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L 000	INITIAL COMMENTS A relicensure and complaint investigation survey was conducted from 10/11/22 through 10/14/22. Event ID# MHTL11. The following intakes were investigated NC00191860. The complaint allegations was substantiated resulting in a deficiency. Intake NC00191860 resulted in a Type A2 violation. The Type A2 violation was identified at 10A NCAC 13D .2208(e). The violation began on 7/31/2022 and was removed on 10/14/22. This statement of deficiencies was issued late due to problems with the State's server.	L 000		
L 037	.2208(C) SAFETY 10A-13D.2208 (c) The facility shall provide training for all employees in emergency procedures upon employment and annually. This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide annual staff Emergency Preparedness training. The findings included: Review of the Emergency Preparedness binder was completed on 10/13/2022 at 1:25 PM with the Director of Facility Services. There was no documentation that the binder had been reviewed or updated or that staff had been trained annually. She stated the Emergency Preparedness binder and training was not reviewed or updated	L 037		

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L 037	Continued From page 1 annually. The Director of Facility Services was not certain when the Emergency Preparedness binder was last reviewed or updated, or the last time staff had received annual training. An interview was completed with the Administrator on 10/13/2022 at 1:14 PM. The Administrator communicated the Emergency Preparedness binder had not been reviewed or updated and staff had not received annual training. She could not recall the last review date or the last time staff received training. She explained the Emergency Preparedness binder would receive a comprehensive review and update and then staff would receive updated training after the next LTC2Prepare Seminar, and an updated guidance manual could be obtained.	L 037		
L 039	.2208(E) SAFETY 10A-13D.2208 (e) The facility shall ensure that: (1) the patients' environment remains as free of accident hazards as possible; and (2) each patient receives adequate supervision and assistance to prevent accidents. This Rule is not met as evidenced by: Based on observation, record review, staff interview and contracted service maintenance provider interview, the facility failed to: 1) prevent 2 of 2 sampled residents (Resident #4 and Resident #5) identified as severely cognitively	L 039		

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impaired and at risk for elopement from exiting the facility without supervision and staff knowledge out of a total of 11 residents identified with wandering behaviors; and 2) maintain and monitor the wander prevention system known as wanderguard. Resident #4 was found outside the building. Resident #5 was found outside of the building twice. Pavement and walkways were broken and had a downward slope which posed a hazard to these wheelchair bound residents with dementia.

A substantial risk that death or serious physical harm would occur began on 7/31/2022 when Resident #4 who was cognitively impaired exited the facility unwitnessed. The violation continued when Resident #5, who was cognitively impaired, exited the facility on 8/30/2022 and 9/20/2022. The substantial risk was removed on 10/14/2022 when the facility implemented a credible allegation of substantial risk removal. The facility remains out of compliance to complete employee education and ensure monitoring systems in place are effective.

The findings included:

1. Resident #4 was admitted to the facility on 11/6/18 with a diagnoses that included moderate to severe dementia and osteopenia.
2.
Record review for Resident #4 revealed an admission nursing evaluation dated 11/6/18. The evaluation stated resident was alert with poor recall and was oriented to person, place, and time. The resident required oversight, encouragement or cueing with no set up or help from staff for transfers and walking in room. There was no further evaluation of Resident #4's activities of daily living (ADLs) in the record, nor

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an elopement/wandering assessment.

A physician order dated 2/11/22 stated check wanderguard system and functioning of the wanderguard system at 10:00 am and 8:00 pm every day. The physician order further stated wanderguard tag to Resident #4.

Residents #4's care plan for review period of 5/10/22 through 8/10/22 stated a problem of Resident #4 had Lewy body dementia and was at risk for further cognitive decline. The goal revealed Resident #4 would maintain her current cognitive and functional status over the course of the review period. The Resident was further care planned for risk for falls. The goal stated Resident #4 would remain free from injurious fall. Resident #4's care plan for the review period of 5/10/22 through 8/10/22 did not reveal the use of a wanderguard system or exit seeking behaviors.

A nursing note dated 7/29/22 and written by Nurse # 3 revealed Resident #4 was exit seeking in the afternoon. The nursing note continued that Resident #4 was given as needed (PRN) trazodone with effective results at 2:30 PM. Nurse #3 would continue to monitor Resident #4.

