| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation survey of 1/6/18. Event ID# N38Y11.<br><br>A recertification and complaint survey was conducted from 1/2/18 through 1/6/18. Immediate Jeopardy was identified at:<br><br>CFR 483.25 at tag F689 at a scope and severity (J)<br>CFR 483.70 at tag F835 at a scope and severity (J)<br><br>The tags F689 J constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 12/9/17 and was removed on 1/6/18. An extended survey was conducted. | F 000 | | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services | F 582 | | 2/5/18 |

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

Electronically Signed | 01/24/2018

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| F 582 | Continued From page 1<br>specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the | F 582 | The statements made on this plan of | |

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| F 582 | Continued From page 2<br>facility failed to provide facility residents with CMS-10055 Skilled Nursing Advanced Beneficiary Notice (SNFABN) prior to discharge from Medicare services for two of three residents reviewed for discharge documentation (Residents # 56 and 69).<br>Findings included:<br>1. Resident #56 was admitted to the facility on 11/7/2017.<br><br>A review of the medical record revealed a CMS-10123 Notice of Medicare Non-coverage letter dated 12/1/2017 and signed by the Resident # 56 ' s responsible party. Medicare coverage for the skilled services were to end 12/6/2017 because the resident had reached maximum potential for skilled therapy and would transition to long term care placement.<br><br>A review of the chart revealed a CMS-10055 SNFABN had not been provided to the resident or responsible party.<br><br>An interview was conducted with the Business Office Manager (BOM) on 1/4/2018 at 2:43 PM and she reported that it was her understanding an CMS-10055 SNFABN was provided by the facility to a resident if they were transitioning from Medicare Part B payment to Medicaid or private pay. The BOM reported that the corporate office had instructed her to provide a resident with an CMS-10055 SNFABN only if they were discharged from Medicare Part B therapy. The BOM reported she was not aware a resident on Medicare Part A services required an CMS-10055 SNFABN to be issued as well as a CMS 10123 Medicare Non-coverage letter upon discharge from Medicare services while remaining in the facility. | F 582 | correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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 dates indicated.<br><br>F- 582 Medicaid and Medicare coverage /Liability Notice<br>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.<br>On 1-6-2018 the facility failed to provide Resident # 56 and Resident # 69 with required CMS 10055 Skilled Nursing Advanced Beneficiary Notice (SNF ABN) prior to discharge from Medicare Services. On 1-18-2018 Resident # 56 responsible party signed CMS 10055 (SNF ABN) On 1-8-2018 Resident # 69 Responsible party signed the Medicare denial letter.<br><br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited. All residents receiving Medicare A benefits and remain in the facility are at risk of the deficient practice On 1-22-2018 the BOM completed a 30 day look back audit of all residents that received Medicare A benefits and have stayed in the facility after their Medicare A benefit had | |

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| F 582 | Continued From page 3<br><br>An interview was conducted with the administrator on 1/6/2018 at 12:51 PM and he reported it was his expectation that the facility provided the residents with appropriate notices prior to discharge from Medicare services.<br><br>2. Resident # 69 was admitted to the facility on 11/24/2017.<br><br>A review of the medical record revealed a CMS 10123 Notice of Medicare Non-coverage letter dated 12/22/2017 and signed by the Resident #69 ' s responsible party. Medicare coverage for skilled services were to end 12/27/2017 because the resident had reached maximum potential and was no longer making progress.<br><br>A review of the chart revealed a CMS 10055 SNFABN had not been provided to the resident or responsible party.<br><br>An interview was conducted with the BOM on 1/4/2018 at 2:43 PM and she reported that it was her understanding an CMS-10055 SNFABN was only provided by the facility to a resident if they were transitioning from Medicare Part B payment to Medicaid or private pay. The BOM reported that the corporate office had instructed her to provide a resident with an CMS-10055 SNFABN only if they were discharged from Medicare Part B therapy. The BOM reported she was not aware a resident on Medicare Part A services required an CMS-10055 SNFABN as well as a CMS-10123 Medicare Non- letter upon discharge from Medicare services while remaining in the facility.<br><br>An interview was conducted with the administrator on 1/6/2018 at 12:51 PM and he | F 582 | stopped. Of those residents identified in the audit 2 had not received the CMS-10055 SNF-ABN. On 1/22/2018 the BOM provided resident #1 received the CMS 10055 (SNF ABN) On 1/22/2018 the BOM provided resident #2 received the CMS 10055 (SNF ABN) .<br>On 1-9-12018 the BOM was provided education by the Regional Business Office Consultant on the following: CMS 10055 (SNFABN) is to be completed for all residents receiving Medicare Part A benefits and remaining in the facility<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements:<br>Starting on 1-30-2018 the BOM along with the QA team will review 3 residents discharging from Medicare services in the weekly QA meeting for verification that residents and /or their responsible party have been provided the CMS 10055 Skilled ABN notification prior to discharge from Medicare services.<br>Audits will be presented to the Administrator and Director of Nursing (DON) weekly that in turn will be shared with the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA/Quality of life Meeting is attended by the Administrator,DON, MDS Coordinator, Unit Manager, Support Nurse, Therapy, | |

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| F 582 | Continued From page 4<br>reported it was his expectation that the facility provided the residents with appropriate notices prior to discharge from Medicare services. | F 582 | HIM, Dietary Manager , Business of Manager and Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility QA process<br><br>Title of the person responsible for implementing the plan of Correction is the Administrator<br><br>Title of the person responsible for implementing the plan of Correction is the Administrator | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interviews the facility failed to accurately document the resident assessment for 2 of 19 residents. Resident #5 was inaccurately coded as having adequate hearing but required hearing aids in both ears; and Resident #81 was inaccurately coded as discharging to the hospital but she was discharged to home.<br><br>Findings included:<br><br>1.Review of the Medical Record revealed Resident #5 was admitted on 10/20/17 with diagnoses of Stroke, Right Sided Weakness, Dementia, Chronic Kidney Disease, and | F 641 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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 dates indicated.<br><br>F- 641- Accuracy of Assessments<br>The plan of correcting the specific | 2/5/18 |

