STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	**24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001**

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F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 8/20/18 - 8/23/18. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 6/13/18 and was removed on 8/23/18. An extended survey was conducted.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free	F 604		9/24/18

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

Electronically Signed | 09/06/2018

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F 604	Continued From page 1 from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to specify the medical symptom to be treated with the use of a physical restraint and facility failed to assess for the least restrictive physical restraint for 3 (Resident #55, Resident #53 and Resident #8) of 3 residents reviewed for physical restraints. The findings included: 1. Resident #55 was admitted 6/26/16 with cumulative diagnoses of anxiety, dementia and Parkinson's Disease. Review of Resident #55's cumulative physician orders indicated an order dated 1/5/18 for thigh restraint at all times when in Broda Chair (high-back wheel chair with tilt-in space capability) for safety. Release every two hours, at meals and PRN (as needed). The order did not include the medical symptom to be treated with the use of the restraint. There was no documented evidence of an assessment for the least restrictive physical restraint. Review of a progress note dated 4/24/18 read Resident #55 had been without his thigh restraint for the past four days and tolerated well. The	F 604	F 604: Restraints Plan for correcting the specific deficiency and process that lead to the deficiency: The facility failed to assess for the least restrictive physical restraint and failed to specify the medical symptom to be treated with the use of a physical restraint. Resident #8 was assessed by the facility supervisor and the lap belt was discontinued 8-21-18 because there was no indication or medical symptom to continue the use of restraint. Resident #53 was assessed by the facility supervisor 9-7-18 for the need for a thigh restraint and the thigh restraint was discontinued 9-7-18 because there was no indication or medical symptom to continue the use of the restraint. Resident # 55 was assessed by the facility supervisor 9-6-18 for the need for a thigh restraint and the thigh restraint was discontinued 9-6-18 because there was no indication or medical symptom to continue the use of the restraint.	

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F 604	Continued From page 2 thigh restraint was discontinued. Review of a Care Conference Note dated 4/24/18 read restraints were discontinued since no longer needed. Review of an incident report dated 4/25/18 at 11:55 PM read Resident #55 was lowered to the floor by staff. He had been sitting in his Broda Chair in the parlor near the nurses' station. He stood and attempted to ambulate. He sustained one skin tear. Review of an incident report dated 4/26/18 at 3:14 PM read Resident #55 was observed on the floor in front of his Broda Chair near the parlor area. He sustained a skin tear. He was placed in his Broda Chair in the reclining position. Review of Resident #55's cumulative physician orders indicated new orders for the thigh restraint dated 4/27/18. There was no documented evidence of medical symptom for the thigh restraint or assessment for the least restrictive physical restraint. Resident #55 was care planned for the use of a thigh restraint on 4/30/18. Interventions included trial restraint free periods, thigh restraint when up in the Broda Chair, release during care, at meals and approximately every two hours. Review of Resident #55's quarterly Minimum Data Set (MDS) dated 8/1/18 indicated severe cognitive impairment and he was coded for rejection of care. Resident #55 was coded for extensive assistance with transfers, locomotion, toileting and non-ambulatory. He was coded with no impairments to his lower extremities, unsteady	F 604	All residents in the facility were reviewed for restraints and no other residents in the facility were noted to have a restraints or restraint orders. This review was completed by the Director of Nursing on 9-7-2018. Procedure for implementing the acceptable plan of correction: Prior to restraint placement residents will be assessed for restraint appropriateness by a licensed nurse. Interventions of other restraint alternatives will be attempted and documented prior to restraint placement. A physician order will be obtained prior to restraint placement. The initial restraint assessment will be completed by the attending hall licensed nurse. Quarterly, significant change, and as needed restraint assessments will be completed by the MDS nurse or Facility Care Coordinator. Director of Nursing, Staff Development Coordinator, Nursing Supervisor and Minimum Data Set Coordinator will be responsible for in-servicing all licensed nursing staff, PRN (as needed), part time and full time regarding state regulation that ensures residents are free from physical or chemical restraints imposed for purposes of discipline or convenience that are not required to treat the resident□s medical symptoms. In-service education will be completed by 9/20/2018 to all licensed nursing staff PRN (as needed), Part-Time and Full time prior to	

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F 604	Continued From page 3 with walking, turning around and surface to surface transfers. Resident #55 was coded for a trunk restraint. In an observation on 8/21/18 at 1:43PM, Resident #55 was sitting asleep in his Broda Chair with a thigh restraint around his lower abdomen and extending in down in between his legs and buckled in the back of his chair preventing him from standing. Nursing Assistant (NA) #11 stated he has had the thigh restraint for as long as she was aware. NA #11 stated it was to be unbuckled during meals and with incontinence care as needed. In an interview on 8/21/18 at 2:00 PM, the Facility Care Coordinator (FCC) stated she completed the MDS and care plan for Resident #55. She stated it was the responsibility of the staff nurse or Unit Manager to call and obtain physician orders with medical symptom for the use of any physical restraint. She stated she was not aware that an assessment was needed to determine the least restrictive physical device prior to initiating the restraint. FCC stated she documented a progress note quarterly about the continued need for the thigh restraint but did not complete an assessment to determine if Resident #55 was ordered the least restrictive physical restraint. Review of a Progress Note dated 8/21/18 read thigh restraint was to be continued but there was no documentation regarding the medical symptom to be treated with the use of a physical restraint or assessment until 8/21/18 at 7:22 PM	F 604	taking an assignment. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected: The Director of Nursing or Staff Development RN will review residents who have orders for restraints to ensure that residents have appropriate documentation, including medical symptom being treated and assessment for least restrictive device. These reviews by the Director of Nursing or Staff Development RN will occur weekly times 12 weeks, biweekly times 8 weeks, then monthly until three months of compliance is sustained. The outcomes will be reported monthly at the Quality Assurance meeting by the Director of Nursing or Staff Development Coordinator. The title of the person responsible for implementing the acceptable plan of correction: Director of Nursing Corrective action will be completed by 9-24-2018.	

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F 604	Continued From page 4	F 604		

In an interview on 8/22/18 at 2:00 PM, NA #8 stated Resident #55 does not attempt to stand unassisted from his Broda Chair. She stated he sleeps most of the time.

In an interview on 8/22/18 at 2:52 PM, the Medical Director stated he was not aware that the use of restraints required a medical symptom for the use of a physical restraint. He stated physical restraints were used to prevent falls.

In an observation on 8/23/18 at 8:29 AM, Resident #55 was sitting at the table with his thigh restraint unbuckled. Staff were prompting him to eat.

In an interview on 8/23/18 at 8:30 AM, Unit Manager (UM) #1 stated restraint reductions had failed in the past and that Resident #55 continued to try and get up unassisted. He stated Resident #55 was unpredictable and would sleep for days then be awake for days. UM #1 stated restraints were implemented by the Interdisciplinary Team (IDT) after the Physician gave the order. He stated he was not aware of the need for a medical symptom to use physical restraints. He stated it was the responsibility of the FCC to complete the assessment for the least restrictive physical restraint.

In a second interview on 8/23/18 at 10:09 AM, the FCC stated she completed Resident #55's an assessment for the least restrictive physical restraint for Resident #55 on 8/22/18.

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F 604	Continued From page 5 In an interview on 8/23/18 at 2:39 PM, the Administrator stated it was her expectation that the facility obtained a medical symptom for the physical restraint and assess for the least restrictive physical restraint. 2. Resident #53 was admitted on 4/9/15 with cumulative diagnoses of Vascular Dementia and Anxiety. Review of an incident report dated 2/9/18 at 10:50 PM revealed, Resident #53 was lying on the floor in another resident's room. She was in her wheel chair prior to the fall. She complained of left hip pain. She was sent to the hospital and diagnosed with a left closed femur fracture. She had disabled her chair alarm and removed her self-releasing seat belt. She was discharged back to the facility on 2/15/18. Resident #53 was seen by Occupational Therapy starting on 2/16/18 and was discharged from services on 3/9/18 having reached her maximum potential. She was discharged using a Broda Chair (high-back wheel chair with tilt-in space capability). Review of Resident #53's cumulative physician orders indicated an order dated 3/9/18 for a thigh restraint to her Broda chair at all times for safety. Release every two hours, during meals and PRN (as needed). The order did not include the medical symptom to be treated with the use of a physical restraint and no documented evidence of an assessment for the least restrictive physical restraint.	F 604		

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F 604	Continued From page 6	F 604		

Review of Resident #53's cumulative orders indicated an order dated 7/16/18 for a Seat Belt to her Broda chair at all times for safety. (This was not a self-releasing seat belt). Release every two hours, during meals and PRN. The order did not include the medical symptom to be treated with the use of a physical restraint and no documented evidence of an assessment for the least restrictive physical restraint until 8/21/18 at 8:20 PM.

Review of Resident #53's last revised care plan dated 7/16/18 read she had a seat belt. Interventions included trial restraint free periods, monitor for proper use of the seat belt, release during care, at meals and approximately every two hours. Review of the undated CNA Guideline for Daily Care reflected the use of a seat belt restraint when up in the Broda Chair.

Resident #53's quarterly Minimum Data Set (MDS) dated 8/1/18 indicated severe cognitive impairment and she was coded for rejection of care. Resident #53 was coded for extensive assistance with transfers, locomotion, toileting and non-ambulatory. She was coded with no impairments to his lower extremities and unsteady with surface to surface transfers. Resident #53 was coded for a trunk restraint.

In an observation on 8/20/18 2:20 PM, Resident #53 was sitting up the Broda Chair in the parlor near the nurses' station. She was observed with a padded seat belt around her abdomen. The seat belt was buckled in the back of the chair.

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In an interview on 8/21/18 at 2:00 PM, the Facility Care Coordinator (FCC) stated she completed the MDS and care plan for Resident #53. She stated she was not aware that an assessment was needed to determine the least restrictive physical device prior to initiating the restraint. FCC stated she documented a progress note quarterly about the continued need for the seat belt restraint but did not complete an assessment to determine if Resident #53 was ordered the least restrictive physical restraint.

In an interview on 8/22/18 at 8:41 AM, Nursing Assistant (NA) #12 stated Resident #53 no longer attempts to get up from her bed or Broda Chair unassisted.

In an observation on 8/22/18 at 8:45 AM, Resident #53 was asleep in bed with NA #13 attempting to feed her breakfast. NA #13 stated Resident #53 still attempted to get up unassisted and the seat belt was removed at meals and if she was sleeping and staff were around to watch her. She stated she had not observed Resident #53 attempting to slid under or climb over the seat belt on her Broda Chair.

