

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

PRINTED: 03/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2016
NAME OF PROVIDER OR SUPPLIER AVANTE AT THOMASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360	
(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	<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, staff interviews and observations the facility failed to have interventions in place to prevent 1 (Resident #2) of 4 sampled residents assessed to have exit seeking behaviors from exiting the facility while unsupervised.</p> <p>The Immediate Jeopardy began on 2/6/16 when the resident exited from the facility while unsupervised and was found by a bystander in the middle of the road in front of the facility. The immediate jeopardy was removed on 2/25/16 when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of systems put in place and 100 percent of employee training.</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on 10/2/15. Diagnoses included dehydration, acute kidney failure, asthma and dementia.</p>	F 323	<p>F 323 SS=J 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility will 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>On 02/06/2016 at approximately 4:45PM, the facility was notified by a visitor (female) "are you missing a resident"? Nursing Assistant #1 exited the building and retrieved resident #2 and returned him to the facility. Nurse #1 exited the dining room and met nursing assistant #1 and escorted resident #2 into the dining room. Upon entering the dining room, resident #2 alarm did not sound. Resident #2 returned to 200 hall nurses station. 100 hall nurse #1 reported to 200 hall nurse #3 of the elopement. Nursing Assistant #1 retrieved a new wander guard bracelet from the facility's central supply closet. Nurse #1 tested the bracelet by taking the bracelet to the front door of the facility which was armed and functioning with a wander guard alarm system. The new wander guard bracelet was tested and placed on resident #2 right ankle. Nurse #1 stated that on 2/6/2016, resident #2 had been returning to his previous room (room 103) on 100 hall, from 200 hall and that she, nurse #1 had not seen resident #2 for approximately 2 hours before the facility was notified that the resident was missing. The facility could not determine which door resident #2 exited from.</p>	

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

TITLE

(X6) DATE

Jan B. [Signature]

03/10/2016

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>A record review of the physician ' s order for Resident #2 written on 10/2/15 revealed an order to place wander guard, to check function every day and to check placement every shift.</p> <p>A record review of the Minimum Data Set (MDS) quarterly assessment dated 12/18/15 revealed the resident was severely cognitively impaired. The MDS indicated no wandering behavior was exhibited for this quarter. The resident did not require any assistance with bed mobility, transfers, walking in room or corridor, or with locomotion on and off unit. The MDS also specified the resident had a steady gait.</p> <p>A record review of the care plans for Resident #2 included wandering related to cognitive impairment written on 10/6/15. The goal was for the resident to remain in facility. Interventions included allowing resident to ambulate as desired on unit, check daily to ensure resident had a wanderer ' s bracelet on. This care plan was updated on 2/6/16 related to an exit out of facility on 2/6/16. The Interventions included to have resident returned to facility, assessed for injury, wander guard checked for function, wander guard checked for placement, every 15-minute checks initiated, order obtained to medicate as needed for restlessness and the Social Worker (SW) to seek placement in a secured facility.</p> <p>A review of a nurse ' s note written on 2/6/16 at 3:45 pm revealed Resident #2 had a room change on this day from the 100 Wing to the 200 Wing. Medications and the Medical Administrator Records (MARs) were given to the day shift nurse on the 200 Wing. A report was given to the nurse and Dietary was made aware of the resident ' s room change.</p>	F 323	<p>Continuation from Page 1</p> <p>The facility cannot determine with 100% accuracy why the wander guard bracelet did not alarm. At approximately 6PM, resident #2 was assessed for injury and vital signs were obtained by 200 hall nurse #3. No injuries were noted and vital signs were within normal ranges for resident #2. Nurse #3 documented resident #2 was pacing 200 hall looking for a way out to go home. Nurse #3 was unable to redirect. At approximately 7:20PM, Nurse #3 called the facility's contract physician assistant and received an order for 1 dose of Haldol 2mg intramuscularly. Nurse #3 administered 1 dose of Haldol 2mg intramuscularly injection in the right upper buttocks and documented the resident tolerated it well. Resident #2 returned to the common area on hall 200, from room 213 bed A, sitting at table with 2 other facility residents.</p> <p>On 02/06/2016, the facility staff initiated 15 minute checks on resident #2 for location and safety.</p> <p>On 02/17/2016 the 15 minute checks on resident #2 for location/safety were discontinued due to hospitalization.</p> <p>On 02/06/2016 at approximately 6:30PM, the director of nursing (DON) reviewed and updated the care plan for resident #2 to reflect wandering, elopement and status of new wander guard bracelet placement and function.</p>		

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F 323	Continued From page 2 A review of a nurse's note written 2/6/16 at 6:00 pm revealed Resident #2 was found outside of the building and escorted back inside. The note specified the wander guard was defective and was replaced with a new one. The resident's vital signs were: blood pressure 134/72, heart rate 82, respiration rate 20, and temperature was 98.5. A record review of a statement written on 2/8/16 by Nurse #1 revealed in part: " I was sitting at nurses station when a lady came to the desk and told me a male was outside in the road and he looked confused and she didn't know if he was a resident here and that she called 911. " Nursing Assistant (NA) #1 heard this and immediately went outside to check. I left and went outside to help look for the male, at which time, the NA drove in the parking lot with Resident #2. We walked him in the building and I told NA #1 his wander guard did not go off. We walked him to the 200 Wing and told Nurse #2 what happened. NA #1 said " I'm going to get a new wander guard " and I told her to give it to me. I then activated the wander guard and checked the exits to make sure it was working. I then put it on the patient and cut the old one off. I looked at the old one and noticed it was not pushed in/activated. An interview with NA #3 at 4:30 pm on 2/23/16, revealed the resident was always walking and talking. He did not try to exit but he was confused about his room. The NA noticed he didn't walk as much when they changed his room. He wore a wander guard. The NA reported the exit doors would only sound if the resident opened the door on Wing 100. She recalled a time on 11/19/16 that he did get out of the door on Wing 100. He	F 323	Continuation from Page 2 On 02/10/2016 the DON and Facility Services Director initiated weekly mock elopement drills for the next 4 weeks. On 02/10/2016, the Facility Social Services Director contacted the Health Care Power of Attorney/Responsible Party to discuss alternate placement (memory care) per safety. On 02/12/2016 Facility Social Services Director initiated communication with appropriate Long Term Care Centers which provide care to residents living with Alzheimer and/or Dementia related diagnosis. On 02/06/2016 the facility DON audited the February 2016 Treatment Administration Record (TAR) for resident #2. The TAR for resident #2 showed that the initial wander guard physician's order was written on 12/01/2015. The TAR wander guard audit for placement, which was checked each shift, showed no holes or missed documentation. The TAR wander guard for function, which was checked on the 11PM-7AM shift every day, showed no holes or missed documentation. On 02/24/2016 the facility administrator reviewed the February 2016 TAR for resident #2 to ensure accuracy. No holes or missed documentation for placement and function was observed.		

