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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING ______ B. WING ______	C 04/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MYERS PARK	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 000	INITIAL COMMENTS A Complaint Investigation survey was conducted on 04/25/19 and 04/26/19. Immediate Jeopardy was identified at: CFR 483.25 at F 689 at a scope and severity of J. The tag 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 04/22/19 and was removed on 04/26/19. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, family member, staff and police officer interviews, and record review, the facility failed to prevent a cognitively impaired resident from exiting the facility without staff supervision for 1 of 11 residents at risk for elopement (Resident #1). Resident #1 was found hours later at a hotel 2 miles away from the facility. The resident required transportation to the hospital for assessment and identification. Resident #1 was returned to the facility without injury.	F 689	Resident #1 returned to the facility from the hospital on 4.23.2019. Resident #1 was reassessed for any apparent injury. No injuries were found. Resident #1's wander guard device was checked and assessed. Resident's #1 wander guard device was deemed to be in proper working condition. The plan of action and system change was discussed with the resident's	5/21/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/18/2019

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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Immediate Jeopardy began on 04/22/19 when Resident #1 left the facility through an exit door without supervision and was found hours later at a hotel 2 miles away from the facility. Immediate Jeopardy was removed on 04/26/19 when the facility provided and implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity (D) (No actual harm with potential for more than minimal harm that is not immediate jeopardy.) for monitoring of the revised systems put into place related to supervision to prevent elopement.

The findings included:

Resident #1 was admitted to the facility on 09/14/18 with diagnoses of dementia and psychosis. Resident #1 was admitted to the facility's secured unit on the third floor.

Review of Resident #1's admission Minimum Data Set (MDS) dated 09/21/18 revealed an assessment of severely impaired cognition with no behavior problems. The MDS indicated Resident #1 required supervision and the assistance of one person with walking.

Review of Resident #1's quarterly MDS dated 04/03/19 revealed an assessment of severely impaired cognition with no behavior problems. The MDS indicated Resident #1 walked independently with supervision.

Review of Resident #1's care plan reviewed on 04/18/19 revealed staff developed a care plan for a risk for elopement. Interventions included activity program involvement, redirection from

F 689

granddaughter/responsible party on 4/25/19. Upon signing a cognitively impaired resident on or off the unit, the nurse will witness the signer and initial beside the signature as acknowledgement of the resident either leaving or returning to the unit with his/her family member or responsible party. A staff member will accompany the resident and responsible party to the exit to ensure supervision and safety is provided.

Wander guard devices for all other residents identified as a wanderer and requiring a wander guard device were checked on 4.25.2019. Families and/or responsible parties of residents identified as wanderers and requiring wander guard devices were notified by phone and/or U.S mail of the facility sign in/out process on Friday, April 26, 2019.

All staff, including nursing, activities, therapy, laundry, housekeeping, admissions, central supply, maintenance and business office have been educated on the proper response to facility door alarms and initial resident search expectations when door alarms are activated (4.23.2019).

In the event facility door/elevator alarms are activated, all staff including nursing, activities, therapy, laundry, housekeeping, admissions, central supply, maintenance and business office, have been trained to search the immediate exterior areas of the facility for unsupervised cognitively impaired residents, prior to deactivating

