STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 12/12/2018

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SOUTHPORT HEALTH AND REHABILITATION CENTER	630 FODALE AVENUE SOUTHPORT, NC 28461

(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 No deficiencies were cited as a result of the complaint investigation. Event ID #WS2911. A recertification and complaint investigation survey was conducted from 12/09/18 through 12/12/18. Immediate Jeopardy was identified on 12/12/18. CFR 483.25 at tag F689 at a scope and severity IJ. The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/25/18 and was removed on 12/12/18. An 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 observation, staff interviews and record review the facility failed to provide supervision to prevent a cognitively impaired resident who displayed wandering behaviors from exiting the facility unsupervised for 1 of 1 sampled residents (Resident #40) reviewed for accidents. Resident #40 was found unsupervised	F 689	F689 Plan to correct specific deficiency and facts that led to the alleged deficient practice Skilled Nursing Facility Resident #40 admitted on 12/20/16 with diagnosis of:	1/3/19

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

Electronically Signed | 01/03/2019

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F 689	Continued From page 1 outside the facility by facility staff and returned inside with no injuries. Immediate Jeopardy began on 11/25/18 when Resident #40 was found outside of the facility without supervision by Nurse #4 when he was heard knocking on the outside of the facility's 700 hall door that was approximately 40 feet from the facility's front parking lot. The parking lot was not in use due to damage from a storm. Immediate Jeopardy was removed on 12/12/18 when the facility provided and implemented an acceptable credible 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 #40 was admitted to the facility on 02/05/16 and had a re-entry date of 12/20/16 with diagnoses that included dementia without behavioral disturbance, anxiety, and major depression. The physician orders for November 2018 included an order to check that the wanderguard bracelet was on Resident #40 every shift. The current plan of care dated 11/08/18 for Resident #40 included focus areas of risk for elopement related to a history of an elopement attempt (initiated on 12/13/17) and the resident displayed exit seeking behaviors at times when he was upset or angry with increased risk for elopement. Goals were for the resident to have no elopement episodes and for the resident's exit	F 689	Atherosclerotic Heart Disease, Old MI, Stage IV Sacral Pressure Ulcer, Colostomy, Other artificial openings of Urinary Tract, GERD, Bilateral AKA, Phantom Limb Syndrome with Pain, Unspecified Dementia without Behaviors, Noncompliance with other medical treatment and regime, Anxiety Disorder, Chronic Pain, Essential Hypertension, Depression, Osteoarthritis. The most recent risk assessment was completed on 11/12/18 and Resident #40 scored a 9, indicating moderate risk for wandering. Wanderguard bracelet was in place as ordered by Medical Director. Care plan and kardex included the wanderguard bracelet interventions. Resident is an independent smoker, which means he can go smoke independently in the secure courtyard, using doors on 100 hall on lobby side and door from the large dining room. Neither of these doors trigger an alarm as they open into a secured courtyard with no exits On November 25, 2018 at approx. 12 noon, Skilled Nursing Facility resident # 40 went out to smoke. It was unwitnessed which of the two doors that lead into the secure that resident exited to go smoke. Neither of these doors are alarmed as they do not lead to exit areas. Resident went into the secured courtyard area for smokers. He was alone as he has been assessed to be an independent smoker, who has the capability to lit his own cigarettes and hold them using safe practices. Nurse#3 saw resident outside smoking, as well as the Activity Director.	

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F 689	Continued From page 2 seeking behaviors to be minimized through interventions in order to reduce the risk for injuries or elopement. Interventions included to check the wanderguard transmitter for proper functioning frequently and to replace as needed. A review of the elopement risk assessment for Resident #40 dated 11/12/18 revealed that Resident #40 had a risk score of "9" indicating that he was a moderate risk for elopement. An annual Minimum Data Set (MDS) assessment dated 11/14/18 documented through a staff assessment that Resident #40 had a memory problem with modified independence cognition. He had no moods or behaviors during the assessment look back period. He was independent for bed mobility, required supervision for transfers and locomotion. He utilized a wheel chair for mobility. He had a wander/elopement alarm that was used daily. A nursing note written by Nurse #3 on 11/25/18 at 1:04 PM documented that the writer noticed that resident was not in the dining room, courtyard, or bedroom at 12:00 PM (all the usual places that resident was). It was reported to the ADON (Assistant Director of Nursing) that the resident was missing. As the ADON was going to check on another unit, the 700 hall nurse, (Nurse #4), found the resident knocking on the 700 hall exit door from outside. The wander guard was active on the wheel chair. The resident was non-verbal but was laughing and aware of his actions. The ADON notified the Administrator. The resident was last seen smoking in the courtyard at 11:10 AM. The resident had been slightly agitated beforehand due to too many people being in the dining room.	F 689	Nursing noticed that resident was not in courtyard, his room or in facility and immediately initiated resident search. Nursing unsure of approximate time that resident may have been outside, but can validate that he was seen by Nurse#3 and activity Director within 10-20 minutes outside smoking as his usual routine. Nurse #4 noted resident to be outside at 700 hall door (Door # 2) and resident was knocking on the door to return in facility. Resident has Brief Interview for Mental Status (BIMS) of 00 due to Aphasia. However, resident is able to communicate using his unique mannerism and staff are familiar with his communication. Immediately on 11/25/18, Assistant Director of Nursing and Director of Nursing interviewed resident and resident denies trying to leave facility. Resident has customary routine of entering this secured smoking courtyard. It is unsure which of the two doors resident exited into the secure unit by. Resident will use door #4 from courtyard as he visits the Nursing Home Administrator. Resident normally takes a left to visit front office areas and this particular time resident went out through two other doors (doors # 2 and #4) and door #4 shut and locked behind him. Resident began knocking on the door # 2 to return. Root cause of resident exiting facility is that door #4 was not locked and door #2 had a chimer that was turned off. On 11/25/18, Resident was immediately assessed by Assistant Director of Nursing and had no injuries or complaints of discomfort. Resident has now refused to	