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F 323	<p>Continued From page 3</p> <p>was easily redirected back into the building.</p> <p>An observation on 2/23/15 at 4:45 pm revealed the facility had a total of seven exit doors. Two exit doors on the 100 Wing, two exit doors on the 200 Wing, the lobby exit door, an exit door which was called the back door that led to the smoking deck, and an exit door at the end of the service hall. The door in the lobby, the back door and the service door all had a monitor located to the side of the door. This monitor was set up to monitor resident wander guards. The two exit doors on Wing 100 and Wing 200 did not have this wander guard monitor. The exit doors were located at each end of each wing. Each of these exits had an alcove that led to the double doors. On the bilateral sides of this alcove, just as you enter, there were monitors on the wall about 1.5 feet up from the floor. The exit doors were noted to have a red fire alarm box on the side of the double exit doors. During this observation, both doors on the 100 Wing were able to be opened easily and no alarm sounded when the doors were opened. The 200 wing also had an exit door at each end of the wing and an alcove leading to the double doors to exit. Both exits on the 200 Wing also had the monitors just as you enter the alcove 1.5 feet up from the floor. A red fire alarm box was located on the side of the double doors. One of the two doors was able to be opened without an alarm sounding. The other door, the alarm sounded when opened. The doors were easily opened.</p> <p>An interview with the DON on 2/23/15 at 5:12 pm revealed the DON was responsible for checking the wanderguard system at each of the door exits with the wander guard monitor which included the lobby, the back door (smoke deck) and the</p>	F 323	<p>Continuation from Page 3</p> <p>2. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;</p> <p>On 02/06/2016 at approximately 6:45PM, the DON identified those residents having the potential to be affected by the same deficient practice.</p> <p>The DON identified 4 residents care planned with wandering behaviors. These residents were previously identified with wandering behaviors at the time of admission or once established as residents with wandering behaviors. At which time, the elopement-risk assessment was completed and the wander guard system/bracelet was tested and applied. Note: the elopement-risk assessment is Deemed appropriate for residents with exit seeking behaviors and/or repetitive verbally expressing desire to leave the facility.</p> <p>The DON, Unit Manager, LPN, Social Services Director, Activity Director, and Therapy Program Director meet weekly for quality of care and change-in-conditions to include behaviors enabling a multi-disciplinary approach to each resident's continuum of care.</p> <p>On 02/06/2016, Audit of Treatment Administration Record (TAR) by the DON showed physician orders for wander guard for the 4 residents.</p>		

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F 323	<p>Continued From page 4</p> <p>service entrance. The DON reported she checked these every day with the tester. To check the system, she opened the door and used the tester designed for the model of these wander guards to ensure the wander guard monitor was working. The doors should alarm if working correctly. The DON reported that all of them were in working order. During the interview, the DON opened both exit doors on the 100 Wing. Both doors opened without the alarm sounding. She reported, " I think they are suppose to sound. The Maintenance Director handles this. " The DON proceeded to the exit doors on the 200 Wing and it was found that one of the doors did not sound when it was opened. There were monitor devices on the bilateral sides of each of the exit area walls. They were 1.5 feet above the floor and screwed to the walls. The DON believed these would alarm if a wanderguard walked through it, but she was not sure.</p> <p>An interview with the Maintenance Director (MD) on 2/23/16 at 6:15 pm was conducted. The MD revealed the exit doors on each wing should alarm when opened. On the 100 Wing, when he opened both doors, they did not alarm. He was curious as to why it did not alarm and realized the fire alarm box to the side of the door had a key lock which showed the position of the lock in the off position. This was noted on both doors on the 100 Wing. The MD opened one of the doors on the 200 Wing which opened without sounding an alarm. He noted that this fire box alarm also had the key position in the off position. On the way to the 200 Wing, the MD stopped in his office to get the key to the fire alarm boxes. The other exit door on Wing 2 did alarm when it was opened and the fire alarm box was noted to be in the on position. The on position showed the key lock</p>	F 323	<p>Continuation from Page4</p> <p>On 02/06/2016 at approximately 6:45PM, the DON assessed each resident with a wander guard bracelet and observed all of them with correct wander guards placement and functioning. The DON validated the functioning of the wander guard of all 4 residents by utilizing the bracelet wander guard universal tester housed in the 200 hall med cart. Additionally, the DON obtained from the central supply closet 4 new wander guard bracelets with 90 day expiration parameters. Each new wander guard bracelet was engaged, tested and applied to each of the 4 residents. The rationale to replace each bracelet is to ensure manufacturer's recommendations and compliance with 90 day expiration; 02/23/2016 through 05/23/2016</p> <p>On 02/06/2016 at approximately 7PM, the DON completed an audit of Treatment Administration Record (TAR) for 4 residents which showed physician orders for wander guards. The DON verified documentation of TAR wander guard audit for placement, which was checked every shift and Treatment Administration Record (TAR) wander guard audit for functioning, which was checked on the 11PM-7AM shift every day. The purpose for obtaining physician's order per resident is to ensure that orders will show as printed on Treatment Administration Record for each month and allow for documentation as required by facility.</p>		

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F 323	<p>Continued From page 5</p> <p>going up and down. The off position showed the key lock going side to side. The MD locked all of these boxes at this time. The doors were tested again to confirm that they did alarm if opened when this fire alarm box was on. They all alarmed. The MD reported the monitors on the bilateral sides of each exit walls were not working, they were part of an old system. The MD was asked who held keys to the alarm boxes and he reported he had them but he did not know if anyone else did. He thought maybe the nurses kept one in their medication carts. The MD was asked who is responsible for ensuring that these doors are secured and he replied, I don ' t check the doors, I don ' t know who does. " I know the DON checks the wander guard doors everyday. " He then replied " I had no idea those doors were not locked. " The MD had no knowledge of any staff monitoring whether or not the exit doors were alarmed.</p> <p>An interview with Nurse #1 on 2/23/16 at 5:15 pm revealed she got a call from the Director of Nursing that day to transfer Resident #2 to the 200 Wing. The change was completed around 2:00 pm. Nurse #1 reported the resident kept coming back to the 100 Wing. The nurse stated " The next thing I knew, he was out of the building. " The nurse reported she realized it when a visitor came in and told her. At this time, NA #1 ran out to go and find him. The nurse went out to the front of the building to see if she could see him and saw him and the NA in a vehicle driving toward the facility. A person had picked them up and drove them back to the facility. The nurse and the NA walked him to the door of the 200 Wing.</p> <p>Nurse #1 reported she knew his wander guard was not working when he walked in through the</p>	F 323	<p>Continuation from Page 5</p> <p>On 02/06/2016 at approximately 8PM, the DON initiated staff in-service education for 100% staff regarding elopement risk protocols and procedures. In-service education was completed on 02/08/2016. Note: the DON completed a portion of in-service by telephone on 02/06/2016 on 2nd and 3rd shifts. The DON performed a mock elopement drill and documented results. The mock elopement drill was announced as Code 10 three (3) times over the facility's intercom system. Code 10 was called to a resident's room number and bed letter. Non-licensed/certified staff immediately began interior/exterior facility search. The facility nursing staff initiated resident headcount and within approximately 1.5 minutes the resident was located and announcement of Code 10 "All Clear" 3 consecutive times.</p>		

