STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(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
E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted from 04/17/23 through 04/20/23. The facility was found in compliance wtih the requirment CFR 483.73, Emergency Preparedness. Event ID #DKHR11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and a complaint investigation was conducted from 04/17/23 through 04/20/23. Event ID# DKHR11. The following intakes were investigated: NC00187576, NC00195826, NC00199331, NC00199676, and NC00194434. 1 of the 10 complaint allegations resulted in deficiency. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 consitituted Substandard Quality of Care. Non-compliance began for F689 on 4/7/23 and the deficiency was corrected as of 4/17/23. An extended survey was conducted. The facility came back into substantial compliance effective 4/20/23.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		5/2/23

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

Electronically Signed | 05/11/2023

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F 623	Continued From page 1 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F 623		

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F 623	Continued From page 2	F 623		

notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information

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F 623	Continued From page 3 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Ombudsman within 30 days and in writing when 2 of 2 sampled residents were discharged to the hospital (Resident #30 and Resident #44). Findings included. 1. Resident # 30 was admitted to the facility on 05/24/22. Resident #30 was discharged to the hospital on 03/04/23 and readmitted to the facility on 03/09/23, then discharged to the hospital again on 03/25/23 and readmitted 03/28/23 with diagnoses including hematuria, and urinary tract infection. A nursing progress note dated 03/04/23 at 7:03 PM indicated Resident #30 experienced a change in condition. Resident #30's Responsible Party (RP) was notified. The primary care provider was notified, and a recommendation was made to send resident to the hospital for further evaluation. A nursing progress note dated 03/25/23 at 5:55	F 623	Cherry Point Bay Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cherry Point Bay Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cherry Point Bay Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

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F 623	Continued From page 4 PM indicated Resident #30 experienced a change in condition. Resident #30's Responsible Party (RP) was notified. The primary care provider was notified, and a recommendation was made to send resident to the hospital for further evaluation. Interview with the Social Worker on 04/20/23 at 8:18 AM indicated she did not send a list of discharges to the Ombudsman. She stated she had never been told to do this and had never heard of it. She stated she was not aware of a regulation regarding notification of the Ombudsman of residents discharged from the facility. Interview with the Director of Nursing (DON) on 04/20/23 at 8:46 AM indicated when a resident was sent to the hospital, the resident or RP was informed verbally of the transfer to the hospital. The DON did not know if anyone notified the Ombudsman of discharges. A follow up interview on 04/20/23 at 8:57 AM with the Social Worker revealed she did not inform the Ombudsman of the facility initiated or resident initiated discharges. She stated she had never been informed to send the Ombudsman a list of discharges. She stated the business office, and the Quality Assurance nurse kept lists of the residents that were discharged but she did not know if either of them sent the lists to the Ombudsman. Interview on 04/20/23 at 9:10 AM with the Quality Assurance nurse indicated she did not inform the Ombudsman of discharges and she had not been informed to do that.	F 623	Written Notification of Transfer with reason for transfer/discharge was mailed by Social Worker on 5/2/2023 to Resident/Resident Representative and to the Office of State Long-Term Care Ombudsman for residents #30 and #44. On 5/1/2023 the Facility Consultant completed an audit of all resident transfer/discharges for the past 30 days to ensure not only the Resident/Resident Representative received written notified but written notification was also sent to the Office of State Long-Term Care Ombudsman indicating the reason for transfer/discharge from the facility. During the audit all areas of concern were addressed by the Social Worker by providing written notification via email with reason to the Office of State Long-Term Care Ombudsman on 5/2/2023. Inservice was completed by Facility Consultant on 5/2/2023 with Social Worker, Director of Nursing, Quality Assurance Nurse, and Nursing Home Administrator regarding providing written Notice of Transfer/ Discharge to Resident/Resident Representative as well as emailing the Office of State Long-Term Care Ombudsman to include the reason for transfer/discharge. All newly hired social workers, Directors of Nursing, Quality Assurance Nurses, and Nursing Home Administrators will be in-serviced by the Staff Educator during orientation regarding providing written Notice of Transfer/Discharge to the Resident/Resident Representative as well	

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F 623	Continued From page 5 Interview on 04/20/23 at 9:11 AM with the Business Office Manger revealed she did not inform the Ombudsman of discharges. Interview with the Administrator on 04/20/23 at 4:45 PM revealed she was not aware of a regulation regarding notification of the Ombudsman of discharges. The Administrator stated the facility would implement a system of sending the Ombudsman written notification of facility discharges. 2. Resident #44 was originally admitted to the facility on 2/17/23. Resident #44 was discharged to the hospital on 2/22/23 and was readmitted to the facility on 2/27/23 with diagnoses of aspiration pneumonia and acute respiratory failure. Nursing progress note on 2/22/2023 at 2:50 PM indicated Resident #44 experienced a change in condition. Resident #44's primary care physician was notified, and recommendation was made to send resident to the hospital for evaluation. Resident #44 was his own responsible party. Resident #44 was discharged to the hospital via emergency medical services (EMS) for evaluation and treatment. Interview with the Social Worker (SW) on 4/20/23 at 8:18 AM indicated she did not send a list of discharges to the Ombudsman. SW stated she had never been told to do this and had never heard of it. SW was not aware of a regulation regarding notification of the Ombudsman of residents discharged from the facility. Interview with the Director of Nursing (DON) on 4/20/23 at 8:46 AM indicated when a resident was sent to the hospital, the resident or responsible	F 623	as to the Office of State Long-Term Care Ombudsman. An audit of all transfers/discharges will be completed by the Quality Assurance Nurse to ensure the Resident/Resident Representative and the Office of State Long-Term Care Ombudsman has received written Notice of Transfer/ Discharge to include the reason for transfer/discharge. Audit will be conducted weekly x4 weeks then monthly x1 month utilizing the Notification Audit Tools. Any areas of concern identified during the audit, the Facility Consultant will retrain the Social Worker, Director of Nursing, Quality Assurance Nurse, and Nursing Home Administrator. The Nursing Home Administrator will forward the Notification Audit Tools to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 month. The Executive QAPI Committee will review the Tools monthly x 2 month to determine trends and/or issues that may need further interventions put into place and to determine the need for further monitoring.	