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F 689	Continued From page 3 According to the National Weather Service computer data base the temperature in Southport, NC, where the facility is located, on 11/25/18, was 62 degrees Fahrenheit. The facility's incident investigation dated 11/26/18 of Resident #40's unsupervised exit from the facility was reviewed. It documented that the 700 hall outside exit door alarm (that Resident #40 exited) had been turned off and did not alarm when it was opened. The resident had a wanderguard on that was functioning but the door did not have a wanderguard alarm. It had a chime alarm. In an interview conducted with the ADON on 12/10/18 at 4:25 PM she stated that she was present on 11/25/18 when Resident #40 was found outside of the facility unsupervised. She said that she checked the alarm on the 700 hall door after Resident #40 was found outside of the facility on 11/25/18 and it had been turned off. The ADON stated she also checked the door leading in from the courtyard into the hallway directly across from the 700 hall exit door and found it was unlocked (approximately 16 feet between doors). She said she was not sure who turned the alarm off or who unlocked the courtyard door that allowed Resident #40 to come into the 700 hall and then exit through the hallway's outside door. She remarked that the door leading into the 700 hall from the courtyard where Resident #40 smoked was to always remain locked to prevent residents from gaining access to exit doors from the courtyard. She remembered it was a Sunday so there were no construction workers in the building but she stated that at times family members turned off the	F 689	wear wanderguard on his wrist and has been placed on 1:1. Patient had a wander guard bracelet placed in correct position on wheelchair as resident is a bilateral above the knee amputee. Wanderguard bracelet was checked by Assistant of Director of Nursing and it was functioning correctly. Medical Director and Responsible Party notified by nurse#4 on 11/25/18. Director of Nursing and Nursing Home Administrator notified 11/25/18. The resident was placed on 1:1 for 24 hours. Identification of potentially affected resident and corrective actions taken: An REQ (Review to Ensure Quality) was initiated by the Director of Nursing on 11/25/18 and 1:1 was immediately initiated for this resident to ensure safety for 24 hours. On 11/25/18 Assistant Director of Nursing immediately locked door # 4 and immediately activated chimer alarm on door #2. Immediately signage was posted on door #4 and door #5 stating “Keep door locked” on door # 4and #5. On 11/25/18 Assistant Director of Nursing immediately checked all other facility doors and alarms to ensure that all doors were locked and all alarm systems were activated to ensure safety. No other areas identified. On 11/25/18, the Assistant Director of Nursing printed a current Skilled Nursing Facility resident census and ensured all Skilled Nursing Facility residents listed on the census were accounted for by utilizing	

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F 689	Continued From page 4 alarms. She said she immediately conducted an in-service for all staff on duty and staff coming onto the evening shift to keep door alarms on and locked. She stated that she did not know who was responsible for checking the alarms and doors on the weekends. She said that it was normal for the third shift nurses to check the doors every night. In an interview conducted with Nurse #4 on 12/10/18 at 4:50 PM she stated that on 11/25/18 (a Sunday) she heard knocking on the 700 hall door leading into the front parking lot of the facility. She said that Resident #40 was knocking on the door trying to get back into the building. Due to his cognition and language deficit he was not able to tell her what he was doing or where he had been. She reported that when she let him in the alarm on the door did not sound because she noticed that it had been turned off. She commented that the door he exited was not wanderguard alarmed but had a regular alarm that sounded if and when the door was opened. Nurse #4 also stated this door did not lock automatically from the inside when a resident wearing a wanderguard approached the door. During an additional interview on 12/12/18 at 1:50 PM with Nurse #4 she stated that she remembered that it was sunny outside and it wasn't rainy or cold when she let Resident #40 back into the building. In an interview with Nurse #3 on 12/10/18 at 4:55 PM she stated that she was the nurse for Resident #40 on 11/25/18 when he was found unsupervised outside of the facility. She said she noticed on 11/25/18 Resident #40 was not in the dining room, court yard or bedroom. She decided to check on the 700 hall for him when Nurse #4	F 689	the list from Point Click Care. Director of Nursing verified that all Skilled Nursing Facility residents at risk for wandering were in facility with functioning wanderguard bracelets. No areas of concern identified. Residents are assessed using the User Defined Assessment of Risk assessments that is an individualized resident assessment in Point Click Care. On 11/25/18, the Assistant Director of Nursing reviewed all Skilled Nursing Facility current residents at risk for elopement to ensure orders were entered and entered for the nursing staff to document in the electronic medical record to the electronic medicine administration records for checking placement and functioning of the wanderguard bracelet and that task are set up electronically for the nursing assistants to document wanderguard placement. No areas of concern identified. On 11/25/18, Health Information Director checked the elopement risk notebooks at each nurse's station and reception desk to ensure that all Skilled Nursing Facility current residents identified as needing a wanderguard bracelet had a picture in place. No areas of concerns identified. The Health Information Manager is responsible for keeping the Elopement Risk notebooks are kept up to date. Measures put in place/Systemic changes to ensure deficient practice does not reoccur: On 12/11/18 the Director of Nursing and	

