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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 04/26/2022 through 04/28/2022. Event ID# DVVB11. 1 of the 2 complaint allegations was substantiated resulting in a deficiency. The following intakes were investigated: NC00186876 and NC00186788. Past Non-Compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. 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 record review, observation, and staff, family, and police interviews, the facility failed to prevent a severely cognitively impaired resident (Resident #2) with known wandering and exit seeking behaviors from exiting the facility unsupervised. Nurse #1 failed to look for the resident when a wanderguard (a bracelet device	F 689	Past noncompliance: no plan of correction required.	5/5/22

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

Electronically Signed | 05/05/2022

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that alarms within several feet of doors) was found in the laundry room during the day shift on 2/23/22 which allowed Resident #2 to leave the facility through the front doors on 2/24/22 without the doors alarming and without staff's knowledge. The resident walked approximately 0.2 miles away from the facility when he was observed by a police officer during a routine patrol in the area at approximately 2:30 AM. This was for 1 of 4 residents reviewed for wandering behaviors.

The findings included:

Resident #2 was admitted to the facility on 7/01/20 with diagnoses that included dementia, insomnia, and unsteadiness on his feet.

An active care plan focused on elopement risk initiated 11/1/20 included a goal for Resident #2 to remain safe and secure through the review period. Interventions included safety checks, elopement risk assessment as needed, and check wanderguard placement every shift.

Record review of Resident #2's physician's orders for February 2022 revealed an active order initiated on 8/15/21 for "check wanderguard placement and functioning each shift (7 AM -7 PM and 7 PM -7 AM).

A nursing progress note dated 2/9/22 completed by Nurse #3 indicated Resident #2 was attempting to exit through a side door and had set off the alarm. He required encouragement for "several minutes" before returning to the building.

A nursing progress note dated 2/13/22 completed by Nurse #1 indicated Resident #2 attempted to exit through the front door "to go home" but was

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returned to the unit by a staff member.

A quarterly Elopement Risk Data Collection Tool dated 2/21/22 completed by Nurse #4 indicated Resident #2 was at high risk to wander due to exit seeking behaviors, verbalizing the desire to go home, and independent mobility.

Resident #2's quarterly Minimum Data Set (MDS) dated 2/23/22 indicated Resident # 2's cognition was severely impaired. The MDS did not indicate wandering behavior was exhibited. Resident #2 was independent with walking and transfers.

Record review of Resident #2's Medication Administration Record (MAR) indicated that the wanderguard check was completed on 2/23/22 day shift.

During an interview on 4/27/22 at 2:10 PM, Laundry Aide #1 recalled she found a wanderguard in the laundry during the day shift on 2/23/22 and brought it to Nurse #1. She recalled the wanderguard was unopened, like it had been slipped over a resident's hand.

During an interview on 4/26/22 at 3:45 PM, Nurse #1 revealed that a laundry aide brought her a wanderguard she had found in the laundry on 2/23/22 during the day shift. There was construction on the unit, and she got distracted and did not find the owner of the wander guard. She did not notify anyone else of the found wander guard.

A nursing progress note dated 2/24/22 at 3:08 AM completed by Nurse #2 indicated she received a phone call at 2:30 AM from the police stating they found Resident #2 at a school next door and

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emergency medical services (EMS) had been called. Resident #2 was brought back to the facility with no injuries noted. The note indicated Resident #2 was last seen at 2:15 AM.

During an interview on 4/27/22 at 3:30 PM, Nurse #2 revealed that she received a call from the police on 2/24/22 around 2:30 AM stating they had found Resident #2 at the school next door. He was not injured but EMS had been called. She recalled Resident #2 was last seen between 2:00-2:15 AM walking the halls which was normal for him. He usually wore a wanderguard which would alert when he got to the front door. She was not told at the beginning of shift that Resident #2 did not have his wanderguard in place and she had not identified that it was missing prior to the police bringing the resident back to the facility. She did not know Resident #2 was missing until the police called. She recalled Resident #2 was wearing blue jeans, a t-shirt, jacket, and socks and shoes when he returned to the facility.