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F 623	Continued From page 6 party was informed verbally of the transfer to the hospital. DON did not know if anyone notified the Ombudsman of discharges. Follow up interview on 4/20/23 at 8:57 AM with the Social Worker revealed she did not inform the Ombudsman of facility initiated or resident initiated discharges. SW stated she had never been informed to send the Ombudsman a list of discharges. SW stated the business office, and the Quality Assurance nurse kept lists of the residents that were discharged but she did not know if either of them sent the lists to the Ombudsman. Interview on 4/20/23 at 9:10 AM with the Quality Assurance nurse indicated she did not inform the Ombudsman of discharges and she had not been informed to do that. Interview on 4/20/23 at 9:11 AM with the Business Office Manager revealed she did not inform the Ombudsman of discharges. Interview with the Administrator on 4/20/23 at 4:45 PM revealed she was not aware of a regulation regarding notification of the Ombudsman of discharges. Administrator stated the facility would implement a system of sending the Ombudsman written notification of facility discharges.	F 623		
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		

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F 689	Continued From page 7 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Physician interviews the facility failed to provide a safe transfer by mechanical lift for a dependent resident (Resident #33) on 04/07/23 when Nurse Aide (NA) #11 used an extra-large sling instead of the medium sized sling the resident was assessed to require. The resident fell out of the sling during the transfer hitting her head on the lift and on the floor. She sustained a laceration to the back of her head with bleeding, she required hospital treatment and 3 staples for the laceration, and she suffered pain from the injury. The facility also failed to prevent a cognitively impaired resident (Resident #39) with known exit seeking behaviors from exiting the facility unsupervised. On 04/14/23 Maintenance Staff #1 thought Resident #39 was a family member of another resident and he let her out of the front door of the facility. She had no staff supervision. She was found approximately 205 feet away from the entrance door to the facility at the bottom edge of the curb where it meets the street level of a highly traveled roadway. This had a high likelihood of resulting in serious harm to Resident #39. This was for 2 of 3 residents reviewed for accidents. Findings included: 1. Resident #33 was admitted to the facility on 09/21/21. Diagnoses included, in part, dementia, severe degenerative joint disease with bilateral knee contractures, and osteoarthritis of knee.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 8	F 689		

The Minimum Data Set (MDS) quarterly assessment dated 03/05/23 revealed Resident #33 was moderately cognitively impaired and required total dependence with one staff physical assistance with transfers, and extensive assistance with one staff physical assistance with bed mobility, dressing, toileting, and personal hygiene. She had impairment to both sides to upper extremities and lower extremities. She was coded as having no falls during this assessment and weight was recorded as 106 pounds (lbs.) and 63 inches in height.

A review of the care plan updated on 03/05/23 revealed Resident #33 had a plan of care in place for Activities of Daily Living/Personal Care with a goal that care would be completed with staff support as appropriate to maintain or achieve highest practical level of functioning with interventions to include, in part, mechanical lift with assistance of one.

Review of the active Resident Care Guide for Resident #33 revealed, in part, the resident was non ambulatory and was to use the medium sized sling (yellow) when transferring with the mechanical lift.

A review of the manufacturer's recommended lift slings by size and patient weight revealed the following:

Color/Size/Weight

- Gray/ Medium Slim (slender adult)/66-121 lbs.
- Yellow/Medium/88-176 lbs.
- Blue/Large/154-265 lbs.

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- Black/Extra-Large/265-551 lbs.
- White/Extra, Extra, Large/441 lbs. or greater

An incident note written by Nurse #9 on 04/07/23 at 6:00 AM revealed the Nurse Aide (NA #11) called this nurse to Resident #33's room to assess a head injury. Nurse Aide reported the resident slipped out of sling and fell to the floor during a transfer from the bed to a shower bed. Resident was responsive, alert to self and current situation. Small laceration noted to back of head with bleeding noted. No other injuries were noted at this time. Vital Signs were temperature 98.1, heart rate was 74 beats per minute (bpm), respiration rate was 18 breaths per minute (bpm), blood pressure was 109/62 millimeters of mercury (mm/hg), and oxygen saturation was 97%. Ice pack placed to injury and neurological (neuro) checks (an assessment to monitor neurological signs and symptoms) started.

A progress note written by Nurse #9 on 04/07/23 at 6:15 AM revealed Emergency Medical Services (EMS) were called in to transport Resident #33 for laceration and swelling at back of head. Resident told EMS she did not want to go to hospital. EMS completed their assessment and stated that if condition worsened or Resident's caseworker stated she must go, to call them and they would come back.

A progress note written by the Director of Nursing on 04/07/23 at 8:00 AM revealed she spoke with the Nurse Practitioner (NP) via phone to update the condition of resident. Informed the NP that EMS was notified and declined to take the resident to the Emergency Department (ED) due to her verbal refusal to go. Notified the NP of injuries (laceration to head). The NP had no new

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orders and stated to call back with any change in condition. Neurological checks to continue per protocol.