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F 323	Continued From page 6 back door (smoking deck) in the dining room. He had one on his ankle and it did not alarm when he walked through the door. She reported there is a device in the nursing medication carts to check the wander guard. If it turns green, it is working. The nurse said it was to be checked daily. She felt it was not activated due to the button not being pushed in. " You need a pen or a key to push in the button to activate it. It 's really hard. " The nurse did not know who placed the wander guard on the resident and if that person activated it. She reported that it could have just " popped " back out. The nurse reported she thought Resident # 2 was gone from the facility for approximately 15 minutes. He was not far, but did not know how far he got. The nurse futher added that the exit doors with the wander guard monitor do not lock when a resident with a wander guard is near them. The doors with the wander guard monitors will sound if the resident is only 2 feet away from the door. The nurse reported there is no system in place to tell which door is alarming when an alarm sounds. The staff just follow the sounds and check all the doors. Nurse #1 told the 200 Wing Nurse #2, he had gotten out. The nurse reported that prior to his transfer to another room he was not exhibiting exit behaviors. He would walk around in circles on the unit, and he would have to be shown where his room was. At times, he would attempt to push the door on 100 Wing open. When you walk into the 100 Wing and go to the right, there is an exit door that he would try to push but he couldn ' t open it. She reported you need a key. The resident had some increased confusion on this day due to the room change. An interview with Nurse #4 at 9:00 am on 2/24/16 on the 200 Wing revealed she does not check the	F 323	Continuation from Page 6 On 02/08/2016 the facility DON initiated the execution of elopement drills on varying shifts to run weekly for four (4) weeks, every other week for four (4) weeks, monthly for four (4) weeks, then quarterly and randomly. The facility has a total of 7 exit doors. Of the seven (7) facility doors, four (4) are emergency fire doors/exits (independent of each other and not tied into fire-panel) with each door being separately alarmed. Two (2) doors are located on the 100 hall and two (2) doors are located on the 200 hall. The alarm is turned on and off by a key. These keys are located in the medication rooms at each nurses' station on each of the 100 and 200 halls. Additional keys are kept with facility administrator, director of nursing and the facilities services director. When the door is opened and the alarm is in the "on" position, the alarm will sound. If and when the alarm is in the "off" position, each door will open without alarming. As of 02/25/2016 at 7PM, these 4 doors are being audited each day and each shift for functional status of alarm being in the "on" position. Each of these four (4) fire/exit doors are being audited/tested for function and/or key "on "position by the facility administrator seven (7) days per week on first and second shifts. The nurses on third shift, are ensuring the key "on "position is consistent with the diagram on the alarm unit is in "on "position.		

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F 323	<p>Continued From page 7</p> <p>doors to see if the alarm is on or off. The nurse reported the MD checks them and she was never instructed to check them. She reported she has a key on the medication cart if it sounds so that she can stop it from alarming. Nurse #4 said that she has never turned the alarms off, but she did not check to see if they were turned on.</p> <p>An interview with Nurse #5 at 9:15 am on 2/24/16 revealed that the nurse 's check the exit doors to be sure they are shut, not alarmed. She reported the MD checks the alarms, but she was not sure the last time they were checked.</p> <p>An observation of the Treatment Administration Record (TAR) at 9:15 am on 2/24/16, revealed that all four residents had a TAR in place for the wander guards. Each TAR was noted to have check placement of wander guard every shift and check operation of wander guard daily on the 11-7 shift. These were all signed off as being done by the nurses for each day for the month of February, 2016. Several attempts were made to contact the nurse who last checked the wander guard for Resident #2. These attempts were unsuccessful.</p> <p>An interview with Nurse #6 on 2/24/16 at 10:35 am revealed she was not aware of which residents had a wander guard. She also reported at this time she did not know how to check a wander guard for operation. She has never had to check one. She has only been working there for one week and she worked the day shift. She was not shown during orientation. The nurse reported that if a resident with wander guard tried to exit, the alarm would sound. She said she thought all the doors were suppose to alarm.</p>	F 323	<p>Continuation from Page 7</p> <p>The remaining three (3) doors are armed and alarmed with a Wander Guard System. These three (3) doors are located: one (1) at the front door entrance, one (1) at the dining room interior/exterior door leading to/from the resident smoking covered patio, and one (1) on the employee service hall leading to/from the employee parking lot.</p> <p>On 02/07/2016 the DON implemented an every day check of all doors equipped with wander guard in the facility to ensure operation of each of the three doors within the facility.</p> <p>On 02/24/2016 the wander guard manufacturing company was called due to 1 of 3 doors armed with the wander guard system was not functioning per manufacturer specifications (alarming upon approach).</p> <p>On 02/25/2016 the facility's regional services coordinator contacted the wander guard company technology support. The problem was identified and remedied. As of 02/25/2016 at approximately 9:15AM, 3 of 3 of the doors armed with the wander guard system are operating per manufacturer recommendations.</p>	

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F 323	<p>Continued From page 8</p> <p>An interview with NA #1 at 11:00 am at 2/24/16 revealed she arrived for work for the 2nd shift at 3:00 pm on 2/6/16. The NA did her first round with her assigned residents. She recalled a lady came in (visitor) and wanted to know if we were missing a patient. The time was between 4:30 pm and 5:00 pm. She knew it was this time because it happened before the dinner trays come out. They were unaware of a patient missing at this time. The NA reported she immediately went out toward the road in the front of building. An older couple pulled up in a car and asked if we were missing a resident. They told her to get in and took her further up the street to the left of building. The NA reported they just passed the facility driveway and she could see him from the car. He was standing on the left side of the street just before the street curved. At this time, he was not in the middle of the road. He was at the edge of the road. The road was a two lane paved road with a speed limit of 35 miles per hour. There were no sidewalks but each side had grassy areas. The area was primarily residential.</p> <p>The NA reported there were cars coming steadily in both directions at this time. The car she was in pulled off to the right. The gentleman driving the car got out of the car as did the NA. The NA reported she went towards the resident. The resident stated " I am going home. " The NA was able to convince the resident to get into the car and go back to the facility. While the resident was sitting in the car he stated again " I want to go home. " The resident was wearing blue jogging pants and hoodie made of nylon. He had no apparent injury. The sun was going down and it was getting colder. The temperature was 46 degrees. Once we got back to the facility, Nurse #1 and NA #1 walked him back into the facility</p>	F 323	<p>Continuation from Page 8</p> <p>As of 02/24/2016 all 7 of the facility's exit doors (means of facility egress) are being manned and monitored by facility staff 24 hours a day, seven days a week.</p> <p>The two (2) fire doors/exits on the 100 hall located between rooms 107/108 and 121 122 will be monitored by one (1) person positioned at the nurses' station as there is a clear " line-of-sight" to both fire doors exits.</p> <p>This rationale is also true for the two (2) fire Doors exits on the 200 hall located between rooms 207/208 and 220/221 with one exception; due to the location of the therapy gym, a predetermined position has been identified to ensure a consistent "line-of-sight". This predetermined position to be monitored by one (1) person is located between rooms 212 and 211. An added level of internal preventative monitoring will be added by installing wireless motion sensor alarm system. These motion sensor with alarms would be installed immediately inside the corridor leading from 100 and 200 halls up to the fire doors exits area measuring 10'x7'x9'.</p>		

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F 323	Continued From page 9 toward the 200 Wing. The resident had his wander guard on his ankle. The wander guard did not alarm as he entered the door by the smoking area. Nurse #1 stated "it's not working." The NA got another one. The Nurse tested the wander guard by using the tester in front of the monitored door they entered. The new wander guard was functioning and was placed on the resident. The NA reported the resident had never opened the exit doors, he just looked out the window. The NA explained that the wander guard worked by pushing a button in on the device to activate. There was a 90-day shelf life for the wander guard and an "activate by" date on the side of the unit. It is tested in front of the three doors that have the wander guard monitoring system. If it sounds when the door is opened, the wander guard is working. The fire exit doors on each wing do not alarm when the resident with a wanderguard goes near them. The alarm at the exit doors will only go off if you open the doors. The NA was not sure if the activating button could pop back out once it was pressed. She also did not know what the "activate by" date was on the wander guard that was not working. She stated she doesn't know if it went passed it's 90 days. She also reported there was no log maintained as to who got a wander guard and what the "activate by" date was when they applied the wander guard to a resident. The NA did not know which door Resident #2 exited. The NA did not recall hearing any alarms going off to alert that someone was exiting the building. The NA reported she did not call a Code 10 (an announcement made over the intercom system to inform the facility a resident had exited) because she just reacted quickly to get the resident to safety.	F 323	Continuation from Page 9 On 03/08/2016 the Wireless Motion Sensor Alarms were installed on the each of these four (4) fire/exit doors. The remaining three (3) Wander Guard System facility doors will be monitored by facility staff 24 hours a day, seven days a week. The one (1) door at dining room interior/exterior leading to and from the resident smoking covered patio is in direct "line-of-sight" of the business office manager as her office is located directly across the hall from the interior dining room door entrance. During standard operating hours and between the hours of 8:30 AM and 5:30 PM the business office manager will monitor the door to ensure the residents' safety and wellbeing. When the business office manager requires a break and/or lunch she will notify either the human resource manager, office, located immediately to her right, or the receptionist office, located immediately to her left, of the change of guards and for what length of time their assistance will be required. Other times than the business hours of 8:30 AM to 5:30 PM, the door will be manned by other staff at all times. The front door entrance door will be monitored at all times. On Saturdays and Sundays, the receptionist will position the facility telephone through the pass-through window and monitor the front door from the foyer/welcome area. This monitoring will occur from 8:00 AM until 5:00PM Both the dining room door and the front door will be monitored by other staff at all times when the receptionist and the business manager are not on duty.	

