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| F 000 | INITIAL COMMENTS<br><br>An unannounced onsite complaint investigation survey was conducted on 01/12/22. The survey team returned to the facility on 01/14/22 to obtain additional information.on 01/31/22 to validate the facility's Credible Allegation. Therefore, the exit date was changed to 01/31/22. A total of 6 allegations were investigated and 3 were substantiated, one without citation. Past non-compliance was identified at:<br><br>CFR 483.25 at tag F 689 at a scope and severity of J.<br><br>The tag F 689 constitued Substandard Quality of Care.<br><br>F 689- Non-compliance began on 09/13/21. The facility came back in compliance effective 09/15/21. | F 000 | | |
| F 689 SS=J | A partial extended survey was conducted.<br>Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and physician and staff interviews, the facility failed to conduct a thorough search in response to an | F 689 | Past noncompliance: no plan of correction required. | 2/11/22 |

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

Electronically Signed | 02/11/2022

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alarm alerting staff that an exit door was opened and failed to determine if a resident had exited the building unsupervised. This affected 1 of 3 residents reviewed for accidents (Resident #3). On 09/13/21 between the hours of 6:30 AM and 6:50 AM, Resident #3, who had severe cognitive impairment, exited the building through the emergency exit doors located at the end of the resident hall and remained outside the building unsupervised. When the alarm at the nurses' station sounded, staff checked all the exit doors but did not search outside the building or conduct a head count to confirm all residents were accounted for. While Resident #3 was outside unattended, there was a high likelihood for serious harm.

The findings included:

Resident #3 admitted to the facility on 02/24/21 with diagnoses that included dementia with Lewy Bodies (disease associated with abnormal deposits of protein that lead to problems with thinking, movement, behavior, and mood), psychotic disorder with delusions, and anxiety.

A care plan initiated on 03/18/21 noted Resident #3 had a wanderguard order in place. The goal was for him to maintain optimal quality of life while living in the skilled nursing facility setting and the intervention was for wanderguard placement. The care plan was noted as resolved on 06/11/21.

A staff progress note written on 06/11/21 by the Administrator read, "Resident #3 is not exit-seeking. Discontinue the wanderguard."

The quarterly Minimum Data Set (MDS) dated

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08/13/21 assessed Resident #3 with severe impairment in cognition for daily decision making. He was independent with walking and locomotion, used a cane and displayed wandering episodes one to three days during the MDS assessment period.

A staff progress note written by Nurse #2 on 09/13/21 at 7:51 PM read in part, "Resident exited out facility door and wandered approximately 100 feet into a residential yard near facility. He was observed on his hands and knees in the yard. Resident #3 denies pain, all limbs moveable without complaints of pain. No abrasion or laceration noted. Resident #3 able to ambulate self-back into facility. Resident #3's Responsible Party and physician notified of incident. Intervention in place as follows: 1) wanderguard placed on left lower leg and 2) skin check administered. Resident #3 resting in room with no distress noted."

During interviews on 01/18/22 at 12:24 PM and 5:02 PM, Nurse Aide (NA) #1 confirmed he worked during the hours of 11:00 PM to 7:00 AM on 09/12/21 to 09/13/21 when Resident #3 exited the facility unsupervised. NA #1 could not recall the exact time he heard the alarm sounding at the nurses' station on 09/13/21 but stated it was somewhere around shift change and he immediately went to check the panel which showed the exit door at the end of the hall had opened. He opened the exit door at the end of the hall to see if anyone had gone outside and when he didn't see anyone, he started checking all the other exit doors throughout the facility but never saw any resident outside the facility doors. NA #1 stated it was still dark when he opened the exit doors to look outside and confirmed he did

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not go outside to check around the perimeter of the building. NA #1 added he did not do a head count of the residents. NA #1 recalled last seeing Resident #3 somewhere between 6:30 AM and 6:45 AM as Resident #3 was walking the hallway as normal and he had displayed no abnormal or exit-seeking behaviors at the time or during the shift. NA #1 added although Resident #3 wandered the halls, prior to the incident on 09/13/21 he had never tried to exit the facility. NA #1 stated when checked the panel at the nurses' station to see what door triggered the alarm, he did not reset the panel and left the alarm on while he checked the exit doors. He was not sure who ended up resetting the alarm. NA #1 confirmed he was trained on elopement procedures which included responding to the alarm, checking the door(s) that triggered and outside perimeter, and completing a head count to ensure no resident had exited the building.

