STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING ______ B. WING ______	C 10/20/2022

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ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted from 10/11/22 through 10/20/22. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# LRC511.	E 000		
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/11/2022 through 10/20/22. Event ID#LRC511. The following intakes were investigated NC00193717, NC00191979, NC00192706, NC00192947 and NC00191431. One of the 16 complaint allegations (NC00193717) was substantiated resulting in a deficiency (F689). Past-noncompliance was identified at CFR 483.25 at tag F689 at a scope and severity (J). Tag F689 constituted Substandard Quality of Care. Noncompliance began on 8/2/2022. The facility came back in compliance effective 09/28/22. 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.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/04/2022

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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F 689	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of manufacturer's instructions, and Medical Doctor, Nurse Practitioner (NP, Psychiatric NP and staff interviews, the facility: 1) failed to prevent a resident, who had been deemed incompetent by the North Carolina Clerk of Superior Court and had a history of wandering and exit seeking behaviors, from exiting the facility unsupervised and without staff knowledge (Resident #1). Resident #1 was located by the police department at a 2-lane highway intersection approximately 8 miles from the facility; and 2) failed to ensure securement was according to manufacturer recommendations for providing a safe facility van transport when a resident slid partially out of the wheelchair, underneath the lap belt, causing her knees to hit the floor of the van resulting in minor bruising to her hand and knees (Resident #2) for 2 of 4 residents reviewed for accidents. The findings included: 1. The Emergency Department (ED) Physician's progress note dated 04/01/22 for Resident #1 read in part, " ...suffers from dementia. He has had 24/7 home health. Will lose weekend care beginning 6:00 PM today, 04/01/22, and will only have caregivers Monday through Friday from 9:00 AM to 6:00 PM. He is unable to cook, has to be reminded to eat and take medications and has walked away from residence on multiple occasions and had to be located by caregivers and brought back home." The State of North Carolina Letter of Appointment for Guardian of the Person dated 04/11/22 revealed Resident #1 was deemed an	F 689	Past noncompliance: no plan of correction required.	

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incompetent person and the Department of Social Services was appointed as his guardian.

Resident #1 admitted to the facility on 05/09/22 with diagnoses that included an infection of the central nervous system, confusional arousals (a form of sleep disorder wherein a sleeping person wakes up but seems disoriented or acts strangely), and dementia with behavioral disturbance.

A care plan initiated on 05/18/22 noted Resident #1 had impaired cognitive function and impaired thought processes related to a diagnosis of dementia. Interventions included: share with Resident #1 when it is time for care/routine related activity, use simple statements and give him time to process them.

A care plan initiated on 05/23/22 noted Resident #1 was an elopement risk/wanderer related to impaired safety awareness and history of wandering. The initial goal initiated on 05/23/22 indicated he would not leave the facility unattended through the next review date. Interventions initiated on 05/23/22 2-lane included: address wandering behavior by walking with Resident #1, redirect him from inappropriate areas, engage in diversional activity, distract Resident #1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, and book, and wanderguard (alarm) device to right ankle.

The quarterly Minimum Data Set (MDS) dated 08/13/22 assessed Resident #1 with intact cognition. He required supervision with locomotion on and off the unit, had no wandering episodes during the 7-day MDS assessment

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period and used a wanderguard device daily.

A Nurse Practitioner (NP) #1 progress note dated 08/30/22 revealed Resident #1 was a poor historian due to cognitive and psychiatric impairment. The FNP noted Resident #1 had poor judgement, impaired insight, disordered thinking, and was confused, forgetful and oriented only to self.

A staff progress note dated 09/27/22 at 10:47 AM written by Nurse #2 read, "Wanderguard applied to right ankle."

During an interview on 10/11/22 at 2:04 PM, Nurse #2 explained Resident #1 was alert and oriented to self and often stood in a military stance (which she described as standing straight with his arms behind his back) staring out the windows or doors but not really trying to exit the facility. Nurse #2 recalled on 09/27/22, between 2:30 PM and 3:00 PM, Resident #1 was "hovering" at the front entrance door while a vender was trying to exit the facility. Nurse #2 stated she was able to get Resident #1 redirected away from the front entrance door and back to his room. Nurse #2 added once he was assisted back to his room, she did not recall noticing him leave his room or going back to the front lobby.

A police report dated 09/27/22 revealed Resident #1 was found at 6:11 PM along a highway intersection located approximately 8 miles from the facility. He was observed walking alone and appeared disoriented. He was taken by police to the local hospital for evaluation.

