STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345423	A. BUILDING _____ B. WING _____	C 03/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON REHABILITATION AND NURSING CENTER	**1705 SOUTH TARBORO STREET WILSON, NC 27893**

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 3/4/19 through 3/8/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GIJF11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of complaint investigation of 3/8/19 Event GIJF11. A recertification survey was conducted from 3/4/19 through 3/8/19. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 2/10/19 and was removed on 3/8/19. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		4/1/19

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

Electronically Signed | 03/28/2019

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to keep the collection bag of an indwelling catheter covered for 1 of 1 residents (Resident # 10) reviewed for catheter care. The findings included: Resident #10 was admitted to the facility on 7/10/17. Her diagnoses included adult failure to	F 550	F550 The facility will ensure a resident who has an indwelling urinary catheter collection bag has the bag properly placed in a privacy bag cover. Resident #10 urinary collection bag was placed in the privacy bag cover on 3/5/2019 by direct care staff.	

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F 550	Continued From page 2 thrive, diabetes and urine retention. A review of the quarterly Minimum Data Set dated 12/9/18 revealed Resident #10 was severely cognitively impaired, had an indwelling urinary catheter and was frequently incontinent of bowel. She required extensive to total assistance for activities of daily living. A review of Resident #10's care plan revised on 1/11/19 revealed she had an indwelling catheter due to unspecified hydro nephrosis, urine retention and chronic cystitis. The interventions included "position catheter bag (with privacy bag) and tubing below the level of the bladder and away from the entrance room door." During an observation from the doorway of Resident #10's room on 3/5/19 at 11:58 am the urine collection bag was visible hanging on the side of the bed. The black privacy bag was observed hanging on the bed rail approximately 1 foot away from the collection bag. During an interview on 3/5/29 at 12:09 pm with NA #3 stated she was unsure why the collection bag the collection was not covered with the privacy bag. She stated the collection bag should be inside the privacy bag. NA #3 stated the nursing assistants were responsible for putting the collection bag inside the privacy bag. During an interview on 3/5/19 at 1:45 PM Nurse #3 stated the urine collection bag should have been inside the privacy bag. Nurse #3 stated the nursing staff were responsible to ensure the catheter bag was covered. On 3/8/19 at 10:00 am during an interview the	F 550	On 3/5/2019, the review of all residents revealed no other residents present in the facility with an indwelling catheter. Staff Development Coordinator will educate staff on the proper use of privacy covers for indwelling urinary collection bags. The Quality Assurance/Infection Control Coordinator or designee will audit presence of privacy bag cover on indwelling catheter bags for 14 days, then weekly for 2 weeks, then monthly for 4 months. The Quality Assurance/ Infection Control Coordinator will report audit results at the monthly QAPI meetings for 5 months.	

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F 550	Continued From page 3 Administrator stated she expected the catheter bag to always be covered.	F 550		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622		4/5/19

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F 622	Continued From page 4	F 622		

exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.

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F 622	Continued From page 5 (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide Physician documentation of criteria for facility-initiated discharge necessary for the resident's welfare, and documentation the facility could not meet the needs of the resident for 1 of 3 residents (Resident #56). Resident #56 was admitted to the facility 12/14/18 with diagnoses that included cerebral infarction, muscle weakness, cognitive communication deficit and heart failure. Review of Resident #56's minimum data set assessment dated 1/11/19 revealed the resident was assessed as moderately cognitively impaired and had displayed wandering behaviors 1 to 3 days of the previous 7 days. He required limited assistance with walking in room and locomotion on unit. He required supervision with locomotion off unit. Review of Resident #56's physician's orders revealed on 1/8/19 the resident was ordered to have a wander guard in place and for the functionality to be checked on third shift daily.	F 622	F622 The facility will ensure residents identified as meeting the criteria for facility-initiated discharge/transfer has the appropriate physician documentation of criteria for facility-initiated discharge and the reason the facility could not meet the needs of the resident. The attending physician will complete the required documentation for Resident # 56. The Administrator provided the attending physician with a copy of the discharge/transfer regulation on 3/21/2019. The Physician stated he read the regulations provided and verbalized understanding of the regulations to the Administrator on 3/28/2019. The Physician will sign acknowledgement of receipt of Transfer and Discharge Requirements for Long Term Care Facilities and understanding of the physician responsibilities regarding	

