

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

PRINTED: 02/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345553	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2013
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF FAYETTEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 71ST SCHOOL ROAD FAYETTEVILLE, NC 28314	
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F 000	INITIAL COMMENTS	F 000		
F 323 SS=J	<p>F 204-D amended - resent statement of deficiency on 12/20/13. IDR held 1/27/14. F 204 deleted.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to prevent 1 of 4 sampled cognitively impaired resident who was at risk for elopement from exiting the facility without staff knowledge (Resident #1).</p> <p>The Immediate Jeopardy began on 10/20/2013 when Resident #1 exited the facility unattended by the facility staff, and was found outside of the facility in the parking lot in his wheelchair. The Immediate Jeopardy was removed on 11/8/13 at 5:45 pm when the facility provided an acceptable Credible Allegation of Compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full implementation and monitoring their corrective action.</p>	F 323	<p>This plan of correction will serve as compliance with requirements of 42 CFR, Part 483, and Subpart B for long term care facilities. Preparation and submission of this plan of correction is in response to HCFA 2567 for the 11-7-13 - 11-8-13 survey and does not constitute an agreement or admission of Autumn Care of Fayetteville of the truth of the facts alleged or the correctness of the conclusions stated on the statement of deficiencies. This plan of correction is prepared and submitted because of the requirements of 42 CFR, Part 483, and Subpart B throughout the time period stated in the statement of deficiencies. In accordance with state and federal law, however, submits this plan of correction to address the statement of deficiencies and to serve as its allegation of compliance</p>	12/2/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/02/2013

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	<p>Continued From page 1</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 4/4/2013. Diagnoses included chronic airway obstruction, diabetes, dehydration and dementia.</p> <p>The admission Minimum Data Set (MDS) dated 4/11/2013 indicated Resident #1's cognitive status was severely impaired and extensive assistance of one person was required with transfers. The assessment further indicated the resident was independent with locomotion on the unit and used a wheelchair for locomotion. The resident was not coded for wandering behavior.</p> <p>A review of Resident #1's care plan dated 4/26/2013 revealed the resident was identified with behavior/ moods needs. The goal stated for this problem was that the resident behavior would be easily altered as needed through next review. Interventions listed for this problem included "monitor wandering."</p> <p>A review of the nurse's note dated 5/23/2013 read "Resident wandering around the halls in facility. Wander guard placed to right lower extremity. Wander guard checked for proper functioning."</p> <p>A review of the nurse's note dated 6/4/2013 stated "When up in wheelchair he propels himself aimlessly around corridors and out of other rooms."</p> <p>The resident was also care planned on 7/12/2013 for elopement risk needs, wander guard bracelet needs, need for cueing, re-direction, distracting, wandering, cognitive impairment and poor safety awareness. The goal stated for these problems were "resident will have no elopements through</p>	F 323	<p>with the pertinent requirements as of the dates stated in the plan of correction and as fully completed as of 12-2-13.</p> <p>For the resident found to be affected, on 10/19/2013 at 1530, a wander-guard was not observed on resident #1 by the licensed charge nurse, she made the decision to not replace. On 10/20/2013, Resident was found outside in front of the facility. This facility identified Resident #1 was an elopement risk on 10/20/2013 after resident was observed outside of the facility. The licensed nurse who observed resident assisted him back into facility, and reported to charge nurse. Charge nurse immediately applied wander-guard and scheduled into the resident's chart that a licensed nurse check placement and functioning every shift, on-going of resident #1 wander-guard. Nursing staff were in-serviced on 10-20-13 to inform staff of elopement risk by charge nurse. There was no harm or injury or negative outcome for resident #1.</p> <p>For other resident's with the potential to be affected, on 10/21/2013 each resident in house had an elopement risk assessment completed by two RN supervisors. After completion of elopement risk assessment, any resident who was deemed an elopement risk, a wander-guard was placed on the resident. Any new admitting residents will have an elopement risk assessment completed on admission, and then a follow up elopement risk assessment will be completed within a week after admission by licensed nurse. Then an elopement</p>		

