STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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E 000	Initial Comments An unannounced Recertification survey was conducted on 07/08/19 through 07/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RJ8N11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted on 07/08/19 through 07/11/19. There was 1 allegation substantiated out of 12.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 1 of 22 residents whose MDS (Minimum Data Set) assessments were reviewed (Resident #43). Findings: Resident #43 was admitted to the facility on 4/14/17 with active diagnoses in part to include; Non-Alzheimer ' s Dementia, and Major Depression. A review of the most recent MDS (Minimum Data Set) dated 4/4/19 and coded as an annual assessment documented that Resident #43 had moderately impaired cognition and required extensive assistance with bed mobility, transfers and activities of daily living. Resident #43 was	F 641	MDS section E was corrected on resident #43 with Wandering behavior. This was completed by the MDS coordinator and corrected on 7/10/19 and submitted on 7/11/19. An MDS audit was conducted utilizing a MDS Audit Tool on 7/10/19 by the MDS Coordinator and Regional MDS Consultant. The tool was used to review section E of MDS for these identified residents for wandering to ensure accuracy. All residents were found to have current accurate information. In-services of completing the MDS, including Section of E of the MDS, was immediately provided on 7/10/19 to the	8/6/19

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

Electronically Signed | 08/02/2019

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F 641	Continued From page 1 coded as having no wandering behaviors during the 7 day look back period. A review of the care plan initiated on 4/6/18 and revised on 4/17/19 documented that Resident #43 was an elopement risk and wanderer related to dementia, impaired cognition, and impaired safety decision making. Interventions included; the resident would not leave the facility unattended, to change the wander guard every 90 days, to check placement and function of the wander guard every shift. A review of the physician order dated 4/1/19 revealed an order for Wander guard to left ankle for exit seeking behaviors. A nursing progress note dated 3/30/19 at 3:10 PM and written by Nurse #4 documented resident (Resident #43) was found out by the tool shed and said she was just wandering around and when asked what she was doing she said she had done it before. Her nursing assistant reported to the nurse when she asked resident if she could get her anything she said yes, some pills that would make her not wake up. The MD communication book was updated. An interview was conducted on 7/11/19 at 11:28 AM with the Minimum Data Set (MDS) nurse. She acknowledged the annual MDS assessment dated 4/4/19 should have captured the residents wandering behaviors in section E900, and due to the incident on 3/30/19 it did fall into the 7 day look back period. She stated the Social Worker was responsible for completing that portion of the MDS assessment and is new to the process. She stated she would be resubmitting the 4/4/19 annual MDS assessment with the correct	F 641	Social Workers, MDS coordinators, Activities coordinators and Director of Nursing by the Regional MDS consultant. An MDS Audit Tool was created to monitor accuracy of behavior coding in section E of the MDS. The Social Workers will initiate the MDS Audit Tool. All information coded on Section E of the MDS that is entered on the Audit Tool will be validated by the MDS Department to ensure accuracy. This will occur once a week for three months and then once a month for 9 months. Any changes that are necessary will be made during these reviews. The results of all monitoring will be presented by the MDS Coordinators to the QAPI committee in the Monthly QAPI meeting for review and recommendations for a minimum of 3 months.	

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F 641	Continued From page 2 information. An interview was conducted on 7/11/19 at 3:26 PM with the facility Social Worker. She acknowledged that she was responsible for completing section E900 of the MDS assessment. She stated the error could have been that she accidently checked that the resident did not exhibit wandering behaviors. She stated her process included reviewing progress notes, and assessments during the 7 day look back period. She acknowledged that resident #43 had exhibited wandering behaviors during that time period. An interview was conducted on 7/11/19 at 3:50 PM with the Director of Nursing. She stated the MDS assessment dated 4/4/19 should have captured the residents wandering behaviors.	F 641		
F 689 SS=D	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 observations, record review, and staff and physician interviews, the facility left a resident, who displayed wandering and exit seeking behaviors, unsupervised outside of the facility for 1 of 1 resident reviewed for elopement (Resident #43).	F 689	Resident returned to facility by staff at time of event. Resident expressed no concerns or issues and there were no reports of injuries noted in nursing progress notes. DON met with resident on 4/1/19, to discuss her recollection of event	8/6/19

