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AUTUMN CARE OF MYRTLE GROVE	5725 CAROLINA BEACH ROAD WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted on-site from 10/29/24 through 10/31/24. Additional information was obtained remotely on 11/1/24. Therefore, the exit date was changed to 11/1/24. The following complaints were investigated: NC00223264, NC00223358, NC00223433, NC00223266, and NC00223389. 5 of the 10 complaint allegations resulted in deficiency. Intakes NC00223264, NC00223358, and NC00223433 resulted in immediate jeopardy. Past non-compliance was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tags F600 and F689 constituted Substandard Quality of Care. Immediate Jeopardy for F689 began on 9/21/24, was removed on 9/25/24, and the tag was corrected on 9/25/24. Immediate Jeopardy for F600 began on 10/17/24, was removed on 10/19/24, and the tag was corrected on 10/19/24. The facility came back in compliance effective 10/19/24. A partial extended survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		

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

Electronically Signed | 11/18/2024

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F 600	Continued From page 1 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with staff, residents, Nurse Practitioner, and family member the facility failed to protect a vulnerable male resident's (Resident #1) right to be free from sexual abuse by a cognitively impaired male resident (Resident #2). On 10/17/24 Resident #2 was observed by Resident #1's family member to have his hand inside Resident #1's brief as Resident #1 laid in bed. Resident #1 was incapable of giving consent for sexual contact and was unable to protect himself. Following the incident, Resident #1's antidepressant was increased due to an increase in agitation and restlessness. A reasonable person expects to be protected from abuse in their home and would have experienced psychosocial harm with feelings such as intimidation, severe anxiety, agitation, humiliation, withdrawal, and fear. This deficient practice was reviewed for 1 of 3 residents for abuse. Findings included: Resident #1 was admitted to the facility on	F 600	Past noncompliance: no plan of correction required.	

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3/22/24 with a diagnosis of dementia and depression.

Review of Resident #1's Minimum Data Set (MDS) dated 9/26/24 revealed the resident had severe cognitive impairment. Resident #1 had no behaviors, had disorganized thinking and inattention. Resident #1 was dependent on staff for bed mobility and transfers, had no limitations of range of motion and received an antidepressant.

Resident #2 was admitted on 8/30/19 with diagnosis which included dementia and conduct disorder.

Review of Resident #2's physician orders revealed an order dated 4/30/24 for paroxetine 20 milligrams (mg) at bedtime for depression.

During an interview with Nurse Practitioner #2 on 10/31/24 at 2:05 PM she indicated Resident #2 was prescribed an antidepressant for depression, but it also was used to manage sexually inappropriate behavior and poor impulse control.

A review of Resident #2's Care Plan included a focus of behavioral symptoms initiated on 1/17/20 with the last routine update on 7/5/24. The care plan indicated Resident #2 had behavioral symptoms including disrobing in public, inappropriate touching of other residents and a history of public displays of inappropriate touching. The Care Plan goal indicated Resident #2 would have no evidence of inappropriate sexual behavior by the next review date. Interventions included intervene as necessary to protect the rights and safety of others, divert resident's attention, and remove from the

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situation and take to an alternate location as needed.
Review of Resident #2's electronic health record revealed a physician progress note dated 9/24/24 at 3:45 PM. The progress note indicated Resident #2 had diagnosis of dementia and inappropriate sexual behaviors. The plan indicated Resident #2 was to continue with the antidepressant paroxetine and was to be followed by psychiatric services.

Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 9/27/24 revealed the resident had moderate difficulty with hearing, short- and long-term memory impairment and exhibited wandering daily and other behavioral symptoms daily (such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, and verbal and vocal symptoms like screaming or disruptive sounds). Resident #2 had no limitations of range of motion, required limited assistance with wheelchair mobility and received an antidepressant.

Review of Resident #1's electronic health record revealed a nursing progress note dated 10/17/24 at 2:45 PM written by Nurse #1. The progress note indicated Resident #1's family member came to the nurses' station and reported that another resident in a wheelchair was in Resident #1's room. Emotional support was provided to Resident #1 and his family member. A head-to-to-toe assessment of Resident #1was completed.

An initial allegation report dated 10/17/24 revealed the following allegation details: Resident #1's family member entered the room to find a male resident in the room next to Resident #1's

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bed. The family member observed Resident #2's hand in Resident #1's brief. The family member voiced that Resident #2's hand was under the covers near Resident #1's genitals. Resident #1 was disoriented at baseline and unable to recall the situation.

Review of a signed witness statement dated 10/17/24 by Resident #1's family member revealed Resident #1 was laying on his back taking a nap. The statement indicated when Resident #1's family member entered the room, there was a man (Resident #2) in a wheelchair next to the bed at an angle facing towards Resident #1. The other resident (Resident #2) had his hand under the covers. The family member pulled back the covers and Resident #2's hand was in Resident #1's "diaper". The family member screamed at Resident #2 to get out at least twice. Resident #2 did not move. The statement indicated Resident #1's family member ran out into the hall yelling for help and yelled at Resident #2 to never come back into that room again.