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F 323	<p>Continued From page 2</p> <p>next review and resident ' s safety needs will be met daily by staff through next review."</p> <p>During the interview with the Minimum Data Set (MDS) coordinator on 11/8/2013 at 1:30 PM, she was asked the reason the wander guard was placed on the resident's ankle in May 23, 2013. The MDS coordinator stated that the wander guard was placed on the resident's ankle because other interventions had been tried and failed to prevent the resident from wandering and being an elopement risk.</p> <p>A review of the activity's note dated 9/4/2013 indicated " Resident often enters other resident's rooms as he is confused that the room is not his. When redirecting resident he raises his voice to staff. Will continue to monitor."</p> <p>A review of the nurse's note dated 10/2/2013 read "Patient alert, wandering this shift, continue to redirect. No acute changes noted this shift."</p> <p>A review of the nurse's note dated 10/4/2013 documented "Pt (patient) alert, wandering this shift, continue to redirect. No acute changes noted this shift."</p> <p>A review of the nurse's note dated 10/20/2013 indicated "Charge nurse notified resident outside facility, resident escorted back in facility by hall nurse. Unit manager and Director of Nursing (DON) notified. Wander guard placed on resident right ankle. Monitoring will continue."</p> <p>A review of the incident report dated 10/20/2013 stated "the resident found outside." Under the comments headlines section, the incident report read " wander Guard replaced."</p> <p>The elopement risk assessment completed on</p>	F 323	<p>risk assessment will be completed at least quarterly and as deemed necessary by licensed nursing staff. Licensed nursing was in-serviced on 11-8-13, 11-9-13, 11-11-13, and 11-12-13 by the Director of Nursing, RN Supervisor, Staff Development Coordinator, or Administrator.</p> <p>All staff in facility was in-serviced on wander-guard function and purpose for a wander-guard, and for residents who may be exhibiting behaviors of possible elopement risk by the Director of Nursing, RN Supervisor, Staff Development Coordinator, or Administrator. The in-service dates were; 11-8-13, 11-9-13, 11-10-13, 11-11-13, 11-12-13, 11-13-13, 11-14-13, and 11-18-13.</p> <p>All Nursing staff was in-serviced on how to monitor wander-guards, how to document on wander-guards, and for licensed staff to monitor the documentation of wander-guards using the TODO list from the EHR by the Director of Nursing, RN Supervisor, Staff Development Coordinator, or Administrator. The in-service dates were; 11-8-13, 11-9-13, 11-10-13, 11-11-13, 11-12-13, and 11-14-13.</p> <p>If a wander-guard has been placed on resident, the Director of Nursing or designee will have authority to give approval for removal of wander-guard. This approval will be granted, once an elopement risk assessment has shown the resident is no longer an elopement risk.</p> <p>For on-going compliance, any resident, who has a wander-guard placed, will have</p>		

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F 323	<p>Continued From page 3</p> <p>10/21/2013 revealed the resident had a score of 22(which meant that the resident was a high risk for elopement).</p> <p>During an interview with Nurse #1 on 11/7/2013 at 10:50 AM, she reported that Resident #1 had a wander guard on his ankle and the staff was required to check the wander guard on the resident ' s ankle each shift. Nurse #1 also stated that Resident #1 was confused about the location of his room and the staff usually reoriented the resident where his room was located.</p> <p>During an interview with Nurse Aide (NA) #1 on 11/7/2013 at 11:00 AM, she indicated that Resident #1 was confused and wandered into other residents' rooms. NA #1 further reported that Resident #1 at times had been observed pushing on the 500 hall exit door. NA #1 added that Resident #1 usually made statements that he wanted to see his wife. NA #1 elaborated that she heard a report from Nurse #2 that on 10/20/2013, Resident # 1 was found outside the facility.</p> <p>During an interview with the Director of Nursing (DON) on 11/7/2013 at 11:30 AM, when questioned how did the facility become aware that Resident #1 was not physically present in the nursing facility, she stated that Nurse #2 was leaving the facility on 10/20/2013 at 3:00 PM and observed the resident sitting outside the facility at the main entrance. The DON added that Nurse #2 wheeled the resident back into the facility and notified the charge nurse that Resident #1 was found outside. The DON further reported that during the facility's investigation, it was discovered that the resident did not have a wander guard on his ankle when he exited the building. She indicated that the staff could not</p>	F 323	<p>it checked Q-shift for placement and function daily by the licensed nurse. The results will be documented in the resident's chart each shift by the licensed nurse. The Director of Nursing or Designee will monitor the licensed nurse TODO List (task/interventions completed for the assigned licensed nurse) to ensure the wander-guard has been tested and checked for placement Q-shift. Director of nursing or designee will monitor this three times a week for four weeks, then monthly on-going.</p> <p>Any resident who is identified as an elopement risk will be added to our Patient at Risk meetings. These residents will be monitored weekly for four weeks, then monthly on-going. The Administrator or designee will monitor patient at risk meeting, weekly for four weeks, then monthly for two months. The meeting will be monitored to ensure any resident at risk for an elopement has been addressed appropriately.</p> <p>To ensure understanding of how to identify a resident at risk for elopement, Director of Nursing or designee, will interview three staff members weekly for four weeks, then monthly for two months.</p> <p>A summary of the audits and their effectiveness will be taken to the Q.A. committee for review and approval. In the interim, the administrator will monitor their effectiveness.</p>		

