STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345195	A. BUILDING _____ B. WING _____	C 06/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGECOMBE HEALTH AND REHAB CENTER	1000 WESTERN BOULEVARD TARBORO, NC 27886

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 06/18/18 through 06/21/18 and an extended survey was conducted on 6/26/18. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tag F689 constituted Substandard Quality of Care.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623		7/25/18

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

Electronically Signed | 07/13/2018

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be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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F 623	Continued From page 2 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge for 5 of 5 residents reviewed for hospitalization. (Resident #116, Resident #63, Resident #94, Resident #83, and Resident #135) Findings included: 1. Resident #116 was admitted to the facility on 9/20/17. His active diagnoses included diabetes	F 623	Please accept this plan of correction as Edgecombe Health and Rehabilitation Center□s credible allegation of compliance for the deficiencies cited. Submission and implementation of this Plan of correction is not an admission the deficiencies exist or that one was cited correctly. The plan of correction is submitted to meet requirements established by Federal and State laws,	

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F 623	Continued From page 3 mellitus, atrial fibrillation, hypertension, anemia, and heart failure. Review of a nurse ' s note dated 5/6/18 revealed Resident #116 was found to have a change in mental status and sent to the hospital for evaluation. Review of Resident #116 ' s chart revealed no written notice of discharge was provided to the resident or resident ' s representative. During an interview on 6/20/18 at 3:57 PM the Social Worker stated she was not aware that the residents, the resident's power of attorney, and ombudsman were to be notified as soon as practicable after an emergency hospitalization in writing. She further stated she did not provided notification in writing to either Resident #116, his responsible party, or the ombudsman following his hospitalization. During an interview on 6/21/18 at 8:51 AM the Administrator stated her expectation was that a written notice of discharge would be provided to residents and resident representatives upon discharge to the hospital. She further stated the facility called the family, document where the resident was going and reason why, and placed that information into the transfer packet, however they were not providing written notice of appeal. 2. Resident #63 was admitted to the facility on 5/2/14. Her active diagnoses included arthritis, depression, and fracture of the right femur. Review of a nurse ' s note dated 4/2/18 revealed the resident sustained a fall and was discharged to the hospital for further evaluation. Review of Resident #63 ' s chart revealed no written notice of discharge was provided to the resident or resident ' s representative. During an interview on 6/20/18 at 3:57 PM the Social Worker stated she was not aware that the	F 623	which requires an acceptable Plan of correction as condition of continued certification. F 623 Notice of transfer/discharge was not completed on resident 116, 63, 94, 83 and 135. Written notification to the Ombudsman was not completed on 116, 63, 94, 83 and 135. Written notice was emailed to the Ombudsman on all transfers/discharges from facility dating back to November 1st, 2017 to include the resident 116, 63, 94, 83, and 135 by the facility social worker on 6/22/18. Written notice was emailed to the Ombudsmen on 7/2/18 by the Social Worker for residents that were discharged/transferred in the month of June 2018. A written notice containing the contents as specified in 483.15 (c) (5) paragraph 3 was implemented on 6/22/18 for residents that are discharged to the hospital to the resident/resident representative. District Director of clinical Services (DDCS) completed inservice with Social Workers, Director of Nursing (DON), Nursing Home Administrator (NHA) and Business office manager on Transfer/Discharge and Ombudsman notification on 6/22/18. The social worker will provide written notice monthly via email to the Ombudsman on all transfers /discharges from the facility for the prior month no later than the 10th of each	

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residents, the resident's power of attorney, and ombudsman were to be notified as soon as practicable after an emergency hospitalization in writing. She further stated she did not provided notification in writing to either Resident #63, her responsible party, or the ombudsman following her hospitalization.
During an interview on 6/21/18 at 8:51 AM the Administrator stated her expectation was that a written notice of discharge would be provided to residents and resident representatives upon discharge to the hospital. She further stated the facility called the family, document where the resident was going and reason why, and placed that information into the transfer packet, however they were not providing written notice of appeal.

3. Resident #94 was transferred to the hospital on 4/15/18 related to fever and chills. A nursing note dated 4/14/18 read, in part, "Resident found shivering from head to toe with several blankets and heat full blast. Temp. (Temperature) 101.2 tympanic. EMS (emergency medical services)."
An additional nursing note dated 4/15/18 at 2:13 PM read, in part, "Resident being admitted to the hospital as reported by resident's (family member)."
A review of the medical record revealed no written notice of transfer was provided to the resident representative.
An interview was conducted on 6/21/18 at 11:00 AM with the Director of Nursing (DON) and Administrator. The DON stated the facility notified the resident representation of Resident #94's transfer to an acute care hospital on the day of transfer (4/15/18), but no written notice was provided. The Administrator her expectation was a written letter needed to be sent to the resident representative for any facility initiated transfer or

month. The social worker and/or business office manager will provide written notice containing the contents as specified in 483.15 (c) (5) paragraph 3 for all residents discharged to the hospital and home as soon as practical once the information becomes available to the resident/resident representative.

