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	345258	A. BUILDING ______ B. WING ______	C 10/19/2023

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TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	**1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083**

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F 000	INITIAL COMMENTS A revisit and complaint survey were conducted from 10/17/2023-10/19/2023. Event ID# JL7E11. The following intakes were investigated: NC00206113 NC00206207 NC00207704 NC00206500 NC00208383 NC00208542 3 of the 17 allegations resulted in deficient practice. Past-noncompliance was identified at: CFR 483.10 at tag F550 at scope and severity D CFR 483.25 at tag F689 at a scope and severity D	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/10/2023

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, resident and staff interviews, the facility failed to maintain a resident's dignity when a Physical Therapist Assistant used profanity directed towards 1 of 3 residents reviewed for dignity (Resident #205). The findings included: Resident #205 was admitted to the facility on 9/5/2023. The admission Minimum Data Set assessment dated 9/11/2023 assessed Resident #205 to be	F 550	Past noncompliance: no plan of correction required.	

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F 550	Continued From page 2 cognitively intact. An initial allegation report dated 9/21/2023 at 3:30 PM documented a nurse overheard a Physical Therapy Assistant (PTA) #1 use profanity directed towards Resident #205. PTA #1 was removed from the facility and suspended during the investigation. The investigative report dated 9/26/2023 documented that the facility investigation into the incident revealed that the exchange did not rise to the level of abuse but was inappropriate. Resident #205 was interviewed by Administrator #2, and Resident #205 reported he had gotten angry and was taking it out on (PTA #1) and "he (PTA #1) didn't do anything, it was my fault." An interview was conducted with the Certified Occupational Therapist Assistant (COTA) #1 on 10/18/2023 at 12:14 PM. COTA #1 reported he and PTA #1 were going to provide a joint therapy session to Resident #205 on 9/21/2023. COTA #1 described arriving at Resident #205's room and the resident was very upset and cursing at PTA #1. COTA #1 explained PTA #1 was trying to calm down Resident #205, but Resident #205 was becoming more upset. COTA #1 reported he said, "We aren't doing this," (meaning provide therapy services with Resident #205 so upset) and told PTA #1 to leave the room with him. As COTA #1 and PTA #1 were leaving the room, Resident #205 shouted "F-you!" and PTA #1 stopped at the doorway, turned around and said, "No, F-you!" The Director of Rehabilitation was interviewed on 10/18/2023 at 12:29 PM. The Director of Rehabilitation reported that she was working on	F 550		

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F 550	Continued From page 3	F 550		

9/21/2023 but she had not been a witness to the verbal altercation between Resident #205 and PTA #1. The Director of Rehabilitation reported PTA #1 was suspended after the incident and then terminated once the investigation was completed. The Director of Rehabilitation reported she had worked with PTA #1 for 15 years and he had never displayed verbal aggression towards any resident and the incident was out of character for PTA #1.

PTA #1 was interviewed by phone on 10/18/2023 at 2:22 PM. PTA #1 reported he had worked at the facility for 28 years and had been very familiar with Resident #205, explaining that Resident #205 became verbally aggressive at times. PTA #1 reported he had been walking towards Resident #205's room on 9/21/2023 "sometime after lunch" when he heard Resident #205 start yelling. PTA #1 explained when he got to Resident #205's room, he was yelling and very upset and called PTA #1 "a stupid M-f-er". PTA #1 said he told Resident #205 he could not speak to him that way and started to leave the room when Resident #205 yelled "F-you!" PTA #1 reported, "I just lost my cool and my professionalism, he got to me, and I turned around and said, "No, F-you" back to Resident #205. PTA #1 explained that he was terminated from his position. PTA #1 reported he had received in-services prior to the incident related to treating the residents with respect and dignity and he was aware of how to approach a resident that was agitated, but "I was upset, he called me names and I snapped."