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| F 641 | Continued From page 5<br>Osteoarthritis.<br><br>Admission MDS assessment dated 3/16/17 revealed Resident #5 was coded as having adequate hearing and did not have hearing aids.<br><br>Quarterly MDS assessment dated 12/15/17 revealed Resident #5 was coded as having adequate hearing and did not have hearing aids.<br><br>Observation of Resident #5 on 1/2/18 at 11:08 am revealed he was not wearing hearing aids and had difficulty hearing normal tone of voice during an interview.<br><br>During an interview on 1/4/18 at 2:33 pm Nurse #5 stated Resident #5 is hard of hearing and wears hearing aids in both ears.<br><br>During an interview on 1/4/18 at 2:40 pm with NA #1 she stated Resident #5 is very hard of hearing and wears hearing aids in both ears.<br><br>An interview on 1/4/18 at 2:47 pm with the MDS Nurse she stated the coding of Resident #5 for not having hearing issues and not wearing hearing aids was an oversite.<br><br>During an interview with the Director of Nursing on 1/6/18 at 12:30 pm she stated her expectation is that all MDS assessments should be coded correctly.<br><br>On 1/6/18 at 12:48 pm an interview with the Administrator revealed his expectation was that the MDS assessments should be correct and have accurate information for each resident.<br>2. Resident #81 was admitted on 9/20/17 with multiple diagnoses that included: Generalized | F 641 | deficiency. The plan should address the processes that lead to the deficiency cited.<br>On 1-4-2018 the facility failed to accurately document assessments on Resident # 5 and Resident # 81 Resident # 5 was coded on the Admission and Quarterly assessment to have adequate hearing and Resident #81 was coded to have been discharged to the hospital but was discharged home. On 1-4-2018 date the MDS coordinator corrected the MDS Quarterly assessment for Resident #5 to demonstrate that he has moderate difficulty with hearing and that he has hearing aides .The MDS coordinator did not identify the hearing aides were present and did not fully interview the resident with the Admission assessment leading to the deficiency.<br>On 1-6-2018 the MDS coordinator corrected the discharge assessment for resident #81 to demonstrate that she discharged home .The MDS nurse completing the assessment did not fully review patient information resulting in deficient practice.<br><br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited<br>All residents requiring a MDS assessment have the potential to be affected by the deficient practice. On 1-19-2018 The MDS coordinator completed a 100% audit of all current residents with hearing aids. On 1-19-2018 the MDS coordinator completed a review of those current residents with hearing aids and then | |

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| F 641 | Continued From page 6<br>weakness.<br><br>The Minimum Data Set (MDS) comprehensive admission assessment with an Assessment Reference Date (ARD) of 9/27/17 indicated Resident #81 was coded as having been cognitively intact.<br>The MDS Discharge assessment with an ARD of 10/10/17 had the resident coded as having had a planned discharge to an acute hospital on 10/10/17.<br><br>A review of the care plan for Resident #81 revealed a care plan which had been initiated on 9/27/17. Resident #81 had the following focus area included in her care plan: Planned discharge to community.<br><br>A review of the Electronic Medical Record (EMR) for Resident #81 revealed a Progress Note for Skilled Nursing dated 10/10/17 which read in part under additional notes: Resident discharged to home via private vehicle.<br><br>Further review of the EMR for Resident #81 revealed a Social Services note dated 10/10/17 which read in part: The resident will discharge to home on 10/10/17 per choice.<br><br>Additional review of the EMR of Resident #81 revealed a Post Discharge Follow Up note dated 10/12/17 signed by the facility Social Worker which documented an attempt to follow up with the resident or her responsible party in regards to the types of services ordered at discharge.<br><br>During an interview conducted with the Registered Nurse (RN) MDS Coordinator on 1/6/18 at 1:37 PM she stated the MDS discharge | F 641 | verifying accurate coding to the most recent Minimum Data Sets (MDS) .The findings of the comparison audit were that one resident was identified to have hearing aids and refused to wear them. The MDS was coded: adequate hearing and no hearing aide. His care plan was updated to reflect his choice to wear hearing aide when he chooses and that her denies hearing loss. All other residents with hearing aides were coded correctly.<br><br>On 1-19-2018 a 60 day look back audit for resident discharging from the facility to home or hospital was completed by the MDS coordinator.<br>The audit findings were that one resident was coded on their discharge assessment that she had gone hospital instead of home. On 1-22-2019 the MDS coordinator submitted a modification to the discharge assessment correcting the coding error.<br><br>The MDS coordinator will be in- serviced on proper coding per the RAI manual (resident assessment instrument) by the regional MDS consultant on 1-23-2018 date. This in service included: A coding accuracy tool to monitor hearing aids, explanation on Resident Assessment Instrument (RAI) auditing criteria and schedule, and care planning needs.<br>When coding the MDS assessment the MDS Nurses and Care Plan Team will follow the instructions for proper coding found in the Resident Assessment Instrument (RAI) Manual and ensure that the assessment accurately reflects the | |

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| F 641 | Continued From page 7<br>assessment had been coded incorrectly. The discharge destination for Resident #18 was to home and not to an acute hospital.<br><br>An interview conducted with the Director of Nursing (DON) on 1/6/18 at 1:59 PM revealed her expectation was for the MDS assessments to be coded correctly. | F 641 | residents current condition<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;<br><br>On 1-30-2018 the MDS Co-coordinator will complete an audit of completed Minimum Data Set (MDS) assessments on 4 random residents weekly x 4 weeks the 3 residents monthly x 3 months using MDS Audit Tool. All identified areas of concern will be addressed immediately by the MDS Coordinator.<br><br>Audits will be presented to the Administrator and Director of Nursing weekly that in turn will be shared with the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager Administrator and Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility QA process<br><br>Title of the person responsible for implementing the plan of correction is the Administrator | |

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| F 641 | Continued From page 8 | F 641 | | |
| | | | Title of the person responsible for implementing the plan of correction is the Administrator | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews, the facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility for one of one resident reviewed for supervision. Resident #18 who was cognitively impaired exited the facility and was found approximately 50 feet away from the entrance door in 32 degree Fahrenheit weather.<br><br>Immediate jeopardy began on 12/9/17 when the facility failed to maintain a safe environment as evidenced by a resident who had been identified | F 689 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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 dates indicated. | 2/5/18 |

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| F 689 | Continued From page 9<br>as a wandering risk who had cognitive loss to have eloped from the facility and was discovered approximately 50 feet from the facility front entrance, on the sidewalk, at the covered drop off/pick area unaccompanied and without supervision. The facility failed to provide supervision which resulted in Resident #18 and other residents to be at risk for elopement at risk for a repeat incident. The Immediate Jeopardy was removed on 1/6/17 at 12:16 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.<br><br>The findings included:<br><br>Resident #18 was admitted to the facility 7/5/16 with diagnoses which included: Parkinson ' s disease, dementia and anxiety.<br><br>A review of Resident #18 ' s Minimum Data Set (MDS) revealed the most recent completed assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 10/5/17. The MDS assessment indicated Resident #18 was severely cognitively impaired. The resident was coded as having had exhibited wandering type behavior for 1-3 days during the seven day look back period of the assessment. The resident was coded as requiring supervision for walking in his room, in the corridor and for moving between locations both on and off of corridor. | F 689 | The plan for correcting the specific deficiency and the process that lead to the deficiency cited:<br>On 12-9-2017 the facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility .On 12-9-2017 Resident # 18 with a wander guard device was seen standing on side walk to front entrance by a therapist and another resident who then returned him inside the facility. The Nurse #1 and nurse aides observed the resident and he remained on his hallway. On 12/09/2017 Nurse #1 checked Resident #18 wander guard transmitter and changed transmitter On 12-9-2017 the wander guard system company completed repairs on the front door wander guard system and notified the nurses in the facility that it was functional.<br><br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All residents requiring the use of a wander guard transmitter are at risk to be affected by the deficient practice. On 12-9-2017 all residents with wander guard transmitters were visually observed by the nursing staff assigned to their hall. 12-9-2017 all residents with wander guards were checked for placement and function. All found to be placed and functional.<br>On 12-9-2017 the wander guard company completed repairs reporting that the system was functional to the nurses.<br>On 1-4-2018 the Director of Nursing | |