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F 323	<p>Continued From page 4</p> <p>trace the location of the wander guard when the resident was found outside and brought back into the facility. The DON concluded that the last time the wander guard was checked by the staff was before the resident exited the building on 10/19/2013.</p> <p>During a follow up interview with NA #1 on 11/7/2013 at 2:40 PM, she reported that she was regularly assigned to Resident #1 and that she regularly had to move Resident #1 from the exit doors and at times she had to call the resident ' s responsible party to calm him down. NA #1 acknowledged that on 10/20/2013 she was working on 1st shift and did not check to make sure that the resident had on the required wander guard. NA #1 stated that Nurse #2 informed her that the resident was found outside the building in the parking lot and that an elderly couple was in the process of driving out of the parking lot and almost hit the resident with the vehicle.</p> <p>During an interview with Nurse #3 on 11/7/2013 at 3:15 PM, she reported that on 10/20/2013, Resident #1 was brought back into the facility from outside the building by Nurse #2 who indicated to her that the resident was found outside the building. Nurse #3 further reported that the resident must have left the facility around 3:00 PM after the activities. Nurse #3 stated that the wander guard was not observed on Resident #1's ankle on October 19, 2013, so she discharged the wander guard order in the computer. Nurse #3 added that Resident #1's wander guard was replaced on 10/20/2013 after the resident was found outside the nursing facility and was brought back into the facility.</p> <p>During a phone interview with Nurse #2 on</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>11/7/2013 at 3:30 PM, stated that she was leaving the building on 10/20/2013 at 4:30 PM, when she saw Resident #1 outside in the parking lot. She reported that she observed an elderly couple in their car actively pulling out of the parking lot and appeared not to have seen the resident in his wheelchair. Nurse #2 reported that she had to stop the elderly couple from running over the resident who was sitting in his wheelchair beside the car. Nurse # 2 stated that she wheeled Resident #1 back into the building and reported the incident to Nurse #2 who was the charge nurse. Nurse #2 added that Resident #1 was an elopement risk and that he would always go into other resident's rooms and tried to push on the exit doors. Nurse #2 concluded that she did not recall seeing a wander guard when she found the resident outside.</p> <p>An interview with the charge nurse (Nurse # 4) on 11/7/2013 at 4:00 pm revealed that on October 19, 2013 Resident #2, who was a new admission, exited the building. So she removed Resident #1's wander guard and placed it on Resident # 2's ankle. Nurse # 4 further added that there were no extra wander guards in the building because the Administrator was the one who ordered the wander guards</p> <p>During an interview with the Administrator on 11/7/2013 at 3:00 PM revealed, the staff did not know when the wander guard became missing though the staff documented that they had observed the wander guard in place on the resident's ankle. The administrator stated that after the resident exited the building that was when they realized that the resident did not have the wander guard intact on his ankle. He added that the staff searched for the wander guard but they could not locate it in the building. The</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>administrator acknowledged that only a staff member could have taken the wander guard off the resident's ankle, because someone must use a scissors to take it off.</p> <p>During a follow up phone interview on 11/8/2013 at 10:00 AM, Nurse #2 reported that she saw Resident #1 last time at the nurse's station at 3:30 PM on 10/20/2013. Nurse #2 further added the next time she saw the resident was at around 5:00 PM when she was driving home and saw the resident next to the handicap parking when a car was pulling out. She stated that she stopped her car, got out, and wheeled the resident back into the facility. Nurse #2 indicated that she could not know how long the resident had been outside. She added that Resident #1 usually did not stay in any activity, so he would not have been in the church activities on 10/20/2013.</p> <p>During an interview on 11/8/2013 at 11:00 AM, the Activity Director reported that Resident #1 normally wandered throughout the unit and did not stay in one place for a long period of time. The activity director elaborated that the resident had never been known to stay in an activity until an activity ends. She indicated that the resident never participated in any activities. The activity director reported that the resident would come in the activity room and leave after a short period of time. She concluded that she did not believe that the resident could have stayed in the church activity for one hour on 10/20/2013.</p> <p>During an observation of the building on 11/8/2013 at 1:00 PM revealed the distance from the activities room to the main entrance door was 342 feet and 90 feet from Resident #1 's room. The main entrance doors were not automatic but manual doors. Further observations of the building revealed there were no door openers for wheel chair by the main entrance doors. There</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>were no alarms by the exit doors and the employees had a code that they had to use in order to exit the building. The facility parking lot was observed to be busy with vehicles coming and leaving, and the handicap section where Resident #1 was located could not be seen from inside the building</p> <p>During an interview with the Administrator on 11/8/2013 at 2:00 PM, he stated that they had replaced Resident #1 wander guard and audited current residents with wander guards in the facility on 10/21/2013. He further reported that the ongoing compliance was to monitor all wander guards 5 times per week for one month beginning 10/21/2013, then weekly for 3 months. The administrator stated that the unit manager was responsible for keeping up with residents ' who had wander guards at in the facility.</p> <p>The administrator was notified of the Immediate Jeopardy on 11/8/2013 at 11:35 am.</p> <p>The facility provided the following Credible Allegation on November 8, 2013 at 5:15 pm:</p> <p>Credible Allegation of Compliance:</p> <p>Resident #1 was admitted to facility on 04/04/2013 and on 10/20/2013 resident was observed in the parking lot outside facility. Resident was brought back into the facility by licensed nurse who observed him sitting outside at which time Unit manager and Director of Nursing were notified. A wander-guard was place on resident at that time. Resident Power of Attorney was notified. Elopement risk was perform on 04/04/2013 day of admission by licensed nurse doing the admission risk assessment and indicated that resident is not considered an elopement risk. However with his course of stay, resident noted to be confused,</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>disoriented and having wandering behaviors inside facility. On 10/21/2013 after resident was observed outside of the facility an elopement risk was completed by RN supervisor which indicated resident is an elopement risk.</p> <p>For the resident affected Resident had wander-guard in place starting 5/23/2013, then on 10/19/2013 at 3:30 PM, wander-guard was not observed on resident #1 by the licensed charge nurse, and she made the decision to not replace. Resident had an elopement on 10/20/2013, outside facility in parking lot. This facility identified Resident #1 was an elopement risk on 10/20/2013 after being observed outside facility in parking lot. Licensed nurse who observed resident assisted him back to his hall nurse, to his unit and reported to charge nurse. Charge nurse immediately applied wander-guard. There was no harm or injury or negative outcome for resident #1.</p> <p>For other resident ' s with potential to be affected On 10/21/2013 each resident in house had an actual elopement risk assessment completed by two RN supervisors. After completion of elopement risk assessment, two others resident, Resident # 4 and Resident # 5 were identified at being at risk for elopement. For Resident # 4, elopement risk assessment was completed on 08/09/2013, and was not considered an elopement risk. For most recent elopement risk on 10/21/2013, Resident # 4 was identified as an elopement risk and wander-guard was place on resident 10/27/2013 and licensed nurse to document placement and function every shift, ongoing. For Resident # 5, elopement risk assessment was completed on 08/12/2013 which</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>indicated resident was an elopement risk, RN completing 8/12/2013 elopement risk assessment made the clinical decision not to place wander-guard on resident due to no efforts have been made to leave facility and had limited physical mobility. Most recent elopement risk assessment was 10/21/2013, identified resident to be at risk for elopement and wander-guard put in place on 10/27/2013 and licensed nurse to check placement and functioning every shift , on-going.</p> <p>Facility action plan to prevent re-occurrence Once wander guard has been placed on resident, the Director of nursing or assistant director of nursing, or licensed nurse will have authority to give approval for removal after reviewing elopement risk assessment in conjunction with care plan team, ongoing.</p> <p>All facility exit/entrance doors are locked at all times, requiring key pad entry with exception of the front-main entrance door, which are locks automatically as programmed. Current times include seven in the morning; doors will unlock and at six in the evening doors will lock down daily, seven days a week. Starting 11/8/2013, front - main entrance door has been programmed to unlock at nine in the morning and lock at five in the afternoon. During the times the front door is programmed to be unlocked (9-5), there will be a reception at the desk at all times, ongoing (reception included in the facility wide in-service).</p> <p>For new admission, an elopement risk assessment will continue to be completed by RN supervisor, Director of Nursing, or designee on day of admission, ongoing. In addition, the RN</p>	F 323			

