STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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 survey was conducted from 3/25/19 through 3/27/19. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity G An extended survey was completed.	F 000		
F 689 SS=G	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 and staff and resident interviews the facility failed to prevent a resident with dementia from exiting the facility while unsupervised for an unknown amount of time for 1 of 1 sampled residents reviewed for elopement (Resident #1). Resident #1 was found outside lying in a drainage ditch approximately 178 feet away from the facility. The resident was returned inside the facility and his body temperature was below normal at 90.5 degrees Fahrenheit (F.) and he was transported to the hospital for evaluation. Findings included:	F 689	Past noncompliance: no plan of correction required.	4/11/19

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

Electronically Signed | 04/11/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 689	Continued From page 1	F 689		

Resident #1 was admitted on 5/18/16 with diagnoses in part, dementia, diabetes mellitus and hemiplegia. Review of the annual Minimum Data Set (MDS) dated 3/5/19 revealed the resident was as cognitively intact with a brief interview of mental status (BIMS) of 14, no assessment for decision making. He had no previous or current wandering behavior. He required extensive assistance with transfers and ambulation on the unit and supervision off the unit.

Review of a nursing note dated 3/19/19 that was written by Nurse # 2 revealed Resident #1 was up most of the night at the nurse's station. Nurse Aide returned him to his room at 4:00AM provided incontinent care. The nurse Aide returned to the room about 6:15 AM the resident wasn't there. Staff went room to room and bathrooms looking for Resident #1. He was found about 7:30 AM on the" floor" outside he was brought back into the building, he was cold to the touch and was assessed for injury. The note specified Resident #1 was so cold the thermometer was unable to provide a temperature, pulse 94 beats per minute, respirations 22 breaths per minute and blood pressure 175/102. He was covered with blankets and the Physician Assistant assessed Resident #1 and sent him to the hospital.

On 3/26/19 at 9:07 AM during an interview via telephone with Nurse #2 indicated that Resident #1 had been up during the night of 3/19/19. Nurse #2 stated Nurse Aide # 2 assisted Resident #1 to bed at 4:00AM. She returned to check on him at 6:00AM and he was not in his room. She reported to me and we began to look for him in all rooms and halls. She had never seen him try to leave the building from any door. Another nurse

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F 689	Continued From page 2	F 689		

found him outside the building and brought him in. He had no injury. He was cold, and she took his body temperature and it was 90.5 degrees F. Nurse #2 stated she called the doctor and he was sent to the hospital.

Record review of the Resident Incident Report dated 3/19/19 for Resident #1, revealed the location of occurrence was, "He was outside the building". His vital signs were recorded as temperature left blank, pulse 94 beats per minute, respirations 22 breaths per minute and blood pressure 175/102. The narrative of the incident stated, "Resident left the building and went outside, we looked around the building in all rooms, bathrooms. We didn't see him, he was found outside on the floor."

Review of the physician's note dated 3/19/19 no time, revealed blood pressure 178/114, heart rate 88beats per minute, body temp 90.6 degrees F. and respiratory rate 20 breaths per minute after outside for unknown amount of time. No injuries.

Review of the temperature record on https://www.accuweather.com/en/us/durham-nc/27701/march-weather/329821 revealed the temperature in the Durham area, where the facility is located, during the morning of 3/19/19 was 34 degrees F.

Record review of the Emergency Medical Service Response report dated 3/19/19 at 9:16 AM revealed chief complaint was hypothermia of Resident #1. He was confused and was alert to person, place, event, time and no physical abnormalities. His temperature at 9:25 AM was 93.3 degrees F, 9:36 AM was 94.4 degrees F. and at 9:46 AM was 95.8 degrees F., and

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 689	Continued From page 3	F 689		

Resident #1 was transported to the hospital at 9:53 AM.

Record review of hospital discharge document dated 3/19/19 no time, revealed his end of visit vital signs were blood pressure 126/84, temperature 97.7 degrees F., pulse 87, and respirations 21 breaths per minute. He came in very cold, no serious injuries.
Record review revealed Resident #1 was readmitted to the facility on 3/19/19. Upon his return to the facility on 3/19/19 the staff assessed Resident #1 as being a high risk for elopement and a wander guard was placed on his ankle.

