7/31/18 revealed the resident was care planned for risk of infections related to the presence of a catheter. The interventions included to check catheter tubing for kinks throughout shift, position catheter bag and tubing below the level of the bladder and away from entrance room door, and provide catheter care every shift. During observation on 10/8/18 at 11:31 AM Resident #23 was observed in bed. Resident #23's catheter bag was observed hanging from the bed frame and the bottom half of the catheter bag was observed lying on the floor with the bed in the lowest position.	F 690	correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F690 1. For resident #23, a corrective action was obtained on 10/09/2018. On 10/09/2018 the Director of Nursing ensured the bed for resident #23 was at an appropriate height as to not allow the catheter bag to touch the floor while resident was resting in bed. Staff members responsible for the care of resident #23 were educated by the Director of nursing regarding positioning of the bed to prevent catheter bag from touching the floor. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with foley catheters have the potential to be affected by the alleged deficient practice. On 10/09/2018, the Unit managers completed an audit observing all current residents with foley catheters for correct placement of the foley bag on the bed frame to ensure the foley bag is not touching the floor.	

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F 690	Continued From page 50 During an interview on 10/8/18 at 11:35 AM Nurse #1 stated catheter bags were to be placed below the level of the bladder and were to never come in contact with the floor. Upon observing Resident #23 she stated the resident's catheter bag was on the floor and it should not have been in contact with the floor due to risk for infection. During observation on 10/9/18 at 8:43 AM Resident #23 was observed in bed. Resident #23's catheter bag was observed hanging from the bed frame and the bottom of the catheter bag was observed to be in contact with the floor again with the bed in the lowest position. During an interview on 10/9/18 at 8:44 AM the Director of Nursing stated catheter bags should not be placed on floor at any time. After observing Resident #23's catheter bag she stated the bag was in contact with the floor and it should not be. She further stated it was her expectation that staff keep the catheter bag from coming in contact with the floor.	F 690	3. Systemic changes In-service education was provided to all full time, part time, and as needed nurses, CNA's, Med Tech's, and Med Aides. Topics included: • Why it is import to ensure the foley bag does not touch the floor. • Where to attach the foley bag on the frame of the bed in order to prevent the bag from touching the floor. • Auditing the foley bag for correct placement when making care rounds. • Adjusting the height of the bed to ensure bag does not touch floor. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nursing staff as stated above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor placement of foley bags weekly x 2 weeks then monthly x 3 months using the Infection control Quality Assurance monitor. Monitoring will include auditing placement of the foley bag ensuring it does not touch the floor.	

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F 690	Continued From page 51	F 690	Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		10/31/18

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F 761	Continued From page 52 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to monitor and report medication refrigerator temperatures for 3 of 3 medication refrigerators reviewed (unit 1, unit 2 and unit 4 refrigerators), failed to remove expired medications, date a multi dose insulin pen, refrigerate eye drops and insulin not yet opened for 4 of 4 medication carts reviewed (cart 100/200, 300, 400 and 800), and failed to discard loose medications in 3 of 4 medication carts reviewed (cart 100/200, 400 and 800). Findings included: 1. On 10/10/18 at 4:18 PM the Unit 1 and 2 medication room was observed with Nurse #1. The Unit 2 medication refrigerator was observed with a temperature reading of 22 degrees Fahrenheit (F). No temperature log was observed and could not be located by Nurse #1. An interview with Nurse #1 was conducted on 10/10/18 at 4:18 PM. The nurse stated the refrigerator temps should have been checked. Medications within the refrigerator included: 2- Tuberculin purified protein injection 5/0.1 milliliter (ml) vials. The medication packaging indicated to store at 35-46 degrees F. 6- Pneumococcal vaccine polyvalent 0.5 ml vials. The medication packaging indicated to store at 36-46 degrees F. 24- Pneumococcal 13-valent conjugate vaccine 0.5 ml vials. The medication packaging indicated to store at 36-46 degrees F.	F 761	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F761 1. A corrective action for the out of range temperatures, expired medications was obtained 10/10/2018. Corrective action for loose pills in medication carts was obtained on 10/26/2018. The Director of Nursing removed all medications that were stored in the Unit 1, Unit 2, and Unit 4 medication room refrigerators and discarded. All new medications were ordered immediately for replacement from McNeill's Pharmacy. All medication carts were cleaned and loose pills were removed and audited for expired medications by Unit Managers, Staff Development Coordinator, and Director of Nursing on 10/26/18. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice.	