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F 622	Continued From page 6 Review of Resident #56's care plan revealed the resident was care planned as an elopement risk which was initiated on 1/8/19. The interventions included a sign with Resident #56's name on it was placed by his door to make it easier for Resident #56 find his room, monitor for fatigue and weight loss, provide assistance with locating room when needed, and wander guard placed with nurses to check placement every shift and function daily. Review of a nurse's note dated 2/10/19 revealed Resident #56 was found outside the facility. Review of a Social Services Coordinator's note dated 2/11/19 revealed Resident #56's family was contacted about transfer to a skilled nursing facility with a secure unit. Review of a Social Services Coordinator's note dated 2/12/19 indicated Resident #56 was discharged from the facility by family for transport to a skilled nursing facility with a secure unit. Review of Resident #56's physician orders dated 2/18/19 revealed Resident #56 was transferred to another facility on 2/12/19. Review of Resident #56's medical record revealed no documentation by the Physician of specific resident needs the facility could not meet, facility efforts to meet those needs, and specific services the receiving facility would provide to meet the needs of the resident. An interview was conducted on 3/8/19 at 2:37 PM with the Social Services Coordinator who stated there was no documentation from the physician which indicated Resident #56's specific needs the	F 622	regulations and requirement for completing discharge summaries for continuity of care 4/5/2019. The Director of Nursing or designee will audit 50% of all discharge/transfer medical records for 30 days, then 25% for 30 days and then randomly thereafter. The Director of Nursing or designee will report audit results at the monthly QAPI meeting for 3 months.	

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F 622	Continued From page 7 facility could not meet, facility efforts to meet those needs, and specific services the facility would provide to meet the needs of the resident. An interview was conducted with the Administrator on 3/8/19 at 5:15 PM who indicated she did not know the reason the doctor did not document Resident #56's specific needs the facility could not meet, the facility efforts to meet those needs and specific services the receiving facility would provide to meet the needs of the resident. Attempts to interview the physician were unsuccessful.	F 622		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		4/5/19

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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 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

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F 623	Continued From page 9 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. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge to the resident or the resident's representative for a facility-initiated discharge for 5 of 5 residents	F 623	F623 The facility will provide written notice of transfer or discharge and reasons for the move to the resident and the resident's representative(s) for a	

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F 623	Continued From page 10 reviewed for a facility-initiated discharge (Resident #56, # 53, # 24, #28, and #54). The findings included: 1. Resident #56 was admitted to the facility on 12/14/18 with diagnoses that included cerebral infarction, muscle weakness, cognitive communication deficit and heart failure. Review of Resident #56's minimum data set assessment dated 1/11/1/19 revealed the resident was assessed as moderately cognitively impaired and had display wandering behaviors 1 to 3 days of the previous 7 days. He required limited assistance with walking in the room and locomotion on the unit. He required supervision with locomotion off the unit. Review of Resident #56's orders revealed on 1/8/19 the resident was ordered to have a wander alarm in place and for the functionality to be checked on third shift daily. Review of a nurse's note dated 2/10/19 revealed Resident #56 was found outside the facility. Review of a Social Service Coordinator's note dated 2/11/19 revealed Resident #56's resident representative was contacted by phone regarding transfer to a skilled nursing facility with a secure unit. The note indicated the resident representative had no issue with the transfer. Review of a Social Services Coordinator's note dated 2/12/19 revealed Resident #56 was discharged from the facility with family members for transport to a skilled nursing facility with a secure unit.	F 623	facility-initiated discharge. The Administrator provided the Business Office Coordinator and Social Services Coordinator a copy of the notice requirements a facility must provide for a facility- initiated transfer/discharge on 3/12/2019. The Business Office Coordinator and Social Services Coordinator signed acknowledgement of receipt of Notice Requirements for Long Term Care Facilities and understanding of the responsibilities regarding regulations and requirement for completing notice requirements before resident discharged/transferred or as soon as practical 4/2/2019. The Business Office Coordinator and Social Services Coordinator prepare a Facility Transfer/Discharge Form to provide to the resident and resident representative as soon as practical of a discharge or transfer initiated by the facility on 3/29/2019. The Director of Nursing and designee provided education to the nursing staff regarding the notice form, location of form, requirements and usage of the form on 4/1/2019. Education will be completed by April 30, 2019. The facility nurse or designee will send the facility - initiated discharge notice with the resident at the time of transfer to ED or other entity. The facility nurse or	