A nursing note dated 7/31/22 and written by Nurse #1 revealed Resident #4 was found outside by the courtyard behind the unit's courtyard on the sidewalk. The nursing note further revealed Resident #4 was safe and back in the building. The note did not indicate which staff located Resident #4.

Review of Resident #4's treatment record (TAR) for July 2022 revealed the resident's wanderguard tag was checked twice daily at 10:00 am and 8:00 pm.

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L 039	Continued From page 4 Review of a 5-day working report dated 8/1/22 revealed a summary that stated on 7/31/22 at 2:00 pm the nursing staff discovered Resident #4 was missing from her room. The Nursing Assistant (name not provided in the report summary) who was caring for her informed Nurse (name not provided in the report summary) and he immediately instructed all nursing staff to begin searching for the resident. They searched the entire building and the outside grounds. Resident #4 was found outside in the bird sanctuary sitting in her wheelchair. The nurse (name not provided in the summary) did a body audit, and it was negative for scratches, bruises, cuts, lacerations. Resident #4 was found at 3:00 pm. The battery was dead, and the nurse changed out the wanderguard system when Resident #4 was retrieved from outside. The note further stated there was a door alarm on the outside door that alarmed as well when someone exited the building, it functioned and had 2 settings. The facility changed the setting to the louder alarm. Additionally, the note revealed Resident #4's wanderguard was checked by the nurse (name not identified in the report) at 10:00 am and it was functioning before the elopement. Interview with Nurse #1 on 10/13/22 at 1:27 pm revealed Resident #4 typically only wandered and did not attempt to exit the building. He described Resident #4 as a cognitively impaired resident that was wheelchair bound and required extensive assistance to complete ADLs. He stated the day of the incident, 7/31/22, he was assigned to Resident #4. He was making rounds and identified Resident #4 was missing. Once he identified she was missing he got the assistance from other staff to find Resident #4. The facility alarm was not working properly because it was	L 039		

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supposed to alert staff when a resident opened a door. He stated he was unsure how long the resident was missing. After she was located by other staff, he assessed the resident for injury. Nurse #1 revealed the facility had discovered there was something wrong with the wanderguard tag system. Nursing staff were to check the wanderguard tag by using a portable checker. It had a button that you must mash that indicated the equipment failed or was activated. Nurse #1 recalled on 7/31/22 the portable checker would say a device was good, but when he walked to an exit the door with the device it wouldn't alarm.

Interview with NA #2 on 10/13/22 at 5:24 pm revealed she located Resident #4 on 7/31/22. She stated she recalled arriving to 2nd shift early. When she arrived, she believed she was told by Nurse #3 that Resident #4 was missing. She stated she and Nurse #3 had located the Resident outside door #1 of the building. They initially did not see Resident #4, but the back of her wheelchair wheel was visible on the side of the bush. NA #2 stated the resident was partially in the bush and wheelchair wheels were locked. She had to jostle Resident #4's wheelchair backwards from the bush to avoid having her get out of the chair. NA #2 revealed the alarm to the door did not sound as they exited. She further stated the resident did have a wanderguard tag on, but it was not working. Following the incident, the facility put a louder alarm on the door and placed a camera at Door # 1.

Interview with Nurse #3 on 10/12/22 at 2:41 pm revealed she was working the day Resident #4 got out the of building unwitnessed. Nurse #3 stated she was PRN and arrived to work around 2:00 pm for her shift that began at 2:30 pm. Nurse #3 was receiving report from Nurse #2

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behind a closed medication room door. An NA (unknown) opened the door and stated they couldn't find Resident #4. She stated she recalled asking the unknown NA where they had looked. She was unaware of how the search for Resident #4 had been before she began looking. She stated she searched for the resident upstairs, and they had staff outside looking for the resident. When she came back to the unit she inquired about where the side door (short hall to courtyard) led to. She was told it went to a grassy area. When Nurse #3 went outside the side door the alarm did not sound. Nurse #3 stated it had a doorbell that went "ding dong" when she opened it. NA #2 was with her during her search. She revealed NA #2 told her to hold on and they looked down a line of bushes that was lined against the building. Resident #4 was at the end of line of bushes in her wheelchair. Nurse #3 recalled Resident #4's wheelchair wheels were locked and stated she was surprised Resident #4 had made it that far on the cracked pavement. Nurse #3 immediately called Nurse #2 to notify her that Resident #4 had been found. She stated the resident did have a wanderguard tag on her when she was located. She recalled Nurse #1 checked the wanderguard tag on Resident #4's wrist and it was not working. After the incident the facility-initiated every hour checks to ensure residents were in the building. She stated the facility checked other residents' wanderguard tag and she recalled there were others that were not working. She wasn't sure if it was the machine that checked the wanderguard tag device or the wanderguard tag system itself. She revealed the facility initiated a book with wanderers at the nursing station.

