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	345070	A. BUILDING ______ B. WING ______	C 10/29/2020

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DURHAM NURSING & REHABILITATION CENTER	**411 S LASALLE STREET DURHAM, NC 27705**

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F 000	INITIAL COMMENTS The complaint investigation survey was conducted from 10/21/20 to 10/29/20, Event ID# KT3Y11. 1 of the 1 complaint allegation was substantiated resulting in deficiency F 689. Immediate Jeopardy was identified at: CFR 483.12 at tag F 689 at a scope and severity (J) The tag F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/9/20 and was removed on 10/22/20. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and Nurse Practitioner interview, the facility failed to supervise a cognitively impaired resident with known exit seeking behaviors to prevent the resident from exiting the facility while unsupervised for 1 of 3 residents reviewed for accidents. (Resident #1). Resident #1 exited the facility while unsupervised and fell from a loading	F 689	F689 The statement included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state	11/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/05/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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dock attached to the facility. The resident was found outside on the ground by staff and was transported to the hospital for evaluation. Resident #1 was diagnosed with a facial laceration, facial bone fractures, head and left hip trauma.

Immediate Jeopardy (IJ) began on 10/9/20, when Resident #1 while unsupervised by staff, exited the facility through an emergency exit to the loading dock outside the building and fell off the loading dock from a height of 4 to 5 feet, landing on her face. She sustained facial laceration, facial bones fracture, head, left hip trauma, and hospitalization. The Immediate Jeopardy was removed on 10/22/20 when the facility provided and implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete staff training and ensure that monitoring systems put into place are effective to prevent accidents.

The findings included:

Resident #1 was admitted to the facility on 2/28/14 with diagnoses, including metastatic breast cancer, psychotic disorder, schizophrenia, diabetes mellitus, and a history of stroke.

The fall risk assessment, dated 7/6/20, revealed that Resident #1 was at high risk for falls due to history of falls, poor balance, psychoactive drug use and unsteady gait.

The resident ' s Quarterly Minimum Data Set assessment, dated 7/7/20, revealed she was

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regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated.

Corrective action accomplished for those residents found to have been affected by the deficient practice.

Resident #1was transferred to the emergency room on 10/9/2020 and did not return to the facility.

Identification of residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected.

10/9/2020 the Maintenance Director placed a wooden hand railing to side of walkway on loading dock by exterior exit door to zone 3.

10/9/2020 all exit doors were checked by the Maintenance Director to ensure proper functioning with no irregularities noted.

Maintenance Director has preventative maintenance scheduled weekly for checking of all exterior doors for proper functioning.

10/9/2020 elopement drill was completed

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severely cognitively impaired, required extensive assistance by one-person physical assistance for activities of daily living (ADL), including walking in the room and corridor. She was frequently incontinent for bowel and bladder, known for verbal behavior toward others, exhibited wandering behavior one to three times per week, received antipsychotics, antianxiety and antidepressant medications.

Resident 1 ' s plan of care, dated 8/4/20, indicated she was at risk for falls, related to declining in the ability to ambulate, history of falls, unsteady gait, impaired cognition, decreased safety awareness, and impaired visual function. Resident #1 was at risk of elopement and exit seeking behavior. The interventions included fall risk assessment, mats to bedside, ambulation with assistance only, distract resident from wandering with structured activities, and wanderguard placement.

The Kardex, dated 9/21/20, for Resident #1 revealed that she required assistance with ambulation, to check placement/function of the wanderguard on her right ankle every shift, and distraction from wandering.

The care tracker for October 2020 revealed that on 10/8/20, Resident #1 was independent (no help or staff oversight at any time) for walking in the corridor on second and third shifts.

A nurses ' notes dated 10/9/20 at 7:04 AM, and written by Nurse #1, revealed that Resident #1 "got out of building side door" around midnight, fell off the dock porch to the ground and sustained 2 inch laceration above the left eye. She was sent to the hospital. The DON, ADON,

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at 2:30pm by facility Administrator with all staff on duty at the time of the drill. Staff successfully responded to missing residents.

10/9/2020-10/11/2020 all residents were reassessed for elopement risk by the Unit Coordinator. Upon assessment residents that indicated risk for elopement had care plan interventions revised and updated as needed upon completion of assessment.

