STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 A complaint investigation was conducted on 10/10/22 through 10/12/22. The following intakes were investigated: NC00193803 and NC00191448. 2 of the 8 allegations were substantiated. Intake NC00193803 resulted in immediate jeopardy. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of J. Tag F689 constituted Substandard Quality of Care. Non-compliance began on 08/12/22. The facility came back in compliance effective 08/14/22. An extended survey was conducted on 10/12/22.	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 record reviews, staff and Medical Director interviews the facility failed to prevent an ambulatory resident with severe cognitive impairment and wandering behaviors from exiting the facility unattended. Resident #1 was observed on the facility video footage on 08/12/22 exiting the facility at 7:38 PM and walking out of the facility parking lot onto a two lane residential road	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 689	Continued From page 1	F 689		

with the speed limit of 35. The Resident was found 1.9 miles away from the facility at 10:26 PM at a local department store and was returned to the facility. This occurred for 1 of 3 residents reviewed for accidents (Resident #1).

The findings include:

Resident #1 was admitted to the facility on 06/15/20 with diagnoses that included dementia.

A review of Resident #1's care plan revised on 05/17/22 revealed the Resident was an elopement risk related to wandering with the goal that he would not leave the facility unattended. The interventions included to complete elopement risk assessments, use diversional tactics and to check the placement and function of the wander guard alarm bracelet (an electronic bracelet used to trigger alarms and can lock monitored doors to prevent wandering residents from leaving) daily.

A review of Resident #1's physician order dated 06/02/22 revealed an order to check the wander guard alarm bracelet for placement and function every day and night.

A review of Resident #1's Elopement Risk Assessment dated 07/19/22 indicated a high elopement risk.
The quarterly Minimum Data Set (MDS) assessment dated 07/17/22 revealed Resident #1 had severe cognitive impairment, wandering behavior not exhibited, ambulated independently, and wore a wander guard alarm daily.

A review of Resident #1's Medication Administration Record (MAR) for August 2022 revealed the wander guard alarm bracelet was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 2	F 689		

checked every day, twice a day through August 12, 2022.
A review of an Incident Report dated 08/12/22 9:42 PM revealed Resident #1 left the building on foot and was noted missing at around 9:40 PM. The Resident was located at 10:26 PM. The Administrator, Director of Nursing and Police were notified. The Medical Director was notified at 08/12/22 9:42 PM and the Guardian was notified at 08/12/22 9:47 PM. Upon return to the facility Resident #1 had the wander guard alarm bracelet on his right ankle. The Resident was placed on one to one care checks. His vital signs were 171/90, 98.0, 70, 18 and oxygen saturation was 96%. The incident report was completed by the Director of Nursing.

A review of an Accuweather report for weather temperature indicated the temperature for the Mt. Airy area on 08/12/22 was 78 degrees for the high and 63 degrees for the low. The sunset time was 8:17 PM.

A review of the Police Department's Call Report indicated they received a call on 08/12/22 9:25 PM from the nursing facility about a missing resident who was last seen around 7:30 PM wearing a black shirt and blue jeans. The report concluded with Resident #1 being found around 10:44 PM and was being brought back to the facility by a facility employee.

A review of the door alarm testing schedule completed by the Maintenance Supervisor revealed the front door alarm was tested for operation on 08/08/22 and 08/12/22 with both tests performed being positive for working order.

A review of Resident #1's Check Sheet initiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 3	F 689		

08/12/22 10:45 PM revealed he was placed on one to one for 24 hours then every 15 minutes for the duration of his stay at the facility.

On 10/10/22 10:00 AM a signage posted at the entrance to the facility noted "Attention Visitors Do Not Assist Our Residents Outside" and "Assure Residents Do Not Follow You Outside".