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F 623	Continued From page 11 A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's transfer to a skilled facility with a secure unit on 2/12/19. During an interview on 3/7/19 at 2:40 pm the Social Services Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's transfer to a skilled facility with a secure unit on 2/12/19. The Social Services Coordinator stated the resident representative was verbally informed of the transfer and agreed with the transfer. During an interview on 3/7/19 at 2:43 pm with the Business Office Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's transfer to a skilled facility with a secure unit on 2/12/19. She added she would create a form to send. During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated she was not aware of the requirement to provide written notification to the resident or responsible party for facility-initiated discharges necessary for the resident's welfare. 2. Resident #53 was admitted to the facility on 8/24/18 with diagnoses that included chronic obstructive pulmonary disease and dementia. Review of a nurse's note dated 1/24/19 revealed Resident #53 was sent to the hospital for evaluation for shortness of breath. A review of the medical record revealed no	F 623	designee will place a copy of the notice in the medical record. The Business Office Coordinator or designee will mail the Facility Transfer/Discharge notice to the resident representative as soon as practical of a discharge or transfer initiated by the facility. The Business Office Coordinator or designee will scan copy of notice to medical record and place copy of the notice in the financial chart. The Administrator or designee will audit all discharges or transfers for 4 weeks and randomly thereafter. The Administrator will report the audit results at the monthly QAPI meeting x 2 months.	

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written notice of discharge was provided to the resident representative for the resident's hospital transfer on 1/24/19.

Review of a nurse's note dated 1/30/19 revealed Resident #53 was readmitted to the facility from the hospital on 1/30/19.

During an interview on 3/7/19 at 2:31 pm with Nurse #4 she stated when a resident was sent to the hospital the paperwork sent included the face sheet, the physician's order, the history and physical and the most recent laboratory results. Nurse #4 said no other paperwork was sent when a resident was sent to the hospital. No written notice of discharge was provided so the written notice of discharge was not provided by Nurse #4.

During an interview on 3/7/19 at 2:40 pm the Social Services Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 1/24/19.

During an interview on 3/7/19 at 2:43 pm with the Business Office Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 1/24/19. She added she would create a form to send.

During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated she was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers.

3. Resident #24 was admitted to the facility on

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5/2/17 with diagnoses that included hypertension and anemia.

Review of a nurse's note dated 9/11/18 revealed Resident #24 was sent to the hospital for evaluation after being found nonresponsive.

A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's hospital transfer on 9/11/18.

Review of a nurse's note dated 9/19/18 revealed Resident #24 was readmitted to the facility from the hospital on 9/19/18.

During an interview on 3/7/19 at 2:31 pm with Nurse #4 she stated when a resident was sent to the hospital the paperwork sent included the face sheet, the physician's order, the history and physical and the most recent laboratory results. Nurse #4 said no other paperwork was sent when a resident was sent to the hospital. No written notice of discharge was provided so the written notice of discharge was not provided by Nurse #4.

During an interview on 3/7/19 at 2:40 pm the Social Services Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 9/11/18.

During an interview on 3/7/19 at 2:43 pm with the Business Office Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 9/11/18. She added she would create a form to send.

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During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated she was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers.

4. Resident #28 was admitted to the facility on 10/3/18 with diagnoses that included atrial fibrillation and diabetes mellitus.

Review of a physician's progress note dated 12/17/18 revealed Resident #28 was sent to the hospital due to altered mental status and confusion on 12/6/18.

A review of the medical record revealed no written notice of discharge was provided to the resident representative for the resident's hospital transfer on 12/6/18.

Review of a physician's progress note dated 12/17/18 revealed Resident #24 was readmitted to the facility from the hospital on 12/8/18.

During an interview on 3/7/19 at 2:31 pm with Nurse #4 she stated when a resident was sent to the hospital the paperwork sent included the face sheet, the physician's order, the history and physical and the most recent laboratory results. Nurse #4 said no other paperwork was sent when a resident was sent to the hospital. No written notice of discharge was provided so the written notice of discharge was not provided by Nurse #4.