Interview with Nurse #2 on 10/12/22 at 12:48 pm revealed she was not working with Resident #4

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when she eloped. She stated she did work close to the hallway door that the resident exited from. While giving report to another nurse (name unknown) she was approached by a NA #1 who asked if she had seen Resident #4. She stated she had seen Resident #4 who was in a wheelchair for ambulation and had been wheeling about the facility during the day. Nurse #2 then assisted in searching for Resident #4 on 7/31/22. She revealed she was not the staff that located Resident #4. The door Resident #4 exited from (door #1) was unlocked and was not guarded by the wanderguard system. The door did not lock down but would alarm. She stated the door #1 would chirp if a resident got close, but the door would stop chirping if a resident was able to exit. Nurse #2 could not recall what type of alarm was on the door prior to the new alarm but the new alarm was louder when the door was opened. Nurse #2 was notified the resident was found in the courtyard beside one of the bushes. She stated the facility had a device that would check if the wanderguard was functioning. It was a sensor that was held over the bracelet. She did not recall hearing an alarm when Resident #4 exited the building.

Interview and observation with the Nursing Supervisor on 10/12/22 at 9:42 am revealed on 7/31/22 Resident #4 got out of the door #1. The observation of door #1 revealed an alarm to the top portion of the door seal. Door #1 led to an area that was not secured. The Nursing Supervisor indicated Resident #4 was located at the end of the walkway outside in her wheelchair. The walkway was observed cracked and the concrete was broken. The walkway had a downward slope between a line of hedges and the building. The line of hedges was estimated to be over 5 feet long. The Nursing Supervisor

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further stated the area Resident #4 was located led to the side parking lot of the building.

Interview with the Director of Facility Services on 10/12/22 at 10:05 am revealed the wanderguard tags were delivered from the contracted service maintenance provider. The system was routinely checked and had increased due to the elopement of Resident #4 and were checked weekly. The system was checked by maintenance staff and herself. She stated they were to be checked monthly. The frequency of checking the system went from monthly to weekly. Nursing staff were to check the wanderguard system tags on residents daily. The Director of Facility Services stated she had recently purchased a new wanderguard system tag tester after the incident as well. She had the contracted service maintenance provider out several times to identify the issues regarding wanderguard tags not alarming doors. The issue with the wanderguard tags not alarming was intermittent, and she was she was unsure if the issue was the wanderguard tags were not alarming the system was or if it was the tester. When checking the doors, she used a wanderguard tag for testing. She did not document her testing but had service reports from the contracted service maintenance provider that provided the service. When Resident #4 left the building, it was a weekend (Sunday). She stated she believed she was notified of the elopement on Monday. She checked the door and checked if the wanderguard tag was good. The Director of Facility Services believed the facility had already replaced the resident's wanderguard tag. She recalled the wanderguard tag battery as being dead. The Director of Facility Services revealed she was told the by the contracted service maintenance provider the wanderguard tag worked for a year and arrived to

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the facility activated (ready to alarm) by the company. She stated the facility purchased wanderguard tags 5 at a time so they wouldn't go bad. Prior to the elopement of Resident #4 there was only a contact alarm on the door, meaning when the door was opened, it chimed, and when it closed, it stopped chiming. Nursing may not have heard it due to the alarm only sounding for a while until the door closed. She stated she replaced the alarm with an alarm that kept sounding as long the was door opened and the staff had to put a code in to stop the alarm. A camera was also placed at door #1.

Interview with the Director of Nursing (DON) on 11/12/22 at 9:38 am revealed Resident #4 got out of the building from the side door (door #1). Following the incident, the facility placed another alarm on the door and maintenance checked the doors in the facility for proper functioning.