The Administrator will be responsible for oversight and review the email that is provided to the Ombudsman prior to the email being sent monthly for three months to ensure that all transfers/discharges are included in the email. This notification will be printed out and maintained as the monitoring tool with the administrator□s notation as reviewed. The results of the review will be discussed at the monthly QAPI meeting for 3 months.

The Administrator will be responsible for oversight and review of the business office weekly audit of any resident that was discharged to the hospital the prior week to ensure the written notification was provided. The Administrator will monitor weekly for four weeks, and then monthly for 2 months. The results of the audits will be reviewed at the monthly QAPI meeting for 3 months.

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discharge.

4. Resident #83 was admitted to the facility on 1/12/12. Her active diagnoses included hypertension, cerebrovascular accident and non-Alzheimer's dementia.
Review of a nurse's note dated 5/1/18 revealed Resident #83 was sent to the hospital for evaluation related to nausea and low blood pressure.
A review of the medical record revealed no written notice of transfer to the hospital was provided to the resident or resident's representative for the resident's transfer to the hospital on 5/1/18.
An interview was conducted on 6/21/18 at 12:44 PM with the Director of Nursing and Administrator. The DON stated the resident representative was notified of the resident's transfer to an acute care hospital on the day of transfer by phone on 5/1/18, but no written notice was provided. The Administrator stated her expectation was a written notice needed to be sent to the resident or resident representative for any facility initiated transfer or discharge.
5. Resident #135 was admitted to the facility on 5/29/18. Her active diagnoses included heart failure, hyperlipidemia, hypertension, asthma, and atrial fibrillation.
Review of a nurse's note dated 6/2/18 revealed the resident was experiencing shortness of breath and was discharged to the hospital for further evaluation.
A review of the medical record revealed no written notice of the resident's transfer to the hospital on 6/2/18 was provided to the resident

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F 623	Continued From page 6 representative. An interview was conducted on 6/21/18 at 12:44 PM with the Director of Nursing and Administrator. The DON stated written notice was provided was not provided to the resident representative for the 6/2/18 transfer. The Administrator stated her expectation was a written notice needed to be sent to the resident or resident representative for any facility initiated transfer or discharge.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the minimum data set (MDS) assessments for 2 of 27 sampled residents: 1. The facility failed to code anxiety as an active diagnosis on a significant change MDS assessment completed for Resident #98. 2. The facility failed to accurately code the behaviors on a significant change MDS completed for Resident #94. Findings included: 1. Resident #98 was admitted to the facility on 10/17/14. Her active diagnoses included dementia, diabetes mellitus, and anxiety. Review of a physician ' s order summary report for Resident #98 signed by the physician on 4/2/18 revealed Resident #98 had an active diagnosis of anxiety. Review of Resident #98 ' s significant change	F 641	Facility failed to code MDS accurately on resident 98 and 94. Resident 98 assessment was modified to reflect accuracy and resident's current status on 6/20/18. Resident 94 assessment was modified to reflect accuracy and resident's current status on 7/11/18. MDS Coordinator and or Social Worker will review comprehensive significant change in status assessments and admission assessments in section I and E completed over the last 30 days. Assessments with errors identified will be corrected as appropriate by the MDS Coordinator/Social Worker. District Director of Care Management inserviced MDS Coordinators, Social	7/25/18

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F 641	Continued From page 7 minimum data set assessment dated 4/27/18 revealed the resident was assessed as having no diagnoses of anxiety in section I question I5700. Review of Resident #98 ' s medication administration record for April 2018 revealed the resident had not received an antianxiety medication during the seven-day lookback period of the minimum data set assessment on 4/27/18. Review of a physician ' s order summary report for Resident #98 signed by the physician on 5/2/18 revealed Resident #98 had an active diagnosis of anxiety. Review of Resident #98 ' s quarterly minimum data set assessment dated 5/18/18 revealed the resident was assessed to have anxiety as a diagnosis in section I question I5700. Review of Resident #98 ' s medication administration record for May 2018 revealed the resident had not received an antianxiety medication during the seven-day lookback period of the minimum data set assessment on 5/18/18. During an interview on 6/20/18 at 11:19 AM MDS Coordinator #1 stated anxiety would only be coded as a diagnosis on a minimum data set assessment if the resident had received an antianxiety medication during the lookback period of seven days prior to the date of the assessment. She stated if the resident had not had an antianxiety medication the diagnosis would not be active and not captured on the minimum data set assessment. She further stated according to the way she performed minimum data set assessment assessments anxiety should not have been documented as an active diagnosis in section I of the quarterly assessment on 5/18/18. During an interview on 6/20/18 at 11:42 AM the Director of Nursing stated it was her expectation that minimum data set assessments accurately	F 641	Workers, DON and NHA on MDS accuracy for section I and E on 7/11/18. The District Director of Care Management is responsible for oversight and monitoring of 5 sample resident's weekly times four weeks and then 5 residents monthly for 2 months to review MDS accuracy of diagnosis coding and wandering. Results of the monitoring will be taken to QAPI.	