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F 323	<p>Continued From page 10</p> <p>During this interview, NA #1 was asked about the policy and procedure when a resident elopes. She replied that someone in the facility calls a Code Pink (which is now code 10), one NA checks the exit doors at each side of the hall, another NA checks the exit doors on the other side of the hall. Then they follow the sound of the alarms to try and figure out where it is coming from. They check all the exit doors and go outside. The NA does not recall if a code 10 was announced this evening because as soon as she heard the visitor ask if they were missing a patient, she left the building to go look for the resident.</p> <p>An observation was conducted on 2/24/16 at 12:50 pm. The front of the building faced a large grassed area with a smooth paved two lane road in front of the grassy area. The driveway to the facility had an entry and an exit. The entrance of the driveway was on the right side of the building. The exit driveway was on the left side of the building. The lobby exit which was monitored with a wander guard system, went out to a parking lot for visitors on the right side of the building. The back door (smoking area) which was monitored with a wander guard system exited to the middle of the exit driveway on the left side. The service exit which was also monitored with a wander guard system exited in rear of building. There were a total of four fire exit doors. At this time, an observation confirmed the location where Resident #2 was found outside of the facility on 2/6/16 was 500 feet to the left of the facility on the two way paved road as reported by NA #1.</p> <p>An Interview was conducted with the DON at 9:15 am on 2/24/16. The DON reported an incident</p>	F 323	<p>Continuation from Page 10</p> <p>On 02/24/2016, the facility secured a signed proposal from an outside company for the installation of a Secure Care Wandering and Locking System to be installed on 03/14/2016.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;</p> <p>On 02/24/2016 the facility DON implemented each Wander-Guard bracelet "function" be tested on each nursing shift and documented on the residents' Medication Administration Record (MAR)</p> <p>On 02/24/2016 the facility DON implemented each Wander-Guard bracelet "placement" be confirmed on each nursing shift and documented on the residents' MAR.</p> <p>On 02/24/2016 the facility DON implemented resident picture-books to be located at each facility door; for all facility and temporary agency staffing to be employed as door watchers.</p> <p>On 02/24/2016 the Human Resource Director implemented Agency/Contractor Orientation for "Door Watching Duties."</p> <p>To include but not limited to: Your post is your responsibility once you are assigned. Please do not leave your post without someone covering for you. Please stay alert. You are on a post that requires your complete attention to details, staff, visitors or residents approaching or using the door. Please – no headsets, headphones, blue-tooth device that will impair your hearing.</p>		

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F 323	<p>Continued From page 11</p> <p>report was not filled out for this elopement. She reported it was an over site that it was not done. She also reported no formal investigation was completed. She did not obtain statements from the staff regarding the incident.</p> <p>An interview with the MD at 11:30 am on 2/24/16 revealed there was no system in place for who checked the alarms at the exit doors. The keys to turn the alarm on and off were kept in the nurse ' s medication carts and the MD also had a key.</p> <p>An observation of a demonstration by the facility staff was done on 2/24/16 at 1:30 pm. A resident with an activated wander guard was taken to each wander guard monitored door. As the wander guard approached the lobby door, the system did not alarm. Once the door was opened, the alarm sounded. The wander guard was then taken to the service entrance doors. Again, the system did not alarm as the door was being approached. The alarm sounded once the door was opened. As the wander guard approached the back doors (smoking deck), the alarm sounded. The doors remained closed.</p> <p>An interview with the MD at 2:20 pm on 2/24/16 revealed the alarm should sound when a resident wearing a wander guard is approaching a door with the wander guard monitor system. It was explained that during the demonstration, the alarm did not sound in the lobby entrance and the service entrance until the resident opened the door. The alarm sounded at the back door (smoking deck) when the resident approached the door, but the doors remained closed. The MD was not sure why it was not alarming as you approach the doors. The MD was unclear as to</p>	F 323	<p>Continuation from Page 11</p> <p>You must be available to hear alarms. you will be asked to log your name on the " Exit Door-Watch Sheet", you will also be logging in every half hour and initialing that you are in place and there is no suspect activity .If you have anything that you feel is unusual or out-of-place</p> <p>PLEASE ALERT THE NURSE OR A MEMBER OF THE LEADERSHIP TEAM IMMEDIATELY.</p> <p>You may be asked to move to another location during your shift. Please know that we are covering 7 doors and it is important to remember that you are on a flexible 'team' and moving around for coverage may be necessary. If you are unable to work your shift CALL COMMUNICATE IMMEDIATELY Additionally, the orientation covered: Fire Safety, Resident Rights, Elder Justice Act, Elopement & Harassment Policies and company dress code. Note: this orientation process is for "temporary agency staffing".</p> <p>On 02/24/2016 both facility and temporary agency staffing were employed as door watchers. The seven (7) facility doors were staffed each day and each shift and " Exit Door-Watch Sheet" were implemented. On certain shifts during the door-watching periods, multi names appear on some Watch Sheet as personal breaks were observed, personnel changed due to availability and duration of availability, (i.e. call-outs, child care needs, and/or tardiness of arriving personnel).</p>		