2. Resident #5 was admitted to the facility on 10/11/21 with diagnoses that included, vascular dementia, left cardiovascular accident, right side weakness and aphasia.

A nursing evaluation dated 10/11/21 revealed Resident #5 had right sided weakness, was alert with poor recall. Resident #5 required staff to provide weight bearing support with 1 staff person assistance for functional range of motion, transfers and dressing. The resident required staff guided maneuvering of limbs or other non-weight bearing assistance with 1 staff for bed mobility and utilized a wheelchair for mobility. The medical record revealed no other assessment that identified the resident's assistance needed for activities of daily living to include transfers, repositioning, or wandering/elopement.

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A physician order dated 10/18/21 stated Resident #5 was to wear a wanderguard tag. Do visible checks on 3rd shift to make sure the resident was in the bed throughout the shift without waking them up.

The physician order dated 10/18/21 stated check placement and functioning of Resident #5's wanderguard tag at 10:00 am and 8:00 pm every day.

Resident #5's care plan for the review period of 6/28/22 through 9/28/22 revealed Resident #5 suffered diagnoses to include vascular dementia. The goal stated Resident #5 would remain comfortable and symptoms controlled with medication. Resident #5 was further care planned for risk of falls secondary to his diseases process. The goal stated Resident #5 would remain free from injurious falls. The interventions included staff to use 2-person assist with any transfers and staff were to make frequent rounds to anticipate resident's needs. Resident #5's care plan for the review period of 6/28/22 through 9/28/22 revealed no goals or interventions regarding the use of a wanderguard tag.

Review of Resident #5's TAR for the month June 2022 revealed his wanderguard tag was checked twice daily at 10:00 am and 8:00 pm.

A nursing note written by Nurse #1 dated 8/30/22 stated at 12:45 pm Resident #5 exited the back of the unit courtyard (door #2) momentarily. No harm came to the resident.

Interview with Nurse # 1 on 10/13/22 at 7:46 pm revealed he was assigned to Resident #5 on the day in which Resident #5 eloped. He stated on 8/30/22 he was approached by the Facility

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Maintenance Staff #1 who informed him that Resident #5 was seen outside of the building by door #2. The door #2 led to a garden area. Resident #5 ambulated using a wheelchair. There was no alarm that sounded, and the elopement was not witnessed. Nurse #1 stated after he was notified by Facility Maintenance Staff #1 that an NA (name unknown) indicated Resident #5 was outside. Nurse #1 revealed he retrieved Resident #5 from outside not too far from door #2. He stated there were a lot of trip hazards outside the door and the resident frequented the door. Nurse #1 revealed sometimes in passing he would notice the resident try to open the door and he would have to stop him.

Interview with NA #2 on 10/13/22 at 5:24 pm revealed she was familiar with Resident #5. She stated the resident would frequent the back door of the facility (door #2). NA#2 recalled Resident #5 being out of the building but could not remember the date. She stated she observed the resident from the double door lounge in the facility. NA #2 further revealed there was no alarm sounding. She notified nursing and Resident #5 was retrieved by a nurse. Following the incident, the facility placed a "STOP" sign on the door.

Interview with Facility Maintenance Staff #1 on 10/14/22 at 12:28 pm revealed he was notified on 8/30/22 by one of the staff that Resident #5 was outside by the greenhouse. He stated when he got the call, he was already on the elevator going to the unit. He told the Nurse #1 that the Resident #5 was outside. Nurse #1 had retrieved the resident was observed wheeling Resident #5 him back into the building. He stated that apparently the staff had entered the code wrong

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to the door.

A physician note dated 8/31/22 stated per nursing report on 8/30/22 at 12:45 pm Resident #5 exited the door #2 momentarily. No harm came to the resident. The assessment and plan stated per nursing administration, the facility was waiting on more wanderguard tags to come in. Resident #5 was currently on hourly checks.

An interview with the DON on 10/12/22 at 12:02 pm revealed the incident recorded in the nursing notes regarding the incident that occurred on 8/30/22 in which Resident #5 had eloped was not recorded due Resident #5 being a seen by staff (name not provided) when the resident exited. She further revealed door #2 was supposed to alarm but did not.