During an interview and observation on 3/25/19 at 10:00 AM with Resident #1 was sitting in his room after breakfast. He watched his television. His demeanor was calm and approachable and he spoke quietly. The wander guard bracelet was observed on his right ankle above his sock. He was observed able to move his extremities normally. He was asked if he remembered being out of the building a couple days ago. He said "Yes". He indicated that he went out the door on the 300 hall, he could not remember how he got out. He could not remember who let him back in. He stated that he was out for "10 or 15 minutes", he had not fallen and he remember was cold. He indicated that he could propel the wheelchair without assistance.

On 3/27/19 at 11:38 AM via telephone Nurse Aide # 2 indicated she was assigned Resident #1 on 3/19/19. He was up and walked during that night. This was not his normal behavior. The last time she put him was when she put him to bed was 4:00AM. He laid down in his bed. She went to another room and returned to Resident #1's room

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 689	Continued From page 4	F 689		

at 5:45 AM. He was not in his room. She told another aide (not named) and we looked in the rooms. When she did not find him she told the nurse about 6:00AM. She had never seen him go to the doors. She had never seen anyone use the 300 hallway exit door.

An Interview on 3/15/19 at 10:32 AM Nurse #1 indicated when he came on duty 3/19/19, the third shift staff was looking for Resident #1. He indicated that he walked out the front door turned left and left again to the side of the building that lead to the back of the building. He yelled Resident #1 name and he answered "Yeah". He was found about 7:20AM, he had laid on top of rocks in a drainage ditch looking up at the sky with his arms crossed on his chest. The ditch had a small amount of water, and the sun was just coming up. Nurse # 1 indicated he had noted frost on the windshield of his car that morning it was not raining. It was cold out.

Resident #1 was dressed in a hospital gown with a brief and socks. His shoes were placed about three feet from him neatly arranged, like he had taken them off and set them together. His right side of the gown was wet. He was cold to the touch. Nurse #1 stated he assessed Resident #1 prior to getting him up and put him into a wheel chair. Resident #1 denied any pain. He brought Resident #1 into the facility and returned him to Nurse #2. The aide who had him was NA #2. Nurse #1 stated that when Resident #1 had walked out of the facility he had no wheelchair. Normally, he used a wheelchair to propel. He walked short distances. He did not exit seek. He did wander in the facility. The 300 hall door was always locked with a key pad code. He did not know the code. That door was used by the

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 689	Continued From page 5	F 689		

ambulance or the funeral home. Usually, staff had not used the door.

An Observation on 3/25/19 at 2:15 PM revealed the measurement of distance taken by the Maintenance Director (MTD) using a tape measure with Nurse #1 present to direct where Resident #1 was found on the ground on 3/19/19. The total distance from the door of the facility down the ramp to a rocky hill which sloped down to the opening of a large drainage pipe that emptied into a drainage ditch filled with rocks was 178 feet. He indicated that he had his assistant immediately checked the functioning of the door. The MTD stated that the assistant reported that the 300 hallway exit door had no malfunction. The [named] contractor that managed the door's lock system was called to check the system for malfunction. The MTD stated the contractor reported to him, "There was no malfunction and the lock system was disengaged manually by someone." That was how the resident was able to exit undetected. No one was to use this door it was for maintenance use only or an emergency exit. He indicated that the contactor recommended an additional safety feature for the door that would prevent staff from disengaging the door.

An interview on 3/25/19 10:26 AM with Nurse Aide (NA) #1 revealed she arrived at the facility on 3/19/19 at 7:00AM and Resident #1 was missing. He was found outside the 300 hall door by Nurse #1 he had on a hospital gown. She indicated that he was able to propel himself in the wheelchair through the building and was able to get up and walk. He didn't exit seek. All the doors had a code to get out. The alarm sounded when anyone goes outside the 300 door.

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 6	F 689		

During an observation on 3/25/19 at 10:26 AM at the 300 exit door revealed Resident #1 was able to stand unassisted and he pushed on the door. The door remained locked. No alarm sounded. Nurse Aide #1 stated she did not know the code to the key pad to get out.
An interview on 3/25/19 at 2:05 PM Nurse # 3 indicated that she worked daily with Resident #1. He did not exit seek and was confused and wandered in the building. He got up and walked.