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reflect the resident diagnoses. She further stated she was unsure which assessment was inaccurate but the District Clinical Director would know.
During an interview on 6/20/18 at 11:47 AM the District Clinical Director stated it was her expectation the minimum data set assessment on 4/27/18 would have reflected the resident's active diagnoses of anxiety based on the doctor's signature indicating anxiety was an active diagnosis for the month of April 2018.

2. Resident #94 was originally admitted to the facility on 1/23/2004 and re-entered the facility 4/19/18 from an acute care hospital.
Review of the medical record revealed Resident #94 left the facility unsupervised, and without the facility's knowledge, on 4/22/18 and was found at a grocery store approximately 0.2 miles from the facility entrance. When Resident #94 was returned to the facility an alarming bracelet was placed on his left wrist and wheelchair to prevent unsupervised exits from the facility.
Review of a significant change MDS (Minimum Data Set-a tool used for resident assessment) dated 4/26/18 revealed Resident #94 was severely cognitively impaired, had adequate speech, hearing, and vision, was understood and understood others, had inattention and disorganized thinking continuously present, and displayed no moods, behaviors. Wandering was not coded. Activities of daily living (ADLs) required limited assistance for locomotion (movement) on and off the unit, supervision for eating, and extensive assistance for all other ADLs. Resident #94 had 1 upper and 1 lower limb impairment, and used a wheelchair for mobility. Active diagnoses included cerebrovascular accident (CVA), hemiplegia (paralysis on 1 side of

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the body), seizure disorder, anxiety, and depression. The restraints/alarms section of the MDS indicated Resident #94 had a wander/elopement alarm used daily.
Review of care plans initiated 4/23/18 and last revised 4/26/18 revealed the following:
"I am at risk of elopement due to attempt to leave facility." The stated goals included, "My safety will be maintained through the review date."
Interventions included: Check placement of device every shift. Date Initiated: 04/23/2018. Revision on: 04/30/2018. Check placement and function of safety monitoring device every shift. WANDER ALERT: Wanderguard applied."
"I am at risk of elopement due to attempt to leave facility. GOAL: I will not leave facility unattended through the review date."
An interview was conducted with the District Clinical Director on 6/20/18 at 2:00 PM. She stated, "I took the RAI (Resident Assessment Instrument) manual and read it try to give the most valid answer in why the MDS was not coded as wandering. I found the RAI manual reads, in part, "Traveling via a planned course to another specific place for example an activity or the dining room is not considered wandering. On the day he (Resident #94) left the facility grounds we did a root cause analysis and the only difference that day was his family member (FM) had not been coming to visit him after working in the facility daily for years. He told us he was trying to go see his (FM). The most immediate thing to do that day to keep him safe was to put a wandering guard on him. And he agreed. We have reevaluated his (alarming bracelet) every 2 weeks, and he has told us he would leave the facility again. So on the next MDS we will code him as a wanderer. Our minds were focused on his safety, and we have re-evaluated him every 2

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weeks and he has made it clear he will go to the road without the bracelet on, but I really feel his exit was a purposeful, deliberate act to find his (FM).
An interview was conducted with the Social Worker (SW #1) on 6/20/18 10:15 AM. She stated, "He (Resident #94) likes going outside on the back porch, visiting residents and staff throughout the building, and he also loves the therapy department. He can go outside on the back porch with the wandering bracelet on. When he exited in April he was mad at his (FM). She quit unexpectedly a couple of weeks before he exited, and a few weeks later he was hospitalized for a few days. When he came back she (FM) didn't visit him. So he said he left to look for her. He has told me he would leave again. Depending on the day, he's either oriented or confused. He knows the rules, he knows what he is supposed to do and not do. Before April 22nd he'd go on the front porch to make his rounds. The front porch was his 4th or 5th stop. He'd look around and then come back in. He knows the facility. His BIMS (Brief Interview for Mental Status-a tool used to assess cognitive function) have always been low but they fluctuate from a 3 (severely impaired) to a 12 (moderately impaired). I do sections C (cognitive status), D (moods), and E (behaviors, which included wandering) of the MDS. I don't consider what (Resident #94) does wandering. Wandering to me is someone who aimlessly wanders about the facility. We have a wandering bracelet on him because I think he would leave the facility again if we took it off. So I wouldn't expect the MDS to be coded for wandering behaviors. What he did that day in April was purposeful, not wandering."
An interview was conducted on 6/20/18 at 11:25 AM with the Director of Nursing (DON). She