Resident #1's hospital records from 09/27/22 were unable to be obtained at the time of this

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F 689	Continued From page 4 investigation. An online website named Google Maps was used to obtain the walking distance from the facility to the location where Resident #1 was found as indicated on the police report. The highway intersection was 2-lanes with a posted speed limit of 35 miles per hour. Depending on the route Resident #1 walked, the distance from the facility to the highway intersection where he was found was 8.2 miles to 9.0 miles. An online website named Time and Date was used to obtain the outside weather in the Hendersonville area on 09/27/22 and noted at 2:54 PM the temperature was 67 degrees Fahrenheit with wind speeds of 10 miles per hour. A staff progress note dated 09/27/22 at 11:00 PM written by Nurse #1 read in part, "this nurse was informed that Resident #1 was brought to the Emergency Department (ED) after being found wandering. This nurse immediately placed calls to the Director of Nursing (DON) and the Administrator. Resident #1's family member was notified. Attempts made to reach Resident #1's Guardian were unsuccessful. Resident #1's wanderguard bracelet was found torn off in his nightstand. Upon returning to the facility, Resident #1 was placed on 15 minute safety checks and a one-to-one sitter. Denies any pain or discomfort. No new skin issues observed. Vital signs within normal limits. This nurse placed a new wanderguard to Resident #1's right ankle and it's functioning properly." During an interview on 10/11/22 at 2:22 PM, Nurse Aide (NA) #3 confirmed she worked during the hours of 7:00 AM to 3:00 PM on 09/27/22.	F 689		

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F 689	Continued From page 5 NA #3 recalled she saw Resident #1 in his room around lunchtime and then again at 1:00 PM when she went back into his room to pick up the lunch trays. NA #3 explained Resident #1 was confused at baseline and around 2:00 PM to 3:00 PM he wandered around the facility trying to find a way out. She stated staff would provide him with as much redirection as he would allow, until he eventually got tired and went back to his room. NA #3 stated it wasn't until just recently (she could not recall an exact date) Resident #1 tried to get staff to cut the wanderguard off for him and they explained they couldn't because it was needed to keep him safe. During an interview on 10/11/22 an 2:40 PM, Nurse #3 confirmed she worked during the hours of 7:00 AM to 7:00 PM on 09/27/22 but was not assigned to provide Resident #1's care. Nurse #3 stated she remembered seeing Resident #1 during the day but couldn't recall the exact time(s). Nurse #3 also stated sometime during the morning of 09/27/22, Resident #1 had removed his wanderguard device and a new one was placed back on. Nurse #3 explained Resident #1's baseline was to pace the halls, checking the doors and stating he needed to go home, and staff would try and redirect him with various techniques that usually worked. During an interview on 10/11/22 at 3:02 PM, NA #1 confirmed she worked during the hours of 2:00 PM to 11:00 PM on 09/27/22 when Resident #1 exited the facility unsupervised and was assigned to provide his care. NA #1 recalled when she arrived to work at approximately 2:05 PM, she noticed Resident #1 walking toward the dining room, he turned and followed her to the employee time clock area. After clocking in, NA #1 stated	F 689		

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F 689	Continued From page 6 as she walked down the hall to the nurses' station to review her assignment, she told Resident #1 where his room was located. NA #1 was not sure if Resident #1 went into his room or if he turned and went back to the front lobby. NA #1 stated after her initial encounter with Resident #1, her afternoon was busy as she started her initial incontinence rounds, assisted one or two residents with a shower, completed another general round of her assigned residents, assisted residents outside to smoke at 4:00 PM, assisted another NA with resident care, and then at approximately 4:45 PM to 5:00 PM, supper trays were delivered to the hall and they all began passing the meal trays out to the residents. NA #1 stated NA #2 had delivered Resident #1's supper tray to his room and did not recall NA #2 mentioning whether or not Resident #1 was in his room at the time. NA #1 stated while she and NA #4 were in a room feeding two residents, NA #2 started picking up supper trays which would have included Resident #1's. NA #1 explained Resident #1 was alert and oriented to self and there were days he would sit in his room and other days, he would walk up and down the halls, at times asking how to get out of the facility. She added, some days he was easily redirected and other times he would become angry, raising his voice and/or cursing. NA #1 stated she could not recall seeing Resident #1 after first arriving to work and it just didn't register with her that she hadn't seen him out in the halls like normal the evening of 09/27/22. NA #1 stated it wasn't until after supper that she was notified by Nurse #1 Resident #1 had exited the building and was taken to the hospital. NA #1 also stated she remembered Nurse #1 telling her earlier that day, Resident #1 had removed his wanderguard device and a new one was placed back on and	F 689		

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then after they had discovered he had exited the building, they found his wanderguard device in a drawer in his room.

During an interview on 10/12/22 at 6:44 AM, NA #2 confirmed he worked during the hours of 1:00 PM to 7:00 AM on 09/27/22. NA #2 stated he remembered seeing Resident #1 during his shift but not specific times. NA #2 stated Resident #1 was not in his room when he delivered his supper tray and explained that was not unusual as Resident #1 would typically wander the halls, go back to his room and eat a little, get up and walk around some more, go back to his room to eat a little more, and then leave the room again. NA #1 stated he did not pay attention to whether or not anything had been eaten when the meal tray was removed from Resident #1's room or if he had even been the one who picked up Resident #1's supper tray that evening. NA #2 stated Resident #1 was always making comments that he was going to escape and wore a wanderguard device on his wrist that was later placed on his ankle due to him removing the device. NA #2 stated he never mentioned Resident #1's comments about leaving to facility Administration and explained given Resident #1's dementia, he just took his comments as part of the disease process. NA #2 stated after they had been notified Resident #1 had exited the building, he searched Resident #1's room and found his wanderguard device in a drawer in his room. NA #2 added, prior to 09/27/22, he had not known Resident #1 to attempt or remove his wanderguard device.