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| F 689 | Continued From page 10<br><br>Review of Resident #18 ' s care plan, dated 10/8/17, revealed the resident had a focus area for being an elopement risk/wanderer as evidenced by the resident wandered aimlessly, had impaired safety awareness, was disoriented to place, and had a history of attempts to leave the facility unattended. The care plan goal specified the resident would not leave the facility unattended. Listed interventions included: Distract resident from wandering, identify pattern of wandering, monitor location, and use of a wander alert anklet transmitter.<br><br>A review of the medical record for Resident #18 revealed a nurses ' note written by Nurse #6, dated 12/9/17, which read in part: This nurse was alerted of elopement of resident. Resident was wearing an anklet transmitter at the time of elopement. The alarm only sounded when he entered the building. The elopement was documented as having occurred at 12:32 PM.<br><br>An interview with the physical therapy assistant (PTA) on 1/4/18 at 3:31 PM revealed she was working in the therapy gym on 12/9/17. The PTA stated she was working with a former resident who pointed out to her that Resident #18 was outside, on the sidewalk, and was at the point where the sidewalk met with the covered drop off/pick up area. The PTA stated the alarm on the front door was not sounding. The PTA said she went outside to assist the resident back inside. The PTA stated the resident did say what he was doing outside, but he said he was cold and was ready to go back inside the facility. She stated the resident was standing outside by himself, there were no other residents or visitors with the resident while he was outside. She stated the | F 689 | (DON) /Unit Manager (UM) began in -services that included caring for residents that are at risk for elopement , the wander guard system, and what to do if the wander guard system becomes non-functional for all departments/staff which includes the Administrator ,Fulltime(FT) , Part time PT) and PRN Registered Nurses(RN), License Practical Nurses(LPN) and Certified Nursing assistance (CNA) , Minimum Data Set (MDS) coordinator, Therapy , Housekeeping, Laundry, Dietary, Social Services (SS), Business Office Manager (BOM) Heath Information Manager(HIM) and receptionist, human resources, and admissions.<br><br>This in servicing was completed on 1-5 -2018. The DON will ensure that any staff member who did not receive the in-service training by 1-5-2018 will not be allowed to work until this is completed. This training was incorporated into the general orientation program. On January 10th, 2018 the wander guard manufacturer company came out to inspect the front door and replaced two antennas to improve upon the locking distance from two and a half feet to four feet when a resident with a wander guard bracelet approaches the front door.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected: | |

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| F 689 | Continued From page 11<br>alarm did not sound until she was assisting him back through the door. The PTA walked with the resident to the 100/200/300 nurses ' station, the alarm continued to sound, and she informed the nursing staff the resident had been discovered to be outside. According to the PTA the alarm was still sounding when she reached the nurses ' station and a member of the nursing staff went and turned off the alarm at the front entrance. The PTA stated the nursing staff had commented the battery had been "messed up" on the transmitter and replaced the transmitter.<br><br>An interview conducted with Nurse #6 on 1/4/18 at 6:52 PM revealed she was the nurse who completed the incident report for the elopement of Resident #18 and had spoken on the phone to the DON on 12/9/17. The nurse stated the PTA had brought Resident #18 to the 100/200/300 Hall nurses ' and informed the nursing staff the resident had been discovered outside under the awning at the pick up/drop off area. The nurse stated she had the PTA write a statement and she called the DON and informed her about the elopement. The nurse stated they attempted to discover how the resident had gotten outside. The nurse stated they started by testing the transmitters on the residents, including Resident #18, by taking them to the front door and the door did not lock. Resident #18 ' s transmitter was the only transmitter which was replaced. The nurse stated the maintenance director (MD) called a contracted service company who repaired the front door on 12/09/17. Prior to the service man coming to service the front door the nursing staff were making rounds to make sure another elopement would not occur. The nurse stated she remembered the service man coming to the facility standing at the front door and when he left | F 689 | On 1-7-2018 The Administrator/Director of Nursing will begin monitor for completion of the daily wander guards and daily door checks using a Quality Assurance audit tool once a week x 4 weeks, then monthly x 2 or until reviewed by the Quality Assurance (QA) team and resolved. The results of this audit will be reviewed at the weekly Quality of Life (QOL) Team Meeting. The QA/QOL Meeting is attended by Administrator, Director of Nursing, Unit Manager, Support Nurse Managers, Social Service, and Dietary Manager. Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility QA process.<br><br>Title of the person responsible for implementing the plan of correction is the Administrator | |

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he had stated the front door was in working order. She stated she checked the other residents ' transmitters ' function with the device from the manufacturer and found each one to be in working order. The nurse stated prior to the therapist bringing Resident #18 to the door she had not heard an alarm from the front door. In addition the nurse stated none of the other staff members she interviewed had heard an alarm when the resident exited the facility. The nurse was not aware of the last time someone had seen Resident #18 in the facility so she was unable to determine the length of time he was outside. She stated she assessed the resident when he came back into the facility and did not observe or discover any negative outcome from having been outside. The nurse also stated she called the resident ' s family and had notified them of the incident.

An interview conducted with NA #3 on 1/4/18 at 2:17 PM revealed she was the NA assigned to Resident #18 during the time of the elopement on 12/9/17. The NA stated on 12/9/17 she was providing care for another resident on the 100 hall and had heard the alarm sound twice. She stated she did not see the resident exit or enter the facility. It was not till after the resident came back in the facility she was aware the resident had left the facility. The NA was unable to provide a time when she had last seen the resident prior to the elopement.

A phone interview conducted with Nurse #7 on 1/4/18 at 6:29 PM revealed she was working on 12/9/17 at the time when Resident #18 eloped. The nurse stated she had not heard a door alarm when the resident had eloped. She stated when

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the MD was called he had instructed the nurses at the facility to call the contracted service company for the elopement security system. The service person arrived at the facility around 3:15 PM to service the alarm.