10/9/2020 in-service education began by Assistant Director of Nursing for all staff related to elopement risk, procedure for missing residents and checking for placement and function of wanderguard devices.

10/12/2020 all residents determined to be at risk for elopement had care plans reviewed by the MDS nurse to ensure that interventions implemented upon completion of elopement risk assessment were noted on care plan as indicated.

10/12/2020 elopement books located at each nurse's station and reception area were reviewed by the Medical Record Coordinator and updated as indicated with pictures of residents assessed to be at risk for elopement.

10/14/2020 all exit doors were checked by door alarm manufacturer (RFT technologies) for proper functioning including alarm function and egress function with no irregularities noted.

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Health Service provider, and family were notified at 12:30 AM. The exit door alarm was not heard by the staff through the building among the simultaneously sounding loudly bed alarms on the same hallway.

A nurses ' notes, dated 10/9/20 at 6:28 AM, revealed that Nurse #2 came to help Nurse #1 with Resident #1, who fell outside of the facility. Nurse #1 was not aware of how Resident #1 went outside. She conducted an assessment and checked vital signs, which were within normal limits. Resident #1 had a 2 inch gash over her left eye and facial swelling. The treatment was provided in a timely manner and Resident #1 was transported to ER via EMS.

An incident report revealed that on 10/9/20 at 12:00 AM, Resident #1 was found outside of the facility on the ground. She fell off the loading dock and injured her left eye with 2 inch laceration. The immediate actions were to call Emergency Medical Service (EMS), conduct assessment, including vital signs, notify the Director of Nursing DON), Assistant Director of Nursing, Health Service provider, and family. Resident #1 was confused but oriented in person. She was ambulating without assistance. There were no witnesses to the incident.

A written statement, provided by Nurse #1, revealed that on 10/9/20 at 12:00 AM, he walked toward the zone 3 nurses ' station, and noticed the door alarm sound. The exit door was closed. Nurse #1 opened the door, did not see anybody on the loading dock, came back to the hallway, and checked Resident #1 in her room, because of her known exit seeking behavior. The resident was not in her room. At 12:05 AM, Nurse #1 went

10/22/2020 Re-education began by Director of Nursing, Assistant Director of Nursing and/or Corporate MDS Consultant related to elopement risk, procedure for missing residents, checking for placement and function of wanderguard devices and response to door alarms. All staff will be inserviced prior to their next scheduled shift.

10/22/2020 Maintenance Director placed signs stating to stop with large red stop sign on all doors exiting to exterior of facility to alert residents to stop and not exit.

Measures/systemic changes made to ensure that the deficient practice will not recur.

10/9/2020 The Maintenance Director placed a wooden hand railing to the side of the walkway on the loading dock by exterior exit door to zone 3.

10/9/2020 In-service education began by Assistant Director of Nursing for all staff related to elopement risk, procedure for missing residents and checking for placement and function of wanderguard devices.

10/22/2020 Re-education began by Director of Nursing, Assistant Director of Nursing and/or Corporate MDS Consultant related to elopement risk, procedure for missing residents, checking for placement and function of wanderguard devices and response to

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back to the loading dock and discovered Resident #1 laying on the ground on her back. She was breathing, alert, talking, moving her legs, and bleeding from the left side face laceration. Nurse #1 notified Nurse #2, received help with further assessment, called EMS, the Health Service provider, and the supervisor. At 12:30 AM, the EMS took Resident #1 to the hospital.

On 10/21/20 at 11:10 AM, during a phone interview, Nurse #1 indicated that on 10/8/20 at 11:45 PM, he was working with the schedule at the back nurses ' station. At midnight, Nurse #1 observed Resident #1 in bed in her room. On the way back to zone 3 nurses ' station (Nurse #1 was unsure of the exact time), he heard the door alarm sound. Nurse #1 went to the side door, opened it, and looked outside the door to the loading dock, attached to the facility. On the dark loading dock, he did not see anybody and came back inside. Nurse #1 checked Resident #1 ' s room, because she was known for exit seeking behavior and her room was near the zone 3 nurses ' station. Resident #1 was not present in her room. Nurse #1 called Nurse #2 for help. Both nurses went back to the loading dock and found Resident #1 on the ground near the loading dock. Resident #1 was alert, could talk, move her extremities but could not explain how she fell. She had a small bleeding laceration above her left eye. Nurse #1 with Nurse #2 assessed the resident and checked the resident ' s vital signs, which were within normal limits. The staff called EMS, notified the DON, the physician on call, and the family. The EMS arrived in 5-10 minutes, assessed the resident, and took her to the ER. Nurse #1 mentioned that he did not observe Nurse Aide #1, assigned for Resident #1, near the zone 3 nurses ' station at the time of the

door alarm. All staff will be inserviced prior to their next schedule shift.

