STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345131	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 000	INITIAL COMMENTS A complaint survey was conducted 4/24/2023 to 4/27/2023. 2 of 2 allegations resulted in a deficiency. Intake NC00201137 resulted in immediate jeopardy. Event ID YKVG11. Immediate jeopardy was identified at: CFR 483.25 at F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care. Immediate jeopardy began on 4/19/2023 and was removed on 4/27/2023. A partial extended survey was conducted.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		5/11/23

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

Electronically Signed | 05/11/2023

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discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 2 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notification of the reason for discharge for 1 of 1 resident, Resident #1, reviewed for discharge to the hospital.	F 623	1.) Resident #1 was discharged from the hospital to another facility. 2.) All residents have the potential to be	

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F 623	Continued From page 3 Findings included: Resident #1 was admitted to the facility on 12/29/2021. A quarterly Minimum Data Set assessment dated 3/15/2023 indicated Resident #1 was moderately impaired cognitively. The medical record indicated Resident #1 was discharged from the facility to the hospital on 4/19/2023 after sustaining bilateral femur fracture, pelvic fracture, and a laceration to the right side of her head during an accident. There was no evidence the facility provided Resident #1's Responsible Party (RP) with written notification that included the reason for the discharge to the hospital. On 4/24/2023 at 11:02 am Resident #1's Guardian and RP stated the facility had not sent her a written notice of why Resident #1 was discharged from the facility to the hospital. The Director of Nursing (DON) was interviewed on 4/24/2023 at 12:57 pm and she stated Resident #1 was injured and sent to the emergency room after an accident on 4/19/2023. The DON stated she called Resident #1's Guardian after she was sent to the hospital and left a message on her voicemail to return her call. The DON stated she had not sent the Guardian a written notice of discharge after Resident #1 was discharged to the hospital on 4/19/23. The DON stated the facility did not send a written notice to the resident and/or RP that included the reason for transfer/discharge to the hospital.	F 623	affected by the deficient practice. An audit of residents that were transferred to the hospital since April 1, 2023 was conducted. Notification was provided to the resident or responsible party of the failure to send written documented in the medical records. 3.) The Administrator provided education to the Social Worker regarding the requirement of written notification to the resident and/or responsible party for any unplanned discharge and must included the location of discharge to, date of discharge and reason for discharge. 4.) The administrator or designee will audit unplanned discharges for verification of written notification to the resident and/or RP weekly for the next 12 weeks. 5.) The Administrator or the designee will bring the audit results to the Quality Assurance Committee meeting for 3 consecutive months	

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F 623	Continued From page 4 The Administrator was interviewed on 4/27/2023 at 12:16 pm and she stated the facility did not send a written notice of discharge to the Guardian when Resident #1 was discharged from the facility to the hospital on 4/19/2023. The Administrator stated the facility also met with the Guardian on 4/20/2023 to discuss her concerns about Resident #1's accident and discharge to the hospital. The Administrator stated the facility had not been sending residents or Responsible Parties written notice of why the resident was transferred/discharged for residents sent to the hospital.	F 623		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with Guardian, staff, Nurse Practitioner and Physician, the facility failed to report a problem with the door latching between the second-floor unit and the ramp leading down to the first-floor unit. Resident #1 who was severely cognitively impaired exited through the second-floor door on her own, lost control of the wheelchair and rolled down a 150-foot ramp to the first floor. Resident #1 collided with an interior wall on the first floor of the facility. She sustained bilateral femur fractures, a pelvic fracture, and a laceration to her head.	F 689	1.) Resident #1 no longer resides in the facility. 2.) The Regional Nurse Consultant reviewed current residents located on 100, 200, and 300 halls to identify if they wander, whether they are in a wheelchair and/or mobile. The residents cognition was reviewed on 4/25/2023 by the Social Worker to identify current residents with severe cognition impairment and if the resident had a BIMS (Brief Interview for	5/11/23