Resident #205 was interviewed on 10/18/2023 at 3:01 PM. Resident # 205 explained he had turned his call bell on 9/21/2023 "sometime after

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F 550	Continued From page 4	F 550		

lunch" and he was waiting for the nursing assistant to help him. Resident #205 reported he had spilled his urinal and he had urine on him and in the bed and when PTA #1 arrived at his room for therapy, Resident #205 reported he was very upset because he had been waiting for "a few minutes." Resident #205 verbalized PTA #1 had told him to calm down, "and that just pissed me off. I called him some names and he told me not to talk to him that way, he was trying to help me." Resident #205 said at that point, COTA #1 had arrived in the room, and he had said to PTA #1 "we aren't doing this," and Resident #205 explained he thought they were going to leave without helping him and he yelled "F-you!" to both PTA #1 and COTA #1. Resident #205 said that PTA #1 stopped at the doorway, turned around and said, "No, F-you." Resident #205 reported he felt terrible about yelling at PTA #1 and he apologized to PTA #1. Resident #205 stated, "I was wrong, he (PTA #1) really helped me (with therapy) and I felt terrible I treated him that way."

The facility action plan dated 9/22/2023 documented the immediate actions the facility took on 9/21/2023 including interviewing and suspending PTA #1, resident interview with Resident #205, and completion of the initial allegation report. The action plan detailed the education provided to all staff in person and over the phone for staff not working, including dignity education which was completed by 9/22/2023. The action plan documented all alert and oriented residents were interviewed by the management staff and the Social Worker related to concerns with staff treatment of them and these interviews were completed by 9/23/2023. The facility had daily Quality Monitoring in place prior to the incident where management and department

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F 550	Continued From page 5 leaders had daily rounds with residents for concerns with care, including the treatment of residents with dignity, and this Quality Monitoring was to continue. No issues were identified during the review of the Quality Monitoring records by the facility. An ad hoc Quality Assurance and Performance Improvement (QAPI) team meeting was conducted on 9/23/2023 to provide education to all departments leaders and to review and discuss the action plan. The results of the Quality Monitoring will be discussed at the monthly QAPI meeting and further concerns will be addressed by the team. The date of completion was 9/26/2023 for education with ongoing monitoring. The action plan was validated by reviewing the education provided to the staff, reviewing the interviews with residents, and reviewing the daily Quality Monitoring documentation. Residents were interviewed during the survey, and none reported having any issues with how staff treated them. Staff were interviewed and they had all received education regarding dignity. The facility completion date of 9/26/2023 was validated.	F 550		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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 any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 602		11/3/23

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F 602	Continued From page 6 Based on record reviews, observations, resident and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of pain medication for 1 of 3 residents reviewed for abuse (Resident #201). The findings included: Resident #201 was admitted to the facility on 7/2/2018 with diagnoses to include stroke and diabetes. The physician orders for Resident #201 included an order for oxycodone 10 milligrams to be administered three times per day. The quarterly Minimum Data Set dated 9/30/2023 assessed Resident #201 to be cognitively intact and she received scheduled pain medication for occasional moderate pain. The facility initial allegation report dated 9/15/2023 documented that a pharmacy request to refill oxycodone for Resident #201 was denied by the pharmacy for being too early. The report indicated the narcotics in the medication cart were reviewed and a card of tablets were missing. The facility ran a report of all narcotics delivered in the past 30 days and checked to ensure all other residents had their medications available. The facility conducted pain assessments on all residents receiving narcotic pain medications and no issues were identified. The facility investigation report dated 9/21/2023 detailed the investigation including the discovery that one other resident was missing narcotics. The facility interviewed residents to determine if they had received their pain medications and no	F 602	F602 Free from Misappropriation/Exploitation 1. Resident #201 was interviewed concerning pain medication and she reported she had not missed any doses of pain medication. On 9/15/23 the facility ordered and received pain medication for Resident #201. On 9/15/23 the facility submitted an initial allegation to the Department of Health and Human Services for Misappropriation. The facility also reported the incident to the Department of Social Services and local police department. 2. On 9/14/23 the Director of Nursing ran a report of all narcotics delivered in the past 30 days and checked to ensure all other residents had their medications available. The Director of Nursing and Unit Managers conducted pain assessments on 9/15/23 for all residents receiving narcotic pain medications and no issues were identified. Residents were also interviewed on 9/15/23 to determine if they had received their pain medications and no issues were identified. The Director of Nursing conducted drug screenings on 9/14/23-9/18/23 for 6 nurses who were on duty during the time the medication was discovered missing. One nurse had an inconclusive drug screen results for possible illicit drugs on 9/18/23 and was immediately suspended pending the final report. On 11/2/2023 the Executive Director reported the incident to the North Carolina Board of Nursing.	