A phone interview was conducted with Nurse Aide (NA) #11 on 04/19/23 at 6:42 PM. NA #11 reported she had been a nurse aide for 2 years and had knowledge of how to operate the mechanical lift. NA #11 stated if a resident was care planned for two staff members for transfers with a mechanical lift, then two staff members would need to be present during the transfer and if the resident was care planned for one staff member to assist with transfers with a mechanical lift then only one staff member would need to be present. NA #11 stated she would access the Resident Care Guide to know what a resident was care planned for via the computer system. She stated the Resident Care Guide for Resident #33 indicated the resident required a mechanical lift with one staff assistance with transfers and to use a medium sling. NA #11 stated on the morning of 04/07/23, she was preparing to give Resident #33 a shower. She stated she was unable to find a medium sized sling that was meant for the resident, so she grabbed an extra-large one that was available in the clean laundry area. She stated she secured the straps between her legs, and she seemed secured and as she was transferring Resident #33 from her bed to the shower bed. NA #11 stated the resident's leg and buttocks slipped out of the bottom of the sling, and she fell backwards, hitting her head on the leg of the lift and the floor. She stated she called for the nurse. Nurse #9 assessed her, and she called EMS because the back of the resident's head was bleeding. NA #11 reported she could not find a medium sized sling and there were no other sizes available except for

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the extra-large. She stated she did not let the nurse know or ask any other aides to assist with locating a medium sized sling. She stated she should have asked for help finding one because the fall could have been avoided if the resident was in the correct size sling during the transfer. NA #11 stated at times it was difficult to find the right sized slings to use for residents but she had not informed any other staff of this issue. She stated most of the times, the sling size assigned to the resident would be located in their rooms, but she was unable to find it and assumed it was sent to be laundered.

A phone interview was conducted with Nurse #9 on 04/20/23 at 9:36 AM. Nurse #9 reported NA #11 informed her Resident #33 slipped out of the sling on 04/07/23. Nurse #9 reported when she went into the room, she assessed Resident #33, and she was bleeding in the back of her head, so she called 911 and notified the Director of Nursing (DON). When EMS arrived, they refused to transport Resident #33 because the resident told him she did not want to go. Nurse #9 stated she notified the DON of the resident's refusal. She stated Resident #33 complained that her head hurt but she was okay, but it was obvious to her that Resident #33 needed sutures. Nurse #9 reported she started neuro checks immediately and there were no neurological changes, applied pressure to the back of the head and applied an ice pack. Nurse #9 stated NA #11 told her the resident had slipped out of the sling and she had not been able to locate a proper size sling and she had used a size larger. Nurse #9 stated she informed the NA if that ever happened, she needed to let her know. Nurse #9 stated no nurse aide had ever notified her that they could not locate a certain size sling. Nurse #9 added, if the

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nurse aides had trouble finding one, they would come to a nurse. She stated usually if the slings were clean, they were kept in the resident's rooms in the closet, and if they were sent to be cleaned, they would be stored in the clean linen area in the laundry room. Nurse #9 stated she was not aware of any aides having difficulty locating medium sized slings for transfers with the mechanical lift.

A progress note written by the Treatment Nurse on 04/07/23 at 9:00 AM revealed she was asked to assess the back of the Resident #33's head. She entered the resident's room and noted the resident to be lying in bed with a towel behind her head with bright red blood. A contusion (bruise) to the upper part of the back of the resident's head was noted and her hair was noted to be matted to the contusion area. The Treatment Nurse indicated she used a towel and normal saline (sterile water) to remove the matted hair from the contusion area in which a scalp laceration approximately 4 centimeters (cm) horizontally was noted in middle of the contusion. The scalp laceration was noted to be open and bleeding. The resident was made aware of the scalp laceration and that the area was still bleeding. The Treatment Nurse exited the room and made a phone call to the NP making her aware of the resident's scalp laceration and that it was still bleeding. The NP made decision for Resident #33 to be sent to ED for evaluation.

A progress note written by Nurse #2 on 04/07/2023 at 9:10 AM revealed the NP was contacted via phone due to the laceration and contusion to back of Residents #33's head assessed by Treatment Nurse. Resident #33 was bleeding from the laceration. Neuro checks

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remained within normal limits. Resident #33 had no change in cognition from baseline and denied pain. The NP provided an order to send the resident to the ED for evaluation. Nurse #2 contacted EMS and they arrived at the facility at 9:10 AM. Resident #33 agreed to ED transfer and treatment. Resident #33 left facility at 9:15 AM via stretcher with the assistance of 2 EMS personnel.

Review of the hospital emergency room records on 04/07/23 revealed, in part, Resident #33 presented to ED for evaluation after a fall. The resident had a diagnosis of dementia and could not offer much history. The resident was noted to have laceration to the back of her head. The resident had hit her head when she fell. A CAT (CT) Scan (a computerized x-ray imaging machine) of the head and neck were obtained as this was suspicious for acute intracranial abnormality such as subdural or epidural hematoma (a solid swelling of clotted blood) and cervical fracture. The CT scan was read by radiology and the physician and there were no acute fractures nor intracranial abnormality. The laceration required repair. Resident tolerated procedure well and was advised to have the sutures removed in 7 - 10 days by her primary care provider.

Review of the Procedure Note for Resident #33 dated 04/07/23 in the ED revealed, in part, Laceration Repair: Laceration of scalp 1.5 centimeters in length was anesthetized locally using 2% lidocaine (a numbing agent) with epinephrine (a medication used to relax blood vessels). Laceration was cleaned using antiseptic with copious (abundant) saline irrigation. Exploration of the wound did not show evidence of foreign body and did not show evidence of

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tendon injury. The laceration was closed with 2 staples.

A progress note written on 04/07/23 at 2:45 PM by Nurse #2 revealed Resident #33 returned from the ED via ambulance/stretcher accompanied by an EMS attendant. The resident was transferred to bed by EMS. A full body assessment was completed. No new injuries were noted. Resident #33 expressed pain to her head but could not verbalize on numerical pain scale. Resident #33 kept saying "ouch my head really hurts when it touches the pillow." The resident returned with an order to not scrub/wash scalp for 2-3 days but may rinse and pat dry laceration in back of head with 3 staples.

A physician's order for Resident #33 written on 04/07/23 revealed remove staples in 7 - 10 days, do not scrub or wash scalp for 2 - 3 days, may rinse and pat dry.