An interview was conducted with Resident #1's family member on 10/29/24 at 4:00 PM. The family member stated she visited Resident #1 daily. Resident #1's family member indicated on 10/17/24, Resident #1 was sliding down in the wheelchair, so staff stated he needed to be lay down for a nap. Resident #1's family member stated she agreed to the staff laying him down for a short nap and she left. Resident #1's family member stated when she returned shortly after and went down to Resident #1's room the door was open when she approached, and she observed a man (Resident #2) in the room with his wheelchair angled towards Resident #1's bed.

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Resident #1's family member went over to the bed where she observed Resident #2's hand under Resident #1's blanket. The family member pulled the blanket back and observed Resident #1 with no pants on, only a shirt and a brief on with Resident #2's hand inside Resident #1's brief making skin to skin contact. The family member stated she could not tell if Resident #1 was awake or asleep and noted that he had a baseball cap covering his face. Resident #1's brief was gaping open at the side and Resident #2's hand was inside the brief from the side. The family member did not observe Resident #1's genitals or if there was any hand motion by Resident #2, but stated it was inappropriate for Resident #2's hand to be inside the brief. When she observed this, Resident #1's family member stated she ran out of the room yelling for staff. Staff came, removed Resident #2 from the room and assessed Resident #1. The family member stated following the incident, Resident #1 was moved to a room on another hall. The family member further stated following the incident, Resident #1 seemed agitated, anxious and restless exhibiting fidgety behaviors and not wanting to participate in usual daily routine. The family member explained she came to the facility daily and Resident #1's normal routine included her taking him outside in his wheelchair, to the dining room and to activities and after this incident, he was more fidgety and not interested. The family member stated after a brief period, Resident #1 returned to his usual routine. The family member indicated Resident #1 was quiet and not able to articulate what he was feeling. The family member stated the Nurse Practitioner evaluated the resident after the incident and increased Resident #1's antidepressant.

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An interview was conducted with Nurse #1 on 10/30/24 at 2:05 PM. Nurse #1 indicated she was assigned to Resident #1 on 10/17/24 from 7:00 AM to 7:00 PM. Nurse #1 stated she was at the nurses' station when she heard yelling from down the hall Resident #1 resided on by Resident #1's room. Nurse #1 stated a staff member, she could not recall who, was quickly pushing Resident #2 in his wheelchair up the hallway from the direction of Resident #1's room. Nurse #1 stated Resident #1's family member was visibly upset and stated Resident #2 was in her family member's room and had touched Resident #1 inappropriately. Nurse #1 stated Resident #1 was having difficulty sitting up in the wheelchair that day, so after lunch the nursing assistant laid him down in bed for a nap. Resident #1's family member left while he was taking a nap and when she returned, she observed Resident #2 in the room in his wheelchair beside Resident #1's bed. Nurse #1 stated Resident #1's family member stated she observed Resident #2's hand in Resident #1's brief. Nurse #1 stated she was familiar with Resident #2 and was aware that he made inappropriate sexual comments to the staff frequently, was combative and refused or resisted care. Nurse #1 stated Resident #1 was moved to another room later that day, so she did not observe changes in his behavior following the incident.

A review of Resident #1's nursing progress notes revealed a note dated 10/17/24 at 2:49 PM written by Unit Manager #1. The note indicated Unit Manager #1 was called to Resident #1's room and indicated the family member was upset. The family member stated she left so that Resident #1 could take a nap and when she came back another resident was sitting in a

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wheelchair next to the bed. The family member noticed that the other resident's hand was under Resident #1's covers. Unit Manager #1 assessed Resident #1. Resident #1 was unable to recall anything that occurred due to his baseline confusion. A head-to-toe assessment of Resident #1 was completed with no concerns noted. The note stated Unit Manager #1 immediately notified the Administrator and Director of Nursing of the incident.

Review of a signed witness statement dated 10/17/24 by Unit Manager #1 revealed she was called to Resident #1's room by the nursing staff. Upon entering the room, the Unit Manager saw Resident #1's family member standing next to Resident #1's bed. Unit Manager #1 stated Resident #1's family member observed Resident #2's hand in the resident's brief. Resident #1 was assessed after the incident. Resident #1 did not recall what occurred. No distress was noted.

An interview was conducted with Unit Manager #1 on 10/30/24 at 3:15 PM. Unit Manager #1 stated she was in a room on another hall when Nurse #1 came and alerted her of a situation with Resident #1 and Resident #2. Unit Manager #1 stated she went down to the hall Resident #1 resided on and saw the family member of Resident #1 in the hallway outside of Resident #1's room. Resident #1's family member stated when she approached the room, she observed Resident #2 in his wheelchair next to Resident #1's bed. Unit Manager #1 further stated Resident #1's family member stated she observed Resident #2's hand inside Resident #1's brief. Unit Manager #1 stated she and the Director of Nursing (DON) assessed Resident #1. Unit Manager #1 stated Resident #1's brief was loosely fastened.

