STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING ______ B. WING ______	C 12/11/2018

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ACCORDIUS HEALTH AT CLEMMONS	**3905 CLEMMONS ROAD CLEMMONS, NC 27012**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/7/18 to 12/8/18. The survey team could not validate the corrective plan until 12/11/18 because of severe weather. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Non-noncompliance began on 12/3/18. The facility came back in compliance effective 12/4/18. A Partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility for 1 of 3 residents (Resident #1) reviewed for supervision. Resident #1 exited the facility and was found approximately 24 feet	F 689	Past noncompliance: no plan of correction required.	12/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/31/2018

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 689	Continued From page 1 away from the door in 45 degree Fahrenheit weather. Findings included: Resident #1 was admitted to the facility on 11/10/17 with diagnoses that included unspecified psychosis, unspecified dementia with behavioral disturbances, and Alzheimer's dementia. A review of Resident #1's most recent Minimum Data Set (MDS), coded as a quarterly assessment and dated 11/21/18, revealed the resident was cognitively impaired. Active diagnoses included Alzheimer's disease, Non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The MDS coded Resident #1 under the behavior section as wandering daily. A review of Resident #1's care plan dated 8/26/18 revealed the resident had a care plan for wandering. The care plan reported the resident had a wander guard in place and the staff would monitor the wander guard daily for the resident's safety. Interventions included that Resident #1 would not leave the facility unattended, the staff would offer activities and distractions when exit seeking, and the staff would check the wander guard placement and function as ordered. A review of Resident #1's MAR (Medication Administration Record) for December 2018 revealed an order that read 'prior to checking placement of wander guard make sure red light is coming on the brown watch box. If the red light isn't coming on, the box isn't working properly and notify the administrator immediately.' It was documented on all three shifts on the December 2018 MAR that the wander guard was working. The nurse that documented on the MAR on 12/3/18 was not available for interview. A review of the nighttime temperature per AccuWeather for 12/3/18 revealed the temperature was 45 degrees Fahrenheit between	F 689		

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F 689	Continued From page 2 8pm and 10pm. A review of the facility incident report dated 12/3/18 at 10:10pm involving Resident #1 revealed a NA (Nursing Assistant) observed the resident exiting the building to the parking lot and immediately escorted the resident back inside. According to the incident report, there were no injuries noted. A review of Resident #1's medical record revealed a nursing note dated 12/4/18 at 12:20pm which read "NP (Nurse Practitioner) (was) called about resident leaving the unit. She wants the exits (doors) monitored closely. Staff will pass this on to am nurse. Currently resident is still up in his w/c (wheelchair) rolling around the unit. Staff will continue to monitor resident closely for safety." A review of Resident #1's medical record revealed a wandering assessment dated 12/4/18 that indicated the resident was at high risk for wandering. This wandering assessment was the only one noted in the medical record. An interview was conducted on 12/7/18 at 3:44pm with NA #1. She reported Resident #1 was usually docile but did get anxious at times. She reported when he got anxious, she would redirect him. She reported Resident #1 had never attempted to exit building while she was caring for him. NA #1 stated Resident #1's wander guard was in place on his right ankle whenever she cared for him but she stated she was not working on 12/3/18. An interview was conducted on 12/7/18 at 3:55pm with Nurse #1. She reported Resident #1 wandered the halls of the locked unit all second shift every day. She reported the resident never attempted to leave the building when she was working but would state "I want to get out of	F 689		

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F 689	Continued From page 3 here." Nurse #1 reported Resident #1 had on wander guard and she checked it on shift to make sure it was working. She reported that she took the wander guard box and put it up to the resident's wander guard. She reported a green light would then come on and that meant it was working. She reported if the green light didn't come on she reported it to her supervisor. She reported she did not have Resident #1 on the night of 12/3/18. An interview was conducted with the administrator on 12/7/18 at 4:25pm. He reported that staff texted him around 10:10pm on 12/3/18 to report Resident #1 had eloped but was back in the building. He reported the staff performed a safety check on all the windows and doors and saw the emergency release box plexiglass was broken and the switch turned off at the door leading to the outside near the front parking lot from the locked unit. He reported the staff made frequent checks on the residents and doors throughout the night. He reported the door was referred to as the "bird door" due to a painting of a bird on it. The administrator reported the maintenance supervisor came in the facility around 6:00 am on 12/4/18 and repaired the emergency box and added another, louder alarm to the outside door. The administrator reported that the former DON (Director of Nursing) informed him on 12/4/18 that Resident #1 did not have on his wander guard because the facility was attempting to wean him off it. He reported he did not know when the wander guard weaning was initiated. He reported there was no documentation of the resident without the wander guard. An interview was conducted on 12/7/18 at 5:00pm with Nurse #2. She reported she worked 3pm - 11pm on the locked unit on 12/3/18. She	F 689		

