STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345376	A. BUILDING _____ B. WING _____	C 07/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND NURSING AND REHABILITATION CENTER	2461 LEGION ROAD FAYETTEVILLE, NC 28306

(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 000	INITIAL COMMENTS 1.483.25(323)at J The Immediate Jeopardy began on 6/4/2017 when Resident # 168 exited the facility unattended by the facility staff, and was found 4 miles away from the facility by the police. The Immediate Jeopardy was removed on 6/13/2017 at 5:00 PM when the facility completed in-servicing the staff on elopement policies and procedures. The facility also completed a review of all the residents who were at risk for elopement on 6/13/2017. The facility provided an acceptable plan of correction completed 6/13/2017.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to treat residents in a dignified manner for 1 of 1 sampled residents when the facility staff allowed a resident who requested incontinent care during a meal to sit in a soiled adult brief while eating (Resident #39). The findings Included: Resident #39 was admitted to the facility on 04/24/14 with diagnoses which included contracture of muscle.	F 241	F241 Resident # 39 was provided incontinent care on 6/20/17 after lunch by assigned certified nurse assistant. Administrator Interviewed resident #39 on 8-11-17; (per the resident) resident is being provided incontinent care prior to meals. 100 % interview of all alert and oriented residents was conducted on 8/9/2017 by the social worker in reference to are residents being treated with dignity and respect, this included but not limited to being soiled during meals utilizing a Resident Rights\ Dignity Audit tool. A	8/16/17

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

Electronically Signed | 08/11/2017

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F 241	Continued From page 1 A review of the annual Minimum Data Set (MDS) dated 03/02/17 revealed Resident #39 to be cognitively intact, was always incontinent of her bowels and bladder and required total dependence on staff for toileting. The MDS indicated Resident #39 was at risk for developing pressure ulcers. A review of Resident #39's Care Plan, last updated 06/02/17, indicated Resident #39 had urinary incontinence and staff were to provide incontinent care after each incontinent episode. The Care Plan indicated Resident #39 was at risk for recurrent urinary tract infections and staff were to provide adequate perineal care. The Care Plan indicated Resident #39 was at risk for skin breakdown or development of pressure ulcers and staff were to provide incontinent care and a protective barrier cream after each incontinent episode. During an interview with Resident #39 on 07/20/17 at 9:20 a.m., Resident #39 stated on 06/20/17 she had an incontinent episode in her adult brief after her lunch tray had been served to her. Resident #39 stated she pushed her call bell for assistance and Nursing Assistant (NA) #1 responded and informed Resident #39 she was busy and would return later. Resident #39 stated she had been told in the past the NAs were not allowed to provide incontinent care during meal times. Resident #39 stated NA #1 returned to her room approximately one hour later and provided incontinent care. During an interview with NA #1 on 07/20/17 at 9:54 a.m., NA #1 stated she responded to Resident #39's call light and request for incontinent care on 06/20/17. NA #1 stated she	F 241	resident concern form will be completed by the social worker and forwarded to administrator and the resident concern policy will be followed for any identified areas of concerns. 100% of all residents will be observed by The Staff facilitator/Quality Improvement nurse prior to a meal to include breakfast, lunch or dinner to ensure proper incontinent care is provided prior to eating utilizing a Resident Care Audit tool to be completed by 8-16-2017. The nursing assistant will be immediately re-trained by the Staff Facilitator and incontinent care will be provided to the resident by the nursing assistant prior to the meal with oversight by the Staff Facilitator for any areas of concerns identified during the audit. A Resident Council meeting was held on 8-10-2017 by the Social Worker and Activities Director to review resident rights (My Rights) with the residents to include resident # 132 with the emphasis on the right to be treated with dignity and respect to include being provided in continent when requested and a copy of My Rights was given to the residents by the Social worker on 8-11-17. A 100% in service was initiated on 7-20-17 by the Staff Facilitator for all nursing assistants and licensed nurses to be completed by 08-16-17, in regards to incontinent care is to be provided while meal trays are on the hall. If a resident requests incontinent care during the passing of meal trays you must provide the care and coordinate with another staff member to continue to pass other	

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F 241	Continued From page 2 informed Resident #39 "the State does not allow them to change residents when the trays are out because it is unsanitary." During an interview with the Director of Nursing (DON) on 07/21/17 at 10:25 a.m., the DON stated it was her expectation nursing staff provide incontinent care to residents whenever it is needed. During an interview with the Administrator on 07/21/17 at 10:30 a.m., the Administrator stated it was her expectation nursing staff provide incontinent care to residents whenever they needed it.	F 241	resident's trays. At no time should we allow residents to be soiled, and not provide incontinent care this includes during meal times. The resident has a right to be provided incontinent care as he/she desires. All new hires will in-serviced during orientation in regards to incontinent care is to be provided while meal trays are on the hall. If a resident requests incontinent care during the passing of meal trays you must provide the care and coordinate with another staff member to continue to pass other resident's trays. At no time should we allow residents to be soiled, and not provide incontinent care this includes during meal times. The resident has a right to be provided incontinent care as he/she desires. 100% in- service on residents' rights to include the right to be treated with dignity and respect to include being provided in continent when requested with Accounts Payable, Accounts Receivable, Scheduler, licensed nurses, Certified Nursing Assistants, Dietary and Housekeeping Department was initiated on 7-20-17 by Staff Facilitator to be completed by 08-16-17. All new hires 10% of alert and oriented residents will be interviewed by the Social Worker to ensure they are being treated with the right to be treated with dignity and respect to include being provided in continent when requested this includes but not limited to being soiled during meals utilizing a Resident Rights\ Dignity Audit tool. The Resident Rights\ Dignity Audit tool will be completed weekly x 4 weeks,	