During an interview on 10/12/22 at 6:31 AM, Nurse #1 confirmed she worked during the hours of 7:00 PM to 7:00 AM on 09/27/22 when Resident #1 exited the facility unsupervised and

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F 689	Continued From page 8 was assigned to provide Resident #1's care. Nurse #1 stated when she first arrived at work, she remembered looking into the residents' rooms as she walked down the hall toward the nurses' station but she did not recall seeing Resident #1 in his room or on the hall. Nurse #1 stated she didn't think anything of it because he typically wandered the facility, she would have to locate him to give him his evening medications and when he was ready to go to bed, he went back to his room. Nurse #1 couldn't recall the exact time but stated she was doing the evening medication pass and was 2 rooms ahead of his when the Nurse from A Hall notified her she had just received a call from the hospital that Resident #1 was brought there by the police. Nurse #1 stated it took her by surprise and she immediately notified the DON and Administrator. Nurse #1 stated when she spoke to staff who were present that evening, no one remembered seeing him during supper and when they had picked up his meal tray, he hadn't eaten which wasn't unusual. When they looked in his room, Nurse #1 reported they found his wanderguard device placed in his drawer where he had removed it. Nurse #1 explained Resident #1 was "alert and oriented to self with extreme confusion", his cognition would "come and go" as sometimes he would say something clear and then not make sense the next second. Nurse #1 stated he would sundown (state of confusion occurring and lasting into the night) during the afternoon/evenings, sometimes he would push on the exit doors but most times he just asked staff to let him out and they were usually able to redirect him with a snack. Once Resident #1 returned from the hospital on 09/27/22, Nurse #1 stated she took his vitals, completed a skin assessment, initiated 15-minute safety checks, and staff were assigned to provide	F 689		

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F 689	Continued From page 9 one-to-one supervision. During a telephone interview on 10/13/22 at 1:30 PM, NA# 4 revealed she worked at the facility per diem through a staffing agency. NA #4 stated on 09/28/22 she was notified by the DON that Resident #1 had exited the facility on 09/27/22 after she had opened the front door to report to work. NA #3 recalled when she arrived to work on 09/27/22, there were visitors waiting at the door and when she entered the code to open the door, the visitors all walked out. NA #4 explained she did not recognize Resident #1 as he was not one of her assigned residents and she thought he was part of the group of visitors who left. During an interview on 10/13/22 at 1:02 PM, the DON revealed Resident #1 was alert and oriented at times with periods of confusion and typically wandered around the facility looking out the windows and doors but had never noticed him trying to get out. The DON could not recall the time but states she was already at home the evening of 09/27/22 when she was notified by Nurse #1 that Resident #1 was found by the police outside the facility. The DON stated she instructed Nurse #1 to do an immediate head count to make sure all other residents were accounted for while she called to notify the Administrator what had happened. The DON stated she then went to the facility and assisted the Administrator with starting the investigation which included obtaining staff statements, checking the functioning of other residents' wanderguard devices, conducting an elopement drill, and providing staff education. The DON stated when she talked with staff, they couldn't recall the last time they had seen Resident #1 in the facility and wasn't aware that he had exited	F 689		

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F 689	Continued From page 10 the building until notified by the police. During interviews on 10/11/22 at 4:35 PM and 10/12/22 at 4:44 PM, the Administrator confirmed she was notified of Resident #1's elopement on 09/27/22 by the DON but could not recall the exact time. The Administrator did recall the facility was notified around 7:00 PM that Resident #1 was at the hospital and she picked him at 10:30 PM to bring him back to the facility. The Administrator explained once Resident #1 returned to the facility, he received a new wanderguard device and was placed on one-to-one staff supervision. The Administrator stated when she was first notified of Resident #1's elopement, she wasn't sure how he had exited the facility since he wore a wanderguard device and it wasn't until she started investigating the incident she learned he had been removing them. She added, had Resident #1 been wearing his wanderguard device at the time he exited the building on 09/27/22, the door would have alarmed to notify staff. The Administrator stated when she reviewed the video footage, Resident #1 was seen on the video around 3:00 PM, wearing a hat and coat, standing by the front entrance door with visitors of other residents and walked out of the facility when the door was opened by NA #4 who was reporting to work. The Administrator confirmed staff were unaware Resident #1 had exited the facility on 09/27/22 until notified by hospital staff at approximately 7:00 PM. She added the time frame from when Resident #1 exited the building and staff were notified he was at the hospital was too long for staff not to realize someone was not in the facility and staff should be aware of where their assigned residents were not only during mealtimes but throughout their shifts. The Administrator	F 689		

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explained during her investigation, she realized staff weren't really familiar with the residents' who wandered and staff needed to familiarize themselves with the residents at risk, not just depend on the wanderguard device to alert them. As part of the investigation, the Administrator stated new pictures were taken of the residents identified as an elopement risk, to better represent what the resident currently looked like, elopement books were updated, and staff were educated. In addition, she explained staff were instructed to immediately report any new behaviors, such as a resident removing a wanderguard device, so that new interventions could be put into place and a sign was placed on the front doors to alert visitors to be more conscientious of residents in the area when entering and exiting the facility.