On 10/10/22 2:44 PM during an interview with Medication Aide (MA) #1 she explained that on 08/12/22 at around 7:30 PM she responded to the front lobby door alarm and observed a family member walking down the sidewalk to the right of the facility where the cars were parked in the parking lot. The MA continued to explain that she looked both to the right and left of the outside but did not open the door to go outside and look for a resident that may have set off the alarm. She assumed it was the family member she observed walking away from the building. The MA explained that she was assigned to medicate Resident #1 on the night of 08/12/22 and when she went to give him his nighttime medication between 9:00 PM to 9:30 PM, she could not find him in his room, so she went to the front lobby where he liked to sit, but the Resident was not in the lobby either. She stated she asked Nurse Aide (NA) #1 if she knew of his whereabouts and the NA reported she had not seen him since supper. MA #1 explained she notified Nurse #1 that they could not locate Resident #1, the Nurse called a Code 10 which meant everyone stopped what they were doing and searched the facility for Resident #1. She reported when they still were not able to locate Resident #1, Nurse #1 notified the Police Department and Administration. MA #1 explained that the Police located Resident #1 and brought him back to the facility unharmed where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 4	F 689		

he was placed on one to one for the remainder of the night. The MA continued to explain that she should have opened the door and done a perimeter sweep when she responded to the door alarm and not just assumed it was the family member who set the alarm off. She indicated she was educated on the proper procedure when responding to the door alarms and had to return demonstration on the procedure.

An interview was conducted with Nurse Aide (NA) #1 on 10/12/22 11:40 AM who confirmed she worked the evening of 08/12/22 when Resident #1 went missing from the facility. NA #1 explained that she last observed Resident #1 in his room on 08/12/22 around 7:30 PM when she picked up his supper tray from his room and he was in his usual state of mind, showing no agitation. The NA continued to explain that a while after that Medication Aide (MA) #1 came to her and asked her if she had seen Resident #1 because she could not find him to give him his medications and NA #1 reported she had not seen the Resident since she picked the supper tray up from his room where she left him watching TV. MA #1 told her that she had already looked in the front lobby where he liked to sit in the evening, but he was not there. They conducted a hall search but when they could not locate him, they informed Nurse #1 that he was missing. The Police found Resident #1 and brought him back to the facility where he stated he was tired from all the walking. Resident #1 was put on one to one the rest of the night and through the next day then every 15-minute visual checks and we had to verify the visual checks by initialing the check sheets every 15 minutes. NA #1 stated the staff member who responded to the door alarm should have gone outside and conducted a perimeter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 5	F 689		

sweep to ensure the door alarm was not set off by a resident wearing a wander guard bracelet. The NA reported the facility conducted education in-services on the correct procedure to follow when the door alarms sound which included searching the outside perimeter for the resident.

During an interview with Nurse #1 on 10/10/22 7:30 PM the Nurse confirmed she worked the evening shift of 08/12/22 when Resident #1 went missing from the facility. Nurse #1 explained that she was notified by NA #1 and MA #1 that Resident #1 was missing after they had searched the hall and they could not find him. Nurse #1 stated she called a Code 10 which meant there was a missing resident, and the staff conducted a facility wide search inside and out. When they still could not locate Resident #1, she called the Police Department and the facility Administration who came to the facility. Nurse #1 continued to explain that the Police found Resident #1 approximately two miles away and brought him back to the facility unharmed. She stated she assessed Resident #1 and obtained his vital signs which were not abnormal for the Resident. Resident #1 was placed on one on one for several days after that. Nurse #1 stated that the facility identified that a Medication Aide #1 responded to the door alarm when Resident #1 left the facility but did not open the door to conduct a perimeter sweep outside because if she had she would have noticed the Resident sitting outside in the rocking chair to the left of the facility. Nurse #1 reported the facility reeducated the staff on the elopement policy and procedure which included responding to the door alarms and conducting perimeter searches outside of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 6	F 689		

During an interview with the Maintenance Supervisor on 10/11/22 3:19 PM he explained that he was called to the facility the night of 08/12/22 when Resident #1 went missing. He stated for a precaution he changed all the door codes that night and checked the wander guard alarm with the activation device as was his practice every day and all the doors were in working order.