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F 241	Continued From page 3	F 241	bi-weekly X 4 weeks and monthly x 1 month. A resident concern form will be completed by the Social Worker and forwarded to the Administrator and the resident concern policy will be followed for any identified areas of concerns. The Administrator will review and initial the results of the Resident Rights\ Dignity Audit tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concerns are addressed. 10% of all residents that require incontinent care will be audited by the Staff Facilitator/Quality Improvement Nurse prior to a meal to include breakfast, lunch or dinner to ensure proper incontinent care provided prior to eating utilizing a Resident Care Audit tool weekly X 8 weeks and monthly X 1 month. The nursing assistant will be immediately re-trained by the Staff Facilitator and incontinent care will be provided to the resident by the nursing assistant prior to the meal with oversight by the Staff Facilitator for any areas of concerns identified during the audit. Social Service Director/Activity Director will discuss residents' rights and dignity during resident council meeting minute agenda monthly X 3 months. The Administrator will review and initial the results of the resident council minutes monthly x 3 months to ensure all areas of concerns are addressed. The Administrator will forward the results of the Resident Care Audit tools and Resident Rights\ Dignity Audit tools to the Executive Committee monthly X 3	

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F 241	Continued From page 4	F 241	months. The Executive Committee will meet monthly and review the Resident Rights\ Dignity Audit tools and address any issues, concerns, and/or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, record review, observation and staff interviews, the facility failed to provide a policy that allows a safe smoker to smoke any time he/she wanted and to smoke unsupervised for 1 of 1 sampled resident (Resident #132). The findings included: Review of Smoking Policy received from Administrator on 7/21/2017 documented the	F 242	F242 Resident # 132's smoking assessment was completed on 7-18-2017 by the Director of Nursing. Resident # 132 was assessed to be a safe smoker. Resident # 132's care plan and care guide was updated on 7-19-2017 by the MDS Nurse. The Administrator reviewed the new smoking policy with resident # 132 on 7-18-2017. Resident # 132 was allowed to smoke any time the resident would like to	8/16/17

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F 242	Continued From page 5 following: "Smoking Policy: Smoking is only allowed in designated areas (smoking area outside of dining room). Residents are only allowed to go out smoking supervised with staff at scheduled smoking times. The smoking times for residents are as follows: 9am, 1pm, 4:30 pm, and 7pm. No resident should smoke outside these times unsupervised. All smoking paraphernalia will be locked in a tackle box and kept inside medication room." Resident #132 was admitted to the facility on 02/10/2017 with diagnoses of Heart failure, Benign Prostatic Hyperplasia, Chronic Pain Syndrome, Depression and Neuropathy. The quarterly MDS (Minimum Data Set) dated 05/20/2017 indicated Resident #132 had no problems with his cognitive skills for daily decision making. The MDS further indicated the Resident #132 was independent for transfers, walk in room, walk in corridor, on and off unit mobility, dressing, toileting and personal hygiene activities. Review of the Resident Concern Form dated 02/15/2017 documented description of concern "Staff is not coming to get resident when it is time for him to smoke. When it is smoke break time, the resident is taking meds and resident wants to be able to go out rather than having to take his medicine. Resident wants time changed on his meds." The form was routed to the DON (Director of Nursing) on 2/15/2017. The Resident Concern review documented: "1) Resident states that he is getting meds during smoke times. Writer informed resident of smoke times and gave him a copy of the smoke times. 2) Resident states no one comes to get him at smoke times.	F 242	beginning on 7-18-2017. A 100% audit was completed on all smokers, smoking assessments on 7-18-2017 by the Director of Nursing for accuracy to include resident # 132. There were 7 inaccurate assessments identified. All 7 inaccurate smoking assessments were revised on 7-18-2017 by the Director of Nursing to include resident # 132. All inaccurate smoking assessments care guides and care plans were updated by the Minimum Data Set Nurse on 7-19-2017. On 7-18-2017 the smoking policy was revised to address that identified safe smokers are allowed to smoke per the resident's preference. 100% of safe smokers reviewed and signed the new smoking policy with the Administrator on 7-18-2017. All residents voiced understanding of the new smoking policy. A Resident Council meeting was held on 8-10-2017 by the Social Worker and Activities Director to review resident rights (My Rights) with the residents to include resident # 132 with the emphasis on the right to make choices in the nursing home to include smoking, daily schedules and plan of care and a copy of My Rights was given to the residents by the Social Worker. 100% of all staff to include department managers (Administrator, Director of Nursing, Quality Assurance Nurse, Minimum Data Set nurses, Payroll Manager, AR Manager, AR assistant, social worker, admissions, medical records manager, housekeeping manager licensed nurses, nursing assistants,	