Resident #5's care plan for the review period of 9/20/22 through 12/20/22 stated a problem of resident gets agitated, increased with tiredness. The goal stated, decrease agitation. The interventions included Seroquel (antipsychotic) as ordered, was scheduled with a PRN dose, put to bed if tired and Resident #5 had a wanderguard tag and check 2 times daily.

A 5-day report dated 9/20/22 included a summary that stated on 9/19/22 at 6:43 pm Resident #5 exited the nursing home via door #2. He was returned at 6:53 pm by a resident who lived in the independent living section of the facility and was walking outside on facility grounds. The DON and the Administrator reviewed the tape for the exact time of elopement and return. The nurse (name not provided in the summary) passing meds on hall stated she had seen Resident #5 multiple times during her med pass but did not witness him exit the building. The resident's

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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) COMPLETE DATE
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family member had taken him outside prior to the incident to sit in the rose garden then returned him to the facility and left. An independent living resident saw Resident #5 about 10 feet from the exterior door and recognized him a as a resident of the skilled nursing facility. She then called another independent resident to bring her a key fob to open the door to get Resident #5 back inside the building. She then pushed Resident #5 into the building and left and called Resident #5's family member to tell her what happened. Resident #5's wife lived in the building, so she came down to the unit to inform the nurse Resident #5 had left the building and was returned by an independent resident. The note continued that the wanderguard tag bracelet was not functioning, and it was removed and a new one attached to his wheelchair. He is wheelchair bound and does not ambulate. A "STOP" sign was put on the door he exited, and staff was re-educated on elopement policy and procedures.

Review of Resident #5's TAR for the month of September 2022 revealed his wanderguard tag was checked twice daily at 10:00 am and 8:00 pm.

A care plan conference summary dated 9/20/22 revealed the wanderguard tag on Resident #5's ankle was not working. The note continued that the DON switched out Resident #5's wanderguard tag. Resident #5 was to possibly go out other doors in the facility other than door #2. The summary indicated Resident #5 had declined with transfers in the past 2 weeks.
Physical therapy identified resident required more cues and identified Resident #5 as very motivated.

An interview was attempted with independent

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living residents identified on the 5-day report on 10/13/22 at 8:31 am and 8:35 am. They were unable to be contacted for an interview.

Interview with Nurse #2 on 10/12/22 at 12:48 pm revealed she was not assigned to Resident #5 on 9/20/22 but was notified about Resident #5's elopement. On 9/19/22 a NA came to her and said an independent resident had found Resident #5 outside. Nurse #2 could not recall which NA approached her about the missing resident or who Resident #5 was assigned to. She stated all outside doors had alarms. She was unaware of which independent resident brought the resident back in the building. Independent living residents used door #2 as a short cut through the building. They could access the unit by a key fob or a key. Door #2 further had a delay and closed slowly. If a resident was sitting by the door when the door was opened, they have been known to attempt to exit. If the wanderguard tag system was working, there would have been an alarm. No alarm was heard on 9/19/22.

Interview with Nurse #3 on 10/12/22 at 2:41 pm revealed Resident #5 went to the door #2 a lot. She stated he was exit seeking all the time and had to be watched all the time. He was able to ambulate with his wheelchair. The back exit (door #2) had a push button to open the door for handicap access. The exit (door #2) led to a garden located between the independent living and the skilled facility. There were a lot of independent residents that used the door. She further revealed she had seen independent residents occasionally hold the door open for residents coming out from the unit. The independent residents didn't always make sure they closed the door all the way. The door further had a slow closing mechanism for 10 seconds.