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F 641	Continued From page 11 stated, "(Resident #94's) behavior is typically erratic. It waxes and wanes. He has had a big mood change since his (FM) left employment. It was quick, with no notice. So one day she was here and the next she was gone. He was very close to her. Both (FMs) don't visit often. Her absence has caused him some stressors and he talks to me about it. He said he knew leaving the facility was wrong, and he'd never done it before, but he wanted to get to see (FM). I talked to him about the (alarming bracelet) and he was okay with it. He knew what he was doing that day. He has not exhibited any exit seeking behavior since then, but he has verbalized he would go out in the street without the bracelet on. I would say when he went out that door he had an idea he was going to find (FM). He had a plan and his exit was purposeful. To me now, because he's verbalizing going to the street and he wants the bracelet I think we should code it as wandering."	F 641		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the state mental health authority or state intellectual disability authority for a resident who had a significant change for 1 of 3 residents reviewed for Pre-Admission Screening and Annual Resident Review (PASARR). (Resident #98)	F 646	Facility to failed to notify the state mental health authority on resident #98 for significant change. The social worker submitted PASRR to the state mental health authority after being notified that this had not been	7/25/18

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F 646	Continued From page 12 Findings included: Review of Resident #98 ' s last PASARR Level Determination Notification revealed the last time the Resident #98 was assessed for PASARR was 10/14/14. Resident #98 was admitted to the facility on 10/17/14. Her active diagnoses included dementia, diabetes mellitus, psychosis, depression, and anxiety. The diagnosis of psychosis was documented to be Resident #98 ' s primary diagnosis. Review of a nurse ' s note dated 4/19/2018 revealed a significant change minimum data set assessment was scheduled for 4/27/18 due to Resident #98 ' s overall decline. Resident #98 was documented to be alert, however her mental status had declined. She also exhibited decreased interest in her self-care, transfers, and other activities of daily living. Review of the significant change minimum data set assessment dated 4/27/18 for Resident #98 revealed the resident was not assessed as a PASARR level 2 by the state. She was assessed as moderately cognitively impaired and had little interest in doing things 2 to 6 days of the lookback period. She felt tired or having little energy and poor appetite or over eating 2 to 6 days of the lookback period. She was assessed to have hallucinations and delusions. Her active diagnoses included atrial fibrillation, heart failure, hypertension, diabetes mellitus, hyperlipidemia, arthritis, dementia, depression, and psychotic disorder. She received insulin, antipsychotic, and antidepressant during the look back window of	F 646	completed for resident 98 on 6/21/18. On June 25th, the facility received notification that the resident would remain a Level 1 PASRR. District Director of Care Management completed inservice with MDS Coordinators, Social Workers, Director of Nursing(DON) and Nursing Home Administrator (NHA) on submission of PASRR requirements on 7/11/18. An audit was conducted on 6/22/18 by the social worker on current residents that had a significant change MDS completed since January 1, 2018 to identify the need for submitting a PASRR to the state mental health authority. Any resident identified as needed a PASRR referral was submitted by 7/25/18. Social Worker will ensure every resident that has a significant change MDS initiated and will submit notification to the state mental authority promptly if warranted on residents with: 1. If the individual's physical status changes significantly, such that his/her intellectual or developmental disability needs are more likely to respond to treatment. 2. If a serious mental illness or Intellectual or Developmental Disabilities/ related condition was not discovered at the preadmission screen, and that condition later emerged or was discovered.	

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F 646	Continued From page 13 the assessment. Review of Resident #98 ' s care plan dated 5/21/18 revealed Resident #98 was care planned for being on the psychiatric case load due to depression, anxiety, and psychosis. The interventions included to consult with Social Services and Psychiatric Service, and encourage her to get out of bed and attend activities. During an interview on 6/20/18 at 2:13 PM the Social Worker stated she was responsible for PASARR referrals since February or March of 2018. She stated new PASARR referrals were to be done upon resident admission, when a resident had a significant change, and development of a new psychiatric diagnosis. She further stated Resident #98's last PASARR referral was on 10/14/14. She stated because the resident ' s significant change was related to a mental status decline and not include behaviors she did not feel it was necessary to perform a PASARR referral. During an interview on 6/20/18 at 3:04 PM the Administrator stated that if there was a significant change related to mental status and dementia was not the resident ' s primary diagnosis, it was her expectation that a PASARR referral would occur.	F 646	3. If an individual has been previously screened for the PASRR population, begins to exhibit increased symptoms or behavioral problems. The District Director of Care Management will be responsible for oversight review and monitoring weekly for one month then monthly for 2 months any resident that a significant change was identified with review of the submitted PASRR if warranted. Results of the monitoring will be reviewed at the monthly QAPI for 3 months.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		7/25/18