During an interview on 3/7/19 at 2:40 pm the Social Services Coordinator stated she did not send written notice of discharge to the resident or

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the resident's representative for the resident's hospital transfer on 12/6/18.

During an interview on 3/7/19 at 2:43 pm with the Business Office Coordinator stated she did not send written notice of discharge to the resident or the resident's representative for the resident's hospital transfer on 12/6/18. She added she would create a form to send.

During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated she was not aware of the requirement to provide written notification to the resident or responsible party for emergent hospital transfers.

5. Resident #54 was admitted to the facility on 11/9/18. Her diagnoses included respiratory infection, depression and diabetes.

A review of Resident #54's Minimum Data Set dated 2/11/19 revealed she was moderately cognitively impaired. She required extensive assistance with most of her activities of daily living.

A review of the nursing notes dated 12/18/19 revealed Resident #54 was sent to the hospital for possible urinary tract infection and abdominal pain.

A record review revealed Resident #54 was readmitted to the facility 12/21/18.

During an interview on 3/7/19 at 2:31 pm with Nurse #4 she stated when a resident was sent to the hospital the paperwork sent included the face sheet, the physician's order, the history and physical and the most recent laboratory results. Nurse #4 said no other paperwork was sent when

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F 623	Continued From page 16 a resident was sent to the hospital. No written notice of discharge was provided so the written notice of discharge was not provided by Nurse #4. During an interview on 3/7/19 at 2:40 pm the Social Services Coordinator stated she did not provide written information to the resident or the resident's responsible party about the discharge to the hospital. During an interview on 3/7/19 at 2:43 pm with the Business Office Coordinator she stated she did not provide any written information to the resident or the family for emergent hospital transfers. She added she would create a form to send. During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated she was not aware of the requirement to provide written notification to the resident or the responsible party for emergent hospital transfers.	F 623		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 6 of 18 resident assessment reviewed (Resident #17 and Resident #26 for use of an anticoagulant, Resident #57 for discharge destination, Resident # 10 for urinary catheter, and Resident #51 and Resident #30 for functional status).	F 641	F641 The facility will ensure accurate assessments that reflect the resident's status. The MDS Nurse #2 completed a MDS modification for Resident #17 and # 26 to reflect accurate coding for Clopidogrel Bisulfate use.	4/5/19

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F 641	Continued From page 17 The finding included: 1. Resident #17 was admitted to the facility on 9/15/16 with diagnoses which included coronary artery disease, congestive heart failure. A review of Resident #17's quarterly Minimum Data Set (MDS) dated 1/4/19 revealed section N at N0410 item E was coded as Resident #17 received an anticoagulant for all 7 days of the look back period. A review of the Medication Administration Record revealed Resident #17 received Clopidogrel Bisulfate 75mg q day during the look back period for the quarterly MDS dated 1/4/19. During an interview with MDS nurse #2 and MDS nurse #1 on 3/8/19 at 12:45 pm MSA nurse #2 reviewed the "Anticoagulation List" and stated Clopidogrel was not on the list. MDS Nurse #2 then reviewed the RAI (Resident Assessment Instrument) manual under section instructions for N0410 which stated "do not include Clopidogrel." MDS Nurse #1 stated she thought the medication was an anticoagulant so she had coded the N0410 item E incorrectly. During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated it was her expectation MDS assessments are coded completely and accurately. 2. Resident #26 was admitted to the facility on 3/5/15 with diagnoses which included stroke, diabetes and dementia. A review of the quarterly Minimum Data Set	F 641	The MDS Nurse #2 completed a MDS modification for Resident # 57 to reflect the accurate discharge destination. The MDS Nurse #2 completed a MDS modification for Resident # 10 to reflect not coding bladder continence for a resident with an indwelling catheter. The MDS Nurse #2 created a list of anticoagulant medications to use as coding reference. The MDS Nurse #2 educated MDS Nurse #1 on appropriate MDS coding for anticoagulation use; not coding bladder continence in presence of an indwelling catheter; discharge destination and functional status on 3/26/2019. The Staff Development Coordinator will educate the Direct Care Nurses on running an end of shift documentation report to validate completeness of nursing assistants documentation by April 30, 2019. The MDS Nurses will run a look back report in preparation for MDS assessment and in absence of nursing assistant documentation in look back report, MDS nurse will interview staff, make observations and document findings in medical record accordingly. The MDS Nurse(s) will provide in-services for nurses and nursing assistants to include correct coding and documentation	

