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CONCORDIA TRANSITIONAL CARE & REHAB-ROSE MANOR	4230 NORTH ROXBORO STREET DURHAM, NC 27704

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F 000	INITIAL COMMENTS A complaint investigation was conducted 2/8/19 through 2/12/19. Immediate Jeopardy was identifed CFR 483.25 at tag F689 at a scope and severity of (J). This was past non-compliance and an extended survey was completed on 2/12/19.	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 observations, record review, staff interviews, the facility failed to provide supervision to prevent a cognitively impaired resident who exhibited exit seeking behaviors from exiting the facility while unsupervised for 1 of 4 residents (Resident #1) sampled for accidents. Resident #1 exited the facility and was unaccounted by staff for a 75 minute period in the late afternoon of 1/26/19, and was returned to the facility by the police with severe agitation, but without any physical injuries. Findings included: Resident #1 had been admitted on 1/8/19. Her admitting diagnoses included altered mental status, cognitive communication deficit, encephalopathy, mood disorder due to known physiological condition with depressive features, epilepsy, diabetes and muscle weakness.	F 689	Past noncompliance: no plan of correction required.	2/20/19

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

Electronically Signed | 02/20/2019

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On 1/9/19 an Unsafe Wandering Risk Evaluation was completed and was noted Resident #1 with impaired cognition, impaired decision making, decreased safety awareness and not at risk for elopement.
On 1/18/19 an Admission Minimum Data Set (MDS) indicated Resident #1 had severe cognitive impairment. No wandering was noted and she did not ambulate. She required extensive assistance with mobility on and off of the unit, bed mobility, transfers, toileting and hygiene. She received insulin, antidepressant and anticoagulant medications.
On 1/25/19 at 1:14 PM nursing documentation indicated Resident #1 had been alert, oriented and confused. She had an order for non-weight bearing and was noncompliant with the order. Resident #1 would stand and walk. She had been redirected every episode, and family members were notified.
On 1/25/19 at 1:55 PM an Unsafe Wandering Risk Evaluation was completed by Nurse #8 and noted Resident #1 had been cognitively impaired, frequently paced or wandered in areas without purpose, impaired decision making with decreased awareness of safety. Resident #1 had expressed a desire to leave the center and anger at being in the facility. Wanderguard placement was recommended.
On 1/25/19 at 3:08 PM nursing documentation, written by Nurse #8, noted Resident #1 had been discovered wandering all over facility this shift. Her cognition was impaired and a wanderguard had been placed on her right ankle to prevent elopement. Resident #1's Responsible Party (RP) had been made aware of the wanderguard placement.
On 1/25/19 a care plan was initiated for Resident #1 regarding elopement risk and wandering as

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evidenced by Resident #1 having a decreased safety awareness, history of wandering, verbalization of wanting to leave and exit seeking. Interventions included to address wandering behavior, attempt to redirect from inappropriate areas, engage in diversional activity, at risk for fall, evaluate need for additional supervision, photo in wander notebook, wander alert bracelet place and check placement every shift.
On 1/26/19 at 2:24 AM nursing documentation, written by Nurse #9, indicated Resident #1 had been alert and oriented to person and place and had appeared very confused this shift. Resident getting up and down out of bed throughout the night and staff had been unable to redirect her.
On 1/26/19 at 5:13 AM nursing documentation, written by nurse #9, indicated Resident #1 had continued to be confused and had exit seeking behaviors. Resident #1 had been walking around the building going to every door pushing it trying to get out. The Nurse Aide (NA) and the nurse were monitoring Resident #1 as she walked around building, wanderguard intact.
A time line of events of Resident #1's unsupervised exit from the facility on 1/26/19, was provided by the facility:
On 1/26/19 at 4:15 PM Resident #1 had been seen by facility staff sitting in a wheelchair in her room and propelling herself in the wheelchair. Staff had asked Resident #1 if she needed anything and she declined.
On 1/26/19 at 4:45 PM the NA #8 went into Resident #1's room to make rounds and noticed that Resident #1 was not in her room. The NA immediately began to look in the facility for Resident #1. A search was conducted per the elopement protocol.
On 1/26/19 at 4:50 PM the nurse manager and staff were looking to determine whereabouts of

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Resident #1 in the facility.
On 1/26/19 at 5:00 PM the Executive Director (ED), Director of Nursing (DON), Assistant DON (ADON), the RP, physician and the police were all contacted regarding Resident #1's status.
On 1/26/19 between 5:00 PM-5:15 PM the search for Resident #1 was being conducted inside and outside of the building. NA #8 who was conducting a search outside of the building had gone to the auto parts store next door and she had been informed that Resident #1 had been seen getting in a police car. During this time the ED, Director of Maintenance (DM), ADON and DON had arrived in the facility to assist staff with the search and to ensure the elopement process was being completed.
On 1/26/19 at 5:20 PM NA #8 returned to facility and informed the charge nurse of her discoveries, the charge nurse then called the police to determine the whereabouts of Resident #1. The charge nurse was informed by the police officer that Resident #1 had requested a ride to the YMCA and had indicated she was employed there. The police officer then informed the charge nurse he would go back to the YMCA to retrieve Resident #1.
On 1/26/19 at 5:30 PM Resident #1 had been returned to the facility by the police officer. No injuries to Resident #1 were observed.
On 1/26/19 between 5:30 PM and 5:45 PM Resident #1's family had been notified of Resident #1's return to facility and status. The physician had also been notified.
On 2/8/19 at 1:00 PM a telephone interview was conducted with the Nurse Aide #8 who had cared for Resident #1 at the time of the elopement and was the last staff member to see her prior to her unsupervised exit from the facility on 1/26/19. NA #8 stated she had started her shift on 1/26/19 at