During a telephone interview on 10/12/22 at 1:48 PM, the Psychiatric Nurse Practitioner explained Resident #1 was not alert and oriented and often wandered throughout the facility. He explained Resident #1's mentation "came and went", sometimes he was "more with it" and able to repeat things said but not able to remember other details. He added Resident #1 could also be threatening and combative at times. The Psychiatric Nurse Practitioner stated he did not feel Resident #1 would be safe outside the facility unsupervised.

During a telephone interview on 10/12/22 at 11:00, NP #1 revealed she treated Resident #1 from the time of his admission until September 2022 when NP #2 took over his care. NP #1 stated Resident #1 was alert and oriented to self and did not feel Resident #1 was someone who would be safe outside unsupervised.

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(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 During a telephone interview on 10/12/22 at 9:54 AM, NP #2 revealed when she took over Resident #1's care in September 2022, he was not alert and oriented but after some medication adjustments, he became more alert. NP #2 stated she tried to conduct a Brief Interview of Mental Status (BIMS) assessment with Resident #1 but when she asked questions about his cognition, he became angry and she wasn't able to complete the BIMS assessment. NP #2 further stated Resident #1 did not have good judgement and given his level of cognition, he would not be safe unsupervised when out of the facility. During an interview on 10/12/22 at 11:58 AM, the facility's Medical Doctor (MD) revealed Resident #1 was very confused, he could hold a conversation but didn't always make sense. The MD stated given Resident #1's level of cognition, he would not be safe outside unsupervised and/or wandering alone alongside a busy road. On 10/13/22 at 12:07 PM, the Administrator, Regional Director of Operations, and Regional Director of Clinical Services were notified of Immediate Jeopardy. The facility provided the following Allegation of Compliance with the correction date of 09/28/22: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Based on record review, staff interview and observation, the facility failed to prevent a Resident from exiting the facility and walking down a main road unsupervised.	F 689		

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Resident #1 was admitted to the facility for long-term care on 05/09/22 with a diagnosis of neurosyphilis, unspecified dementia with behaviors, mood disorder, anxiety disorder, abnormal gait and mobility, confusional arousals, muscle weakness, and lack of coordination. Resident #1 was assessed upon admission at risk for elopement and care plan in place with intervention of wanderguard to ankle. Resident #1 has periods of cognitive clarity and sever confusion with the most recent BIMS score assessed as a 13 (cognitively intact) on 08/11/22.

On 09/27/22 at approximately 10:30 AM, the licensed nurse noted his wanderguard was not in place to the right ankle and reapplied a new device. Per the Medication Administration Record (MAR) review, the device was assessed as in place and properly functioning during previous routine monitoring. At 8:20 PM, the facility licensed nurse received a c all from police that Resident #1 had been brought to the ED after being observed walking alone along a main road. The DON, Administrator and Medical Provider were immediately notified and multiple attempts were made to contact the Guardian and family member who were both made aware of the incident. Resident #1 returned to the facility at 10:45 PM and was assessed by the licensed nurse without injury or pain and vitals at baseline. Updated wandering risk assessment completed, wanderguard replaced to ankle and continuous one-to-one staff supervision initiated. Care plan, Kardex and orders updated accordingly.

Effective 09/27/22 at 10:45 PM, Resident #1 will remain on one-to-one supervision until further determined by the Interdisciplinary team.

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Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Residents who exhibit exit-seeking behaviors wand who are assessed as an elopement risk are at risk of exiting the facility without supervision. The following plan has been formulated to address this issue and updates to the facility risk assessment made accordingly:

" On 09/27/22 at 8:25 PM, the facility initiated a 100 percent census verification an all residents accounted for and safe.
"
" On 09/27/22 at 8:30 PM, all facility doors and windows and wanderguard system doors verified as secure and properly functioning. No concerns identified.
"
" On 09/27/22 at 8:45 PM, licensed nurses verified placement and proper functioning of wanderguard devices for all other residents as per plan of care. Residents also reviewed for known behaviors or removing or attempting to remove wanderguard device. No additional concerns identified.
"
" On 09/27/22 at 9:00 PM, the licensed nurses completed an elopement audit by updating wandering risk assessments for all current facility residents to identify those at risk for elopement and to ensure appropriate care plan and Kardex in place and current wanderguard orders with monitoring for placement and function. Elopement risk binders verified for accuracy, completeness and placement at nurse stations

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F 689	Continued From page 15 and reception desk with copy of resident profile, phot and care plan by the Director of Nursing (DON). Residents also reviewed for any behavior of removing and/or attempting to remove wanderguard device. No additional residents identified as current risk. " " On 09/27/22 at 9:15 PM, the DON conducted an elopement drill with current facility staff and initiated elopement education with all current facility and agency staff. Education included: 1) review of the elopement policy, 2) response in the event of a missing resident, 3) recognizing residents exhibiting exit-seeking behaviors such as pushing on exit doors, removing, or attempting to remove wanderguard devices, verbalizing desire to go home, purposeless wandering, etc., 4)responding to exit-seeing behaviors by providing redirection or distraction and reporting to supervisor when attempts are unsuccessful, 5) reporting to supervisor in the event a wanderguard device is improperly functioning or not in place per resident plan of care and immediate implementation of additional intervention to ensure safety, 6) ensuing staff awareness of residents identified at risk for elopement and location of elopement binders at the nurse stations and reception desk, 7) ensuing staff heightened awareness when entering or exiting facility doors that residents are clear from doorway, 8) providing routine care rounds every two hours for residents with wandering and exit-seeking behaviors to ensure supervision to prevent exit from the facility, 9) licensed nurses to complete wandering risk assessment (admission, quarterly and with all changes) and document proper function and placement of wanderguard devices as ordered don the MAR, and 10) IDT review of residents at risk for elopement during	F 689		

