DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 02/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to prevent 1 of 6 cognitively impaired residents (Resident # 2) at risk for elopement, from exiting the facility unsupervised, resulting in a fall and fractured left hip. Originally admitted on 7/8/10, Resident # 2 was subsequently re-admitted to the facility on 12/20/10 and 12/14/11. Cumulative diagnosis included dementia, depression, anxiety disorder, stroke with aphasia and dysphasia, seizure disorder, hypoglycemia and status post surgical repair of fractured left hip on 12/11/11. A Potential Risk for Elopement Status form dated 1/7/11 was completed following re-admission on 12/20/11 and revealed the resident was at risk for elopement based on cognitive impairment, dementia, independent ambulation, aphasia, and expressing a desire to go home. The elopement status review was completed 30 days after each subsequent re-admission and quarterly thereafter indicating an ongoing elopement risk and review of the interventions care planned.	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debbie Williams	Adm	3-14-12

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 323	Continued From page 1 Review of the latest Quarterly Minimum Data Set (MDS) dated 11/23/11 revealed the resident 's cognitive skills for daily decision making were moderately impaired, the resident experienced long term memory loss and the resident had not wandered in the seven days prior to completion of the assessment. Resident # 2's Care Plan, dated 12/6/11, listed elopement as a potential problem. Approaches included: 1) Assist resident with supervised outside visits as per request. 2) Elopement checks to be completed and documented as per facility policy. 3) Photograph of resident to be on elopement sheet. 4) Refer to NP/MD for increased behaviors. 5) Staff to be aware of resident wandering risk. 6) Wander guard checks to be completed and documented as per facility policy. Wander guard located on left ankle. 7) Wander guard/Code Alert to be in place at all times. 8) Redirect when agitated and attempting to exit facility. The goal for this problem was resident will agree to wear code alert and will not leave the facility unsupervised thru review period. Nurses Notes dated 12/9/11 at 6:30 pm revealed " This nurse took all smokers outside to smoke two cigarettes including Resident # 2. After resident smoked nurse let resident back inside the facility. Wander guard intact and working. (Signed by Nurse # 1) Nurses Notes dated 12/9/11 at 7:10 pm revealed dietary aide reported that he saw resident walking outside. Dietary aide came into facility got assistance of a nursing assistant. The nursing	F 323		

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F 323	Continued From page 2 assistant observed patient walking and by the time she was able to reach resident, resident fell onto gravel and hit his left side & head. Nurse observed resident lying in gravel on his left side. Patient was unable to move left leg. Three staff members assisted patient back to wheelchair and brought back into facility and placed in bed. Patient complained of left hip pain. No visual injuries noted. Neuro-checks within normal limits. Full range of motion of bilateral arms and right leg. Doctor notified. Administrator and Director of Nursing notified. Responsible party notified. New order received to send patient to Emergency Department (ED) for evaluation and treatment. Emergency Medical Services (EMS) notified. (Signed by Nurse # 1). Nurses Notes dated 12/9/11 at 7:30 pm revealed EMS arrived to transport pt. via stretcher to ED. Patient was alert and verbal. Neuro (neurological) checks remain WNL. VS-99.1, 62, 20, 110/56 (vital signs -temperature 99.1 degrees F, pulse 62 beats per minute, respirations 20 breaths per minute, blood pressure 110 systolic and 56 diastolic). " (Signed by Nurse # 1). Review of the Quality Assurance Event Report dated 12/9/11 indicated " Patient eloped out of facility. A dietary aide observed patient outside and came and got a nursing assistant. Nursing assistant saw patient get up to walk. By the time the nursing assistant was able to reach patient, patient, had already fallen. Patient hit left hip, left side of head. The report indicated Resident # 2 had no new illness, no new diagnosis, and no recent change in mental status and that a personal body alarm (PBA), wander guard and wheelchair were in use. The question, " Was	F 323		