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L 039	Continued From page 15 Resident #5's room was located on the hall of door #2. She stated when she saw independent residents holding the door, she would notify them that Resident #5 was not able to go out alone. Resident #5's family member lived in the independent living facility and when she took him out, she utilized door #2. The exit led to the independent living and the independent living parking lot and main entrance. Nurse #3 further explained the exit could also lead to independent living houses and a 4-lane street. Interview with the Director of Facility Services on 10/12/22 at 10:05 am revealed it was surprising that Resident #5 was able to open the door himself. There was an ADA (handicapped access button) that was located at the door for independent residents. She further stated independent residents used the unit exit as an entrance into the unit by means of a key fob. After the resident was located outside of the building, she had placed a plexiglass cover over the button, so it had to be lifted to push the ADA button to open the door. The Director of Facility Services revealed Resident #5 wouldn't be able to lift the door to push the exit ADA button. The facility did not have doors that locked. If the resident had broken the barrier it would alarm. She stated she did not keep a log of wanderguard tag system checks. She had been meaning to make a spreadsheet to begin documentation. Interview with the Director of Facility Services on 10/13/22 at 10:55 am reiterated she did not activate the wanderguard tag devices. She stated she was not provided with a device that activated the system. She only had the devices that checked the system. The Director of Facility Services revealed she knew they were already activated because she brought them in the	L 039		

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building, they would alarm the front door.

Interview with the Director of Facility Services on 10/13/22 at 1:35 pm revealed she contacted the contracted service maintenance provider interview on 10/13/22. She was told that the wanderguard tags were activated when they were delivered and pass a scanning device. The Director of Facility Services stated that's why she assumed the wanderguard were activated when they entered the building due to setting off the alarm. The alarm was being activate by the facility system located in the hallway. The year of the activation would have started upon passing the elopement system.

Interview with contracted service maintenance provider on 10/13/22 at 10:06 am stated the wanderguard tags were referred to as "patient tags." In a continued interview with the contracted service maintenance provider at 10:23 am revealed the battery life of the wanderguard tag was 1 year upon activation. He further stated the facility, not the company, was responsible for activating the wanderguard tags. The Director of Facility Services had been provided a tag activator. The contracted service maintenance provider revealed as soon as the activator was introduced to the wanderguard tag it would be activated. It could also be activated by the wanderguard tag checker.

Interview and observation with the DON and Nursing Supervisor on 10/12/22 at 9:50 am revealed Resident #5 was able to exit the building through door #2 that led to independent living. The DON stated she was contacted by an independent living resident that Resident #5 had exited the building. The DON had attempted to contact the two independent living residents by

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phone but was unsuccessful and she had not attempted to make further contact. An observation of the door #2 revealed there were four walkways going in various directions. One of the walkways led directly down a steep slope that led to a parking lot. The other walkways led to the independent living apartments and independent living housing. These walkways were surrounded by foliage, trees, and various plants included in the landscaping. The terrain around the facility was observed as having hills with various degrees of steepness and inclining areas. The DON revealed all walkways lead to independent living. Observation of the wanderguard tag revealed it to not have an expiration date on the reverse side of the device. The DON and Nursing Supervisor stated they did not have instruction regarding how long the device lasted. She had asked about expiration with the company that delivered the wanderguard tag and was told the device would expire one year after activation. The DON revealed the wanderguard tag came activated from the manufacturer.

Interview with the DON and the Nurse Supervisor on 10/13/22 at 10:40 am revealed the facility did not have an elopement risk assessment. They stated that the wanderguard tag did not alarm on 9/20/22. Following the incident, they contacted the contracted service maintenance provider regarding the error. The facility did not have the ability to activate the wanderguard tag and came activated (ready to alarm). The DON stated prior to the wanderguard tags she received in September 2022 she did not know who kept up with the expiration dates. They just changed the wanderguard tag when they were no longer working.

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L 039	Continued From page 18 The Administrator was notified of the immediate jeopardy on 10/13/22 at 4:24 PM. The facility responded with the following credible allegation of immediate jeopardy removal. " Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #4 wandered from the building unsupervised on 7/31/22 and was missing for ~ one hour. Resident #5 was found outside of the building unsupervised on each of the three dates in July, August and September. We have identified a total of 11 (including Resident #4 and Resident #5 above) residents that are high risk for elopement. " 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. Monitoring tool was developed, and staff was educated immediately on 10/13/2022 and prior to start of shift. DON or designee will conduct the education on each shift. A record of each staff who received the education will sign the in-service sheet. Monitoring tool will include resident name, date, time, staff signature, and location monitored/comments. A CNA or Nurse will be assigned every shift to complete monitoring tool. The monitoring tool will be completed every 15 minutes to start immediately and continue until system failure has been resolved. The DON or designee will review the monitoring tool daily for completion. The monitoring tool will be stored in the DON office. This enhanced monitoring will be done for each of	L 039		