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F 323	<p>Continued From page 12</p> <p>when the wander guard monitors should alarm. He confirmed he did not know if it should alarm as you approach the door or if the door was opened. The manufacturers information was requested at this time from the MD and DON.</p> <p>An interview via phone with NA #6 at 2:48 pm on 2/24/16 revealed she worked on the 100 Wing on 2/6/16 7am - 7pm on weekends. She did not take care of Resident #2 this day. She knows that he did have a room change from the 100 Wing to the 200 Wing. The NA reported she recalled a female visitor come into the facility (unknown time) and reported there was a patient in the middle of the road. She did not participate in the search for the resident as she was not aware until after he was brought back in. Additionally, she did not assist with moving the resident and his belongings from one wing to the other. She reported the last time she saw the resident was approximately 1:00 pm, but she could not say for certain what the time was. During the morning hours on the 100 Wing, Resident #2 was not walking around the wing. She believed he was in his room until he was moved to the other side.</p> <p>An interview with NA #7 at 3:07 pm on 2/24/16 via phone revealed she was working on the 2nd shift the night of 2/6/16 on the 200 Wing. She was not assigned to this resident, but did recall him walking around the 200 Wing at the start of the shift (approximately 3:00 pm). She was not aware the resident left the building until after he was returned. There was no announcement (code 10 or Code Pink) over the intercom. The NA reported that his room was on the 100 Wing until 2/6/16. The NA reported she was aware he was on every 15 minute checks when they</p>	F 323	<p>Continuation from Page 12</p> <p>On 02/26/2015 the facility administrator continued the auditing of four (4) fire doors/exits each day and each shift for functional status of alarm being in the "on" position. Each of these four (4) fire/exit doors are being audited and/or tested for function and/or key "on" position by the facility administrator seven (7) days per week on first and second shifts. The nurses on third shift, are ensuring the key "on" position is consistent with the diagram on the alarm unit is in "on" position.</p> <p>On 02/29/2016 the facility director of nursing created and updated wander guard bracelet log. This log documents the dates wander guard bracelet applied, the expiration date of each unit. The director of nursing will monitor and replace resident bracelet(s) before the manufactures expiration date(s). On 03/01/2016 the facility director of nursing created an education tool "How do you know if someone is an elopement risk?" Signs and symptoms to be aware of but not limited to: unhappy with surroundings, pacing with no destination, stating "I need or want to go home", increased anxiety and or agitation, staying close to exits, asking staff and visitors if they can go home or leave. This notice is posted in the facility bathrooms, at the nurses' station, and at the time clock. Additionally, it is requested anyone aware of the potential signs and symptoms report immediately to nurse, nurse assistant or member of management don't leave without telling someone.</p>		

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F 323	<p>Continued From page 13</p> <p>brought him back to the facility. She did not recall the time he came back, she thought it was about 5:30 pm.</p> <p>An interview with NA #8 at 3:30 pm on 2/24/16 via phone revealed Resident #2 had eloped and was returned back to the facility before her shift started on 2/6/16. She worked 7pm - 7am on the weekends on the 200 Wing. He was very confused during this shift and kept asking to go home. He was being checked every 15 minutes and the NA walked him and watched him through out the shift. The NA reported the resident wanted to keep going back to the 100 Wing. The NA stated that this resident did have a wander guard on his ankle. She reported that if a resident eloped, a staff member would call Code Pink or Code 10, search the facility and the grounds. Once the resident was located and returned, have the nurse assess the resident.</p> <p>An interview with the Compliance Manager of the manufacturer of the wander guard was conducted at 4:46 pm on 2/24/16. The manager reported there were two basic components of the wander guard. There was a rectangular piece mounted by each door the facility chose to protect. The range can detect approximately three feet to devices/bracelets that were worn by the resident. This was detected by a radio frequency. The system generates an alarm with two conditions. The first condition was the equipment on the door and the bracelet/device need to be compatible. The second condition was if the door was opened. He reported it integrates with a magnetic lock. If the two conditions are met, it will sound the alarm. The facility had the option to get a lock mechanism. If this lock mechanism is in place it will activate the doors to lock when</p>	F 323	<p>Continuation from Page 13</p> <p>On 03/08/2016 the Wireless Motion Sensor Alarms were installed on the each of these four (4) fire/exit doors and the previously implemented, documented, and evaluation of seven (7) facility doors monitors and watch sheets each day were reduced to five (5) facility doors monitors and watch sheets each day.</p> <p>On 03/14 through 03/17 the facility did undergo the installation of a Secure Care Wandering and Locking System as identified on 02/24/2016. The Secure Care LLC, The Secure Care Wandering component Door Guardian U-DE is installed but not operational due to unidentified "electrical frequency" interference(s). The Secure Care Locking component, Universal 500DE, of the installation is completed and fully functional on all seven (7) facility doors. The preferred method for testing the Door Guardian U-DE (according to the manufacturer) is to install equipment and order only one transmitter. With Secure Care's method, the technicians test the system with one transmitter and then determine if a frequency change must be made. If not, then the technicians order the remaining number of the transmitters (which would take an additional two weeks to receive) and send them to the facility. This prescribed method works in situations where ample time is available to install a system.</p>		

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F 323	<p>Continued From page 14</p> <p>the resident is about three feet away. The Manager reported that if the magnetic switch is broken or misaligned it would cause malfunction. He also reported to activate a wander guard, there is a button on the side of the wander guard unit. It needs to be pressed in flush to the case. Once the button is pressed in, it should be tested by an open door. If it alarms and turns green, it is activated and can then be applied to the resident. The manager reported that it is possible for the button to pop back out, however it will not deactivate the device. He reported the causes of deactivation would be if the 90-day use period had expired or with impact such as going through a washer or dryer, misuse or abuse.</p> <p>An interview with the DON on 2/25/16 at 9:15 am revealed she did not keep a log of the wander guard devices or the " activate by " date when a new one was applied to a resident. She knew she applied all new devices to the wander guard residents on 2/6/16. The " activate by " date was 2/23/16. Nurse #1 applied a new wander guard to Resident #2 on 2/6/16. The " activate by " date was 2/23/16. Resident #2 ' s wander guard was discontinued on 2/17/16 when he was sent to the hospital. The DON reported she marked it on her desk calendar to replace the wander guards on May 3. She reported they would expire on May 6, 2016 which was the 90th day since it was activated. The DON did not keep the wander guard that was on Resident #2 prior to 2/6/16 and also did not know what the " activate by " date on that wander guard was. During this interview, it was discussed that many staff members were interviewed and not everyone had the same understanding of how the wander guards worked or when the exit doors would alarm. There were many inconsistencies.</p>	F 323	<p>Continuation from Page 14</p> <p>Products of installation Included the Universal 500DE and Door Guardian U-DE. The Universal500DE system components are: Interfacing the magnetic lock to the U-500DE Exit Panels interfacing two (2) magnetic locks per door, interfacing the push-button and remote keypad, and the delayed egress and fire alarm connections.</p> <p>A copy of the installation manual to The Universal 500DE system will be kept by The facilities administrator, director of nursing and director of facility services. Section 11, page 38 of 52 in installation manual recommends weekly testing of the 500DE on both Perimeter Control and Perimeter Control with Locks. The Door Guardian U-DE. system components are: U-DE exit panels, , EXIU,4 or 8 Channel LED Nurse Station Annunciator, Indoor and Outdoor Remote Keypad Layout, and Indoor Outdoor (N/O) Push Button. On page 20 of 71 section 8 of the installation manual of The Door Guardian U-DE instructs on the theory of operation:</p> <p>The U-DE Exit Panel is a microprocessor Based unit that recognizes pulse signals Sent from Secure Care Transmitters. This Control panel can allow for traffic to pass Normally, but can engage an optional Magnetic lock when a Secure Care Transmitter is within detection range. The U-DE Should create an audible and visual alarm When a transmitter is in detection range and The door is open.</p>		

