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	345462	A. BUILDING _____ B. WING _____	C 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(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 An unannounced onsite complaint investigation survey was conducted on 06/02/21. The survey team returned to the facility on 06/09/21 to obtain additional information and exited on 06/09/21. The survey team returned to the facility on 06/16/21 to conduct a partial extended survey and exited on 06/16/21; therefore, the exit date was changed to 06/16/21.One allegation was investigated and substantiated. Past non-compliance was identified at: CFR 483.12 at tag F 600 at a scope and severity of J. CFR 483.25 at tag F 689 at a scope and severity of J. The tags F 600 and F 689 constitued Substandard Quality of Care. F 600- Non-compliance began on 05/27/21. The facility came back in compliance effective 06/01/21. F 689- Non-compliance began on 02/28/21. The facility came back in compliance effective 03/23/21.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		7/6/21

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

Electronically Signed | 07/06/2021

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F 600	Continued From page 1 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, Physician Assistant (PA) and Physician interviews, the facility failed to identify the urgent need for medical attention or notify the physician when an acute change was first identified for 1 of 3 residents reviewed for accidents (Resident #1). Resident #1 was admitted to the hospital on 05/27/21 and diagnosed with an impacted (occurs when the broken ends of the bone are jammed together by the force of the injury), angulated (where the normal axis of the bone has been altered causing the distal portion of the bone to point off in the opposite direction) and comminuted (the bone has broken into three or more pieces and in most cases, the number of bone fragments corresponds with the amount of force needed to break the bone) right femoral diaphyseal (bone break that occurs along the shaft of the long bone) periprosthetic (broken bone that occurs around the implants of a total hip replacement) fracture that required immediate surgical repair. Resident #1 was also diagnosed with bilateral Deep Vein Thrombosis (DVT; blood clots that form in veins deep inside the body) and subsequently passed away on 06/02/21. Findings included: Resident #1 admitted to the facility on 10/20/20	F 600	Past noncompliance: no plan of correction required.	

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with diagnoses that included Alzheimer's disease and contractures of the left hip, knee and ankle.

The quarterly Minimum Data Set (MDS) dated 03/20/21 assessed Resident #1 with moderate impairment in cognition for daily decision making but could usually make herself understood and usually understood others. Resident #1 required extensive assistance of two staff members with bed mobility, transfers, toileting and bathing and supervision with locomotion on the unit using a wheelchair for mobility. The MDS further noted she had impaired range of motion on both lower extremities.

Resident #1's medical record revealed none of her active care plans specified the level of assistance she required with transfers.

The Physician Assistant (PA) progress note dated 05/19/21 noted Resident #1 was seen to evaluate increased lower extremity edema (swelling caused by excess fluid accumulation in the body tissues). Upon exam, she had 2 + lower extremity edema mid-thigh distally to ankles and a new order was written for Lasix (medication used to reduce extra fluid in the body) 20 milligrams (mg) daily.

Nurse's note written on 05/27/21 at 2:37 AM by Nurse #1 read in part, during nighttime rounds, Resident #1 indicated pain whenever her right leg was touched. Nurse Aide (NA) #1 called Nurse #1 to look at the leg which was at a 25-degree angle to the right, the curve inward at the knee. Did not float her heels as Resident #1 stated to move the leg hurt "bad." Will check with the on-call provider in the AM and possibly request an x-ray. Will continue to observe throughout the

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night.

During a telephone interview on 06/03/21 at 9:13 AM, Nurse Aide (NA) #1 confirmed she worked 7:00 PM to 7:00 AM on 05/26/21 to 05/27/21 and was assigned to provide care to Resident #1. NA #1 recalled when she started her shift, Resident #1 was in her wheelchair out in the common area and remained in her wheelchair until around 9:00 PM to 9:30 PM when she assisted Resident #1 to bed. She explained when assisting Resident #1 with transfers, sometimes she assisted independently and other times she had another staff member help assist. NA #1 confirmed she transferred Resident #1 to bed independently the evening of 05/27/21 and explained she lowered the bed, put her arms around Resident #1, underneath her armpits "like I was giving her a hug", lifted her up and over to the side of the bed and then lifted her legs as she laid back on the bed. NA #1 verified that was how she normally transferred Resident #1. NA #1 added Resident #1 did not fall, hit her leg on the wheelchair or bed or complain of any discomfort during the transfer. NA #1 didn't recall noticing anything abnormal after she assisted Resident #1 to bed and stated she covered her up and left the room. Around 2:30 AM, NA #1 stated she checked on Resident #1, pulled the covers off to float her heels on a pillow and noticed her right leg was "rotated outward and didn't look right." She informed Nurse #1 and they both went back to Resident #1's room. NA #1 recalled Nurse #1 lifted Resident #1's leg slightly and touched her thigh area. When Nurse #1 pushed on Resident #1's thigh, a "lump" came up and then disappeared. She added Nurse #1 assisted her with changing Resident #1, covered her back up and she fell back to sleep when they exited the room. NA #1

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added when asked Resident #1 told Nurse #1 her leg hurt but never grimaced or cried out in pain when incontinence care was provided or when her leg was touched by Nurse #1.

During a telephone interview on 06/02/21 at 2:10 PM, Nurse #1 confirmed she was the nurse assigned to provide care to Resident #1 during the hours of 7:00 PM to 7:00 AM on 05/26/21 to 05/27/21. Nurse #1 recalled at the start of the shift Resident #1 was up in her wheelchair "tooling around" like normal until sometime between 9:30 PM and 10:00 PM when NA #1 assisted her to bed. Nurse #1 stated at around 2:30 AM NA #1 was doing incontinence rounds and got her to look at Resident #1's leg. When she went to assess Resident #1, she noticed her leg "looked odd" and different than usual. She explained she did a "cursory exam" of Resident #1's leg but did not check for pedal pulse. She could not recall if Resident #1's foot was mottled at that time and stated her lower extremities were "somewhat edematous but not as edematous as usual." Nurse #1 asked Resident #1 if she was hurting and Resident #1 replied yes but stated she didn't display any non-verbal indicators of pain or distress such as facial grimacing or moaning. She added Resident #1 fell back asleep and appeared to rest comfortably the remainder of the night. Around 6:30 AM, she and NA #1 went back into Resident #1's room, her legs were "kind of straight but looked odd", they carefully changed her and then she had Nurse #2 come into the room to assess Resident 1's leg. Nurse #1 recalled Nurse #2 stating she would notify the PA when he came into the facility that morning. Nurse #1 confirmed typically she would call the on-call provider if "something was amiss" but did not on this date as she didn't feel it was

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emergent since Resident #1 only vocalized pain but displayed no other signs of distress or discomfort and fell back asleep.