During an interview on 4/28/22 at 9:20 AM, the police officer recalled patrolling the area on 2/24/22 around 2:00 AM and seeing Resident #2 walking in front of the school. Resident #2 stated he was out for a walk and told the officer his name but did not answer additional questions appropriately. The police officer called EMS and called the facility questioning if he lived there. Resident #2 was not injured. The police officer reviewed body camera footage which revealed Resident #2 was wearing blue jeans, a jacket or sweater, and shoes.

An observation was made on 4/27/22 at 4:00 PM looking out the front door of the facility down the

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street to the school. The school and facility sat at a T-intersection with a large ditch on either side of the cross-street. The school was surrounded by a long fence. The speed limit of the major roadway was 35 miles per hour and then entered a school zone. Only one streetlight was observed prior to the end of the fence and the entry to the school parking lot.

A web search revealed the temperature on 2/24/22 at 2:00 AM was 60 degrees Fahrenheit (wunderground.com). The distance between the facility and school was 0.2 miles and was a 3-minute walk (googlemaps.com).

During an interview on 4/26/22 at 3:10 PM, Nurse Aide (NA) #1 recalled Resident #2 pacing the halls on night shift of 2/23/22 but did not see him exit the building. He recalled the front doors were not locked and not alarmed. He revealed the last time he saw Resident #2 was around 2:00 AM. He did not know Resident #2 was gone until the police called.

During an interview on 4/27/22 at 4:15 PM, the Director of Nursing (DON) revealed that on 2/24/22 Resident #2 had exited through the front door, and it was believed he walked down the major roadway to the school. The side doors required a code to exit but the front door was the egress door and remained unlocked. She indicated that Resident #2's wanderguard would have set off the alarm at the front door had he been wearing it. She revealed the wanderguard was last seen on Resident #2's wrist on 2/23/22 around 9:00 AM.

During an interview on 4/26/22 at 11:15 AM, Resident #2's family member revealed the

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wanderguard had been in place since Resident #2 was admitted to the facility due to exit seeking behaviors. He recalled the facility informing him Resident #2 was found at the school next door after exiting through the front doors around 2:00 AM.

During an interview on 4/27/22 at 4:45 PM, the Administrator revealed that Resident #2 was able to leave through the front door as it remained unlocked. The wanderguard would have set off an alarm prior to him exiting the front door. Nurse #1 should have located the resident who the wanderguard belonged to immediately when the wanderguard was found.

An observation was made on 4/26/22 at 10:20 AM of Resident #2 in his room packing up his clothes. He was wearing his wanderguard on his right wrist and was calm. Another observation was made on 4/26/22 at 11:30 AM of Resident #2 standing alone at the front nurse's station near the exit. His wanderguard was in place.

The facility provided the following corrective action plan with a completion date of 3/4/22:

Problem identified: Nurses on duty are to document the placement and function of the wanderguards each shift on the medication administration record. If a wanderguard is not present or nonfunctional it should be replaced immediately by the nurse on duty. On 2/23/22 during the day shift laundry staff found a wanderguard in the laundry when she pulled the linen from the unit. She located the nurse (Nurse #1) on the unit and gave her the wanderguard. The nurse failed to identify the resident (Resident #2) who was missing the wanderguard and failed

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to report this discrepancy to the oncoming nurse. She failed to follow the process that all wanderguards would be replaced immediately. Resident #2 was able to leave the facility unsupervised and without staff's knowledge on 2/24/22 since his Wanderguard was removed. He was seen by the local police department at a school nearby the facility at approximately 2:24 AM.

EMS was called by the local Police Department on 2/24/2022 at 2:24 a.m. EMS arrived at 2:31 a.m. The EMS report states that patient (Resident #2) had no injuries and vitals were normal. Patient was safely returned to the facility without incident.

Immediate action identified: An audit was completed to ensure 100% of residents were in the building by Nurse #2, NA #1, NA #2, NA #3, and NA #4 immediately after phone call received from the local Police Department. All other residents in facility were present.

Resident #2 was placed on 1 on 1 [monitoring] immediately upon return to facility. 1 on 1 ended on 3/3/2022. No further incidents occurred, and staff education had been completed.