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Resident #1 was moved to a room on the other side of the facility after the incident. Resident #2 was assisted to his room by NA #2 and placed in bed immediately after the incident. Unit Manager #1 stated Resident #2 was unable to get out of bed without assistance. When Resident #2 was up in his wheelchair, a staff member, either the Nursing Assistant (NA) assigned to him or an ancillary staff member, was assigned for 1:1 supervision.

Review of a focused head-to-toe evaluation dated 10/17/24 at 4:16 PM by Unit Manager #1 revealed Resident #1 was assessed due to resident-to-resident sexual abuse. No negative findings were observed.

Review of a signed witness statement dated 10/17/24 by Nursing Assistant (NA) #1 revealed she was assigned to Resident #2 on 10/17/24 on 7:00 AM to 3:00 PM shift. The witness statement indicated NA #1 got Resident #2 up at 11:00 AM to eat lunch. When she returned from her break at 1:30 PM Resident #2 was in his wheelchair down the hallway where Resident #1 resided.

A telephone interview conducted on 10/29/24 at 3:15 PM with NA #1 revealed she had been in the position for 2 years and was assigned to Resident #2 on 10/17/24 from 7:00 AM to 3:00 PM. NA #1 stated Resident #2 was rude and used sexual language, but she had not observed him touching other residents. NA #1 stated Resident #2 was able to propel his wheelchair independently, wandered in the hallways but did not typically enter other resident rooms, was confused and had no limitations using his hands. NA #1 stated that when she went on her lunch break, Resident #2 was propelling himself in his wheelchair on the

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hall that Resident #1 resided on. NA #1 stated when she returned from her break, she observed Resident #2 on the hall Resident #1 resided on in his wheelchair. NA #1 indicated she went to assist another staff member on another hall and when she returned to her assigned area, she observed Resident #1's family member crying. NA #1 indicated she assisted Resident #2 to his room and assisted him to bed following the incident. NA #1 stated Resident #2 required assistance to get into and out of bed.

A telephone interview was conducted with NA #2 on 10/30/24 at 12:32 PM. NA #2 stated she was assigned to Resident #1 on 10/17/24 from 7:00 AM to 3:00 PM. NA #2 indicated she laid Resident #1 down for a nap with his brief and a shirt on. NA #2 stated she did not have the correct size brief available when she changed Resident #1, so she applied a larger sized brief. NA #2 stated she went to take her lunch break and when she returned, she was informed there was an incident with Resident #2 inappropriately touching Resident #1. NA #2 stated shortly after the incident, Resident #1 was moved to a room on the other side of the facility.

Review of a Nurse Practitioner (NP) progress note written on 10/17/24 at 4:50 PM by NP #1 revealed Resident #1 was seen and examined with no abnormal physical findings. A recommendation was made to increase resident's ordered antidepressant medication.

A physician's order for Resident #1 dated 10/17/24 indicated his sertraline (antidepressant) was increased from 25 milligram (mg) to 50 mg at bedtime daily.

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An interview was conducted with Nurse Practitioner (NP) #1 on 10/30/24 at 9:00 AM. NP #1 stated Resident #1 was cognitively impaired, confused and disoriented. NP #1 stated she was not in the facility at the time of the incident but was made aware of the incident with Resident #2 found in Resident #1's room touching him. The NP indicated she was informed by Unit Manager #1 Resident #2's hand was inside Resident #1's brief. NP #1 stated Resident #1 was unable to comprehend or give consent to Resident #2 touching him. NP #1 indicated she assessed Resident #1 following the incident and there were no abnormal physical findings with no redness to his hips, thighs or groin and no evidence of trauma. NP #1 stated Resident #1 had no recall of what happened. NP #1 indicated Resident #1's antidepressant was increased due to increased agitation and restlessness.

A review of Resident #2's electronic health record revealed a note written by Nurse Practitioner #2 dated 10/17/24 at 5:38 PM. The note indicated Resident #2 was assessed due to inappropriate touching of another resident. The progress note indicated Resident #2 had a diagnosis of severe vascular dementia with psychotic disturbance and inappropriate sexual behavior. The Nurse Practitioner recommended an increase of the medication paroxetine, an antidepressant, due to sexual behavior and would consult with the psychiatric provider.

An interview was conducted with Nurse Practitioner #2 on 10/31/24 at 2:05 PM. Nurse Practitioner #2 stated she saw Resident #2 on 10/17/24 after she was informed by the NA of the incident that occurred. Nurse Practitioner #2 stated Resident #2 did not recall the incident.

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Nurse Practitioner #2 indicated Resident #2 had dementia. Nurse Practitioner #2 stated staff reported that Resident #2 used very foul and derogatory language and made comments that were sexual in nature at times. Nurse Practitioner #2 indicated at one time when she examined Resident #2 he demonstrated sexually suggestive behavior during a physical exam. The NP stated she was surprised by the incident but not surprised at the same time as behaviors in dementia can be unpredictable.