During a follow-up telephone interview on 06/03/21, Nurse #1 clarified she did touch Resident #1's right thigh but didn't really "lift the leg." Nurse #1 stated there was a lump and described it as fleeting (lasting a very short time) and wasn't sure if it was just fatty tissue. She stated Resident #1 had her hand on her thigh and stated it "hurt bad" but her facial features and overall affect didn't indicate she was in any discomfort or distress. She added Resident #1 voiced no complaints of pain when Nurse #2 went into the room with her to assess Resident #1.

Resident #1's March 2021 Medication Administration Record revealed a physician's order dated 05/10/21 for Tylenol 325 milligrams (mg), one tablet three times a day at 9:00 AM, 1:00 PM and 5:00 PM. It was documented on the MAR the last dose administered to Resident #1 was on 05/26/21 at 5:00 PM. There were no orders for as needed pain medications.

Further review revealed there was no documentation of nurse assessment completed on 05/27/21 by Nurse #1 related to the acute change to Resident #1's right leg.

Nurse's notes written on 05/27/21 at 9:14 AM by Nurse #2 noted the Physician Assistant (PA) evaluated Resident #1 and gave orders for a right femur x-ray, 9:40 AM written by Nurse #2 noted a new order was received to send Resident #1 to the hospital for evaluation and 9:54 AM written by Nurse #2 read in part, Emergency Medical Services (EMS) arrived at the facility and

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transported Resident #1 to the hospital.

During a telephone interview on 06/03/21 at 2:17 PM, Nurse #2 reported after being notified by Nurse #1 during shift report that something was wrong with Resident #1's leg, she and Nurse #1 went to Resident #1's room to assess and noticed her right leg was angled in the thigh area with a 25 degree curve to the outer part of the leg. Nurse #2 explained Nurse #1 reported she checked for pedal pulses during the night, so she didn't check for a pedal pulse at that time nor did she touch Resident #1's skin to see if it was cold. Nurse #2 added Resident #1's foot did not appear mottled and explained edema on Resident #1's lower extremities were normal for her. Nurse #2 stated Resident #1 did not appear to be in any pain and she knew the Physician Assistant (PA) would be at the facility within the hour so she did not call him at the time. Nurse #2 did not recall asking Resident #1 what had happened and stated she was not sure how Resident #1 could have sustained a leg fracture. She added although Resident #1 required a "good bit" of assistance during transfers, one staff member could assist her because she was a small lady and able to stand/pivot during a transfer.

During an interview on 06/02/21 at 12:34 PM, NA #3 confirmed she was assigned to work on the Memory Support Unit (MSU) on 05/27/21 7:00 AM to 7:00 PM. NA #3 stated she and NA #2 were notified in shift report by NA #1 something was wrong with Resident #1's leg. NA #3 stated when she, NA #1 and NA #2 went to Resident #1's room, she was lying on her back in bed and her right leg was curved inward, appeared shorter than the other leg and when asked if she was in pain, Resident #1 replied "yes." NA #2 explained

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Nurse #2 was already aware and going to talk to the PA when he arrived at the facility, so she went to get the Physical Therapist (PT) to look at Resident #1's leg since he had been working with her. NA #2 stated although Resident #1 could stand and pivot with guidance she always got another staff member to assist her when transferring Resident #1.

During a telephone interview on 06/04/21 at 3:20 PM, NA #2 confirmed she was assigned to work on the MSU on 05/27/21 7:00 AM to 3:00 PM and she and NA #3 were both notified during shift report that NA #1 and Nurse #1 had discovered something wrong with Resident #1's leg during the middle of the night. NA #2 added she and NA #3 went with NA #1 to Resident #1's room and when NA #1 uncovered Resident #1 legs and pulled her gown up, she noticed her right leg was angulated at the knee and rotated outward. NA #2 recalled Resident #1 was alert and didn't appear to be in any distress. NA #2 stated Resident #1 denied any pain or discomfort when she asked her; however, when NA #3 asked if she was in pain, Resident #1 replied "yes." NA #2 stated neither she nor NA #3 attempted to move or touch Resident #1's leg at that time and could not recall what her foot looked like but explained her legs usually looked mottled from the knee down due to edema. NA #2 added when they all observed Resident #1 around 7:00 AM on 05/27/21, "everything about her seemed normal other than her leg being angulated." NA #2 stated Resident #1 required one to two staff assistance with transfers and when she transferred her independently, she used a mechanical lift. NA #2 recalled when she provided care to Resident #1 the day before, on 05/26/21 until the end of her shift at 3:00 PM, Resident #1 was at baseline, her

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right leg was intact with no angulation and she had remained in bed until PT got her up that afternoon for therapy.

The Physician Assistant (PA) progress note dated 05/27/21 at 9:10 AM read, "notified by nursing that Resident #1 was noted to have an abnormal angulation of her right femur overnight. Resident #1 noted to have pain upon movement of lower extremity. Right femur with 30-degree angulation with positive pedal pulses. X-ray ordered."

During an interview on 06/02/21 at 1:50 PM, the PA confirmed he was asked to evaluate Resident #1's right leg on 05/27/21 at approximately 8:10 AM to 8:20 AM. The PA recalled Resident #1 was lying on her back in bed and when he looked at her right leg, her femur was misaligned at a 30-degree angle. He gave orders to obtain an x-ray but "a few minutes later" he decided she needed to go to the hospital for an evaluation due to "obvious" fracture. He stated when he touched Resident #1's leg, she voiced no discomfort, the skin of her leg did not feel cold and he felt a "very faint" pulse. He was not sure how Resident #1 could have obtained a fracture as she did not attempt to self-transfer or self-ambulate, she was not found on the floor and there was no report of a fall or other incident. He stated given her advanced age and poor nutritional status, it was very likely she was osteopenic in which case, just rolling her over for care "could cause something to snap." The PA reported he was the after hours on-call provider 05/26/21 PM to 05/27/21 AM and stated Nurse #1 should have called him at 2:37 AM when Resident #1's leg was first noticed to be misaligned and he would have instructed her to be sent to the hospital for evaluation.