An interview conducted with NA #1 on 1/4/18 at 5:09 PM revealed she had been working on 12/9/17 when Resident #18 was discovered outside and had not heard a door alarm sound. The NA further stated they did not have enough staff to have a staff member assigned to provide continuous monitoring of the front door. The NA stated as an additional preventive measure they closed the secondary doors to the front lobby as an extra barrier.

A review of Resident # 18 ' s Treatment Administration Record (TAR) from 12/1/17 through 1/3/18 revealed a line item labeled, transmitter battery check every night by the night shift. Nightly checks were documented for all nights except for 12/6/17. There was an additional line item labeled, check the placement of the transmitter anklet to the right ankle every shift. There was documentation for each shift except for day shift 12/4/17, night shift 12/6/17, day shift 12/15/17, day shift 12/22/17, and day shift 12/28/17.

A review of the weather conditions per Weather Underground web site revealed the following data for Salisbury, North Carolina (NC) on 12/9/17 at 12:05 PM were 32.0 degrees Fahrenheit (F) with no wind and overcast. The conditions at 12:25 PM were 32.2 degrees F, with a wind chill temperature of 28.9 degrees F. There was a North wind at 3.5 miles per hour (MPH). There was 0.02 inches of snow and the weather

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conditions were light snow. The conditions at 12:45 PM were 32.4 degrees F, with a wind chill of 29.1 degrees F. There was a Northwest wind at 3.5 MPH. There was 0.03 inches of snow and the conditions were light snow.

The area where Resident #18 was initially observed to have been outside on 12/9/17 was approximately 50 feet 6 inches from the front entrance. The area was a covered and paved walkway which extended from the front entrance of the facility and connected to a covered pick up/drop off area connected to the parking lot. The reported site the resident was initially observed outside has a direct line of vision from the therapy gym.

An observation of Resident #18 on 1/3/18 at 9:30 AM revealed the resident to be ambulating in his room without the assistance of a device or another individual. Resident appeared slightly unsteady but was able to ambulate to a chair located in his room and sit down unassisted.

An interview conducted with Nursing Assistant (NA) #2 on 1/4/18 at 9:33 AM revealed Resident #18 was able to walk throughout the facility independently but had cognitive loss. The NA pointed out a transmitter anklet was on the resident ' s left ankle. The NA stated when the resident would get near a door which had a sensor, the sensor would pick up the signal from the transmitter and the door would automatically lock.

An interview and observation was conducted with Nurse #5 on 1/4/18 at 9:46 AM in regards to how the automatically engaged magnetic lock worked on the front entrance door at the facility. Nurse

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#5 demonstrated the front door automatically locked when a resident with a transmitter anklet on her left ankle was wheeled toward the front door. When the resident was at the door, the magnetic lock on the door had engaged and the door was locked in a closed position and there was no audible alarm. When the resident was rolled away from the door, the magnetic lock disengaged and the door could be opened. The nurse further explained if the door happened to be open and there was a resident with a transmitter in the vicinity of the door, an audible alarm would sound.

An interview and observation conducted with the Wound Treatment Nurse on 1/4/18 at 10:05 AM revealed she checked the transmitters on wandering residents. She stated she checked for placement, function, and the expiration date. She explained the function of the transmitters were checked with a device from the manufacturer of the transmitters. She demonstrated how she used the function testing device on Residents #18, #27, and #280. All transmitters were found to be in proper working order according to the Wound Treatment Nurse. In addition the nurse explained she checked the transmitters on the days she worked and it was the night nurses ' responsibility to check the transmitters for function nightly. The Wound Treatment Nurse stated she did not document her checks for the function of the transmitter anklets.

An interview conducted with the Director of Nursing (DON) on 1/4/18 at 10:23 AM revealed Resident #18 had exited the facility on 12/9/17. The DON stated the resident was assisted back into the facility from an area near the front of the facility by a PTA. The DON stated she was

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unable to identify the exact length of time the resident was outside. The DON did not identify how the resident was dressed at the time he was discovered outside. The DON stated the nurses went and checked all of the residents with transmitters and Resident #18 ' s transmitter was discovered to be malfunctioning. The DON stated in addition to Resident #18 ' s transmitter malfunctioning there was a concern the front door magnetic lock for the elopement security system was not functioning properly. The DON stated there was not a specific individual assigned to provide continuous monitoring of the front door. The DON stated, she called the Maintenance Director (MD) on 12/9/17, after she was notified of Resident #18 exiting the facility, to inform him about the concern about the front door. The MD contacted the service company for the elopement security system and the company came out on 12/9/17 to service the door. The DON stated the transmitters located on the residents were checked for placement each shift by the nurses. The DON further stated the function of the transmitters were checked by the Wound Treatment Nurse when she worked and every night by third shift. The DON stated the doors were checked to make sure they were locked at the end of second shift every night by the second shift nurses. In regards to the function of the transmitter engaged electromagnetic lock located on the front door she stated it was checked periodically for function by the Maintenance Director. The DON stated she did not come to the facility on 12/9/17.

An interview conducted with the DON on 1/4/18 at 6:22 PM revealed she had not come in on 12/9/17. The DON stated she had spoken exclusively to Nurse #6 on the phone on 12/9/17.

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The DON stated she directed the nurse to check the transmitters and to change them if they were found to be out of date or out of order. The DON stated Resident #18 ' s transmitter was found to be malfunctioning and it was replaced. The malfunctioning transmitter was discarded. The DON stated the nurse documented the information about the resident elopement but had not documented the interviews. The DON stated the nurse had interviewed all of the staff at the facility during the time of the elopement and none of the interviewed staff had heard the alarm at the time of the elopement but it had sounded when the resident re-entered the facility. The DON told the nurse at the facility to call the MD and then she called the MD herself. She did not think the MD had come into the facility on 12/9/17, if he did, it was later in the evening.

During an interview with the MD on 1/4/18 at 10:41 AM he stated he checked the function of the transmitter engaged electromagnetic locks once per week. The MD was able to provide documentation that each door in the facility which had the electromagnetic locks, including the front door, were tested, and found to be in proper working order on 12/4/17, 12/11/17, and 12/26/17. The MD also provided documentation from the second shift nurse for the date of 12/19/17 where the magnetic locks had been found to be working on all doors with magnetic locks. He stated he had contacted the service company for the electromagnetic locks and they had come out on 12/9/17. The MD provided a copy of the work order from the service call. The documented arrival time of the service technician on the work order for 12/9/17 was 3:15 PM and the departure time was 4:30 PM. The MD stated he had not come to the facility on 12/9/17.