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F 242	Continued From page 6 Informed resident that he has to walk up to the nursing station so that he can go out smoke." Comments regarding follow-up with resident/family/representative and response documented: "Resident agreed that he would come to nursing station at scheduled smoke times. He also received a copy of the smoke times to post on his board in room to remind him what time he needs to be a nursing station." Review of the medical record revealed that there was no smoking assessment completed on admission. Review of Resident #132 ' s smoking assessment dated 7/18/2017 documented the resident was a safe smoker and may smoke independently. The care plan addressed his smoking habit in relation to his behaviors. During the Interview on 7/18/2017 at 10:37 AM, the resident reported he would like to smoke any time he wanted but the staff had given him time frames to go outside for smoking. The resident further stated he would like for the facility to give additional time to go outside to smoke. He stated he had taken brought it to the facility as a concern and they gave him a sign to post in his room with times that he could go smoke. Observation of the resident ' s room on 7/18/2017 at 10:40 AM, revealed the smoking schedule posted. The time frames listed were 9:00 AM, 1:00 PM, 4:30 PM, and 7:00 PM. During the interview on 7/21/2017 at 10:15 AM, the DON (Director of Nursing) stated the facility assess residents during their admission if the resident discloses he/she smoked. The DON added Resident #132 had filed a Resident Concern in February 2017 and she knew he	F 242	dietary staff, housekeeping and therapy staff in-servicing was initiated on 7-18-17 by the Staff Facilitator on unsupervised (safe) smokers and supervised smokers to include times residents are allowed to go out to be completed on 8-16-2017. . All newly hired staff to include department managers (Administrator, Director of Nursing, Quality Assurance Nurse, Minimum Data Set nurses, Payroll Manager, AR Manager, AR assistant, social worker, admissions, medical records manager, housekeeping manager licensed nurses, nursing assistants, dietary staff, housekeeping and therapy staff will receive the education regarding unsupervised (safe) smokers and supervised smokers to include times residents are allowed to go out during orientation. 100 % of all staff to include department managers (Administrator, Director of Nursing, Quality Assurance Nurse, Minimum Data Set nurses, Payroll Manager, AR Manager, AR assistant, social worker, admissions, medical records manager, housekeeping manager licensed nurses, nursing assistants, dietary staff, housekeeping and therapy staff in-servicing in-servicing was initiated on 7-18-2017 by the Staff Facilitator in regards to the new smoking policy to be completed by 8-16-2017. All new hired staff to include department managers (Administrator, Director of Nursing, Quality Assurance Nurse, Minimum Data Set nurses, Payroll Manager, AR Manager, AR assistant, social worker, admissions, medical records manager,	

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F 242	Continued From page 7 smoked. The DON added the resident current smoking assessment revealed he could smoke safe and could smoke independently. She further added the smoking policy had been updated and all independent residents could now go out to smoke. During the interview with the Administrator on 7/21/2017 at 11:25 AM she reported the policy had been updated and all current residents had updated smoking assessments completed on 7/18/2017. She further stated it was her expectation that all residents are assessed on admission for safe smoking if the residents disclosed they smoke and at that time the residents would be care planned. She continued by stating, all residents will be provided choices of times for smoking. During the follow-up interview with Resident #132 on 7/21/17 at 3:10 PM, the resident stated the facility completed his smoking assessment and he was told he could go outside to smoke whenever he wanted.	F 242	housekeeping manager licensed nurses, nursing assistants, dietary staff, housekeeping and therapy staff will be in-serviced on the smoking policy during orientation. 100% of all staff to include department managers (Administrator, Director of Nursing, Quality Assurance Nurse, Minimum Data Set nurses, Payroll Manager, AR Manager, AR assistant, social worker, admissions, medical records manager, housekeeping manager licensed nurses, nursing assistants, dietary staff, housekeeping and therapy staff in-servicing was initiated on 7-20-17 by the Staff Facilitator on resident rights with the emphasis on the right to make choices in the nursing home to include smoking, daily schedules and plan of care to be completed on 8-16-2017. All newly hired staff to include department managers (Administrator, Director of Nursing, Quality Assurance Nurse, Minimum Data Set nurses, Payroll Manager, AR Manager, AR assistant, social worker, admissions, medical records manager, housekeeping manager licensed nurses, nursing assistants, dietary staff, housekeeping and therapy staff will be in-serviced on residents rights with the emphasis on the right to make choices in the nursing home to include smoking, daily schedules and plan of care during orientation. 10% of all residents and safe smokers to include resident# 132 will be interviewed by the Social Worker to ensure resident's choices are being honored to include smoking utilizing Resident Interview tool.	