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L 039	Continued From page 19 the residents identified and for any newly admitted resident identified to be at risk for elopement. Wander guard vendor states system is functioning and will provide backup documentation, Friday, October 14, 2022. DON or designee will implement newly implemented device. Currently wander guards are on the residents and functioning. This evening a nurse completed an audit and documents all wander guards were functioning. Continue to do wander guard checks twice a day for function. The side door does have a wander guard which is now functioning and was enhanced with a louder alarm and camera. These actions will be completed Friday, October 14, 2022. The facility's credible allegation of immediate jeopardy removal was validated on 10/14/22. The validation was evidenced by staff interviews, record reviews and review of in-service attendance sheets to verify education had been provided to staff that addressed resident elopement. It was further evidenced by the facility's wanderguard tag system being serviced. The interventions included servicing of the wanderguard tag system, identifying residents having the potential to be affected, 15 minute checks for residents assessed as at risk for elopement and monitoring tools. The immediate jeopardy was removed on 10/14/22.	L 039		

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L 040	Continued From page 20	L 040		
L 040	.2209(A) INFECTION CONTROL 10A-13D.2209 (a) (a) A facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection. This Rule is not met as evidenced by: Based on staff interviews and record review, the facility failed to have an on-site designated staff member that had completed approved specialized training in infection prevention. Additionally, the facility failed to have a water management safety program in place. These areas were reviewed for Infection Control. The findings included: 1. An interview on 10/12/22 at 12:07 PM with the Director of Nursing revealed there was no employee who was certified in a specialized infection control prevention program in the facility. An interview on 10/13/22 at 10:20 AM with the Clinical Manager revealed that the previous Director of Nursing was a trained infection prevention nurse, and she left the facility in September of 2021. Another nurse had taken the specialized training in infection prevention and terminated her employment January of 2022. There had not been a specialized trained infection prevention person since. An interview on 10/13/22 at 1:32 PM with the	L 040		

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L 040	Continued From page 21 Executive Director indicated that there was no certified infection prevention trained personnel in the facility. 2. Review of the Emergency and Disaster Preparedness binder was completed at 1:25 PM on 10/13/2022 with the Director of Facility Services. She revealed there was no information on water safety management for Legionella. She verbalized there was no water safety management program in place. The Director of Facility Services communicated the facility utilized local emergency alerts from the city regarding water management. An interview was completed with the Administrator at 1:41 PM on 10/13/2022. She was not aware of the facility having a water safety management program in place for Legionella. She verbalized the facility used local city guidance for water management. She was not aware the facility should have a water safety management program in place for Legionella.	L 040		
L 062	.2301(B) PATIENT ASSESSMENT AND CARE PLANNING 10A-13D.2301 (b) The facility shall perform, within 14 days of admission and at least annually, a comprehensive, accurate, documented assessment of each patient's capability to perform daily life functions. This comprehensive assessment shall be coordinated by a registered nurse and shall include at least the following: (1) current medical diagnoses; (2) medical status measurements, including current cognitive status, stability of current conditions and diseases, vital signs, and abnormal lab values and diagnostic tests that are	L 062		

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L 062	Continued From page 22 a part of the medical history; (3) the patient's ability to perform activities of daily living, including the need for staff assistance and assistive devices, and the patient's ability to make decisions; (4) presence of neurological or muscular deficits; (5) nutritional status measurements and requirements, including but not limited to height, weight, lab work, eating habits and preferences, and any dietary restrictions; (6) special care needs, including but not limited to pressure sores, enteral feedings, specialized rehabilitation services or respiratory care; (7) indicators of special needs related to patient behavior or mood, interpersonal relationships and other psychosocial needs; (8) facility's expectation of discharging the patient within the three months following admission; (9) condition of teeth and gums, and need and use of dentures or other dental appliances; (10) patient's ability and desire to take part in activities, including an assessment of the patient's normal routine and lifetime preferences; (11) patient's ability to improve in functional abilities through restorative care; (12) presence of visual, hearing or other sensory deficits; and (13) drug therapy. This Rule is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to perform an annual assessment for 1 of 5 sampled resident (Resident #4). The findings included: 1. Resident #4 was admitted to the facility on 11/6/18 with a diagnosis that included dementia	L 062		