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F 689	Continued From page 4 reported she normally worked the 200 hall but due to renovations, she and the residents had been moved to the locked unit. Nurse #2 stated she did not have Resident #1 to care for on 12/3/18. She reported that prior to Resident #1 leaving the building, she noticed him going to all the doors and shaking them. She reported at one point, she noticed Resident #1 was sitting in a chair by the outside "bird" door pushing buttons on the keypad. Nurse #2 reported she mentioned it to one of the aides who normally worked on the locked unit but does not remember which one. She reported the aide told her that Resident #1 did that all the time but would get tired of it and move on to something else. She reported it was probably between 8:00pm and 9:00pm on 12/3/18 that NA #2 came through the main door on the unit (the interior door going into the rest of the facility) with Resident #1. Nurse #2 reported that the NA told the staff he saw the resident come through the outside door but didn't know who it was until he walked up to Resident #1 in the parking lot. A telephone interview was conducted on 12/8/18 at 10:00am with NA #3. She reported she was the NA who cared for Resident #1 on 12/3/18 from 7:00am until 11:00pm. NA #3 reported she did her rounds after supper on 12/3/18 but unsure of time. She reported she cleaned up Resident #1 as he had come out of his room carrying a brief. She reported she applied a clean brief, pajama bottoms and a long sleeve grey t-shirt. She reported Resident #1 then laid down in the bed and she went to the next room to take care of her next resident. She reported she did not remember seeing a wander guard on Resident #1 when she put him to bed. NA #3 reported she thought that the resident normally had a wander guard because she remembered hearing it go off	F 689		

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F 689	Continued From page 5 when he got near a door. She reported when she came out of the next resident's room, another NA was bringing Resident #1 back in from outside. She reported he was still in his pajama bottoms, long sleeve shirt and was wearing brown slippers. NA #3 reported she was told the resident went outside because the side door was unlocked. She reported it was only 10-15 minutes from the time she left Resident #1 in bed and finished up the next resident. An interview was conducted on 12/8/18 at 11:30am with Nurse #3 and Medication aide #1. Both reported they only work as needed and neither worked on 12/3/18. They both stated that when they worked, Resident #1 always had on his wander guard. A telephone interview was conducted on 12/8/18 at 12:20pm with NA #2. He reported that on the evening on 12/3/18, he was outside at the building where smoking was allowed for the staff. This building was located across the street from the facility and was approximately 142 feet from the facility door Resident #1 eloped from. NA #2 reported he was standing outside of the building and had a direct view of the facility door near the front parking lot. He reported he saw the door open and knew no one should be coming out of that door so he ran back across the street. He reported Resident #1 was standing outside next to the door and the door had just shut. NA #2 reported he then escorted Resident #1 back into the facility through the front door. He took the resident back to the locked unit and left him with the staff there. He reported he wasn't sure what time the incident occurred, but it was before 11:00pm. The front door and the door from inside the facility to the locked unit did not have a wander guard system.	F 689		

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F 689	Continued From page 6 A telephone interview was conducted on 12/8/18 at 12:25pm with Nurse #4 who was the former DON (Director of Nursing). She reported she was called by Nurse #5 on 12/3/18 sometime after 9:00pm. She reported the nurse called to inform her that Resident #1 had walked out of the "bird door" - the door going to the outside front parking lot from the locked unit. Nurse #4 reported she spoke to the nurse that did the incident report and was told one of the NAs was out in the parking lot and saw the resident in the parking lot and brought him back in. Nurse #4 reported Resident #1 was supposed to be wearing a wander guard but during the stand-up meeting on 12/4/18, someone reported he needed one. She reported the staff told her the batteries were almost dead in the alarm on the bird door and no one could hear the alarm sound. Nurse #4 reported she was told maintenance was going to replace the alarm on the bird door on 12/4/18. She reported she did not interview the NA that found Resident #1 as the Administrator was going to talk to him. She reported she had no knowledge that Resident #1 was being weaned off the wander guard. An interview was conducted with the Maintenance Supervisor on 12/8/18 at 12:40pm. He reported he was told on 12/4/18 that the alarm on the "bird door" - the door going outside to the front parking lot from the locked unit - was difficult to hear. He reported he replaced the alarm with a louder alarm on 12/4/18. He reported he checked the doors and alarms monthly and all were functioning correctly in November. He reported he was told about the plexiglass being broken on 12/4/18 around 6:00am and repaired the plexiglass around 6:40am on 12/4/18. Numerous unsuccessful attempts were made to contact Nurse #5 who cared for Resident #1 on the evening of 12/3/18 and filed the incident	F 689		