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F 242	Continued From page 8	F 242	Resident interview tool to be completed weekly x 8 weeks and monthly x 1 month. Any new concerns made will be addressed on a resident concern form by Social Worker and forwarded to Administrator. The Administrator will review and initial the Resident Interview QI tool and resident concern form for completion weekly x 8 weeks and monthly x 1 month. The Administrator will forward the results of the Resident interview tools to the Executive committee monthly X 3 months. The Executive QI committee will meet monthly and review Resident Interview tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		8/11/17

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F 323	Continued From page 9 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observation, the facility failed to prevent 1of 2 cognitively impaired residents with exit seeking behaviors from exiting a locked unit in in the facility and then eloping from the facility via and unsecured door, the police found the resident on a busy street. The resident was not injured (Resident # 168). The Immediate Jeopardy began on 6/4/2017 when Resident # 168 exited the facility unattended by the facility staff, and was found 4 miles away from the facility by the police. The Immediate Jeopardy was removed on 6/13/2017 at 5:00 PM when the facility completed in-servicing the staff on elopement policies and procedures. The facility also completed a review of all the residents who were at risk for elopement on 6/13/2017. The facility provided an acceptable plan of correction completed 6/13/2017. The findings included: Resident # 168 was admitted to the facility on 5/24/2017. Resident # 168's diagnoses included dementia without behavioral disturbance, cognitive communication deficit and age- related physical debility.	F 323	Past noncompliance: no plan of correction required.	

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Review of the resident's admission Wandering Risk Evaluation dated 5/24/2017 revealed the resident scored a 7(score greater that 5 is at risk for wandering) was at high risk for wandering.

The admission Minimum Data Set (MDS) dated 5/31/2017 indicated Resident # 168's cognitive status was severely impaired. The MDS also indicated the resident was independent with locomotion in the unit.

The care plan dated 6/1/2017 indicated Resident # 164's problem of "wandering and/or at risk for unsupervised exits from facility related to: cognitive impairment due to worsening of his dementia." The goals included "allow resident to ventilate feelings regarding nursing home placement, allow resident to wander on unit, Wander Guard in place and resident to stay in Spark unit (locked unit).

A review of the Nurse's Note dated 6/4/2017written by Nurse #2 at 4:25 PM documented the resident returned to facility. He was ambulatory with slow steady gait, alert and pleasantly confused as usual. Resident # 168 stated "I had to go to the house check on those people that sneak in at night to steal my little bit of things" When asked how he exited the facility the resident stated, "I just followed a bunch of them people going out that door.

A review of the Nurse's Note dated 6/4/2017 written by Nurse # 1 at 6:48 PM documented "Resident left facility unsupervised. Resident found and brought back to facility by police; resident refused to go to hospital to be evaluated; resident stated that he was just going to come

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back to facility that he just needed to go check on his stuff. Resident in room with no distress noted."

Facility incident report dated 6/4/2017 revealed that on 6/4/2017 at approximately 1:20 pm staff were unable to locate Resident #168. Immediately upon recognizing Resident #168 was missing; a code orange (a code for a missing resident) was announced by Nurse #2. Nurse #1 then started the unsupervised exit protocol by delegating all the staff to begin searching for the missing resident. Law enforcement was called by Nurse #1 at approximately 2 pm in regards to elopement of Resident # 168 and police arrived at the facility at 2:10 pm. At 2:10 pm, Nurse #1 notified medical director of Resident #168's elopement and Responsible representative was notified of Resident #168's elopement. The police department notified Nurse #2 resident had been found. Resident # 168 was returned to the facility at approximately 4:20 pm by the police department. Resident # 168 was immediately placed on one on one supervision by Administrator. A head to toe assessment was completed on Resident # 168 with no injuries or S\S (signs) of dehydration noted by Nurse #3. Vital signs stable, BP (blood pressure) 165/74 P(pulse) 55 R(heart rate) 16 T(temperature) 98.9 O(oxygen)@ Sats(saturation) 99% resident denied any pain. Medical Director (MD) gave verbal order to encourage po (by mouth) fluids

Review of the resident's Wandering Risk Evaluation dated 6/4/2017 revealed the resident scored a 12 (score greater that 5 is at risk for wandering) the resident was a high risk for wandering.

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Statement written by Housekeeper manager on 6/4/2017 documented "on 6/4/2017, I was stripping and waxing the front entrance to the building, I had detoured all visitors and staff to go through the therapy room outside door because it was right off the main sidewalk. The door was open but closely monitored at all times. The only time I left the front area, was when I had to get something. Each time I left I had my floor technician to monitor the door until I returned. At no point during the day was the door left unattended. After the resident was discussed to be missing, the floor technician said that the resident had been telling everyone he was leaving today."

Statement written on 6/4/2017 by Nurse # 1 who was assigned Resident # 168 on 6/4/2017 documented at approximately 9:00 AM she was on 300 hall checking on another resident and she saw Resident # 168 walking down the hall stating he needed to leave because he had a doctor's appointment. She returned to the hall around 1:20 PM to pass some medications and Nurse Aide (NA) # 3 asked if she had seen Resident # 168 and she said no as she had just come on the floor. She notified Director of Nursing (DON) the resident was missing around 1:30 PM. She did an overhead page and notified all staff of the elopement and advised staff to do a search of facility and outside perimeter.