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F 323	<p>Continued From page 15</p> <p>The DON agreed that not all staff were aware of how the alarms were suppose to function. The DON further added that her expectation was that all staff know how each and every exit door alarmed and when they alarm. Additionally, her expectation was that staff have a full understanding of how the wander guard system worked.</p> <p>An interview with NA #9 via phone at 12:45 pm on 2/25/16 revealed that she was not assigned to the resident on 2/6/16 but she did remember that on this day he slept all morning and part of the early afternoon. She reported he had lunch in his room. The NA reported that he was moved to the other wing at approximately 2:00 pm. She recalled seeing him back on the 100 Wing around 3:00 pm. She said he seemed very confused and walked around the wing looking for his room. The NA reported she did not observe him trying to exit out of any doors. The NA reported she did not see the resident after NA #1 brought him back into the building and to the 200 Wing.</p> <p>The Administrator was notified of the immediate jeopardy on 2/24/16 at 8:50 am. The Facility provided an acceptable credible allegation on 2/25/16 at 7:40 pm.</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>On 02/06/2016 at approximately 4:45 PM, the facility was notified by a visitor (female) " are you missing a resident " ? Nursing Assistant #1 exited the building and retrieved resident #2 and returned him to the facility. Nurse #1 exited the dining room and met nursing assistant #1 and</p>	F 323	<p>Continuation from Page 15</p> <p>The system can trigger an Alarm at either an A0230901/A02040901LED Annunciator, or a PC based Secure Care Software Graphic Annunciator in a Specified remote location.</p> <p>The escort feature allows adults to be escorted without alarms when an authorized, user program-able, four (4) digit code is entered. The anti-tailgate feature should immediately re-armthe system when the door has closed to prevent an unauthorized exit. The PM feature allows the system to lock or alarmfor exit and entry during specified time periods.</p> <p>The EXIU communication hub is designed to provide a method of message control for all fields installed devices using the CAN bus architecture for supervision and event message transmission. Up to 95 total devices may be connected to one EXIU unit. each device will require its own uniquely programmed addressable ID. The EXUI passes the input messages through to a PC based Secure Care Software Graphical Annunciator. The EXUI is equipped with two (2) auxiliary relays which activate during specified time periods.</p>		

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F 323	<p>Continued From page 16</p> <p>escorted resident #2 into the dining room. Upon entering the dining room, resident #2 alarm did not sound. Resident #2 returned to 200 hall nurses station. 100 hall nurse #1 reported to 200 hall nurse #3 of the elopement. Nursing Assistant #1 retrieved a new wander guard bracelet from the facility ' s central supply closet. Nurse #1 tested the bracelet by taking the bracelet to the front door of the facility which was armed and functioning with a wander guard alarm system. The new wander guard bracelet was tested and placed on resident #2 right ankle. Nurse #1 stated that on 2/6/2016, resident #2 had been returning to his previous room (room 103) on 100 hall, from 200 hall and that she, nurse #1, had not seen resident #2 for approximately 2 hours before the facility was notified that the resident was missing. The facility could not determine which door resident #2 exited. The facility cannot determine with 100% accuracy why the wander guard bracelet did not alarm.</p> <p>At approximately 6 PM, resident #2 was assessed for injury and vital signs were obtained by 200 hall nurse #3. No injuries were noted and vital signs were within normal ranges for resident #2. Nurse #3 documented resident #2 was pacing 200 hall looking for a way out to go home. Nurse #3 was unable to redirect.</p> <p>At approximately 7:20 PM, Nurse #3 called the facility ' s contract physician assistant and received an order for 1 dose of Haldol 2 mg intramuscularly. Nurse #3 administered one dose of Haldol 2 mg intramuscularly injection in the right upper buttocks and documented the resident tolerated it well. Resident #2 returned to the common area on hall 200, from room 213 bed A, sitting at table with 2 other facility residents.</p>	F 323	<p>Continuation from Page 16</p> <p>The Indoor and Outdoor Remote Keypad A05030900 is used to perform all of the functions if the Exit Panel keypad at an additional location. Typically, the remote keypad is mounted on the opposite side of the wall from the exit panel to allow for escort and reset functions from either side of the door. The remote keypad receives its power from the exit panel connected to it. The keypad only offers an input to the exit panel; it does not offer any internal relays or timers.</p> <p>The Indoor/Outdoor (N/O) Push Button A04150900 normally open (N/O) push-button can be interfaced to any U-DE or Kinder Guard Exit Panel. It is used to Bypass the panel. Usually the push button Is mounted in the other side of the door to Allow access from the other side of the door. The push button can only reset an alarm condition in advanced push button mode.</p> <p>On page 46 of 71 section 11of The Door Guardian U-DE installation manual weekly testing is recommended of the Door Guardian U-DE of wandering patient monitoring with locking feature for: patient escort, anti-tailgate, delayed egress, remote keypad, push-button, and advanced security mode.</p>		

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F 323	Continued From page 17 On 02/06/2016, the facility staff initiated 15-minute checks on resident #2 for location/safety. On 02/17/2016, the 15 minute checks on resident #2 for location/safety were discontinued due to hospitalization. On 02/06/2016 at approximately 6:30 PM, the director of nursing (DON) reviewed and updated the care plan for resident #2 to reflect wandering, elopement and status of new wander guard bracelet placement/function. On 02/10/2016, the DON and the Facility Services Director initiated weekly mock elopement drills for the next 4 weeks. On 02/10/2016, the Facility Social Services Director contacted the Health Care Power of Attorney/Responsible Party to discuss alternate placement (memory care) per safety. On 02/12/2016, Facility Social Services Director initiated communication with appropriate Long Term Care Centers, which provide care to residents living with Alzheimer and/or Dementia related diagnosis. On 02/06/2016 the facility DON audited the February 2016 Treatment Administration Record (TAR) for resident #2. The TAR for resident #2 showed that the initial wander guard physician 's order was written on 12/01/2015. The TAR wander guard audit for placement, which was checked each shift, showed no holes or missed documentation. The TAR wander guard for function, which was checked on the 11PM-7AM shift every day, showed no holes or	F 323	Continuation from Page 17 On 03/17/2016 the SouthMed Inc. lead-technician inserviced the facility administrator, director of nursing, director of facility services and approximately 25% of facility staff per the Secure Care Wandering and Locking System. On 03/17-18-19/2016 the director of facility services continued the inservice of facility staff to include but not limited to the proper access code, code security, mag-locks engaged vs. disengaged, identification of operational systems and system notification On 03/17/2016 the facility Activity Coordinator created and posted laminated Signs at: The three (3) doors, one (1) at the front door entrance, one (1) at the dining room interior and exterior door leading to and from the resident smoking covered patio, and one (1) on the employee service hall leading to and from the employee parking lot. Sign reads: Attention: Effective Today March17, 2016 these doors are locked between 9P and8AM. On the four (4) emergency fire doors exits (independent of each other and tied into fire-panel) with each door being separately alarmed and locked. Two (2) doors are located on the 100 hall and two (2) doors are located on the 200 hall Sign reads: Attention: Effective Today March17, 2016: Emergency Exit Only, Door Is Locked and Secured.		

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F 323	<p>Continued From page 18 missed documentation.</p> <p>On 02/24/2016, the facility administrator reviewed the February 2016 TAR for resident #2 to ensure accuracy. No holes or missed documentation for placement and function were observed.</p> <p>Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;</p> <p>On 02/06/2016 at approximately 6:45 PM, the DON identified those residents having the potential to be affected by the same deficient practice.</p> <p>The DON identified four residents who had care plans for wandering behaviors. These residents were previously identified with wandering behaviors at the time of admission or once established as residents with wandering behaviors. At which time, the elopement-risk assessment was completed and the wander guard system/bracelet was tested and applied. Note: the elopement-risk assessment was deemed appropriate for residents with exit seeking behaviors and/or repetitive verbally expressing desire to leave the facility.</p> <p>The DON, Unit Manager, Social Services Director, Activity Director, and Therapy Program Director meet weekly for quality of care and change-in-conditions to include behaviors enabling a multi-disciplinary approach to each resident 's continuum of care.</p> <p>On 02/06/2016, Audit of Treatment Administration Record (TAR) by the DON showed physician orders for wander guard for the 4 residents.</p>	F 323	<p>Continuation from Page 18</p> <p>On the door one (1) at the front door entrance Sign reads: Attention: Effective Today March17, 2016: this door is locked between 9PM and 8AM. To enter you must either Ring Doorbell to right of door or please call facility For staff assistance 336-472-7771</p> <p>On 03/17/2016 Signs posted at each nurses station read: Please ensure a member of our staff is available to allow entrance for EMS when called, as the doors are locked between 9PM and 8AM.</p> <p>On 03/18/2016 the facility administrator, director of nursing, director of facility services, director of social services, and activities coordinator requested to hold an mid-month resident council meeting to share and explain applicable details of recent installation and overall safety features, precautions, posted hours at the main entrance unlocked vs. locked and engaged our residents in general questions and answers. Our resident council president was available and did attend to champion this added measure of security. Note: residents were informed the access code to any and all keys pads would not be shared to residents, family members, friends of residents, responsible parties of residents, and this access code is only to be used and shared amongst facility staff. Also, the access code would be reprogrammed randomly.</p>		