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L 062	Continued From page 23 (moderate-severe). Record review for Resident #4 revealed an admission nursing evaluation dated 11/6/18. The evaluation stated resident was alert with poor recall and was oriented to person, place, and time. The resident required oversight, encouragement or cueing with no set up or help from staff for transfers and walking in room. The assessment identified the resident's vision, hearing, speech and behaviors. Wandering was not checked as a behavior. There was no further evaluation of Resident #4. Interview with the Director of Nursing and the Nursing Supervisor on 10/13/22 at 10:40 am revealed Nursing notes were identified as a form of an assessment. She further revealed nursing documented per acute issues. They stated other than the admission nursing assessment there was no other formal assessment that identified a resident's ability to perform activities of daily living. The DON stated Therapy would assess a resident's activities of daily living.	L 062		
L 064	.2301(D) PATIENT ASSESSMENT AND CARE PLANNING 10A-13D.2301 (d) The facility shall review comprehensive assessments and plans of care no less frequently than once every 90 days and make necessary revisions to ensure accuracy. This Rule is not met as evidenced by: Based on observation, record review and staff interview the facility failed to care plan 2 of 2 sampled residents (Resident #4 and Resident #5) for risk of elopement.	L 064		

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The findings included:

1. Resident #4 was admitted to the facility on 11/6/18 with a diagnosis that included dementia (moderate-severe).

Record review for Resident #4 revealed an admission nursing evaluation dated 11/6/18. The evaluation stated resident was alert with poor recall and was oriented to person, place, and time. The resident required oversight, encouragement or cueing with no set up or help from staff for transfers and walking in room. There was no further evaluation of Resident #4's Activities of daily living in the record, nor an elopement/wandering assessment.

Physician order dated 2/11/22 stated check wanderguard system and functioning of the wanderguard system at 10:00 am and 8:00 pm every day. The physician order further stated wanderguard tag to Resident #4.

Resident #4's care plan for the review period of 5/10/22 through 8/10/22 did not reveal the use of a wanderguard tag or exit seeking behaviors.

Nursing note dated 7/29/22 revealed Resident #4 was exit seeking in the afternoon.

Interview with the Director of Nursing and the Nursing Supervisor on 10/13/22 at 10:40 am revealed they were responsible for care planning at the facility. Resident #4 did not have a care plan for risk of elopement because she had not yet eloped. A care plan was developed for Resident #4 after she eloped on 7/31/22. The DON stated that she was told by the previous DON that residents were care planned after an

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actual elopement. An actual elopement was explained as a resident that passed the threshold of the door.

2. Resident #5 was admitted to the facility on 10/11/21 with a diagnosis that included vascular dementia, left cardiovascular accident (CVA), right side weakness and aphasia.

Review of nursing evaluation dated 10/11/21 stated Resident #5 had right sided weakness, was alert and with poor recall. Resident #5 required staff to provide weight bearing support with 1 staff person assistance for functional range of motion, transfers, and dressing. The resident required staff guided maneuvering of limbs or other non-weight bearing assistance with 1 staff for bed mobility and utilized a wheelchair for mobility. The medical record revealed no other assessment that identified the resident's assistance needed for activities of daily living to include transfers, repositioning, or wandering/elopement.

Review of Physician order dated 10/18/21 stated Resident #5 was to wear a wanderguard tag. Do visible checks on 3rd shift to make sure the resident was in the bed throughout the shift without waking them up. The physician order stated check placement and functioning of Resident #5's wanderguard tag at 10:00 am and 8:00 pm every day.

Review of Resident #5's care plan for the review period of 6/28/22 through 9/28/22 revealed no goals or interventions regarding the use of a wanderguard/patient tag.

Interview with the Director of Nursing and the Nursing Supervisor on 10/13/22 at 10:40 am

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	NH0107	A. BUILDING: _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKS-HOWELL HOME	266 MERRIMON AVENUE ASHEVILLE, NC 28801

(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) COMPLETE DATE
L 064	Continued From page 26 revealed they were responsible for care planning at the facility. The DON stated that she was told by the previous DON that residents were care planned after an actual elopement. An actual elopement was explained as a resident that passed the threshold of the door.	L 064		