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F 323	Continued From page 3 resident authorized to be at location of event? " was answered with a check mark in the " No " box. " Action Rounds " was written under the section " Additional comments and/or steps taken to prevent recurrence: " Review of the Daily Quality Assurance Code Alert Check for 12/9/11 indicated Resident # 2 ' s wander guard was functional. Review of the Elopement Risk Sheet for 12/9/11 completed by Nursing Assistant # 3 who was assigned to Resident ' #2 ' s 3 pm to 11 pm care, revealed elopement checks were documented as completed per policy at 3:00 pm, 5:00 pm and 7:00 pm. Review of the Medication Administration Record revealed documentation for 12/9/11 indicated Resident # 2 's wander guard was in place on the resident. According to wunderground.com the temperature on 12/9/11 at 7:00 pm was 41 degrees F. Hospital Records revealed on 12/11/11 Resident # 2 underwent surgery for open reduction and internal fixation of the left hip and was discharged back to the facility on 12/14/11. On 2/22/12 at 12:20 am, Nurse # 2 was interviewed regarding the elopement. Nurse # 2 stated she worked that evening and was not sure of the date but identified the resident as Resident # 2. Nurse # 2 stated she responded when a dietary aide alerted staff that the resident was outside. Nurse # 2 stated she did not hear an alarm sound and did not see the resident exit the	F 323		

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F 323	Continued From page 4 building, but assumed he went out the employee door. Nurse # 2 stated the resident was standing over near the dumpster and she went after the resident and when she was 10-15 feet from the resident he turned and fell. Nurse # 2 stated the wander guard was on the resident when he was outside and that the Maintenance Supervisor came in that evening and checked the door alarms and found they worked. Nurse # 2 stated the resident ' s alarm was checked and worked. Nurse # 2 desribed Resident # 2 as alert and oriented at times and confused at other times. She stated she does not know how resident got out of the door or which door he went out. She stated Nurse # 1 assessed the resident outside and that it was cold outside so they gently put the resident back into his wheelchair and brought him back in the facility. She stated Nurse # 1 completed an incident report. On 2/22/12 at 10:00 am the Administrator was interviewed regarding the elopement. The Administrator stated a church group had been in the facility the evening of 12/9/11 and she thought the church group may have let Resident # 2 out the door and indicated the door was the employee entrance. The Administrator stated the resident was wearing thick gray sweat pants and that the technician from the company called in to check the alarms thought the signal may not have been high enough to pick up and the technician turned up the signal then re-checked Resident # 2's alarm and it sounded. The Administrator stated the Activity Director, had arranged for the church group to come in and they did not have contact information so were not able to talk to the church group about the event-this was not the usual church group. The Administrator stated the	F 323		

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F 323	Continued From page 5 church group arrived around 6:00 pm on 12/9/11 and left around 7:00 pm and was gone when Resident # 2 was discovered outside. The Administrator stated a dietary aide discovered the resident outside and was assisted by a nursing assistant. The Administrator stated as a follow up to ensure residents were safe the alarm service company checked the door and adjusted the signal higher, a second keyed-alarm was added to the employee door and would be locked by the Maintenance Supervisor at 3:00 pm each day and unlocked when the Maintenance Supervisor came in each morning, and staff were inserviced on 12/9/11, 12/10/11 and 12/12/11 regarding Action Rounds, door alarms and response if a resident was found outside. The Administrator also stated every 2 hour checks were conducted and documented for all resident identified as elopement risks-the list of resident's at risk for elopement and the documentation sheets were in a notebook at each nurses station. The Administrator stated resident alarms were checked to be functional daily by Restorative Nursing and that Nursing checked placement on the resident each shift and both checks were documented. The Administrator stated the Activity Director responsible for coordinating the church group visit on 12/9/11 was no longer employeed by the facility. On 2/22/12 at 11:03 am a telephone interview was conducted with the service manager of the company that serviced the Mag-Lock Door Alarm System at the facility on the evening of 12/9/11. The service manager stated he supervised the technicians sent out to service the alarms and stated the technician who serviced the alarm system on the evening of 12/9/11 was not	F 323		