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F 641	Continued From page 18 (MDS) dated 1/18/19 for Resident #26 revealed section N at N0410 item E was coded as the resident received an anticoagulant for all 7 days of the lookback period. A review of the Medication Administration Record revealed Resident #26 received Clopidogrel Bisulfate daily during the look back period for the quarterly MDS dated 1/18/19. During an interview with MDS nurse #2 and MDS #1 on 3/8/19 at 12:45 pm MDS nurse #2 reviewed the "Anticoagulation List" and stated Clopidogrel was not on the list. MDS Nurse #2 then reviewed the RAI (Resident Assessment Instrument manual under section instructions for N0410 which stated "do not include Clopidogrel." MDS Nurse #1 stated she thought the medication was an anticoagulant so she had coded it incorrectly. During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated it was her expectation MDS assessments are coded completely and accurately. 3. Resident # 10 was admitted to the facility 7/1/17 with diagnoses which included urinary retention, chronic cystitis and adult failure to thrive. A review of the quarterly Minimum Data Set (MDS) revealed section H item A was coded that Resident #10 had an indwelling catheter. This MDS also coded item H0300 as frequently incontinent. During an interview with MDS nurse #1 on 3/8/19 at 11:52 am she stated if a resident had a catheter then the bladder continence would not	F 641	for functional status of residents by April 30, 2019. The MDS Nurse #2 will audit 50% of MDS Nurse #1 completed MDSs for 2 weeks, then 25% of MDS Nurse #1 MDSs for 2 weeks, then randomly thereafter. The MDS Nurse #2 will report audit results at the monthly QAPI meeting for one month.	

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be coded and instead it should be coded a 9 as not rated resident had a catheter. She stated it was a coding error.

During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated it was her expectation MDS assessments are coded completely and accurately.

4. Resident #57 was admitted to the facility 1/15/19 with diagnoses which included metabolic encephalopathy, difficulty walking and glaucoma.

A review of the discharge Minimum Data Set (MDS) dated 2/13/18 revealed section A at item F was coded as 10. Discharge assessment - return not anticipated. Also in Section A at A2100 the discharge status was coded as item 03 acute hospital.

A review of the nursing notes revealed Resident #57 was discharged home.

A record review revealed a Discharge Summary form which indicated Resident #57 was discharged on 2/13/19 as a planned discharge to home. The form was signed by the physician.

During an interview with MDS nurse #1 on 3/8/19 at 2:45 PM she stated the MDS coding for discharge destination was not coded correctly.

During an interview with the Administrator on 3/8/19 at 5:15 PM she indicated it was her expectation MDS assessments are coded completely and accurately.

5. Resident #51 was admitted to the facility on 9/17/15 with diagnoses that included hypertension and glaucoma.

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Review of Resident #51's annual minimum data set (MDS) assessment dated 7/4/18 revealed Resident #51 was not assessed in Section G, question G0100E for locomotion on the unit, Section G, question G0100F for locomotion off the unit and Section G, question G0120 for bathing.

During an interview on 3/8/18 at 11:52 AM with MDS Nurse #1 she stated Resident #51 should have been assessed for locomotion on and off the unit and bathing. She indicated these areas were not coded by staff and she was unaware questions G0100E, G0100F, and G0120 were answered as not assessed.

During an interview with the Administrator on 3/8/19 at 5:15 PM who indicated it is her expectation MDS assessments are coded completely and accurately.

6. Resident # 30 was admitted to the facility on 5/11/17 with diagnoses that included atrial fibrillation and osteoarthritis.

Review of Resident #30's annual minimum data set (MDS) assessment dated 5/14/18 revealed Resident #30 was not assessed in Section G, question G0100C for walking in her room, Section G, question G0100D for walking in the corridor, Section G, question G0100E for locomotion on the unit, Section G, question G100F for locomotion off the unit, and Section G, question G100I for toilet use.