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F 689	Continued From page 2 doors and use of a wander guard. Review of Resident #1's Release of Responsibility for Leave of Absence form revealed a family member signed Resident #1 out of the facility on 04/17/19 at 7:20 PM. The family member signed Resident #1's return to the facility on 04/22/19 at 6:20 PM. Review of a nursing note dated 04/23/19 at 1:00 AM revealed Nurse #4, the night charge nurse, documented a call received from the hospital at 12:40 AM which informed the facility of Resident #1's location and retrieval from an uptown location. Resident #1 returned to the facility on 4/23/19 at 4:00 AM with no new orders and no injury. Telephone interview on 04/25/19 at 10:09 AM with Nurse Aide (NA) #2 revealed she worked from 3:00 PM to 11:00 PM on 04/22/19. NA #2 reported her assignment included Resident #1. She explained on 04/22/19 Resident #1 and Resident #1's family member came onto the third floor during the supper meal delivery which was at approximately at 6:00 PM. She saw Resident #1 and Resident #1's family member in Resident #1's room talking to each other. NA #2 reported she saw Resident #1 walking after the family member in the hallway approximately at 6:45 PM on 04/22/19. She assumed the family member was taking Resident #1 out of the facility to continue the leave of absence (LOA). NA #2 reported she remade Resident #1's bed but did not report her visualization of Resident #2 in the hall since she assumed Resident #1 left with the family member. An alarm did not sound during her shift on 04/22/19. NA #2 explained that when a person who wore a wander guard was near the	F 689	facility door/elevator alarms. All licensed and certified nursing staff were educated on the facility “buddy system” (4.25.2019). Staff shall accompany the resident and their responsible party to the facility exit if the resident is cognitively impaired to ensure supervision and safety is provided. Staff not present for the in-servicing shall be educated prior to the start of their shift. All new hires shall be educated during new hire orientation. To ensure compliance, beginning 5.21.2019, the unit nurse manager shall conduct audits of the sign in/out sheet 5 times weekly for 4 weeks. Thereafter, 3 days weekly for 4 weeks, and then once weekly for 4 weeks. Beginning 5.21.2019, video validation shall occur for cognitively impaired residents entering or exiting the facility shall be conducted per occurrence. Beginning 5.21.2019, all facility doors and elevators with wander guard sensors will be audited by the facility maintenance director to ensure proper functioning. Audits will be conducted 5 times weekly for 4 weeks. Thereafter, 3 times weekly for 4 weeks, and then twice weekly for 4 weeks. Beginning 5.21.2019, the unit charge nurse will audit staff members response to facility door alarms and initial resident search expectations when door alarms are activated. Audits will be conducted 3 times weekly for 4 weeks. Thereafter,	

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F 689	Continued From page 3 opened elevator doors, the alarm would sound. During a telephone interview with Nurse #3, the evening charge nurse, on 04/25/19 at 12:09 PM, Nurse #3 stated she worked the evening of 04/22/19 from 3:00 PM to 11:00 PM. Nurse #3 reported she observed Resident #1 with a family member during the 04/22/19 supper meal service. Nurse #3 explained she did not speak with Resident #1's family member and continued with medication administration to other residents. Continued telephone interview with Nurse #3 revealed she did not hear an alarm or silence an alarm at the elevator doors during the evening of 04/22/19. Nurse #3 explained she thought Resident #1 remained on LOA with the family member. Nurse #3 reported on 04/22/19 she saw Resident #1 walking in the hall with the family member and thought they were leaving together. Telephone interview with NA #3 on 04/25/19 at 12:26 PM revealed she worked the evening of 04/22/19 on the secured unit. NA # 3 reported she did not hear or silence an alarm at the elevator doors. NA #3 did not observe Resident #1 during the evening of 04/22/19. Telephone interview with NA #4 on 04/25/19 at 12:29 PM revealed she worked the evening of 04/22/19 on the secured unit. NA #4 reported she did not hear or silence an alarm at the elevator doors. NA #4 did not observe Resident #1 during the evening of 04/22/19. Telephone interview with NA #5 on 04/25/19 at 12:33 PM revealed she worked the evening of 04/22/19 on the secured unit. During the	F 689	twice weekly for 4 weeks, and then once weekly for 4 weeks. Results will be shared with the administrator weekly and discussed monthly during the facility QAPI Committee meeting.	

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interview, NA #5 reported she did not hear or silence an alarm at the elevator doors. NA #5 observed Resident #1 and Resident #1's family member during the supper meal on 4/22/19. NA #5 reported she observed Resident #1 and the family member enter Resident #1's room approximately at 6:30 PM on 04/22/19.

Telephone interview with Nurse #4, night shift charge nurse, on 04/25/19 at 12:46 PM revealed he received report Resident #1 remained on LOA upon his arrival to duty at 11:00 PM on 04/22/19. The night shift charge nurse reported he received a telephone call approximately at 12:30 AM on 04/23/19 from the hospital regarding Resident #1. He informed the hospital that Resident #1 was on LOA. Nurse #4 received information from the hospital that Resident #1's family member returned Resident #1 to the facility the evening of 04/22/19. The night shift charge nurse notified the Director of Nursing (DON) and the unit manager of the conflicting information and expected return of Resident #1. Resident #1 returned to the facility with no new orders and without injury.

Telephone interview with the police officer on 04/25/19 at 11:09 AM revealed he received a call from hotel staff at 11:00 PM on 04/22/19 who requested assistance with a confused person with symptoms of mental illness. He reported the hotel's location was in the city's downtown area. Continued interview revealed he arrived at the hotel at 11:03 PM on 04/22/19. Resident #1 was in the hotel lobby, upset about lack of money and did not know her name. Resident #1 calmed with oral reassurance and appeared well groomed with a wander guard on her leg. He explained Resident #1 was taken by ambulance to the

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hospital for evaluation and identification. The hospital's palm identification system (A scan which produces a unique biometric template of a person's unique vein pattern.) identified Resident #1 and gave an emergency contact number. He called the contact number, Resident #1's family member, who informed him that Resident #1 was a resident in the facility and should have a wander guard.