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F 689	Continued From page 5 heard the knocking. She said the resident was not able to verbalize where he had been or why he was outside due to his cognition (history of a stroke). In an interview with Physician #1 on 12/11/18 at 9:30 AM he stated he was notified when Resident #40 eloped from the building. He said the nurse who notified him informed him that the resident had been assessed and had no injuries. He commented that it was his expectation that any resident who eloped and returned be assessed for harm and then be kept safe. He would also expect to be told what measures were being done to monitor the resident. He said Resident #40 was always wandering around the facility and had communication limitations. He also noted that Resident #40 was on a high dose of pain medications for phantom limb pain and may have gotten confused that one time and went out the wrong door. He felt the elopement was an isolated incident. He said the resident usually went out to the courtyard alone to smoke and had never been an elopement risk. He had never been concerned that Resident #40 would try to elope. In an interview conducted on 12/10/18 at 8:45 AM with the Maintenance Assistant he stated that he had been employed at the facility for four years and worked from 5:30 AM to 1:00 PM Monday through Friday. He reported that he alternated on-call on the weekends with the Maintenance Director. He said maintenance personnel did not come to the facility on weekends unless they were called for an emergent situation. He reported that he checked all the door alarms and locks every morning during the week before the residents got up but he did not keep a log. He	F 689	licensed nurses began in-servicing facility wide, all full time, all part time and all PRN staff on the following: • Elopement Prevention Training to prevent resident injury/harm or potential for injury/harm • Elopement training on what to do if residents begin to initiate exit seeking behaviors, including making verbal statements, such as “I’ve got my bags packed”, “I’m going to meet my sister”. Staff are instructed to redirect and provide 1:1. • All staff (this includes Full time, Part time and PRN staff) to be trained by 12/12/18 or they will not be allowed to work until training is completed • All staff educated on not cutting off alarms or unlocking doors. All staff educated on what to do if there is a concern with a door lock or any type of alarming system. • All staff educated on the process of providing 1:1 with a resident or 1:1 door monitoring if assigned. Staff educated on the expectation of constant visual monitoring and how to handle when the need for breaks, meals and/or any type of emergency may arise. Staff educated to report to charge nurse of any concerns or needs while providing 1:1 with a resident and/or door monitoring. Staff educated on the process of documenting the 1:1 with a resident and/or door monitoring. • All nurses educated on the process of completing Risk Assessments for ALF residents on admission and readmission • All nurses educated on the system process of checking all doors and	

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F 689	Continued From page 6 said he was not aware of who checked the alarms and doors on the weekends or holidays when maintenance staff were not on duty. An interview was conducted on 12/11/18 at 9:58 AM with the Maintenance Director. He said that maintenance checked the doors in the facility daily Monday through Friday. They checked the doors on Saturday and Sunday only if they were called in for an emergency. He was not aware of who was responsible for checking the doors on weekends. He reported that doors equipped with wanderguard were checked every Wednesday and the checks were documented in a log. He commented that doors that were not equipped with wanderguard but that had regular magnetic chiming alarms were sometimes turned off by visitors using the door. He said that on the day that Resident #40 eloped out the 700 Hall exit door he was called in. He stated that he checked the keypad on the outside of the door at approximately 3:00 PM on 11/25/18 and nothing was wrong with it but he replaced it anyway. He checked the chime alarm and it was working properly at the same time. He said he set the closer at the top of the door tighter in case the door had swollen with the weather change to make it a little heavier so that it would always latch. An interview was conducted on 12/11/18 at 10:55 AM with the Director of Nursing. She stated that it was expected and the normal practice of the third shift nurses to check the doors and alarms each night to secure the building. An interview was conducted on 12/12/18 at 2:45 PM with Nurse #5. She stated that she normally worked the 7:00 PM to 7:00 AM shift. She said	F 689	alarming systems every shift 7 days per week during shift changes, including holidays and weekends. This system process will be documented on the Quality Assurance door check sheet kept in the narcotic count book. • All staff educated on the different types of alarm systems and door locking systems • All staff educated on the proper placement of the wanderguard bracelets as recommended by the manufacturer • This will also be added to the facility new hire orientation This education will be conducted facility wide, licensed nurses will educate all clinical staff and Department head will educate non-clinical staff with hand written education material provided and verbal discussions on education. Learners will be provided opportunities for discussions and/or questions for clarifications. All staff will sign an attestation document on receiving the education. On 12/12/18 Nursing Home Administrator sent telephonic message to all families and Responsible Parties educating families regarding ensuring safety for residents and not unlocking any doors and/or turning off any alarms, including chiming alarms or squealer boxes. Families do not have codes to turn alarms off. How will the facility monitor its performance that solutions/measures are sustained?	