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During an interview conducted with the Administrator on 1/4/18 at 6:09 PM he stated all of the transmitters on the wandering residents were changed on 12/9/17. The sensor and the electromagnetic lock were found to be in working order by the contracted service company on 12/09/17. The Administrator stated there were only two ways the resident could have gotten out of the facility. The resident could have pushed on the door for 15-20 seconds and the electromagnetic lock would release or the resident could have followed another person out of the door when it was open. The Administrator stated in either case the alarm should have sounded. The Administrator stated Resident #18 was discovered outside near where the van loads and unloads residents (A distance measured to be approximately 50 feet 6 inches from the front door). The Administrator stated the DON interviewed staff members over the phone.

Review of the work order from the contracted service company for the elopement security system from 12/9/17 revealed, under services rendered which read in part: Obtained transmitter from staff and tested the front door multiple times. Front door system picked up tag and locked door every time.

An interview was conducted with the Service Manager (SM) from the contracted company for the elopement security system on 1/5/18 at 8:34 AM. The SM stated it was possible an individual had entered the code into the punch pad for the elopement security system which would have turned off the alarm. The SM reviewed the work order from 12/9/17 and stated from the documentation on the work order indicated that

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the service technician found the elopement system was in working order when he made the service call on 12/9/17. The SM stated the service technician tested the system at the front door with a transmitter he had obtained from the nurses ' station. The SM further stated there was no documentation the service technician made any repairs or any adjustments to the front door during the service call on 12/9/17.

An interview was conducted with the Administrator on 1/6/18 at 12:45 PM. The Administrator stated it was his expectation for the elopement security system to function properly, for staff to respond to elopement alarms, and for residents not to elope.

The Administrator was informed of Immediate Jeopardy on 1/5/18 at 9:32 AM.

On 1/6/18 at 12:16 PM, the facility provided the following Credible Allegation of Compliance:

Plan to correct specific deficiency and facts that led to the alleged deficient practice

On 12-9-2017 at around 11:48am Resident #18 was observed by an outpatient resident in the therapy gym who then told the therapist about resident #18 being outside approximately 50 feet. Away. Resident #18 was immediately brought in by the therapy staff member who exited an alarmed door and the alarm to the front door went off at that time he was brought back in .The resident was returned to his room and examined by the nurse no injuries were noted. The (DON )Director of Nursing and Maintenance Director were notified by the LPN on the hallway that Resident #18 had been found outside the main

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entrance and no alarm had been heard by the nurses or aides in the building prior to him leaving . The responsible party (RP) and (MD) Medical Director were notified by the LPN and there were no new orders given. Resident #18 wander guard was checked at that time by his nurse .All other residents with wander guards in the facility were checked by their nurse .The maintenance supervisor and the Director of Nurses (DON) called the wand guard company who arrived around 3:15 pm and door was repaired by 4:30pm. The front door wander guard antenna was repaired on 12/9/17 by wander guard company. On 12-9-2017, the doors were all check and found functional by the wander guard company. On 12-11-2017 the QA team met in QOL meeting which included the Administrator, DON, RN supervisor, Unit manager, MDS coordinator, for a root cause investigation of the elopement .Their finding were that the resident walks around the facility frequently and looks out the windows. The front door alarm did not sound when he went out the door with a visitor.
On 1/6/18 further review of the event revealed that a NA told the surveyors during the survey that she heard two alarms sound. On 1/6/18, the administrator interviewed the NA and she reports that she was in a closed room on 300 hall that is in the back of the facility and recalls hearing the alarm and stepping into the hallway. During the interview, the NA was unable to provide further clarification on hearing the alarm and is uncertain as to whether or not she heard a second alarm after further reflection. Because this NA was not part of the interviews conducted immediately after the event it is difficult to further clarify. The only explanation for her hearing two alarms is that the alarm went off when he exited the first time. The corrective action described below accounts for

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the fact that staff may not have responded to the first alarm when the patient exited the door.
A sign was posted at the front door to alert visitors and on 1-5-2018. The administrator added to the visitor sign in book not to help any residents out the door on 12/11/7.

Procedure for implementing a plan of correction for the alleged deficient practice
All residents needing a wander guard device have the potential to be affected.
On 12-9-2017, the nurses at the direction of the DON begin monitoring the patients by using the elopement book for identification of those at risk and using a wander guard transmitter. All residents were observed by the staff until the door was repaired by the alarm company on 12-9-2017 were completed. All doors with alarms were checked and found to be functional by nursing staff.
All wander guards are checked for placement every shift by the nurse and function by night shift prior to the elopement and after 12-9-2017. The nurses use a checking device provided by the manufacturer to check for functioning. The maintenance director checks the doors daily with the code alert tags Monday through Friday and checked weekly through (TELS) system which is building maintenance management computerized program, this was done prior to and after 12-9-2017 elopement.
On 1-4-2018 all residents with wander guards were checked the DON, Unit manager, support nurse and functioning. On 1-4-2018 all door alarms were checked maintenance and found to be functional.
On 1-4-2018 the DON /UM begin education for FT , PT and PRN RN ' s, LPN ' s and CNA ' s , therapy, housekeeping laundry, dietary staff,

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| F 689 | Continued From page 22<br>social services, business office manager, heath information manager. This education will be completed by 1-5-2018. The DON will ensure that any staff member who did not receive the in-service training by 1-5-2018 will not be allowed to work until this is completed. As of 1-5-2018 12:00 noon 20 of nursing staff had not received this training. This training was incorporated into the general orientation program.<br>All staff education:<br><br>· Do not forget that frequent monitoring and supervision are needed in order to ensure resident safety. This means that you should be aware of the at risk for elopement resident ' s location. Do not accept the wander guard system as a substitution for resident supervision.<br>Residents at risk for elopement are identified by this facility by placing a picture of the resident in an Elopement Risk notebook and it is located at front, nurses and receptionist desk. It is each employee ' s responsibility to review this notebook at the beginning of each shift so that you are familiar with residents who are at risk.<br>· Any time an exit door alarm sounds or a squeal box alarms, then a staff member must immediately physically go to that door and check to see if a resident has exited or attempted to exit before resetting the alarm.<br>· At no time can a staff member disable an exit door/wander guard system alarm without the knowledge and approval of the Administrator or DON.<br>· If a resident begins to exhibit exit seeking behaviors such as sitting for long periods of time at the doors, trying to open exit doors, exhibits anxiousness about leaving or expecting a family member to arrive, and other activities that involve | F 689 | | |

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| F 689 | Continued From page 23 | F 689 | | |

trying to leave the facility or verbalizing that they want to leave or are going to leave. Notify the Nurse immediately. Redirect the resident by encouraging them to participate in activities that they enjoy or meeting physical needs such as toileting or hunger/thirst. Assess for evidence of pain and address as indicated. The care plan/kardex is a good resource for additional interventions.

· Once the resident starts exhibiting exit seeking behavior or any of the above behaviors, if the interventions are not effective in redirecting the behavior, then one-on-one should be initiated and you should call the Administrator or DON when this occurs. The MD, RP, DON, & Administrator should be notified of the exit seeking behavior for further interventions.