An interview was conducted with Medical Records on 10/29/24 at 3:30 PM. Medical Records stated she was in the dining room on 10/17/24 when the incident between Resident #1 and Resident #2 occurred. Medical Records stated Resident #2 exhibited behaviors of wandering in his wheelchair, used foul language and sexual language. Medical Records stated Resident #2 propelled his wheelchair independently and had full use of his hands.

An interview was conducted with the Social Worker (SW) on 10/30/24 at 11:30 AM. The SW stated she had been in the position since March 2024, and she was not aware of Resident #2 touching any other residents in a sexually inappropriate manner prior to the incident on 10/17/24. The SW stated she was made aware of the incident that afternoon and talked to Resident #1's family member, Resident #1 and Resident #2. The SW stated she did not observe Resident #1 to have any changes and he did not recall the incident. The SW indicated Resident #2 did not recall the incident later that afternoon when she interviewed him. The SW stated Resident #2 had short- and long-term memory impairment and exhibited wandering behaviors

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propelling himself independently in the facility.

An interview was conducted with Nurse #2 on 10/30/24 at 2:15 PM. Nurse #2 stated she was not working on 10/17/24 but was frequently assigned to Resident #2. Nurse #2 stated Resident #2 exhibited behaviors of wandering, propelling himself in his wheelchair throughout the facility, using vulgar language and making sexually inappropriate comments to the staff.

Resident #2 was observed and interviewed on 10/30/24 at 4:30 PM in bed. Resident #2 was confused and continuously attempted to grab the writer's hands. Resident #2 was unable to recall the incident with Resident #1.

An observation and interview of Resident #2 was conducted on 10/31/24 at 9:50 AM. Resident #2 was observed in bed, alert and pleasant. Resident #2 stated he wanted to get up out of bed today and that he enjoyed getting up in the wheelchair and seeing other people.

An observation of Resident #2 was conducted on 10/31/24 at 11:10 AM. Resident #2 was sitting up in a wheelchair in the dining room with NA # 6 sitting beside him. Resident #2 stated he was happy to be out of bed with a "beautiful woman" beside him, referring to NA # 6.

An interview was conducted with the Administrator on 10/30/24 at 1:40 PM. The Administrator stated he was informed by Unit Manager #1 of the incident between Resident #2 and Resident #1 immediately after it occurred. Prior to this incident, he was not aware of Resident #2 entering other resident rooms or exhibiting sexual behaviors of this nature. The

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Administrator stated the family member reported the incident between Residents #1 and #2 with no other witnesses present. The Administrator stated after interviewing the family member several times, the staff felt there were discrepancies regarding her testimony stating at first, Resident #1 was asleep when she entered the room and then stating she couldn't tell if he was asleep or awake. The Administrator was unable to provide any other discrepancies identified. The Administrator stated although he was unable to gather sufficient witness testimony that the incident occurred, measures were initiated to protect Resident #1 and other residents from abuse.

The Administrator was notified of immediate jeopardy on 10/30/24 at 1:45 PM.

The facility provided the following corrective action plan:

1. The facility failed to protect Resident #1's right to be protected from sexual abuse perpetrated by Resident #2 on October 17, 2024. Resident #2 was redirected by his assigned certified nursing assistant once the nurse was made aware of the interaction. Resident #1 was assessed by the Director of Nursing with no signs of injury or emotional distress on October 17, 2024. Resident #1 was then moved to another room on the opposite side of the building on October 17, 2024. The Director of Nursing started continuous monitoring with Resident #2 on October 17, 2024 while he was out of bed since Resident #2 cannot transfer independently. The continuous monitoring is one to one and is being performed by clinical and non-clinical staff members. This monitoring is ongoing. The Nursing Home

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Administrator notified the local police department, the Department of Health and Human Services and Adult Protective Services of the incident on October 17, 2024. Resident #1 was referred to psychiatric services and is pending Veteran Affair approval. Resident #2 was referred to psychiatric services and was seen in the facility on October 23, 2024. A root cause analysis was completed on October 17, and it was determined that Resident #2 had poor impulse control and needed increased supervision while out of bed.

2. On October 17, 2024, the Director of Nursing, Unit Manager #1 and Unit Manager #2 interviewed all alert and oriented residents to ensure that no additional incidents had occurred in the facility. There were no additional incidents reported. On October 17, 2024, the Director of Nursing, Unit Manager #1 and Unit Manager #2 assessed all cognitively impaired residents to ensure there were no signs of abuse. There were no negative findings on the physical assessments. On October 17, 2024, the Interdisciplinary Team, consisting of the Director of Nursing, Unit Manager #1, Unit Manager #2, Nursing Home Administrator and the Minimum Data Set nurse reviewed resident care plans to identify any additional residents with similar behaviors. One additional resident was identified with like behaviors but had no documented behaviors since May 1, 2024. The additional resident was also placed on hourly visual observations that are conducted by the assigned nurse and certified nursing assistant.