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F 689	Continued From page 16 Monday-Friday morning meeting for effective plan of care and/or need for revision with communication to nursing staff with any changes. Facility and agency staff not receiving initial education will not be permitted to work until education completed. The Staff Development Coordinator (SDC) will be responsible for ensuing education completion. " " On 09/27/22 at 9:45 PM, the Administrator conducted an Ad-Hoc QA meeting via telephone conference with the DON, Unit Manager, Regional Director of Clinical Operations (RDCS), Regional Director of Operations (RDO, VP Risk Management, and Medical Director to discuss incident, review facility elopement policy and to initiate an immediate performance improvement plan based on root cause analysis. Root cause analysis determined that the facility failed to prevent a resident from exiting the facility by 1) failure to ensure a staff member recognized and prevented an at risk resident from exiting the lobby door with visitors as staff member entered from break and 2) failure to ensure staff properly responded to, report and implement a new intervention when a resident knowingly removes a wanderguard device. " " On 09/27/22 at 10:00 PM, the RDCS provided education to the Administrator and DON on the elopement policy and facility responsibility of maintaining an effective process to prevent residents from exiting the facility without supervision to ensure safety. Education included 1) strategies to ensure staff understanding and compliance of the elopement policy and ongoing monitoring, 2) interventions to prevent an unsupervised exit from the facility of an at-risk resident and ongoing monitoring, 3) interventions	F 689		

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F 689	Continued From page 17 to enhance staff awareness of residents identified at risk and ongoing monitoring, and 4) maintaining an effective QAPI program whereby the Interdisciplinary Team (IDT) monitors the effectiveness of the corrective action plan of the elopement prevention program and makes changes to the plan as necessary to maintain compliance with preventing residents from unsupervised exits of the facility. Newly hired Administrators and DON will receive education during the orientation process. " Effective 09/27/22, the facility will conduct elopement drills on all shifts bi-monthly to ensure continued staff understanding of the elopement policy and procedures in the event of a missing resident. The IDT will monitor for ongoing compliance during monthly QAPI meeting. Effective 09/27/22, the IDT will monitor residents at risk for elopement during the monthly meeting process Monday-Friday utilizing the Elopement Huddle Tool to evaluate ongoing effectiveness of care plan and will make revisions to the plan as necessary to maintain resident safety. The IDT will communicate with nursing staff any concerns or changes to residents at risk. Monitoring will be documented on the Elopement Huddle tool and maintained by the Administrator. Effective 09/27/22, the Maintenance Director or Administrator will complete daily door, window and wanderguard system checks for proper function. Any concerns will be addressed immediately through QAPI to ensure continued resident safety. Effective 09/27/22, the facility will conduct questionnaires with five (5) facility or agency staff	F 689		

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F 689	Continued From page 18 to ensure understanding of providing care and supervision for residents at risk for elopement to prevent unsupervised exits from the facility. Monitoring will be completed by the Administrator or DON five times weekly for four weeks, then 3 times weekly for four weeks and then weekly for 4 weeks. Effective 09/27/22, residents identified at risk for elopement will be audited for a current, accurate wandering risk assessment, effective care plan, monitoring of wanderguard devices for propre placement and functioning, accurate and updated elopement risk binders at the nurse stations and reception desk, documentation of daily door, window and wanderguard system checks for proper function, bi-monthly elopement drills and daily review by the IDT per review of the Elopement Huddle Tool. Monitoring will be completed by the Administrator or DON five times weekly for four weeks, then 3 times weekly for four weeks, then weekly for four weeks. Effective 09/27/22, the Administrator will be ultimately responsible to ensure implementation of this corrective plan. Alleged date of compliance: 09/28/22. 2. Review of the manufacturer's instructions for the "QRT-1 Series", which is the system used on the facility's transport van to secure residents who are seated in wheelchairs during transport, specified in part: "B. Secure Passenger: 1. Attach lap belts by using integrated stiffeners to feed belts through opening between seat backs and bottoms and/or armrests to ensure proper belt fit around occupant. 2) Attach shoulder belt by extending the belt over the passenger's	F 689		

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F 689	Continued From page 19 shoulder, across upper torso and fasten pin connector onto the lap belt. 3) Ensure belts are adjusted as firmly as possible but consistent with user comfort. Warning: Lap and shoulder belt should not be held away from the passenger's body by wheelchair components or parts such as the wheelchair's wheels, armrests, panels, or frame. Belts should always bear upon the bony structure of passenger's body and be worn low across the front of the pelvis, with the junction between lap and should belts located near the passenger's hip." The manufacturer's instructions provided no guidance regarding occupants sitting on cushions or mechanical lift slings while they were seated in their wheelchair during transport. Resident #2 was admitted to the facility on 12/15/21 with multiple diagnoses that included intellectual disabilities, pervasive developmental disorder (delays in the development of socialization and communication skills), and age-related physical debility. The quarterly Minimum Data Set (MDS) dated 08/19/22 assessed Resident #2 with severe impairment in cognition and was nonverbal with communication. She required total staff assistance with all activities of daily living and had impairment on both sides of the upper and lower extremities. The MDS indicated Resident #2's height was 67 inches and she weighed 181 pounds. The Resident Incident Report dated 08/02/22 at 4:26 PM noted Resident #2 slid out of the wheelchair while in the facility van during transport and was taken to the Emergency Department (ED) for evaluation.	F 689		