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F 689	Continued From page 5 The hospital determined she would not survive surgery to repair her fractures and she was admitted to a hospice house for palliative care measures. This deficient practice affected one of three residents reviewed for accident hazards. Immediate jeopardy began on 4/19/2023 when Resident #1 exited the second floor through an unlatched door and rolled down the ramp to the first floor resulting in impact with the wall. The immediate jeopardy was removed on 4/27/2023 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 12/29/2021 and her diagnoses included cognitive deficit and Alzheimer's Disease. A quarterly Minimum Data Set assessment dated 3/15/2023 indicated Resident #1 was unable to complete the brief interview for mental status indicating severe cognitive impairment. The assessment further indicated Resident #1 required extensive assistance with bed mobility and required assistance of staff for locomotion in wheelchair on and off the unit. The assessment did not indicate the resident had any wandering behaviors. A Wandering Assessment dated 4/11/2023 indicated Resident #1 did not have wandering	F 689	Mental Status) score of 7 and below along with having the mobility of going thru the door located in the hallway leading to 300 hall the resident will be moved to the 300 hall to decrease the likelihood of the residents attempting to go down the ramp on 4/26/2023. On 4/26/2023 the Social Worker will call the residents representative party or guardian before the residents identified are moved, to give notification and reason as to why. Completed on 4/29/2023. On 4/26/2023, signage was placed at the doors that were identified to be securely closed and locked. On 4/25/2023 the Maintenance Director tested all operating doors that are to be locked to ensure doors are closed securely and locked. 3.) On 4/25/2023, the Maintenance Director educated the Administrator and Director of Nursing on how to keep the mechanical door locked (the mechanical lock on the other side of the keypad should be turned horizontal, that were identified too remain locked and how to identify that the doors close are secured. On 4/25/2023, the Director of Nursing and the Administrator educated all current staff on how to keep the doors locked that were identified to remain locked and that doors are closed securely. Any staff member that finds a door that is not locking or closing securely, they are to stay with the door and notify the Administrator and/or Maintenance Director immediately. The current staff will continue to ensure the doors are secured. On 4/25/2023, the Regional	

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F 689	Continued From page 6 behaviors. An interview was conducted by phone with Resident #1's Guardian. She stated she had visited Resident #1 on 4/18/2023, the day before the accident, and when she was leaving the facility, the door to the ramp that leads to the first floor was ajar slightly and had not latched. The Guardian stated she had not seen the door unlatched on her previous visits and when she went through the door, she made sure it latched behind her. Nurse Aide #2 was interviewed by phone on 4/24/2023 at 3:38 pm. She stated she was not assigned to Resident #1 on 4/19/23 but she saw her in the dining room shortly before her accident. Nurse Aide #2 stated she was called to another resident's room and when she returned Resident #1 was not in the dining room. Nurse Aide #2 stated she had seen the door to the second floor that was at the top of the ramp that leads to the first floor stick on the carpet and not latch. She stated she made sure it latched when she went through the door. She had never notified the Maintenance Director of the door not latching. On 4/24/2023 at 2:45 pm Medication Aide #1 was interviewed and stated she cared for Resident #1 on 4/19/2023 when the accident happened. The Medication Aide #1 stated she saw Resident #1 right before the accident in the hallway when she was in another resident's room. Medication Aide #1 stated Resident #1 did wander around the second floor, but she had never seen her attempt to go through the door to the ramp that leads to the first floor. An interview was conducted with Nurse Aide #1	F 689	Nurse Consultant educated the Administrator and Director of Nursing on how to identify residents that are severely cognitively impaired and mobile, whether they are in a wheelchair and/or mobile and that the residents are to be placed on the 300 hall due to decreasing the likelihood of going down the ramp. On 4/25/2023 The Director of Nursing and administrator educated all current staff on residents that have severe cognitive impairment and mobile, whether they are in a wheelchair and/or mobile to ensure they are redirected to a safe area. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift. Education will be completed on 4/26/2023 by the Director of Nursing and Administrator. On 5/9/2023 the Maintenance Director change the mechanical lock to a magnet lock. This will allow the door to lock automatically when the door closes. This will allow residents that are severely cognitively impaired and mobile to safely move throughout the 2nd floor. 4.) Effectively 4/26/2023 the Maintenance Director will check the doors weekly x8 weeks to ensure the doors close securely and lock appropriately. 5.)Results of the audit will be reviewed at Monthly Quality Assurance Meeting x3 months for further problem resolution if needed. The administrator will review the results of weekly audits to ensure any	