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F 689	Continued From page 3 Findings included: Resident #43 was admitted to the facility on 4/14/17 with active diagnoses in part to include; Non-Alzheimer ' s Dementia, and Major Depression. The resident ' s care plan initiated on 4/6/18 documented that Resident #43 was an elopement risk and wanderer related to dementia, impaired cognition, and impaired safety decision making. Interventions included; the resident would not leave the facility unattended, to change the wander guard every 90 days, to check placement and function of the wander guard every shift. Resident #43 ' s physician orders dated 8/27/18 revealed an order for Wander guard to left ankle for exit seeking behaviors. The resident ' s quarterly MDS (Minimum Data Set) assessment dated 1/2/19 documented that Resident #43 had moderately impaired cognition and required extensive assistance with transfers, and activities of daily living. She had no wandering behaviors during the 7 day look back period. A nursing progress note dated 3/30/19 at 3:10 PM and written by Nurse #4 documented resident (Resident #43) was found out by the tool shed and said she was just wandering around and when asked what she was doing she said she had done it before. Her nursing assistant reported to the nurse when she asked resident if she could get her anything she said yes, some pills that would make her not wake up. The MD communication book was updated.	F 689	on 3/30/19. Resident is a poor historian but did state that she loves to go outdoors and sit in the sun on nice days and participate in garden club. Charge nurse completed a resident Head to Toe assessment on 4/1/2019, with no significant findings noted. GATES Wandering Assessment tool completed by unit manager on 4/1/2019 and a BIMS assessment was completed by social worker on 4/1/2019. Care Plan and interventions were reviewed and remain appropriate (completed on 4/1/2019 by IDT). A 100% audit of residents for wandering was completed on 7/10/19 by the MDS Coordinator and Regional MDS Consultant. Ten residents had been identified prior to this audit for wandering risks and no new residents were identified. Education was provided to staff on the Abuse and Neglect Policy, Abuse Prevention, Unsupervised Exits, Resident Rights, Safety and Supervision of Residents, and Notification Protocols (Includes Immediate notification of Administrator and/or DON of any adverse event per facility S.T.E.P. program.) These were presented by the Staff Development coordinator and/or designee. Education completed on 7/26/2019. New staff will receive the education during orientation and any prn staff that have not received will be receive education prior to their next scheduled shift. These education topics will be	

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F 689	Continued From page 4 The facility ' s 4/5/19 investigation summary of Resident #43 being found unsupervised outside the facility on 3/30/19 documented that it was reported that a resident (Resident #43) was left unsupervised for some period of time by one of the staff. An investigation was immediately conducted by the Administrator and DON (Director of Nursing) to determine the facts related to the event. After multiple interviews conducted with staff and residents there were no findings and were unable to substantiate neglect. Corrective actions included in servicing on multiple topics that included neglect and abuse and reporting protocols. A witness statement dated 4/2/19 and written by Nurse #7, documented that the resident (who no longer resides in the facility) stated that on 3/30/19 he observed the smoke aide (nurse aide #7) let resident (Resident #43) out onto the smoking patio. This occurred between 1:30 to 1:45 PM. The resident stated that the smoke aide (nurse aide #7) left the resident on the back patio and then left the building on her lunch break. The resident stated that approximately one hour later he was outside in his wheelchair in the back of the building and saw the resident (Resident #43) in the backyard beyond the gated patio. He went back to the patio and knocked on the door to get the staff ' s attention. Nurse #8 answered and was informed by the resident that a resident was out in the backyard. Nurse #8 went directly to the resident and brought her back into the building. Included in the facility investigation was a note dated 4/1/19 at 6:11 PM written by Nurse #9, and documented on 3/30/19, nurse aide #7 walked up at 2:56 PM after her lunch break. When asked if	F 689	presented to staff on annually and as necessary. Each week the DON, staff development coordinator or Unit managers will interview a total of 10 staff members regarding reporting of abuse, neglect, misappropriation, exploitation, safety and supervision of residents, unsupervised exits. Wandering/Elopement drills will be conducted monthly (each shift will have a drill completed quarterly). A log will be kept of results and participants. The DON and Maintenance director will be responsible for this process and maintaining records. Residents with wandering behaviors who choose to go outside the facility onto patios will be accompanied by a staff member. The staff member will be required to sign the resident out in the Wandering OOF Book&information to be included will be date, time, resident name, and staff member accompanying, charge nurse notified/signature of nurse required for exit and return, location of resident while outside, and time returned to inside facility. The results of all monitoring will be presented by the Director of Nursing or Staff Development Coordinator to the QAPI committee during the Monthly QAPI meeting for review and recommendations for a minimum of 3 months.	

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F 689	Continued From page 5	F 689		

she took the resident (Resident #43) out she said, "No, I left around 1:35 PM for my lunch after I brought all the people in from their smoke break." Nurse #9 documented that nurse aide #7 said she did not take her out and didn ' t know she was out there.