A Progress note written by the Nurse Practitioner on 04/13/23 revealed, in part, Resident #33 had a fall with head injury, and this was a follow up from ED visit. Resident #33 slipped out of the sling during a transfer to the shower and hit the back of her head causing a 1.5 cm laceration that was bleeding. Resident #33 initially refused transfer to the ED but the laceration kept bleeding and staff called EMS. Upon arrival to the ED, the resident denied any pain, and her vital signs were stable with a blood pressure of 110/68 mm/hg and heart rate of 88 bpm. Her laceration required repair with 3 staples and she tolerated this well. The resident returned to the facility in stable condition. The Nurse Practitioner's exam of her head revealed 1.5 cm well approximated superficial laceration to posterior (back) head repaired with 3 staples and

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no underlying swelling or bruising. Resident was sitting up in her recliner in no acute distress or complaints of pain.

An observation and interview were conducted with Resident #33 on 04/17/23 at 12:45 PM. Resident #33 was alert and pleasantly confused. She was sitting on the edge of the bed eating her lunch and had no complaints of pain. She denied ever having any falls.

An interview with Nurse #2 on 04/19/23 at 2:30 PM revealed Resident #33 sustained a fall on 04/07/23 on the night shift when an aide used the wrong size sling, and she slipped out of the sling while being transferred with a mechanical lift. Nurse #2 stated Resident #33 was care planned to be transferred with one staff assist. Nurse #2 stated the sling size was determined by a nurse based on the resident's height and weight. Nurse #2 confirmed Resident #33's weight was 106 lbs., and a medium sized sling was correct.

An observation on 04/19/23 at 4:30 PM of the clean laundry area for availability of mechanical lift slings revealed there were several slings hanging on the wall upon entry. There were noted to be 4 medium slings (indicated by the color yellow stripe on the sling and a tag insert indicating it was a size medium) hanging in the clean laundry section.

An interview was conducted with NA #3 on 04/20/23 at 10:35 AM. NA #3 revealed if she needed a mechanical lift sling she would go to the clean laundry section where they were hanging and get the size she needed. She stated there were usually enough available in all sizes including medium. She stated the medium slings

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had a yellow stripe on them. She stated many times the slings the resident used were located in their rooms. She stated the nurses had to select the right size sling to use based on the resident's weight and height. She stated she would not make that decision and that it was decided by a nurse, and it would be documented in the care plan and Resident Care Guide.

An interview with the Director of Nursing on 04/20/23 revealed she had been notified via phone on 04/07/23 that Resident #33 had a fall from the mechanical lift, sustained an injury to her head and refused to go to the hospital with EMS. She stated when she came in that morning, she notified the NP about Resident #33's refusal and the NP stated to monitor the resident for any change of condition. Shortly after she notified the NP, Nurse #2 reported Resident #33 had increased bleeding and the treatment nurse assessed her and cleaned her up. The DON stated at that point, the NP was notified again, and she gave the order to send the resident to the ED for further evaluation. The DON stated the resident agreed to go with EMS to the hospital and when she returned she had 3 staples to the back of her head. The DON confirmed there were 3 staples used to close the laceration and not 2 staples as indicated on the ED report.

The Nurse Practitioner was not available for an interview.

2. Resident #39 was admitted to the facility on 12/13/21 with diagnoses including Intracranial injury, history of fractures, repeated falls, and dementia with behavioral disturbance.

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A care plan dated 10/26/22 revealed Resident #39 had a plan of care in place due to wandering and was at risk for unsupervised exits from the facility related to cognitive impairment. The goal of care was for Resident #39 to have no episodes of unsupervised exits from the facility through the next review. Interventions included administering medications as ordered. Implementing the at-risk wandering protocol which included to ensure the resident's picture and name were on the wandering resident board, to post the residents name on their door as allowed and placing a wander guard alarm bracelet to Resident #39's left ankle.

A physician's order dated 12/14/22 for Resident # 39 revealed to ensure wander guard was in place to left ankle and to check every shift due to frontal lobe and executive function deficit.

The Minimum Data Set quarterly assessment dated 02/21/23 revealed Resident #39 had moderately impaired cognition. She required limited one person assistance with transfers and walking in room and corridor and extensive one person assistance with locomotion off and on the unit. Resident #39 had no impaired range of motion and used a walker for mobility and used a wander guard alarm daily. Resident #39 had no wandering behaviors at the time of the assessment.

A progress note dated 03/31/23 at 02:51 AM written by Nurse #6 revealed in part; Resident #39 remained at baseline cognitive function and was oriented to person only. Resident continued to ask for bible study and continued to attempt to walk out to the door to "catch my ride". Resident #39 continued to believe that someone was

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coming to pick them up for church. Nurse #6 indicated Resident #39 would continue to be monitored and reassessed.

A progress note dated 04/14/23 written by Nurse #1 revealed Resident #39 had an unwitnessed exit from the building. Resident #39 was assisted back to the building by staff and taken to her room where a head-to-toe body assessment was performed with no injury identified. Vital signs were within normal limits, neurologic checks were done, and one-to-one supervision was provided. Resident #39 stated, "I was going to bible study." She was smiling and laughing. She was wearing a white tank top with a green button-up shirt over it, purple pants and sneakers. The weather outside during the time of the occurrence was approximately 70 degrees and sunny.

An investigation summary completed by the Administrator dated 04/14/23 revealed Resident #39 approached the front entrance door at approximately 4:40 PM without an assistive device and asked Maintenance Staff #1 from a sister facility if she could go outside to which he replied yes. Maintenance Staff #1 was not familiar with Resident #39 and believed her to be a family member when he told her she could go outside. Resident #39 exited the building, stepped off the front porch, turned to the right to walk across the parking lot and into the street that runs parallel to the building. Once Resident #39 crossed the street she wound up on the sidewalk in front of a housing development beside the building. A van passing by the facility pulled into the parking lot and notified the Social Worker that one of their residents might be standing across the street. The Social Worker looked across the street and realized it was Resident #39 and asked the

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receptionist to please call a code orange (elopement) while the Social Worker went to assist the resident back to the building. Resident #39 was given her walker and assisted back to the building safely without injuries.