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F 689	Continued From page 7 that on night shift she locked the front and back doors and checked all the wanderguard doors with a wanderguard to make sure they were locking correctly. An observation made on 12/12/18 at 1:00 PM of the facility's 700 hall exit door, where Resident #40 was found on 11/25/18, revealed that it opened from the inside with a bar release and locked from the outside. It lead onto an evenly paved sidewalk that was 40 feet from the front parking lot which was not in use. The lot had been blocked off due to damage and had no activity. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on 12/12/18 at 10:05 AM. On 12/12/18 at 7:05 PM the facility provided the following credible allegation of immediate jeopardy removal: Plan to correct specific deficiency and facts that led to the alleged deficient practice: Skilled Nursing Facility (SNF) Resident #40 was admitted on 12/20/16 with diagnosis of: Atherosclerotic Heart Disease, Old MI (Myocardial Infarction), Stage IV Sacral Pressure Ulcer, Colostomy, Other artificial openings of Urinary Tract, GERD (Gastroesophageal Reflux Disease), Bilateral AKA (Above the Knee Amputation), Phantom Limb Syndrome with Pain, Unspecified Dementia without Behaviors, Noncompliance with other medical treatment and regime, Anxiety Disorder, Chronic Pain, Essential Hypertension, Depression, Osteoarthritis.	F 689	All doors, door locks and alarm systems will be checked q shift to ensure the alarm systems are working properly, all door locks are secure and all door and systems are working correctly q shift seven days per week by nursing. The checks will be documented on the Quality Assurance Door Check sheets q shift and kept in the narcotic count notebook. The Director of Nursing will audit all 14 door checks daily five days per week x 2 weeks then weekly x 4 weeks and then monthly x 2 months. Maintenance Director will continue to check all doors and alarm systems weekly utilizing the facility's electronic monitoring system to ensure doors and alarm systems are working properly. The Quality Assurance Committee, which consists of Director of Nursing, Nursing Home Administrator, Minimum Data Set Nurse, Unit Manager, Therapy Director, Health Information Manager, Dietary Manager and Social Worker will continue to monitor for any trends/concerns/opportunities to ensure the safety of residents with current door locking and alarming systems. Any areas of concern will be immediately addressed by the Director of nursing and/or Nursing Home Administrator. 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, Wound Nurse, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health	

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F 689	Continued From page 8 The most recent risk assessment was completed on 11/12/18 and Resident #40 scored a 9, indicating moderate risk for wandering. Wanderguard bracelet was in place as ordered by Medical Director (MD). Care plan and kardex included the wanderguard bracelet interventions. Resident is an independent smoker, which means he can go smoke independently in the secure courtyard, using doors on 100 hall on lobby side and door from the large dining room. Neither of these doors trigger an alarm as they open into a secured courtyard with no exits. Corrective Action for Involved Resident: On November 25, 2018 at approximately 12:00 noon, SNF resident # 40 went out to smoke. It was unwitnessed which of the two doors that lead into the secure that resident exited to go smoke. Neither of these doors are alarmed as they do not lead to exit areas. Resident went into the secured courtyard area for smokers. He was alone as he had been assessed to be an independent smoker, who has the capability to light his own cigarettes and hold them using safe practices. Nurse #4 saw resident outside smoking, as well as the Activity Director. Nursing noticed that resident was not in courtyard, his room or in facility and immediately initiated resident search. Nursing unsure of approximate time that resident may have been outside, but can validate that he was seen by Nurse #4 and activity Director within 10-20 minutes outside smoking as his usual routine. Nurse #4 noted resident to be outside at 700 hall door (Door # 2) and resident was knocking on the door to return in facility. Resident has a Brief Interview for Mental Status (BIMS) of 00 due to Aphasia. However, resident	F 689	Information Manager, Dietary Manager, Maintenance Director and the Administrator. The Nursing Home Administrator is responsible for implementing and ensuring this plan of correction. Completion Date: 12/12/18	

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F 689	Continued From page 9	F 689		

is able to communicate using his unique mannerism and staff are familiar with his communication. Assistant Director of Nursing (ADON) and the Director of Nursing (DON) interviewed resident and resident denies trying to leave facility. Resident has customary routine of entering this secured smoking courtyard. It is unsure which of the two doors resident exited into the secure unit by. Resident will use door #4 from courtyard as he visits the Nursing Home Administrator. Resident normally takes a left to visit front office areas and this particular time resident went out through two other doors (doors # 2 and #4) and door #4 shut and locked behind him. Resident began knocking on the door # 2 to return. Root cause of resident exiting facility is that door #4 was not locked and door #2 had a chimer that was turned off.