During an interview on 01/13/22 at 3:50 PM, Nurse #1 recalled it was early in the morning on 09/13/21, just before shift change at 7:00 AM, when the alarm at the nurses' station sounded alerting them an exit door was opened. Nurse #1 did not recall checking the alarm panel herself and explained NA #1 checked the exit and front entrance doors and reported to her he did not see anyone other than staff entering the building. Nurse #1 could not recall the exact time she last saw Resident #3 but stated she typically checked his sugar every morning between 6:00 AM and 6:30 AM. Nurse #1 confirmed she was trained on elopement procedures which included what to do when an alarm triggered such as check the exit doors and outside perimeter of the building, conduct a head count of residents if not sure how the alarm was activated, and if unable to locate a

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resident, call 911. Nurse #1 explained when they heard the alarm at the nurses' station sound that morning and staff did not see any residents outside when they checked the exit doors, they did not do a head count because at the time they weren't aware Resident #3 had exited the facility and thought the alarm likely sounded due to staff entering the building during shift change. Nurse #1 added Resident #3 typically wandered the halls but did not recall him displaying decreased confusion, agitation, or exit seeking behaviors during the shift.

During interviews, on 01/12/22 at 4:36 PM and 01/18/22 at 10:42 AM, the Administrator explained on the morning of 09/13/21, at approximately 7:15 AM, she responded to a knock at the entrance doors of the facility and was informed by a police officer a resident was found in the front yard of a residential home located up behind the building. The Administrator went to the location where Resident #3 was found and recalled he was sitting down in the front yard. Emergency Medical Services (EMS) arrived, assessed Resident #3, stated he was fine and she brought him back to the facility without incident which she recalled was approximately 7:45 AM. She added, after Resident #3 was returned to the facility, a wanderguard was placed on his ankle and all exit doors were checked. The Administrator confirmed they were unaware Resident #3 had exited the facility until notified by the police officer and when they reviewed the video footage, she seemed to recall he went out the exit door at 6:50 AM. She stated the alarm at the nurses' station was functioning at the time of the incident on 09/13/21 to alert staff if any of the exit doors were opened. The Administrator explained staff were re-educated to pay attention

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to the alarms when sounding, check the area where the alarm triggered and if unable to determine how the alarm was activated, they were to conduct a head count, perimeter check and notify management.

During an interview on 01/13/22 at 10:55 AM, Nurse #2 stated when she arrived to work on 09/13/21 she was informed Resident #3 had exited the building just before 7:00 AM shift change. She added the Administrator was already at the facility when notified by police Resident #3 was found at one of the residential houses located behind the facility. Nurse #2 stated they reviewed the video footage to determine which door Resident #3 exited and could not recall the exact time he exited the building or when he was brought back to the facility but stated it was only a couple of minutes, "maybe 5 minutes or so." Nurse #2 added once Resident #3 was back in the facility, he was assessed with no injuries noted and a wanderguard was put in place.

An online website named Time and Date was used to obtain the outside weather in the Hendersonville area on 09/13/21 and noted at 6:54 AM the temperature was 61 degrees Fahrenheit with no wind. It was further noted, sunrise was 7:06 AM.

An observation with the Administrator was conducted of the facility property on 01/14/22 at 9:05 AM. At the front entrance of the facility, to the left, was a road leading up to a memory care facility and several residential houses. Behind and to the side of the facility, there were steps leading up to the memory care parking lot which was located across from the side road leading to

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the residential homes. Trees and wooded areas were also along the perimeter of the facility and the back of the residential homes. Per the Administrator, Resident #3 was found in the front yard of the first home. She was not sure what route Resident #3 walked to arrive at the residential home. The distance from the front entrance of the facility to the residential home was approximately 0.1 miles or 528 feet.

Observations of the alarm panel located at the nurses' station and exit doors was conducted with the Maintenance Director on 01/14/22 at 1:14 PM. The emergency exit used by Resident #3 when he exited the facility was located at the end of A Hall and when the Maintenance Director pushed down on the door handle for 15 seconds, the door opened, and an alarm sounded at the door and nurses' station. The Maintenance Director then entered the code into the keypad panel located at the exit door and the alarm turned off. The alarm at the nurses' station continued to beep rapidly until the panel was reset and identified the exit door that was opened.

During a telephone interview on 01/12/22 at 2:15 PM, the facility's Medical Doctor (MD) stated he did not recall being notified of the incident on 09/13/21 when Resident #3 exited the facility. The MD explained Resident #3 was pretty stable when ambulating; however, was not appropriate to be outside the facility unattended. The MD added he would be concerned that when outside unattended, Resident #3 could have easily wandered down the road to the main highway.

On 01/18/22 at 6:45 PM, the Administrator was notified of Immediate Jeopardy.

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The facility provided the following Corrective Action Plan with the correction date of 09/15/21:

On 9/13/2021 Resident #3 left the facility unattended. Resident #3 was found in the yard of a residential house beside the facility.