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The ED hospital records for Resident #2 dated 08/02/22 read in part, "Resident #2 presents with family for fall out of wheelchair while being transported inside of a van prior to arrival. Resident #2 is nonverbal and reportedly fell forward out of the wheelchair injuring her left knee and ankle. Also has superficial wounds to left hand." Upon physical exam it was noted Resident #2 had "abrasions to the left knee, ankle, and hand with no rash, pruritus (itching), or wounds." It was further noted x-rays conducted on 08/02/22 of Resident #2's left fingers, knee and ankle were negative for acute fractures.

A staff progress note dated 08/02/22 at 11:00 PM and written by Nurse #1 read in part, "Resident #2 returned from the Emergency Department (ED) via stretcher, returned to bed, skin assessment done."

A skin assessment dated 08/02/22 completed by Nurse #1 revealed Resident #2 had a new open area to the center of her top lip that was not bleeding and new bruising to the left fingers, right hip, front of the right thigh and lower leg, front of the left thigh and lower leg, right toe(s) and ankle, and left toe(s) and ankle.
The facility's investigation into the van incident involving Resident #2, completed and signed by the Administrator on 08/04/22, included an action plan that noted in part, "On 08/02/22, Resident #2 was improperly positioned sitting on top of a mechanical lift sling in the wheelchair while in the facility van during transport. Resident #2 was seen in the ED for post-fall evaluation, and x-rays of the knee, ankle and hand were all negative. Resident #2 returned to the facility on 08/02/22 with no new orders."

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The facility's investigation also included an Ad-Hoc Quality Assurance and Performance Improvement (QAPI) summary dated 08/03/22 that read in part, "On 08/02/22, Resident #2 sustained a fall from the wheelchair while being transported in the facility van. Resident #2 was enroute to a Neurology appointment when the van drove over a speed bump in the parking lot. Resident #2 fell forward sustaining bruising and abrasions to the knee, ankle, and hand. Resident #2 was transported to the ED for evaluation. X-rays were negative. Root cause analysis indicated that Resident #2 was positioned in her wheelchair sitting on a wheelchair cushion and mechanical lift sling. The mechanical lift sling was not removed prior to transport. The wheelchair and restraints were properly and securely positioned prior to transport."
Resident #2 was unable to be interviewed due to cognition. An unsuccessful telephone attempt was made to speak with Resident #2's Responsible Party on 10/13/22 at 9:23 AM.

During an interview on 10/12/22 at 10:37 AM, Nurse Aide (NA) #1 confirmed she was the facility's transportation driver on 08/02/22 when the accident occurred with Resident #2. NA #1 explained when she initially took the transportation driver position, she was trained on proper securement by the previous Maintenance Director and recalled it was sometime in June 2022. NA #1 revealed in September 2022 she changed positions and no longer transported residents to appointments except on rare occasion. NA #1 recalled on 08/02/22 prior to departure, she made sure Resident #2's wheelchair was secured in the facility van by locking the wheelchair brakes, attaching the securement straps to the wheelchair, and

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F 689	Continued From page 22 applying the shoulder and lap belts. NA #1 stated as she was pulling into the hospital parking lot for Resident #2's appointment, she went over a speed bump and Resident #2 slid out of the wheelchair onto her knees. NA #1 stated the wheelchair remained secured and Resident #2 was still strapped in by the shoulder belt which prevented her from falling forward onto the floor of the van. NA #1 stated she was not sure if she had the lap belt tight enough around Resident #2 and added prior to leaving the facility, she was confident it had been but "maybe too confident." NA #1 added Resident #2 had a cushion and mechanical lift sling in the wheelchair she was sitting on and thought the sling might have made the seat slippery, causing Resident #2's bottom to slide underneath the lap belt. NA #1 stated since she was already in the hospital parking lot, she immediately went into the doctor's office to see if staff would come out to the van to assess Resident #2 and assist with getting her back into the wheelchair for her appointment but they told her they couldn't and it was against their policy. When she got back out to the van, NA #1 recalled Resident #2's Responsible Party (RP) was there and had already called the Administrator to inform her of the incident. She added Resident #2's RP kept insisting NA #1 get her back up into the wheelchair and into the doctor's office for her appointment. After she assisted Resident #2 back into her wheelchair, NA #1 recalled Resident #2's knees and lip were "scratched up" but did not observe any other injuries. NA #1 stated she waited in the van while Resident #2 went to her appointment and after a little while, she went into the doctor's office to check on her and was told Resident #2's RP had her sent to the ED for evaluation. NA #1 stated she then went back to the van and returned to the facility. After the	F 689		