Resident was immediately assessed by the ADON and had no injuries or complaints of discomfort. Resident has now refused to wear wanderguard on his wrist and has been placed on 1:1. Had a wander guard bracelet placed in correct position on wheelchair as resident is a bilateral above the knee amputee. Wanderguard bracelet was checked by the ADON and it was functioning correctly.

Update: As of 12/12/18 at 7:00 PM resident is refusing to have wander guard bracelet removed from his wheelchair and placed on his wrist. Education provided by DON and Administrator 12/12/18. 1:1 initiated.

Medical Director and Responsible Party notified by Nurse #3 on 11/25/18.

DON and Nursing Home Administrator (NHA)

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notified 11/25/18.

The resident was placed on 1:1 for 24 hours.

Identification of potentially affected resident and corrective actions taken:

An REQ (Review to Ensure Quality) was initiated by the DON on 11/25/18 and 1:1 was immediately initiated for this resident to ensure safety for 24 hours.

On 11/25/18 ADON immediately locked door # 4 and immediately activated chimer alarm on door #2. Immediately signage was posted on door #4 and door #5 stating, "Keep door locked" on door # 4 and #5.

On 11/25/18 ADON immediately checked all other facility doors and alarms to ensure that all doors were locked and all alarm systems were activated to ensure safety. No other areas identified.

On 11/25/18, the ADON printed a current SNF resident census and ensured all SNF residents listed on the census were accounted for by utilizing the list from Point Click Care. DON verified that all SNF residents at risk for wandering were in facility with functioning wanderguard bracelets. No areas of concern identified. Residents are assessed using the User Defined Assessment of Risk assessments that is an individualized resident assessment in Point Click Care.

On 11/25/18, the ADON reviewed all SNF current residents at risk for elopement to ensure orders were entered for the nursing staff to document in the electronic medical record to the Electronic

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Medication Administration Record (eMAR) for checking placement and functioning of the wanderguard bracelet and that task are set up electronically for the nursing assistants to document wanderguard placement. No areas of concern identified.

On 11/25/18, Health Information Director checked the elopement risk notebooks at each nurse's station and reception desk to ensure that all SNF current residents identified as needing a wanderguard bracelet had a picture in place. No areas of concerns identified. The Health Information Manager is responsible for keeping the Elopement Risk notebooks are kept up to date.

Measures put in place/Systemic changes to ensure deficient practice does not reoccur:

On 12/11/18 the Director of Nursing and licensed nurses began in-servicing facility wide, all full time, all part time and all as needed (PRN) staff on the following:

Elopement Prevention Training to prevent resident injury/harm or potential for injury/harm.

Elopement training on what to do if residents begin to initiate exit seeking behaviors, including making verbal statements, such as "I've got my bags packed", "I'm going to meet my sister". Staff are instructed to redirect and provide 1:1.

All staff (this includes Full time, Part time and PRN staff) to be trained by 12/12/18 or they will not be allowed to work until training is completed.

All staff educated on not cutting off alarms or

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unlocking doors. All staff educated on what to do if there is a concern with a door lock or any type of alarming system.

All staff educated on the process of providing 1:1 with a resident or 1:1 door monitoring if assigned. Staff educated on the expectation of constant visual monitoring and how to handle when the need for breaks, meals and/or any type of emergency may arise. Staff educated to report to charge nurse of any concerns or needs while providing 1:1 with a resident and/or door monitoring. Staff educated on the process of documenting the 1:1 with a resident and/or door monitoring.

All nurses educated on the process of completing Risk Assessments for Assisted Living Facility (ALF) residents on admission and readmission.

All nurses educated on the system process of checking all doors and alarming systems every shift 7 days per week during shift changes, including holidays and weekends. This system process will be documented on the Quality Assurance (QA) door check sheet kept in the narcotic count book.

All staff educated on the different types of alarm systems and door locking systems.

All staff educated on the proper placement of the wanderguard bracelets as recommended by the manufacturer.

This will also be added to the facility new hire orientation.

This education will be conducted facility wide,

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licensed nurses will educate all clinical staff and Department head will educate non-clinical staff with hand written education material provided and verbal discussions on education. Learners will be provided opportunities for discussions and/or questions for clarifications. All staff will sign an attestation document on receiving the education.

On 12/12/18 NHA sent telephonic message to all families and Responsible Parties educating families regarding ensuring safety for residents and not unlocking any doors and/or turning off any alarms, including chiming alarms or squealer boxes. Families do not have codes to turn alarms off.

How will the facility monitor its performance that solutions/measures are sustained?

All doors, door locks and alarm systems will be checked q shift to ensure the alarm systems are working properly, all door locks are secure and all door and systems are working correctly q shift seven days per week by nursing. The checks will be documented on the Quality Assurance (QA) Door Check sheets every shift and kept in the narcotic count notebook. The DON will audit all 14 door checks daily five days per week x 2 weeks then weekly x 4 weeks and then monthly x 2 months.