A phone interview was conducted on 7/10/19 at 10:18 AM with Nurse #8 who assisted in getting Resident #43 back into the building on 3/30/19. She stated on 3/30/19 a resident began knocking on the smoking patio door and notified her that a resident was out by the tool shed. She and a nurse aide (nurse aide #8) went out to assist her, and stated she was not sure at the time how she got out and up the pathway, and the front wheels of the wheelchair were stuck in the sand. Nurse #8 stated it was hard to tell how long the resident was outside, that the smoking hour was from 1:00 PM - 2:00 PM and the resident was found outside around 2:30 - 2:45 PM, then stated she was not exactly sure of the times that she was found but it was near the end of her shift. She stated the resident was fully assessed and no injuries were noted, and the wander guard was in place and working when the incident occurred. She stated the weather at that time was sunny and typical spring like weather, and the resident was dressed appropriately in pants and a sweater wrap. She stated the resident laughed nervously when she was found, and the resident didn ' t think she was doing anything wrong. She stated the resident did require 1:1 supervision, and stated the facility alarmed the patio gates after that incident.

An interview was conducted on 7/11/19 at 9:34 AM with nurse aide #8 who assisted the nurse in getting the resident back inside the building following the incident on 3/30/19. She stated that

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F 689	Continued From page 6	F 689		

Resident #43 was seated in her wheelchair on a walkway that was behind the shed and the wheels of her wheelchair were stuck in the sand. She stated she brought the resident back inside and the nurse checked her, and she had no injuries. She stated the weather was sunny but could not recall what type of clothing she was wearing. She stated she had not observed the resident outside unattended before or since that time, and her cognition was "the same as she always was."

An attempt was made to contact the smoke aide (nurse aide #7) who assisted the resident outside onto the patio on 3/30/19 and who was no longer employed by the facility. The number was disconnected.

An observation by the surveyor was conducted on 7/10/19 at 2:31 PM of the area where Resident #43 was found outside behind the tool shed seated in her wheelchair on a walk way. The shed was approximately 75 feet away from the smoking patio gate where she exited from A wooden trellis fence was located on the side of the tool shed which obstructed the view from the smoking patio, and the resident would not have been visible to staff.

A follow up interview and observation was conducted on 7/11/19 at 2:40 PM with nurse aide #8 who assisted the resident back inside the facility on 3/30/19. She acknowledged that resident #43 was found on the other side of the tool shed which was not visible from any point on the smoking patio.

An observation was conducted on 7/11/19 at 2:40 PM of Resident #43. She was alert and oriented

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F 689	Continued From page 7 to person only and sitting outside on the smoking patio supervised 1:1 by a staff member. An interview was conducted on 7/10/19 at 12:00 PM with the facility physician. He stated he did assess the resident on the morning of 7/10/19 for further evaluation of possible exit seeking behaviors. He stated that staff reported that she goes in and out of coherence, and stated psychiatric services asked her about leaving the building over the weekend and the resident did not recall the incident but said to psych services, "where would I go, I have no place else to live." He stated she liked to be outside in the sun. An interview was conducted on 7/9/19 at 4:45 PM with the facility Physician Assistant. She stated she was not sure if the resident ' s behaviors were considered exit seeking because she likes to be outside. She stated her safety awareness comes and goes, and she is followed by psych services who just evaluated her recently on 7/8/19. An interview was conducted on 7/11/19 at 3:50 PM with the DON. She stated she recently was employed by the facility beginning May 2019. She stated she was unaware that an action plan including audits was implemented regarding an elopement on 3/30/19 for Resident #43. An interview was conducted on 7/11/19 at 12:00 PM with the Administrator. He acknowledged that Resident #43 should not have been left unattended outside by staff on 3/30/19 due to her exit seeking behaviors.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		8/6/19

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F 761	Continued From page 8 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 5 medication carts observed (600 hall medication cart) and failed to keep unattended medications secured by leaving them on top of the medication carts for 1 of 5 medication carts observed (200 hall medication cart on two different shifts). Findings included: 1. In an observation on 07/08/19 beginning at	F 761	The medications on the carts were stored properly and the medication cart was locked. The nurses that were observed to have deficient practice were counseled and education was provided on proper medication storage by the Director of Nursing on 7/10/19. All medications were observed by the DON, Unit Coordinators and Nurse Supervisor to be appropriately locked and	