Review of the psychiatrist evaluation completed 6/6/2017 documented the staff reported patient left facility over the weekend and requested evaluation to assist patient. Patient was reported to be non- combative and was returned safely. Patient presents as very confused pleasant and

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engaging; obsessed with home and returning to full fill perceived obligations. Worried about his dogs and his car. Patient shared about being a truck driver and feeling the need to be "on the go." Patient very fixated on finding a way to return home

Interview with Nurse # 2 on 7/21/2017 at 9:30 AM revealed she was the nurse supervisor on Sunday 6/4/2017 when the resident was found missing from the locked unit. She stated a nurse assistant in the locked unit reported to her that they were not able to locate Resident # 168. She announced the code for missing resident and the staff began searching for the resident on the facility grounds. She reported the police were notified after the staff could not locate the resident. She added they were not sure at what time the resident left the building but there was speculation that the family of another resident might have let the resident off the locked unit. She also indicated the resident had a Wander Guard but no staff in the facility heard the alarm going off. She indicated the resident left the building using an unsecured exit door in the physical therapy room after the housekeeper left the door unlocked while waxing the floor by the front door. Nurse # 2 also indicated the families visiting on Sunday of 6/4/2017 were using the physical therapy exit door because the front door was locked due to the waxing of the floor.

Interviews with NA # 1 and NA # 2 on 7/21/2017 at 10:00 AM revealed the resident always stated he wanted to go home and was obsessed with wanting to leave to go home since he was admitted to the facility.

During the interview on 7/21/2017 at 10:30 AM,

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NA # 3 who was assigned to Resident # 168 on Sunday 6/4/2017 she realized the resident was missing from the building when she was getting ready to pass the trays at lunch time. NA # 3 also added she had seen the resident earlier that morning and he (Resident # 168) had indicated he wanted to go home.

During the interview on 7/21/2017 at 11:30 AM, the floor technician reported on Sunday morning of 6/4/2017 at 2 separate times at approximately 8:00 AM and 9:30 AM he had seen the resident standing by the locked unit entrance door and redirected the resident to go back to his room. He reported the resident had stated that he was leaving to go to the doctor's appointment.

Interview with the DON on 7/21/2017 at 2:00 PM revealed the resident was assessed as a high risk and was placed on the locked unit with a Wander Guard. She added there were no witnesses to state how the resident got off the locked unit and the building. She further added the speculation was that a family member who did not know Resident # 168 was a patient in the locked unit had let the resident off the unit. The DON added they are not sure as to the reason why the locked unit doors did not sound the alarm since the resident had on a Wander Guard. She also indicated the resident got out of the building using the physical therapy exit door. She indicated the only door at the facility that is equipped with a Wander Guard alarm is the front door. Other doors at the facility are not equipped to sound an alarm when a resident with the Wander Guard approaches the door. She added the housekeeper was waxing the front lobby and opened the physical therapy exit door for the families to use. The DON also indicated it was

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wrong for the Housekeeper Manager to open the therapy exit door because it was not safe for the residents.

Interview with Administrator on 7/21/2017 at 2:30 PM indicated her expectation was for staff to monitor the residents in the locked unit closely and for the housekeeper not to have opened the physical therapy exit door because it was not equipped with the door alarm. She added a plan of correction was put into place following the elopement incident. Thirty minute checks were initiated on 6/5/2017 for all residents in the locked unit and Resident # 168 remains on one on one monitoring.

The Housekeeper Manager who opened the physical therapy door was not available for interview. The Housekeeper was no longer employed at the facility.

Nurse # 1 who was assigned to Resident # 168 on Sunday 6-4-2017 was not available for an interview. The nurse was no longer employed at the facility.

Observation of the building on 7/21/2017 at 3:00 PM, revealed the main entrance and the locked unit entrance were equipped with Wander Guard alarm. The alarms were observed to be working and they were checked daily by the Maintenance Director to make sure they were functioning. Further observations of the building revealed there 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 there was a busy road in front of the facility which the speech limit was 45 miles

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per hour. The temperature on Sunday 6/4/2017 in the afternoon was 98 degrees.

The administrator was notified of the Immediate Jeopardy on 7/21/2017 at 10:30 AM.

CORRECTIVE ACTION FOR THE AFFECTED RESIDENT
Resident # 168 was found by Fayetteville police department at approximately 3:21 pm, approximately 4 miles from the facility. Per police officer EMS arrived on the scene and assessed Resident # 168. EMS (Emergency services) asked Resident # 168 if he wanted to go to hospital but Resident # 168 stated he wanted to return to the facility. Resident # 168 was returned to the facility at approximately 4:20 pm by the police department. Resident # 168 was immediately placed on one on one supervision by Administrator. A head to toe assessment was completed on Resident # 168 with no injuries or S\S (signs) of dehydration noted by Nurse #3. Vital signs stable. , BP(blood pressure) 165/74 P(pulse) 55 R(heart rate) 16 T (temperature)98.9 O(oxygen)@ Sats(saturation) 99% resident denied any pain. Medical Director gave verbal order to encourage po(by mouth) fluids Administrator and Social worker attempted to send Resident # 168 to hospital for evaluation per MD(medical doctor) order; Resident # 168 refused. Resident's Wander Guard was checked by the Director of Nursing with Administrator present, immediately upon entering facility. Resident # 168's Wander Guard worked appropriately. Wandering Risk assessment for resident #168 reviewed and updated by Director of Nursing. On 6/5/2017 Director of Nursing received order for psych referral to evaluate and

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treat Resident #168 the resident was seen by Health Network on 6/6/17 for collection of identifying information and 6/7/17 by MD who ordered for the resident to remain on supervision with no other orders. "He will continue for monitoring for mood and behaviors.