On 3/26/19 at 10:47 AM Nurse Practitioner (NP) indicated that she was familiar with Resident #1 and his normal demeanor was to sit outside his room and socialize. He had not been observed as exit seeking. He was alert and able to answer questions accurately. He had short term memory loss and was able to ask questions but his ability to reason was poor. He varied day to day. His assessment for cognition was accurate.

On 3/25/19 at 2:45 PM Maintenance Assistant indicated he was not at the building when Resident #1 was found. When he arrived he checked and all the switches had been reset and the 300 hallway's magnetic door lock was engaged. He found no malfunction of the system.

Review of the contracted vender service report for the emergency exit door (300 hallway exit door) dated 3/20/19 revealed "physical manipulation required (emergency switch engaged blocking open door, etc.) for door /mag lock not to work properly.

On 3/25/19 at 4:48 PM Administrator indicated that Resident #1 was sent back to the facility from the hospital the same day, with no injury. An

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F 689	Continued From page 7	F 689		

investigation was unable to determine who or why the 300 hallway exit door was disengaged. On 3/26/19 at 3:51 PM via telephone Nurse#4 indicated she supervised the second shift. She indicated that staff were not to go out the emergency doors to smoke or to go to their cars. All doors were to remain locked unless there was an emergency. The staff were aware how to operate the door locks during an emergency by flipping up the toggle switch and closing the plastic cover to stop the audible door alarm.
On 3/27/19 at 10:07 AM the Administrator used a surveyor wheel from the therapy department to measure the distance from Resident #1 room to the 300 hall exit door, it was 55 feet. The distance from the exit door down the ramp to the drainage ditch where Resident #1 was found was 159 feet. During interview the Administrator indicated the lights came on with sensors in the evening the door had to be left unlocked for Resident #1 to exit. It was unknown who left the 300 hallway exit door unlocked.

CORRECTIVE ACTION
Resident #1 was assessed by nurse immediately when resident was located no physical injuries noted and resident was responsive to questions. Once Resident #1 was returned to room he was assessed by the Physician Assistant in the am, resident was transported to the hospital approximately 9:30 am. Resident returned the same day in the evening around 7:30 pm with no known injuries. Upon return, an elopement assessment was completed, his score was 15, a score of 15 means the resident, at the present moment, is at high risk for wandering. A wander guard was placed on resident #1 right ankle, care plan updated (to address the resident's new wander assessment and placement of

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 8	F 689		

wandergaurd), CNA Care intervention record form was updated, and picture of resident #1 was added to elopement risk book along with resident's demographics which include race, gender, ambulatory status, height, weight, and location of wander guard with expiration date.

On 3/19/19, the assistant maintenance director completed a 100% audit of exit doors to ensure doors were functioning properly. All 8 out of 8 facility exit doors were checked, no issues were noted.

On 3/20/19 starting at 915am, BFPE, a sprinkler/security/alarm company, completed a service check for all exit doors, no issues were noted after their inspection. The facility did investigate to determine how the resident walked outside without being detected by staff and determine the door's safety switch must have been disabled to allow exit and entry. The plastic cover of the switch does make a loud alarm sound when removed but stops when cover is replaced, noted to be working properly. Interviews with residents and staff no one heard alarms activated.

On 3/19/19 licensed nurses completed elopement risk observation forms on 100% in house residents. MDS nurse and nurse management team reviewed elopement risk assessment. Any resident that scored 5 or above had care plan updated including elopement interventions. If resident scored above 5 and was unable to ambulate, non-mobile (Bed bound needing assistance from staff to get up and move throughout the facility), and/or total care with activities of daily living (not able to perform basic activities, i.e.; wash face, ambulate, nor wheel

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

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F 689	Continued From page 9	F 689		

themselves in their wheelchairs without assistance from staff), they were not care planned as exit seeking. There were 56 residents with updated care plans for elopement risk. There were 72 residents that did not warrant an updated care plan for elopement risk.

On 3/19/19 Administrator and Director of Health Services started in-services of licensed nursing staff and non-licensed personnel including certified nursing assistant, dietary staff, housekeeping staff, laundry personnel, maintenance, social service director and business office personnel on Elopement Prevention (ensuring facility doors are never disabled unless in an emergency), Missing person (Code Pink) including the procedure for searching the facility and procedure for notification of management. Any staff who has not been in-serviced as of 3/22/19 cannot work until in-service has been completed. If employee is on FMLA, on leave or are PRN, employees will be in-service upon return before next schedule shift. In-service will be added to orientation process. In-service was completed on 3/22/19.