The timeline of events included in the investigation summary that was completed by the Administrator on 04/14/23 included:

At approximately 3:30 PM Resident #39 was in her room with no exit seeking behavior observed.

At approximately 3:35 PM Resident #39 was observed ambulating in the hallway without a walker. The staff went to get her walker and found her in the charting room. Resident was provided her walker and began ambulating down the hallway.

At approximately 4:00 PM another resident (Resident #2) was sitting outside on the front porch.

At approximately 4:40 PM a nurse aide returning from break observed Resident #39 seated in the lobby.

At approximately 4:40 PM Resident #39 was observed in the lobby by the Activities Director sitting in a chair looking at a magazine. Maintenance Staff #1 was observed working on the front entrance door code. Resident #39 asked Maintenance Staff #1 if she could go outside. Resident #39 did not have an assistive device and was able to walk up to the entrance door without assistance. Maintenance Staff #1 believing that Resident #39 was a visitor answered yes. Resident #39 then proceeded to

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exit the front entrance into the parking lot. The door did not alarm or lock when the resident exited the facility. Resident #39 had a wander guard in place to her left ankle at the time of the event and it had previously been noted to have been working properly.

At approximately 4:45 PM Resident #2 was sitting outside on the front patio and observed Resident #39 exit the front door walking very fast. A transport van pulled into the parking lot at approximately the same time and the driver notified the Social Worker that a person was outside and may be a resident of the facility. The Social Worker observed Resident #39 on the far side sidewalk walking along the sidewalk with a magazine in her hand. The Social Worker immediately assisted Resident #39 back to the facility. Upon entering the facility, the door alarm was triggered by the resident's wander guard.

At approximately 4:50 PM Resident #39 was assessed by Nurse #1 with no negative findings. Resident #39 stated "I was going to bible study". Resident #39 was immediately placed on one-to-one observation.

At approximately 4:48 PM the Quality Assurance (QA) Nurse was returning to the building and observed Resident #2 sitting on the front porch of the facility. Resident #2 informed the QA Nurse that Resident #39 had gotten out the front door and pointed to the right side of the building. The QA Nurse observed the Social Worker with Resident #39 in the parking lot driveway heading back to the building. The QA Nurse entered the building to get assistance.

At approximately 4:55 PM the Director of Nursing

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(DON) was returning to the facility, while walking up to the building the QA Nurse informed her that Resident #39 had exited the building. The DON observed the Social Worker walking Resident #39 back to the building.

The DON immediately instructed staff to complete a 100% head count to ensure all residents were accounted for.

The DON asked Resident #39's primary nurse (Nurse #1) to initiate vital signs and a full head to toe assessment with neurological checks. When the DON asked Resident #39 where she was going, she stated "to bible study, and I wanted my husband to go with me, but he was asleep".

The investigation summary completed by the Administrator dated 04/14/23 revealed Resident #39 was care planned for being at risk for wandering since July 2022 and wore a wander guard. Resident #39 resided in her room with her spouse and generally spent most of the day in her room. Resident #39 ambulated with a walker or independently in the hallway and was easily redirected by staff. Resident #39 had no prior unsupervised exits. Per staff report Resident #39 was last seen approximately 10 minutes before exiting the facility sitting in the lobby with no exit seeking behaviors. The resident was out of the facility for approximately 10 minutes and was observed by an alert and oriented resident exiting the facility.

A witness statement from Maintenance Staff #1 dated 04/14/23 revealed that at approximately 4:40 PM, he was standing at the entrance door in the lobby getting ready to change the door code when Resident #39 approached the front door

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and asked if she could go outside. He replied "yes" believing that she was visiting a family member. The resident did not have an assistive device and was able to walk up to the front door without assistance. Resident #39 proceeded to exit the front entrance out into the parking lot. He was later notified that the resident wore a wander guard and was at risk of wandering. At the time of her exit the door alarm did not sound and the door did not lock. After the resident went outside, he changed the door code and went to report this to the Administrator. He had no further interactions with this resident. No other employees were present the receptionist had left her desk to make copies. No other residents or visitors were present in the lobby.

Attempts were made to contact Maintenance Staff #1 during the investigation with no response.

During an interview conducted on 04/20/23 at 2:58 PM the Social Worker stated on 04/14/23 around 4:45 PM she was leaving for the day and as she walked out of the front door a random lady came up to her and stated she wanted to know if that was one of their residents over in the neighborhood next to the facility. She stated she looked over and saw Resident #39 in the adjacent neighborhood and she ran toward the resident while calling the facility with her cell phone to have them call a code orange. She stated Resident #39 started walking towards her from the street in the neighborhood and told her she was going to bible study and stated she returned Resident #39 back to the building and the nurses took over from there. She stated she observed no visible injuries on Resident #39. She stated she received education on wandering behaviors and preventing resident elopements

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following the incident.

During an interview conducted on 04/19/23 at 4:40 PM the DON stated she had just returned from a training event on 04/14/23 and came into the parking lot when she saw the Social Worker escorting Resident #39 back into the facility and she was informed of what had just occurred. She stated she was told by the QA Nurse Resident #39 was seen by someone passing by on the highway and that person thought she could be one of their residents, so she came and notified the facility. She stated she was told by the QA Nurse Resident #39 was in the street in the adjacent neighborhood. Resident #39 stated she was going to bible study and stated Maintenance Staff #1 was working on the door code and thought the resident was a visitor and allowed her to go out. She stated a full assessment of Resident #39 was completed by the nurse (Nurse #1) and no injuries were identified. She indicated a plan of correction was implemented on 04/14/23 including a complete head count of residents, checking wander guards and door alarms, wandering assessments were completed, and staff education was initiated.