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F 761	Continued From page 9 11:51 AM a medication cart was against the wall toward the beginning of the 600 hall. The drawers and the lock of the cart were facing into the hallway. The lock of the medication cart did not appear to be engaged. The medication cart was unattended. A continuous observation of the medication cart was conducted until 11:53 AM when Nurse #4 came around the corner and returned to the medication cart. Nurse #4 verified that the medication cart was unlocked. In an interview on 07/08/19 at 11:53 AM Nurse #4 stated she had been called away from the medication cart and had left it unlocked. She stated that medication carts should never be left unlocked because anyone could get into the cart and take medications out. In an interview on 07/11/19 at 4:47 PM the Director of Nursing (DON) stated that medication carts should always be locked when out of sight of the nurse because someone could take the medications out of the cart. 2. A. In an observation on 07/10/19 beginning at 8:02 AM a clear plastic cup with liquid and a spoon was sitting on top of the 200 hall medication cart outside room 206. There was no staff member with the medication cart. Nurse #1 approached the cart at 8:03 AM and verified that the cup that had been left unattended on top of the medication cart contained a medication called MiraLAX that had been mixed with water. In an interview on 07/10/19 at 8:03 AM Nurse #1 indicated he had stepped away from the cart for a minute and that medications should not be left unattended on top of the medication cart because someone could take them and there could be an	F 761	medications were properly stored on 7/10/19. All nurses were in-serviced by the Staff Development Coordinator on proper medication storage procedures on 7/23/19. A Medication Storage Audit Tool was created to monitor the storage of medications. This tool will be used by the DON, Unit Coordinators and Nurse Supervisor to monitor and ensure medications are stored properly. The medication carts will be monitored utilizing the Medication Storage Audit Tool. Observations will be made of the storage carts and their use by a member of Nursing Administration. This will occur once a shift, five days a week for 2 weeks. Then, three times a week for two weeks. Then weekly for 2 months. The results of all monitoring will be presented by the DON to the QAPI committee during the Monthly QAPI meeting for review and recommendations for a minimum of 3 months.	

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F 761	Continued From page 10 adverse outcome. In an interview on 07/11/19 at 4:47 PM the DON stated that medications should not be left unattended on top of medication carts. She indicated that medications should be locked up because someone could potentially ingest them. B. In an observation on 07/10/19 beginning at 4:52 PM a medium sized white bottle was seen on top of the 200 hall medication cart outside room 206. The medication cart was unattended. Nurse #5 approached the cart at 4:55 PM and verified the white bottle contained 80, 25 milligram tablets of geridryl (a generic Benadryl). In an interview on 07/10/19 at 4:55 PM Nurse #5 stated she was going to give the geridryl to a resident and was waiting for the order. She stated she left the medication on top of the cart while she went to check to see if the order had come in yet. Nurse #5 stated that medications should not be left unattended on top of the medication carts because anyone could come and take them. In an interview on 07/11/19 at 4:47 PM the DON stated that medications should not be left unattended on top of medication carts. She indicated that medications should be locked up because someone could potentially ingest them.	F 761		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		8/6/19

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F 867	Continued From page 11 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's quality assurance (QA) program failed to prevent the reoccurrence of deficient practice related to the inaccurate completion of Minimum Data Set (MDS) assessments which resulted in a repeat deficiency at F641. The re-citing of F641 during the last year of federal survey history showed a pattern of the facility's inability to sustain an effective QA program. Findings included: 1) This tag is cross-referenced to: F641: Accuracy of Assessments: Based on record review and staff interviews the facility failed to accurately assess 1 of 22 residents whose MDS assessments were reviewed (Resident #43). Review of the facility's survey history revealed F641 was cited during the facility's 06/21/18 annual recertification/complaint investigation survey for failing to accurately complete MDS assessments. The facility was re-cited during the current 07/11/19 annual recertification/ complaint investigation survey for the same issue of inaccurately completed MDS assessments. In an interview on 7/11/19 at 4:45 PM with the Administrator he commented he felt the facility was receiving a repeat tag for inaccurate MDS assessments because the same staff were in place as last year and the audit tools that had been developed in 2018 had not been	F 867	A QAPI has been developed in order to maintain accuracy of MDS. All residents can be affected by MDS coding and will be monitored and maintained by QAPI developed utilizing the MDS Accuracy Audit Tool. This tool was initially completed on 7/29/19 and will be completed weekly on three residents by the MDS coordinators. On 7/16/19, the Regional Director of Clinical Services in- serviced the Administrator and Director of Nursing on the QAPI process. The department managers have been in-serviced on the QAPI process by the Administrator and Director of Nursing on 7/19/19. The MDS process will be monitored by the MDS Accuracy Tool on a weekly basis by the MDS Coordinators. The review will occur weekly for one year. The results of all monitoring will be presented by the MDS Coordinators to the QAPI committee during the Monthly QAPI meeting for review each month for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 12 implemented or followed.	F 867		