Resident #3 was reassessed for potential to elopement on 9/13/2021 by the Director of Nursing. Body audit completed for Resident #3 by the Director of Nursing on 9/13/2021. Psychosocial assessment was completed by the Social Worker on 9/13/2021. Wanderguard bracelet placed on Resident #3 on 9/13/2021. Resident #3's care plan was reviewed and updated by Minimum Data Set (MDS) Nurse on 9/13/2021.

All residents with dementia or dementia related diagnosis and low BIMS score are at risk for elopement. Regional Clinical Nurse and Director of Nursing audited all at risk and high-risk residents for potential elopement and updated assessments as needed on 9/13/2021.

Regional Clinical Nurse and Director of Nursing updated Care Plans for all resident at risk for elopement on 9/13/2021.
Director of Nursing and Maintenance Director audited all wanderguard bracelets on 9/13/2021 for function.

Nursing updated all Elopement Binders for nursing stations and lobby desk on 9/13/2021. Elopement binders will be updated as needed with admissions and discharges by the Director of Nursing. All new at-risk residents will be reviewed upon admission by IDT team and all

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others quarterly during care plan review.

Maintenance Director audited all doors for alarm function on 9/13/2021. Maintenance Director found no issues. Maintenance Director will continue to check all doors daily for alarm function.

Elopement Drill was completed on 9/13/2021 with all staff to ensure proper response to door alarms by the Maintenance Director. Maintenance Director to complete elopement drills quarterly and during orientation of any new staff. Maintenance Director completed a 2nd elopement drill on 01/06/2022. Maintenance Director will continue to complete elopement drills quarterly.

Administrator/Director of Nursing in-serviced all staff on elopement procedures on 9/13/2021 for proper response. Education included:
The door monitoring device at A wing nurses station only has 3 exit doors labeled to leave on. One is A-wing end of hall door, one is main dining room door, and the final is B-wing end of hall door. These doors do not have wanderguard functionality installed on them and the end of hall doors do not have mag lock or locking capabilities. They are emergency egress corridors which must exit without key service. The exterior access of these doors are locked, hence once outside you will not be able to re-enter without being allowed entry from the interior.
If any three of these sounds, you must identify who opened the door. You should be able to identify which door opened by reviewing the monitoring device located to the left of the medication room to the right of the Emergency

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Generator panel. If the panel indicates A-wing door for example the end of hall door should still be alarming if the door device is functioning properly. The codes are 1234, do not tamper with these devices. They are in place for your safety and the safety of the residents. If you do not see anyone near the door and are not aware of who may have triggered the annunciator you must do an exterior perimeter check. If you do not know the length of time it has been alarming a census count must be completed by the nurses.
If it is identified that a resident is missing the Director of Nursing or Administrator is to be contacted immediately to implement the emergency procedures. To reset the device at the nurses station you depress the button at which the door is alarming and press it again to reactivate for monitoring.
The codes should not be given to family or residents at any time.
Do not disregard any alarm
Do not block or prop open exits at any time.
Do not shut off any alarms until you have investigated the reason for the alarm to annunciate and have eliminated any potential risk.
If you are unsure or it is unsafe to leave your position you can page for a census count.

Staff were re-educated to check the facility for missing residents and conduct a head count when alarm has sounded. Staff were also instructed to search outside facility for any residents. Instruction on who to call such as Administrator, Director of Nursing for further direction. Education included the use of the elopement binders for high-risk residents. Any new hires or new agency staff will be in-serviced on the elopement process prior to starting a shift

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going forward.
All residents listed in elopement books are reviewed monthly in Risk meetings which includes Director of Nursing, MDS Nurse, Social Worker and Dietary Manager.

Quality Assurance Performance Improvement meeting was completed on 9/14/2021 by Administrator, Director of Nursing, Social Worker and Business office manager. Medical Director was informed of the incident and facility changes on 9/14/2021.

All findings will be reviewed by the Interdisciplinary Team during Quality Assurance Performance Improvement meetings and quarterly thereafter. All recommendations will be implemented as needed by the Administrator.

Completion Date: 9/15/2021

The Corrective Action Plan was validated on 01/31/22 and concluded the facility implemented an acceptable corrective action plan on 09/15/21 once staff education was provided on the elopement process and the elopement plan was reviewed during a QAPI meeting held on 09/14/21.

The daily monitoring schedule of the facility exit doors alarms for September 2021 to January 2022 were reviewed with no concerns identified. Elopement books were observed at each nurses' station and reception desk. The elopement books contained information and pictures for each resident identified as high risk. Multiple staff on various shifts were interviewed and verified they received re-education related to elopement and were able to describe facility processes for:

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| F 689 | Continued From page 11<br>what to do when a resident demonstrated elopement/exit seeking behaviors, where the elopement books were located and what information they contained, responding to door alarms, checking the exit doors and outside perimeter of the building, conduct a head count of all residents, and who to notify in the event of an elopement. | F 689 | | |