In an interview on 8/22/18 at 2:00, NA #8 stated Resident #53 does attempt to stand while in the Broda Chair if her seat belt was not buckled but that she is easily redirected.

In an interview on 8/22/18 at 2:52 PM, the Medical Director stated he was not aware that the use of restraints required a medical symptom for use of a physical restraint. He stated physical

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F 604	Continued From page 8 restraints were used to prevent falls. In an interview on 8/23/18 at 8:30 AM, Unit Manager #1 stated Resident #53 would sleep during the day then be awake for days. He stated restraint reductions had failed in the past and that Resident #53 continued to try and get up unassisted. UM #1 stated restraints were implemented by the Interdisciplinary Team (IDT) after the Physician gave the order. He stated he was not aware of the need for a medical symptom to use physical restraints. He stated it was the responsibility of the FCC to complete the assessment for the least restrictive physical restraint. In a second interview on 8/23/18 at 10:09 AM, the FCC stated she completed Resident #53's an assessment for the least restrictive physical restraint on 8/22/18. In an interview on 8/23/18 at 2:39 PM, the Administrator stated it was her expectation that the facility obtained a medical symptom for the physical restraint and assess for the least restrictive physical restraint. 3. Resident # 8 was originally admitted to the facility on 10/12/17 and was readmitted on 1/12/18, 6/1/81 and 8/5/18. He had multiple diagnoses including dementia and history of hip fracture.	F 604		

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Review of Resident #8's readmission physician orders dated 8/5/18 revealed no orders for the use of a physical restraint.

The significant change in status Minimum Data Set (MDS) assessment dated 8/13/18 indicated that Resident #8 had severe cognitive impairment, had a fall prior to admission and had no restraints.

Resident #8's care plan dated 8/13/18 was reviewed. There was no comprehensive care plan developed for restraints.

On 8/20/18 at 2:19 PM, Resident #8 was observed up in wheelchair in his room. He was observed wearing a Velcro type lap belt. When asked to remove the lap belt, Resident #8 was unable to remove the belt on command.

On 8/21/18 at 1:50 PM, Resident #8 was observed up in wheelchair in his room wearing a Velcro type lap belt. The facility's Care Coordinator was observed asking the resident to remove the belt and the resident was unable to undo it.

On 8/21/18 at 1:55 PM, Nurse Aide (NA) #9, assigned to Resident #8, was interviewed. She stated Resident #8 had the lap belt since he was readmitted from the hospital this August 2018. NA #9 indicated that the resident was high risk for falls.

On 8/21/18 at 2:15 PM, Nurse #1, assigned to Resident #8 was interviewed. She stated that Resident #8 had the lap belt since he was readmitted from the hospital in August 2018.

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F 604	Continued From page 10 Nurse #1 stated that the resident was confused and was high risk for falls. On 8/21/18 at 2:20 PM, the Unit Manager (UM) #2 was interviewed. He stated that Resident #8 had the lap belt since June 2018 after his fall. The UM confirmed that there was no restraint assessment nor least restrictive device tried before the lap belt was restarted in August 2018. He added that the resident's family member wanted the lap belt used for resident's safety. On 8/22/18 at 4:10 PM, the MDS Nurse was interviewed. She stated that she was responsible for the restraint assessment. She indicated that a restraint assessment should have been completed prior to the use of the lap belt. The MDS Nurse stated that she was not aware that Resident #8 was using a lap belt until 8/21/18 and therefore there was no restraint assessment completed. The MDS Nurse revealed she had discontinued the lap belt on 8/21/18 because there was no indication or medical symptom that warrant the use of the lap belt. On 8/23/18 at 2:28 PM, the Administrator was interviewed. She stated that she expected the staff to follow the facility's policy on restraints. The policy indicated that the resident should be assessed for the need of the restraint prior to the use of the restraint.	F 604		
F 623 SS=C	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	F 623		9/24/18

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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 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

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F 623	Continued From page 12 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 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.	F 623		

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	345109	A. BUILDING _____ B. WING _____	C 08/23/2018

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F 623	Continued From page 13 §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 ombudsman and staff interview, the facility failed to send a notice to the ombudsman when a resident was transferred or discharged from the facility for 3 (Residents # 8, #9 & #67) of 3 sampled residents reviewed for discharges. Findings included: 1. Resident # 8 was originally admitted to the facility on 10/12/17 and was discharged to the hospital on 7/24/18 and 7/29/18. Review of the social service notes and the nurse's notes revealed that there was no documentation that a notice of discharge was sent to the Ombudsman when Resident #8 was discharged to the hospital. On 8/22/18 at 4:00 PM, the Social Worker (SW) was interviewed. She stated that she didn't know that the facility was supposed to send a notice of discharge to the Ombudsman. On 8/22/18 at 4:02 PM, the Business Office	F 623	F 623: Notice of requirements before transfer/discharge The process that lead to the deficiency: Based on record review the facility failed to send notice to the ombudsman when a resident was transferred or discharged from the facility for three residents. The process of notification of transfer and discharge was not being completed as required. The ombudsman had not received any notifications of transfer discharge notices from facility. The administrator interviewed the social worker who confirmed no transfer discharge notices had been completed. Review of the social service notes and the nurses notes revealed that there was no documentation that a notice of discharge was sent to the ombudsman when resident #8,#67,or #9 was discharged to the hospital. Plans of correcting the deficiency:	

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F 623	Continued From page 14 Manager (BOM) was interviewed. She stated that the Ombudsman was only notified when a resident was given a 30 day notice of discharge. On 8/23/18 at 9:10 AM, the Health Information Specialist (HIS) was interviewed. She stated that she had been the facility's HIS for 2 years and she didn't know that she was supposed to send a notice of discharge or transfer to the Ombudsman. On 8/23/18 at 10:02 AM, the Ombudsman was interviewed. She stated that she had mentioned to the Administrator this summer that she was not getting notification of discharges/transfers from the facility and she still was not receiving any notices from the facility. On 8/23/18 at 9:09 AM, the Administrator was interviewed. She stated that she was aware of the requirement that a notice of discharge/transfer should be sent to the Ombudsman and she expected the Health Information Specialist (HIS) responsible for sending the notification to the Ombudsman. 2. Resident #9 was originally admitted to the facility on 3/24/17 and was discharged to the hospital on 6/2/18. Review of the social service notes and the nurse's notes revealed that there was no documentation that a notice of discharge was sent to the Ombudsman when the resident was discharged to the hospital on 6/2/18. On 8/22/18 at 4:00 PM, the Social Worker (SW) was interviewed. She stated that she didn't know	F 623	The deficiency was corrected by the health information specialist by completing and sending a Discharge Transfer Notice to the ombudsman on 9-5-2018 for the discharge dates 7-24-2018 and 7-29-2018 for resident #8. Discharge notification was documented in resident #8 chart. The health information specialist completed and sent a Discharge Transfer Notice to the ombudsman on 9-5-2018 for resident #67 discharge date of 6-19-2018. Notification was sent to the Ombudsman and documented in #67 medical record. The health information specialist completed and sent a Transfer Discharge Notice to the ombudsman on 9-5-2018 for resident #9 discharge date 6-2-2018. Notation was made in chart of Ombudsman notification. The social worker confirmed that no prior transfer discharge notices had been forwarded to the ombudsman prior to 9-5-2018 for any facility resident. This was also confirmed by the administrator by speaking with the ombudsman on 9-12-2018. Procedure for implementing a the plan of correction: The facility will provide Discharge Transfer Notices to all residents or resident representatives by the health information specialist or health information specialist assistant during transfer or discharge of	

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F 623	Continued From page 15 that the facility was supposed to send a notice of discharge to the Ombudsman. On 8/22/18 at 4:02 PM, the Business Office Manager (BOM) was interviewed. She stated that the Ombudsman was only notified when a resident was given a 30 day notice of discharge. On 8/23/18 at 9:10 AM, the Health Information Specialist (HIS) was interviewed. She stated that she had been the HIS for 2 years and she didn't know that she was supposed to send a notice of discharge or transfer to the Ombudsman. On 8/23/18 at 10:02 AM, the Ombudsman was interviewed. She stated that she had mentioned to the Administrator this summer that she was not getting notification of discharges/transfers from the facility and she still was not receiving any notices from the facility. On 8/23/18 at 9:09 AM, the Administrator was interviewed. She stated that she was aware of the requirement that a notice of discharge/transfer should be sent to the Ombudsman and she expected the Health Information Specialist (HIS) responsible for sending the notification to the Ombudsman. 3. Resident #67 was admitted to the facility on 5/27/18 and discharged on 6/19/18. Review of the social service notes and the nurse's notes revealed that there was no documentation that a notice of discharge was sent to the Ombudsman when Resident #67 was discharged on 6/19/18.	F 623	residents from the facility. The health information specialist or health information assistant will notify the ombudsman weekly by fax of all Transfer Discharge Notices. The Administrator confirmed with ombudsman that transfer discharge notices are now being received weekly 9-12-2018. On 9-5-18, an in-service was conducted by the director of nursing with director of social services, business office manager, and health information specialist regarding Tag F 623: Notice before transfer. The training stated that effective 9-5-18, all residents either discharged or pending discharge/transfer will have documentation in the medical record that notice of discharge was sent to the Ombudsman by the health information specialist or health information specialist assistant. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements: Effective 9-10-18 all discharged residents charts will be audited weekly by the Administrator or Director of Nursing to ensure that discharge documentation is noted in the medical record and that notice of discharge/transfer has been sent to the ombudsman. The weekly audits will continue until three months of compliance has been sustained.	