Identification of other residents who might be affected: All residents with wanderguards were checked for placement and function by the unit manager on 2/24/22. All wanderguards were in place and functioning properly per physician order.

Measures put in place to prevent recurrence: All licensed nurses were trained to check wanderguards at the start of each shift.

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Wanderguard placement checks were added to the NA care guide to increase staff awareness of resident elopement risk. All CNAs were educated on this addition to the card guide.

All staff were educated by Staff Development Coordinator on effective techniques to monitor and supervise residents and elopement. Residents will be assessed for elopement risk upon admission, quarterly, and as needed by the nurse on duty. A physician order is written when a new wanderguard is placed on a patient. Nurses on duty are to document the placement and function of the wanderguards each shift on the medication administration record. If wanderguard is not present or nonfunctional it should be replaced immediately. Staff were also educated on checking door alarms every shift. Education was completed on 2/28/2022. This included full-time, part-time, as needed, and contracted staff. New staff will be educated upon hire and current be staff will in-serviced annually. Wanderguard book continues to be at each nurse station as part of the normal facility protocol. The DON and/or designee monitored and ensured that the wanderguard books were up to date and present at each nurse station 5 days a week for 2 weeks then weekly for 4 weeks.

Systemic changes made: the facility's protocol for checking door alarms as a precautionary measure to prevent unsupervised exits. Prior to the incident the maintenance department checked the doors and alarms weekly. A door alarm book was placed at the front nurse's station on 2/24/2022 for the Nurse on duty and/or designee on the rehab unit to monitor all exit doors throughout facility for 5 days a week for 2 weeks, then weekly for 4 weeks. As part of the

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systemic change Maintenance will check the doors daily and report any malfunctions to nurse supervisor immediately. The Director of Nursing reviewed audits weekly for compliance and to ensure the process was effective.

Monitoring process: The process will be reviewed by the Quality Assurance (QA) Committee by the DON or designee every month and ongoing to ensure the process remains effective and changes will be made as needed with any concerns identified. The QA committee consists of: Chief Administrative Officer, Director of Nursing, and two additional staff members monthly and Medical Director and Pharmacist quarterly.
To ensure substantial compliance once the Quality Assurance (QA) Committee determines the problem no longer exits, then the review will be completed on a random basis by the DON or designee.

Person responsible: All corrective action was completed by 3/4/22. The Director of Nursing is responsible for implementing the acceptable plan of correction.

Onsite validation was completed on 4/28/22 through staff interviews and record review. Staff were interviewed to validate in-service completion on monitoring and preventing elopements and process for monitoring wanderguards for placement and function. Observations were made of a sample of residents with orders for wanderguards for placement. Documentation of wanderguard and door alarm audits was reviewed. QA meeting signatures were reviewed. The facility's correction action plan was validated to be completed as of 3/4/22.

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F 843 SS=F	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a transfer agreement in place for transferring residents to the local hospital for evaluation and treatment, which had	F 843	A hospital transfer agreement was initiated and submitted with a local hospital by the Chief Administrative Officer (CAO) on May 5, 2022. No residents were	5/5/22

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F 843	Continued From page 10 the potential to effect 63 of 63 residents who resided in the facility. The findings included: Review of the facility contracts with local entities revealed that the transfer agreement with the local hospital was not executed. During an interview on 4/28/22 at 3:30 PM, the Administrator indicated residents and family were able to choose which hospital they attended. They did not have a transfer agreement with these hospitals. She revealed she had contacted the hospital and they stated they were required to treat anyone coming in under federal law.	F 843	identified as being affected by the deficient practice. All residents in the facility had the potential to be affected by the deficient practice. No residents were identified as being affected by the deficient practice. The CAO reviewed all transfer agreements on April 28, 2022 and no other missing agreements were identified. An up to date and active hospital transfer agreement with a local hospital will remain in effect at all times. The CAO will review hospital transfer agreement at least annually and revise the agreement as needed. The QAA committee will review the hospital transfer agreement in QAA monthly x 3 and ongoing annually to ensure the hospital agreement remains active and up to date.	