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F 658	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to avoid a conflict of interest when 1 of 1 residents' (Resident #94) family member completed a resident assessment for the Minimum Data Set (a tool used for resident assessment) and revised Resident #94's care plan. Findings included: Resident #94 was originally admitted to the facility on 1/23/2004 with diagnoses which included cerebral infarction due to unspecified occlusion or stenosis unspecified cerebral artery, hemiplegia (paralysis on one side of the body) following cerebrovascular disease, and muscle weakness. Review of a quarterly Minimum Data Set (MDS) dated 1/16/18 revealed Resident #94 was severely cognitively impaired, had adequate speech, hearing, and vision, was understood and understood others, had inattention and disorganized thinking continuously present, and displayed no moods, behaviors, or wandering. Rejection of care was present 1-3 out of 7 days and had no acute changes in his mental status. Activities of daily living (ADLs) required limited assistance for locomotion (movement) on and off the unit, supervision for eating, and extensive assistance for all other ADLs. Resident #94 had 1 upper and 1 lower limb impairment, and used a wheelchair for mobility. Active diagnoses included cerebrovascular accident (CVA), hemiplegia (paralysis on 1 side of the body), seizure disorder, anxiety, and depression. Review of a quarterly MDS dated 5/29/17 revealed the RN (Registered Nurse) Assessment Coordinator Attestation of Completion was signed by the former Resident Care Manager Director (RCMD) who was a relative of Resident #94.	F 658	Facility was unaware of the conflict of interest when resident #94 family member completed a resident assessment for the MDS and revised Resident #94□s care plan. Resident #94 family member no longer works at the facility. Per family member employee file there was no evidence of voiced concerns of conflict of interest to supervisor or Compliance Officer. Per employee file written acknowledgment indicated this employee was in-serviced on code of conduct/conflict of interest 2016 and 2017 and was not employed during the 2018 education. The code of conduct under conflict of interest does state if an employee has any doubt about a conflict of interest they should disclose the situation to their supervisor or Compliance Officer. Nursing home Administrator and/ or Director of Staff Development completed re-education of current staff to include Nursing staff, Therapy and Department Managers and Assistants on Code of Conduct/Conflict of Interest by 7/25/18 . This education will continue to be part of new employees□ orientation. Nursing Home Administrator will be responsible for oversight and will monitor for conflict of interest concerns by asking 5 random employees each week for four weeks, then 5 random employees monthly for 2 months to validate their	

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F 658	Continued From page 15 Review of a 5 day MDS dated 6/14/17 revealed the former RCMD completed an assessment of Resident #94. Review of a significant change MDS dated 7/19/17 revealed the RN Assessment Coordinator Attestation of Completion was signed by the former RCMD. Review of a quarterly MDS dated 10/17/17 revealed the RN Assessment Coordinator Attestation of Completion was signed by the former RCMD. Review of a 14 day MDS dated 12/29/17 revealed the RN Assessment Coordinator Attestation of Completion was signed by the former RCMD. A review of care plans, resolved and current, revealed revisions were completed by Resident #94's family member on 8/7/17 and 10/5/17. An interview was conducted on 6/23/18 at 10:00 AM with the former RCMD. She stated she supervised the MDS Coordinators, but there were times she completed MDS assessments. She stated she had the other MDS Coordinators complete Resident #94's assessments and care plans "most of the time, but not 100 percent of the time." She also stated, "There were times I had to complete (Resident #94's) care plans and assessments. But I tried not to because I didn't want there to appear to be a conflict of interest." She stated as the RCMD her duties included care plan meetings with families and paperwork like billing. She stated she was not aware if the facility had a conflict of interest policy. An interview was conducted with MDS Nurse #1 on 6/23/18 at 10:38 AM. She stated there were 2 MDS Coordinators and 1 Supervisor titled Resident Care Manager Director (RCMD). She also stated the RCMD completed some care plans and MDS and the former RCMD was no exception. She stated the former RCMD	F 658	understanding of the Code of conflict/conflict of interest and inquire if they have any such concerns during the inquiry. The results will be taken to QAPI for 3 months.	

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F 658	Continued From page 16 completed a resident assessment on Resident #94 in June of 2017. She also stated the system stamped "revision by" and the name of the person who revised the care plan only if that particular person actually revised something and not just looked at the care plan. An interview was conducted on 6/23/18 at 11:02 AM with the Administrator and Director of Nursing (DON). The Administrator stated the facility Code of Conduct book has a section related to conflict of interest which directed employees to report any questioned conflict of interest to their supervisor or compliance officer. The Code of Conduct was reviewed at hire and annually and the DON stated she had not recalled any concerns related to conflict of interest voiced by the former RCMD. The Administrator stated there were numerous current employees whose family members resided in the facility and there were never concerns related to conflicts of interest voiced until now. The DON also stated she had no recollection of assessments or MDS for Resident #94 being completed by the former RCMD.	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews with staff, residents, family members of	F 689	Past noncompliance: no plan of correction required.	7/13/18

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dependent residents, and the facility physician, the facility failed to provide supervision to prevent 1 of 1 sampled residents (Resident #94) from leaving facility property unaccompanied and had no knowledge of Resident #94's whereabouts until family members notified the facility Resident #94 was off the property at a grocery store located 0.2 miles from the facility entrance. No injuries were assessed after Resident #94 was brought back to the facility by staff.