An interview was conducted with the Director of Nursing (DON) on 10/10/22 at 2:20 PM. The DON explained that on 08/12/22 around 9:30 PM Resident #1 could not be found to give him his nighttime medications so Nurse #1 called a Code 10 which was the facility's code for a missing resident. The protocol included to conduct a facility wide search inside and outside for the Resident, but he could not be located so Nurse #1 called the Police Department, the Administrator, and the DON. She indicated the Medical Director and Resident #1's Guardian were also notified that he was missing. The DON continued to explain that the facility's camera footage showed that Resident #1 was sitting in the front lobby around 7:30 PM when a family member approached the door to go out and the door alarm sounded because Resident #1's wander guard alarm bracelet was too close to the door and set the alarm off. The family member held the door engaged for 15 seconds and the alarm went off which allowed the family member to open the door and leave the facility and walk down the sidewalk to the right. Resident #1 followed the family member out the open door and went to the rocking chair to the left of the entrance where he normally sat when he was outside. The Resident was wearing a black shirt and jeans. The camera showed that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 7	F 689		

Medication Aide (MA) #1 approached the door to check the alarm and observed the family member walking down the sidewalk on the right toward her car but did not open the door to conduct a sweep of the perimeter. If the Medication Aide had walked outside, she would have noticed Resident #1 sitting in the rocking chair to the left of the entrance. The MA later stated she assumed it was the family member who she saw walking toward her car that triggered the alarm when she left the facility. The DON reported Nurse #1 gave the Police a description of Resident #1 and the Police found the Resident approximately a mile or so away from the facility at a department store and he was brought back to the facility unharmed. The DON stated Resident #1's wander guard alarm was functioning when he came into the facility because it set the alarm off.

An interview was conducted with the Administrator on 10/11/22 4:15 PM who explained that she felt the staff responded appropriately on 08/12/22 when Resident #1 could not be located. Nurse #1 called a Code 10 which indicated a missing resident. She continued to explain the staff conducted a facility wide search inside and outside and when the Resident could not be located, Nurse #1 notified the Police Department, the Director of Nursing and herself who went to the facility. The Medical Director was notified as well as the Resident's Guardian who came to the facility to assist in the search. The Administrator reported the Police were given a description and a picture of Resident #1 and he was located about 1.9 miles away from the facility. When the Resident was found he would not get in the Police car, so they called back to the facility and the Guardian went to get the Resident to bring him back but after they returned to the facility, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 8	F 689		

Resident refused to get out of the car until he was offered a drink and pizza. She stated Resident #1 was unharmed and was assessed by Nurse #1 and found to have no injuries. He was put on a one-to-one observation for 24 hours then every 15 minute checks until 08/19/22 when he was discharged to a facility with a locked unit. The Administrator explained that she watched the video footage of the event and determined Resident #1 was sitting in the front entrance lobby around 7:38 PM when a family member approached the door and attempted to open it but when the door alarmed because Resident #1 was sitting nearby, the family member held the door engaged for 15 seconds which released the door and she was able to open the door and leave the facility and walked to the right of the building. Resident #1 then walked out behind the family member and walked to the left and sat in the rocking chair where he stayed for a few minutes then walked up the parking lot out of sight of the camera. MA #1 responded to the door alarm and noticed the visitor walking to the right of the sidewalk and assumed she was the one who set off the alarm, but the MA did not open the door to go outside to sweep the perimeter for a resident. When MA #1 went to medicate Resident #1, she could not locate him and notified Nurse #1 who called the Code 10. The Police were notified around 9:30 PM who located Resident #1 and he was brought back to the facility around 10:45 PM. The Administrator explained that the facility immediately checked all the alarmed doors for proper working order and changed the codes as well. They reeducated the entire facility staff and new hires on the missing person process and updated all the resident information in the notebooks for the eight residents who were at risk for elopement. The facility sent out mass phone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 9	F 689		

messages to the family members and informed them not to assist residents out of the facility and to notify a staff member if the doors were locked and posted signs to that effect as well. The facility will conduct mock elopement drills weekly for 12 weeks and will review the results of the drills in the Quality Assurance Performance Improvement (QAPI) meetings and will modify the plan as needed.

An interview was conducted with the Medical Director (MD) on 10/10/22 4:46 PM. The MD explained that Resident #1 was alert and ambulatory but had a long history of dementia. The MD stated he was made aware that Resident #1 was missing from the facility on the evening of 08/12/22 and was later found by the Police. The MD indicated that Resident #1 was not safe to be 1.9 miles away from the facility unsupervised.

The Administrator and the Director of Nursing were notified of Immediate Jeopardy 10/10/22 4:15 PM.