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F 602	Continued From page 7 issues were identified. The report indicated the facility was unable to determine at the time of the report if the medications were returned to the pharmacy or had been misappropriated and the facility put a plan of correction into place to prevent future misappropriation of medications. The facility reported the incident to the Department of Social Services and local police department on 9/15/2023. Nurse #2 was interviewed on 10/18/2023 at 11:54 AM. Nurse #2 reported that when narcotics were delivered from the pharmacy, two nurses were required to count the narcotics and sign the delivery sheet before the pharmacy courier could leave the facility. Nurse #3 was interviewed on 10/18/2023 at 2:36 PM. Nurse #3 reported that when narcotics were delivered from the pharmacy, two nurses were required to accept the delivery and the nurses had to count the narcotics and sign before the delivery was accepted. Nurse #4 was interviewed on 10/18/2023 at 4:01 PM. Nurse #4 confirmed that two nurses were required to check and count deliveries of narcotics and sign before the pharmacy courier could leave the facility. Resident #201 was interviewed on 10/19/2023 at 9:18 AM and she reported she had not missed any doses of pain medication. An interview was conducted with the Director of Nursing (DON) on 10/19/2023 at 10:01 AM. The DON explained the facility became aware of the missing medications on 9/14/2023 when a request for a refill was denied by the pharmacy.	F 602	3. The Director of Nursing reeducated all licensed nurses on misappropriation of medications, the process for accepting medications delivered to the facility, and nurses given a zero-tolerance policy on drug diversion. This education and the drug diversion form will be provided to new hire nurses during orientation. The education will be completed by 11/2/2023. On 11/2/2023 the Regional Director of Clinical Services and Executive Director Market Leader educated the Executive Director and Director of Nursing on Reporting Allegation/Suspicion of Drug Diversion to the North Carolina Board of Nursing. 4. The Director of Nursing and/or Unit Mangers to perform quality monitoring weekly x 12 weeks then monthly x 2 of the medication carts on discontinued medications, as well as audits on the narcotic count sheets. The monitoring will be discussed at the monthly Quality Assurance Performance Improvement meeting.	

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F 602	Continued From page 8 The DON explained that Resident #201 had three cards of oxycodone, and the 2nd card was missing. The DON explained the narcotic count was correct until the facility attempted to request a refill on the medication. The DON described the investigative process, which included reviewing all narcotics delivered to the facility, audits of the residents receiving narcotics, pain assessments of the residents receiving narcotics, and drug screening 6 nurses who were on duty during the time the medication was discovered missing. The DON reported the facility initially concluded the medications had been sent back to the pharmacy without the proper documentation but had since determined the medications were taken by a nurse. The DON reported one nurse had inconclusive drug screen results for illicit drugs and they were still waiting for the final report. The DON explained the nurse was suspended pending the results of the drug screen and a report would be made to the Board of Nursing once those results were received. The DON described the process of auditing narcotics and administration records and changing the process for receiving narcotics from the pharmacy. During the interview, the DON explained that prior to this updated process to accept controlled medications from the pharmacy, only one nurse would count the narcotics and sign for them. The DON explained that 2 nurses were expected to count new delivery narcotics, and both would sign before the pharmacy courier could leave the facility. The DON reported the facility was not using agency staff, and this education related to drug diversion would be provided to all new hires. The facility action plan dated 9/14/2023 was reviewed. The action plan included performing drug screening for nursing staff on-duty, audits of	F 602		