Maintenance Director will continue to check all doors and alarm systems weekly utilizing the TELS (Maintenance Software electronic program) system to ensure doors and alarm systems are working properly. The QA Committee, which consists of DON, NHA, MDS, Unit Manager, Therapy Director, HIM (Health Information Manager), Dietary Manager and Social Work will

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continue to monitor for any trends/concerns/opportunities to ensure the safety of residents with current door locking and alarming systems. Any areas of concern will be immediately addressed by the Director of nursing and/or NHA.

Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager, Maintenance Director and the Administrator.

The NHA is responsible for implementing and ensuring this plan of correction.

Completion Date: 12/12/18

The credible allegation of Immediate Jeopardy removal was validated on 12/12/18 at 8:25 PM.

A sample of staff that included nurses, nurse aides, and non-clinical employees were interviewed regarding in-servicing related to the deficient practice. All interviewed staff members stated they had been in-serviced regarding elopement and the facility procedure for checking alarmed or locked doors. A review of all documents developed to correct the deficient practice was completed. All facility policies and procedures that were revised to address the deficient practice were reviewed. A review of audit forms that were developed to ensure that in-services presented to all staff were understood and allowed an opportunity for staff to interact with dialogue were also reviewed. All doors that

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F 689	Continued From page 15 were alarmed were checked (3 wanderguard and 6 chime alarmed) and verified to be working properly.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure dietary staff preparing foods were wearing hair nets, failed to ensure kitchenware was dry before stacking it in storage, failed to cover brewed tea stored in a canister, failed to de-stain coffee mugs, and failed to dispose of kitchenware with abraded interior surfaces. The facility also failed to monitor storage areas which resulted in foods which had been opened not being labeled and dated, foods past their "best by" date not being disposed of,	F 812	F 812 1. Plan to correct specific deficiency and facts that led to the alleged deficient practice On 1/3/2019 corrective action was given to the dietary employee that was not wearing appropriate hair restraint by the dietary manager. On 12/12/2018 tea that was brewed and stored in uncovered container was	1/3/19

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F 812	Continued From page 16 and thawing meats not having a "pull date" on them. Findings included: 1. During initial tour of the kitchen, beginning at 9:08 AM on 12/09/18, a dietary employee preparing a cake was not wearing a hair net. Her bangs were held off her forehead by a cloth hair band about an inch and a half wide. However, the rest of her hair was uncovered, including a long pony tail which extended half way down her back. At 2:33 PM on 12/11/18 the Dietary Manager (DM) stated all dietary employees had been educated that anytime they were in the kitchen they had to wear hair nets which covered all of the hair on their heads. He reported this was especially important for staff preparing foods and/or handling kitchenware since loose hair could contaminate food and kitchenware surfaces, increasing the chances of a foodborne illness outbreak. At 2:45 PM on 12/11/18 Cook #1 stated the dietary employee who was not wearing a hair net during initial tour did not like to wear hair nets for some unknown reason. She reported that not wearing hear nets increased the chance that food could be contaminated during food preparation tasks. She commented many of the elderly population already had compromised immune systems so introducing contaminants into their food was very risky. 2. During initial tour of the kitchen, beginning at 9:08 AM on 12/09/18, 15 of 18 fluted dessert cups were stacked wet on top of one another. The wet dessert cups were stored and ready for	F 812	discarded by the dietary manager. On 12/12/2018 all food which had been opened but not properly resealed, labeled and dated, foods past their “best by” or expiration date and thawing meats that did not have a “pull date” on them were disposed of by the dietary manager. On 12/12/2018 all stained coffee mugs and kitchenware with abraded interior surfaces were disposed of by the dietary manager. On 12/27/2018 all dietary staff were in-serviced by the dietary manager on the proper attire required to work in the dietary department. All staff were re-trained on the requirement that anyone that is present in the kitchen will be required to wear a hair net or similar covering at all times. Beard restraints will be worn as appropriate for all male employees with facial hair. On 12/27/2018 all dietary staff were in-serviced on the proper technique for air drying kitchenware before stacking and storing kitchenware items by the dietary manager. On 12/27/2018 all dietary staff were in-serviced on ensuring that all tea containers must be covered when brewing is completed and tea remains in container by the dietary manager. 2. Identification of potentially affected resident and corrective actions taken: All residents have the potential to be affected by the alleged deficient practice. All dietary staff was in-serviced on 12/27/18 regarding proper work attire,	