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F 623	Continued From page 16 On 8/22/18 at 4:00 PM, the Social Worker (SW) was interviewed. She stated that she didn't know that the facility was supposed to send a notice of discharge to the Ombudsman. On 8/22/18 at 4:02 PM, the Business Office Manager (BOM) was interviewed. She stated that the Ombudsman was only notified when a resident was given a 30-day notice of discharge. On 8/23/18 at 9:10 AM, the Health Information Specialist (HIS) was interviewed. She stated that she had been the facility's HIS for 2 years and she didn't know that she was supposed to send a notice of discharge or transfer to the Ombudsman. On 8/23/18 at 10:02 AM, the Ombudsman was interviewed. She stated that she had mentioned to the Administrator this summer that she was not getting notification of discharges/transfers from the facility and she still was not receiving any notices from the facility. On 8/23/18 at 9:09 AM, the Administrator was interviewed. She stated that she was aware of the requirement that a notice of discharge/transfer should be sent to the Ombudsman and she expected the Health Information Specialist (HIS) responsible for sending the notification to the Ombudsman.	F 623	This information will be reported at monthly quality assurance performance improvement meetings by the health information specialist. Title of person responsible for implementing the plan of correction: Health Information Specialist Corrective action will be completed by 9-24-2018.	
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.	F 641		9/24/18

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F 641	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the admission Minimum Data Set (MDS) and quarterly MDS for 1 (Resident #15) of 1 reviewed for hospice services and failed to accurately code the quarterly MDS for 1 (Resident #30) of 5 residents reviewed for unnecessary medications. The findings included: 1. Resident #15 was admitted on 1/4/18 with a diagnosis of Alzheimer's Disease. Review of Resident #15's admission orders dated 1/4/18 indicated she was admitted to the facility on hospice services. Review of Resident #15's admission MDS dated 1/10/18 indicated a prognosis of less than 6 months but she was not coded as receiving hospice services. Review of Resident #15's quarterly MDS dated 4/11/18 indicated a prognosis of less than 6 months but she was not coded as receiving hospices services. Review of Resident #15's care plan last revised on 7/29/18 read she was care planned for hospice services on 5/11/18. In an interview on 8/21/18 at 2:42 PM, with the Facility Care Coordinator (FCC) stated she was responsible for Long Term Care MDS and care plans. FCC confirmed the error in the hospice coding for Resident #15 on the resident's admission MDS dated 1/10/18 and quarterly MDS dated 4/11/18. She stated she added the hospice	F 641	F 641 Accuracy of assessments The process that lead to the deficiency and plans to correct the deficiency: The facility failed to accurately code the admission minimum data set and quarterly minimum data set for resident #15 for hospice services and failed to accurately code the quarterly minimum data set for resident #30 for unnecessary medications. This was determined to be a clerical oversight when inputting data into the MDS. Resident # 15 minimum data set assessment was corrected to accurately reflect hospice services and submitted by the facility care coordinator nurse on 8-21-2018. Validation was received. Resident # 30 s minimum data set assessment was corrected by the facility care coordinator nurse to accurately reflect the correct number of days that insulin injections were received and submitted on 9-3-2018. Validation was received. The procedure for implementing the acceptable plan of correction: The Facility Care Coordinator nurse reviewed minimum data set assessments for all residents receiving Hospice services to ensure that the minimum data set assessments were accurately coded.	

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F 641	Continued From page 18 care plan on 5/11/18. In an interview on 8/23/18 at 2:31 PM, the Administrator stated it was her expectation that the admission MDS dated 1/10/18 and the quarterly MDS dated 4/11/18 would have been coded accurately. She further stated it was her expectation that when the error was noted, a correction MDS should have been submitted. 2. Resident #30 was admitted to the facility on 4/14/18 with diagnoses that included diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated 7/4/18 indicated Resident #30's cognition was severely impaired and he had an active diagnosis of diabetes mellitus. Section N, the Medications Section, indicated Resident #30 had received injections (of any type) on 6 of 7 days and insulin injections on 6 of 7 days during the MDS review period (6/28/18 through 7/4/18). Section N of Resident #30 ' s 7/4/18 MDS was completed by the Facility Care Coordinator (FCC). A review of the Medication Administration Records (MARs) for Resident #30 during the 7/4/18 MDS review period (6/28/18 through 7/4/18) indicated he received Humalog (insulin) injection on 5 of 7 days (6/28, 6/29, 6/30, 7/2, and 7/3). This MAR indicated Resident #30 received no other injections during the 7/4/18 MDS review period. An interview was conducted with the FCC on 8/21/18 at 1:30 PM. Section N of the MDS dated	F 641	The results of the review indicated residents receiving Hospice services were accurately coded on the MDS. The Facility Care Coordinator nurse reviewed minimum data set assessments and medication administration records for all residents that are receiving insulin injections to ensure that the minimum data set assessments are accurately coded to reflect the number of insulin injections. The results of the review indicated that residents receiving insulin injections were coded accurately on the MDS. Education was provided by the Director of Nursing to the MDS nurse and Facility Care Coordinator on accurately coding Hospice services and Injections on the MDS 9-13-2018 The monitoring procedure to ensure the plan of correction is effective: The MDS nurse will audit Hospice and Insulin Injection coding on the MDS completed by Facility Care Coordinator. These audits will be performed by the MDS nurse weekly for 12 weeks, biweekly times 8 weeks, then monthly until three months of compliance is sustained. The Facility Care Coordinator will audit coding for Hospice and Insulin Injection coding on the MDS completed by the MDS RN. These coding audits will be performed by the Facility Care Coordinator weekly for 12 weeks,	

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F 641	Continued From page 19 7/4/18 for Resident #30 that indicated he had received injections (of any type) on 6 of 7 days and insulin injections on 6 of 7 days during the MDS review period was reviewed with the FCC. The MARs that indicated Resident #30 had received Humalog injections on 5 of 7 days and no other injections during the 7/4/18 MDS review period was reviewed with the FCC. She reviewed the record and confirmed this 7/4/18 MDS for Resident #30 was coded incorrectly for insulin injections. The FCC revealed she had made an error. An interview was conducted with the Administrator on 8/23/18 at 2:31 PM. She indicated she expected the MDS to be coded accurately.	F 641	biweekly times 8 weeks, then monthly until three months of compliance is sustained. All Hospice coding and Insulin Injection coding audits will be reported monthly at the Quality Assurance Committee meeting by the MDS RN. The title of the person responsible for implementing the acceptable plan of correction: MDS RN Corrective action will be completed by 9-24-2018.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		9/24/18

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F 656	Continued From page 20 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan with interventions and/or approaches to address the known wandering behaviors for 1 of 1 residents (Resident #30) reviewed for wandering behaviors. The findings included: Resident #30 was admitted to the facility on 4/14/18 with diagnoses that included Alzheimer ' s Disease, dementia, and anxiety. The admission Minimum Data Set (MDS) assessment dated 4/21/18 indicated Resident	F 656	F 656 Comprehensive Care Plans The process that lead to the deficiency is as follows: On June 13th, 2018, Resident #30 exited the rehab hall exit door. Prior to the incident there were no interventions specific to wandering or exit seeking, and no new interventions were added to Resident #30□s care plan after this incident. Although any nurse can add to the care plan, the minimum data set nurse is responsible for overseeing the process and ensuring new interventions are added	

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F 656	Continued From page 21 #30 ' s cognition was severely impaired. He was coded with no wandering behaviors. A Nurse Practitioner (NP) note dated 5/4/18 indicated Resident #30 was wheelchair bound but was able to self-propel independently. A nursing note dated 5/14/18 indicated Resident #30 self-propelled through the halls in his wheelchair. A plan of care for Resident #30 indicated the initiation of a problem area, "I am an: identified wanderer" on 5/14/18. This care plan indicated Resident #30 had a diagnosis of dementia and had exhibited the behavior of wandering to exits. There were no approaches/interventions to address this problem area. The goals for Resident #30 were to wander within the facility where his safety could be maintained and monitored, have no injuries, make no attempts to leave the facility, and accept redirection. A physician ' s order dated 5/14/18 indicated a wander guard (an electronic alert system utilized for cognitively impaired residents with wandering behaviors) was applied to his left leg. A nursing note dated 6/11/18 indicated Resident #30 was confused, mobile in wheelchair, and out of his room around the nursing station when he had no visitors. An acute condition note dated 6/14/18 at 2:05 PM completed by Unit Manager (UM) #2 indicated Resident #30 was observed outside at 11:04 PM (6/13/18) by outgoing staff. A late entry incident note for 6/13/18 was	F 656	and a care plan is updated. Staff did actively put new interventions in place, but nothing was typed into the care plan. The facility completed a root cause analysis on why the care plan update was not completed to include new interventions, determine who was responsible, and why it was not completed. The facility determined the following: The minimum data set nurse was not included in the thorough investigation process led by the director of nursing. Though any nurse can add interventions to a care plan, the minimum data set nurse is ultimately responsible for updating the care plan. Because the minimum data set nurse was not included in the thorough investigation process, it was not clear to the minimum data set nurse that the care plan needed to be updated. The facility completed another root cause analysis to determine why no interventions were put into place prior to the incident. The facility determined the following: The director of social services is responsible for updating care plans with new interventions related to behaviors (including exit seeking). When the director of social services was completing the care plan for Resident #30, she inadvertently missed the intervention button in the electronic medical records charting system and went straight to the goal section. The interventions were not added due to the clerical error.	

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F 656	Continued From page 22	F 656		

completed on 6/15/18 by UM #2. This late entry incident note indicated Resident #30 had an unsupervised exit from the building on 6/13/18 at 11:00 PM. Resident #30 was noted as independently mobile in wheelchair and with poor cognition. He had no injuries.

Resident #30 ' s care plan related to wandering continued to include no approaches/interventions to address this problem area after his unsupervised exit from the facility on 6/13/18 at 11:00 PM.

An NP Note dated 6/15/18 indicated staff reported Resident #30 wandered at night and wore a wander guard. He was noted to sleep during day and was up and restless at night.

A behavior note and mood note dated 6/26/18 indicated during the first shift (7:00 AM - 3:00 PM) Resident #30 was in the therapy room in his wheelchair "trying to get out of the double doors to go outside". He was noted to be pushing on one door and then the other. The note indicated Resident #30 was mobile in his wheelchair, he was confused, and he had not wanted to sit in his room alone.

The quarterly MDS assessment dated 7/4/18 indicated Resident #30 ' s cognition was severely impaired. He was assessed with wandering behaviors on 1 to 3 days and had a wander/elopement alarm in place daily.