CORRECTIVE ACTION FOR THE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED
A 100% Head Count was completed on 6/4/2017 by staff nurses per the census for accountability of all residents. All residents present and accounted for.

A 100 % audit was completed on 6/4/2017 by the Maintenance Supervisor of all entrance/exit doors in the facility to ensure all doors were locked and functioning properly. No negative findings found.

A 100% audit was completed on 6/4/2017 by the Director of Nursing on all residents for At Risk for Wandering. Appropriate interventions were implemented as indicated from the review.

All identified at risk for wandering care guides and care plans were updated by the Director of Nursing, Assistant Director of Nursing, and MDS Nurse completed on 6/5/2017.

Q (Every) 30 min checks were initiated on 6/5/2017 for all SPARK (locked unit) unit residents. Resident # 168 remains on 1-1 monitoring. Resident #1 will remain on 1:1 supervision until the residents condition would deteriorate and no longer be able to ambulate and therefore no longer be assessed as an elopement risk or upon the resident's representative choice to discharge.

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WHAT MEASURES WERE PUT INTO PLACE OF SYSTEMIC CHANGES MADE
An In-service was initiated on 6/4/2017 by the Director of Nursing/Administrator/Staff Facilitator for nursing, administrative, dietary, activities, and contract services (Rehabilitation and Housekeeping and Laundry services) Maintenance, Payroll coordinator, and Accounts payable manager, central supply coordinator and receptionist. The Action Checklist for Unsupervised exits to be completed by 6/13/2017. The In-Service includes appropriate steps to take for a missing resident. First start a missing resident search and delegate other staff to notify Director of Nursing and Administrator, (use Pink Book at the Main Nurses Station which has the Action Checklist for Unsupervised Exits, and notify corporate staff). Notify the attending Medical Director, family, and appropriate Authorities delegated by Administrator. Assessment of residents' condition must be completed and Implementing measures to protect other residents. Reviewing Resident #168 and other residents identified as risk for wandering care plan and updating wandering assessment and making sure wandering board pictures are current by the Director of Nursing and Quality Improvement Nurse on 6/5/17.

An In- Service was initiated on 6/4/2017 by the Staff Facilitator/Director of Nursing to all staff on Elopement and wandering residents to be completed by 6/13/2017. Please make sure residents' with alarm are not left to exit the building unassisted. Doors with alarms should not be reset without making sure that all residents are safe and secure. All residents on the locked unit should have on A Wander Guard Alarm. Do not

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prop open exit/entrance doors for any reason as this will and can be a way for exit for residents. Exit Door Keys will not be used to unlock any exit door unless prior approval is attained by the Administrator. All wandering residents should be redirected. Please refer to the Pink Book at the main nurse's station when residents are missing.

An In-Service was initiated on 6/4/2017 by the Administrator to the Maintenance Supervisor and all Department Supervisors in reference to unsupervised exits and checking of the wander guard to be completed by 6/13/2017. Manager on Duty must be sure that all wander guards, door checks are completed. Failure to do so will lead up to disciplinary action or termination of employment. This system is in place to keep our residents safe and free from harm.

An In-service for nursing, administrative, dietary, activities, and contract services (Rehabilitation and Housekeeping and Laundry services), Maintenance, Payroll coordinator, and Accounts payable manager, central supply coordinator and receptionist. The in-service was started on 6/4/2017 by the Administrator\Staff Facilitator Assistant in regards to proper steps on how to enter\exit the SPARK unit to was completed by 6/13/2017.

An Elopement quiz was initiated by the Administrator on 6/4/2017 with all staff and was completed on 6/13/2017. In the case when a staff member can't locate a resident and the resident is nowhere to be found in the facility is called a code orange.

An In-service was initiated on 6/4/2107 on 1-1montoring with licensed nurses, nursing

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assistants, dietary staff and department heads and was completed on 6/13/2017. 1:1 means for the staff member to be sitting with the resident at all times. Staff member cannot allow resident to be out the supervision. The staff are not allowed to leave the resident unattended unless relieved from another staff member. If this system fails the staff member will be terminated for not ensuring the resident is safe at all times.

Resident care audit tools initiated on 6/4/2017 with all staff return demonstration in regards to entering and or exiting the SPARK unit by the Administrator and Staff Facilitator assistant and was completed on 6/13/2017.

HOW THE FACILITY PLANS TO MONITOR CHANGES IMPLEMENTED
Entrance/exit doors to be monitored by maintenance supervisor daily for 1 week then three times a week for 1 week; twice a week times 1 week; 1 time a week times one week; then monthly times two months beginning on 6/4/17. To ensure the door alarm is sounding when the threshold is approached and the door automatically locks down with a wander guard and if the door is constantly locked then the door remains locked upon approach to exit. Any identified areas of concern identified be either the door not enunciating or locking will result in a guard being placed at the door to assure no exit occurs from a wandering resident until the issue is resolved.