On 3/19/19 Administrator started to in-service all licensed nursing staff and non-licensed personnel including certified nursing assistant, dietary staff, housekeeping staff, laundry personnel, maintenance, social service director and business office personnel on facility door security (to include not disabling facility door alarms). Any staff who has not been in-serviced as of 3/22/19 cannot work until in-service has been completed. If employee is on FMLA, on leave or are PRN, employees will be in-service upon return before next schedule shift. In-service will be added to orientation process. In-service was completed on

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 10 3/22/19. On 3/19/19 Director of Health Services started in-service of all licensed nurses and non-licensed nursing staff (certified nursing assistant) for nursing staff for rounding/incontinence care every 2 hours. Any staff who has not been in-serviced as of 3/22/19 cannot work until in-service has been completed. If employee is on FMLA, on leave or are PRN, employees will be in-service upon return before next schedule shift. In-service will be added to orientation process. If employee is on FMLA, on leave or are PRN, employees will be in-service upon return before next schedule shift. In-service will be added to orientation process. In-service was completed on 3/22/19. On 3/21/19 Administrator started in-services of licensed nursing staff and non-licensed personnel including certified nursing assistant, dietary staff, housekeeping staff, laundry personnel, maintenance, social service director and business office personnel for any resident that is leaving a secure environment to unsecure environment always address/redirect residents. Any staff who has not been in-serviced as of 3/22/19 cannot work until in-service has been completed. If employee is on FMLA, on leave or are PRN, employees will be in-service upon return before next schedule shift. In-service will be added to orientation process. In-service was completed on 3/22/19. Maintenance director and/or assistant maintenance director will complete a daily check on all exit doors to ensure doors are functioning properly. Audits will be turned into the Administrator daily for review.	F 689		

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PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

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F 689	Continued From page 11 On 3/19/19 the licensed nurses were trained and will check all exit doors every shift to ensure the doors are functioning correctly and alarms working. If the doors are not functioning properly the licensed nurse will notify the maintenance director and/or Administrator immediately and a staff member will man door until fixed. The facility door audit is turned into the facility Administrator every shift for review. Licensed nurses will complete head counts of assigned resident four times per shift, if a resident is noted missing or unable to locate, the licensed nurse is responsible to initiate Code Pink and notify Administrator immediately. The Resident Head count audit is turned into the administrator every shift for review. Upon admission/readmission an elopement risk observation form is completed and all residents who score above a 5, interventions will be put into place and their care plan will be up dated to reflect resident elopement status Maintenance director will track and trend the daily door checks and provide the analysis to the Quality Assurance and Performance Improvements Committee monthly until 3 months of substantiate compliance maintain then quarterly after. Administrator will track and trend the daily door checks from licensed nursing staff and provide the analysis to Quality Assurance and Performance Improvements Committee monthly until 3 months of substantiate compliance maintain then quarterly after. Administrator will track and trend the head counts of assigned residents from licensed nursing staff	F 689		

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	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12	F 689		

and provide the analysis to the Quality Assurance and Performance Improvements Committee monthly until 3 months of substantiate compliance maintain then quarterly after.

The Director of Health Services will track and trend all admission/readmission elopement risk assessment and provide the analysis to Quality Assurance and Performance Improvements Committee monthly until 3 months of substantiate compliance maintain then quarterly after.
Final date of compliance 3/22/19.

The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the credible allegation of compliance for prevention of accidents.

As part of the validation process on 3/25/19 through 3/27/19, the plan of correction was reviewed including the re-education of staff and observations of interventions put into place to ensure the door remained locked. Resident #1 was in the facility at the time of the investigation. Observation on 3/25/19 at 10:00 AM revealed he was in his room with a wandergaurd bracelet intact.

Observations were made of other residents who were potential elopement risks. Interviews with licensed staff and nursing assistants revealed nurses and nurse aides were retrained to do a visual head count of the resident and check the emergency exit doors every two hours and nurses to document on audit sheets. A review of the monitoring tools revealed that the facility completed the audits of residents and the doors every two hours. The facility's alleged compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345551	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-CAROLINA POINT	5935 MOUNT SINAI ROAD DURHAM, NC 27705

(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 13 date of 3/22/19 was verified.	F 689		