Resident #30 ' s care plan related to wandering was noted as reviewed on 7/9/18. The problem area remained unchanged, "I am: an identified wanderer". This care plan indicated Resident #30 had a diagnosis of dementia and had

The plan to correct the deficiency:

On August 22nd, 2018, Resident #30□s care plan was updated by the minimum data set nurse to include new patient centered interventions. The specific interventions added include:
" I need my nurses to□record any episodes of wandering. Ensure my photo is available. Observe me for increased safety risks, wandering into other rooms, constant wandering without rest, and exit seeking behaviors. Notify MD as indicated.
" I need my nurse aides to---be able to ID me, ensure wanderguard is in place and notify my nurse if wanderguard is missing, take me for supervised walks. If I am restless, report to my nurse if I have increased safety risk, wandering into other rooms, constant wandering without rest, or exit seeking behaviors, going to doors, trying to open doors, etc. Report to my nurse if I have agitation, check to see if I have any physical comfort needs or pain. Notify my nurse as needed.
" I need social services to---offer redirection, refer to activity staff for diversional activities.
" I need activity staff to---provide me with diversional activities that are specific to my likes and dislikes and past roles, provide me with a western book to read and provide country music for me to listen to if I am restless, take me to church services and hymn singing. If I am restless at night take me outside in the courtyard because I like to go outside to

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F 656	Continued From page 23 exhibited the behavior of wandering in hallways. There continued to be no approaches and/or interventions to address this problem area. The goals for Resident #30 remained unchanged: wander within the facility where his safety could be maintained and monitored, have no injuries, make no attempts to leave the facility, and accept redirection. A behavior note entered as a late entry note on 7/26/18 indicated on 7/25/18 during the second shift (3:00 PM - 11:00 PM) Resident #30 was exit seeking. He was noted to self-propel back and forth between the exit doors on the rehabilitation hall (F hall). Resident #30 ' s care plan related to wandering was noted as reviewed on 8/6/18. The problem area remained unchanged, "I am: an identified wanderer". This care plan indicated Resident #30 had a diagnosis of dementia and had exhibited the behavior of wandering in hallways. There continued to be no approaches and/or interventions to address this problem area. The goals for Resident #30 remained unchanged: wander within the facility where his safety could be maintained and monitored, have no injuries, make no attempts to leave the facility, and accept redirection. A behavior note dated 8/9/18 indicated Resident #30 was exit seeking. Resident #30 ' s NA guidelines for daily care, undated, was reviewed on 8/21/18. This form indicated Resident #30 had a diagnosis of dementia, poor short-term and long-term memory, and was an identified wandered. He was noted with a wander guard.	F 656	get fresh air. If I become restless take me to see my childhood friend. On August 22nd, 2018, to ensure that all residents care plans, related to exit seeking, had appropriate interventions, the Minimum Data Set nurse (MDS RN) and Facility Care Coordinator audited the care plans for residents who were identified as having exit seeking behaviors. Care plans were updated as needed by the Minimum Data Set nurse and the Facility Care Coordinator. Effective 8/23/18, the minimum data set nurse will be included in all incident and accident investigations along with the administrator, director of nursing and staff development coordinator. The audit concluded that all 10 current residents coded as wandering residents needed to have updated care plan person centered interventions for wandering behaviors. Education was provided on August 22nd, 2018, by the Director of Clinical Services to the care plan team, which includes the administrator, the director of nursing, the minimum data set nurse, the care coordinator, the director of social services, dietary, and the director of life enrichment. The training included: a. When to complete a new resident risk assessment to determine if the resident has additional needs or if the plan of care needs to be updated. This new procedure will be followed with all resident	

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F 656	Continued From page 24 As of 8/21/18 at 1:30 PM Resident #30 ' s care plan related to wandering continued to include no approaches/interventions to address this problem area. An interview was conducted with UM #2 on 8/21/18 at 1:45 PM. He confirmed he had written the acute condition note and the late entry incident note related to Resident #30 ' s unsupervised exit from the facility on 6/13/18. He stated Resident #30 was cognitively impaired and was able to self-propel in his wheelchair. He indicated Resident #30 wandered throughout the facility daily. An interview was conducted with Nurse #2 on 8/21/18 at 3:20 PM. She indicated Resident #30 was a known wanderer, was able to self-propel in his wheelchair, and was cognitively impaired. She stated Resident #30 really wanted to go home and he was an exit seeker. An interview was conducted with Nurse #4 on 8/21/18 at 2:25 PM. He indicated Resident #30 was cognitively impaired, was a known wanderer, and self-propelled his wheelchair all over the facility. An interview was conducted with NA #6 on 8/21/18 at 2:20 PM. She indicated Resident #30 was cognitively impaired and he wandered daily by self-propelling his wheelchair throughout he facility. A phone interview was conducted with NA # 4 on 8/22/18 at 9:41 AM. She indicated Resident #30 was cognitively impaired and he wandered daily by self-propelling his wheelchair throughout he facility.	F 656	assessments going forward including residents with new exit seeking behaviors. b. When to add new interventions c. What interventions are appropriate, e.g. patient centered interventions On August 22nd, 2018, the director of clinical services in serviced the administrator and director of nursing on: a. Reviewed Quality Assurance and Performance Improvement (QAPI) and root cause analysis procedures b. Proper procedures that staff are expected to follow for reporting any incidents c. The procedures to follow to investigate an incident d. The procedures for developing a plan of correction The system changes and procedures for monitoring include: Each morning, Monday through Friday, the director of nursing will meet with the Minimum Data Set nurse to review all new incidents, accidents, change of condition per the 24-hour report and per the report of the facility supervisor to determine which residents may need a new elopement risk assessment and an updated care plan. All residents that received a new assessment and an updated care plan will be discussed in the weekly quality assurance meeting to ensure that that care plans are updated appropriately.	

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F 656	Continued From page 25 An interview was conducted with the Facility Care Coordinator (FCC) on 8/21/18 at 1:58 PM. She indicated she was aware Resident #30 had an unsupervised exit from the facility on 6/13/18. She was asked who was responsible for the development of comprehensive care plans related to wandering behaviors. She stated the Social Worker (SW) was responsible for all behavior related care plans. The care plan related to wandering for Resident #30 that was initiated on 5/14/18 and reviewed on 7/9/18 and 8/6/18 and included no approaches/interventions was reviewed with the FCC. She confirmed that this care plan was not comprehensive as it had not included approaches/interventions to address his wandering behaviors. An interview was conducted with the SW on 8/21/18 at 4:35 PM. She indicated she was aware Resident #30 had an unsupervised exit from the facility on 6/13/18. She confirmed she was responsible for the completion of care plans related to wandering behaviors. The care plan related to wandering for Resident #30 that was initiated on 5/14/18 and reviewed on 7/9/18 and 8/6/18 and included no approaches/interventions was reviewed with the SW. She was unable to explain why there were no approaches/interventions on the care plan to address Resident #30 ' s wandering. The SW stated that approaches/interventions should have been added to Resident #30 ' s care plan to address his wandering behaviors when the care plan was initiated on 5/14/18. She indicated that following Resident #30 ' s unsupervised exit from the facility on 6/13/18 his care plan should have been reviewed to ensure appropriate approaches/interventions were in place. The	F 656	Attendants of the weekly quality assurance meeting include: Administrator, Director of Nursing, Staff Development Coordinator, Nurse Supervisor, Director of Life Enrichment, Health Information Specialist, Minimum Data Set nurse, Facility Care Coordinator, Therapy Manager, Director of Social Services, the treatment nurse and the Nurse Practitioner. The Minimum Data Set nurse will be responsible for giving the director of nursing (or the staff development coordinator in the absence of the director of nursing) a list every Monday of all residents who have had new care plans in the past seven days. The Director of Nursing will then audit all new care plans to ensure the care plans and interventions are person centered and appropriate. These audits will be completed weekly for three months and then weekly until three months of compliance is sustained. The Director of Nursing will make any needed changes and provide education to the appropriate care plan team member who did not complete the care plan appropriately. The Director of Nursing will be responsible for reporting the care plan audit outcomes at the monthly quality assurance meeting. The title of the person responsible for implementing the plan of correction will be the Director of Nursing.	

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F 656	Continued From page 26 SW was again unable to explain why it had not been identified during the reviews of Resident #30 ' s care plan on 7/9/18 and 8/6/18 that there were no approaches/interventions to address the problem area of wandering. An interview was conducted with the Administrator on 8/23/18 at 2:30 PM. The Administrator indicated that she expected all residents to have comprehensive care plans that included approaches/interventions utilized to meet the goals of identified problem areas. She stated that her expectation was for Resident #30 ' s care plan related to wandering to have included approaches/interventions at the time of its initiation on 5/14/18. She indicated that following Resident #30 ' s unsupervised exit from the facility on 6/13/18 she expected his care plan related to wandering to be reviewed to ensure appropriate approaches/interventions were in place. The Administrator additionally indicated that she expected it to be identified during the care plan reviews on 7/9/18 and 8/6/18 that there were no approaches/interventions to address Resident #30 ' s wandering behaviors.	F 656	Date of completion 9/24/2018	
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:	F 689		9/24/18

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F 689	Continued From page 27 Based on record review, staff interview, and observation, the facility failed to provide supervision to prevent a resident with severe cognitive impairment who displayed wandering behaviors from exiting the facility unsupervised for 1 of 1 residents (Resident #30) reviewed for wandering behaviors. Resident #30 was found unsupervised outside of the facility by a visitor and returned inside the facility by staff with no injuries. Immediate Jeopardy began on 6/13/18 when Resident #30 was observed in his wheelchair outside of the facility without supervision at approximately 11:00 PM. Immediate Jeopardy was removed on 8/23/18 when the facility provided and implemented an acceptable credible allegation of removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. The findings included: Resident #30 was admitted to the facility on 4/14/18 with diagnoses that included Alzheimer ' s Disease, dementia, and anxiety. Record review indicated Resident #30 resided in the rehabilitation (rehab) unit of the facility. An elopement risk assessment dated 4/14/18 indicated Resident #30 was not at risk for elopement. The admission Minimum Data Set (MDS) assessment dated 4/21/18 indicated Resident #30 ' s cognition was severely impaired. He was	F 689	The process that lead to his deficiency was as follows: The facility did not provide supervision to Resident #30 outside of facility on 6/13/2018 at 11pm. Resident followed staff member out exit door without being noticed by staff member. The resident was redirected back into facility a few minutes later by visitor with no injury. The plans of correcting the deficiency: On August 22nd , 2018 all the exterior doors were checked for functioning, including proper closure, by the maintenance director and the director of nursing. the "Door Check" document demonstrates which employee checked which doors. On August 22, 2018, the rehab hall exit door was repaired by the maintenance director to latch when door is minimally opened by slightly sanding the paint off the metal door frame. (An annunciator is a panel that alarms when doors are opened for a certain amount of time that is audible and visible at both nurse stations) was checked an was sounding in the nurses' station. The doors were checked again on August 23rd, 2018 by the director of nursing and maintenance director and all are still functioning properly, including proper closure. On August 22nd, 2018, education to all staff by the Director of Nursing and the Director of Clinical service began on the following topics:	