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F 689	Continued From page 23 incident, NA #1 stated she was reeducated by the Maintenance Director on proper securement when transporting residents in the facility van. A Neurologist progress note dated 08/02/22 read in part, "No seizures reported. Patient continues to cry out in pain. Mom feels pain might be related to extremity spasms. Today, patient was injured in transport due to a fall by the transporter. Patient has a busted lip, swollen ankles and left fingers across the knuckle are blue in color. Patient has abrasions which are mildly bleeding. Assessment/Plan: She did have an accidental fall from her wheelchair, before she was brought to my clinic, examined her and told mom to take her to the ED." During an interview on 10/13/22 at 12:33 PM, the Administrator confirmed the facility was currently without a transport driver and residents were transported to medical appointments using an outside transport service. A joint interview was conducted with the Administrator and Regional Director of Clinical Services (RDCS) on 10/12/22 at 4:44 PM. The Administrator confirmed she was notified on 08/02/22 of the incident involving Resident #2 but could not recall if she was notified by NA #1 or Resident #2's RP. The Administrator stated a plan of correction was initiated on 08/02/22 which included monitoring systems for ensuring a safe transport. The Administrator could not explain how she monitored residents for a safe transport and stated most of the residents included in the monitoring tools were alert and oriented, could tell her if there had been an incident during transport and no concerns were reported.	F 689		

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F 689	Continued From page 24 A joint interview was conducted with the Administrator and Regional Director of Clinical Services (RDCS) on 10/12/22 at 4:44 PM. The RDCS stated she had NA #1 reenact the event with her that included explaining how she had secured Resident #2 into the wheelchair prior to transport. The RDCS stated based on the explanation from NA #1, when she drove over the speed bump in the road, it caused Resident #2 to bounce up in her seat which must have loosened the lap belt slightly and Resident #2's bottom slid off the wheelchair underneath the lap belt and her knees hit the floor of the van. She added Resident #2 also had a mechanical lift sling on top of the wheelchair cushion she was seated on and the material of the sling could have potentially made it easier for her to slide when she bounced up in the seat. The RDCS stated the abrasion to Resident #2's lip likely occurred from the shoulder strap as she slid off the wheelchair and under the lap belt. The RDCS explained based on NA #1's reenactment they determined Resident #2 was secured properly and the root cause resulted from the mechanical lift sling being left in the wheelchair. The RDCS stated NA #1 knew she was supposed to have a Nurse assess Resident #2 prior to assisting her back into the wheelchair and felt NA #1 was overwhelmed at the situation because the nursing staff at the doctor's office told her it was against their policy to provide assistance and Resident #2's mother was insistent on getting Resident #2 back into the wheelchair to be assessed at her appointment. The RDCS clarified that validation for a safe transport meant no resident was transported with a mechanical lift sling under their wheelchair, which was what they had determined to be the root cause.	F 689		

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F 689	Continued From page 25 An observation of the facility transport van and follow-up interview was conducted with NA #1 on 10/13/22 at 10:20 AM. Surveyor #1 was seated in the transport wheelchair with a pressure relieving cushion and mechanical lift sling similar to what was used to transport Resident #2 on 08/02/22. The wheelchair was placed behind the driver's seat and NA #1 then made sure the wheelchair brakes were locked, attached the floor anchor straps to the wheelchair frame and checked for securement. NA #1 attached the chest/shoulder strap, made sure it was secure and then attached the lap belt, leaving it loose. When the strap of the lap belt was held straight out from the body, it extended approximately 9 inches. NA #1 confirmed she placed the lap belt on Surveyor #1 exactly as she had with Resident #2 on 08/02/22. NA #1 agreed the lap belt was loose and extended approximately 9 inches when held straight out. NA #1 was unable to explain why she didn't tighten the lap belt when securing Resident #2 into the wheelchair on 08/02/22 and stated she should have. NA #1 further stated when reenacting the incident with facility Administration, she did not inform them she had left the lap belt that loose when securing Resident #2 into the wheelchair and explained details were becoming clearer the more she remembered and reenacted the incident. NA #1 stated when she was provided reeducation from the Maintenance Director after the incident, he showed her that when she secured the lap belt, it should only be loose enough to fit her fingers between the strap and resident's lap. NA #1 restated when Resident #2 slid out of the wheelchair during transport, the wheelchair remained secure and didn't tip over, her shoulder belt remained intact and Resident #2 slid off the seat of the wheelchair under the lap belt which caused her	F 689		

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F 689	Continued From page 26 knees to hit the floor of the van and the shoulder strap must have slid upward causing an abrasion to her lip. During an interview on 10/13/22 at 10:38 AM, the Maintenance Director confirmed he provided NA #1 with education on wheelchair securement after the van incident involving Resident #2. The Maintenance Director explained he strapped himself into the wheelchair while showing and explaining each step to NA #1. The Maintenance Director did not recall NA #1 mentioning she had left the lap belt loose when securing Resident #2 into the wheelchair and added he instructed NA #1 when securing the lap belt to make sure it was tight with just enough room for her to slide her fingers between the strap and resident's lap. During follow-up interviews on 10/13/22 at 10:50 AM and 11:50 AM, the RDCS stated she was unaware NA #1 had reported during the reenactment that she had not secured Resident #2's lap belt tightly prior to transporting her in the facility van on 08/02/22. The RDCS stated they had a reenactment with NA #1 this morning before the survey team arrived at the facility and she never mentioned that detail. In addition, the RDCS stated she had several conversations with NA #1 after the incident and she had never mentioned leaving the lap belt loose. The RDCS stated when she spoke to NA #1 today (10/13/22) about the lap belt, NA #1 confirmed it had been left loose when she secured Resident #2 into the wheelchair on 08/02/22. The RDCS added when she asked NA #1 why she hadn't mentioned that detail to them but did when asked by the survey team, NA #1 stated she was nervous and didn't want to lie. The RDCS explained they developed the plan of correction and put solid plans in place	F 689		

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F 689	Continued From page 27	F 689		

based on the information they knew at the time and stated she didn't know how the facility could account for recollection of additional details.