Review of Resident #30's quarterly MDS assessment dated 2/2/19 revealed Resident #30 was not assessed in Section G, question G100I

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F 641	Continued From page 21 for toilet use. During an interview on 3/8/19 at 11:52 AM with MDS Nurse #1 she stated Resident #30 should have been assessed for walking in her room and the corridor, locomotion on and off the unit and toilet use. She said these areas were not coded by staff and she was unaware questions G100C, G100D, G100E, G100F, and G100I were answered as not assessed on Resident #30's MDS assessment dated 5/14/18. She stated she was unaware question 100I was coded as not assessed on Resident #30's MDS assessment dated 2/2/19. During an interview with the Administrator on 3/8/19 at 5:15 PM who indicated it is her expectation MDS assessments are coded completely and accurately.	F 641		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, security video review, and staff interviews the facility failed to provide supervision to prevent a moderately cognitively impaired resident (Resident #56) who displayed wandering behaviors, from exiting the facility unsupervised for 1 of 2 residents reviewed for	F 689	F689 The facility will provide supervision to prevent accidents. 1.Resident #56 was returned immediately back into the facility on 2/10/2019. 1 to 1 monitoring utilized. Resident discharge to	4/5/19

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F 689	Continued From page 22 accidents. The resident was returned to the facility after a housekeeping staff member saw the resident open the service entrance door to the facility and attempt to come in. Resident #56 was retrieved by the housekeeping staff member and nursing staff. No injuries were reported. The facility also failed to ensure a resident dependent on transfers by lift was transferred by a lift which resulted in an assisted fall without injury for 1 of 2 residents reviewed for accidents (Resident #156). Immediate Jeopardy began on 2/10/19 when Resident #56 made an unsupervised exit from the facility. The resident was assessed and retrieved by Nurse #1 and Housekeeper #1 and returned to the facility with no physical injuries. Immediate jeopardy was removed on 3/8/19 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy 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. Example #2 (Resident #156) was cited at a scope and severity of a D where a plan of correction is required. Findings included: 1. Resident #56 was admitted to the facility on 12/14/18. His active diagnoses included cerebral infarction, muscle weakness, cognitive communication deficit, atrial fibrillation, and heart failure. Review of an elopement risk assessment dated 1/4/19 revealed Resident #56 was assessed to require a wander guard. (A wrist band which made the doors alarm if the resident attempted to	F 689	secured unit on 2/12/2019. Staff Development Coordinator tested wander guard on resident and all other residents using the wander guard devices. No issues were found with the wander guard system. Wander board was verified and found to be up-to-date. These actions occurred 2/10/2019. Admitting Nurse will continue to complete elopement assessment on all admissions. MDS nurse(s) will complete elopement assessment within one day or on day 7 and quarterly for all residents. The wander guard system will continue to be utilized for any resident that triggers as an elopement risk. Staff Development Coordinator or designee will perform daily wander guard system checks on the facility doors. Staff Development Coordinator will review and educate on the functionality with staff of the wander guard system including differentiation of door alarming sounds with or without the wander guard device activation by April 30, 2019. The Staff Development Coordinator will conduct elopement drills on alternating shifts 2x/week for 4 weeks, 1x/week for 4 weeks and then once per month for 3 months and quarterly thereafter. During educational training, the staff will be instructed if resident is not immediately visible, to go out the door that alarmed and look around the immediate area and	