10% of the staff for nursing, administrative, dietary, activities, and contract services (Rehabilitation and Housekeeping and Laundry services), Maintenance, Payroll coordinator, and

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Accounts payable manager, central supply coordinator and receptionist to be monitored entering and exiting the locked Alzheimer's/Dementia care unit weekly for 8 weeks and monthly X 1 month utilizing the Resident care audit-SPARK door observation tool by the Administrator, DON, RN supervisor, Staff Facilitator. This monitoring tool is to ensure staff take proper precautions prior to entering or exiting sparks unit, checking surroundings for a resident that may be close by the door, and making sure door is closed completely prior to proceeding. This tool is utilized for nursing, administrative, dietary, activities, and all other respective departments.

The Quality Improvement Executive Committee will review all audit information monthly x 3 months for any recommendations, take actions as appropriate and to monitor continued compliance in this area. On 6/5/17 the Quality Improvement Committee that included the Administrator, Director of Nursing, Quality Improvement Nurse, Admission, Social Worker, Dietary manager, Activity Director, Therapy Manager, Medical Records, Treatment Nurse, Staff Development Nurse, Staff Development Coordinator, maintenance Supervisor, Medical Director Minimum Data Set Nurse and Housekeeping manager to reviewed the plan of correction on for elopement and ascertain the root cause of the elopement. The committee reviewed the occurrence from 06/05/17 for resident #1. The committee determined that the housekeeping supervisor failure to communicate and to report the disarming of the door caused the resident access to exit the facility due to him overriding the door alarm and that staff were not assuring no one was leaving the unit while the

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doors were closing on the locked unit. The housekeeping supervisor is no longer employed at the facility due to the occurrence of failed to ensure resident safety and communicate the rerouting of the traffic due to buffing the floors. The supervisor was removed from the facility on 6/5/17 by Health Care Services Group.

All staff that were involved on the date of the exit (6/4/17) were interviewed. The investigation was not conclusive because no one witnessed the resident leaving the locked unity that is why the in-service was initiated with return demonstration on ensuring when you leave the locked unit no one leaves the unit or that you do not assist anyone from the unit. The investigation was undetermined only on how the resident left the locked unit, the second part of the investigation was admitted to by the housekeeping supervisor of unarming the front door and failure to communicate with the director of nursing or administrator of the occurrence to place a guard at the door. The housekeeping supervisor was terminated in relation to this lack of communication on 6/5/17.

It was speculated the housekeeping aide did not secure the door upon exiting and the resident had walked out behind the employee. The facility implemented the in-servicing to ensure the doors upon entering and exiting are secured prior to walking away from the doors and that no resident has left the unit.

A laminated sign was placed on the entry doors to the locked unit stating, "Attention Visitors Please make sure the 300 hall doors are closed and locked upon entering and exiting" on 6/4/17 by the Administrator. On the main entrance doors of

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F 323	Continued From page 23 the facility a laminated sign was placed by the Administrator on 6/4/17 stating, "Before assisting a resident outside please see a staff member." On the main front entry doors another laminated sign was placed by the administrator on 6/4/17 stating, "Please do not allow residents out of the building unless authorized by the nursing department Thank you for your cooperation." As part of the validation process on 7/21/2017 at 4:30 PM, the entire plan of correction was reviewed including interviews of all 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. A review of the monitoring tools revealed that the facility had completed 100% of their in- servicing on 6/13/2017.	F 323		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		8/16/17

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F 371	Continued From page 24 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of the policy entitled "Hand Hygiene", the facility failed to ensure staff did not handle food with their bare hands for 1 of 1 meal observed for resident #52. The findings included: A review of the Dietary Infection Control Responsibilities, from the Infection Control Manual dated 9/2014, indicated safe food handling procedures are essential to protect our residents.....wear vinyl or plastic gloves for handling food. During an observation on 07/17/2017 at 12:40 p.m., Nursing Assistant (NA) #5 washed her hands and sat down with resident #52. NA#5 was observed to pick up his chicken breast and tear the meat into three smaller pieces. NA#5 placed a piece of the meat in the resident's hand and requested him to eat the chicken. During an interview with NA #5 on 07/20/2017 at 11:29 a.m., NA #5 stated it is hard to break up the meat without forks and knives. When asked what she could have done to cut the meat smaller	F 371	F371 Nursing Assistant #5 was in- serviced on safe food handling procedures to include not touching residents food with bare hands on 7-17-2017 by the Staff Facilitator. A return demonstration was given by Nursing Assistant #5 on proper hand hygiene to include not handling food with nursing assistant's bare hands by the Staff Facilitator on 7-17-2017 after receiving the re-education with no identified areas of concerns. Resident #52 food will continue to be handled safely by all staff. A 100% of all licensed nurses and nursing assistants to include NA #2 will be observed by the Staff Facilitator performing hand hygiene during meal tray set-up to include not handling resident's to include resident # 52 food with bare hands to be completed by 8-16-2017. The licensed nurse and\or nursing assistant will be immediately retrained during the observation by the Staff Facilitator in regards to proper hand hygiene per the facility and dietary infection control responsibilities.	