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F 689	Continued From page 7 report. An observation was made of Resident #1 on 12/7/18 at 3:44pm. The resident was ambulating in the hall near the nurses area. It was observed that Resident #1 went to the locked door leading to the main facility and tried to open the door. The staff redirected him to the dining area where there was a craft being done. It was noted Resident #1 had a wander guard on right ankle. An observation was made on 12/8/18 at 10:30am with the maintenance supervisor of the distance from the outside door where Resident #1 went out to the parking lot. It measured 22 feet. The distance from the outside door to the road on that side of the building was 67 feet. The measurement from the outside door to the road in front of the facility was 123 feet. The smoking building was located on the other side of the side road and was measured at 75 feet from the building to the parking lot. It was observed sitting on the bench inside the building on the right side or standing outside the building gave a direct view of the outside door. An observation was made on 12/8/18 at 11:15am of the outside doors on the locked unit with the maintenance supervisor. He demonstrated when the emergency switch was turned off the outside door was able to be opened but the alarm went off. If the emergency switch was on, the door would not budge. The emergency alarm was a switch which was enclosed by a red metal box with plexiglass window on the front. The only way to disable the alarm was to break the plexiglass and flip the switch to the off position. The maintenance supervisor demonstrated that a wander guard alarms loudly 6 feet from all outside exit doors and the kitchen door. It was noted the replaced alarm at the outside door that Resident #1 went out was much louder than the	F 689		

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F 689	Continued From page 8 other outside door alarms but all could be heard throughout the locked unit. On 12/8/18 at 1:00pm the observation was made through demonstration with the Administrator, DON, and the surveyors that it would take approximately 14 seconds to run from the smoking building to the parking lot. The facility implemented the following corrective action: Resident #1 was admitted to the facility on 11/9/17. His current BIMS (Brief Interview for Mental Status) score is 6 as of 11/21/18. The most recent wandering assessment was completed on 12/12/17. At 9:45PM on 12/3/18, Resident #1 exited the building via unit 1 and was immediately spotted by a male CNA (nursing assistant) who was smoking across the street. According to his statement, the male CNA first saw the light from the opening door, then saw the resident, and ran across the street, and assisted the resident back to the secure unit. Resident #1 had been placed in bed approximately ten minutes prior to being brought back to the secure unit. Upon Resident #1's return, Nurse K checked all exit doors and found that alarms were functioning, though the alarm on the "bird door" was not very loud. This alarm is a magnetic alarm intended for back-up purposes and is not the primary safety feature as the door is equipped with the emergency switch and wander guard. Nurse K noted that the switch cover on the emergency switch was now broken which allowed access to the switch that releases the lock on the side door. The door emergency switch is housed in a plexi glass paneled box designed to be pushed in/broken in an emergency allowing for the switch to be manipulated releasing the door. When intact, the switch remains engaged and the door cannot be	F 689		

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F 689	Continued From page 9 opened. As part of the facility's response the secondary alarm on that door was replaced with a much louder alarm to support the backup alarm function. The alarm was replaced on 12/4/18 by the Maintenance Director. Earlier in the evening, the 3-11 nurse had checked the position and function of Resident #1's wanderguard bracelet and it was intact per the medication administration record dated 12/3/18. However, when he returned, Resident #1 did not have his wander guard on. Although it was not found, Resident #1 appears to have removed his wanderguard by sliding it down his arm as Nurse S states he has done in the past. All Wander guard bracelets are checked daily by nurses using the "wand" to assure they are properly placed on residents and functioning. Additionally, wander guard doors and all door alarms had been checked weekly and the side door was working on 11/30/18 by the Maintenance Director. Doors are now verified as working and documented as such on a daily basis effective 12/4/18. Nurse J immediately completed a head to toe assessment on Resident #1, with no injury noted. An updated wandering assessment was completed by the DON (the Director of Nursing), on 12/4/18. The care plan for Resident #1 was reviewed and updated by the DON, on 12/4/18 to include reviewing the current interventions and the use of a wander guard. Nurse J, Nurse T and Nurse K initiated increased supervision for Resident #1 to include constant knowledge of whereabouts through hall monitoring as well as every 15 min checks to document his location per the Administrator's instruction on 12/3/18. These checks were completed by the CNAs, nurses and documented on a log for 72 hours following the incident. Post	F 689		