Findings included:

Resident #94 was originally admitted to the facility on 1/23/2004 and re-entered the facility 4/19/18 from an acute care hospital. Review of a quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 1/16/18 revealed Resident #94 was severely cognitively impaired, had adequate speech, hearing, and vision, was understood and understood others, had inattention and disorganized thinking continuously present, and displayed no moods, behaviors, or wandering. Rejection of care was present 1-3 out of 7 days and had no acute changes in his mental status. Activities of daily living (ADLs) required limited assistance for locomotion (movement) on and off the unit, supervision for eating, and extensive assistance for all other ADLs. Resident #94 had 1 upper and 1 lower limb impairment, and used a wheelchair for mobility. Active diagnoses included cerebrovascular accident (CVA), hemiplegia (paralysis on 1 side of the body), seizure disorder, anxiety, and depression. Resident #94 received anti-anxiety and anti-depressant medications 7 out of 7 days during the look back period.

A care plan, last updated 1/5/18, focused on Resident #94's high risk for falls related to (r/t) impulsive behavior and non-compliance with safety precautions. The goal was no fall or related

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injuries, and interventions included, but were not limited to, continued resident education r/t calls for assistance. No interventions related to supervision were included.
Review of a behavioral health consult dated 1/30/18 revealed Resident #94 had "recent baseline, progressive decline in overall function/cognition," and had fair to poor insight and judgment.
A care plan last updated 2/25/18 had a stated focus "Adjustment issues, anxiety disorder." Goals included (monitor) adverse reactions r/t anti-anxiety therapy. Interventions included, but were not limited to, "monitor for side effects. Anti-anxiety medications-confusion. Observe the resident for safety. The resident is taking anti-anxiety meds (medications) which are associated with an increased risk of confusion, amnesia, and cognitive impairment that looks like dementia. Observe/record occurrence of for target behavior symptoms pacing, wandering, inappropriate response to verbal communication." No other interventions r/t supervision were included.
A care plan last updated 3/1/18 read, in part, "I have a serious mental illness (major depressive disorder) recurrent, severe with psychotic symptoms." The stated goal was to maintain the highest functional and psychological potential and prevent avoidable decline. Interventions included, but were not limited to, observation for behavioral or condition changes. No interventions r/t supervision were included.
Review of a behavioral health consult dated 3/27/18 revealed Resident #94 presented with increased anxiety and reported his (FM) no longer worked in the facility. His mood was assessed as "anxious", and his insight and judgment were listed as fair to poor.

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Multiple attempts were made throughout the day on 6/26/18 to conduct an interview with the Nurse Practitioner who completed the behavioral health consults on Resident #94, but the Nurse Practitioner could not be reached for interview.
Review of a Brief Interview for Mental Status Assessment (an assessment tool used to establish cognitive impairment) dated 4/20/18 revealed Resident #94 was severely cognitively impaired.
Review of the medical record revealed Resident #94 had been in bed on 4/22/18 (the day he left the facility property) at 11:12 AM. An additional nursing note on 4/22/18 at 1:33 PM read, in part, "Resident went outside per his normal and customary routine. On this day resident rolled his wheelchair to (grocery store) which is situated to the left of the facility. A friend of his (FM) saw him in the parking lot and phoned his (FM). His (FM) alerted us via phone."
Review of a facility incident report dated 4/22/18 and subsequent investigation dated 4/23/18 read, in part, "Resident is alert and verbal and able to make his needs known. Thorough (throughout) his long stay in the facility (he was originally admitted 1/23/2004) he has always sat outside for short periods of time without direct supervision without incident. BIMS (Brief Interview for Mental Status-an assessment tool used to determine cognitive status) has fluctuated between 2 (severely cognitively impaired) and 11 (moderately impaired). The most recent assessment on 4/20/18 a score of 7 (severe cognitive impairment). Resident's family does assist him at times to sit (out) and enjoy the weather. In fact, he was observed 4/21/18 (the day before he left the property) outside by the Administrator. He was observed rolling to end of walkway and returned to the porch. On 4/22/18

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resident did go into the parking lot at the (grocery store) which is located beside the center. Observed by a friend of the family and they called the family but did not stay with resident. (FM) called the facility and staff went to the parking lot and assisted the resident back in the facility." The investigation report also revealed Resident #94 was last seen inside the facility at 11:55 AM and the facility received a phone call for the FM at 12:15 PM.

An observation of the grocery store parking lot, where Resident #94 was found in his wheel chair, was made on 6/18/18 at 9:45 AM. The grocery store parking lot was paved with black asphalt. Surfaces were observed to be predominantly smooth with some areas to be uneven and cracked. No speed limits were posted, and no stop signs were observed. The front of the grocery store was 0.2 miles from the facility entrance.

An interview was attempted and an observation was made of Resident #94 on 6/18/18 at 11:00 AM. He was not able to appropriately answer questions r/t his supervision needs.