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(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	<p>Continued From page 10</p> <p>supervisor will schedule an elopement risk assessment in the electronic medical records to be completed on day seven after admission by the license nurse, ongoing. In the event once assessment completed, resident is considered to be an elopement risk, the licensed nurse completing the assessment will either place a wander-guard or assign one to one assignment(certified nursing assistant and one resident) monitoring for the resident, ongoing. Quarterly elopement risk assessment will be completed on all residents by licensed nurse, ongoing.</p> <p>Residents who are identified to be an elopement risk will be reviewed in Patient at Risk meeting weekly, which consist of Director of Nursing, RN supervisor, and dietitian, X 4 weeks then monthly, ongoing. For those residents who have a wander-guard in-place, it will be scheduled in the electronic health record, to be documented placement every shift by the licensed nurse, ongoing. It will be documented checking function by using the tester every shift, ongoing. The licensed nurses are required to complete a To-Do-List (task/interventions that are scheduled to be completed by licensed nurse and certified nursing assistant on their shift for their assigned hall). At the end of each shift the license nurse will print the To-Do-List to ensure there is not any task or interventions left not completed by the licensed nurse or certified nursing assistant, ongoing. In addition to completing To-Do-List, the license nurse off-going and on-coming license nurse will validate by signing the To-Do-List that there are no task or interventions left not completed prior to leaving the facility, ongoing.</p> <p>Facility will maintain 3 additional wander-guard</p>	F 323			