The facility provided the following corrective action plan with a completion date of 08/14/22:

*Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of noncompliance.

On 08/12/22 at approximately 9:30 PM staff noted that Resident #1 could not be located during bedtime medication pass. A Code 10 was called, and staff began a search of the building and the grounds, the Resident could not be located so the Director of Nursing (DON), Administrator and the Police Department were notified at 9:42 PM. The Resident's Guardian was also notified. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 10	F 689		

Charge Nurse met with the Police and provided a picture and a description of Resident #1. The facility cameras were reviewed, and it was noted the Resident was sitting in the front lobby when a family member pushed and held in the front door until it alarmed and released so they could go out. The Resident then went out the door as well at 7:38 PM. The Police located Resident #1 1.9 miles away from the facility. The Resident stated, "I was looking for my brother's house, he used to live over here, and I was coming to see him". The Police reported the Resident as found at 10:26 PM to the DON and the Resident's Guardian. The Guardian then left the facility to pick Resident #1 up and return him to the facility. Upon returning to the facility the Resident refused to come inside until he was offered a drink and pizza. A full body assessment was performed with vital signs by Nurse with no issues noted. The wander guard alarm bracelet was intact and functioning to the Resident's right ankle.
The Medical Director was notified of the events and assessment with no new orders given at that time, but the Medical Director was contacted at a later time where the Resident's antianxiety order was resumed.

Resident #1 was place on one to one care for 24 hours then every 15 minutes. Discharge plans will be discussed with the Guardian related to finding a secured unit for the Resident.

The Director of Nursing completed an incident report on 08/12/22.

*All residents who are at risk for elopement have the potential to be affected.

All door alarms were assessed and were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 11	F 689		

functioning by the Maintenance Supervisor on 08/12/22.

Residents with wander guard alarm bracelets were assessed for bracelets being present and functioning properly as well as validation of elopement assessments and care plans on 08/12/22 by the DON and Charge Nurse.

The wander guard alarm checker was present and functioning and checked by the DON on 08/12/22 with no issues identified.

The door codes were changed by the Maintenance Supervisor on 08/12/22.

A sign was placed in the front entrance lobby on 08/13/22 by the Administrator reminding visitors to ask for assistance when the doors are locked and not to assist the residents out of the building and to be mindful of the residents attempting to follow them out.

On 08/13/22 mock drills were performed by the Charge Nurse on day and night shifts with good response times noted from the staff and no issues were noted.

*Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome form occurring or recurring and when the action will be complete.

All staff will be educated on the elopement process and procedures prior to working on 08/14/22. Educated will include door alarm response time, perimeter checks, policy and procedure related to elopements. The education will be provided by the DON, Clinical Educator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 12	F 689		

and Unit Manager. The training will be provided to all new staff during orientation.

A family call utilizing the Wizard Phone system was sent out to all current resident's responsible parties to alert them of the potential hazard of holding the door until it alarms and disengages the wander guard alarm system and they needed to seek assistance out of the facility if the door was locked.

The facility held an Ad hock QAPI meeting to discuss the event and it was determined elopement drills will be conducted weekly for 12 weeks and the results will be reviewed during the QAPI meeting with modifications as needed.

The facility alleged compliance on 08/14/22.

The Corrective Action plan was validated on 10/11/22 where it was determined through multiple staff interviews and proof of inservice education sign in sheets that the facility educated the staff on the policy and procedures of the missing resident (Code 10) to include conducting a perimeter sweep of the exterior of the facility in response to the door alarms. The staff vocalized procedures in the event of a Code 10 situation and their role in the process that included mock drills. The Maintenance Supervisor also revealed the wander guard alarm doors were checked and were in working order as well as all the door codes had been changed. Record reviews (elopement notebooks) confirmed the eight residents with wander guard alarm bracelets were reassessed and their bracelets were checked for good working order and current information on the resident was in the notebooks located at the front desk. Observations of the signs were posted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING _____ B. WING _____	C 10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 689	Continued From page 13 in the front entrance lobby for families advising to seek staff if the door was locked and not to assist the residents out of the facility. The results of the monitoring and auditing will be presented at the next quarterly Quality Assurance meeting. The facility was back in compliance on 08/14/22.	F 689		