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The Emergency Medical Services (EMS) report dated 05/27/21 noted a call was received at 9:32 AM and they were with Resident #1 at the facility at 9:43 AM. The EMS report indicated Resident #1 was lying supine (laying face upward) in bed in minimal distress and upon assessment, Resident #1's right femur, midshaft was severely angulated laterally, pedal pulses (arterial pulse which can be felt on top of the foot in front of the ankle) were absent, the foot was mottled (marked with spots or smears of color) and cold to the touch. With assistance of staff, Resident #1 was transferred to the stretcher and transported to the hospital at 9:56 AM.

The hospital radiology report dated 05/27/21 at 11:04 AM confirmed Resident #1 had a lateral and anteriorly angulated, impacted and comminuted right femoral diaphyseal periprosthetic fracture and chronic appearing right superior and inferior pubic rami (arm or branch of a bone) fractures. There was no mention of osteopenia (reduced bone mass) or osteoporosis (condition when bone strength weakens and is susceptible to fracture).

The hospital discharge summary dated 06/02/21 read in part, Resident #1 was also found to have bilateral DVTs (deep vein thrombosis) and was started on Heparin (blood thinner). On 06/02/21, she was unexpectedly found pulseless and apneic (stopped breathing) and considering the circumstances, it was thought that a pulmonary embolism (condition in which one of the pulmonary arteries in the lung gets blocked by a blood clot) was the most likely cause of death.

During an interview on 06/02/21 at 12:20 PM and follow-up telephone interview on 06/04/21 at 8:32

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AM, the Physical Therapist (PT) explained prior to Resident #1 being admitted to the hospital on 05/27/21, she was on therapy caseload for transfers, bed mobility, positioning and range of motion. The PT explained she was dependent with all mobility and needed extensive staff assistance with transfers. He added Resident #1 had limited range of motion on her left leg due to contractures but could stand and pivot during transfers with one or two staff assistance, depending on the comfort level of the person completing the transfer. The PT recalled on the afternoon of 05/26/21, he worked with Resident #1 on lower extremity range of motion exercises and her right leg was intact during their session. On 05/27/21 around 9:00 AM, he was asked by NA #2 to look at Resident #1's leg and when he observed Resident #1, she was lying on her back in bed and her right leg was "deviated quite a bit" from its normal position and curved inward. He recalled her skin was intact but stated he felt it appeared to be fractured and she needed to be sent to the hospital. The PT spoke to Nurse #2 who stated to him she was aware and would have the PA assess Resident #1 when he arrived at the facility. After speaking to Nurse #2, the PT stated he reported his observation to the Administrator.

During a joint interview on 06/02/21 at 3:31 PM, the Director of Health Services (DHS) recalled when she arrived at the facility the morning of 05/27/21, Nurse #2 reported to her that Resident #1's right leg was misaligned, the PA had already seen Resident #1 and ordered an x-ray. The DHS added when she visualized Resident #1's leg, it was misaligned, the skin was intact with no bruising or swelling and Resident #1 voiced no complaints of pain. She stated she spoke with the PA and they decided to send her out to the

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hospital for evaluation. The DHS stated she had no idea how Resident #1 sustained an injury to her leg and explained she wasn't mobile, had poor intake, if she had fallen she wouldn't have been able to get up on her own and other than her leg being angled, her skin was intact with no swelling or bruising. The DHS confirmed the change to Resident #1's leg was first identified at 2:37 PM by NA #1 and Nurse #1 and indicated Nurse #1 should have contacted the on-call provider when Resident #1's leg was first noticed to be misaligned and at the very least, Nurse #2 should have contacted the on-call provider when informed during shift report at 6:30 AM instead of waiting until the PA arrived at the facility. She added nursing staff, including Nurse #1 and Nurse #2, were instructed to immediately call her and/or the PA, Physician or on-call provider whenever there was a change in condition which included injury of unknown origin.

During a joint interview on 06/02/21 at 3:31 PM, the Administrator stated on 05/27/21 at 8:45 AM, the PT informed her Resident #1's leg was misaligned at a 25 to 30-degree angle. She added the PT worked with Resident #1 the afternoon of 05/26/21 and her leg was intact at that time. When she spoke with Nurse #1, she stated after assessing Resident #1's leg around 2:30 AM, she did not notify the on-call provider because Resident #1 appeared comfortable and slept the remainder of the shift and felt it would be ok to wait until later in the morning.

During a telephone interview on 06/08/21 at 4:53 PM, the Medical Director (MD) stated Resident #1 was a very frail, elderly lady with advanced dementia and poor nutritional status. The MD could not state what could have caused her to

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sustain a femur fracture and explained any clinical condition could potentially cause mottling and lack of pedal pulse.

During a telephone interview on 06/11/21 at 2:11 PM, the hospital Radiologist (physician specializing in Radiology) stated the x-ray results for Resident #1 confirmed she had an angulated, impacted and comminuted right femoral diaphyseal periprosthetic fracture. The Radiologist explained there would had to have been a "good amount of impact" to cause this type of fracture and typically, this type of fracture was caused by a traumatic event such as a fall out of bed or knocking the leg into a wall forcefully. The Radiologist added although Resident #1 was osteopenic at baseline, she did not have an insufficiency fracture (type of stress fracture which is the result of normal stresses on abnormal bone); therefore, it was "highly unlikely" the fracture occurred due to turning or repositioning Resident #1 in bed during care.

The facility provided the following the following Corrective Action Plan with the correction date of 06/01/21:

Resident #1's leg was first noticed to be misaligned (incorrect position) 5/27/21 at 237 am indicative of a possible fracture which resulted in a delay of treatment. In addition, licensed professionals also failed to assess/establish the plan of care for transfers for Resident #1. On 05/27/21 at approximately 2:30AM, Nurse Aide (NA) #1 noticed Resident #1's leg was angulated and notified Nurse #1. Nurse #1 assessed Resident #1's leg and noted it to be misaligned 25 degrees but did not notify the facility provider at that time. Nurse #2 was notified by Nurse #1 at

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approximately 6:30 AM that something was wrong with Resident #1's leg and visually assessed Resident #1 with Nurse #2. Nurse #1 informed Nurse #2 she would notify the Physician Assistant (PA) when he arrived at the facility later that morning. The PA was notified around 8:15 AM to 8:20 AM, assessed Resident #1 and gave initial orders to obtain an x-ray but later decided to send her to the hospital for evaluation and treatment due to possible femur fracture. Emergency Medical Services (EMS) was notified, arrived at the facility, and transported Resident #1 to the hospital at 9:56 AM.

What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?