10/22/2020 Maintenance Director placed signs stating to stop with large red stop signs on all doors exiting to exterior of the facility to alert residents to stop and not exit.

Maintenance Director has Preventive maintenance scheduled weekly for checking of all exterior doors for proper functioning.

Education related to elopement risk, procedure for missing residents and checking for placement and function of wanderguard devices included in facility orientation and quarterly for all staff.

The facility Administrator,Director of Nursing, Assistant Direector of Nursing and/or Unit Coordinator will conduct elopement drills two times weekly including off shifts and weekends X4 weeks, weekly X4 weeks then monthly on going.

Facility plans to monitor performance to make sure solutions are sustained.

The Administrator will report findings of elopement drills to the Quality Assurance and Performance Improvement Committee monthly for a minimum of 3 months. The Quality Assurance and Performance Improvement

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incident.

On 10/21/20 at 3:40 PM, during an interview, Nurse #2 indicated that on 10/9/20 at 12:10 AM, she worked on another nurses ' station. Among multiple intravenous and tube feeding pump alarms on the hallway she heard the door alarm sound from another hallway. Nurse #2 could not recall the exact time of the alarm activation on zone 3 exit door. She walked to the zone 3 nurses ' station area and observe Nurse #1 opened the side door to the loading dock. Nurse #2 was holding the side door when Nurse #1 told her he found Resident #1 outside on the ground near the loading dock. Nurse #2 came outside to loading dock and assessed Resident #1 together with Nurse #1. Upon assessment, Resident #1 was alert, had a small laceration on her left eye area, with normal vital signs and no other visible injury. Nurse #2 remained with the resident while the staff called EMS, the physician on call, supervisor, and family. The EMS arrived within a few minutes, assessed the resident, and took her to the hospital.

On 10/21/20 at 12:20 PM, during the phone interview, Nurse Aide #1 indicted she was assigned for Resident #1 on the third shift of 10/8/20. Resident #1 showed wandering behavior, walked independently on the hallway and the staff often redirected her to her room. She had wanderguard on her ankle, which should initiate the door alarm, every time Resident #1 comes close to any exit door. At the beginning of the third shift, Nurse Aide #1 observed Resident #1 in her room in the bed. The resident did not attempt to leave her room. After midnight, Nurse Aide #1 was in another resident ' s room on the hallway, providing care. She could not hear the

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side door alarm from the hallway, because of the sounding bed alarm in the resident ' s room. Nurse Aide #1 did not observe how Resident #1 opened the side door and left the facility. By the time Nurse Aide #1 came to the zone 3 nurses ' station, the staff already found Resident #1. Nurse Aide #1 continued that she did not receive report from the second shift about Resident 1 ' s exit seeking activity.

The EMS report revealed that the 911 call from the facility was received on 10/9/20 at 12:52 AM. The EMS team arrived at the facility at 1:08 AM. Upon assessment, Resident #1 was alert, laid on her left side on the ground near the loading dock, attached to the facility. The resident complained of neck and back pain and did not follow simple commands. She had 2 inch of bleeding laceration to the forehead along with a hematoma and crepitus (a grating sound, associated with fractured bones) in the right jaw. The resident was loaded into the ambulance via stretcher and was transported to the ER. The EMS team departed the facility at 1:14 AM and transferred Resident #1 to the Emergency Room (ER) at 1:20 AM.

The hospital records revealed that Resident #1 arrived at the ER in the hospital on 10/9/20 at 1:21 AM. After assessment and a series of imaging diagnostic tests, her diagnoses included fall, head injury with multiple intracranial hemorrhages, multiple bones facial fractures, face skin laceration, and left hip hematoma. Due to the severity of multiple injuries and underlying metastatic breast cancer, the patient was transitioned to comfort care/inpatient hospice.