An observation was conducted along with the DON on 04/19/23 at 4:40 PM through 4:45 PM of the area of the street in the adjacent neighborhood where Resident #39 was found unsupervised outside of the facility on 04/14/23. There were sidewalks noted on each side of the neighborhood street, beyond each sidewalk there was a small grassy area that ended at the curb on the edge of the street. There were no posted speed limit signs in the neighborhood. Three cars passed by driving into the neighborhood during the observation. The observed area of the street

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CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

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where the DON indicated Resident #39 was found was a short distance from the entrance to the neighborhood which led to a highly traveled street. There were no visible speed limit signs.

During an interview conducted on 04/20/23 at 3:04 PM Nurse #1 stated she was the assigned nurse for Resident #39 on 04/14/23 and saw her at the medication cart earlier that day and in the alcove where the nurse aides sit, and a nurse aide assisted her back into the hallway. She stated Resident #39 normally roamed the halls so that was not out of her normal behavior. She stated as the evening went on, she was told Resident #39 was missing and then she heard the code orange on the intercom. She stated another staff member told her the resident was outside next door to the facility, so she ran outside and assisted the Social Worker with bringing her back inside the building. She stated by that time, Resident #39 and the Social Worker were already walking back toward the building, so she was unsure of her location when the Social Worker got to her. She stated Resident #39 was talking and saying she was going to bible study. She asked her if she was okay, and the resident stated yes. She stated she assisted her inside and did a full head to toe assessment and there were no injuries. She stated Resident #39 was placed on one-to-one observation at that time and stated her wander guard was in place when the incident occurred. She stated her wander guard was checked earlier that day and was functioning properly and it was checked again after the incident for functioning, and it worked. She stated she received in-service training on wandering behaviors, and elopement over the weekend of 4/15/23 and again this week.

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An observation was conducted along with Maintenance Staff #2 on 04/20/23 at 3:00 PM of the area of the street in the adjacent neighborhood where Resident #39 was found on 04/14/23 unsupervised outside of the facility. Maintenance Staff #2 measured the distance from the front door of the facility to the approximate area of the street where Resident #39 was found. The distance measured 205 feet.

An observation was conducted along with the Social Worker on 04/20/23 at 4:15 PM of the area of the street in the adjacent neighborhood where Resident #39 was found unsupervised outside of the facility on 04/14/23. The Social Worker stated when she got to Resident #39, she was standing in the curb on the edge of the street in the neighborhood.

An interview was conducted 04/20/23 at 4:25 PM with Resident #2 who was sitting on the front porch during the incident. Resident #2 was alert and oriented and stated he was sitting on the front porch that day and saw her (Resident #39) walk out the front door and walk down the sidewalk. He stated he thought she was going behind the building then the next thing he knew someone pulled into the parking lot and came and asked if that was a resident here. He stated the Social Worker came out and went to get her (Resident #39), and stated he saw her "over there on the street" and pointed to the street in the adjacent neighborhood. He indicated he was not sure of how long she was outside unsupervised.

An observation conducted on 04/19/23 at 5:05 PM revealed Resident #39 was lying in bed with no signs of exit seeking behaviors observed. A nurse aide was observed sitting in the resident's

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room for one-to-one supervision. A wander guard was in place on Resident #39's left ankle.

During a follow up interview on 04/20/23 at 4:40 PM the DON stated Resident #39 had not exited the building unsupervised prior to the incident on 04/14/23. She indicated Resident #39 was care planned for exit seeking behaviors prior to this incident and measures were already in place such as using a wander guard and checking alarms. She indicated all staff had been educated from 04/14/23 through 04/16/23 on interventions for wandering behaviors and preventing elopement and any staff that had not worked must complete in-service training prior to their next shift.

During an interview on 04/20/23 at 6:00 PM the Administrator indicated they had measures in place to prevent residents from exiting the building unsupervised. She indicated this incident was due to human error and Maintenance Staff #1 who was not familiar with their residents mistakenly thought Resident #39 was a visitor. She stated interventions have been implemented such as the receptionist must notify the supervisor to find coverage before leaving the front desk to help prevent reoccurrence and education had been provided to all staff including Maintenance Staff #1.

The Administrator was notified of immediate jeopardy on 04/20/23 at 12:04 PM

The facility submitted the following corrective action:

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Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

1) Resident #33 is alert but confused with a Brief Interview for Mental Status (BIMS) of 9. The resident can make needs known. The resident is care planned for a one-person mechanical device / total dependence utilizing a mechanical lift and medium sling. On 4/7/23 at approximately 6:00 am, Nursing Assistant (NA) #1 was in Resident #33's room preparing to transfer Resident #33 from the bed to shower table utilizing a mechanical lift. NA #1 obtained a lift; however, the NA could not locate a medium sling. Therefore, NA #1 utilized an extra-large sling. NA #1 relates that when raising Resident #33 from the bed, the resident's leg slipped out of the sling, and the resident slid out of the sling to the floor, striking her head on one of the horizontal legs of the mechanical Lift.

Nurse #1 was called to the room by NA #1. The nurse assessed the resident and noted bleeding from a laceration on Resident #33's posterior head. First aid was performed, bleeding ceased, and 911 was notified. Neuro checks were initiated, and within normal limits, and Resident #33 had a range of motion (ROM) of bilateral upper and lower extremities, per usual. When Emergency Medical Services (EMS) personnel arrived, Resident #33 was asked if the resident wanted to go to the emergency room. Resident #33 declined to go to the hospital, and EMS left the facility. On 4/7/23 at approximately 7:31 am, the Nurse Supervisor notified the physician of the fall with no new orders. At approximately 10:00 am, the laceration to Resident #33 posterior head began to bleed again. The Director of Nursing

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evaluated Resident #33 and notified Emergency Medical Services (EMS) to transport Resident #33 to the emergency room for further evaluation and treatment. There were no changes noted to Resident #33's usual mentation.

On 4/8/23, at approximately 3:12 am, Resident #33 returned from the emergency room with three (3) staples noted to a laceration on the posterior head. Staff re-initiated neuro checks and vital signs to be completed x 48 hours. On 4/8/23 at approximately 10:05 am, the Nurse Supervisor notified the resident representative of the fall.