· If new exit seeking behavior is noted, check the resident ' s vital signs and assess for a change in condition. Notify MD of the findings.

· If the resident does not have a wander guard band on, then initiate one. Additional wander guard bands are located at the nurses stations.

· The CNA ' s check placement of the wander bracelet q shift and this is documented on the electronic charting in POC. If the bracelet is not found on the resident ankle or wrist immediately notify the nurse for a replacement. Placement and function of wander guards is completed by the shift nurse/ med tech every shift and all door checks completed weekly by maintenance director.

· Procedure for this: Bracelets are deemed functional when red light is flashing and non-functional when light is off and all contain a battery that lasts at least 1 year when activated, and verified by the date with function and placement checks and by support nurse.

· This placement and functional check is

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| F 689 | Continued From page 24<br>documented on the eMAR.<br>· If an elopements occurs, complete an incident report with notification of MD and RP. You must also immediately notify the Administrator or Director of Nursing.<br><br>Wander guard system<br>We have a wander guard system that will alarm if a resident is trying to leave the facility.<br><br>IF AN ALARM SOUNDS<br>· Staff should quickly respond to the location and determine the cause of the alarm.<br>· If it is possible that a resident has left the facility then implement the missing person procedure.<br>· Complete an incident report for QA follow up.<br><br>WHEN THE SYSTEM MAY NOT WORK<br>· The system shuts down anytime the fire alarm is sounded. All doors should be checked to make sure that they lock back after the fire alarm is finished. The charge nurses responsible for that area should check. Exit doors and employee entrance should be checked by the hall nurse.<br>· If a resident stands at the door for more than 20 seconds and applies pressure the door will release. If a resident is seen standing at the door they should be redirected.<br>· Any time the system is not functioning properly the administrator and maintenance director should be immediately notified.<br><br>Monitoring Procedure<br>The Admin/DON will monitor for completion of the | F 689 | | |

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| F 689 | Continued From page 25 | F 689 | | |

daily wander guards and daily door checks using a QA audit tool twice a week x 4 weeks, then monthly x 2 or until reviewed by the QA and team and resolved. The results of this audit will be reviewed at the weekly QOL Team Meeting.
The administrator/DON will also conduct mock response drills by setting off the front door alarm and ensuring that staff respond to the door alarm promptly. This will be done weekly on all three shifts and the again on the weekend. This will be completed for 4 weeks, then monthly for at least 2 months until reviewed by the QA team and resolved.
Corrective actions for these audits will be implemented to improve performance or correct issues.
The QA/QOL Meeting is attended by Administrator, Director of Nursing, Unit Manager, Support Nurse Managers, Social Service, and Dietary Manager. Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility QA process.

Title of person responsible for implementing the acceptable plan of correction: Administrator
Date of removal of immediate jeopardy 1/6/18

The credible allegation was verified on 1/6/18 at 2:00 PM as evidenced by staff interviews. Staff education was initiated on 1/4/18 regarding residents who have been identified to be at risk for wandering or may start to display behaviors which would place the resident at risk for wandering. All staff interviewed (nursing and non-nursing staff, administrative staff) stated they were to respond to respond to exit door alarms by immediately going to the door which triggered the alarm and investigate to see if a resident had exited or attempted to exit which would have

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| F 689 | Continued From page 26<br>triggered the alarm. Verification of education for staff regarding the education regarding wandering residents was completed on 1/6/18. | F 689 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews the facility failed to clean food service equipment and maintain intact food contact surfaces. The facility failed to maintain clean knobs on three of three food preparation appliances observed for cleanliness. The facility failed to provide plate covers with an intact interior surface on 9 of 89 plate covers stored on a rolling drying rack and 3 of 14 plate covers covering resident food in a tray cart. | F 812 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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 | 2/5/18 |

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| F 812 | Continued From page 27<br>Findings Included:<br><br>1. An observation of the kitchen conducted on 1/2/18 at 10:24 AM revealed the following:<br>a. Three of three appliances had knobs or a switch which were observed to have had a buildup of grease, dirt, and debris. The observation included eleven of eleven knobs on the flat top 6 burner stove, two of two knobs on the convection oven, two of two knobs and one switch on the steamer, had a buildup of grease, dirt, and debris.<br>b. Nine of eighty-nine plate covers which were stored on rolling drying rack were observed to have had an impaired integrity surface, where the material from which the cover was made was observed to be flaking off on the interior side of the plate covers.<br><br>2. An observation of the kitchen conducted on 1/5/18 at 11:53 AM revealed the following:<br>a. Three of three appliances had knobs or a switch which were observed to have had a buildup of grease, dirt, and debris. The observation included eleven of eleven knobs on the flat top 6 burner stove, two of two knobs on the convection oven, two of two knobs and one switch on the steamer, had a buildup of grease, dirt, and debris.<br>b. Three of fourteen plate covers which were on resident food trays in a cart which was to be delivered to the 400 hall were observed to have an impaired integrity surface, where the material from which the cover was made was observed to flaking off on the interior side of the plate covers.<br><br>An interview and observation that was conducted with the Dietary Manager on 1/5/18 at 12:01 PM revealed the 400 hall meal tray cart was ready to | F 812 | corrected by the dates indicated.<br><br>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited On 1-5-2018 the facility failed to clean food service equipment and maintain intact food contact surfaces. The facility failed to maintain clean knobs on food preparation appliances. The facility failed to supply plate covers with an intact interior surface. On 1-5-2018 the dietary services manager removed the defective plate covers from service .On 1-5-2018 the dietary manger cleaned and inspected the stove, oven, and steamer which included the stove knobs and switches. On 1-5-2018 replacement knobs were ordered and then replaced on 1-11-2018 by dietary manager.<br><br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All residents have the potential for being affected by kitchen and meal equipment failing to properly clean and maintain equipment. On 1-5-2018 the dietary services manager completed 100 % audit of all plate covers and removed 13 plate covers from service. On 1-5-2018 the dietary manger cleaned and inspected the stove, oven and steamer which included the stove knobs and switches. On 1-5-2018 replacement knobs ordered and were replaced on 1-11-2018 by dietary manager<br>On 1-11-2018 the dietary manager in serviced all dietary staff on assuring intact | |