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

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F 323	<p>Continued From page 11</p> <p>bracelets, in the event there are no wander-guards available when resident has been identified to be at risk for elopement, one to one assignment (one certified nursing assistant and one resident) will be initiated until wander-guard can be obtained.</p> <p>In-services provided to ensure sustained compliance Licensed staff in-serviced by staff development or designee beginning 11/8/2013, on their responsibility as it relates to completion of the elopement questionnaires which identifies residents to be at risk for elopement. All license nurses will be in-serviced on interventions to be put in place once identified to be at risk. (Intervention will either be one to one assignment (one Certified nursing assistant with one resident) or wander-guard bracelet All licensed nurses will be in-serviced prior to their next scheduled tour of duty by staff development or designee .</p> <p>Licensed staff in-serviced by staff development or designee beginning 11/8/2013 on responsibilities of ensuring all task and interventions are completed timely on their assign shift. By completing a To-Do-List (task/ interventions that are scheduled to be completed by the licensed nurse and certified nursing assistant on their shift for their assigned hall). Licensed nurse will be in-serviced prior to the next scheduled tour of duty by staff development or designee. Licensed nurse in-serviced by staff development or designee beginning 11/8/2013 on scheduling of elopement risk assessment seven days after admission. Licensed nurse will be in-serviced prior to the next scheduled tour of duty by the staff development or designee. All staff in-serviced by staff development or designee</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>beginning 11/8/2013 on Resident at risk for Elopement and wander-guard bracelet, ensuring placement and function, and notifying all staff of current residents that are at risk for elopement. All staff in-serviced to ensure that all staff are aware of resident at risk and the need to be aware doors, visitors and other staff exiting building, and report to supervisor any elopement behaviors-example-resident shaking exit doors. To provide basic supervision during routine care rounds to ensure resident safety. Staff will be in-serviced prior to shift ending on 11/8/2013. All staff will be in-serviced prior to the next scheduled tour of duty by the staff development or designee. Patient at Risk team members (Director of nursing, RN supervisor, and dietitian) in-serviced starting 11/8/2013, for review of resident identified to be at risk for elopement, monitored x 4 weeks, then monthly, ongoing. Staff will be in-serviced prior to shift ending on 11/8/2013</p> <p>All staff will be in-serviced by staff development or designee beginning 11/8/2013 on what constitutes decision to remove wander-guard. All staff will be in-serviced prior to the next scheduled tour of duty by the staff development of designee.</p> <p>On 11/8/13 at 5:15 pm, verification of the credible allegation was evidenced by interviews of all staff related to identifying residents at risk for elopement, ensuring placement and function of the wander guard. The staff was also aware of whom to report the elopement behaviors.</p>	F 323			