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F 689	Continued From page 10 event at approximately 9:55pm on 12/3/18, a head count of all residents on the secure unit was conducted by Nurse J, and Nurse T. All residents were present and accounted for. Nurse T notified Resident #1's responsible party, FNP (family nurse practitioner), on 12/3/18 at 10:00pm regarding Resident #1 exiting the facility, physical assessment following the event and plan for increased monitoring. No new physician orders were received. Nurse T notified the DON and administrator of the event on 12/3/18 at approximately 10:00pm On 12/4/18 at 6:40am, the Administrator completed an additional head to toe assessment finding no signs of injury. The Administrator also noted that resident had no recollection of the events of the previous evening and exhibited no signs of distress. It was determined on 12/4/2018 during an Interdisciplinary team meeting and Quality Improvement Process improvement impromptu meeting (DON, Assistant Director of Nursing, Staff Development Coordinator, the MDS nurse, the Maintenance Director and the Administrator) that Resident #1 was able to open the exit door on the short hall of the secure unit. The exit door was checked, and the alarm was working but the emergency release switch for that exit door had been broken and was uncovered. All exit doors were checked and secured immediately. All exit doors on secure unit were checked hourly until 8:00am on 12/4/18. On 12/4/18 the Maintenance Director checked all doors and alarms, replaced the secure panel for release switch for exit door on short hall of secure unit. During the above QAPI meeting, the process and policy were also reviewed and updated. A review identifying residents that have exit-seeking-behaviors (Gates Wandering	F 689		

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F 689	Continued From page 11 Assessment) was initiated for the entire facility was completed by the DON, ADON, and Supervisors on 12/4/18 to ensure they have a wandering risk assessment and care plan is reflective of interventions. "Exit seeking Risk" books containing face sheets with photographs of each resident who was at risk, were updated by the DON, ADON and Supervisors on 12/4/18 and placed on each unit. The Gates scale breaks risk in to low (0-4), moderate (5-10) and high risk (11 and up). Each resident was then reviewed on 12/4/18 by the nursing management team (DON, ADON, Night Supervisor and Administrator) to discuss the triggers that caused the score to be high or low and each was then assigned a validated score. For residents who were at high risk, wander guards were placed by the DON and Social Worker on 12/4/18. For those at moderate risk, wander guards were placed by the Social Worker and DON on 12/4/18 if the risk suggested the resident had the motivation and the ability to wander, and those who were at low risk did not receive new wandering-related interventions. The DON will review residents at moderate and high risk for elopement weekly for 12 weeks to ensure interventions remain in place and are effective. Residents exhibiting new behaviors of wandering or exit seeking will be reviewed by the Interdisciplinary Team (DON, ADON, Nursing Supervisor, Social Worker, Administrator) to ensure the Gates Wandering Assessment is accurate and interventions are in place. In addition, the risk team (DON, ADON, House Supervisor, Social Worker, MDS Nurse, CNA) will ask the direct care staff and then discuss during weekly risk meetings, beginning with the risk team meeting on 12/4/18, and weekly thereafter, about new potential wandering behaviors including exit seeking, requests to go home or to	F 689		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 other locations, increased agitation or restlessness, and similar behaviors. For those identified through this process, new Gates Wandering Assessments will be completed and recorded. In addition direct care staff has been in-serviced on 12/4/18 to alert a nurse supervisor anytime they observe behavior that suggests an increased potential for wandering with instruction to stay with the resident until the nursing supervisor can implement immediate interventions as well as to notify the DON/ADON to complete a new Gates Wandering Assessment, and if appropriate, add the resident to the At Risk for Wandering book and update the care plan. Any residents the team may consider trialing for reduction of level of intervention, including removing the wander guard bracelet, will have their plan of care adjusted to reflect close supervision for brief but potentially extending periods, and monitoring for signs of increased wandering behavior risks. At this time, Resident #1 is not a candidate for reduced interventions. On 12/4/18 the Maintenance Director, re-checked all exit doors on the secure unit and documented on the exit door check log. Current staff from all departments, including contract housekeeping and laundry staff, were re-educated on 12/4/18 by staff development coordinator. Education includes the facility policy on elopements and wandering/unsafe residents. It also included recognition of exit seeking behaviors in residents and what intervention strategies could be put into place along with the supervision required. Re-education was conducted by the regional nurse consultant with the maintenance staff on 12/4/18 regarding expectations for frequency in monitoring of exit doors and alarms. Exit doors	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING ______ B. WING ______	C 12/11/2018

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F 689	Continued From page 13 are checked daily by maintenance or nursing staff to ensure they are functioning properly and a tool was created for this to be logged effective 12/4/18. The administrator will check all exit doors weekly for 12 weeks to ensure the doors and wanderguard and secondary alarms are functioning properly. Results of door checks, wanderguard checks, wandering assessments and "At Risk for Wandering" books will be presented to QAPI on a monthly basis for 6 months then quarterly for 1 year to assure sustained compliance. The credible allegation was verified on 12/11/18 at 4:00pm as evidenced by staff interviews. Staff education was initiated on 12/4/18 regarding resident who have been identified to be at risk for wandering or may start to display behaviors which would place the resident at risk for wandering. All staff interviewed (nursing and non-nursing staff, administrative staff) stated they were to respond to exit door alarms by immediately going to the door which triggered the alarm and investigate to see if a resident had exited or attempted to exit which would have triggered the alarm. Verification of education for staff regarding wandering residents was completed on 12/11/18.	F 689		