Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0089	A. BUILDING: ______ B. WING ______	08/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	**120 SOUTHWOOD DRIVE BOX 379 CLINTON, NC 28328**

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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, and staff interviews, the facility failed to provide supervision to prevent a resident from leaving the facility ' s property for one (Resident # 1) of four sampled residents identified to have wandering behavior. The findings included: Record review revealed Resident # 1 was admitted on 4/18/14. The resident had diagnoses of Alzheimer ' s disease, macular degeneration, and depression. Record review revealed the resident had a current order for a Wanderguard bracelet to be on at all times. An interview with the Unit Manager on 7/30/16 at 5:30 PM revealed this order originated in November, 2014. The Unit Manager stated there was no corresponding notation to why it had initially been ordered but the bracelet had been used since that time. Record review revealed on 4/1/16 the facility completed a form entitled, " AL (assisted living) Combined Risk Assessment. " Located on the form were questions regarding the resident ' s risk for elopement. The staff member who completed the form had documented " yes " to the following questions located on the form: " Does the resident ambulate independently, with or without the use of an assistive device	L 039	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. L039 Corrective Action for Resident Affected: For resident # 1 a new wanderguard bracelet was placed on his right ankle and, an additional wanderguard bracelet was also placed on his wheelchair which was secured using a zip tie. This was completed on 5/22/16 by Maintenance Director. One on one supervision was immediately initiated on 5/22/16 by the Administrator and Director of Nursing. As	8/19/16

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L 039	Continued From page 1 (including a wheel chair)? Does the resident have any hearing, vision, or communication problems? Is the resident cognitively impaired with poor decision-making skills (i.e. intermittent confusion, cognitive deficits, disoriented?) Has the resident verbally expressed the desire to go home, packed belongings to go home, talked about going on a trip, or stayed near exit door? " The staff member, who completed the form, documented in the summary section that the resident was at risk for elopement based on the assessment. Review of the resident ' s " Adult Care Home Personal Care Physician Authorization and Care Plan, " dated 4/27/16, revealed the following information regarding the resident: He was alert and oriented to " self only; " disoriented to place and time; recognized familiar staff but did not always know their names; had poor visual acuity but was able to propel himself through the facility without running into objects; and needed a wheelchair or walker as an assistive device for ambulation and locomotion. The care plan also included the notation, " Pt (patient) is on wanderguard program with bracelet worn. " On 7/30/16 at 11:55 AM a brief conversation was held with Resident # 1 as he sat in the hallway. The surveyor asked if it would be possible to speak to him later within his room following lunch. The resident responded politely and appropriately. It was observed by the surveyor that it was not immediately obvious that the resident was confused during this brief exchange of conversation. The resident was also observed on 7/30/16 at 1:35 PM as he stood to walk to the bathroom after being seated in his wheelchair. The resident was observed to take a few steps while holding onto his family member or things for support as he walked to the bathroom. Medical record review revealed MT (Medicine	L 039	of 5/27/16, resident had not displayed any further exit seeking behaviors, so the Administrator and Director of Nursing discontinued one on one supervision and initiated resident on every 15 minute well-being checks. These checks continued through 5/30/16. On 5/30/16, upon direction of Director of Nursing, the Unit Manager discontinued resident from every 15 minute well being checks, due to him having no further episodes of exit seeking behaviors displayed. On 5/22/16, his room was also searched by nursing staff for any type of device/tool that could be used to cut wanderguard bracelet. New, more highly visible signs were placed at the double doors at Unit I nursing station as well as by sliding doors at main entrance alerting visitors to not assist any resident outside without speaking to a nurse. This was completed on 05/31/16 by the Administrator. Corrective Action for Resident Potentially Affected: All residents scoring at risk for elopement have the potential to be affected by this practice. The Nurse Management Team will audit all residents' most recent elopement risk score for risk of elopement. Once the audit is complete, a list of residents at risk for elopement will be generated. This will be completed by 8/19/16. The Nurse Consultant will conduct an audit of all residents who are identified as being at risk for elopement to ensure the following: appropriate tasks are firing for checking placement and	