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F 761	Continued From page 53 95- Arformoterol tartrate 15 micrograms (mcg)/2 ml inhaler doses. The medication packaging indicated to store at 36-46 degrees F. 1- Liraglutide injection pen 6 milligrams (mg)/ml. The medication packaging indicated "refrigerate before first use- do not freeze" 1- Novolin R u (units)-100 10 ml vial. The medication packaging indicated "do not freeze." 1-Humulin R 100 u/ml 3 ml vial. The medication packaging indicated "refrigerate, do not freeze." 5-exenatide extended release injection pens 2 mg/pen. The medication packaging indicated "Store refrigerated 36-46 degrees. Do not freeze." 4- Humulin 70/30 u-100 injection pens. The medication packaging indicated "refrigerate unopened." 24- Novolog injection pens 100 u/ml. The medication packaging indicated "refrigerate until opened." 2- Epoetin alfa 10,000 units 1 ml vials. A pharmacy label on the packaging indicated "refrigerate immediately upon receipt." 12- Promethazine suppositories 12.5 mg. A pharmacy label on the packaging indicated "refrigerate immediately upon receipt." 22- Promethazine suppositories 25 mg. A pharmacy label on the packaging indicated "refrigerate immediately upon receipt." 2. On 10/10/18 at 4:18 PM the unit 1 and 2 medication room was observed with Nurse #1. The Unit 1 medication refrigerator was observed with a temperature reading of 28 degrees Fahrenheit (F). A temperature log was observed in a pocket attached to the front of the refrigerator. The temperature log sheet indicated it was for Unit 2, the month of 10/18. There was only one entry on the log for 10/9/18 and noted a refrigerator temperature of 40 degrees F. The	F 761	All residents have the potential to be affected by the alleged deficient practice. On 10/15/2018, the Staff Development Coordinator completed an audit observing all current medication room refrigerators for the following: refrigerator temperature logs in place and filled out daily with the temperature, observed temperatures logged and current temperature to ensure the correct range is noted, and audited each medication in the refrigerator for date opened and expiration dates. All medication carts were audited for expired medications and loose pills. 3. Systemic changes In-service education was provided to all full time, part time, and as needed nurses, medication aides, and Medication Tech's. Topics included: • Nightly on 11-7 shift each hall nurse is responsible for logging the medication refrigerator temperatures on Units 1, 2, and 4 prior to midnight. • Acceptable medication refrigerator temperature range is 36-46 degrees fahrenheit. • What you should do in the event the current temperature falls outside the acceptable temperature range. • Who to notify when the temperature falls outside the acceptable temperature range. • Proper storage of medications. • Medication cart cleaning schedule • Cleaning spills and pills from the medication cart drawer when they occur.	