3. The Director of Nursing educated all staff on October 18, 2024, on the North Carolina Abuse Policy and Procedure as well as Management of Sexual Behaviors Policy. The education

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reinforced documentation of behaviors, implementing immediate intervention to ensure the safety of other residents from inappropriate or unwanted sexual behaviors or conduct. The education also reviewed the development of individualized care plans and notification to the Director of Nursing and the Provider. All staff that were not educated face to face on October 18, 2024, were educated via phone. Any staff member that the Director of Nursing was unable to reach will be required to sign the education prior to working their next scheduled shift. All newly hired staff will be educated by the Director of Nursing, upon hire, prior to working in resident care areas.

4. The facility decided to monitor and take the plan of correction to the Quality Assurance Committee which consisted of the Director of Nursing, Nursing Home Administrator, Unit Managers, Wound Care Nurse, Minimum Data Set Nurse and the Social Worker, on October 17, 2024. To monitor and maintain ongoing compliance, the Director of Nursing or designee will conduct 5 resident interviews weekly for 4 weeks, then 3 resident interviews weekly for 4 weeks, then 1 resident interview weekly for 4 weeks to ensure there are no allegations of inappropriate sexual touching. In addition, the Director of Nursing or designee will conduct 5 skin assessments on cognitively impaired residents weekly for 4 weeks, then 3 skin assessments on cognitively impaired residents weekly for 4 weeks, then 1 skin assessment on cognitively impaired residents weekly for 4 weeks to ensure there are no signs of inappropriate sexual touching. Audits will be reviewed by the Quality Assurance Performance Improvement Committee, which consist of the Director of

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Nursing, Nursing Home Administrator, Unit Managers, Wound Care Nurse, Minimum Data Set Nurse and the Social Worker monthly for 3 months.

Allegation of immediate jeopardy removal and compliance date: 10/19/24.

The corrective action plan was validated onsite on 10/31/24 when it was verified through staff interviews that Residents #1 and #2 were immediately separated and assessed for injury. Observations and interviews during the survey validated that Resident #1 was moved to another room on the opposite side of the facility and Resident #2 was in a room by himself. An observation of Resident #2 was conducted on 10/31/24 at 11:10 AM. Resident #2 was sitting up in a wheelchair in the dining room with NA # 6 sitting beside him. Interviews with Unit Manager #1, nurses and NAs revealed that Resident #2 received 1:1 supervision when out of bed. Audit tools were reviewed and validated that all cognitively intact residents were interviewed to ensure that no other incidents of sexual abuse had occurred. No other incidents were reported. Audit tools were reviewed and validated that all cognitively impaired residents were assessed for signs of sexual abuse with no negative findings. A sample of staff that included nurses, medication aides and nursing assistants were interviewed regarding in-service training. All staff stated they received in-service training as indicated in the corrective action plan to include abuse and sexual abuse training. The audit forms that were utilized for monitoring that the systems put in place were effective were reviewed and validated. Skin assessments and resident interviews were conducted as designated in the corrective action

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F 600	Continued From page 17 plan. The facility's corrective action plan's compliance date of 10/19/24 was validated.	F 600		
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 observations, record review, Nurse Practitioner (NP), staff, and resident interviews, the facility failed to provide supervision to Resident #7, a severely cognitively impaired resident, who asked the Weekend Receptionist to sit on the porch. Resident #7 exited from the building without nursing staff's knowledge when the Weekend Receptionist unlocked the front door and let the resident out of the facility unsupervised at approximately 12:00 PM on 9/21/2024. The resident was outside unsupervised, until Nurse #5 who was inside the building observed Resident #7 self-propelling on the road in the facility's parking lot near the curb on the right side of the building around 1:15 to 1:20 PM. The distance was approximately 332 feet from the porch of the facility. Nurse #5 instructed Nurse Aide (NA) #3 to bring Resident #7 back into the facility. The resident had taken her sweater off and stated she was warm. According to the Weather Channel website, the	F 689	Past noncompliance: no plan of correction required.	

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temperature on 9/21/2024 was approximately 82 degrees in Wilmington at noon. NA #3 stated Resident #7 was trying to get her wheelchair up on the curb, and Resident #7 stated she was going to church. This noncompliance created a high likelihood for serious harm. If Resident #7 had self-propelled toward the left instead of the right, she would have been on a busy four lane highway with a speed limit of 45 miles per hour. The highway had a shoulder and no sidewalks. This deficient practice was identified for 1 of 4 residents reviewed for supervision to prevent accidents.

The findings included:

Resident #7 was admitted to the facility on 9/26/2023 with diagnoses including non-traumatic brain dysfunction, unspecified dementia, history of falling, and unsteadiness on feet.