An interview was conducted with resident #94's FM on 6/18/18 at 2:39 PM. She stated Resident #94 had not left the property before, but was not cognitively aware enough to be outside unsupervised and was concerned the facility had not known Resident #94 had left the property on 4/22/18.

An additional observation and interview was conducted with Resident #94 on 6/19/18 at 3:00 PM. The resident was in bed and stated he had been able to go outside by himself until the day he left the property to look for his (FM) who used to work at the facility. He stated, "I was looking for my (FM). She used to work here. I was on the side of the store where my (FM) lives. I was angry

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so I went to look for her. "
An interview was conducted on 6/19/18 at 3:15 PM with a nursing assistant (NA #1) who typically cared for resident #94. He stated Resident #94 displayed inappropriate behaviors. He stated Resident #94 requested to get out of bed, then requested to get back into bed 5 minutes later. He also stated if his needs were not immediately met he became agitated and his mental status would change. He stated he had no recall of Resident #94 ever being supervised inside or outside the facility.
An interview was conducted with Nurse #1 on 6/19/18 at 3:35 PM. She stated Resident #94 was non-compliant and compulsive at times. She also stated a (FM) used to work at the facility, but when she left Resident #94 became upset and his anger and behaviors increased r/t a lack of FM visits. Nurse #1 also stated when Resident #94 was returned to the facility by staff on 4/22/18 he had verbalized he was looking for his FM when he left the facility property. She also stated he had not had any supervision while outside the front of the facility prior to 4/22/18.
An interview was conducted on 6/20/18 at 9:45 AM with the facility Medical Director (MD). He stated Resident #94 had childlike behaviors and juvenile impulse control. He also stated Resident #94 knew right from wrong and was angered after his (FM) abruptly left the employ of the facility. The MD also stated he believed Resident #94 would leave the facility property again without supervision, so the facility placed an alarming bracelet on his wrist and wheelchair. He was not aware of any other supervision interventions.
An interview was conducted with the Social Worker (SW #1) on 6/20/18 at 10:15 AM. She stated when resident #94 left the facility property on 4/22/18 he was angry at his (FM). She stated

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the FM had abruptly stopped work at the facility "a couple of weeks" before he left (4/22/18) and had not visited him after he re-entered the facility (4/19/18) from the hospital. She also stated his cognition and mental status fluctuated, he was manipulative at times, was attention seeking, and childlike in his behaviors. The facility had not provided any supervision prior to the day Resident #94 left the facility property, and placed an alarming bracelet on his wrist and wheelchair after he was returned to the facility on 4/22/18. She had not included any other interventions r/t supervision.

An interview was conducted on 6/21/18 at 11:25 AM with the Administrator and Director of Nursing (DON). The Administrator stated Resident #94 had never gone further than the end of the walkway before. She stated he had always turned around and returned to the facility when he reached the end of the walkway. She stated this had been his "usual and customary routine" until the day he was angry with his FM and left the facility property (4/22/18). On the day he left (4/22/18) he had not told anyone he was going further than the end of the walkway. When staff were called and told Resident #94 was seated in his wheelchair at the grocery store staff went to the grocery store and returned Resident #94 to the facility. Resident #94 told staff he was looking for his (FM) who used to work at the facility. The Administrator also stated Resident #94 was childlike in his thinking and behavior. The DON stated Resident #94 typically had erratic behavior, like a child, and she was "very close" to him. She also stated she had worked with him since his admission in 2004 and he had a big mood change since his (FM) abruptly stopped working at the facility at the end of March 2018.

On 6/26/18, the facility provided the following

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	345195	A. BUILDING _____ B. WING _____	C 06/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGECOMBE HEALTH AND REHAB CENTER	1000 WESTERN BOULEVARD TARBORO, NC 27886

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Allegation of Compliance (AOC) with a compliance date of 4/27/18:
Allegation of compliance
1. On 4/22/18 at approximately 12:00 pm Resident #94 exited the facility via the front door onto the porch in his usual and customary manner. The front door opens automatically unless it is diverted by a Wander guard signal. Resident #94 propels himself in his wheelchair without assistance.
At approximately 12:15pm Nurse #1 received a call from Resident #94's Responsible Party, stating that a friend saw Resident #94 seated in his wheelchair in the parking lot of the grocery store adjacent to the facility. Resident #94 had explained to the friend that he was looking for his sister.
Nurse #1 and the Unit Secretary immediately went to the grocery store parking lot and assisted Resident #94 back in the facility.
Nurse #1 completed a head to toe assessment of Resident #94, after returning to the facility, with no signs of injury noted. Resident #1 explained to Nurse #1 and Nurse Supervisor #2 that he was looking for his sister.
The Administrator (NHA) and the Director of Nursing (DON) were informed by Nurse #1 at 12:30 pm.
The NHA contacted the responsible party for Resident #94 at approximately 12:53 pm to alert her that Resident #94 was returned to the facility without any evidence of injury. The NHA discussed the initiation of a Wander guard with the responsible party as an immediate intervention, as well as, supervised visits outside going forward. Nurse #1 and the Nurse Supervisor #2 explained the use of the Wander guard to Resident #94 and he was agreeable.
Nurse #1 notified the on call physician and