Resident #1 was assessed on 05/27/21 at 2:37 AM by Nurse #1.
Nurse #1 and Nurse #2 completed shift change between 6:00 AM-6:30 AM and assessed Resident #1.
Physician Assistant assessed Resident #1 between 8:10 AM and 8:20 AM and ordered a mobile x-ray.
Director of Nursing saw Resident #1 and requested the Nurse Practitioner to send her to the Emergency Room around 9:00 AM upon her arrival.
Resident #1 was sent to the hospital on 05/27/21 at approximately 9:56 AM.
Responsible Party was notified of Resident #1's transfer to the hospital on 05/27/21.
Primary MD was notified of transfer on 05/27/21.
Nurse #2 was reeducated by the Director of Nursing (DHS) on notification of change of condition on 5/27/2021.
24-hour report for injury of unknown was made to

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the state on 05/27/21.
The 5 day investigation was completed on 06/01/21.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents have the potential to be affected Evaluation of all long-term residents of transfer status from bed to chair and chair to bed and care plan will be updated to reflect current transfer status. Therapy and nursing coordinated and evaluated resident transfer from chair to bed transfer status to determine the most appropriate of resident transfer status. This began on 5/27/2021 after the adhoc QAPI (Quality Assurance Performance Improvement) meeting and was completed on 05/28/21. The current record and care plans were reviewed and updated by the MDS Coordinator and Director of Therapy. The current records and care plans will be reviewed and updated for new admissions, quarterly and significant changes on an on-going basis by the MDS Coordinator and Director of Therapy.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

1. Education began on 5/27/21 conducted by the Director of Health Services (DHS) for all staff/all departments to include but not limited to licensed nurses and nursing assistants on Change of condition to include but not limited to:

a. Facility uses Interact program to provide guidance to nurses on when to communicate

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acute changes in resident condition provider.
The change in condition file cards are decision support tools for the nursing staff to help with determining whether to report specific symptoms, signs, and lab results immediately, vs. non immediately (e.g. the next day). This was reviewed with all staff at an in-service that was provided on 05/27/21 and completed on 06/01/21.
b. Notification - immediately to the physician when the resident has a medical change in condition.
c. What a change in condition is:
i. An incident to include but not limited to skin tear, fall, bruise, etc. depending on type, location and severity of injury
ii. Injury known or unknown origin
iii. Transfer to the hospital
iv. Allegation of abuse or neglect
d. Notification of the Director of Nursing of the change of condition.
e. Assessment/observation of the change in condition should be documented in nurse's notes or via SBAR (Situation, Background, Appearance, Review and Notify) at time of note of change which includes but not limited to:
i. Vital Signs
ii. Head to toe assessment/observation
iii. Pedal pulses
iv. Lung sounds
v. Bowel sounds
vi. Nurses notes
Any staff not receiving education due to scheduled time off or FMLA will be educated before their next scheduled shift. Education will also be added to new partner orientation on a go forward basis. The DHS is tracking education to ensure education has been completed.

2. Education began on 05/27/21 conducted by

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the DHS for all staff/all departments on the following policies:

Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property:
Definition of abuse and neglect
Reporting Patient Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Property policy to include but not limited to:
Reporting within 2 hours after an allegation is made if an event upon which the allegation is based involve abuse or results in serious bodily injury
Reporting within 24 of a suspicious crime however if the suspicious crime involves serious bodily injury to the patient, the incident should be reported to local law enforcement within 2 hours after forming the suspicious.
Investigating of Patient Abuse, Neglect, Exploitation, Mistreatment and Mistreatment, and Misappropriation of Property:
If and injury has occurred including an injury of unknown origin, or abuse, neglect and occurrence report with supervisory investigation should be completed
Completed witness statements form all staff
Any staff not receiving education due to scheduled time off or FMLA will be educated before their next scheduled shift. Education will also be added to new partner orientation on a go forward basis. The DHS is tracking education to ensure education has been completed.

3. Nurse management will review the Facility Activity Report (24-hr report) daily and DHS will review the report on Fridays beginning on 05/27/21 of resident's incidents and accidents report for change of condition documentation and

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notifications of providers and responsible party time 4 weeks then monthly. Nurse Manager will review weekend reports remotely. The report will capture any significant changes of condition, ongoing audits will be determined based on the results. Audit tools will be reviewed by the Administrator and the DHS weekly and during the monthly QAPI committee meeting until substantial compliance is achieved.

4. ADHOC Quality Assurance Performance Improvement meeting was held on 5/27/2021 conducted by the Administrator and DHS to discuss the plans other interventions were identified as below
a. The DHS and Nurse management staff will conduct weekly observation of 10 residents for transfer status beginning 05/28/21 to ensure resident is being transferred appropriately as determined by care plan times 4 weeks then monthly. Ongoing audits will be determined based on the results. Audit tools will be reviewed by the Administrator and the DHS weekly and during the monthly QAPI committee meeting until substantial compliance is achieved.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

1. The DHS will review the results from the audits conducted from the incidents and accidents report to ensure that the change in condition documentation and notification of the physicians and DHS were completed. This information will be reviewed at the monthly QAPI committee meeting times 3 months or until substantial compliance is achieved.

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F 600	Continued From page 18 2. The DHS will review the audit tools related to the transfer from bed to chair and will be reviewed during the monthly QAPI committee meeting times 3 months or until substantial compliance is achieved. Date of Completion: June 1, 2021 The Corrective Action plan was validated on 06/16/21 and concluded the facility implemented an acceptable corrective action plan on 06/01/21 as evidenced by facility documentation and staff interviews. Review of the in-service attendance sheets 05/27/21 to 06/01/21 revealed all staff received education on the facility's abuse policy, timely reporting of suspected abuse, injuries of unknown origin and procedure for acute change in condition to include assessment, observation and timely notification. Review of the document utilizing the 05/27/21 resident census revealed all residents were assessed for transfer status and care plans updated accordingly. Review of the facility's audit tools completed 05/27/21 to 06/13/21 revealed no identified concerns. Interviews conducted with staff confirmed they received in-service education and were able to describe what to do when an acute change was identified, which included completing and documenting a thorough assessment, when to report and who to notify of the acute change.	F 600		
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	F 689		6/29/21

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F 689	Continued From page 19 §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 physician and staff interviews, the facility failed to prevent a cognitively impaired resident with known wandering and exiting seeking behaviors from exiting the facility unsupervised on three separate occasions. This affected 1 of 3 residents reviewed for accidents (Resident #2). While Resident #2 was outside unattended, there was a high likelihood for serious injury. The findings included: Resident #2 admitted to the facility on 01/09/21 with diagnoses that included Alzheimer's disease and history of falls. A care plan initiated on 01/09/21 noted Resident #2 was at risk for falls related to generalized weakness, poor safety awareness, history of falls and an actual fall on 01/09/21 with the goal he would not sustain an injury. Interventions included: assist with toileting and transfers as needed, cue for safety awareness and place call light within reach. A care plan initiated on 01/11/21 noted Resident #2 was an elopement risk based on the high-risk score from his admission elopement assessment with the goal he would not elope from the facility through the next review. Interventions included: consider placing a wanderguard on the resident for exit seeking behaviors, monitor his location closely, and redirect as needed.	F 689	Past noncompliance: no plan of correction required.	