On 10/21/20 at 9:30 AM, during a phone

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interview, the Director of Nursing (DON) indicated that the staff reported on 10/9/20 at midnight, Resident #1 was wandering near the zone 3 nurses ' station, opened the side door, left the facility, and fell off the loading dock. The staff heard the door alarm, came to the side door to assess the situation but could not observe the resident outside the door. The staff could not locate Resident #1 in her room, went back to the loading dock outside the side door, and found Resident #1 on the ground with face laceration. Per staff, she was alert, could talk but could not explain what happened. Resident 1 ' s vital signs were normal. The staff called EMS, notified the nurse supervisor, physician on call, and family. The EMS arrived quickly and took the resident to the hospital for evaluation. The staff confirmed Resident #1 had her wanderguard in place at the time of the incident. The resident ' s room was near the nurses ' station and the staff redirected her back to her room every time she came to the hallway. All the staff was aware of her exit seeking behavior. Last time, the staff observed Resident #1 in her room before midnight on 10/8/20.

On 10/21/20 at 11:00 AM, the Maintenance Director stated that the side door to the loading dock was equipped with an alarm system that will sound when opened without entering the special code. Together with the sound alarm, there was a light notification system on every nurses ' station, to show the alarm location. The wanderguard related alarm system was mounted on the main entrance door only. The maintenance staff tested the door alarms for all doors in the facility weekly, and the side door to the loading dock passed the test on 10/5/20. The Maintenance Director was aware of Resident 1 ' s exit seeking behavior, but

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F 689	Continued From page 8 for fire safety, the side door cannot be permanently locked. On 10/21/20 at 11:05 AM, during observation with the Maintenance Director and the Administrator of the zone 3 nurses ' station area, room #40, where Resident #1 resided, located approximately 15-20 feet from the side exit door. The zone 3 nurses ' station was between the resident ' s room and the side exit door. The side door to the loading dock was closed and locked. The Maintenance Director pushed the door handle for three-five seconds, opened the door and the alarm began. At the same time, the light with the zone number was activated on the nurses ' station near the side door. The Maintenance Director entered the digital code to stop the alarm sound. During observation outside of the side exit door, there was the loading dock, with four-five feet drop from the edge of the loading dock to where Resident #1 was found on the ground on 10/09/20. On the side of the loading dock, there was a dark red wooden handrail installed. The maintenance logbook for October 2020 revealed that the weekly test operation of the doors and locks was conducted on 10/5/20 and the zone 3 door (the door, Resident #1 opened to leave the facility) passed the test. This emergency exit door was not associated with the wanderguard system. The description indicated: push the door release hard for more than three seconds, the door alarm will sound, and the door will automatically open within 15-30 seconds. Close the door and reset the alarm. On 10/29/20 at 1:30 PM, a phone interview, was conducted with the Administrator. The	F 689		

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Administrator was asked about time discrepancies between the EMS report and the statements from the staff regarding how things transpired when Resident # 1 was found by staff outside of the facility on 10/09/20. The Administrator stated that during this stressful situation, when the resident was found outside of the facility, the staff were not accurate with their reporting of time, because they concentrated on assessment and communication with EMS and healthcare provider. After the incident, Nurse #1 and Nurse #2 could provide approximate times only. The administrator specified after Nurse #1 discovered Resident #1 on the ground, he called EMS within about 10 minutes.

On 10/21/20 at 2:30 PM, during an interview, Nurse Practitioner #1 indicated that Resident #1 received psychotropic treatment for psychotic disorder, schizophrenia, was known with wandering behavior, and was not stable on her medications. Recently, he observed a psychiatric Nurse Practitioner reviewed Resident 1 ' s medication regimen to adjust the therapy for better results. He was aware of the recent resident ' s unsupervised exit from the facility which resulted in a fall with injury. Resident #1 received psychiatric service but often refused to take psychotropic medications. Nurse Practitioner #1 believed, Resident #1 did not require one-by-one monitoring but needed supervision for safety.