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F 602	Continued From page 9 all residents with controlled medications, interviews of all nursing staff who worked on the medication cart with the missing medications, quality review of the manifest from the pharmacy from 8/14/2023 until 9/14/2023 of all controlled medications delivered to the facility, and pain assessment on all residents receiving narcotic pain medications. The facility reported the incident to the Department of Social Services and the local police department on 9/15/2023. The action plan included education of all nurses on misappropriation of medications, the process for accepting medications delivered to the facility, and nurses given a zero-tolerance policy on drug diversion. This education and the drug diversion form would be provided to new hire nurses. The action plan included weekly monitoring to be conducted on the medication carts by the unit managers and Assistant Director of Nursing on discontinued medications, as well as audits on the narcotic count sheets. The monitoring would be discussed at the monthly Quality Assurance Performance Improvement meeting. The action plan had a completion date of 10/13/2023, however because the Board of Nursing had not been notified of the allegation of drug diversion, the action plan could not be validated and the citation cannot be past non-compliance.	F 602		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to accurately code the Minimum	F 641	F641 Accuracy of Assessments:	11/3/23

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F 641	Continued From page 10 Data Set (MDS) assessment for 1 of 1 resident reviewed for the presence and frequency of wandering behaviors (Resident #11). Findings included: Resident #11 was readmitted to the facility 9/4/23 with diagnoses that included dementia, insomnia, and liver cirrhosis. Review of a quarterly MDS assessment dated 9/12/23 revealed Resident #11 had severe cognitive impairment and did not exhibit wandering behaviors. The MDS assessment was signed by MDS Nurse #2 for all assessment Review of facility incident reports dated 9/9/23 revealed Resident #11 eloped (exited the facility without supervision) at 11:30 AM and 4:30 PM. An interview with MDS Nurse #1 and MDS Nurse #2 was conducted on 10/18/23 at 2:42 PM. During the interview it was revealed that MDS Nurse #2 signed Resident #11's MDS assessment dated 9/12/23 as completing all sections. MDS Nurse #2 was not able to recall that she completed the behaviors section because the Social Work department was assigned to complete it and indicated there may have been a computer system glitch as she only signed the sections she completed. Both MDS Nurses revealed they were aware Resident #11 had a history of elopements and MDS Nurse #2 revealed that she reviewed medical records and would have coded Resident #11 as a wandering or elopement risk. An interview with the Regional MDS Nurse on 10/18/23 at 2:247 PM revealed he was not aware of any recent computer glitches. He was not able	F 641	1. Resident #11 Minimum Data Set (MDS) dated 9/12/23 was corrected in the area of wandering behaviors (Section E0900) on 10/18/23 by the Social Services Director to accurately reflect the resident and submitted by the MDS Nurse. 2. The MDS Coordinator completed a quality review audit on all current residents who exhibit wandering behaviors to validate their most recent MDS assessments have been coded appropriately and accurately reflect each resident□s wandering behaviors during the look back period on 10/19/2023. Of the Minimum Data Sets reviewed no further issues identified related to coding of wandering behaviors. An ADHOC Quality Assurance Performance Improvement Committee was held on 10/19/23 to formulate and approve a plan of correction for the deficient practice. 3. The Regional MDS Coordinator educated the Center□s MDS Coordinators and Social Services department on accurately assessing and coding wandering behaviors utilizing the RAI on 10/18/23. 4. The Director of Nursing or designee will conduct Quality reviews 2 times a week for 12 weeks of residents□ MDS assessments in the areas of wandering behaviors (Section E) to ensure the MDS is coded accurately. The Executive Director will report the results of the quality monitoring (audit) and report to the	