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L 039	Continued From page 2 Technician ' s)#1 ' s entry dated 4/1/16 at 6:02 PM noting the resident was voicing, " he was going home, he had a car outside and was going to drive himself. " There was documentation in the record the resident had to be redirected. On 5/22/16 MT # 2 documented at 6:34 PM the resident had left the facility and was returned by a CNA uninjured. The medicine technician documented the resident stated he had been going to get gas to go home. MT # 2 also documented the resident ' s Wanderguard bracelet was found in his drawer. Interview with the Administrator on 7/30/16 at 9:57 AM revealed he had investigated the 5/22/16 incident. This interview with the Administrator revealed the following information about the incident and his investigation. NA (Nurse Aide) #2, who was driving back to the facility following an evening break, saw the resident near a road and returned him unharmed to the facility. The Administrator stated the resident had not had his Wanderguard bracelet on and therefore their system had not alarmed to alert staff he had left the building. The Administrator looked at the Wanderguard after it was found and he stated it appeared to have been stretched somehow, but he did not know how the resident had been able to remove it. The Administrator also stated the facility was equipped with cameras for the front exits and he had reviewed video footage following the incident and saw where a young person helped roll the resident through the front door. The Administrator stated it was not always easily apparent when initially talking to Resident # 1 that he was confused, and therefore a visitor might have felt that it was permissible to help Resident # 1 through the door. The Administrator stated the video recording did not show the resident going directly to the road, and therefore he thought the resident could have possibly taken a walkway	L 039	proper functioning of the wandergaurd bracelet/transmitter every shift and that elopement risk and wanderguard use are care planned. This will be completed by 8/19/16. The Staff Development Coordinator will begin conducting routine elopement drills at a minimum of at least one per quarter. This will be initiated no later than 8/19/16. Systemic Changes: On 8/16/16, the Staff Development Coordinator began inservicing all full time, part time and PRN staff members in all departments, including temporary agency staff members on risks associated with residents who are at risk for elopement, including: monitoring whereabouts of residents who are on elopement program, monitoring placement and proper function of wanderguard bracelets/transmitters, being able to identify, divert and report exit seeking behaviors. This education will be completed for all employees no later than 8/19/16. Any facility staff member who did not receive in-service training by 8/19/16 will not be allowed to work until training has been completed. Temporary staff members will not be allowed to work until after completion of this training. This information has been integrated into the standard orientation training for all new	

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L 039	Continued From page 3 which leads to an adjacent property and which eventually leads to the road where the resident was found. The Unit Manager was interviewed on 7/30/16 at 1:55 PM regarding Resident # 1 ' s ability to walk and move around the facility. The Unit Manager stated the resident walked short distances while holding onto handrails or walked behind his wheelchair which he pushed. MT # 2, who documented the entry on 5/22/16, was interviewed on 7/30/16 at 3:40 PM. This interview revealed the following information. MT # 2 stated the resident usually wheeled himself in a wheelchair and went around the facility. She had seen the resident approximately 15 to 30 minutes prior to the time he was brought back in the facility. She had been busy administering medications and had not known he had exited the facility. She did not know how the resident had been able to remove the Wanderguard bracelet. NA # 1, who was assigned to care for the resident on 5/22/16, was interviewed on 7/30/16 at 3:25 PM. This interview revealed the following information. She had seen Resident # 1 that evening at the desk wheeling himself in his wheelchair around the facility and this was his normal behavior. She then was busy with other residents providing care and did not know he had left the building or how he got out. Once he returned he did not have his Wanderguard bracelet on him. Staff members started looking for the bracelet, and the resident told them and showed them where he had put it. It was located in a drawer and had somehow been torn or cut apart in a slanted fashion. The NA stated it was not an " up and down " break in the bracelet band. The NA did not know how the resident had removed it. NA # 2, who found the resident on 5/22/16, was interviewed on 8/1/16 at 10 AM. The interview	L 039	staff members and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance: The Director of Nursing will be responsible for auditing (5) residents who are identified as at risk for elopement weekly times 4 weeks then monthly x 2 months to ensure that proper monitoring of wanderguard bracelet/transmitter is being conducted and documented every shift. Reports will be presented to the weekly QA committee by the Administrator/ whoever to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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L 039	Continued From page 4 revealed the following information. She was returning to the facility during her dinner break when she saw the resident on the side of the road approximately .3 miles away from the facility. The resident was within a foot of the pavement in his wheelchair. She pulled into a drive near him and approached him to offer help. He seemed to recognize her as a facility staff member. He willingly got into her car and returned to the facility.	L 039		