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F 323	Continued From page 19 On 02/06/2016 at approximately 6:45PM, the DON assessed each resident with a wander guard bracelet and observed all of them with correct wander guards placement and functioning. The DON validated the functioning of the wander guard of all four residents by utilizing the bracelet wander guard universal tester housed in the 200 hall med cart. Additionally, the DON obtained from the central supply closet four new wander guard bracelets with 90 day expiration parameters. Each new wander guard bracelet was engaged, tested and applied to each of the four residents. The rationale to replace each bracelet is to ensure manufacturer ' s recommendations and compliance with 90 day expiration; 02/23/2016 through 05/23/2016. On 02/06/2016 at approximately 7 PM, the DON completed an audit of Treatment Administration Record (TAR) for 4 residents which showed physician orders for wander guards. The DON verified documentation of TAR wander guard audit for placement, which was checked every shift and Treatment Administration Record (TAR) wander guard audit for functioning, which was checked on the 11PM-7AM shift every day. The purpose for obtaining physician ' s order per resident is to ensure that orders will show as printed on Treatment Administration Record for each month and allow for documentation as required by facility. On 02/06/2016 at approximately 8 PM, the DON initiated staff in-service education for 100% staff regarding elopement risk protocols and procedures. In-service education was completed on 02/08/2016.	F 323	Continuation from Page 19 On 03/18/2016 the facility administrator created a one page letter of notification to family members, resident responsible parties, power-of-attorneys, and friends of center regarding recent installation of Secure Care Wandering and Locking System. On 03/18/2016 at approximately 9:20 AM the facility received the Letter of Completion and Certification from SouthMed Inc. stating the system had been tested and is operational per manufactures specifications and recommendations dated and signed 03/17/16 On 03/18/2016 the previously implemented, documented, and evaluation of five (5) facility doors monitors and watch sheets for each 24 hour day of 03/08/2016, were reduced to one (1) door monitor and watch sheet from the hours of 5PM to PM. The three (3) doors that will remain monitored: one (1) at the front door entrance, one (1) at the dining room interior and exterior door leading to and from the resident smoking covered patio, and one (1) on the employee service hall leading to and from the employee parking lot. Each of these three (3) doors have primary access from the administrative hall, all three (3) doors are within approximately twenty feet of front reception foyer area of facility. As an added level of security and during this initial phase of orientation to the Universal 500DE Locking System and until the Door Guardian U-DE is Fully functional we believe observance of the three (3) high-traffic doors is proactive for the safety of our residents.		

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F 323	Continued From page 20 Note: the DON completed a portion of in-service by telephone. On 02/06/2016, on the 2nd and 3rd shifts, the DON performed mock elopement drill and documented results. Mock elopement drill was announced as Code 10 three times over the facility ' s intercom system. Code 10 was called to a resident ' s room number and bed letter. Non-licensed/certified staff immediately began interior/exterior facility search. The facility nursing staff initiated resident headcount and within approximately 1.5 minutes the resident was located and announcement was made of Code 10 " All Clear " 3 consecutive times. The facility had a total of 7 exit doors. Of the seven (7) facility doors, four (4) are emergency fire doors/exits (independent of each other and not tied into fire-panel) with each door being separately alarmed. Two (2) doors are located on the 100 hall and two (2) doors are located on the 200 hall. The alarm is turned on and off by a key. These keys are located in the medication rooms at each nurses ' station on each of the 100 and 200 halls. Additional keys are kept with facility administrator, director of nursing and the facility ' s services director. When the door is opened and the alarm is in the " on " position, the alarm will sound. If and when the alarm is in the " off " position, each door will open without alarming. As 02/25/2016 at 7 PM, these 4 doors are being audited each day and each shift for functional status of alarm being in the " on " position. Each of these four (4) fire/exit doors are being audited/tested for function and/or key " on " position by the facility administrator seven (7) days per week on first and second shifts. The nurses on third shift, are ensuring the key " on " position is consistent with the diagram on the alarm unit is in	F 323	Continuation from Page 20 Additionally during the hours of 5PM to 9PM staffing a facility associate can promote good will to visitors and family members who may ask questions regarding the Secure Care Wandering and Locking System. On 03/17/2016 on first-shift the facility administrator discontinued the auditing of four (4) fire doors/exits each day and each shift for functional status of alarm being in the "on" position. Each of these four (4) fire exit doors are being audited and/or tested for function and or key "on" position by the facility administrator seven (7) days per week on first and second shifts. The nurses on third shift, are ensuring the key "on" position is consistent with the diagram on the alarm unit is in "on" position. The rationale being, the Secure Care Locking System installed, operational, tested and certified as of 03/17/2016. The facility staff which are scheduled to work have been inserviced, on the Secure Care Locking System and all seven (7) doors are programmed to "lock" 9PM through 8AM. The systems visual and audible monitoring wands are wall-mounted adjacent to both 100 and 200 hall nurses stations, and the four (4) fire doors exits two (2) on the 100 hall and two (2) on the 200 hall are locked 24 hours each day, every day.		

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F 323	<p>Continued From page 21 " on " position.</p> <p>The remaining three (3) doors are armed/alarmed with a Wander Guard System. These three (3) doors are located: one (1) at the front door entrance, one (1) at the dining room interior/exterior door leading to/from the resident smoking covered patio, and one (1) on the employee service hall leading to/from the employee parking lot. On 02/07/2016, the DON implemented an everyday check of all doors equipped with wander guard in the facility to ensure operation of each of the three doors within the facility. On 02/24/2016 the wander guard manufacturing company was called due to 1 of 3 doors armed with the wander guard system was not functioning per manufacturer specifications (alarming upon approach). On 02/25/2016 the facility ' s regional services coordinator contacted the wander guard company technology support. The problem was identified and remedied. As of 02/25/2016 at approximately 9:15 AM, 3 of 3 of the doors armed with the wander guard system are operating per manufacturer recommendations.</p> <p>As of 02/24/2016, all 7 of the facility ' s exit doors (means of facility egress) are being manned and monitored by facility staff 24 hours a day, seven days a week.</p> <p>The two (2) fire doors/exits on the 100 hall located between rooms 107/108 and 121/122 will be monitored by one (1) person positioned at the nurses station as there is a clear " line-of-sight " to both fire doors/exits. This rationale is also true for the two (2) fire doors/exits on the 200 hall located between rooms 207/208 and 220/221 with one exception; due to the location of the</p>	F 323	<p>Continuation from Page 21</p> <p>On 03/18/2016 the facility services director Conducted an unannounced mock Elopement Drill between 1st and 2nd nursing shifts. The Resident was escorted from the fire exit door Numbered 4 on the 200 hall, the resident was accompanied outside to safe location and resident was accompanied during duration of drill. Upon exit of resident from 200 hall. Facility services director engaged "screamer" Lid (cover for Kill switch to alarm/lock); Screamer lid lifted and closed. The Therapy staff first to arrive at location. Code 10 was unannounced three (3) times over the facility's intercom system. Code 10 was not called to location of Alarm Signal. The resident was recovered within approximately three (3) minutes. All clear was not announced three (3) times over the facility's intercom system. Note: the elopement drill showed poor immediate attendance due to previous testing and monitoring each shift and daily testing of alarms.</p> <p>On 03/19 through 03/26 2016 the facility director of nursing implemented an every four (4) hour wander guard "placement" check to be documented in nursing notes.</p> <p>On 03/19 through 03/26 2016 the facility director of nursing implemented an every thirty (30) minute check on our residents identified and care planned as exit-seeking to be documented in nursing notes.</p>		