On 10/23/20 at 3:30 PM, during the phone interview, Nurse Practitioner #2 indicated she provided psychiatric service for Resident #1. The resident often refused to take psychotropic medications, was not aggressive or dangerous to self and others. During the last visit, on 10/8/20,

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Resident #1 refused to communicate with Nurse Practitioner #2. Nurse Practitioner #2 reviewed the resident ' s medication regimen.

The Administrator and DON were notified of Immediate Jeopardy on 10/22/20 at 12:20 PM. On 10/22/20 at 6:10 PM, the facility provided the following credible allegation of Immediate Jeopardy removal:

1 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
The interdisciplinary team (IDT) including the Administrator, Director of Nursing, and Corporate Regional Director of Operations met on 10/9/2020. The root cause was determined that the facility failed to provide supervision to prevent the resident from exiting the building. The facility staff failed to respond to the door alarm to prevent the resident from exiting to the loading dock and sustaining a fall. At the time the resident exited the building facility staff were adjusting the staffing assignment as a staff member left duty for the shift. Per nurse, there were other alarms for air mattress malfunctions sounding at the same time which decreased the staff's ability to hear door alarm.

The resident had previously been identified as at risk for elopement. The resident had a wanderguard in place at the time of the incident. The wanderguard system is in place for the front door of the facility only. All other exterior doors are keypad entry and exit. All exit doors have 15-second egress to be compliant with the life safety code. If exterior doors are opened without utilizing a keypad and/or are left open for an extended period they will alarm to alert staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING ______ B. WING ______	C 10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET 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 11	F 689		

The resident is noted to have a history of psychiatric conditions with behaviors and was evaluated by psychiatry services.
Residents that have been assessed as at risk for elopement and exhibit exit seeking behaviors have the potential to be affected.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

On 10/9/20, the Maintenance Director placed wooden hand railing to side of the walkway on loading dock by the exterior exit door to zone 3, checked all exit doors to ensure proper functioning with no irregularities noted, an elopement drill was completed on 10/9/20 at 2:30 PM by the facility Administrator with all staff on duty at the time of the drill. The staff successfully responded to the missing resident. On 10/9/2020, the in-service education began by Assistant Director of Nursing for all staff related to elopement risk, the procedure for missing residents, and checking for placement and function of wanderguard devices.

On 10/9/2020 - 10/11/2020, all residents were reassessed for elopement risk by the Unit Coordinator. Upon assessment residents that indicated a risk for elopement had care plan interventions revised and updated as needed upon completion of the assessment.

On 10/14/20 all exit doors were checked by the door alarm manufacturer for proper functioning including alarm function and egress function with no irregularities noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING ______ B. WING ______	C 10/29/2020

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DURHAM NURSING & REHABILITATION CENTER	**411 S LASALLE STREET DURHAM, NC 27705**

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F 689	Continued From page 12 On 10/22/20, re-education began by Director of Nursing, Assistant Director of Nursing, and/or Corporate MDS Consultant related to elopement risk, the procedure for missing residents, checking for placement and function of wanderguard devices, and response to door alarms. All staff will be in-serviced prior to their next scheduled shift. On 10/22/20, Maintenance Director placed signs stating to stop with a large red stop sign on all doors exiting to the exterior of the facility to alert residents to stop and not exit. Beginning 10/9/20. the facility Administrator, Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator conducted elopement drills and drills were performed on 10/9/2020 2:30 PM, 10/13/2020 3:00 AM, 10/16/2020 3:30 PM, 10/19/2020 11:00 AM and 10/22/2020 5:15 PM. The Administrator, DON, ADON, and other administrative nurses were responsible for the implementation of the credible allegation of Immediate Jeopardy removal. The date of the removal of the immediate jeopardy is 10/22/20. The credible allegation of IJ removal was verified on 10/23/20 as evidenced by licensed and non-licensed nursing staff interviews on each of the halls on all three shifts. The staff had been re-educated on the procedure for missing residents, checking for placement and function of wanderguard devices, and response to door alarms. Interviews with the licensed and unlicensed staff confirmed they were in-serviced prior to working on the floor. The facility's credible allegation of Immediate Jeopardy removal was	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING ______ B. WING ______	C 10/29/2020

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F 689	Continued From page 13 verified as having been implemented as of 10/23/20. The facility ' s IJ removal date of 10/22/20 was validated.	F 689		