The quarterly Minimum Data Set (MDS) assessment dated 7/4/2024 indicated Resident #7 was severely cognitively impaired. She was not coded for wandering, and required supervision with transfers, and activities of daily living. She was coded as ambulatory with walker and not a wheelchair.

The Care Plan for Resident #7 updated 8/3/2024 revealed a plan of care for impaired cognitive function and impaired thought processes related to dementia with a goal for being able to communicate basic needs on a daily basis for next 90 days. Interventions included to break tasks into one step at a time and do not rush or show annoyance or impatience and to cue, reorient, and supervise as needed dated. The care plan included a risk for falls characterized by

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history of falls, and multiple risk factors related to falls such as weakness, need for activities of daily living (ADL) assistance, and cognitive impairment and incontinence plan of care dated 7/4/2024 with the goal to minimize risks for falls and minimize injuries related to falls through next 90 days. Interventions included to maintain call bell within reach, maintain resident's needed items within reach, and physical therapy (PT), occupational therapy (OT), and Speech and Language therapist SLP to screen and treat as necessary.

An interview with the Weekend Receptionist was conducted on 10/30/2024 at 3:30 PM. The Weekend Receptionist stated she had only been working at the facility for a few weeks when the incident with Resident #7 occurred. She stated that on Sunday 9/21/2024 at approximately 12:00 PM she had noticed Resident #7 sitting in her wheelchair close to the front door. The Weekend Receptionist further stated that Resident #7 was appropriately dressed and wearing shoes, and she was holding a notebook. She stated that she asked Resident #7 if she could help her, and Resident #7 stated that she wanted to go out and sit on the front porch and read her notebook. The Weekend Receptionist stated that Resident #7 was not wearing a wander guard, and she assumed she could go outside by herself. She further stated that she did not check with the nurse prior to letting Resident #7 out of the facility. The Weekend Receptionist further stated that she was called away from the desk to deliver a meal to a resident, and when she returned Resident #7 was not on the front porch. She stated that it was over an hour before the nursing staff had come to her and asked her if she knew how Resident #7 exited the facility. The Weekend Receptionist indicated that she took full

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responsibility for her actions and that she should have asked someone prior to letting Resident #7 outside by herself.

A telephone interview was completed with NA #3 on 10/31/2024 at 10:53 AM. NA #3 stated she was working on the 200 Hall and it was after lunch on 9/21/2024 when the incident occurred. She further stated that Nurse #5 told her Resident #7 was outside and for her to go get her and bring her inside the facility. NA #3 indicated she went outside and found Resident #7 trying to get her wheelchair up on the sidewalk so she could reach the doors. She stated Resident #7 told her she was going to church and that she had taken off her sweater because she was warm. NA #3 further stated that it was warm and sunny that day and it was not raining. She indicated that Resident #7 was assessed by Nurse #5 and was given a drink of water.

An interview with Nurse Aide (NA) #4 was completed on 10/30/2024 at 2:45 PM. NA #4 stated that Resident #7 was not displaying any exit seeking behaviors prior to her elopement. She further stated Resident #7 enjoyed staying in her room most of the time looking at her pictures and books. NA #4 indicated that the staff tried to keep an eye on her most of the time and redirect her when she was wandering. She further indicated when Resident #7 wandered before the elopement she usually went as far as the nurse's station or the dining room. NA #4 stated Resident #7 loved potato chips and was easily redirected with a bag of chips. NA #4 further stated Resident #7 was not wearing a wander guard prior to her elopement.

A follow-up interview with NA #4 was completed

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on 10/31/2024 at 10:05 AM. NA #4 stated she was assigned to care for Resident #7 on the day she eloped. She further stated she had been giving a shower to another resident that took her about two hours to complete and when she came out, she was told by Nurse #5 that Resident #7 was found outside. She stated that she was unsure of the time that she went into the shower, but it was sometime before lunch and lunch had been served when they came out.

An interview was conducted with NA #5 on 10/31/2024 at 10:13 AM. NA #5 stated she was the other nurse aide assigned to the 200 Hall on 9/21/2024 when Resident #7 eloped. She further stated she was on her break when Resident #7 was found outside the facility. NA #5 indicated that she last saw Resident #7 that day around lunch time and that it was around 1:15 PM when she was found.

A nurse's progress note written by Nurse #5 on 9/21/2024 at 3:45 PM, read in part, that Resident #7 was observed in her wheelchair propelling herself in the parking lot. Resident was taken back to her room and offered something to drink. The staff was educated on her elopement and a wander guard was placed on resident's left wrist at the time with the expiration date 7/28/2027. The Responsible Party (RP) and NP were notified of the elopement.

A facility Event Report dated 9/21/2024 at 3:14 PM written by Nurse #5 revealed Resident #7 was found unsupervised in the facility parking lot. According to the report, Resident #7 was not experiencing any new traumas, or stressors, recent changes in medications, or abnormal lab values in the last 30 days, and was not exhibiting

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any exiting behaviors. The intervention listed was the door alarm band (wander guard) was applied. The on-call provider was notified at 1:20 PM and the RP was notified at 3:46 PM.