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The admission Minimum Data Set (MDS) dated 01/13/21 assessed Resident #2 with severe impairment in cognition for daily decision making. He required supervision with walking and locomotion, used no mobility devices and displayed wandering episodes daily during the MDS assessment period that placed him at significant risk of getting to a potentially dangerous place.

a. Nurse's progress note written on 02/25/21 at 1:25 PM by Nurse #1 read in part, frequent attempts to get out. Resident #2 opened his room window earlier this morning and said he was trying to leave. Staff able to redirect only for short periods of time.

Telephone attempt to speak with Nurse #1 on 06/15/21 at 11:38 AM was unsuccessful.

Nurse's progress note dated 02/28/21 at 11:24 AM written by Nurse #2 read in part, while doing rounds, Resident #2 was not found anywhere on unit. In another resident's room, the window was found unlocked with the screen pushed out. Resident #2 was found in the woods behind the building and returned inside with staff calmly. No injuries were identified and vitals stable upon assessment.

During a telephone interview on 06/04/21 at 3:20 PM, Nurse Aide (NA) #2 stated on 02/28/21, she could not recall the exact time but sometime after breakfast she had started doing her rounds on the Memory Support Unit (MSU) when she noticed Resident #2 standing by the window in another resident's room. When she asked him what he was doing, he replied "nothing, just looking out the window." NA #2 stated she really

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didn't think much about it and went into the resident room next door to provide care. Approximately 5 to 7 minutes later as she was exiting the resident's room, Dietary Aide (DA) #1 came to the unit to let them know he was outside the building. NA #2 stated she immediately went outside to get him; he was near the wooded trees behind the building and came back inside without incident. She added he had no visible injures or appeared to be in any distress.

During a telephone interview on 06/09/21 at 2:52 PM, DA #1 recalled sometime before lunch on 02/28/21 she had stepped out the back of the building from the kitchen to take a break and noticed someone walking down the road toward her from the left side of the building. DA #1 added she realized it was Resident #2, went back into the kitchen and told other dietary staff who then went out to get Resident #2 while she went to alert staff on the MSU. When she got back outside, the dietary staff and another NA were already walking the resident back toward the facility. She did not recall Resident #2 displaying any signs of distress as he was led back into the facility.

During a telephone interview on 06/04/21 at 9:49 AM, Nurse #2 stated Resident #2's normal behavior was to wander around the MSU and exit-seek and staff all try to keep an eye on him. On 02/28/21, Nurse #2 recalled she and NA #2 started looking for him and realized he wasn't on the unit. They both started doing room checks and discovered a screen pushed out of an opened window in another resident's room. Nurse #1 stated she immediately called the facility's missing person code; an all staff search was started of the premises and Resident #2 was

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found out behind the building near the wooded area and brought back into the building. She added he was found within a few minutes of calling the code. Nurse #2 reported upon assessment, Resident #2 had no injuries, vitals were stable, and he voiced no complaints of pain or distress. Nurse #2 could not recall the last time Resident #2 was on the unit prior to finding him outside around 11:00 AM to 11:30 AM. Nurse #2 added they tried hard to keep an eye on all the residents on MSU but it could be challenging when there was only one Nurse and one NA.

An observation of the room where Resident #2 opened the window and exited the building on 02/28/21 was conducted with the Administrator on 06/09/21 at 11:05 AM. The window slid open to the left and drilled into the window frame was a screw that prevented the window from opening more than 6 inches. The room was located at the end of the hall facing the backside of the building and property. The distance from the window on the side of the building to the opposite edge of the road was approximately 20 to 25 feet. When turning from the main road onto the driveway of the facility, the distance from the driveway entrance to the facility was .2 miles or 1,056 feet. Each side of the driveway headed toward the facility, the driveway around the perimeter of the building and parking lots were surrounded by trees that separated the facility from other residential homes and wooded areas. Resident #2 was noticed walking along the road toward the middle, back area of the building where the dumpsters, kitchen, parking spaces and maintenance building were located.

An online website named Custom Weather was used to obtain the outside weather in the Brevard

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area on 02/28/21 and noted at 10:54 AM and 11:54 AM the temperature was 66 degrees Fahrenheit with wind speeds of 16 miles per hour (mph).

The facility's investigation timeline provided by the Administrator revealed the following details upon Resident #2's return to the facility on 02/28/21: Resident #2 was assessed by the nurse, a head count was completed of all residents on the memory care unit and additional staff were assigned during waking hours to assist with observation of Resident #2's location. It was discovered the memory care unit had a window alarm system that was disarmed, leadership staff were unaware the system existed, and the alarm company was notified to have it reactivated. Each shift, staff ensured all windows were closed and locked.

b. Nurse's progress note written on 03/03/21 at 2:56 PM by Nurse #3 read in part, Resident #2 was last seen on the unit at approximately 2:10 PM. At 2:20 PM, staff were notified he was located on the road outside of the facility. Resident #2 was returned to the facility and upon nurse assessment, had no apparent injury, vitals were stable and mental status at baseline. Upon inspection, window screen was observed pushed out of another resident's room window and laying on the ground.

Telephone attempts on 06/04/21 at 3:15 PM and 06/10/21 at 4:10 PM to speak with NA #3 were unsuccessful.