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3:00 PM and had observed Resident #1 rummaging in her closet. Sometime after 4:00 PM, the NA had come around again to prepare Resident #1 for dinner but Resident #1 was no longer in her room. The NA stated she walked around the building looking for Resident #1 and asked other staff if they had seen her. An elopement code was then called by one of the nurses. The NA stated she looked out the front door and had observed Resident #1's wheelchair (WC) outside. The NA went outside and to the auto parts store next door. The clerk there had indicated Resident #1 had been there and had asked for a ride. The clerk had called the police who came and picked up Resident #1. The NA stated she returned to the nursing facility and reported all these findings to the supervisor.

On 2/8/19 at 12:11PM an interview with Nurse #6 who had been present the time of the elopement. She stated she had been in a room and had not heard the elopement code called but stated she quickly learned a resident was missing and staff looking for her. She had been asked to call the police to ask about a resident having been picked up from the auto parts store, next door, and the location of the police and the resident. She stated the police operator had indicated Resident #1 had been taken to the YMCA and dropped off. The police operator was able to contact the officer to have Resident #1 picked up again and return her to the facility.

On 2/8/19 at 1:41 PM a phone interview with Nurse #5 who had been present the day of the elopement was conducted. He stated he had seen Resident #1 on 1/26/19 and had spoken with her about 10 minutes before he heard the elopement code called. He stated a search was ongoing and staff had gone out of the building looking for Resident #1. A NA had reported back

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to him that Resident #1 had been seen at the auto parts store and that the police had picked her up. He stated the police were called to see where Resident #1 was, the ED and the RP were also called. He stated it was not long after this that the police brought Resident #1 back. The nursing staff, resident and the RP determined it was best for Resident #1 to go to hospital due to severe agitation.

On 2/8/19 at 2:38 PM an interview was conducted with Nurse #7, who had cared for Resident #1 on the day of the elopement. She stated she observed Resident #1 on 1/26/19 when she first arrived at about 3:00 PM for the shift, and again about 4:00 PM in the front lobby talking with other residents and their visitors, having a nice conversation. The nurse stated she had not observed Resident #1 talking about leaving. Shortly after this, the NA alerted the nurse that Resident #1 was missing and an elopement code had been called. The NA had noticed Resident #1's WC outside and had discovered Resident #1 had been seen at the auto parts store and had been picked up by the police. The police, the RP, the physician and ED were all notified. The nurse stated after Resident #1 returned, she had been determined to leave the facility and had agreed with her daughter to go to the Emergency Room (ER). After Resident #1 left for the ER, the ED conducted elopement in-services with all of the staff and all residents with wanderguards had been checked for placement and function.

On 2/8/19 at 3:00 PM an observation was made of the location of the auto parts store where Resident #1 was picked up by the police on 1/26/19 after she exited the facility while unsupervised. The observation revealed the auto parts store parking lot and the facility parking lot were separated by a narrow strip of grass and

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trees, approximately 10 feet wide, and the ground was level. The approximate distance between the facility front door and the auto parts door was 200 feet.
Weather history, provided by Accuweather.com, indicated that on 1/26/19 Durham had a high of 50 degrees Fahrenheit (F) and a low of 24 degrees F, with no precipitation.
On 1/26/19 at 7:46 PM facility documentation entered by the ED indicated Resident #1 continued to have exit seeking behaviors sitting while sitting in the lobby. Resident #1 had expressed she wanted to leave the facility, 911 to be called, the police called, and had become combative with the staff and her daughter. The physician had given an order for Resident #1 to be transferred to the Emergency Room (ER). Resident #1 had been transported to the ER via the Emergency Medical System (EMS).
On 2/8/19 at 10:45 AM an interview with the Executive Director (ED) was conducted. The ED stated closed circuit television (CCTV) had been reviewed and had observed on 01/26/19 a visitor coming in from the outside had let resident out the front door, which had been locked from the inside due to the wanderguard system had been activated. This had been about 4:40 PM. The ED stated after so much time, the recording gets erased and unable to review that day any longer. The ED stated when she had received a call regarding a missing resident, she came immediately to the facility and was present when the resident was returned by the police. The ED stated upon investigation it had been discovered when the wanderguard alarmed inside of the building at the front door, and the front door outside activation switch was activated, this turned off the wanderguard alarm. Staff had heard the wanderguard alarm, but it had turned