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F 689	Continued From page 28 coded with no wandering behaviors. He required the extensive assistance of 2 or more staff with bed mobility and transfers. Resident #30 was assessed as requiring the assistance of 1 staff for locomotion on and off the unit and these activities were indicated to happen only once or twice during the 7-day review period. He had impairment on 1 side of his lower extremities and utilized a wheelchair. A Nurse Practitioner (NP) note dated 5/4/18 indicated Resident #30 was wheelchair bound but was able to self-propel independently. He was noted with cognitive deficits that made it difficult to obtain reliable information. A nursing note dated 5/14/18 indicated Resident #30 self-propelled through the halls in his wheelchair. A plan of care for Resident #30 indicated the initiation of a problem area, "I am an: identified wanderer" on 5/14/18. This care plan indicated Resident #30 had a diagnosis of dementia and had exhibited the behavior of wandering to exits. There were no approaches and/or interventions for this problem area. The goals for Resident #30 were to wander within the facility where his safety could be maintained and monitored, have no injuries, make no attempts to leave the facility, and accept redirection. A physician ' s order dated 5/14/18 indicated a wander guard (an electronic alert system that alarms and locks the facility exit doors when cognitively impaired residents with wandering behaviors attempt to exit the building) was applied to Resident #30 ' s left leg.	F 689	A) Staff and visitors are only permitted to use the main entrance for entering and exiting the building; the only exception is the A hall door code will be given to the Nursing Supervisor in charge, Maintenance Director, Director of Nursing, Administrator, Staff Development Coordinator and the Housekeeping Director, so that trash can be taken to the dumpster and supplies can be brought inside facility. (All of the codes on the exterior doors will be changed by August 23rd, 2018) B) Lutheran Service's Carolinas (LSC) policy titled, "Elopement and Unsafe Wandering" C) The expectations for completing work order for any equipment that needs repair, any hazard that is found, or for any other issue that needs attention by maintenance personnel. The procedures for completing work orders that was used to train all staff is titled, " Trinity Place Procedures for Notifying Maintenance". This training will be completed by August 23, 2018. Any staff member that cannot be reached or is on vacation will be in-serviced prior to their next working shift by the director of nursing, nurse supervisor or the staff development coordinator. This training will become part of the orientation process so that all new staff members will be in serviced on this information. This training includes all staff: full time, part time, as needed (PRN) and contracted staff. 3. On August 22nd, 2018 all residents were assessed for the risk of elopement by the Minimum Data Set nurse and the	

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F 689	Continued From page 29 A fall risk assessment dated 6/9/18 indicated Resident #30 was at high risk for falls. His risk factors included intermittent confusion, self-propelled wheelchair, and inability to retrain due to cognitive deficits. A nursing note dated 6/11/18 indicated Resident #30 was confused, mobile in wheelchair, and out of his room around the nursing station when he had no visitors. A physician ' s note dated 6/13/18 indicated Resident #30 had cognitive impairment, memory deficits, and impaired decision-making skills. He was noted to require frequent monitoring to prevent falls with potential injuries or fractures. An acute condition note dated 6/14/18 at 2:05 PM completed by Unit Manager #2 (UM) indicated Resident #30 was observed outside at 11:04 PM (on 6/13/18) by outgoing staff. No injuries were noted. Resident #30 reportedly stated he just wanted to go outside for a while. A late entry incident note for 6/13/18 was completed on 6/15/18 by UM #2. This late entry note specified, Resident #30 was noted with an unsupervised exit from the building on 6/13/18 at 11:00 PM. Resident #30 was noted with poor cognition and was independently mobile in his wheelchair. He had no apparent injuries. The immediate action was placement of a staff member with Resident #30 for one on one (1:1) supervision for the remainder of the shift. Resident #30 ' s care plan related to wandering continued to include no approaches and/or interventions for this problem area after his unsupervised exit from the facility on 6/13/18.	F 689	Facility Care Coordinator. All care plans were updated by the Minimum Data Set nurse and the Care Coordinator on August 22nd, 2018. Ten residents were identified as elopement risks, an ten care plans were updated. All wandering residents identified have photo located in pink designated note books at nurses station and receptionist desk. The staff development coordinator received training on 8/27/2018 immediately after returning from vacation from the director of nursing A) Staff and visitors are only permitted to use the main entrance for entering and exiting the building; the only exception is the A hall door code will be given to the Nursing Supervisor in charge, Maintenance Director, Director of Nursing, Administrator, Staff Development Coordinator and the Housekeeping Director, so that trash can be taken to the dumpster and supplies can be brought inside facility. (All of the codes on the exterior doors will be changed by August 23rd, 2018) B) Lutheran Service's Carolinas (LSC) policy titled, "Elopement and Unsafe Wandering" C) The expectations for completing work order for any equipment that needs repair, any hazard that is found, or for any other issue that needs attention by maintenance personnel. The procedures for completing work orders that was used to train all staff is titled, " Trinity Place Procedures for Notifying Maintenance".	

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F 689	Continued From page 30 A physician ' s order dated 6/15/18 indicated a second wander guard was placed on the back of Resident #30 ' s wheelchair. An NP Note dated 6/15/18 indicated staff reported Resident #30 wandered at night and wore a wander guard. He was noted to sleep during day and was up and restless at night. A behavior note and mood note dated 6/26/18 indicated Resident #30 was in the therapy room in his wheelchair "trying to get out of the double doors to go outside". He was noted to be pushing on one door and then the other. The note indicated Resident #30 was mobile in his wheelchair, he was confused, and he had not wanted to sit in his room alone. A review of the staff schedules from 6/14/18 through 6/26/18 indicated 1:1 supervision was provided for Resident #30 during the third shift (11:00 PM - 7:00 AM). On 6/27/18 Resident #30 was moved from the rehab unit (F hall that connected to the E hall) to the long-term care unit (A, B, C, and D halls) on the opposite side of the building. An elopement risk assessment dated 7/3/18 for Resident #30 indicated he may be at risk for elopement. A review of the nursing notes indicated Resident #30 continued to self-propel his wheelchair from the long-term care unit to the rehab unit on 6/29/18, 7/9/18, 7/19/18, 7/22/18, 7/25/18, 8/7/18, and 8/9/18.	F 689	This training will be completed by August 23, 2018. Any staff member that cannot be reached or is on vacation will be in-serviced prior to their next working shift by the director of nursing, nurse supervisor or the staff development coordinator. This training will become part of the orientation process so that all new staff members will be in serviced on this information. This training includes all staff: full time, part time, as needed (PRN) and contracted staff. 3. On August 22nd, 2018 all residents were assessed for the risk of elopement by the Minimum Data Set nurse and the Facility Care Coordinator. All care plans were updated by the Minimum Data Set nurse and the Care Coordinator on August 22nd, 2018. Ten residents were identified as elopement risks, an ten care plans were updated. All wandering residents identified have photo located in pink designated note books at nurses station and receptionist desk. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected is as follows: The Maintenance Director and Maintenance Assistant will be responsible for checking every exterior door in the facility daily Monday- Friday. For the first four weeks the daily checks on weekends will be completed by the Nursing Supervisor. If the doors fail to close properly during the checks the	

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F 689	Continued From page 31 As of 8/21/18 at 1:30 PM Resident #30 ' s care plan related to wandering continued to include no approaches and/or interventions for this problem area. Resident #30 ' s NA guidelines for daily care, undated, was reviewed on 8/21/18. This form indicated Resident #30 had a diagnosis of dementia, poor short-term and long-term memory, and was identified as a wanderer. He was noted with a wander guard. A review of the weather conditions per Weather Underground ' s website (www.wanderground.com) for Albemarle ' s weather history indicated the temperature on 6/13/18 at 11:00 PM was 74 degrees Fahrenheit and there was no precipitation. An interview with the Business Office Manager (BOM) on 8/22/18 at 9:15 AM revealed the facility had video surveillance of the rehab hall. This video was available for only a 72-hour period and then it was overwritten. The BOM indicated she reviewed the video and completed a written timeline on 6/14/18 and 6/15/18 for the time period leading up to Resident #30 ' s unsupervised exit from the facility on 6/13/18. This timeline was reviewed with the BOM. She stated that the video camera on the rehab hall gave a view of the hallway. She explained that the rehab hall exit door was in a short corridor off the hall and that it was outside of the video camera ' s range. She stated that the video showed NA #10 turn the corner toward the exit door located off the rehab hall around 11:00 PM and within 20 seconds of this, Resident #30 was seen self-propelling his wheelchair around the same corner. The timeline indicated there was a	F 689	Administrator and/ or Director of Nursing must immediately be notified by staff member. The checking of exterior door audit will be completed daily for four weeks, than three times a week for eight weeks, and then once a week until three months of compliance is sustained. The audit log will be titled "Door Check Document" was developed 8/23/2018. The Director of Maintenance will provide a copy of the door check logs to the Director of Nursing every Monday. The Director of Nursing will be responsible for reviewing the door check documents to ensure the checks are being completed as required. The audits will be reviewed at QAPI by the Maintenance Director or Director of Nursing. The title of the person responsible for implementing the plan of correction will be the Administrator. Completion Date 9/24/2018	

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F 689	Continued From page 32	F 689		

period of 4 minutes and 31 seconds from the time Resident #30 turned that corner to the time that NA #1 was seen bringing Resident #30 back inside through the rehab hall exit door. The BOM explained that this exit door on the rehab hall was not equipped for wander guard security. She stated that this door was secured by a numerical security code that was entered into a keypad. She indicated that staff members who worked on the rehab unit and facility visitors had been entering and exiting through that door as it was a shorter walk from the parking lot.

A written statement, dated 6/25/18, completed by NA #10 was reviewed. She indicated she was not on duty on 6/13/18 at the time of Resident #30 ' s unsupervised exit from the facility. She wrote that she had been in the facility to visit another staff member that evening. She reported that around 11:00 PM on 6/13/18 as she was preparing to exit the facility through the rehab hall ' s exit door she saw Resident #30 seated in his wheelchair near the corridor that led to the exit door. NA #10 indicated she had not redirected him away from vicinity of the exit door. She reported she exited the door and ensured it was closed prior to walking to her car. She indicated she had not seen Resident #30 outside of the facility.

An interview was conducted with NA #10 on 8/21/18 at 4:50 PM. She confirmed her written statement, dated 6/25/18, related to the events on 6/13/18 prior to Resident #30 ' s unsupervised exit from the facility. She reported Resident #30 was a known wanderer, he self-propelled throughout the facility in his wheelchair, he was regularly up during the night, and he was alert to himself with confusion. She stated that she saw Resident #30 near the rehab hall ' s exit door

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when she was leaving the facility, but she had not redirected him as she was not on duty. She indicated she entered the numerical code to unlock the door, proceeded out of the door, and then shut the door behind her. NA #10 reported there was always a delay on the locking mechanism of the door, so it had not locked as soon as it was shut.

An observation was conducted of the rehab hall exit door with NA #10 on 8/21/18 at 5:00 PM. A sign was observed on the door that stated, "Use Front Door to Enter and Exit Building". The door was observed opening and closing multiple times. A numerical code was entered into the keypad, the door unlocked, and remained unlocked for about ten seconds prior to the lock engaging. It was observed that if the door was not closed prior to the end of the ten seconds that an audible alarm sounded in the nurse ' s station. NA #10 indicated the alarm had to be manually turned off by staff or it continued to sound.