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F 323	<p>Continued From page 22</p> <p>therapy gym, a predetermined position has been identified to ensure a consistent " line-of-sight ". This predetermined position to be monitored by one (1) person is located between rooms 212 and 211. An added level of internal preventative monitoring will be added by installing wireless motion sensor alarm system. These alarms would be installed immediately inside the corridor leading from 100 and 200 halls up to the fire doors/exits area measuring 10 ' x7 ' x9 ' . The Wireless Motion Sensor Alarms will be installed on the each of these four (4) fire/exit doors on 03/08/2016.</p> <p>The remaining three (3) Wander Guard System facility doors will be monitored by facility staff 24 hours a day, seven days a week. The one (1) door at dining room interior/exterior leading to/from the resident smoking covered patio is in direct " line-of-sight " of the business office manager as her office is located directly across the hall from the interior dining room door entrance. During standard operating hours and between the hours of 8:30 AM and 5:30 PM the business office manager will monitor the door to ensure the residents ' safety and wellbeing. When the business office manager requires a break and/or lunch she will notify either the human resource manager, office located immediately to her right, or the receptionist, office located immediately to her left, of the change of guards and for what length of time their assistance will be required. Other times than the business hours of 8:30 AM to 5:30 PM, the door will be manned by other staff at all times. The front door entrance door will be monitored at all times. On Saturdays and Sundays, the receptionist will position the facility telephone through the pass-through window and monitor the</p>	F 323	<p>Continuation from Page 22</p> <p>4. The facility will develop a plan(s) for ensuring that correction is achieved and sustained. The plan(s) will be implemented and the corrective action(s) evaluated for their effectiveness. Our PoC is integrated into our quality assurance system.</p> <p>The facility administrator, director of nursing, and director of facility services will be the primary representatives to ensure substantial compliance is met through implementation and evaluation for each measure put into place and systemic change made.</p> <p>Unless otherwise specified by manufactures recommendations and requirements, each measure put into place and systemic changes made will be monitored weekly for four (4) weeks, then every other week for four (4) weeks and then quarterly. If substantial is not obtained within the initial parameters then each measure will remain monitored weekly for four (4) weeks until substantial compliance is obtained. All applicable data and results will be reviewed each morning during department head meeting. Further review and evaluation will be monitored during monthly facility quality assurance meeting.</p>		

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F 323	Continued From page 23 front door from the foyer/welcome area. This monitoring will occur from 8:00 AM until 5:00 PM Both the dining room door and the front door will be monitored by other staff at all times when the receptionist and the business manager are not on duty. On 02/24/2016, the facility secured a signed proposal from an outside company for the installation of a Secure Care Wandering and Locking System to be installed on 03/14/2016. Validation on 2/25/16 at 1:00 pm verified the credible allegation were evidenced by interviews with direct nursing staff related to education/in service on elopement. This included weekly mock drills on assigned shifts with in services dated 2/8/16, 2/15/16 and 2/23/16. The DON and Administrator will audit the Treatment Administration Records to ensure placement of the wander guard is checked every shift and the operation of the wander guard is checked daily. The TAR 's have been signed off each day for the month of February as being checked. Elopement risk assessments have been updated. The wander guard monitoring system for each of the three doors are checked daily by the DON. All exit doors are being manned by a person until the new alarm system is installed which is scheduled for 3/14/16. The nurses are monitoring the fire exit doors on each wing to ensure that each alarm is positioned in the " on " position to indicate the alarm is armed on each shift daily and documenting this in the Medical Administration Record (MAR). All the exit doors are being monitored by individuals assigned to monitor the doors. All the wander guards and the monitors are in working order.	F 323	Continuation from Page 23 The facility director of services will ensure that both the Universal 500DE system and the Door Guardian U-DE, system will be tested weekly per manufactures recommendations. The testing of both systems will occur on the same day of each week. The testing of both systems will be a scheduled task in the TELS System. In the event that the facility director of services is unable to test one or both systems, the facility administrator will perform one or both system tests. In the event that both facility director of services and facility administrator are unable to perform scheduled system tests, the director of nursing will perform scheduled test. The results of testing will be documented on specified form provided by manufacture of system. The education of proper operational and function will become a component of all new hire orientation. Random education will occur as needed or requested; all education to be recorded dated and signed by facilitator and participants. The facility director of nursing, the Unit manager and the MDS Coordinator will ensure that all physician orders are care planned, and the MDS and Care Plans are updated as physicians orders are completed. The physician orders will be reviewed at approximately 9:15 AM before each morning department head meeting.		

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F 323	Continued From page 23 front door from the foyer/welcome area. This monitoring will occur from 8:00 AM until 5:00 PM Both the dining room door and the front door will be monitored by other staff at all times when the receptionist and the business manager are not on duty. On 02/24/2016, the facility secured a signed proposal from an outside company for the installation of a Secure Care Wandering and Locking System to be installed on 03/14/2016. Validation on 2/25/16 at 1:00 pm verified the credible allegation were evidenced by interviews with direct nursing staff related to education/in service on elopement. This included weekly mock drills on assigned shifts with in services dated 2/8/16, 2/15/16 and 2/23/16. The DON and Administrator will audit the Treatment Administration Records to ensure placement of the wander guard is checked every shift and the operation of the wander guard is checked daily. The TAR 's have been signed off each day for the month of February as being checked. Elopement risk assessments have been updated. The wander guard monitoring system for each of the three doors are checked daily by the DON. All exit doors are being manned by a person until the new alarm system is installed which is scheduled for 3/14/16. The nurses are monitoring the fire exit doors on each wing to ensure that each alarm is positioned in the " on " position to indicate the alarm is armed on each shift daily and documenting this in the Medical Administration Record (MAR). All the exit doors are being monitored by individuals assigned to monitor the doors. All the wander guards and the monitors are in working order.	F 323	Continuation from Page 24 All applicable information pertaining to resident care and quality of life will be discussed with the Inter-departmental Team (IDT) members to ensure continuum of care is met for each resident. The facility director of nursing, the unit manager and the facility administrator will continue the monitoring of wander guard function, and placement every shift and every day by the nurses and documented on the MAR. The facility director of nursing will continue the monitoring of wander guard doors function testing every day documented on the Wander Guard Door Log. The facility director of nursing and facility administrator will determine, based upon compliance, when the facility will establish manufactures weekly system tests. All applicable information pertaining to resident care and quality of life will be discussed with IDT members to ensure continuum of care is met for each resident. The facility administrator, director of nursing, and director of facility services will collectively perform staff education by ensuring elopement drills are employed and evaluated. These drills will occur on all shifts at varying times, weekly for four (4) weeks, every other week for four (4) weeks, quarterly and with each new hire orientation.		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345520	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2016
NAME OF PROVIDER OR SUPPLIER AVANTE AT THOMASVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1028 BLAIR STREET THOMASVILLE, NC 27360	
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