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off. The ED stated this malfunction had not been known previously to this incident but had been discovered on this occasion. The ED also stated the facility initiated a 4 point plan to prevent unsupervised resident exits from the facility. A copy of the plan had been provided at this time. The facility's plan indicated the following:
1. Resident affected: Resident #1 exited the facility through the main entrance door on 1/26/19. A family member of another resident assisted her out the door. Charge nurse and floor staff began a search for Resident #1 and were able to locate her. Charge nurse ensured Resident #1 was safe once she was back in the facility and 1:1 sitter placed with her. Nurse supervisor and charge nurse attempted to do a head to toe skin check upon immediate return to the facility however Resident #1 refused. The On call MD was made aware by the nurse supervisor and gave orders for Seroquel 50 mg which she also refused. Maintenance Director checked the wanderguard and the charge nurse checked for placement immediately upon return. The Executive director informed Resident #1 family of resident status. A phone care plan was held with daughter and executive director and the assistant DON in regard to Resident #1 status. The decision was made to send Resident #1 to the Emergency Room for evaluation by the family. ED and medical director per family and Resident #1 request. Daughter requested if Resident #1 could not be transferred prior to her arrival; Resident #1 continues with 1:1 until daughter arrival. Orders written by charge nurse for Resident #1 to be sent to the ER with daughter accompanying. Resident #1 to be evaluated for alternate placement. Charge nurse, floor nurses and staff completed a head count to ensure all residents were in the facility on 1/26/19. The maintenance

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director checked door function to ensure wanderguard system was functioning properly on 1/26/19. No issues found.
2. Residents with potential to be affected:
On 1/26/19 Nurse Managers reviewed the current residents with wanderguard to ensure wanderguards are in place and functioning properly, for orders verifying placement and functioning, location included in the order, evaluation up to date and in wanderguard book with picture, and care plans up to date.
3. Systemic Change:
Current residents with wanderguards will be reviewed in morning meeting to verify checks are occurring and signed off on the Medication Administration Record (MAR) and that the wanderguard system is checked. This review will be completed by the IDT consisting of the ED, DON, ADON, SDC, unit managers, Social Worker (SW), Culinary Manager (CM), Activities Director (AD), Director of Maintenance (DM) and MDS nurse. Beginning on 1/26/19 the DON will perform an audit that will be done 5 days per week for 4 weeks, then 3 days per week for 4 weeks, once a week for 4 weeks and randomly afterwards to ensure compliance. On 1/26/19; the DON, nurse managers and charge nurses completed head counts and door checks each shift for 72 hours and after resident incident and return. Beginning on 1/26/19 and continuing education was provided by the ED, DON, SDC, and the nurse managers on the following the elopement procedure and checking the wanderguard placement and function as ordered. An ad hoc QAPI was held on Monday 1/28/19 with the AQPI team consisting of the medical director, ED, DON, ADON, unit managers, SDC, SW, CM, AD, DM, MDS nurse, and Admissions Director. Newly hired staff will be educated during

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orientation and as needed.
4. Monitoring:
The ED will review audits monthly for the next 3 months with the Quality Assurance and Performance Improvement (QAPI) meeting and the team consisting of the following: Medical Director, ED, DON, ADON, unit managers, SDC, SW, CM, AD, DM, MDS nurse, and Admissions Director.
Verification of the above referenced plan of correction was completed on 2/8/19.
Documentation was observed in the facility record and indicated that Resident #1 had been allowed to exit the facility through the front door by another resident's family member. Staff had begun search and Resident #1 had been located. After Resident #1 had returned to the facility a 1:1 sitter had been placed with her, the physician had been notified, her wanderguard had been checked for function and found to have been working properly. Family had also been notified. A decision had been made with the daughter to send Resident #1 to ED for evaluation.
Documentation was observed in the facility record identifying other current residents with wanderguards. Verification for the other identified residents of wanderguard placement, functioning, physician orders, care plans and the wanderguard book were reviewed and updated as needed.
Audit tools were observed in use for the monitoring of residents' wanderguard placement, function, and door alarm system and function.
Maintenance and repair receipts were observed from the companies managing the wanderguard alarms and the automatic door systems.
Evidence of staff education beginning on 1/26/19 through 2/7/19 was observed in the facility documentation regarding the elopement policy

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F 689	Continued From page 10 and procedure. Interviews were conducted with staff from various disciplines and shifts, and staff were able to verify in-services regarding elopement policy and procedure had been conducted. Documentation of an initial QAPI meeting had been held on 1/29/19 and included the ED, DON, ADON, DM, Unit Managers, Business Office Manager, all department heads, Rehab Manager, Social Worker, Activities, MDS Nurse, Human Resources Manager, Admission Manager, and the Medical Director. Observations of facility exit doors revealed signs were posted which alerted visitors not to open or assist residents out doors and that doors with wanderguard alarms functioned properly to prevent unsupervised resident exits. Staff interviews revealed staff were educated on the facility's elopement policy and no other residents had exited the facility while unsupervised since 1/26/19. The facility's date of compliance of 2/7/19 was validated.	F 689		