An interview with Nurse #5 occurred on 10/29/2024 at 2:20 PM. Nurse #5 pointed down the hallway and stated that she could see the emergency exit doors down the 100 and 200 Halls from the nurse's station. She further stated that approximately a month ago on 9/21/2024, she was standing at the nurse's station and looked out the door down at the end of the 100 hall and saw Resident #7 propelling herself in her wheelchair in the facility parking lot. Nurse #5 indicated Resident #7 was found safe and uninjured. She stated that Resident #7 was exhibiting wandering behaviors prior to the elopement but was not exit seeking. Nurse #5 further stated that prior to the elopement Resident #7 was usually wandering up and down the hall to the nurse's station.

A progress note written by Unit Manager #2 recorded as a late entry on 9/21/2024, read in part, that Resident #7 was placed in a safe area when she was brought in, and a skin check was performed, and her needs were met. Resident #7 was not experiencing any distress or pain, and remained at baseline cognition, and knew her name and her family. Resident #7 was unable to voice the name of the facility, but she was aware of her room location and personal belongings that were in the room. Resident #7 was able to move all extremities without difficulty and was verbally responsive to questions.

A follow-up telephone interview was conducted with Nurse #5 on 10/31/2024 at 8:21 AM. Nurse

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#5 stated that when she had spotted Resident #7 outside of the facility on 9/21/2024 she sent NA #3 to go outside and bring her back in the facility. She further stated that Resident #7 had self-propelled from her room at the end of the 200 Hall all the way outside to the parking lot. Nurse #5 indicated Resident #7 was smiling and self-propelling near the curb not in the middle of the parking lot. Nurse #5 indicated Resident #7 was wearing pants, shirt a sweater, and shoes. She stated Resident #7 did not say anything about being outside, and they gave her a drink of water. Nurse #5 further indicated that she had assessed Resident #7 for injuries and there were no injuries. She stated that Resident #7 had never exhibited exit seeking behaviors before and that she mostly stayed in her room. Nurse #5 further stated that she put the wander guard bracelet on Resident #7, completed the incident report, and filled out the assessment and observation form.

An interview with Nurse Practitioner (NP) was completed on 10/30/2024 at 09:01 AM. NP #1 stated she was familiar with Resident #7 and her recent elopement. She stated that Resident #7 was severely cognitively impaired and unaware of safety hazards. NP further stated that as far as she knew Resident #7 was not experiencing any exit seeking behaviors prior to the elopement on 9/21/2024. She further stated Resident #7 was able to ambulate short distances prior to using the wheelchair to self-propel.

A measurement from the facility front porch to the curb in the parking lot outside the 100 hall doors was completed on 10/31/2024 at 8:45 AM with the Maintenance Director using the therapy measuring roller. The distance from the front

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porch to the curb outside the 100 Hall door was 332 feet and the distance from the front porch to the entrance stop sign at the highway was 185 feet. The parking lot was divided into a left and right parking lot and there were no sidewalks on the sides of the building, only in the front. There were no accessible places to get on the sidewalk except at the main entrance, and Resident #7 had to self-propel through the parking lot that is narrow on the right side which is where she was found. According to the visitors log there were 32 visitors to the facility on 9/21/2024 that would have parked in the parking lot.

A measurement of the 200 hallway was completed with Occupational Therapist (OT) #1 on 10/31/2024 at 9:00 AM. The measurement was 70 feet from Resident #7's door to the nurse's station. OT #1 timed Resident #7 self-propelling in her wheelchair to the nurse's station and she was able to reach the desk in one minute. The OT indicated that Resident #7 was able to self-propel her wheelchair at a normal walking pace.

According to the Weather Channel website it was 82 degrees and sunny in Wilmington, NC on 9/21/2024 at 12:00 PM.

An interview was conducted with the Administrator on 10/31/2024 at 12:45 PM. The Administrator stated that a severely cognitively impaired resident was found outside the facility on 9/21/2024. He further stated that it was just a human mistake, and the Weekend Receptionist was unaware of the resident's cognitive status and made the mistake of letting her go outside by herself. The Administrator indicated the Weekend Receptionist should have asked the nursing staff

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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
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prior to letting Resident #7 out the front door.

The Administrator was notified of immediate jeopardy on 10/31/2024 at 12:54 PM.