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F 761	Continued From page 54 temperature log sheet notation at the bottom indicated "temperature must be checked daily around 4-5 AM by the even numbered hall nurses. Any temperature not ranging between 36-46 must be rechecked 1/2 hour later if still not in the above range report to DON (Director of Nursing)." An interview with Nurse #1 was conducted on 10/10/18 at 4:18 PM. The nurse stated the refrigerator temps should have been checked. Medications within the refrigerator included: 29- Albuterol 0.083% nebulizer doses. The medication packaging indicated to store at 36-77 degrees F. 1-Adalimumab injection pen 40 mg/0.8 ml. The medication packaging indicated to store at 36-46 degrees F. 1-Humulin R 100 u/ml 3 ml vial. The medication packaging indicated "refrigerate, do not freeze" 1- Novolin R u-100 10 ml vial. The medication packaging indicated "do not freeze." 1- Novolog flex pen 100 u/ml. The medication packaging indicated "refrigerate until opened." 3. On 10/10/18 at 5:48 PM the Unit 4 medication room was observed with the Director of Nursing (DON). The Unit 4 medication refrigerator was observed with a temperature reading of 29 degrees Fahrenheit (F). The temperature log sheet attached to the refrigerator indicated it was for the month of 10/18. There was only one entry on the log for 10/3/18 and noted a refrigerator temperature of 36 degrees F. The temperature log sheet notation at the bottom indicated "temperature must be checked daily around 4-5 AM by the even numbered hall nurses. Any	F 761	This information has been integrated into the standard orientation training and in the required in-service refresher courses for all nurses, Medication Aides, and Medication Tech's and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor medication room refrigerators on Units 1, 2, and 4 for temperature log, temperature ranges, and for expired or undated open medications weekly x 2 weeks then monthly x 3 months using the Residents rights/privacy Quality Assurance monitor. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager	

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temperature not ranging between 36-46 must be rechecked 1/2 hour later if still not in the above range report to DON."

On 10/10/18 at 5:48 PM an interview with the DON was conducted. The DON stated the refrigerator temperatures should be checked daily and logged and if the temps are not in range the DON should be notified. The DON stated she did not know why the temp logs had not been documented on or the temps checked.

Medications within the refrigerator included:

9- Acetaminophen 650 mg suppositories. Product packaging indicated "store at room temperature."
1- Novolin N 10 ml vial. Product packaging indicated "keep unopened in the refrigerator 36-46 degrees F. Do not freeze."
1- Humulin R U-100 10 ml vial. Product packaging indicated "refrigerate, do not freeze"

4. On 10/10/18 at 4:12 PM the 800 hall medication cart was reviewed with Nurse #5. One 10 ml vial of Humulin Regular insulin was observed and noted as opened on 7/1/18.

An interview with Nurse #5 was conducted on 10/10/18 at 4:12 PM. She stated the insulin was expired and should have been discarded. The nurse also stated the resident no longer used that type of insulin.

5. On 10/10/18 at 5:23 PM the 400 hall cart was observed with Nurse #4.

a. One Novolog insulin injection pen was observed dated as opened on 9/2/18. The pharmacy sticker on the insulin pen indicated

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"expires after 28 days."
b. One insulin glargine injection pen was observed with the product safety seal broken, indicating it had been opened. The label was not marked when the insulin had been opened.
c. One Xalatan eye drop bottle was observed with the safety seal still intact. A label on the bottle indicated it had been opened on 10/9/18. The instructions on the bottle indicate "Store unopened bottle in fridge. Opened store room temp for 6 weeks."

An interview with Nurse #4 was conducted on 10/10/18 at 5:23 PM. She stated The Novolog insulin pen was expired and should have been discarded and the insulin glargine pen should have been marked when opened. The nurse stated the eye drops had come from the pharmacy the day before and were to start today.

6. On 10/11/18 at 8:38 AM the 100/200 hall medication cart was reviewed with Nurse #1.
One Novolog insulin injection pen was observed with the safety seal still on, not marked as opened with storage instructions to "refrigerate until opened, after initial use do not refrigerate." The prescription date was noted as 10/5/18.

An interview with Nurse #1 was conducted on 10/11/18 at 8:38 AM. The nurse stated the insulin pen should have been stored in the refrigerator until needed.

7. On 10/11/18 at 8:53 AM the 300 hall cart was reviewed with Nurse #3.
One stock bottle of fexofenadine 180 mg with an expiration date of 7/2018 was observed.