On 4/7/23, the sling was evaluated and showed no signs of wear and tear. The mechanical lift and sling were immediately removed from service pending inspection by maintenance to ensure the lift is functioning properly and safely and the sling is free of tear, fraying, or damage from excessive wear. There were no concerns identified during the audit.

On 4/7/23, the Director of Nursing (DON) and Quality Assurance (QA) Nurse initiated questionnaires with all alert and oriented residents regarding lift transfers. The purpose of the interviews is to identify any resident concerns related to transfers, including transfers via lift. Resident questionnaires were completed by 4/8/23. There were no concerns identified.

On 4/7/23, the DON and QA Nurse initiated skin assessments of all residents not able to report injury during transfers. This is to ensure residents have no bruising, swelling, new or worsening pain, limb deformity, or new skin injury that may be related to utilizing a mechanical lift. The assessments were completed by 4/8/23. There

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were no concerns identified.

2) Resident #39 was originally admitted to the facility on 12/13/2021 with a most recent admission date of 10/17/2022. Resident #39 has a Brief Interview for Mental Status (BIMS) score of 9 and diagnoses including but not limited to Intracranial injury, history of fractures, repeated falls, metabolic encephalopathy, dementia, type 2 diabetes mellitus, osteoarthritis, asthma, hypertension, personality change due to known physiological condition, major depressive disorder, and insufficient sleep syndrome. Resident #39 was care planned to have exit-seeking behaviors due to cognitive impairment. Resident #39 requires limited physical assistance by one person with all activities of daily living (ADLs) except transferring which she only requires supervision. Resident #1 had wander guard in place.

On 4/14/23 at approximately 4:40 pm, Resident #39 was observed by the activity's director and nursing assistant in the lobby, sitting in a chair facing the bird cage and looking at a magazine. Maintenance Staff from a sister facility were also observed by the activity's director working on the front entrance door code. Resident #39 then asked the Maintenance Staff from the sister facility if she could go outside. The Maintenance Staff from the sister facility, believing Resident #39 was a visitor, answered "Yes." Resident #39 had no assistive device and could walk to the entrance door without assistance. Resident #39 then exited the front entrance into the parking lot. The door did not alarm or lock when the resident exited the facility due to Maintenance Staff from the sister facility working on the door. On 4/14/23

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at approximately 4:45 pm, an alert and oriented resident was sitting outside on the front patio and observed Resident #39 exit the front door walking very fast. A van pulled into the parking lot at approximately the same time and the driver notified the Social Worker that a resident was outside. The Social Worker observed Resident #39 walking along the curb with a magazine in hand. The Social Worker immediately assisted Resident #39 back to the facility. Upon entering the facility, the resident's wander guard triggered the door alarm. On 4/14/23 at approximately 4:50 pm, the resident was assessed by Nurse #1 with no negative findings. Resident #39 stated, "I was going to bible study." Resident #39 was immediately placed on one to one observation.

On 4/14/23 at approximately 5:10pm, the hall nurses completed a 100% headcount. All residents were present and accounted for.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

1) On 4/7/23, the Director of Nursing (DON) and Quality Assurance Nurse (QA) initiated questionnaires with all nursing assistants regarding lift transfers. These questionnaires were to identify any concerns related to the residents' ability to transfer safely and to ensure that transfer status is reviewed, and interventions initiated when indicated. The Staff Development Coordinator (SDC) will address all concerns identified during the questionnaires, including but not limited to initiating therapy referral for transfer safety and updating the resident care plan/care guide when indicated. Questionnaires will be completed by 4/8/23. After 4/8/23, any nursing

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assistant who still needs to complete the questionnaire will complete it before the next scheduled work shift.

On 4/7/23, the Director of Nursing (DON) and the QA nurse completed an inspection of all lifts to ensure that the lift is working properly: the sling bar will lift and lower, the sling bar is secure, sling bar clips are in place, manual emergency lowering works, lift wheels roll without problems, remote works properly, and battery charged. There were no identified areas of concern.

On 4/7/23, the DON and QA nurse completed an inspection of all lift pads to ensure lift pads were intact and not torn, frayed, or damaged from excessive wear. There were no identified areas of concern.

2) On 4/14/23, the Administrator initiated constant monitoring of the front entrance door until inspected by the Maintenance Director. The door was inspected and found to be working properly.

On 4/14/23, the Activities Director completed a 100 % audit of all entrance/exit doors/wander guards in the facility to ensure all doors were locked and functioning properly and all wander guards were in place and working. There were no concerns identified.

On 4/15/23, the Maintenance Director completed a second inspection of the front entrance door and found the door functioning properly.

On 4/14/23, the Quality Assurance nurse (QA) completed a 100% audit of residents at risk for wandering to include Resident #39 photos in the elopement book with no negative findings.

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On 4/14/23, the QA Nurse audited 100% of all resident progress notes to include Resident #39 for the past 30 days. This audit is to identify any residents with exit-seeking behaviors, including wandering in and out of resident's rooms, wandering around the facility, attempting to pry open exit doors, tampering or removing wander guards, and making comments about exiting the facility to ensure appropriate interventions were put into place for the prevention of unsupervised exit. No concerns were identified.

On 4/14/23, the Director of Nursing (DON) and hall nurses initiated an audit of all wandering assessments to ensure assessments were completed accurately, all residents who were triggered as at risk were care planned for wandering risk, and the resident had a wander guard in place per facility protocol. The Nursing Supervisor addressed all concerns identified during the audit, including completing the wander assessment as indicated, applying a wander guard to residents at risk for wandering, and updating the care plan as indicated. The audit was completed by 4/16/23.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

1) On 4/7/23, the DON initiated an audit of all incident reports for the past 30 days related to lift transfers. This audit is to identify any trends related to falls during lift transfers. There were no identified concerns.