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F 323	Continued From page 6 currently available for interview. The Service Manager stated the Mag-Lock Door Alarm System operated with a wireless raido frequency signal; each door box contained an antenna and the transmitter or tag (often referred to as a wander guard) worn by the reisdent enmitted a signal to the antenna in the door box. He stated each door box was set to alarm at a pre-determined distance in feet and this distance could be adjusted. When a resident wearing a transmitter (or wander guard) came within the pre-determined distance of the door, the door was designed to lock. If the door was already opened and a resident wearing a transmitter (or wander guard) came within the pre-determined distance of the door an alarm sounded. He stated a transmitter (or wander guard) should not be placed on a metal part of a wheelchiar as the metal would interfer with the transmission of the signal and that thick clothing over a transmitter might prevent transmission of a signal. Review of the manufactures ' s instructions provided by the facilty confirmed a transmitter should not be placed on a metal part of a wheelchair, but no reference was make to clothing. On 2/22/12 at 11:16 am a telephone interview was conducted with Dietary Aide # 1 who stated he took the trash out to the dumpster before he went home on 12/9/11 and when he returned from the dumpster he saw Resident # 2 outside around church people. He stated he was told never to touch a resident since he was not nursing staff, so he ran into the facility to tell nursing. Dietary Aide # 1 stated when he went out to empty the trash Resident # 2 was walking on the sidewalk next to the building pushing his wheel chair. Dietray Aide # 1 stated he was	F 323		

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F 323	Continued From page 7 surprised to see the resident outside and though to himself what is the resident doing outside? The dietary aide stated he was written up after the incident and was told he should have stayed outside with the resident and waited for help, called back in on his cell phone, knocked on the window or yelled to get help. He stated he knows there was a good system on the doors to prevent residents from getting out. On 2/22/12 at 11:25 am a telephone interview was conducted with Nurse # 1 who stated she had the smokers out to smoke around 6:30 pm on 12/9/11 including Resident # 2 and that all residents came back in with her after smoking. The smoking area was off the East Wing (100 Hall) at opposite ends of the building from the West Wing (300 Hall). She stated she did not hear an alarm sound. Nurse # 1 stated she and other C N As were on East Nursing Station by the smoking door and Resident # 2 did not exit that door. She stated when she went outside through the employee entrance to assist Resident # 2 she did not see any church people at the time. She stated she started inservices that night (12/9/11) and told staff to make sure the doors were locked and that if anyone was leaving staff would have to walk them out. Nurse # 1 stated the exit door locks were checked each shift and checks documented in a book at the nurses station and that resident alarms were checked every shift also. Nurse # 1 stated a church group met in the dining room that evening and exited the employee door out to the parking lot adjacent to Ennis Street. On 2/22/12 at 12:08 pm all exit doors were checked by the Director of Nursing (DON) and	F 323		

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F 323	Continued From page 8 found to be functional. The DON indicated she also reviewed the daily documented checks of the wander guards done by Restorative Nursing and initialed the records when she completed the review and that the 3-11 shift nurse and the 11-7 shift nurse also checked the exit door alarms for function and documented the checks on the daily staffing sheet. Record review of the Restorative Nursing sheets and the staffing sheet revealed the above mentioned checks were initialed as being completed on 12/9/11 the day Resident # 2 eloped. On 2/22/12 at 12:25 pm the Maintenance Supervisor was interviewed and maintenance records were reviewed. The Maintenance Supervisor indicated all exit doors were checked weekly, usually first thing on Monday morning. He indicated each door was equipped with a Mag-Lock Alarm system and an additional keyed alarm. The Maintenance Supervisor indicated the additional keyed alarm was added to the employee entrance door the evening of the elopement on 12/9/11 and that since 12/9/11 weekly checks of each door was documented and reviewed by the Administrator. On 2/23/12 at 4:20 pm Dietary Aide # 1 was working at the facility and identified the approximate location he first saw Resident # 2 outside. He indicated the resident was on the sidewalk adjacent to the 300 hall (West Wing) of the facility at the back of the building adjacent to the employee parking lot which exits to Ennis Street. The resident's location was approximately 50 feet from the employee entrance door, which is the door near where the church group was seen. He stated there were probably eight or	F 323		