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| F 812 | Continued From page 28<br>be delivered to residents. Observation of the three of the fourteen plate covers revealed. The interior surface of these plate covers had become impaired to the point it could be easily scratched off or fall off and get into the resident foods. The Dietary Manager stated it was his expectation for the food contact surfaces such as the interior surface of the plate covers be intact so pieces of the cover could not drop onto resident's food. The Dietary Manager was observed to have removed the plate covers with the impaired integrity from the trays in the resident cart. In addition the Dietary Manager stated it was his expectation for the knobs and switches on appliances to be kept clean.<br><br>During an interview conducted on 1/6/18 at 12:45 PM, the Administrator stated it was his expectation for knobs and switches to be kept clean on kitchen appliances and for covers to be intact without the potential for pieces of the cover being able to drop onto resident's food. In addition the Administrator stated he had placed an order with his food equipment supplier to replace the knobs on the appliances as well as replace the plate covers found to have impaired surface integrity. | F 812 | meal service equipment and clean food preparation equipment. The in-service included: After each washing cycle dietary staff is to observe the plate covers and to bring any that are not intact to the dietary mangers attention for removal from resident service. The food preparation equipment will be inspected by dietary manager or designee at the end of each meal service to verify equipment has been cleaned<br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements<br><br>On 1-12-2018 the dietary manager/designee implemented a Quality Assurance (QA) audit tool for worn food service equipment and cleanliness of kitchen equipment to be completed weekly x4 then monthly x 3.<br>Audits will be presented to the Administrator and Director of Nursing (DON) weekly that in turn will be shared with the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance/Quality of life Meeting is attended by the Administrator , Director of Nurses, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager , and Medical Director. Deficits that are identified during the monitoring process will be addressed through the | |

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| F 812 | Continued From page 29 | F 812 | facility Quality Assurance process<br><br>The Administrator is responsible for implementing the plan of correction. | |
| F 835 SS=J | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, contracted service interviews, and staff interviews, the administration failed to provide oversight and leadership to facility staff to maintain a safe environment and analyze an incident immediately for one of one resident reviewed for supervision. Resident #18 who was cognitively impaired exited the facility and was found approximately 50 feet away from the entrance door in 32 degree Fahrenheit weather.<br><br>Immediate jeopardy began on 12/9/17 when the facility failed to maintain a safe environment as evidenced by a resident who had been identified as a wandering risk who had cognitive loss to have eloped from the facility and was discovered approximately 50 feet from the facility front entrance, on the sidewalk, at the covered drop off/pick area unaccompanied and without supervision. The facility administration failed to conduct a timely and thorough analysis to identify | F 835 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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 dates indicated.<br><br>F-835 Administrative<br>The plan for correcting the specific deficiency and the process that lead to the alleged deficiency: On 12-9-2017 the facility administration failed to provide oversight and leadership to facility staff to maintain a safe environment and to analyze an incident immediately for one | 2/5/18 |

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| F 835 | Continued From page 30<br>a causative factor that directly led to the incident which lead Resident #18 and other residents at risk for elopement at risk for a repeat incident. The Immediate Jeopardy was removed on 1/6/17 at 12:16 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.<br><br>The findings included:<br><br>Cross Refer to F689:<br>Based on observations, record review and staff interviews, the facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility for one of one resident reviewed for supervision. Resident #18 who was cognitively impaired exited the facility and was found approximately 50 feet 6 inches away from the entrance door in 32 degree F weather.<br><br>On 1/5/17 at 9:32 AM, the Administrator was informed of the Immediate Jeopardy for F835.<br><br>On 1/6/18 at 12:16 PM, the facility provided the following Credible Allegation of Compliance:<br><br>The statements made on this credible allegation are not an admission to and do not constitute an agreement with the alleged deficiencies.<br><br>To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this credible | F 835 | resident reviewed for supervision. On 12-9/2017 The Administrator and the Director of Nursing failed to document and complete investigation of resident #18 elopement incident. On 1-4-2018 through 1-8-2018 the incident investigation was completed and documented by the Administrator and Director of a resident #18<br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited .All residents that have had incidents in the facility are at risk by the deficient practice. On 1-5-2018 the Quality Assurance Nurse completed an audit of resident incident reports for past 30 days for any other residents at risk from the deficient practice, the findings were that there were no other residents with incidents that were not analyzed and investigated .<br>On 1/5/18 the Vice President of Operations for the facility educated the Administrator and Director of Nursing on the required immediate actions and how to complete an investigation, develop a root cause, implementing corrective action, and meeting with the Quality Assurance committee for reviews.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements<br><br>On 1/5/2018, the Vice President of | |

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| F 835 | Continued From page 31<br>allegation. The credible allegation 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.<br><br>Tag 835<br>Plan to correct specific deficiency and facts that led to the alleged deficient practice<br>On 12/9/17, the facility began an investigation of the event that occurred; however a thorough investigation was not completed or documented.<br>On 12-9-2017 immediately after the event the Director of Nursing told all nursing staff members to observe all patients with wandering risk until door checks could be completed. On 12-9-2017 all residents who were required to wear a transmitter due to an elopement risk where checked by the nurses in the building to ensure that the devices were on the patient and functioning properly. No concerns were identified. On 12/9/17, the alarm company checked all doors. On 12-9-2017 the director of nursing obtained witness statements from the nurses in the building, they were obtained but were not written. Not all staff working that day were interviewed. On 12-11-2017 the QA team met in QOL meeting which included the Administrator, DON, RN supervisor, Unit manager, MDS coordinator, for a root cause investigation of the elopement. Their finding were that the resident walks around the facility frequently and looks out the windows.<br>A new sign was posted at the front door to alert visitors not to let resident out on 12/11/17. The team continued to do quality audits of all of the door alarms by taking a transmitter bracelet to the door to verify that the alarm sounded and the door locked as appropriate. This was an audit that was completed prior to the event as part of | F 835 | Operations and/or the Nurse Consultant will monitor incident reports weekly x 4 then monthly x 2 to identify any elopement activity that may have occurred. If elopement activity occurred the Vice President of Operations and/or the nurse consultant will review the facility investigation, root cause analysis and the corrective action plan to ensure that it is consistent with the education provided in this document.<br>Audits will be presented to the Administrator and Director of Nursing (DON) weekly that in turn will be shared with the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance/Quality of life Meeting is attended by the Administrator , Director of Nurses, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager , and Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility Quality Assurance process<br><br>Title of the person responsible for implementing the plan of correction is the Administrator | |

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| F 835 | Continued From page 32 | F 835 | | |

our quality program and it continued on 12/10/17 after the event. No new quality audits were initiated as a result of the event and/or investigation.
On 1/6/18 further review of the event revealed that a NA told the surveyors during the survey that she heard two alarms sound. On 1/6/18, the administrator interviewed the NA and she reports that she was in a closed room on 300 hall that is in the back of the facility and recalls hearing the alarm and stepping into the hallway. During the interview, the NA was unable to provide further clarification on hearing the alarm and is uncertain as to whether or not she heard a second alarm after further reflection. Because this NA was not part of the interviews conducted immediately after the event it is difficult to further clarify. The only explanation for her hearing two alarms is that the alarm went off when he exited the first time. The corrective action described below accounts for the fact that staff may not have responded to the first alarm when the patient exited the door.