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received new orders for Wander guard placement at 2:00 pm on 4/22/18. Resident #94 was continuously monitored by Nurse #1 until the Wander guard was placed.
Resident #94 was previously assessed as no risk for elopement on every prior assessment with the most recent one with assessment date of 4/19/18. He has resided in this facility for over 14 years and part of his daily routine has included safely sitting on the front porch unsupervised without any attempts to leave or without ever expressing any desire to leave the facility. He had a BIMS of 7 most recently assessed on 4/20/18 by the Social Worker.
On 4/22/18 Nurse #2 completed a new elopement assessment now identifying Resident #94 at risk for elopement based on this event. Nurse #1 placed a Wander guard on the left wrist of Resident #94, initiated ongoing monitoring of the device and updated the care plan to reflect this new behavior of wandering. Resident #94 is offered and upon request to sit on the porch supervised by facility staff.
An incident report was completed by Nurse #1 on 4/22/18.
The interdisciplinary team (IDT) which included the NHA, DON, Medical Director, District Director of Clinical Services, Social Worker, Assistant Director of Nursing, MDS Nurse, Activities Director, Wing Nurse Manager, Business Office Director, Housekeeping Supervisor, and Rehab (Rehabilitation) Manager met on 4/23/18 and 4/24/18 to conduct a root cause analysis of the events surrounding Resident #94 exiting the facility's front porch without supervision on 4/22/18. The IDT determined that Resident #94 had no prior history of wandering or exit seeking behaviors, expressing a desire to leave the facility, or exhibiting behaviors that would indicate

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poor decision making related to remaining safe on the facility grounds. It was determined, a recent change of condition/circumstances reduced the daily visitation routines of Resident #94's Responsible Party and negatively affected his decision making ability. Resident #94 acknowledged , during an interview with the Social Worker on 4/24/18 that he had feelings of anger towards his family, that they had "dumped him" at the facility and this made him do "crazy things". He again acknowledged that he was looking for his sister. Resident #94 has ongoing Psych Services. The Social Services Director continued to provide ongoing emotional support as well.

2. On 4/22/18 Nurse #2 completed a head count to validate the safe location of all current residents.

Nurse #2 verified on 4/22/18 that the current residents with Wander guards were in place and functioning properly.

Nurse #2 validated the elopement book was current with accurate information for residents at risk for elopement.

An audit was completed by the Social Worker on 4/23/18 to ensure that all residents had an accurate elopement risk assessment completed within the last quarter.

The Social Worker and DON reviewed current residents to determine those with a change of condition/circumstance during the last 30 days who exhibit severe cognitive impairment with a BIMS of 7 or lower. The current elopement assessments for these residents were reviewed for accuracy. No other residents were identified at an increased risk for elopement based on this review. This review was completed on 4/23/18.

The Social Worker used the Assessment Scoring report, which pulls the most recent completed

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BIMS for current residents, to review the facility's current BIMS interviews and overall cognition to ensure residents who could be at risk for elopement had measures in place on 4/23/18 to keep them safe.
The Social Worker validated that residents at risk for elopement were care planned on 4/23/18.
The Maintenance Director painted stop signs on the cement at the end of the front porch walkways that lead into the parking lot to define boundaries on 4/27/18 as additional reminders for the residents that sit out front.
The Activity Director offers at least 2 outside activities per week, weather permitting, for residents who require supervision to be outside the facility.
On 4/22/18 the Wing Nurse Manager initiated re-education with current facility staff regarding the facility policy for elopement, changes in resident condition, and the abuse and neglect policy. The Staff Development Coordinator, NHA, Wing Nurse Managers, and DON continued with the education. No staff shall work after 4/27/18 before receiving this education. This education has been added to the Facility Orientation program for all new hires to be completed prior to beginning work after 4/27/18.
3. The DON, Nurse Managers and Social Worker will review new admissions and readmissions and review the 24 hour report and the clinical dashboard during the Clinical Morning Meeting 5x weekly to identify residents with a change of condition/circumstance and validate accurate elopement assessments, interventions and care plans are initiated.
The Social worker will review current residents assessed at risk for elopement monthly to validate accurate assessments and care plans.
The LNHA is responsible for the completion of

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F 689	Continued From page 27 this credible allegation. Date of compliance: 4/27/18 Validation of the above referenced AOC was completed on 6/26/18 during an extended survey. Validation included staff interviews r/t supervision of residents at risk for accidents/wandering, observations of the functional alarming bracelet system used by the facility and included review of the maintenance logs for April, May, and June, review of updated care plans for residents who required supervision to prevent wandering away from facility property, review of the in-services received by all staff on or before 4/27/18, and the monitoring which occurred 5 times weekly, and continued monthly as stated in the AOC.	F 689		