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F 641	Continued From page 11 to determine who completed the behaviors section for Resident #11's quarterly MDS Assessment dated 9/12/23. The Social Work Manager (SW #1) and the Social Work Assistant (SW #2) were interviewed on 10/18/23 at 3:19 PM. SW #1 revealed that she and SW #2 completed MDS the cognition, mood, behavior, and participation in assessment sections and were able to sign their MDS sections as completed when they were finished. SW #2 revealed he definitely did not complete the quarterly MDS assessment for Resident #11. SW #1 revealed if she completed an MDS assessment for any resident she would sign when it was completed. An interview conducted with the current Executive Director on 10/19/23 at 9:43 AM revealed he believed that the MDS Nurses and Social Work staff required additional education related to MDS assessment coding and that audits needed to be initiated to monitor correct MDS assessment coding.	F 641	QAPI committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated as indicated.	
F 689 SS=D	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, observations, staff, and	F 689	Past noncompliance: no plan of	

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F 689	Continued From page 12 resident interview the facility failed to prevent 1 of 1 resident (Resident #11) from having two unsupervised exits from the facility, both of which occurred on 09/09/23. Findings included: Resident #11 was readmitted to the facility on 09/04/23 with diagnoses that included dementia and anxiety. A quarterly Minimum Data Set (MDS) assessment dated 08/10/23 revealed Resident #11 had severe cognitive impairment and did not exhibit wandering behaviors. Resident #11 utilized a wheelchair for mobility, was able to self-propel the wheelchair with supervision and verbal cues at times. A review of care plans for Resident #11, revised 09/04/23, included Resident #11 had exit seeking behaviors and wandered. The goal was that Resident #11 would not leave the facility unsupervised. date. Interventions included to maintain a functioning wander guard (a bracelet to trigger alarms and can lock monitored doors to prevent the resident leaving unattended), check placement and function every nightshift and document on the Medication Administration Record of Resident #11. 1a. Review of a facility Incident report dated 09/09/23, a Saturday, at 11:30 AM completed by the Director of Nursing (DON) revealed Resident #11 was discovered by Housekeeper #1 at the back of the facility in the grass area across the driveway. The DON revealed Resident #11 was brought into the facility and a complete skin assessment was performed with no areas of	F 689	correction required.	

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F 689	Continued From page 13 concern identified including injury. The wander guard that Resident #11 wore was checked for function and was in working order. All facility doors were checked and securely locked. Resident #11 reported she was leaving the facility to go home. Housekeeper #1 was interviewed on 10/18/23 at 3:14 PM. He revealed he observed Resident #11 outside behind the facility across the back parking lot driveway in a small grass area, her wheelchair was stuck in the grass. Housekeeper #1 recalled he asked Resident #11 if she was okay or injured and Resident #11 revealed she did not fall or get hurt and he wheeled Resident #11 into the facility to her nurse unit and explained what he saw to the nurse. Housekeeper #1 confirmed Resident #11 never fell or sustained any injury. An interview with the DON on 10/18/23 at 11:30 AM revealed in part that on 09/09/23 about 11:30 AM she received a phone call from facility nurse and was informed Resident #11 was outside unsupervised and brought her back into the facility. A skin assessment was completed and revealed no injury or pain voiced by Resident #11. The nurse revealed that Resident #11 had been seen inside the facility at 11:15 AM, propelling herself through the halls. The DON told the nurse to place Resident #11 on 1:1 staff supervision, complete a head count of every resident in the facility, check all exit doors were locked and the screamer alarms (an audible alarm that triggered when the exit doors). The DON arrived at the facility about 45 minutes later and called the Executive Director (ED) and informed her what happened. The DON checked on Resident #11 when she arrived at the facility and a Nurse Assistant (NA) was with her, Resident #11	F 689		