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on 4/24/2023 at 3:30 pm by phone and she stated she was assigned to Resident #1 on 4/19/2023 when she went out the door to the second floor and rolled down the ramp to the first floor and hit the wall at the bottom of the ramp. Nurse Aide #1 stated she was usually assigned to Resident #1 when she worked. She confirmed Resident #1 wandered around the second floor in her wheelchair. Nurse Aide #1 stated she did not see Resident #1 leave the unit because she was in a room assisting another resident.

On 4/24/2023 at 3:14 pm an interview was conducted with Nurse #1. She stated she was assigned to the first floor on 4/19/2023 when Resident #1 exited the second floor, rolled down the ramp leading to the first floor and hit the wall. Nurse #1 stated she did not see Resident #1 come down the ramp or hit the wall, but she did hear her hit the wall. Nurse #1 stated when she got to Resident #1, she had her head down and there was a small laceration to the right side of her head. She stated the laceration was bleeding and it was hard to tell how big it was, but she stated she knew the laceration would require sutures. Nurse #1 stated Resident #1's wheelchair had not turned over and she was sitting in the wheelchair, and she did not see any other injuries. Nurse #1 stated she and Nurse #2 took Resident #1 up the ramp to the second floor where Resident #1 resided to call emergency services and get copies of the medical record to send with her to the hospital.

Nurse #2 was interviewed on 4/26/2023 at 1:10 pm and stated she was working on the first floor on 4/19/2023 when Resident #1 came down the ramp and hit the wall. Nurse #2 stated she did not see Resident #1 come down the ramp or her

issues identified are corrected.

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hitting the wall, but she did hear it and it was a loud crash. Nurse #2 stated Nurse #1 was already with Resident #1 by the time she got to her. She stated Nurse #1 was checking Resident #1 for injuries when she arrived, and she had a laceration to the right side of her head. Nurse #2 stated she assisted Nurse #1 with taking Resident #1 back to the second floor and assisted with calling emergency services and getting copies of the chart to send to the hospital. Nurse #2 stated she had observed the door to the second floor at the top of the ramp stick and not latch before and you had to make sure it would close all the way. She stated she did not tell the Maintenance Director about the door sticking because she made sure it shut behind her.

A Nurse's Progress Note dated 4/19/2023 at 11:20 am written by the Director of Nursing which stated she was called to the unit due to Resident #1 rolling down the hallway and obtaining a laceration to the right side of her head and the injury was dressed and neurological checks were initiated. The nurse's progress note further stated Resident #1 was assessed and the Nurse Practitioner and Physician were notified, and Resident #1 was sent to the emergency room for evaluation and treatment.

An interview was conducted with the Director of Nursing (DON) on 4/24/2023 at 12:57 pm and she stated Resident #1 was discovered at the bottom of the ramp that led from the second floor where she resided to the first floor of the facility. The DON stated Resident #1 hit the wall and resident room door at the bottom of the ramp but remained upright in the wheelchair. The DON stated she had gone to the facility's conference room for the facility's Morning Meeting when the

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accident happened and the two first floor nurses, Nurse #1 and Nurse #2, had heard Resident #1 hit the wall and resident room door at the bottom of the ramp. The DON stated Nurse #1 and Nurse #2 took Resident #1 back up the ramp to the second floor, where she resided and called emergency services. The DON stated she assessed Resident #1's injuries. She stated Resident #1 had a nickel sized laceration to the right side of her head, but she did not have bruises or skin tears anywhere else on her arms, legs or body. The DON stated Resident #1 did not appear to be in pain except when she was loaded on the stretcher by emergency services, and she did put her hand to her head. The DON stated after Resident #1 left with emergency services she went around the unit and made sure everyone else was accounted for and checked the door that Resident #1 had gone through to the ramp, and it was locked.