An interview with Nurse #3 was conducted on

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	345218	A. BUILDING _____ B. WING _____	C 10/11/2018

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F 761	Continued From page 57 10/11/18 at 8:53 AM. The nurse stated she did not currently have any residents receiving this medication. She also stated when expired medications were discovered on the cart she would alert the DON and the next shift so they can review the cart and check for further expired medications. 8. On 10/10/18 at 4:12 PM the 800 hall medication cart was reviewed with Nurse #5. A total of 10 lose pills were discovered in the bottom of the second and third drawers of the medication cart. 9. On 10/10/18 at 5:23 PM the 400 hall cart was reviewed with Nurse #4. A total of 13 loose pills were discovered in the bottom of the left side second drawer. 10. On 10/11/18 at 8:38 AM the 100/200 hall medication cart was reviewed with Nurse #1. The top left drawer contained many twist off tabs for lancets and one loose pill was discovered. A total of 79 loose pills were discovered in the second and third drawers. On 10/11/18 at 11:30 AM an interview with the DON was conducted. The DON stated it was her expectation of the nursing staff to check the refrigerator temperatures and notify her if the temperatures were out of range, to clean the medication carts weekly and as needed and to remove expired medications from the cart.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		10/31/18

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F 880	Continued From page 58	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 59 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to implement proper isolation precautions when providing care to a resident on contact isolation for 1 of 2 residents reviewed for isolation precautions. (Resident #96) Findings included: Resident #96 was admitted to the facility on 9/7/11. Her active diagnoses included anemia, heart failure, hypertension, and Methicillin-Resistant Staphylococcus Aureus (MRSA) infection in urine.	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. 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 plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	

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F 880	Continued From page 60 Review of the facility's contact precautions policy revised 5/2014 revealed when a resident was on contact precautions staff must wear a gown when entering the resident's room. During observation on 10/9/18 at 8:29 AM Nurse Aide #1 was observed in Resident #96's room with a mask on but no gown or gloves assisting Resident #96 with breakfast. Resident #96's room was a contact isolation room with the appropriate signage and personal protective equipment placed at the entrance to the room. The signage stated to don a gown and gloves prior to entering the room. At 8:34 AM Nurse Aide #1 discarded her mask, exited Resident #96's room, and performed hand hygiene with hand sanitizer. During an interview on 10/9/18 at 8:35 AM Nurse Aide #1 stated she did not gown and glove when providing assistance with breakfast to Resident #96 because whatever the resident had was in her urine. During an interview on 10/9/18 at 8:46 AM the Director of Nursing stated if residents were on contact isolation staff would place gown and gloves on when providing care. She further stated it was her expectation that when providing care in a contact isolation room that staff always gown and glove prior to entering and Nurse Aide #1 should have had a gown and gloves on when assisting Resident #96 with breakfast.	F 880	F880 1. For resident #96, a corrective action was obtained on 10/09/2018. The CNA who failed to put on the correct PPE was verbally counseled by the Director of Nursing on 10/09/20018 regarding donning any applicable PPE such as gown, gloves, mask, goggles, or face shields as indicated on the isolation sign posted on the outside of the affected residents room. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents on transmission based precautions have the potential to be affected by the alleged deficient practice. On 10/09/2018, the Staff Development Coordinator completed infection control rounds to observe staff entering and exiting resident rooms who are on isolation precautions. The staff were audited for donning correct PPE according to the isolation precaution sign posted outside the resident door prior to entering the room and doffing the PPE prior to exiting the room and the PPE was properly disposed. 3. Systemic changes On 10/31/2018, the Staff Development Coordinator provided an in-service education to all full time, part time, and as needed nurses, CNA's, Med Tech's, House Keeping Staff, Dietary Staff,	

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F 880	Continued From page 61	F 880	Maintenance Staff, and Department Manager staff. Topics included: • Donning PPE prior to entering a resident room that is on isolation precautions according to the required PPE listed on the posted isolation sign. • Doffing the PPE prior to exiting the resident's room and how to properly dispose of the PPE. • Hand hygiene after exiting the isolation room. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Staff Development Coordinator or designee will monitor procedures for resident's rights weekly x 2 weeks then monthly x 3 months using the Residents rights/privacy Quality Assurance monitor. Monitoring will include auditing staff for knocking and asking permission to enter a resident's room prior to entering. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager.	