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F 689	Continued From page 14 revealed she was fine, but wanted to go home. Resident #11 reported she knew how to silence the exit door screamer alarms and locks by lifting the clear covers over the red buttons, she pushed the red button, so the alarm and door locks did not work. The DON checked all exit doors and all locks and alarms functioned properly, but the 500 hall exit door was unlocked and did not alarm. The DON locked the door. The DON interviewed nursing staff and confirmed all residents were present. The DON notified the Executive Director, Medical Director and left a message for Resident #11's RP (Responsible Party) to call the facility. The DON began to immediately educate all staff present in the facility about the elopement protocols, checking all exterior doors if they heard an alarm , checking wander guard bracelets for placement and function, update the Elopement Risk logbook for accuracy and check wander guards for placement and function as ordered. She informed staff Resident #11 was to be maintained on 1:1 until further notice. The DON revealed the RP came to the facility about 4:00 PM and she informed him what happened and asked him to please inform staff when he was leaving the facility and to be sure Resident #11 was not left without staff supervision. The RP voiced that he understood. 1b. Review of a facility Incident report dated 09/09/23 at 4:30PM also completed by the DON revealed in part the RP of Resident #11 had visited the facility at about 4:00 PM. When he left the facility, he did not report he was leaving or where Resident #11 was. Resident #11 was located (approximately 30 minutes after the RP left the facility) in the front parking lot on the left side of the facility, a staff member observed her	F 689		

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and brought her back into the facility. A complete head to toe assessment was performed with no injury or complaints verbalized by Resident #11. The facility exit doors were checked again and all exit doors were locked except the exit door at the end of the 200 hall and the alarm was turned off. The ED, Medical Director and the RP were notified at 5:30 PM.
A review of care plans for Resident #11, revised 09/09/23 to include Resident #11 had exit seeking behaviors, wandered, and required 1:1 (1 staff assigned to monitor one resident at all times) staff supervision. The goal was that Resident #11 would not leave the facility unattended, maintain 1:1 supervision and check wander guard placement and function of Resident #11's wander guard through the next review date. Interventions included to provide 1:1 supervision and maintain a functioning, wander guard (a bracelet to trigger alarms and can lock monitored doors to prevent the resident leaving unattended) to be checked for placement and function every night shift and recorded on the Medication Administration Record of Resident #11.

On 10/18/23 at 2:32 PM Nurse #1 was interviewed and revealed that she was assigned to the 200 hall on 09/09/23. Nurse #1 revealed she had observed Resident #11 wheeling herself through the facility many times, but never observed her trying to exit the 200 hall door and Nurse #1 revealed she never heard the wander guard alarm sounding.

During the interview with the DON on 10/18/23 at 11:40 AM she revealed on 9/9/23 at approximately 4:30 PM or 5:00 PM the RP of Resident #11 was brought back into the facility and left unsupervised in the television (TV)

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lounge. The DON revealed that a staff member observed Resident #11 outside in the side front parking lot and a staff member went and immediately brought Resident #11 back into the facility. A head-to-toe assessment of Resident #11 was completed with no injury identified and no complaints of pain by Resident #11. The staff at the facility completed all steps required as educated earlier that day. Resident #11 revealed she just wanted to follow the RP home. The RP, ED and Medical Director were made aware of the incident. The DON revealed the staff assigned to 1:1 with Resident #11 explained that while the RP and Resident #11 visited the staff member went to the hall to assist with other resident's care and had no idea the RP left Resident #11 unsupervised in the lounge. The DON revealed the Executive Director and Maintenances Director arrived and checked door alarms again and temporary screaming alarms were immediately placed on all exit doors.

A phone interview with the Executive Director conducted on 10/18/23 at 2:03PM revealed the DON informed her about Resident #11 exiting the facility without supervision about 11:30 AM on 09/09/23. The Executive Director explained she was traveling to the facility and had called the Maintenance Director to meet her at the facility. The Executive Director arrived at the facility and the DON reported Resident #11 exited the facility for the second time on 09/09/23 at approximately 4:00 PM to 4:30 PM. Resident #11 was not injured or harmed, the Medical Director and RP were notified. The DON, Executive Director and Maintenance Director toured the facility and confirmed doors screamer locks were engaged and properly working as well as the mag locks, however, the exit door at the end of the 200 hall