Procedure for implementing a plan of correction for the alleged deficient practice
On 1/5/18 the Vice President of Operations for the facility educated the Administrator and Director of nursing on the following items:
1. Any time a patient who is an elopement risk leaves the facility whether it is witnessed or not, immediate actions and a comprehensive investigation must be completed and documented immediately after the event.
2. Immediate actions should be initiated immediately by the Administrator or the Director of Nursing. These actions should include posting a door guard at the door that was exited and placing 1:1 supervision for the patient. These

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actions should be kept in place until it is determined that the doors and transmitters are functioning properly and that the patient is deemed to not be at risk for additional elopements.
3. All resident transmitter must be checked to ensure that they are properly functioning. All door must be checked to ensure that they are functioning properly. These duties should be assigned to appropriate staff members by the administrator or the Director of Nursing if the administrator is not available.
4. The investigation must include at a minimum witness statements from all staff who are on duty at the time of the event and a time line based on the interviews. A comprehensive chart review must also be conducted to identify if the elopement risk assessment was timely and accurate, whether the risk has been care planned, whether transmitter bracelets had been issued to the patient and if the bracelets were checked every shift for placement and daily for functioning.
5. Based on the investigation the quality assurance team must identify all the possible root causes.
6. Based on the root cause analysis, a corrective action plan must be developed and implemented. The action plan should address any and all failures or concerns identified in the investigation. Education to all staff must be provided based on failures or concerns that are identified.
7. The investigation and corrective action plan must be finished within 72 hours of the event.
8. Based on the corrective actions, quality assurance monitoring must be completed at least weekly for four weeks until resolved by the Quality Assurance Committee.

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| F 835 | Continued From page 34<br>9. Immediate notification of the Vice President of Operations and the Nurse Consultant assigned to the facility must be made by the administrator.<br><br>Monitoring Procedure<br>On 1/5/2018, the vice president of operations and/or the nurse consultant will monitor incident reports weekly to identify any elopement activity that may have occurred. If elopement activity occurred the Vice President of Operations and/or the nurse consultant will review the facility investigation, root cause analysis and the corrective action plan to ensure that it is consistent with the education provided in this document.<br>Reports will be presented to the administrator and Director of Nursing weekly that in turn will be shared with the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager Administrator and Medical Director.<br><br>Title of person responsible for implementing the acceptable plan of correction: Administrator<br>Date of removal of immediate jeopardy 1/6/18<br><br>The credible allegation was verified on 1/6/18 at 2:00 PM as evidenced by staff interviews. Staff education was initiated on 1/4/18 regarding residents who have been identified to be at risk for wandering or may start to display behaviors which would place the resident at risk for wandering. All staff interviewed (nursing and non-nursing staff, administrative staff) stated they were to respond to respond to exit door alarms by | F 835 | | |

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| F 835 | Continued From page 35<br>immediately going to the door which triggered the alarm and investigate to see if a resident had exited or attempted to exit which would have triggered the alarm. Verification of education for staff regarding the education regarding wandering residents was completed on 1/6/18. | F 835 | | |
| F 865 SS=E | QAPI Prgm/Plan, Disclosure/Good Faith Attmpt<br>CFR(s): 483.75(a)(2)(h)(i)<br><br>§483.75(a) Quality assurance and performance improvement (QAPI) program.<br><br>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;<br><br>§483.75(h) Disclosure of information.<br>A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>§483.75(i) Sanctions.<br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 2/14/17 recertification survey. This was for one deficiency in the area of Food and Nutrition Services. The deficiency was recited on the current recertification 2/6/17. The continued | F 865 | The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.<br>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 | 2/5/18 |

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| F 865 | Continued From page 36<br>failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program.<br>The findings included:<br>This tag is cross referenced to:<br><br>1. 483.60-Based on observation, staff interview, and documentation review the facility failed to have dietary staff keep their hair completely covered for preparation and serving of food and failed to store hamburger meat in the proper location and at the proper temperature.<br>2. 483.60-Based on observation and staff interview the facility failed to clean food service equipment and maintain intact food contact services.<br><br>An interview was conducted with the Administrator on 1/5/18 at 2:06 pm. He stated the Quality of Life Meeting or QAA meeting was held once a month with all of the department managers. He also stated there is a quarterly meeting that includes the medical director and the pharmacist. The Administrator stated his expectation was that a deficiency would not be repeated. | F 865 | compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.<br><br>F-865 Quality Assurance and Performance Improvement program<br><br>The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to maintain implemented procedures and monitor interventions of an effective Quality Assessment and Assurance program in the area of Food and Nutritional services. On 1-12-2018 the dietary manager/designee implemented a Quality Assurance audit tool for worn food service equipment and cleanliness of kitchen equipment to be completed weekly x4 then monthly x 3 to extend time frame of areas to be monitored.<br><br>The procedure for implementing the acceptable plan of correction for the specific deficiency cited:<br>All residents have the potential to be affected by the deficient practice of failing to maintain an effective Quality Assessment and Assurance Program.<br>On 1-22-2018 and on 1-23-2018 All members of the Quality Assurance team were in serviced by the Quality Assurance Nurse consultant and Administrator. This includes the Purpose and Responsibility of the Quality Improvement Committee, the Quality Assurance teams□ members, and meeting requirements.<br>Responsibilities: | |

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| F 865 | Continued From page 37 | F 865 | 1. Assuring the activities as directed toward the maintenance of good care and the resolution of problems that have potential for improvement in resident care.<br>2. Assuring that written criteria and or standards of care provided against which the data derived from assessment activities may be measured and problems identified<br>3. Assuring that appropriate actions are implemented to eliminate or reduce identified problems to the greatest degree reasonably possible that any corrective action has been adequate by subsequent monitoring.<br>4. Assuring that the effectiveness of the Facility program is reappraised annually.<br>5. This committee also is responsible for the duties of the Pharmacy committee, medication review committee and the Infection control committee.<br><br>The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.<br><br>Beginning on 1-26-2018 the Administrator will complete a kitchen inspection audit month x 3 to maintain implemented procedures and monitor interventions of an effective Quality Assessment and Assurance program in the area of Food and Nutritional services.<br>The Administrator will review the Monthly audit findings with the Quality Assurance committee to ensure corrective action for | |

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| F 865 | Continued From page 38 | F 865 | trends or ongoing concerns is initiated as appropriate. The Monthly Quality Assurance Meeting is attended by the Director of Nurses, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager Administrator and Medical Director. Deficits that are identified during the monitoring process will be addressed through the facility Quality Assusrance process<br><br>The title of the person responsible for implementing the acceptable plan of correction is the Administrator. | |