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F 812	Continued From page 17 staff use. At 2:33 PM on 12/11/18 the Dietary Manager (DM) stated all dietary employees had been educated that pieces of kitchenware were supposed to be completely air dried before stacking them on top of one another in storage areas. He reported that moisture trapped between kitchenware items could cause bacteria to grow which could make residents sick. At 2:45 PM on 12/11/18 Cook #1 stated she had attended multiple in-services during which the dietary staff was told to make sure kitchenware was dry and free of dried food particles before stacking it in storage. She explained that mold could grow in moisture which was trapped between pieces of kitchenware. 3. During initial tour of the kitchen, which took place between 9:08 AM and 9:42 AM on 12/09/18, a canister which contained brewed tea was uncovered. During a follow-up tour of the kitchen, which took place between 9:16 AM and 9:50 AM on 12/11/18, a canister which contained brewed tea was uncovered. At 2:33 PM on 12/11/18 the Dietary Manager (DM) stated the tea canister should remain covered with a lid to prevent contamination introduced by flies and gnats. At 2:45 PM on 12/11/18 Cook #1 stated the tea canister was supposed to be covered to prevent the introduction of contaminants which could make residents sick.	F 812	proper drying technique for kitchenware, all beverage preparation equipment covered as necessary, all abraded kitchenware disposed of as necessary, and all food properly resealed, labeled and dated as required or discarded as necessary. Cleaning schedule was modified on 1/3/2019 to include de-staining serviceware. Signs were posted at all microwave oven locations that food and fluids are not to be reheated in insulated serviceware on 1/3/2019 An audit tool (Dietary Quality Assurance Monitor) was implemented 1/2/19. An additional in-service education module covering the F812 PoC was given to all dietary staff on 1/3/19. 3. Measures put in place/Systemic changes to ensure deficient practice does not reoccur: In-service education was provided to all full time, part time, and as needed staff. Topics included: • Proper work attire for dietary staff • Proper drying techniques for kitchenware • Proper covering of kitchenware and drink ware • Removal and disposal of kitchenware that is no longer in good condition • Proper labeling and dating of food items • Proper disposal of food items that are past their use by date or expiration date.	

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F 812	Continued From page 18 4. During an inspection of kitchenware, which began at 9:22 AM on 12/11/18, 22 of 25 plastic coffee mugs had dark brown stains inside of them. The coffee mugs were stored and ready for staff use. At 2:33 PM on 12/11/18 the Dietary Manager (DM) stated the facility's kitchen currently had no de-staining program in place because he was not aware that bleach could be used in the kitchen. At 2:45 PM on 12/11/18 Cook #1 stated when kitchenware became stained the staff disposed of it because eating and drinking out of kitchenware that was discolored was not appetizing for the residents. 5. During an inspection of kitchenware, which began at 9:22 AM on 12/11/18, 12 of 25 plastic coffee mugs had abraded interior surfaces, and 10 of 22 plastic soup/cereal bowls also had abraded interior surfaces. These coffee cups and soup/cereal bowls were stored and ready for staff use. At 2:33 PM on 12/11/18 the Dietary Manager (DM) stated dietary staff were supposed to notify him when kitchenware became compromised with cracks, chips, and abrasions so he could dispose of damaged items and order replacements. He reported heating plastic coffee cups and soup bowls in the microwave caused the plastic material to break down and slough off. He commented residents could accidentally ingest some of the plastic material which might produce negative health effects. At 2:45 PM on 12/11/18 Cook #1 stated when kitchenware became abraded it was supposed to	F 812	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. How will the facility monitor its performance that solutions/measures are sustained? The Administrator, Dietary Manager or designee will monitor procedures to ensure that dietary staff are following proper procedures for wearing proper hair restraints, proper warewashing and drying procedures for serviceware, proper disposal of stained or abraded kitchenware, proper covering of beverage making equipment and proper labeling, dating, and disposal of food items. This will be completed 5 times a week x 4 weeks, then weekly x 2 months, then monthly for 3 additional month using the Dietary 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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be disposed of because it was more difficult to keep clean, and could more easily harbor germs and bacteria.

6. During initial tour of the kitchen, beginning at 9:08 AM on 12/09/18, two roasts which had been removed from shipping boxes and were thawing on a large baking pan in the walk-in refrigerator did not have a "pull date" on them documenting when the thawing process began. A container of cottage cheese in the walk-in refrigerator had a "best by" date of 11/23/18 on it. A bag of brown sugar in the dry storage room, which had been opened and was wrapped in aluminum foil, did not have a label or date on it. In the walk-in freezer a blue bag of butter beans which had been opened and a storage bag containing whipped topping which had been opened did not have dates or labels on them. In the reach-in refrigerator a gallon container of light mayonnaise and a pack of orange cheese slices were opened but without labels and dates. Bags of cereal resembling Rice Krispies, Cheerios, and Cornflakes were opened and stored in a tray pan under the steam table unit, but did not have labels and dates on them. In addition, an opened 5-pound bag of grits on a storage cart in the kitchen did not have a label or date on it.

At 2:33 PM on 12/11/18 the Dietary Manager (DM) stated the cooks were supposed to monitor the storage areas daily to make sure all opened food items were resealed with labels and dates applied to indicate when the items were opened. He also reported during the monitoring of all storage areas the cooks were supposed to dispose of food items past their "use by" or "best by" dates, and the cooks were supposed to make sure all thawing meats had "pull dates" on them.