Review of Resident #1's emergency room evaluation dated 04/23/19 at 12:22 AM revealed the emergency room physician documented Resident #1 wandered from a skilled nursing facility. The emergency room physician documented hotel staff discovered Resident #1 on the 10th floor of an uptown hotel knocking on room doors. The emergency room physician documented the skilled nursing facility assumed Resident #1 was with a family member. Resident #1's family member informed the emergency room physician that Resident #1 was returned to the skilled nursing facility the evening of 04/22/19. Resident #1 had no signs of serious illness or injury. Resident #1 received a discharge back to the facility on 04/23/19 at 3:42 AM.

Telephone interview with Resident #1's family member on 04/25/19 at 10:25 AM revealed prior to Resident #1 being admitted to the facility in September 2018 the resident wandered away from home on occasions. The family member stated she brought Resident #1 back to the facility on 04/22/19 at 6:20 PM after a LOA. Resident #1's family member reported she orally informed the evening charge nurse, Nurse #3, on 04/22/19 of Resident #1's return. Resident #1's family member reported Nurse #3 gave her the Release of Responsibility for Leave of Absence

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form to sign. Resident #1's family member reported a police officer notified the family member of Resident #1's presence at the hospital after midnight on 04/23/19. The family member informed the police officer of Resident #1's status as a resident of the facility.

Interview with Nurse #2, unit manager, on 04/25/19 at 9:18 AM revealed Resident #1 wandered on the unit and used a wander guard. Nurse #2 explained Resident #1 was independent in all activities of daily living but required supervision due to confusion. Nurse #2 reported Resident #1 had a history of exit seeking prior to her admission according to Resident #1's family member. Nurse #2 reported the night charge nurse, Nurse #4, notified her immediately on 04/23/19 at approximately 12:45 AM that Resident #1 had been found at a local hotel, taken to the hospital and due to return. Nurse #2 explained facility staff thought Resident #1 remained on leave of absence with a family member. Nurse #2 reported she immediately came to the facility. Nurse #2 checked Resident #1's wander guard with the wander guard tester (a hand held, battery powered device) and the wander guard functioned properly. Nurse # 2 reported Resident #1 had no injury, appeared tired and had no new orders from the emergency room visit. Nurse #2 reported Resident #1 received visual checks every 15 minutes for 72 hours after the incident.

Review of a city map revealed the hotel Resident #1 was located at on 04/22/19 was 2.0 miles from the facility. From the facility to the hotel, the metropolitan environment contained office buildings, city bus terminal, light rail station, restaurants, hotels and night clubs. The hotel is

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located across the street from a major sports/entertainment arena. Observation on 04/23/19 at 11:45 AM revealed the potential routes to the location consisted of side walk lined, 2 to 4 lane streets with speed limits of 25 miles per hour (MPH) to 35 MPH. According to a local weather station website, the outside temperature ranged from 62 degrees Fahrenheit at 7:00 PM to 55 degrees Fahrenheit at 11:00 PM on 04/22/19.

Observation on 04/25/19 at 12:21 PM revealed Resident #1 ambulated independently with a steady gait. During attempted interview, Resident #1 was oriented to self only. Resident #1's left ankle had a wander guard.

Interview with the Director of Nurses (DON) on 04/25/19 at 1:22 PM revealed she received notification of Resident #1's elopement upon arrival to work on 04/23/19. The DON reported she suspended NA #2 and Nurse #3 pending the outcome of the facility's investigation which was not concluded. The DON explained staff who worked the evening of 04/22/19 reported hearing no alarms and assumed Resident #1 remained on LOA.

Interview with the Administrator on 04/25/19 at 1:33 PM revealed the facility's wander guard system had alarms on both elevators on the third floor. In addition, both exterior doors on the first floor were alarmed. The Administrator explained both exterior doors locked when a resident with a wander guard came near but did open when the handicap door opener was pushed. Alarms sounded when a wander guard was near regardless of the open door and could only be silenced with a code known to staff members only. The wander guard system did not track

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dates and times of alarms. The Administrator explained the facility used a security video tape system at both exterior doors.