The facility provided the following corrective action plan.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice

On September 21, 2024 Nurse #5 assigned to Resident #7 notified the Unit Manager that Resident #7 needed a wander guard band because resident #7 was in the side parking lot of the building. It was determined Resident #7 had been assisted out of front door by the Weekend Receptionist and had self-propelled to the side parking lot. Resident #7 was assisted back into the facility on September 21, 2024 by Nursing Assistant #3 and assessed for injuries by Nurse #5. Resident #7 was in no distress and had no injuries from the unauthorized departure. The wander guard was placed on Resident #7 by Nurse #5 on September 21, 2024. The responsible party and provider were notified on September 21, 2024 by Nurse #1. Resident #7's elopement assessment prior to the unauthorized departure was reviewed by the Director of Nursing and it was determined that the resident was not at risk for elopement at the time of the assessment. On September 22, 2024 the Director of Nursing reviewed the progress notes between the date of the last elopement assessment that was completed on June 30, 2024 and the date of the unauthorized departure to ensure there was no documentation of wandering behaviors. There was no documentation of wandering or exit

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	345507	A. BUILDING _____ B. WING _____	C 11/01/2024

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seeking behavior in the Electronic Medical Record. The root cause of the incident was discussed by the Interdisciplinary team on September 23, 2024 and it was determined that Resident #7 displayed new onset of exit seeking behaviors not reported to nurse #5 by the receptionist, therefore Resident #7 did not have a wander guard in place. Also the receptionist failed to consult with Nurse #5 on the condition of Resident #7 prior to assisting Resident #7 out of the front door. The Receptionist was re-educated by the DON on 9/23/2024 to consult with the nurse before letting residents onto the porch and checking the wander guard book located at the reception desk. The Interdisciplinary team consisted of the Director of Nursing, Unit Manager #1, Unit Manager #2, Minimum Data Set Nurse, Administrator, Social Worker, Wound Care Nurse and Infection Control Nurse.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice

On September 23 and September 24, 2024 the Director of Nursing, Unit Manager #1, Unit Manager #2 and the Infection Control nurse completed a new Brief Interview for Mental Status assessment and an Elopement assessment on all residents in the facility that had not been assessed since August 23, 2024. On September 23, 2024 the Director of Nursing reviewed all progress notes since August 21, 2024 to ensure all residents with documented wandering behavior had a wander guard and care plan in place. No additional new residents were identified with wandering behaviors. The wander guard books were updated on September 24, 2024, by the Director of Nursing, following the completion

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of the Elopement assessments.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

Staff education was started by the Director of Nursing on September 24, 2024 on the Elopement Policy and Procedure and Immediately reporting exit seeking behaviors to the nurse and administration. "When in doubt ask a nurse". The "When in doubt ask a nurse" education included consulting with the nurse assigned to a resident prior to letting a resident out of the facility. Education also included consulting the wander guard books which were placed at all three nurse stations and the reception desk. The wander guard books include photo ID of all residents that are at risk for unauthorized departures. Anyone that the Director of Nursing could not educate face to face was educated via phone. Anyone that the Director of Nursing could not educate will be educated prior to their next scheduled shift. All newly hired staff will be educated by the Director of Nursing on the Elopement Policy and Procedure and Immediately reporting exit seeking behaviors to the nurse and administration "When in doubt ask a nurse" before the end of their employee orientation. The Director of Nursing also validated there was a sign on the main entrance informing visitors and staff to talk with a nurse prior to assisting residents out of the facility.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained

The facility decided to take the elopement

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incident and the plan of correction to the Quality Assurance Performance Improvement team on September 23, 2024. The Quality Assurance Performance Improvement Committee consisted of the Director of Nursing, Unit Managers, Social Worker, Administrator, Minimum Data Set Nurse, Wound Care Nurse and the Therapy Director. To ensure ongoing compliance the Director of Nursing will review all progress notes 5 times a week for 8 weeks to ensure all residents with wandering behaviors have a wander guard in place and that there are no other instances of other unsafe residents being outside of the facility without supervision. In addition, the Director of Nursing will interview 3 employees weekly for 8 weeks to ensure all staff understand the elopement drill process. Elopement books will be reviewed weekly during resident review to ensure the books are up-to-date and all residents at risk for elopement are listed in the books. The audits will be reviewed by the Quality Assurance Performance Improvement Committee for 3 months.

The facility alleged IJ removal date of 9/25/24 and the completion date for the corrective action plan was 9/25/2024.

As part of the validation process on 10/31/2024, the corrective action plan was reviewed and included a sample of staff which included nurse aides, receptionists, nurses, and housekeeping staff regarding the in-services and training related to elopements. The wander guard books were reviewed and all residents with wandering behaviors were identified and were wearing wander guards. The staff verified the education and training. The receptionists verified the training and provided the updated wander guard

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F 689	Continued From page 29 book located at the front entrance and the wander books were verified on the nursing units by the nursing staff. The monitoring tools and continued monitoring were reviewed to ensure compliance. An observation and interview with Resident #7 occurred on 10/30/2024 at 2:20 PM. Resident #7 was observed sitting up in her wheelchair self-propelling in her room and a wander guard was attached to the frame of the wheelchair. Resident #7 stated that she used to walk with her walker, but she felt safer in the wheelchair, because she did not want to fall. The immediate jeopardy was removed on 9/25/2024 and the compliance date of 9/25/2024 was validated.	F 689		