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F 689	Continued From page 17 was unlocked and the screamer alarm did not sound. The Executive Director directed the Maintenance Director to go to the local hardware store and purchase temporary door screamer alarms (small white colored alarms secured to the upper left corners of all exit doors) for immediate installment. The Executive Director placed an order for new clear plastic covers (covers installed over the red button that disabled the exit door mag locks when pushed). The replacement parts were installed on all exit doors when they were delivered to the facility. The Executive Director revealed the facility initiated a four-point plan of correction per the QAPI (Quality Assurance and Improvement Plan) protocol on 9/9/23. The facility submitted the following Plan of Correction on 09/09/23: An Elopement Risk Evaluation dated 09/10/23 at 10:05 AM, which was after Resident #11 was found outside the facility on 09/09/23 at 11:30 AM and at approximately 4:00 PM. The evaluation revealed Resident #11 had previous elopements and a care plan should be implemented immediately to ensure her safety. On 09/09/23 around 11:30 AM Resident #11 was discovered by staff outside the facility in the back parking lot on the grass by a housekeeper and a Certified Nursing Assistant. The parking lot is rarely utilized on the weekend. The weather was overcast as it had been raining earlier in the day. Resident #11 immediately returned to inside of the facility by staff. Skin sweep performed and no new areas of concern noted. The Medical Director and Responsible Party were notified. No new orders were received. The Director of	F 689		

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F 689	Continued From page 18 Nursing and Executive Director were notified of the event, resident was placed on 1:1 supervision with an assigned CNA. A head count was immediately conducted of all residents in the building to ensure that no other residents were at risk, all residents were accounted for. The Director of Nursing checked all exterior doors for functionality, no issues were noted. The Director of Nursing immediately began educating all present staff on facility elopement protocols, staffing policies to ensure staff respond immediately to exit door alarms, identifying wandering behaviors, and exit seeking behaviors. After Resident #11 was interviewed it was stated by her that she exited the building by bypassing the maglock system at the 500 hall door. It was discovered that Resident #11 is knowledgeable about pressing the red button to disengage the maglock alarm. Resident #11 stated that she was looking for her husband (RP). Resident #11 was last seen at approximately 11:15 AM according to her assigned NA and she was self-propelling herself around the interior of the building. On 09/09/23 around 4:00 PM Resident #11's husband arrived at the facility to visit with the resident. Resident #11's husband took the resident out of the facility to sit on the front porch. The receptionist on duty opened the door for the resident and her husband. The 1:1 staff member returned to the unit to assist staff while Resident #11 was under the supervision of her husband and visited with husband. The Director of Nursing spoke with husband in person regarding elopement and exit seeking behavior and he was made aware to tell staff when he was finished visiting with the resident and left the facility. The resident's husband returned Resident #11 inside the facility at approximately 5:00 PM and the	F 689		

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F 689	Continued From page 19 receptionist let the couple back in to the facility. On 09/09/23 around 5:30 PM Resident #11 was observed by a nurse outside of the facility in the side parking lot. This parking lot is not busy on the weekend because visitors park in front of the building on weekends. Resident #11 exited the building through the 200 hall door that was parallel to the parking lot. Resident #11 stated that she was leaving looking for her husband. Resident #11 was immediately brought back into the facility and a skin sweep was completed with no new areas of concern noted. The Medical Director and the Responsible Party were notified. No new orders were received. The Director of Nursing and Executive Director were notified of the event, resident placed on 1:1. Resident #11 interviewed and stated she "hit the red button" to get out and go look for her husband. A head count was immediately conducted of all residents in the building to ensure that no other residents were at risk, all were accounted for. At 5:45 PM the Executive Director checked all exterior doors to include screamers for functionality, and 200 hall door maglock was noted to be bypassed by the red button being depressed. This door did have a plastic cover on top of the button but when lifted an alarm did not sound. On 09/09/23 all wander guards were checked for function and placement on current wandering residents. No issues were identified. The Maintenance Director checked exterior doors to ensure secure and maglock functionality on 09/09/23. On 09/09/23 a root cause analysis determined that Resident #11 was able to disengage the maglock by pushing an override emergency red button by the doors. Temporary door alarms installed on all exterior doors by maintenance to alert staff by sound to when	F 689		

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doors are opened until the ordered screamer door alarms would arrive on 09/12/23. These temporary door alarms will remain on the doors even after installation of screamer door alarms as needed. Nursing Management to include Director of Nursing, Assistant Director of Nursing, and Unit Managers reviewed Elopement Assessments for current residents and updated care plans as needed. Alarming maglock covers were installed on 09/12/23 that cover the red buttons so that when it is lifted it will alarm as well as screamers that are placed on the door itself to sound when the door is opened, for all exterior doors.