Observation with the Administrator on 04/25/19 at 1:40 PM of the facility's security video revealed Resident #1's family member exited through the first floor back door on 04/22/19 at 6:42 PM. Resident #1 exited the facility through the back door alone on 04/22/19 at 6:47 PM. Resident #1 wore street clothes, shoes and a jacket and pressed the handicap door opener which opened the back exterior door. The Administrator reported the person who silenced the alarm could not be identified due to lack of clarity on the video since only the back of the staff member could be seen. Prior to and after silencing the door alarm, the staff member made no attempt to look outside to see if a resident had exited the facility without supervision.

The facility's Administrator was notified of the immediate jeopardy on 04/25/19 at 5:34 PM.

The facility provided an acceptable credible allegation of immediate jeopardy removal which included:

Resident #1 was brought back to the facility accompanied by her granddaughter with no apparent harm or injury. Resident #1 has been put on every 15-minute checks for 72 hours to monitor for active exit seeking behaviors. Acknowledgement and investigation findings were shared with the resident's family/responsible party beginning on 4.23.2019. The plan of action was discussed with the resident's family/responsible party on 4/25/19. Validation of this process change was made by the resident

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F 689	Continued From page 9 family/responsible party on to the facility administrator on 4.25.2019. All other residents at risk for elopement were accounted for upon notification of resident #1 being at the ER on 04/23/2019 by the 11-7 staff nurse. All residents at risk for elopement reside on the 3rd floor unit. On 4/25/19, every facility door and both elevators tied into the facility wander guard system was checked by the maintenance director to ensure proper functionality. Additionally, all residents at risk for elopement's wander guard device was also checked by the nurse manager and primary nurse to ensure proper functionality. Beginning on 4/23/2019 through current, all direct care staff, which includes licensed nurses and Certified Nursing Assistants have been educated by the Administrator, Director of Nursing and Nurse Managers on the resident sign in/out process. This process is the responsibility of the resident's primary nurse. Upon return to the unit, the primary nurse will physically observe the resident's presence. The primary nurse will witness the family member signing the resident into the facility and acknowledge by placing their initial next to their signature. Families and/or responsible parties will be notified by phone and U.S. mail of the sign in/out process on Friday, April 26, 2019. Reeducation of direct care staff also included proper end of shift report, which includes accounting for all in-house residents. Beginning on 4/23/2019 through current, all staff,	F 689		

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which include but are not limited to, direct care staff, (licensed nurses, certified nursing assistants, and therapist), non-direct care staff (Business Office, Social Services, and Activities) and ancillary employees (Dietary, Housekeeping) have been educated on the proper response to the facility wander guard system by the Administrator, Director of Nursing, Director of Rehab, Director of Dietary, and the Unit Nurse Managers. Education also included re-dissemination of the facility wander guard system's numeric codes and code use. This step is to ensure everyone knows the proper response process and how to identify the need to act or request for assistance.

The systemic change implemented by the facility shall be a buddy system. All residents at risk for elopement reside on the facility's third floor. Third floor residents at risk for elopement who have signed out with a family member or a responsible party shall be accompanied by a staff member to the elevator and exit doors. This process change implementation is to ensure deactivation of the facility wander guard system and help ensure the resident has safely exited the facility. Residents at risk for elopement signed out or exiting the facility by a staff member shall be accompanied by a teammate to the exit doors. This process change implementation is to ensure deactivation of the facility wander guard system. If in the event of the facility's wander guard system is alarmed, and no resident is present or witnessed, the staff member shall do the following:

Search the immediate area. If no resident is still present or witnessed, the staff member will notify the 3rd floor nurse or unit manager to conduct an immediate head count of all residents at risk for

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COMPLETE CARE AT MYERS PARK	**300 PROVIDENCE ROAD CHARLOTTE, NC 28207**

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F 689	Continued From page 11 elopement. If then no resident is accounted for, a Code Amber/Missing Resident Protocol shall be initiated. Beginning 4.25.2019, All staff members, which include but are not limited to, direct care staff, (licensed nurses, certified nursing assistants, and therapist), non-direct care staff (Business Office, Social Services, and Activities) and ancillary employees (Dietary, Housekeeping) shall be educated to this process prior to the start of their shift by their immediate supervisor or designee. Systemic changes have been made through staff re-education and implementation of the facility "Buddy System." Review of the events leading up to this event have determined to be caused by human error and not mechanical or equipment malfunction. The immediate jeopardy was removed on 04/26/19 following observations of staff supervision of residents identified as at risk for elopement. Observations included staff response to activation of wander guard alarms and implementation of the "Buddy System." Staff interviews revealed receipt of training related to response to alarms, implementation of the "Buddy System" and sign out procedures. Documentation was reviewed regarding staff training and family member notification of the procedure to take a resident off of the secured third floor unit.	F 689		