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	345376	A. BUILDING _____ B. WING _____	C 07/21/2017

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F 371	Continued From page 25 rather than pull it apart with her hands, NA #5 stated she could have called the kitchen to let them know the chicken was too big for the resident. NA #5 stated she should have had gloves on while touching the resident's food. During an interview with the Director of Nursing (DON) on 7/20/17 at 9:30 a.m., the DON stated it was her expectation nursing staff should not use their bare hands to handle residents' food. During an interview with the Administrator on 07/21/2017 at 11:54 a.m., the Administrator stated it was her expectation for staff to use gloves when touching residents' food and for staff to use utensils to cut food if needed.	F 371	100% of all licensed nurses and nursing assistants to include NA #5 in-servicing was initiated on 7-17-2017 by the Staff Facilitator to be completed on 8-16-2017 regarding hand hygiene to include not handling food with bare hands. Resident's food is to be touched with vinyl or plastic gloves. All newly hired licensed nurses and nursing assistants will receive the education regarding the hand hygiene and to include not touching resident's food with bare hands in orientation by the staff Facilitator. 10 % of all licensed nurses and nursing assistants to include Nursing Assistant #5 will be observed by the Staff Facilitator and\or the Quality Improvement Nurse to ensure proper hand hygiene is being performed to include not handling residents food with bare hands to include resident #52 during meal tray set-up utilizing the Resident Care Audit tool weekly x 8 weeks then monthly x 1 month.The Staff Facilitator and\ or the Quality Improvement Nurse will immediately retrain the licensed nurse and/or nursing assistant for any identified concerns during the audit. The Director of Nursing will review and initial the results of the Resident Care Audit Tools weekly x 8 weeks then monthly x 1 month for completion and ensure all areas of concerns were addressed. The DON will forward the results of the Resident Care Audit Tools to the Executive committee monthly X 3 months. The Executive Committee will meet monthly and review the Resident Care audit tools and address any issues,	

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F 371	Continued From page 26	F 371	concerns and\or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		8/16/17

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F 441	Continued From page 27 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to wash their hands before and after wearing gloves for 1 of 1 observations of a dirty task performed during a time when meal trays were being served. The findings included:	F 441	F441 Nursing Assistant #2 was in-serviced on proper hand hygiene per the facility policy on handwashing on 7-17-2017 by the Staff Facilitator. A return demonstration was given by Nursing Assistant #2 on	

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F 441	Continued From page 28 During an observation of meal trays being served to residents on 07/17/17 at 12:42 p.m., Nursing Assistant #2 was observed to enter Resident #175's room (room 241A), put on a pair of gloves and empty urine from the resident's urinal into the toilet. NA #2 removed her gloves. NA #2 did not wash her hands before putting on the gloves or after taking the gloves off. NA #2 then arranged Resident' #175's over-bed table in preparation for the meal tray. NA #2 was then observed to serve Resident #175's meal tray to him and observed providing set-up help with the items on the tray. During an interview with NA #2 on 07/17/17 at 12:50 p.m., NA #2 realized she had not washed her hands before and after wearing gloves. When asked why she did not wash her hands, NA #2 stated she was "just moving, doing a lot, I had to go feed a man, I was rushing because I had a lot to do." During an interview with the Director of Nursing (DON) on 07/21/17 at 10:25 a.m., the DON stated it was her expectation nursing staff follow the handwashing policy of the facility. During an interview with the Administrator on 07/231/17 at 10:30 a.m., the Administrator stated it was her expectation the staff follow the facility handwashing policy at all times.	F 441	proper hand hygiene to include washing hands before and after wearing gloves after performing a dirty task to the Staff Facilitator on 7-17-2017 after receiving the re-education with no identified areas of concerns. A 100% of all licensed nurses and nursing assistants (NA) to include NA #2 will be observed by the Staff Facilitator performing proper hand hygiene to include washing hands before and after wearing gloves after performing a dirty task to ensure the facility handwashing policy is being followed to be completed by 8-16-17. The licensed nurse and\or nursing assistant will be immediately retrained during the observation by the Staff Facilitator for any identified areas of concern. 100% of all licensed nurses and nursing assistants to include NA #2 will be in-serviced regarding the handwashing policy to include washing hands before and after wearing gloves and after performing a dirty task by the Staff Facilitator to be completed by 8-16-2017. All newly hired licensed nurses and nursing assistants will receive the education regarding the handwashing policy to include washing hands before and after wearing gloves and after performing a dirty task in orientation by the staff Facilitator. 10% of all licensed nurses and nursing assistants to include Nursing Assistant #2 will be observed by the Staff Facilitator to	

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F 441	Continued From page 29	F 441	ensure proper hand hygiene is being performed to include washing hands before and after wearing gloves and after performing a dirty task utilizing a Resident Care Audit tool weekly x 8 weeks then monthly x 1 month. The Staff Facilitator will immediately retrain the licensed nurse and/or nursing assistant for any identified concerns during the audit. The Director of Nursing will review and initial the results of the Resident Care Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concerns were addressed. The Director of Nursing will forward the results of the Resident Care Audit tools to the Executive Committee monthly X 3 months. The Executive committee will meet monthly and review the Resident Care Audit tools and address any issues, concerns and\or trends to make changes as needed, to include continued frequency of monitoring x 3 months.	