An interview with the Maintenance Director as well as an observation of the rehab hall exit door in his presence was conducted on 8/22/18 at 6:24 PM. He confirmed the rehab hall exit door had a 10 second delay from the time the numerical code was entered on the keypad to the time the door lock re-engaged. He also confirmed if the door was not closed by the end of the 10 seconds that an audible alarm sounded in the nurse ' s station. He stated this audible alarm had to manually be shut off from the nurse ' s station.

A written statement, undated, completed by NA #1 was reviewed. NA #1 was working on the long-term care unit on 6/13/18 during the second shift. She indicated she punched out on the time

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clock shortly after 11:00 PM and when she was leaving the building through the main entrance she was notified of Resident #30 ' s presence outside. She indicated she hurried over to Resident #30 and that he was found in his wheelchair in the grass area outside of the rehab unit. Resident #30 had not informed her how he got outside. NA #1 pushed Resident #30 back inside and she alerted staff on the rehab unit that he had been outside.

A phone interview was conducted with NA #1 on 8/22/18 at 8:24 AM. She confirmed her written statement related to Resident #30 ' s unsupervised exit from the facility on 6/13/18. She stated that a facility visitor, her name was unknown to NA #1, saw her as she was leaving the building and told her a resident was outside. She stated Resident #30 had not answered her when she asked him what he was doing outside. She indicated she pushed Resident #30 to the rehab unit ' s exit door, punched in the numerical code because the door was locked, and took the resident back inside. She reported she informed the staff on his unit that he had been outside. NA #1 stated that although she had never worked with Resident #30 she was aware he was a wanderer as she had seen him self-propel his wheelchair throughout the facility.

The facility visitor was unable to be reached for interview during the survey as there was no contact information available.

An interview was conducted with UM #2 on 8/21/18 at 1:45 PM. He confirmed he had written the acute condition note and the late entry incident note related to Resident #30 ' s unsupervised exit from the facility on 6/13/18. He

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stated he was not present at the facility when the incident occurred but had been asked by the previous Director of Nursing (DON) to document the incident. He reported that at the time of the incident, staff and visitors were using that exit door to enter and exit the facility because it was closer to the parking lot. He indicated that since the incident no one was supposed to enter and exit through the rehab hall exit door. He confirmed Resident #30 was cognitively impaired, a known wanderer, and was able to self-propel in his wheelchair. He stated that Resident #30 continued to come over to the rehab unit after his room was moved to the long-term care unit. UM #2 was asked what interventions were utilized to address Resident #30 ' s known wandering and exit seeking behaviors. He reported that Resident #30 had a wanderguard that was monitored for function and placement by nursing staff. He indicated when Resident #30 was having exit seeking behaviors that staff tried to redirect him toward an area near the nurse ' s station so it was easier to keep an eye on him.

A written statement, dated 6/14/18, completed by Nurse #2 was reviewed. Nurse #2 was assigned to Resident #30 during the second shift (3:00 PM - 11:00 PM) on the date he exited the facility unsupervised (6/13/18). Her statement indicated she was in another resident ' s room when NA #7 informed her Resident #30 was outside. She indicated by the time she completed care for the other resident and returned to the nurse ' s station she saw NA #1 pushing Resident #30 in his wheelchair inside of the facility. She indicated 1:1 supervision was initiated as a precaution and the DON was notified by phone.

An interview was conducted with Nurse #2 on

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8/21/18 at 3:20 PM. She confirmed she was assigned to Resident #30 on the second shift on 6/13/18. She verified her written statement related to his unsupervised exit from the facility and additionally revealed staff had not known that Resident #30 was missing until the facility visitor alerted NA #1 of his presence outside on 6/13/18. She reported she assessed Resident #30 after NA #1 returned him inside and she identified no apparent injuries. She indicated he was oriented to self only and when asked how he got out of the building he had pointed toward the main entrance of the facility. Nurse #1 stated that because Resident #30 pointed toward the main entrance that staff initially believed he had exited through that entrance. She stated his wander guard was checked for proper function and placement and it was in working condition. She indicated an additional wander guard was placed on Resident #30 ' s wheelchair because at that time, staff believed there must have been a problem with the wander guard system if he was able to exit through the main entrance. Nurse #1 stated that 1:1 supervision was initiated for Resident #30 during the third shift (11:00 PM - 7:00 AM) beginning on 6/13/18. She revealed the investigation of the incident showed Resident #30 had exited out of the rehab hall exit door which was not equipped for the wander guard.

This interview with Nurse #2 continued. She verified that Resident #30 was a known wanderer, was able to self-propel in his wheelchair, and was cognitively impaired. She stated Resident #30 really wanted to go home and he was an exit seeker. She confirmed UM #2 ' s statement that Resident #30 continued to self-propel to the rehab unit after his room was moved to the long-term care unit. She

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additionally confirmed that since the incident no one was permitted to enter and exit the facility through the rehab hall exit door. Nurse #2 was asked what interventions were utilized to address Resident #30 ' s known wandering and exit seeking behaviors. She indicated that Resident #30 had a wander guard and that he was able to wander through the facility as he chose. She stated that when he was exhibiting exit seeking behaviors staff tried to keep him by the nurse ' s station for easier monitoring. She reported if he was showing increased anxiety or agitation with the exit seeking behaviors that staff ensured his basic needs were met. She explained that this meant he was offered things such as toileting, food and/or drink, and a pain assessment to make sure he was comfortable.

A phone interview was conducted with NA #7 on 8/21/18 at 4:27 PM. She stated she had worked on the rehab unit on 6/13/18 for the second shift. She stated she had punched out of work for the evening and was headed out of the building when a facility visitor alerted her and NA #1 that a resident was outside. She revealed she had not known Resident #30 was missing prior to this facility visitor ' s report. She indicated NA #1 went to Resident #30 and she informed Nurse #2 that he was found outside. She reported that she was not assigned to Resident #30 on 6/13/18. She stated she believed NA #2 was assigned to Resident #30.

A written statement, undated, completed by NA #2 was reviewed. NA #2 was assigned to Resident #30 during the second shift on the date he exited the facility unsupervised (6/13/18). The statement indicated Resident #30 requested to get out of bed around 10:30 PM. She stated she

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assisted him up and into his wheelchair and pushed him down the hall in front of the nurse ' s station. She noted that she closed the double doors that separated the rehab unit from the long-care unit "to keep [Resident #30] from going down onto the other halls because of shift change and I needed to keep an eye out on him". NA #2 noted around 11:00 PM NA #1 saw Resident #30 outside of the exit door of the rehab hall. NA #1 brought Resident #30 back inside.

A phone interview was conducted with NA #2 on 8/22/18 at 12:53 PM. NA #2 stated she was no longer employed at the facility. She confirmed that she was assigned to Resident #30 for the second shift on 6/13/18. She verified her written statement related to his unsupervised exit from the facility on 6/13/18 and additionally revealed she had not known Resident #30 was missing until she saw NA #1 bring him back inside. She reported Resident #30 was a known wanderer, he self-propelled throughout the facility in his wheelchair, he was regularly up during the night, and he was alert to himself with confusion. NA #2 was asked what interventions she had utilized to address Resident #30 ' s known wandering behaviors. She stated that if Resident #30 was having his normal wandering that she just tried to keep an eye on him. She indicated if he seemed agitated or anxious in addition to the wandering that she tried to redirect to an area near the nurse ' s station so it was easier to watch him.

A written statement, undated, completed by Nurse #3 was reviewed. She indicated she was working the third shift on Resident #30 ' s unit on the date he exited the building unsupervised (6/13/18). She wrote that prior to receiving her report at the beginning of her shift, NA #1 brought

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Resident #30 into the facility and informed staff he was found outside. Nurse #3 noted that 1:1 supervision was initiated that night. Resident #30 was noted to be wandering through the hallways continuing to go to the rehab door and pulling at the door handles while on 1:1 supervision.

A phone interview was conducted with Nurse #3 on 8/22/18 at 5:00 PM. She confirmed her written statement related to Resident #30 ' s unsupervised exit from the facility on 6/13/18 and additionally revealed she had not known Resident #30 was missing until NA #1 brought him back into the facility. She stated that she provided 1:1 supervision for Resident #30 during the third shift on 6/13/18 through 6/14/18. She indicated that NA #5 stayed over from the second shift and performed the medication cart duties for her during the third shift as she was also a medication technician. Nurse #3 confirmed Resident #30 was cognitively impaired, a known wanderer, and was able to self-propel in his wheelchair. She additionally confirmed that Resident #30 continued to self-propel his wheelchair to the rehab unit after his room was moved to the long-term care unit.

A phone interview was conducted with NA #5 on 8/22/18 at 2:20 PM. She confirmed she stayed over from the second shift on 6/13/18 to work the third shift on the medication cart so Nurse #3 was able to provide 1:1 supervision for Resident #30.

A phone interview was conducted with NA #3 on 8/22/18 at 9:33 AM. She stated that she was working the third shift on the date Resident #30 had an unsupervised exit from the facility (6/13/18). She indicated she was splitting the rehab unit with NA #4 that night. She reported

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she believed she saw Resident #30 in his wheelchair by the nurse ' s station when she came into the facility that night, but she was not certain as it was shift change and there many people in that area. NA #3 revealed she had not known Resident #30 was missing until NA #1 brought him back into the facility.
She stated it was normal behavior for Resident #30 to be awake at that time of night. She indicated Resident #30 was cognitively impaired and he wandered daily by self-propelling his wheelchair throughout he facility.

A phone interview was conducted with NA # 4 on 8/22/18 at 9:41 AM. She stated that she was working the third shift on the date Resident #30 had an unsupervised exit from the facility (6/13/18). She indicated she was splitting the rehab unit with NA #3 that night. She stated she had not seen Resident #30 that night and had not known he was missing until NA #1 brought him back inside. She indicated Resident #30 was cognitively impaired and he wandered daily by self-propelling his wheelchair throughout he facility.

An interview was conducted with NA #6 on 8/21/18 at 2:20 PM. She stated that she normally worked on the long-term care unit. She reported she had not worked with Resident #30, but she was familiar with him. She indicated he was cognitively impaired and he wandered daily by self-propelling his wheelchair throughout he facility. She reported he went over the rehab unit on most days as he previously resided there. NA #6 stated she was not aware Resident #30 had an unsupervised exit from the facility when he resided on the rehab unit.
An interview was conducted with Nurse #4 on

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8/21/18 at 2:25 PM. He stated he was a nurse on the long-term care unit. He indicated that Resident #30 was cognitively impaired, was a known wanderer, and self-propelled his wheelchair. He reported Resident #30 self-propelled to the rehab unit daily. Nurse #4 stated he was not aware Resident #30 had an unsupervised exit from the facility when he resided on the rehab unit.