On 10/13/22 at 12:07 PM, the Administrator, Regional Director of Operations, and Regional Director of Clinical Services were notified of Immediate Jeopardy.

The facility provided the following Allegation of Compliance with the correction date of 08/05/22:

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

Based on record review, staff interview and observation, the facility failed to prevent a resident from falling and sustaining multiple abrasions and bruising during van transport.

On 08/02/22, Resident #2 was transported to a medical appointment via facility van transport when the van hit a bump in the road the resident's buttocks slid forward causing her to come to her knees. Resident #2 was evaluated at the doctor's office and then transport to the hospital for further assessment. Daughter present at the doctor's office and went to hospital with Resident #2. Van driver immediately notified Administrator of the incident and Administrator notified the Medical Director.

Resident #2 returned to the facility on 08/02/22 at 10:00 PM in stable condition. Licensed nurses completed skin assessment and noted multiple abrasions and bruising. Resident #2's pain managed and effective with as needed Tramadol.

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F 689	Continued From page 28 On 08/03/22, the Administrator conducted an Ad Hoc QA meeting with key department heads and Medical Director to discuss incident, review facility van policy and to initiate a performance improvement plan based on root cause analysis. Root cause analysis determined that wen the van hit a bump in the road, the Resident's buttocks slid forward causing her to come to her knees. It was further determined that her lift sling had not been removed from the chair prior to transport and contributed to her sliding from the chair. Seatbelt and wheelchair confirmed as properly secured. Effective 08/03/22, Resident #2 will be transported via outside transport provider per family preference. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Residents who are transported via facility van are at risk for this deficient practice. The following plan has been formulated to address this issue: " On 08/03/22, the Director of Nursing provided education to the facility van driver on the importance of verifying that Hoyer slings are not in wheelchair prior to transport to ensure resident safety. Education included that the van driver should request nursing assistance for proper sling removal prior to transport if necessary. Newly hired van transporters will be educated upon hire and prior to transporting a resident. " " On 08/04/22, the facility van driver was in-serviced by the Maintenance Director on safe	F 689		

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F 689	Continued From page 29 van transport including proper wheelchair securement and in-depth training on the Q-straint system. Competency validated by return demonstration. Newly hired van transporters will be educated upon hire and prior to transporting a resident. " " On 08/03/22 and 08/04/22, Maintenance completed a safety inspection per the Transportation Vehicle Monthly Safety Inspection of the facility van to verify van safety, including proper functioning and security of seatbelts and security straps. No safety concerns identified. " Effective 08/03/22, the Maintenance Director will complete monthly safety inspections of the company van. Effective 08/03/22, the Administrator and Director of Nursing will complete audits of residents transported via facility van to validate safe transfers. Monitoring will be conducted weekly for 12 weeks. Effective 08/03/22, the facility Administrator will discuss results of monitor with IDT in monthly QAPI and make changes to the plan as necessary to maintain compliance with van safety. Effective 08/03/22, the Administrator will be ultimate responsible to ensure implementation of this corrective plan. Alleged date of compliance: 08/05/22. The Allegation of Compliance was validated 10/12/22 to 10/13/22 and concluded the facility implemented an acceptable corrective action plan	F 689		

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F 689	Continued From page 30 effective 08/05/22 by the following: NA #1 was observed providing a return demonstration on securing a resident per manufacturer guidance and confirmed receipt of education regarding how to secure the wheelchair for transport using the Q-straint wheelchair securement system. NA #1 was able to describe how to strap a resident in the wheelchair using a lap/chest seat belt and checking the wheelchair and resident for securement prior to transport. A Transport Driver Skills Assessment was completed with NA #1 by the Maintenance Director on 08/04/22. Monitoring and audit tools were reviewed with no concerns identified. The Allegation of Compliance was validated 10/11/22 to 10/13/22 and concluded the facility implemented an acceptable corrective action plan effective 09/28/22 when Resident #1 was placed on one-to-one supervision, staff education was provided on the elopement process and residents at risk for elopement and the elopement plan was reviewed during a QAPI meeting held via telephone conference on 09/27/22 at 9:45 PM. 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. Monitoring and audits were reviewed with no concerns identified. Multiple staff on various shifts were interviewed and verified they received re-education related to elopement and were able to describe facility processes for: what to do when a resident demonstrated elopement/exit seeking behaviors, where the elopement books were located and what information they contained, and to immediately report any new behaviors such as exit seeking and removing wanderguard devices.	F 689		

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F 689	Continued From page 31 The credible allegations of immediate jeopardy removal were validated with a compliance date of 9/28/22.	F 689		