The Nurse Practitioner was interviewed on 4/24/2023 at 12:24 pm and stated before the accident Resident #1 was able to propel herself in her wheelchair and went all over the unit when she was out of bed.

During an interview with the Physician on 4/24/2023 at 12:32 pm he stated he was Resident #1's physician and he called Resident #1's Guardian when the facility notified him of her injuries. The Physician stated Resident #1 did wander in the unit on the second floor where she resided. He stated Resident #1 was on the first floor until three months ago and was moved to the second floor because she repeatedly went to the outside exit door on the first floor. The Physician stated he had not seen anyone prop the door to the second floor open, but the door

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did need to be pulled closed or it would not latch.

During an interview and observation on 4/24/2023 at 2:00 pm the Maintenance Director measured the length of the ramp leading from the second floor to the first floor and indicated the ramp was 150-feet long. The Maintenance Director stated he had not had any complaints or issues reported about the door and he examined it when the accident happened and did not find any problems with the latch on the door. The Maintenance Director also stated he had never seen the door ajar or propped open. The Maintenance Director stated before the accident he checked the battery in the lock on the door monthly, but they had not done an audit of the door after the accident.

On 4/24/2023 at 10:30 am the Administrator stated Resident #1 exited the door leading from the second floor to a ramp that led to the first floor of the facility. She stated Resident #1 was in her wheelchair and rolled down the ramp and hit the wall at the end of the ramp. The Administrator stated she had interviewed the staff that were present when the accident happened and no one saw Resident #1 come down the ramp, but staff did hear her hit the wall and resident door, which caused her injuries. The Administrator stated Resident #1's wheelchair did not turn over and she was still sitting upright when Nurse #1 and Nurse #2 got to her. The Administrator stated Resident #1 was assessed, given care to the laceration on her head, and emergency services were notified and responded. The Administrator indicated Resident #1 had gone from the hospital to a hospice house and had not returned to the facility. The Administrator stated they had investigated the accident but had not been able to identify how Resident #1 had

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exited the door. The Administrator stated the facility had added a temporary alarm and ordered a better alarm to the door to alert staff when the door was open, and the facility had provided a staff education regarding the importance of keeping the door shut and locked at all times.

Clinical Notes dated 4/19/2023 from the hospital indicated Resident #1 had bilateral femur fractures, a pelvis fracture, and a laceration to her head, which required staples to close. The Clinical Notes further stated Resident #1 was moved to intensive care from the emergency room and then the determination was made she would not survive surgical repair of her fractures.

The Administrator was notified of the Immediate Jeopardy on 4/25/2023 at 4:50 pm.

On 4/26/2023 the facility provided the following plan for immediate jeopardy removal:
F689: Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #1, who had severe cognitive impairment exited the second floor of the facility through a door on 200 hall which was routinely locked to a ramp which led to the first floor of the facility and rolled down a 150-foot ramp in her wheelchair where she hit an interior wall and resident room door on the first floor of the facility. Resident #1 sustained bilateral femur fractures, a pelvic fracture, and a laceration to her head which resulted in her being hospitalized in critical condition. During her hospitalization it was determined she would not survive surgery and she was admitted to a hospice house from the hospital.