An email written by the Administrator dated 6/14/18 at 2:55 PM was sent to the Medical Records Coordinator, the facility ward clerks, and the facility care plan team. This email indicated that Resident #30 had an unsupervised exit from the facility at 11:00 PM and was found outside at 11:04 PM. The email stated, "patient will continue one to one observation until he is placed in a locked unit, patient will have a wander guard placed on the wheelchair in addition to his person, patient will be asked if he wants to go outside and will be allowed to sit outside with supervision, system will continue to be checked daily to assure it is working properly".

A documentation of a staff inservice, undated and untitled began with the statement, "Due to some recent events that have taken place, there will be some changes effective immediately". This training read:
"1. When a hall alarm is ringing, someone must check the door and announce on their walkie [portable multi-way radio used for communication]- [specific hall] is clear, before resetting the alarm.
2. All staff should have an assigned walkie with them while clocked in for their shift(s).
3. Staff will no longer use the E or F Hall doors to exit the building at the end of their shift. All staff

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will use the front door to exit.
4. Front entrance will be locked at 7:00pm or after front office staff are done for the day. Staff and family can exit the facility, however you must be buzzed in to return.
5. No [NAs] shall remain in the nursing station. If you are taking a 5 [minute] break to cool off, that is acceptable. There are always things that need to be done for the residents. Please see your charge nurse if you have any questions.
6. When leaving your assigned area, please notify your charge nurse if you have any questions.
7. When leaving the facility for any reason, you must clock out and sign out so in case of emergency, your supervisor can account for your location ..."
There were 28 staff signatures on the inservice sign in sheet. The inservice had not mentioned Resident #30 ' s unsupervised exit from the facility.

An interview was conducted with the Administrator on 8/21/18 at 3:25 PM. She stated that based on the facility ' s investigation and video surveillance evidence, Resident #30 had exited the facility from a door on the rehab hall (F hall) of the facility and was outside of the building for approximately 4 minutes around 11:00 PM on 6/13/18. She confirmed staff had not known he was missing until a facility visitor alerted NA #1 and NA #7. She indicated it was believed Resident #30 got out of the rehab hall exit door after NA #10 and prior to the door lock re-engaging. The Administrator verified that previously, staff on the rehab unit and visitors had been utilizing this door to enter and exit the facility by using the numerical code to unlock the door. She stated that after the 6/13/18 incident a sign

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was placed on the rehab hall exit door that indicated it was not to be used to enter or exit the building. She revealed the numerical code had not been changed after the 6/13/18 incident. The Administrator stated that following the incident (6/13/18) she was off for a few days and had not returned to the facility until 6/18/18. She reported that on 6/18/18 she and the previous DON checked the rehab hall ' s exit door and observed it to be working properly. The staff inservice, undated, and the sign in sheet with 28 staff signatures were reviewed with the Administrator. She was asked who was responsible for providing the inservice and if all staff received the inservice. She indicated the previous DON and the Staff Development Coordinator were responsible for the education. The Administrator revealed the 28 signatures had not accounted for all staff at the facility. She stated her expectation was for all full-time, part-time, as needed (PRN), and contracted staff to receive the inservice as all of these employees had access to the rehab hall exit door. She verified the rehab department employees were contracted staff and that the rehab hall exit door was located right next to the rehab department. She additionally verified that there was no evidence the rehab department ' s contracted staff had received the inservice.

This interview with the Administrator continued. The email dated 6/14/18 at 2:55 PM related to Resident #30 ' s unsupervised exit from the facility on 6/13/18 was reviewed with the Administrator. She confirmed this email was sent to the Medical Records Coordinator, the facility ward clerks, and the facility care plan team. The care plan team was noted to include the DON, MDS Nurse, Care Coordinator, Social Worker, Dietary Manager, and Life Enrichment Director.

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The interventions noted on the email (patient will continue one to one observation until he is placed in a locked unit, patient will have a wanderguard placed on the wheelchair in addition to his person, patient will be asked if he wants to go outside and will be allowed to sit outside with supervision, and system will continue to be checked daily to assure it is working properly) were reviewed with the Administrator. She reported that at the time of email, it was believed that Resident #30 had gotten out of the building through the main entrance. She stated this was why an additional wander guard was placed on his wheelchair. She indicated that as part of the facility ' s normal protocol, all wander guards in use were checked for function and placement on each shift daily and that this protocol continued. She reported that initially, the facility felt that Resident #30 needed a locked unit to ensure his safety and the plan was to place him on 1:1 supervision until that occurred. She indicated this was re-evaluated and Resident #30 was instead moved to the long-term care unit on 6/27/18 so he was further away from the rehab hall exit doors. She confirmed the 1:1 supervision was only in place during the third shift and that it ended when Resident #30 was moved to the long-term care unit (6/27/18). The Administrator was asked why 1:1 supervision was provided only during the third shift as the 6/14/18 email indicated Resident #30 was going to be on 1:1 supervision until he moved. She was unable to explain why 1:1 supervision was only provided to Resident #30 during the third shift. The staff interviews and nursing notes that indicated Resident #30 continued to self-propel his wheelchair to the rehab unit after his move to the long-term care unit were reviewed with the Administrator. She was asked if any increased

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monitoring was in place for Resident #30 since his move to the long-term care unit as the move had not kept him from going to the rehab unit. She confirmed there had been no increased monitoring for Resident #30 since 6/27/18 when he was moved to the long-term care unit.

The Staff Development Coordinator (SDC) was out of the country and unavailable for interview.

A phone interview was conducted with the previous DON on 8/22/18 at 10:14 AM. She confirmed she was the DON on 6/13/18 when Resident #30 had an unsupervised exit from the facility. She confirmed that the findings of the investigation indicated Resident #30 exited the building unsupervised through the rehab hall exit door at approximately 11:00 PM on 6/13/18. Resident #30 was outside for around 4 minutes prior to staff being alerted by a facility visitor of his presence outside. She verified staff had not known Resident #30 was missing until the facility visitor alerted them.

The previous DON was asked about the interventions implemented following Resident #30 ' s unsupervised exit from the facility. She stated that during the third shift on 6/13/18 Resident #30 ' s wander guard was checked for function and placement and an additional wander guard was placed on his wheelchair. She indicated Resident #30 was placed on either 1:1 supervision or 15 minute checks, she was unable to recall which intervention, during the third shift. She stated this increased monitoring continued for several days, but she was unable to recall how long. She confirmed there was no increased monitoring during the first or second shifts. The previous DON indicated that all residents with wander

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guards had their devices checked for function and placement each shift daily and that this process was completed during the third shift on 6/13/18 following the incident.

This interview with the previous DON continued. She was asked about the inservice, undated, and the sign in sheet with 28 staff signatures. She reported she thought the SDC provided the inservice to all nursing staff. She confirmed the 28 signatures had not accounted for all staff at the facility. She stated that she recalled all department heads were notified of Resident #30 ' s unsupervised exit from the facility during a meeting, but she was unable to recall the date of the meeting. There was no evidence that all staff (full-time, part-time, as needed, and contracted staff) were informed of Resident #30 ' s unsupervised exit from the building on 6/13/18 or that they had received the inservice.

An interview was conducted with the facility ' s Chief Operating Officer (COO) on 8/22/18 at 3:30 PM. She confirmed that following Resident #30 ' s unsupervised exit from the facility on 6/13/18 he was placed on 1:1 supervision during the third shift until he was moved from the rehab unit to the long-term care unit (6/27/18). She additionally confirmed there was no increased monitoring for Resident #30 during the first shift or second shift while he was on the rehab unit and there was no increased monitoring in place on any shift since his move to the long-term care unit (6/27/18). The COO revealed the numerical code to the rehab hall ' s exit door was changed on this date (8/22/18) and that prior to this date it had not been changed after Resident #30 ' s unsupervised exit from the facility on 6/13/18.

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The Administrator and current DON were notified of the Immediate Jeopardy on 8/22/18 at 11:00 AM.

On 8/23/18 at 2:42 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

This credible allegation has been developed to address the deficient practice associated with tag F689, which was cited as an IJ on 8/22/2018.

The incident associated with the deficient practice occurred on June 13th, 2018 at approximately 11 pm. Resident #30 was identified as a wanderer and the wanderguard had been in place on this resident since 5/14/18. An off-duty staff member exited the rehab hall exit door at approximately 11 pm on June 13th, 2018, and Resident #30 exited the rehab hall exit door behind the staff member. This door does not have a wanderguard system on it, but it has a maglock system with a keypad. Resident #30 was observed outside of the building by a facility visitor four minutes after the resident exited the door. This is demonstrated by Trinity Place ' s security camera footage.

Trinity Place believes, after reviewing documentation, interviewing staff and analyzing the incident, that when the off-duty staff member exited the rehab hall exit door, the door closed but did not latch because the maglock system is designed to have a ten (10) second delay before it locks closed. Resident #30 (as seen on security camera footage) was close to the rehab hall exit

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door when the off-duty staff member exited the rehab hall exit door and the resident exited the door behind the off-duty staff member. The off-duty staff member did not notice that Resident #30 exited. After investigating the incident, it is believed that the off-duty staff member did not notice that Resident #30 exited because the off-duty staff member was conversing with another individual who was exiting the building too; this is why the off-duty staff member did not stop to see if the door latched.
Resident #30 exited the door following the off-duty staff member. To address this, Trinity Place took the following steps to correct:
1. On June 13th, 2018 the director of nursing was called by the licensed practical nurse as soon as the resident was brought inside the building. The director of nursing instructed the licensed practical nurse that was on duty to do the following:
a. Begin 1:1 with the resident during third shift until 6/27/18 when the resident was moved to an area of the building that has more activities designed for memory deficits and is geared more toward residents with cognitive impairments.
b. Assess the resident for any injury. No injuries noted.
c. Check to ensure all residents were accounted for. All residents were accounted for. This occurs every shift change.