On 09/09/23 the Director of Nursing immediately began educating all present staff in facility on elopement protocols, policies to ensure staff respond immediately to exit door alarms, identifying wandering behaviors, and exit seeking behaviors. The Executive Director continued education on 09/09/23 with the current staff on elopement protocols to include 1:1 not to leave resident unattended even when responsible party is visiting. Education was completed on 09/12/23 for current staff, to include Nursing, Dietary, Therapy, and Housekeeping, with the exception of a few as needed staff that were not allowed to work until they have received the education. Newly hired staff to be educated prior to working. On 09/10/23 a Quality Monitoring Tool was started by the Director of Nursing to monitor placement of wander guards every shift and function daily and document on the Medication Administration Record. The Director of Nursing will audit wander guards daily for 14 days then three times a week for 4 weeks then weekly for 4 weeks.

On 09/10/23 an AdHoc Quality Assurance

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F 689	Continued From page 21 Performance Improvement meeting was held with the interdisciplinary team members setting goals and actions to address the events and ensure resident safety moving forward. On 09/09/23 the Maintenance Director started a Quality Monitoring Tool to monitor exterior doors 5 x week Monday-Friday to ensure all are locked and the mag lock bypass button had been reset and the Manager on Duty will audit on Saturday and Sunday daily for 8 weeks. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 09/10/23. The Executive Director is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum to review the results of the audit tools. Alleged date of compliance: 09/13/23. The plan was validated for the alleged date of compliance of 09/13/23 on 10/18/23. The Plan of Correction was validated on 10/18/23	F 689		

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F 689	Continued From page 22 for the alleged date of compliance of 09/13/23. The Quality Assessment and Performance Improvement Plan was reviewed, each intervention had corresponding documentation to support the actions taken by the facility. The facility assessed all residents for risk of elopement and put interventions into place to ensure the safety of Resident #11 and all at risk residents. The facility nursing staff were educated on how to complete the Elopement Risk Assessment correctly, the appropriate function and placement of the wander alert bracelet, documentation of the wander alert bracelet on the residents Medication Administration Record, listening for exterior exit door alarms and responding to the alarms, and the elopement policy 79 nurse staff signed and dated the education attendance form. The facility completed Elopement Risk Assessments on all residents and put interventions into place. The facility's doors were checked for proper functioning and the alarm sounding. The facility also completed the monitoring they put into place and continued to monitor as of the date of the survey. The facility also brought monitoring to the Quality Assurance Performance Improvement meeting for review. Review of nurse Quality Monitoring tools initiated by the DON on 09/10/23 for 14 days and three times weekly for four weeks were reviewed with no concerns identified. The weekly audits were in progress. Review of binders located at each nurse station and the receptionist desk at the front lobby revealed all residents identified by the facility with wandering behaviors were included in the binders with their photographs, and vital information needed in case of an unsupervised exit from the facility.	F 689		

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F 689	Continued From page 23 Review of the Maintenance Director's daily audits of eleven exit door locks and alarm function dated 09/09/23 through 10/18/23 revealed no concerns with function was identified. On 10/17/23 and 10/18/23 random staff interviews were conducted and revealed staff was educated to monitor door alarms and respond immediately, report elopement concerns to the nurse, complete a facility census count of all residents. Review of QAPI meeting minutes dated 09/10/23 and 10/10/23 were reviewed and included a review of all Risk Management / Quality Improvement Data Collection Forms from all departments were reviewed.	F 689		