During a telephone interview on 06/07/21 at 9:46 AM, Nurse #3 confirmed he was assigned to work on the MSU 03/03/21 7:00 AM to 7:00 PM when

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Resident #2 eloped from the building. Nurse #3 recalled Resident #2 had been wandering around the unit that day as normal and at approximately 2:00 PM, he was sitting out in the common area with Nurse #3, NA #3 and other residents on the unit but would frequently get up and make "loops around the unit." About 5 to 10 minutes later, Nurse #3 stated he and NA #3 noticed Resident #2 was no longer in the common area with them and when they began looking for him, they discovered a screen was pushed out of one of the resident's unlocked window. Around that same time, Nurse #3 stated he was notified by staff (could not recall who) that Resident #2 was outside on the main driveway entrance and he was immediately brought back into the facility without incident. He could not recall the exact location where Resident #2 was found but stated he had stepped off the driveway and was headed toward the wooded area. Nurse #3 stated once Resident #2 was back in the building, he was assessed with no injuries identified, his vitals were within normal limits and he was placed on one-to-one supervision for the remainder of the shift. He added later that same afternoon, the windows in the resident rooms on MSU were fixed so they would only open a few inches. Nurse #2 explained there was usually one Nurse and one NA assigned on the MSU and residents were usually kept out in the common area of the unit with staff for supervision. He added with residents that that frequently wandered, staff checked on their whereabouts frequently. He didn't recall receiving any specific education after the first elopement incident on 02/28/21 other than making sure the windows were locked and Resident #2's whereabouts monitored.

An observation of the room where Resident #2

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opened the window and exited the building on 03/03/21 was conducted with the Administrator on 06/09/21 at 11:05 AM. It was the same room and window he exited from on 02/28/21. Facility staff were unable to state the exact location on the driveway or how close to the entrance where Resident #2 was found.

An online website named Custom Weather was used to obtain the outside weather in the Brevard area on 03/03/21 and noted at 1:54 PM the temperature was 58 degrees Fahrenheit with wind speeds of 13 mph. At 2:54 PM the temperature was 60 degrees Fahrenheit with wind speeds of 13 miles mph.

The facility's investigation timeline provided by the Administrator revealed the following details upon Resident #2's return to the facility on 03/03/21: Resident #2 was assessed by the nurse, a head count was completed of all residents on the memory care unit and floor tech assigned for the day to provide one-to-one supervision to Resident #2. Alarm company had still not arrived on-site to evaluate the window alarm system. On 03/04/21, window stops were placed on all windows allowing them to only open 6 inches to eliminate risk of elopement.

Resident #2's elopement care plan was revised on 03/04/21 with an intervention added for staff to ensure windows were secured and safety checks were completed throughout each shift.

A physician's progress noted dated 03/09/21 noted Resident #2 was seen for follow-up of dementia with behavioral disturbances and read in part, "his dementia has progressed to the point he needs constant supervision and care. He has

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an awareness that something isn't right but does not understand what." His medications were reviewed with no changes and instructions were for staff to continue to try and redirect as possible.

c. Nurse's progress note written on 03/12/21 at 6:10 PM by Nurse #2 read in part, Resident #2 wandering unit this shift and was seen trying to unlock the front door but was unable and came back to common area. When passing out dinner trays, he was not in his room. All staff were alerted, Resident #2 was found outside on premises and brought back into the facility. Assessment completed and no injury noted.

During a telephone interview on 06/04/21 at 3:20 PM, NA #2 recalled on 03/12/21 she was working on the MSU with Nurse #2 when Resident #2 eloped from the building. NA #1 stated she remembered seeing Resident #2 around 4:00 PM to 4:15 PM when she started doing incontinence rounds before dinner. She did not remember how long it took her to complete her rounds but stated the dinner trays were usually delivered to the unit around 5:00 PM. As she started to help Nurse #2 pass out the meal trays, she noticed Resident #2 was not on the unit and an all staff search was started. NA #2 was not sure of the exact location but stated he was found outside near the wooded area beside the building. NA #2 explained since the window screen alarms had already been repaired by this time, the only thing they could determine was he followed the dietary staff off the unit when they delivered the meal trays due to a delay on the front entrance door locking system. She added, after this incident the facility had the entrance door fixed and a new keypad installed which fixed the delay. NA #2

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stated there were usually one Nurse and one or two NAs assigned to the MSU. She explained when there was only a Nurse and NA assigned to MSU, it was more difficult to provide constant supervision of the residents; however, they worked together to make sure one of them was supervising the residents if the other staff member was providing care.

During an interview on 06/09/21 at 11:26 AM, Nurse #2 confirmed she was assigned to the MSU on 03/12/21 7:00 AM to 7:00 PM when Resident #2 eloped from the building. Nurse #2 stated it was around dinner time as the meal trays had been delivered to the unit when she and NA #2 discovered he was not in his room. Nurse #2 stated she immediately called the missing person code, an all-staff search was started, Resident #2 was found outside the building by the Former Assistant Director of Nursing (FADON) and immediately brought back inside the building. Nurse #2 stated once Resident #2 was back in the building, he was assessed with no injuries identified. She explained they had been keeping a close eye on him due to his exit-seeking and the only thing they could determine was he must have gotten out the front door when dietary staff delivered the meal trays.

During a telephone interview on 06/11/21 at 3:33 PM, the FADON explained staff were aware of Resident #2's exit-seeking behaviors and tried their best to keep their eyes on him. On 3/12/21, the FADON recalled she was working on the opposite side of the facility when she heard the missing person code and an all staff search was immediately conducted. She explained since he was found along the driveway toward the front entrance the last time he eloped, she decided to

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get into her vehicle to go and search for him while staff searched the other areas of the premises. The FADON stated as she was driving down the driveway toward the entrance, she looked off to the left side and noticed Resident #2 standing in a clear spot of field that led straight into a wooded area. She stopped her car, ran over to where he was standing, and when asked what he was doing he replied, "I was looking for you". He was agreeable to get into the car with her and they both returned to the facility without further incident. She explained when you stood on the porch in front of the MSU front entrance, to the right of the building was the driveway that led out to the main road and she found him approximately two-thirds down the driveway from the building to the stop sign. The FADON added upon assessment, Resident #2 had no injuries from his elopement. The FADON stated after talking to staff, she couldn't get a clear story as to how he was able to get off the unit and explained the NA assigned to the unit was in the shower room with another resident while the floor technician and Nurse were monitoring the other residents and "in the blink of an eye", he was gone. She added they identified a delay in the front entrance locking system and assumed that was how he was able to get out of the building. The FADON stated at the time, dietary staff used the front entrance to deliver meal trays as well as other facility staff when coming in and out of the building but "no one was going to admit" that they did not check to make sure the door locked back when it was opened. After that incident on 03/12/21, she reported all staff were educated to stand and wait for the door to close and lock back securely before leaving the area. The FADON voiced the staff on the MSU "really looked out for the residents" but it was hard providing constant

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supervision when there was only one Nurse and one NA on the unit.