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	345131	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR HILLS CENTER FOR NURSING AND REHABILITATION	3905 CLEMMONS ROAD CLEMMONS, NC 27012

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F 689	Continued From page 12 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: The Regional Nurse Consultant reviewed current residents located on 100, 200, and 300 halls to identify if they wander, whether they are in a wheelchair and/or mobile. The residents' cognition was reviewed on 4/25/2023 by the Social Worker to identify current residents with severe cognitive impairment and if the resident had a BIMS (Brief Interview for Mental Status) score of 7 and below along with having the mobility of going through the door located in the hallway leading to 300 hall the resident will be moved to the 300 hall to decrease the likelihood of the residents attempting go down the ramp on 4/26/2023. On 4/26/2023 the Social Worker will call the residents representative party or guardian before the residents identified are moved, to give notification and reason as to why. On 4/25/2023, the Administrator placed a certified nursing assistant at the door located on 200 hall to protect residents that have severe cognitive impairment and mobile, whether they are in a wheelchair and/or mobile, from incidents and accidents. The Certified Nursing assistant will redirect the residents to a safe area located on the unit. The Certified Nursing assistant was provided with a list of residents that have severe cognitive impairment and mobile, whether they are in a wheelchair and/or mobile from the Social Worker. A Certified Nursing Assistant will always remain at the doors until all residents that were identified move to the 300 hall. On 4/24/2023 it was noted the door leading to the	F 689		

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ramp was not securely shutting and the maintenance director adjusted the door with a new pin allowing the door to close and lock with ease. On 4/25/2023 the maintenance director tested all operating doors that are to be locked to ensure doors closed securely and locked. Effectively 4/26/2023 the maintenance director will check the doors weekly to ensure doors close securely and lock appropriately. This is to include 6 doors in the facility, one with a mechanical lock and five others with magnetic locks. There were not life safety egress issues noted nor created with the credible allegation.

On 4/25/2023, the Maintenance Director educated the Administrator and Director of Nursing on how to keep the mechanical door locked (the mechanical lock on the other side of the keypad should be turned horizontal), that were identified to remain locked and how to identify that the doors close are secured. On 4/26/2023, signage was placed at the doors that were identified to be securely closed and locked. On 4/25/2023, the Director of Nursing and the administrator educated all current staff on how to keep the doors locked that were identified to remain locked and that doors are closed securely. Any staff member that finds a door that is not locking or closing securely, they are to stay with the door and notify the administrator and/or maintenance director immediately. The current staff will continue to ensure the doors are secured.

On 4/25/2023, the Regional Nurse Consultant educated the Administrator and Director of Nursing on how to identify residents that are severely cognitively impaired and mobile, whether they are in a wheelchair and/or mobile and that

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F 689	Continued From page 14	F 689		

the residents are to be placed on the 300 hall due to decreasing the likelihood of going down the ramp. On 4/25/2023 The Director of Nursing and administrator educated all current staff on residents that have severe cognitive impairment and mobile, whether they are in a wheelchair and/or mobile to ensure they are redirected to a safe area. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires including agency will receive education prior to the beginning of their next shift. Education will be completed on 4/26/23 by the Director of Nursing and Administrator.

Effective 04/25/2023, the Administrator will be responsible for ensuring implementation of this IJ removal plan for this alleged non-compliance.

The alleged date of IJ removal is 4/27/2023.

On 4/27/2023, the facility's credible allegation for immediate jeopardy removal was validated by the following:

Review of the facility's audit of current residents to identify wandering behaviors, cognition, and ability to ambulate or move themselves about the facility in a wheelchair. The facility identified 7 residents who were at risk and after notification of their Responsible Parties and explaining to the resident the rationale they moved the residents to the first floor.

ON 4/27/2023 at 11:25 am observation of the door to the 2nd floor that opened to the ramp revealed the door was functioning properly. The door closed completely, and the latch engaged. The alarm sounded as soon as the door opened, and the Nurse Aide attendant was just inside the

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F 689	Continued From page 15 door. The Maintenance Director was interviewed and stated he had adjusted the door to the second floor that opened to the ramp and replaced the pin allowing the door to close and lock easily. The Maintenance Director provided documentation of audits, which will be done weekly, showing he had tested all doors that were to be locked to ensure they closed securely and locked. A sample of staff were interviewed regarding their understanding of which doors in the facility were to be locked; what to do if a door that should be locked does not work properly; and who to report a lock that does not function properly. All staff stated they had the education and verbalized understanding of the education. The immediate jeopardy was removed on 4/27/2023.	F 689		