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F 812	Continued From page 20 He commented that the labeling and dating of opened food items was important in the first-in, first out (FIFO) principle practiced by the facility to ensure residents received the freshest foods. According to the DM, the disposal of foods past the "use by" and "best by" dates and the labeling of thawing meats were important to protect residents against spoilage. He stated the facility did not use any food items which had exceeded their "use by" and "best by" dates. At 2:45 PM on 12/11/18 Cook #1 stated daily all employees who entered and exited storage areas were supposed to check to make sure all opened and resealed food items were labeled and dated, food items past their "use by" and "best by" dates were thrown away, and thawing meats had a "pull date" on them. She reported the monitoring of storage areas for these practices was important to make sure the residents received the best quality of food without fear of spoilage and the resulting possibility of sickness.	F 812		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility's quality assurance (QA) program failed to prevent the reoccurrence of deficient practice related to the kitchen sanitation processes of stacking kitchenware in storage and	F 867	F 867 QA 1. Plan to correct specific deficiency and facts that led to the alleged deficient practice On 1/3/2019 corrective action was given	1/3/19

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F 867	Continued From page 21 labeling and dating opened food items which resulted in a repeat deficiency at F371/F812. The re-citing of F371/F812 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: This tag is cross-referenced to: F812: Kitchen Sanitation: Based on observation and staff interview the facility failed to ensure dietary staff preparing foods were wearing hair nets, failed to ensure kitchenware was dry before stacking it in storage, failed to cover brewed tea stored in a canister, failed to de-stain coffee mugs, and failed to dispose of kitchenware with abraded interior surfaces. The facility also failed to monitor storage areas which resulted in foods which had been opened not being labeled and dated, foods past their "best by" date not being disposed of, and thawing meats not having a "pull date" on them. Review of the facility's survey history revealed F371 was cited during the facility's 11/22/17 annual recertification/complaint investigation survey for stacking kitchenware wet in storage and failing to label and date opened food items. The facility was re-cited during the current 12/12/18 annual recertification/complaint investigation survey for the same issues of stacking kitchenware wet in storage and failing to label and date opened food items at F812. At 5:40 PM on 12/12/18 the Administrator stated he was unsure why the facility had not corrected the issues of stacking kitchenware wet and failing to label and date opened food items because the facility had completed a plan of correction and	F 867	to the dietary employee that was not wearing appropriate hair restraint by the dietary manager. On 12/12/2018 tea that was brewed and stored in uncovered container was discarded by the dietary manager. On 12/12/2018 all food which had been opened but not properly resealed, labeled and dated, foods past their “best by” or expiration date and thawing meats that did not have a “pull date” on them were disposed of by the dietary manager. On 12/12/2018 all stained coffee mugs and kitchenware with abraded interior surfaces were disposed of by the dietary manager. On 12/27/2018 all dietary staff were in-serviced by the dietary manager on the proper attire required to work in the dietary department. All staff were re-trained on the requirement that anyone that is present in the kitchen will be required to wear a hair net or similar covering at all times. Beard restraints will be worn as appropriate for all male employees with facial hair. On 12/27/2018 all dietary staff were in-serviced by the dietary manager on the proper technique for air drying kitchenware before stacking and storing kitchenware items. On 12/27/2018 all dietary staff were in-serviced by the dietary manager on ensuring that all tea containers must be covered when brewing is completed and tea remains in container. 2. Identification of potentially affected resident and corrective actions taken: All residents have the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345373	A. BUILDING _____ B. WING _____	C 12/12/2018

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F 867	Continued From page 22 audits since they were cited for this deficient practice in 2017. He reported that there were a couple of new employees in the dietary department since last year, but all indications were that the staff understood basic sanitation principles since the Dietary Manager observed no problems when he completed his kitchen walk-through audits last week.	F 867	affected by the alleged deficient practice. All dietary staff was in-serviced on 12/27/18 regarding proper work attire, proper drying technique for kitchenware, all beverage preparation equipment covered as necessary, all abraded kitchenware disposed of as necessary, and all food properly resealed, labeled and dated as required or discarded as necessary. Cleaning schedule was modified on 1/3/2019 to include de-staining serviceware. Signs were posted at all microwave oven locations that food and fluids are not to be reheated in insulated serviceware on 1/3/2019 An audit tool (Dietary Quality Assurance Monitor) was implemented 1/2/19. An additional in-service education module covering the F812 PoC was given to all dietary staff on 1/3/19. 3. Measures put in place/Systemic changes to ensure deficient practice does not reoccur: In-service education was provided to all full time, part time, and as needed staff by the dietary manager. Topics included: • Proper work attire for dietary staff • Proper drying techniques for kitchenware • Proper covering of kitchenware and drink ware • Removal and disposal of kitchenware that is no longer in good condition • Proper labeling and dating of food items • Proper disposal of food items that are	

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F 867	Continued From page 23	F 867		

past their use by date or expiration date.

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. How will the facility monitor its performance that solutions/measures are sustained?

The Administrator, Dietary Manager or designee will monitor procedures to ensure that dietary staff are following proper procedures for wearing proper hair restraints, proper warewashing and drying procedures for serviceware, proper disposal of stained or abraded kitchenware, proper covering of beverage making equipment and proper labeling, dating, and disposal of food items. This will be completed 5 times a week x 3 months, then weekly x 3 months, then monthly for 3 additional months for a total auditing period of 9 months, using the Dietary 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,

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F 867	Continued From page 24	F 867	and the Dietary Manager.	