An observation of the front entrance door to the Memory Support Unit (MSU) was conducted on 06/09/21 at 11:05 AM. The entrance doors opened to a covered porch leading out to the driveway and parking lot. To the right of the door as you exited the porch was an area of grass leading to the side road that circled the perimeter of the building to the main driveway that led in and out of the facility. The side road to the right of the building was approximately 60 feet from the edge of the porch. When turning from the main road onto the driveway of the facility, the distance from the driveway entrance to the facility was .2 miles or 1,056 feet. Each side of the driveway headed toward the facility, the driveway around the perimeter of the building and parking lots were surrounded by trees that separated the facility from other residential homes and wooded areas.

An online website named Custom Weather was used to obtain the outside weather in the Brevard area on 03/12/21 and noted at 4:54 PM the temperature was 69 degrees Fahrenheit with wind speeds of 13 mph.

The facility investigation timeline provided by the Administrator revealed the following details upon Resident #2's return to the facility on 03/12/21: Resident #2 was assessed by the nurse, a head count was completed of all residents on the memory care unit and no point of elopement was identified; however, a 45 second delay was identified on the front entrance door of the unit before the door locked back after opening. Alarm company notified. Education provided to all staff

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to remain at the door until a red light appeared and then manually ensure door was locked before leaving the door.

During an interview on 06/09/21 at 10:45 AM, the Administrator stated she started employment at the facility on 03/04/21 but was provided a timeline by the former DHS of Resident #2's elopements from the facility. The Administrator stated after Resident #2 eloped on 02/28/21, they discovered there was a non-functioning window screen alarm system on the MSU. She explained on 03/01/21 when they contacted the alarm company for them to come onsite to assess the alarm system, they were told there would be a two-week waiting period. She added they had also contacted other alarm companies in the area but were unable to locate one that could come onsite any sooner. After Resident #2's second elopement on 03/03/21, the Administrator explained window stoppers where placed on all the windows in the MSU to prevent them opening more than 6 inches and the alarm company they originally contacted arrived onsite 03/09/21 and repaired the window screen alarm system. On 03/12/21, the Administrator explained the floor technician had been sitting with Resident #2 all afternoon and around dinner time, he started assisting staff pass out dinner trays, turned around to look for Resident #2 and noticed he was gone. She added they discovered there was a delay with the entrance door lock and the only thing they could determine was when dietary staff brought trays to the unit, he must have exited through the front door after the dietary staff left the unit. The Administrator since the window screen alarm system and delay in the entrance door lock were both repaired, there have been no further incidents of elopements.

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During a telephone interview on 06/16/21 at 1:55 PM, the Medical Director (MD) confirmed it would not be safe for Resident #2 to be outside unsupervised due to the severe impairment in his cognition.

The facility provided the following Corrective Action Plan with the correction date of 03/23/21:

The facility failed to supervise a cognitively impaired resident with wandering behaviors from exiting the facility unsupervised on three separate occasions.

What Corrective action will be accomplished for the residents found to have been affected by the deficient practice?
2/28/21
* Resident #2 was admitted on 01/09/21. Resident #2 exited the facility unsupervised from the Memory Support Unit (MSU) on 02/28/2021 and was observed by dietary staff at approximately 11:26 am standing at edge of woods behind the facility. Resident was last observed ambulating in unit around 11:15am. Resident #2 was assisted back to the facility. Assessment was completed upon return to facility. No injuries were found. Upon admission his BIMS score was 2 (severe cognitive impairment). Elopement Risk Assessment was performed on admission. Resident was identified as high risk; therefore, he was admitted on the Memory Support Unit (MSU). He was care planned for elopement risk upon admission.

* Resident rooms were inspected in the unit on 02/28/21 following the incident and window in Room 12 was found open and screen pushed

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out. It was determined that resident had climbed out of another resident's window.

* Nonclinical staff scheduled on unit during waking hours on 02/28/21 for additional support and visual observation of Resident #2.

* During the unit inspection on 02/28/21 after the incident, it was determined that the facility has an existing window alarm in the MSU but has not been activated for more than a year.

3/3/21
* Resident #2 exited the facility unsupervised on 03/03/2021 and found at end of the facility driveway at approximately 2:20 pm by the Sheriff's Department. The distance from the point of exit to the facility driveway is 2/10 of a mile. Resident was transported back to facility via vehicle by Sheriff's Dept. Resident was last observed walking in the halls of the MSU at 2:10 pm. Assessment was completed on 03/03/2021. No injuries were found.

* Upon return to unit, resident was placed on one on one observation during waking hours for closer monitoring. This continued for 24 hours.

* Resident rooms and unit inspection completed on 03/03/21. During the inspection the window in Room 12 was found open and screen pushed out. It was determined that resident had climbed out again of the same window, same as the previous incident on 02/28/21.

3/12/21
*Resident #2 exited the facility unsupervised on 03/12/2021. Resident #2 was observed on right side of the building by staff at 5:08pm. Resident

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was last observed in dining room at approximately 4:10pm. Staff assisted resident back to facility. Assessment was completed 03/12/21. No injuries were found.

* Upon return to facility, Resident #2 was placed on hourly visual checks through 03/16/2021.

* Resident rooms were inspected on 03/12/21. All windows are locked and screen intact.

* Window alarm tested on 03/12/21 and was found to be functioning. All window screens will need to be intact and attached for the window alarm not to be activated.

* The Assistant Director of Health Service inspected the exit doors on unit on 03/12/21 after the incident. Upon inspection, a 30 second delay in the locking mechanism system of the front door of Memory Care Unit (MSU) was identified.

* It was determined that resident may have exited the front door of the MSU when the dinner meal trays were delivered.
How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

*Elopement Book was reviewed by Director of Health Service (DHS) on 03/04/21 to ensure all high-risk elopement residents have appropriate intervention and identified on facility elopement book. Elopement Book is kept at each nurse's station and at front desk. Each resident at MSU and residents with Wanderguard has a face sheet and a picture in the book for ease of identification. This is to identify residents at high risk for elopement.

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Facility will continue to complete elopement risk assessments upon admission, every quarterly and significant change to identify high risk wanderers per policy.

What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur?

2/28/21
* The DHS provided education to all MSU staff on 02/28/21 to ensure all windows are closed and locked every shift. The remaining facility staff including nursing, activities, therapy, laundry, housekeeping, central supply, maintenance, dietary and business office were educated on checking all windows are closed and locked when rounding in MSU. All other staff who are on FMLA or otherwise out will receive in-service prior to returning to work.

* Alarm Company was contacted on 03/01/2021 to evaluate status of existing window alarm and request was made to reactivate the alarm.