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F 323	Continued From page 9 nine people in the church group but not sure as it was " kinda dark " . He stated he did not hear a door alarm. On 2/23/12 at 5:00 pm Nurse # 1 was working at the faiclity and identified the apporximate location she found the resident lying on the drive way near the dumpster. The location was to the back of and adjacent to the far side of the West Wing (300 Hall) approximately 110 feet from the employee entrance. Nurse #1 stated she was assisted by Nurse # 2 and another staff person she did not know by name. Nurse # 1 stated she was " pretty sure-almost positive " the alarm sounded when the resident was brought back inside through the employee door. On 2/24/12 at 8:45 am a telephone interview was conducted with the technician who serviced the Mag-Lock Door alarm system at the facility on 12/9/11. The technician stated he was called to the facility to check the system and was told the door did not lock down when a resident had a tag (transmitter) on and left the building. The technician stated he checked the voltage connections and checked the system repeatedly with a transmitter and the system worked each time. On 3/7/11 at 3:55 pm and interview was conducted with Nursing Assistant # 3 who stated she often cared for Resident # 2 and was assigned to Resident# 2 on 12/9/11. She indicated Resident # 2 was alert but became confused at times. She gave the example that the resident was told not to stand up unassisted out of his wheelchair, but he did not understand. NA # 3 stated Resident # 2 self propelled around	F 323		

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F 323	Continued From page 10 the facility in his wheelchair and she had seen him in the TV room and going for coffee to the dining room. She indicated if some one else was going out the smoking door the resident might try to go out also and she had re-directed the resident away from the door, telling him he could not go out and turned the wheel chair away from the door. She stated the wander guard set off the door alarm the time she re-directed the resident away from the door. NA # 3 stated she signed off the Elopement Sheet for Resident # 2 on the evening of 12/9/11 and had last seen the resident outside smoking with the nurse around 6:45 evening of 12/9/11 and had last seen the resident outside smoking with the nurse around 6:45 pm. She stated she then when to assist another NA and did not see the resident again until she heard he was found outside. She stated she did not notice any thing different or unusual about the resident ' s behavior on 12/9/11. She stated the resident ' s wander guard was in place on his ankle but she did not recall what the resident was wearing. NA # 3 stated she was not the nursing assistant who assisted the resident when he was outside on 12/9/11 and stated to her knowledge the resident had not left the building unsupervised before. On 3/8/12 at 2:36 pm a telephone interview was conducted with the facility's previous Activity Director. The Activity Director stated her last day of employment at the facility was 12/7/11 therefore she did not have any knowledge of what occurred at the facility on 12/9/11. The Corrective Action for Past Non Compliance included:	F 323		

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F 323	Continued From page 11 1. The resident was immediately, 12/9/11, placed on action rounds which consist of the staff ensuring his location every 30 minutes within the facility to prevent leaving the facility unsupervised. 2. Administrator immediately, 12/9/11, called the Maintenance Supervisor to come and check the Code Alert System to ensure it was functioning properly and to call Modern Systems to come to facility as an emergency situation to ensure the system was working properly. This was completed by 10:15 p.m. on 12/9/11. Modern Systems could not determine a problem with the system itself, but did turn up the receptors as far as they could go to ensure better reception. 3. Administrator directed Maintenance Supervisor, 12/9/11, to place a keyed alarm box over the door used to egress as a secondary alarm just in case system did not function properly. The alarm is turned on by the Maintenance Supervisor Monday through Friday at 3:00 pm each day and then turned off at 7:00 am each morning or when Administrative Staff Person listed arrives for duty. The Weekend Nurse Manager is responsible for this task on Saturday and Sunday. If the Maintenance Supervisor is absent the Administratior is responsible to complete this task and as a third back-up if the other two are not here the Clinical Services Nurse will complete this task. 4. Charge Nurse was instructed by Clinical Services Nurse 12/9/11 to do 30 minute action rounds on all of the residents with wander guard bracelets until Modern Systems arrives and states the door is working properly. 5. Administrator instructed Charge Nurse on 12/9/11 to in-service all staff (including non-nursing staff) on the following topics a. If a resident is found outside by any staff	F 323		