On 4/7/23, the DON and QA nurse initiated an audit of all resident care plans regarding transfer

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status. This audit ensures the care guide reflects the most current transfer information, including but not limited to the type of lift transfer and sling size when indicated. The DON, QA nurse and SDC will address all concerns identified during the audit, including updating the care plan/care guide for the resident current transfer needs/status. The audit was completed by 4/8/23.

On 4/7/23, the SDC initiated an in-service with all nurses and nursing assistants to include the agency regarding proper technique for using mechanical lifts with return demonstration utilizing the Lift Skills Checklist to include (1) checking the care guide before care is provided for the appropriate transfer method, (2) visually inspect lift for external damage or excessive wear (3) checking that the lift sling is not torn, frayed or damaged from excessive wear, (4) inspect the lift to ensure it is working properly: sling bar will lift and lower, sling bar is secure, sling bar clips are in place, manual emergency lowering works, lift wheels roll without problems, remote works properly, battery charged. Remember that wheel locks are unlocked during routine lifts, and (5) if any areas of concern are noted during lift inspection, remove the lift immediately from the care area. Tag lift to indicate "out of order," complete a work order, and immediately report any broken area to the Administrator, DON, or Maintenance Supervisor. Education with return demonstrations were completed by 4/8/23. After 4/9/23, any nurse or nursing assistant who has not completed the training with a return demonstration will complete it upon the next scheduled work shift. All newly hired nurses and NAs, including agency staff, will be trained by the SDC during orientation on the proper procedure for using all mechanical lifts with a return

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demonstration utilizing the Lift Skills Checklist.

On 4/7/23, the SDC initiated an in-service with all nurses and nursing assistants to include agency regarding (1) Safe Handling with emphasis on checking the care guide on the iPad prior to providing care to include but not limited to ensuring appropriate transfer status is utilized; (2) Transfer Following a Fall with emphasis on following care guide for transfers when a resident sustains a fall and not lifting resident utilizing arms and legs; (3) Assessment following a fall with an emphasis on not moving resident from the floor until licensed nurse conducts a thorough evaluation. (4) Mechanical Lifts Slings with emphasis on using appropriate sling size, not substituting slings sizes, location of extra slings, and notification of nurse when appropriate sling size not available. In-services were completed by 4/8/23. After 4/8/23, any nurse or nursing assistant who still needs to complete the training will complete it upon the next scheduled work shift. All newly hired nurses and NAs to include the agency, will be trained by the SDC during orientation regarding Safe Handling, Transfer Following a Fall, Assessment Following a Fall, and Mechanical Lift Slings.

2) On 4/14/23, the Staff Development Coordinator educated the Maintenance Staff member regarding only assisting residents or unknown people outside the facility after checking with nursing staff to ensure the resident is safe to be outside unsupervised.

On 4/14/23, the Director of Nursing initiated an in-service with all nurses regarding (1) initiating an intervention if residents are exhibiting wandering behaviors or statements about seeking

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an exit; (2) receptionist must stay at the front desk and call a supervisor to find coverage during times she must leave for a break or lunch or to complete a task during the receptionist's shift until automatic door lock times initiated each evening.

On 4/16/23, in-service was initiated by the Staff Development Coordinator with all staff regarding only assisting people known or unknown outside the facility after checking with nursing staff to ensure the resident was safe to be outside unsupervised.

All in-services will be completed by 4/16/23. After 4/16/23, any staff who has yet to work or receive the in-services will receive education prior to the next scheduled work shift. Proactively, the facility will mail in-services to any staff who still needs to complete in-service by 4/16/23 with instructions to read, sign and return in-services to the Administrator and/or DON prior to the next scheduled work shift.

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

1) The QA Nurse and/or SDC will complete 10 observations of mechanical lift transfers to include Resident #33 weekly x4 weeks. This audit is to ensure staff checked the care guide prior to care to identify the transfer status indicated, staff inspected the lift and sling prior to transfer, that the staff used appropriate technique during lift transfer, including appropriate sling size, and that the staff immediately stopped the transfer and notified the nurse for any concerns identified. The SDC will address all concerns identified during the audit, including but not limited to immediate

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retraining of staff. The Administrator and/or DON will review and initial all observations of mechanical lift transfer weekly x 4 weeks to ensure all concerns were addressed.

The Administrator will forward the results of mechanical lift observations to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 1 month. The QAPI Committee will meet monthly x 1 month, and review the results of mechanical lift observations, to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.

2) The DON, Nurse Facilitator, Social Worker will complete 5 observations of the front entrance area weekly x 4 weeks to ensure the receptionist is present while doors are unlocked, another staff member is present during maintenance of doors and that facility staff, non-facility staff and visitors are not allowing residents, to include Resident #39, who are at risk for wandering outside, without supervision. The Administrator will review the observations weekly x 4 weeks to ensure all concerns have been addressed.

The DON will forward the results of the observations to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 1 month. The QAPI Committee will meet monthly x 1 month and review the observations to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.

Date of corrective action completion: 4/16/23.

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	345487	A. BUILDING _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(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
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The corrective action plan with a completion date of 4/16/23 for Residents #33 and #39 was validated onsite on 4/20/23. This included a review of dates and content of the in services and training that was conducted with all staff. During the investigation, direct care staff were interviewed regarding in-service training related to using the correct size sling when transferring a resident with a mechanical lift, and notifying the nurse if the correct size sling cannot be located. Additionally, direct care staff were interviewed regarding in-service training related to wandering behaviors and preventing elopements. An observation of Resident #33 was conducted of a mechanical lift transfer and confirmed a medium sized sling was used and observations of the availably and location of the mechanical lift slings revealed there were several slings hanging on the wall upon entry. There were noted to be 4 medium slings (indicated by the color yellow stripe on the sling and a tag insert indicating it was a size medium) hanging in the clean laundry section. Observations were conducted of residents with wander guard placement, and wander guard and door alarms were checked to ensure proper functioning with no concerns identified. The validation verified the corrective action plan was completed on 4/16/23 and the deficiency was corrected as of 4/17/23.