The procedures for implementing the acceptable plan of correction for the deficiency cited associated with tag F689 are as follows:

1. On June 14th, 2018, the administrative team, which included the director of nursing, business office manager, and the staff development

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coordinator reviewed the incident. This team determined that Resident #30 exited out of the rehab hall exit door (via the security cameras) and the director of nursing checked the door to ensure proper functioning. The door was opening and closing properly. A sign was put on this door that stated, "Use Front Door to Enter and Exit Building."
2. Staff education by the staff development coordinator, second shift charge nurse, and third shift charge nurse began on June 14th, 2018 and included: Employees permitted to only use the main entrance for exiting and entering the building. No employees were permitted to exit any of the side doors. Education was provided to those that signed the staff education sheet. Training was provided during all shifts on 6/14/18 through 6/19/18. The number of people that were in-serviced and that signed the sign-in sheet is 28. This does not account for all of the staff at Trinity Place.
3. On August 22nd, 2018, the care plan for Resident #30 was updated and new interventions were added. The minimum data set nurse added the following interventions. The new interventions include:
- I need my nurses to-record any episodes of wandering. Ensure my photo is available. Observe me for increased safety risks, wandering into other rooms, constant wandering without rest, and exit seeking behaviors. Notify MD as indicated.
- I need my nurse aides to---be able to ID me, ensure wanderguard is in place and notify my nurse if wanderguard is missing, take me for supervised walks. If I am restless, report to my nurse if I have increased safety risk, wandering into other rooms, constant wandering without rest, or exit seeking behaviors, going to doors,

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trying to open doors, etc. Report to my nurse if I have agitation, check to see if I have any physical comfort needs or pain. Notify my nurse as needed.
- I need social services to---offer redirection, refer to activity staff for diversional activities.
- I need activity staff to---provide me with diversional activities that are specific to my likes and dislikes and pat roles, provide me with a western book to read and provide country music for me to listen to if I am restless, take me to church services and hymn singing. If I am restless at night take me outside in the courtyard because I like to go outside to "get fresh air". If I become restless take me to see my childhood friend.

To ensure this deficient practice does not occur again, Trinity Place has implemented the following system changes:

1. On August 22nd, 2018, all of the exterior doors were checked for functioning, including proper closure, by the maintenance director and the director of nursing. The "Door Check" document demonstrates which employee checked which doors. On August 22, 2018, the rehab hall exit door was repaired by the maintenance director to latch when door is minimally opened by slightly sanding the paint off the metal door and frame. The annunciator (An annunciator is a panel that alarms when doors are opened for a certain amount of time. The annunciator shows which door is alarming. The annunciator is audible and visible at both nurse stations) was checked and was sounding in the nurses ' stations. The doors were checked again on August 23rd, 2018 by the director of nursing and maintenance director and all are still functioning properly, including proper

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closure. The maintenance director and the maintenance assistant will be responsible for checking every exterior door in the facility daily for four weeks to ensure the door is closing properly, then three times a week for eight weeks and then once a week. A new log titled, "Door Check Document" was developed on 8/23/18. During the first four weeks when the doors will be checked daily, the facility nursing supervisor will be responsible for checking the doors on Saturday and Sunday.

2. On August 22nd, 2018, education to all staff by the director of nursing and the director of clinical services began on the following topics:

a. Staff and visitors are only permitted to use the main entrance for entering and exiting the building; the only exception is that the A-hall door code will be given to the nursing supervisor in charge and the housekeeping director so that trash can be taken to the dumpster. (All of the codes on the exterior doors will be changed by August 23rd, 2018.)

b. Lutheran Services Carolinas (LSC) policy titled, "Elopement and Unsafe Wandering".

c. The expectations for completing work orders for any equipment that needs repair, any hazard that is found, or for any other issue that needs attention by maintenance personnel. The procedures for completing work orders that was used to train all staff is titled, "Trinity Place Procedures for Notifying Maintenance".

This training will be completed by August 23, 2018. Any staff member that cannot be reached or is on vacation will be inserviced prior to their next working shift by the director of nursing, nurse supervisor, or the staff development coordinator. This training will become part of the orientation process so that all new staff members will be in serviced on this information. This training

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includes all staff: full time, part time, as needed (PRN), and contracted staff.
3. On August 22nd, 2018, all residents were assessed for the risk of elopement by the Minimum Data Set nurse and the Facility Care Coordinator. All care plans were updated by the Minimum Data Set nurse and the Care Coordinator on August 22nd, 2018. Ten residents were identified as elopement risks, and ten care plans were updated.
The monitoring procedures to ensure the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliances is effective are below.

To monitor these changes, the director of maintenance will be responsible for monitoring and reporting the information by completing door checks. A new "Door Check" document was developed on August 23rd, 2018 to include a more comprehensive check. The new document includes a requirement for checking all nine exterior doors and includes the below procedures:
- In order to determine that each door is securely closing, the following procedures must be followed and then documented below:
- Open the door and allow it to fully close.
- The door must be opened and closed from two different open positions.
- Any incidences of failure must be either immediately reported to maintenance or immediately repaired.
Any issues found will be corrected immediately, and all data will be reported at the monthly quarterly assurance meeting.
The director of maintenance will provide a copy of the door checks to the director of nursing every Monday. The director of nursing will be

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F 689	Continued From page 53 responsible for reviewing the door check documents to ensure the checks are being completed as required. The administrator will be responsible for implementing the acceptable plan of correction. The credible allegation of Immediate Jeopardy removal was validated on 8/23/18 at 3:30 PM. Resident #30 ' s care plan was reviewed and had been updated with interventions. Record review indicated elopement risk assessments for all residents and revised care plans for the residents identified as an elopement risk were completed. The "Door Check" document was verified. Observations confirmed that the repair to the rehab hall exit door was completed, the door was in proper working condition, the numerical code was changed, and the annunciator was in proper working condition. A review of inservice sign in sheets as well as staff interviews verified education was provided on 8/22/18 and 8/23/18 on the Elopement and Unsafe Wandering policy, the main entrance door being the only permitted entrance for staff and visitors, and expectations for completion of work orders.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		9/24/18

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F 756	Continued From page 54 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, Consultant Pharmacist, and Psychiatric Nurse Consultant, the Consultant Pharmacist failed to identify the need to address a gradual dose reduction for an antianxiety medication for 1 of 5 residents (Resident #50) reviewed for unnecessary medications.	F 756	The plan of correcting the specific deficiency of the failure to identify the need to address a gradual dose reduction for antianxiety medication is as follows: The pharmacy consultant failed to address the need for gradual dose reductions as required for resident #50.	

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F 756	Continued From page 55 The findings included: Resident #50 was admitted on 6/5/14 with cumulative diagnoses of Dementia, Depression and Anxiety. Review of Resident #50's cumulative physician orders read she was to receive Ativan 0.5 milligrams (mg) at 4:00 PM daily. The date this order was indicated was 4/16/15. Review of the Consultant Pharmacist Recommendations from 6/29/16 to present included one recommendation dated 6/29/16 regarding the Ativan. At this time, Resident #50's PRN (as needed) Ativan was discontinued. There was no evidence of a Consultant Pharmacist Recommendation regarding the scheduled Ativan at 4:00 PM from 6/29/16 to present. Review of the monthly Consultant Pharmacist notes from 6/9/17 to present included no evidence that a GDR was attempted or recommended of Resident #50's scheduled Ativan. Review of Resident #50's care plan last revised 8/3/18 indicated she was to be considered for gradual dose reduction (GDR) of her antianxiety medication as indicated. Resident #50's quarterly Minimum Data Set dated 8/6/18 indicated moderate cognitive impairment and coded with no behaviors. She was coded for taking an antianxiety medication daily. In an interview on 8/22/18 at 2:52 PM, the Medical Director stated it was his expectation that	F 756	The gradual dose reduction for resident #50 antianxiety medication was completed on 9/6/2018. The procedure for implementing the acceptable plan of correction or the specific deficiency cited: The consultant pharmacist completed a review of all residents receiving antianxiety medication on 9/12/2018. The audit identified one resident due a Gradual Dose Reduction. This GDR (Gradual Dose Reduction) was recommended to the physician. Education was provided on 9-11-2018 to the pharmacy consultant by the administrator and director of nursing. The monitoring procedure to ensure that the plan of correction is effective is as follows: An GDR (gradual dose reduction) audit will be conducted weekly to review the antianxiety medications for 10 weeks and then monthly until three months of compliance is sustained by the Director of Nursing. All audits will be reviewed at QAPI presented by the Director of Nursing or Staff Development Coordinator The Title of the person responsible for the plan of correction is the Director of Nursing Date of Completion 9/24/2018	

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the Consultant Pharmacist complete a recommendation for an annual assessment for the continued need or possible GDR of Resident #50's scheduled Ativan. He further stated it was his expectation that any recommendation regarding the scheduled Ativan be acted on by the Psychiatric Nurse Consultant and an attempt at a GDR be done unless contraindicated.

In a telephone interview on 8/22/18 at 3:49 PM, the Consultant Pharmacist stated she reviewed Resident #50's electronic medical record on 6/9/18 when an annual re-evaluation of Resident #50's Ativan would be due for the consideration of a GDR. She confirmed she made no recommendation for Resident #50's scheduled Ativan since 6/29/16. The Consultant Pharmacist stated she did not routinely make recommendations if a resident was being followed by the Psychiatric Nurse Consultant.

In an interview on 8/22/18 at 2:00 PM, Nursing Assistant (NA) #8 stated Resident #50 continues to have episodes of anxiety and continues to talk about her husband's death. She stated her husband died a little over a year ago.

In an interview and observation with Resident #50 on 8/23/18 at 8:20 AM, she was in bed eating breakfast. She was alert and oriented with a flat affect. She mentioned the death of her husband and family dynamics involving her home. She stated she does not leave the facility for family visits as often as she once did.

In an interview on 8/23/18 at 11:11 AM, Unit Manager #1 stated Resident #50 was known to laugh and joke with him daily but continues to

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	345109	A. BUILDING _____ B. WING _____	C 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	24724 SOUTH BUSINESS 52 ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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have episodes of sadness and anxiety about her husband's death and changes in her family dynamic since his death.

In a telephone interview on 8/23/18 at 11:48 AM, the Psychiatric Nurse Consultant stated she noted the need for a GDR of Resident #50's scheduled Ativan during her onsite visit on 6/11/18 but she was exhibiting anxiety and staff reported episodes of anxiety. She stated she did not receive a recommendation to look at the scheduled Ativan but noted it herself. The Psychiatric Nurse Consultant stated Resident #50 was cognitively intact and exhibiting signs of depression and anxiety during her on-site visit 7/13/18. She stated she increased her antidepressant medication and felt it was not the time to consider a GDR of her scheduled Ativan. She stated normally she receives a pharmacy recommendation for her residents taking psychotropics but there have been instances where the recommendations were placed in the Medical Director's box and she would not see them.

In an interview on 8/23/18 at 2:31 PM, the Administrator stated it was her expectation that the Consultant Pharmacist made recommendations for providers to consider possible GDR's of psychotropic medications.