* Maintenance Director made several follow-up calls and facility placed on two-week waiting list due to volume of calls and referrals at the alarm company.

3/3/21
* Window stops were placed on all windows allowing windows to open approximately 6 inches on 03/04/21.

* Social Worker sent referrals on 03/04/2021 to other facilities specific to behavior management.

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* On 03/03/21 request also sent for psychiatry consult for increased behavior and exit seeking. Chart review showed resident was just recently seen by Psychiatry on 03/02/2021 and no changes were made on medication at that time. Follow up referral was made to request for alternative intervention or possible alternative placement.

* A Town Hall Meeting was held on 03/06/2021 at various times. This meeting was for all staff members/all departments. Agenda items included but were not limited to significance of resident elopement, completing Elopement Risk Assessment Form upon admission, every quarterly significant change and/or annually per policy, elopement book location at nurse's station and front desk. Facility had a memory support resident who was able to elope from facility so systems where put into place so this incident will not happen again, and staff was explained as to what their roles are to prevent this from happening again. Roles to include but not limited to the doors locked, door alarms functioning, windows are locked and functioning. Staff was also educated on resident behavior indicators, resident verbalizing to go home, packing their belongings or history of exit seeking. Previous Director of Health Services followed with up employees that did not attend the Town Hall Meeting and ensure that they were educated on materials presented on the meeting.

*Alarm company onsite on 03/08/21 and repair was made on window alarm. Window alarm in MSU activated.
3/12/21.

* The DHS held in-services on 03/12/21 and

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completed on 03/16/21 with all staff to review the delay on the locking mechanism on the front door in MSU. All staff exiting the MSU through front door will remain at door until red light appears and manually ensure door is locked before leaving front door. The DHS tracked the employee education.

* All staff were educated by DHS on 03/12/21 to 03/16/21 on residents at risk for elopement and elopement prevention program. Inservice included but not limited to delay in locking system of MSU door, staff needing to wait until panel light turn red, the completion of resident elopement risk assessment and the intervention put in place. The DHS tracked the employee education. The Elopement Program includes management of patients/residents residing in the facility and procedure for elopement risk assessment. Also discussed resident behaviors that put them at high risk such as verbalizing desire to go home, packing belongings or history of exit seeking.

* All other staff who are on FMLA or otherwise out will receive in-service prior to returning to work. All Department Managers are responsible of keeping track of in-services in each department.

* Alarm company was contacted to evaluate the delay on the locking mechanism on the keypad on 03/12/21. Alarm company was onsite on 03/14/2021 and replaced keypad on MSU door. This fixed the delay on the keypad.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

* During the monthly Quality Assurance and Performance Improvement (QAPI) meeting on

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March 23, 2021, elopement incidents and controls were discussed. This includes the checking of Wanderguard door to ensure functioning. This is done by using the Wanderguard checker, the light on the Wanderguard checker turns green to confirm the Wanderguard system on door is functional. The Maintenance Director checks Wanderguard system door which include front door and MSU door daily during the week, Manager on duty on weekends, to ensure function of keypad. Residents residing in the locked MSU do not require a Wanderguard.

* The elopement program was also reviewed during the QAPI meeting on March 23, 2021. MDS Coordinator reviewed the process utilizing the Elopement Risk Assessment Form and reviewed Wanderguard orders.

* The Elopement Book was reviewed 03/13/21. The Elopement Book is in each nurse's station and at the front desk. Each resident at high risk for elopement has a face sheet and a picture printed and placed in the Elopement Book. This is determined by completing an Elopement Risk Assessment Form upon admission, quarterly, significant change and/or quarterly. A resident with a score of 11 or higher will be considered a high risk and interventions put in place. Face Sheets of residents on MSU are in the Elopement Book and residents with Wanderguard are also in the elopement book.

* The DHS and/or designee will audit the Elopement Book every week times 4 weeks, then every other week times 2 weeks, every month times 2 months to ensure the book is up to date and current. These audits began on 03/16/21.

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* The MDS Coordinator will audit Elopement Risk Assessment Form completion every week times 4 weeks then monthly times 4 months. These audits began on 03/16/21.
** Note: After review of audits, unable to locate previous documentation from elopement or elopement assessments but was able to validate and findings reviewed on monthly QAPI in March, April and May 2021.

*The Maintenance Director will audit function of keypad of the MSU front door daily times 4 weeks, Manager on duty on weekends, then monthly times 2 months. These audits began on 03/16/21.

* The Maintenance Director will audit function of window alarm daily, Manager on duty on weekends times 4 weeks, then monthly times 2 months. These audits began on 03/16/21.

* Ongoing audits will be determined based on the results of prior audits. Audit tools will be reviewed by Administrator and/or DHS weekly and results will be presented during the monthly QAPI Committee Meetings until substantial compliance is achieved.

Date of Completion: 3/23/2021

The Corrective Action Plan was validated on 06/16/21 and concluded the facility implemented an acceptable corrective action plan on 03/23/21 once the window screen alarm system was reactivated on the MSU, the locking mechanism for the front entrance door to the MSU was replaced and the elopement plan was reviewed during QAPI meetings held on 03/23/21, 04/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. BUILDING _____ B. WING _____	C 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(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 39	F 689		

and 05/31/21.

The daily monitoring report of the facility exit doors and window screen alarms for March 2021 to June 2021 were reviewed with no concerns identified. Observations conducted with the Administrator and Maintenance Director on 06/09/21 revealed when a screen was removed from a window of the MSU, the panel next to the nurses' station identified the room number and alarm sounded. When the Administrator entered the code into the keypad panel, the alarm turned off for a few seconds and then started to alarm again until the Maintenance Director placed the screen back into the window. The alarm turned off once the window screen was secure and the code was reentered into the panel. The front entrance door to the MSU had a key panel, when the door was opened, the light turned green and once the door was shut, it automatically locked within a few seconds and the light on the keypad panel turned red. Elopement books were observed at each nurses' station throughout the facility and reception desk. The elopement books contained information and pictures for each resident identified as high risk.

The Administrator was unable to locate documentation of the staff training conducted on 02/28/21; however, multiple staff on various shifts and departments were interviewed and verified they received re-education related to elopement in March 2021 and/or June 2021 and were able to describe facility processes for: what to do when a resident demonstrated elopement/exit seeking behaviors, where the elopement books were located, what information they contained, responding to window/door alarms, making sure entry/exit doors were locked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 40 before leaving the area, and what to do in the event of an elopement.	F 689		