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F 323	Continued From page 12 member they are not to leave that resident for any reason. b. The staff member should keep trying to redirect the resident until they can get them back into facility or into a safe place. c. If staff members have a cell phone call facility and let the other staff know you need assistance; do not leave the resident. d. All staff members were informed that a key alarm had been placed over the door and the alram must be left on at all time after 3:00 p.m. In-service was completed by Charge Nurse for 2nd and 3rd Shift on 12/9/11. 6. Administrator then instructed Clinical Services Nurse to in-service the weekend staff concerning the items listed in # 5. This was completed on 12/10/11 and 12/11/11 by Clinical Services Nurse. 7. Administrator completed another in-service with all of the staff on 12/12/11 as a repeat of the 12/9/11 to ensrue all staff had been in-serviced and understood new procedures implemented. The content was same as listed in # 5 and she re-iterated the importance of never leaving a resident unattended. 8. The maintenance Supervisor is responsible to check the Mag Lock system on a weekly basis to ensure they are working properly and documents completion of this in Log Book on QA rounds Check List. The first check was done on 12/9/11 and continues as a QA process. The Administrator reviews his Log Book on a weekly basis to ensure teh QA checks are being completed during teh weekly QA Committee Meeting. 9. The Restorative Aides are responsible to check the Code Alert bracelets that are on residents at risk for elopement on a daily basis.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 02/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 13 This is documented in a Log Book on QA Rounds Check List. The Director of Nursing and the Administrator reviews the Log Books on a weekly basis to ensure teh QA Checks are being completed at teh weekly QA Committee. This was a system always in place however teh information required on the QA Form was changed 12/12/11 to reflect teh expiration date adn serialnumber to ensure the bracelet alarm had not expired. 10. Upon admission all residents have an Elopement Assessment completedto determine if they are at risk for elopement. If determined they are at risk a Code Alert bracelet is placed on the resident on day of admission. This is not a new system, this is to reiterate the process. 11. The Church groups present on 12/10/11 and 12/11/11 was talked to by the Clinical Services Nurse and informed them they are not allowed to let any resident exit the facility without a staff member present. 12. On 12/12/11 the Activities Director called all Volunteer Groups to inform them they are not to let any resident exit the facility. This list was obtained from the groups that she spoke to on 12/12/11. 13. The night-time activities were moved on 12/12/11 from the dining room to the recreation room which is located on the East Hallway which is visible to the Nursing Staff for closer supervision. The facility's Quality Assurance Committee is responsible for reveiwing all records and documentation to ensure that compliance is maintained. The Corrective Action Plan was signed and dated	F 323		

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F 323	Continued From page 14 by the administrator on 2/23/12. On 2/23/12, surveyors validated through observation, record reveiw and staff interviews the facility's compliance with the Corrective Action for Past Non-Compliance. Direct care staff interviewed were aware of facility expectation of what to do if a resident is found unsupervised outside, could locate the Elopement Risk Sheets and explain facility policy for use and were aware of residents on the Elopement List. Licensed staff interviewed was aware of responsibility to check and document wander guard placement each shift. Record review revealed daily function of wander guards was tested by restorative nursing and reviewed by the Director of Nursing, and weekly checks of all exit door alarms was completed and documented by the Maintenance Supervisor. The Administrator indicated during an interview on 2/23/12 at 5:30 pm that quality assurance measures continued as indicated in the Corrective Action Plan.	F 323		