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F 689	Continued From page 23 leave the facility) Review of Resident #56's physician's orders revealed on 1/8/19 the resident was ordered to have a wander guard in place and for the functionality to be checked on third shift daily. Review of Resident #56's care plan revealed the resident was care planned as an elopement risk which was initiated on 1/8/19. The interventions included a sign with Resident #56's name on it was placed by his door to make it easier for Resident #56 find his room, monitor for fatigue and weight loss, provide assistance with locating room when needed, and wander guard placed on resident with nurses to check placement every shift and function daily. Review of Resident #56's 30-day Minimum Data Set assessment dated 1/11/19 revealed the resident was assessed as moderately cognitively impaired and had displayed wandering behaviors 1 to 3 days of the previous 7 days. He required limited assistance with walking in room and locomotion on unit. He required supervision with locomotion off unit. Review of a nurse's note dated 2/9/19 at 12:34 PM revealed Resident #56 was observed wandering around the unit and needed frequent monitoring and redirection. Review of a nurse's note dated 2/10/19 at 2:25 PM reveled Resident #56 was in his wheelchair wandering around and talking about calling a cab to go home. He was redirected frequently. The security videos of the facility on 2/10/19 were reviewed. Resident #56 approached the front	F 689	down each side of the building. MDS nurse will continue to keep log of elopement risk residents, ensure orders placed on MAR to check presence of wander guard every shift and function test nightly. The MDS nurse(s) will monitor daily documentation for each order on all elopement risk residents for 2 weeks, then 2x/week for 2 weeks, then 1x/week for 2 weeks then monthly for 3 months, then randomly thereafter. Staff Development Coordinator and MDS nurse will report drill and audit information at the monthly QAPI meeting for 5 months. This part of the F689 credible allegation plan completed 3/8/2019. F689 The facility will ensure a resident dependent on transfers by lift will be transferred by a lift to prevent accidents. 2.Therapy Program Director immediately educated NA #4 on transfer lift requirement while assisting resident #156 back into bed. Nursing Supervisor reminded direct care staff to use Kardex for resident information before providing care and transferring residents according to plan of care. Director of Nursing or designee to re-educate on use of Kardex, expectations to follow plan of care, and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24 entrance to the rehabilitation unit on 2/10/19 at 7:41 PM and the resident was observed by Nurse #2 at that time. Resident #56 was self-propelling in his wheelchair with his jacket on as well as shoes. Resident #56 then turned from the door when it did not immediately open and went back on the rehabilitation hall at 7:42 PM. At 7:44 PM Resident #56 entered the rehabilitation dining room area. Nurse #2 had continued further down the rehabilitation hall, around the corner, at that time entered another resident ' s room and could not see Resident #56. At 7:44 PM Resident #56 was observed to begin pressing against the rehabilitation dining room emergency exit door which would initiate the door alarm. At 7:45 the emergency exit door opened and Resident #56 attempted to self-propel his himself out of the open door while still sitting in his wheelchair. The rise in the threshold prevented the resident from rolling his wheelchair outside while he was sitting in it. He continued to try multiple times. At 7:45 PM Resident #56 stood from his wheelchair holding the door open. He turned around, grabbed the left wheelchair armrest while holding the door open, and stepped outside at 7:46 pulling his wheelchair outside with him. The door closed behind him at 7:46 PM and Resident #56 was observed to hold his wheelchair by the handles behind the wheelchair and turned to the right and began to walk around the building outside out of sight. At 7:46 PM a visitor was observed to enter the rehabilitation dining room. He stopped and looked at the door, went over to the door, and looked out the door window. He then turned and walked away from the door towards the coffee machine out of the camera ' s view. At 7:47 the footage jumped to 2/10/19 at 7:48 PM and continued. At 7:48 PM Nurse Aide #1 was observed to enter the rehabilitation dining	F 689	transfer according to plan of care for each resident. Director of Nursing or designee to visually audit transfers with/without manual lift and compare to the residents pan of care 2x/week for 4 weeks, 1x/week for 4 weeks and then randomly for 4 months. Director of Nursing will report audit results at the monthly QAPI meeting for 6 months.	

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room and at 7:48 PM entered a code at the emergency door. At 7:48 PM she briefly glanced out of the emergency door window and then walked out of the rehabilitation dining room at 7:48 PM. Nurse Aide #1 then walked down the rehabilitation hall and to check Resident #56 ' s room at 7:49 PM, and upon not finding him there she continued to walk down the rehabilitation hall. Also, at 7:49 PM Housekeeper #1 observed Resident #56 attempting to enter the facility through the service entry doors. Housekeeper #1 walked down the entrance hallway hall out of the screen at 7:49 PM and then walked back into the screen 7:49 PM, placed his cleaning equipment on his housekeeping cart, and then continued down the entrance hall to the exit to retrieve Resident #56. At 7:49 PM, while looking for Resident #56 on the rehabilitation hall, Nurse Aide #1 was observed to exit the security screen monitor in the direction of the staff member station in the corner of the rehabilitation unit. At 7:49 PM Housekeeper #1 turned into the main dining room out of view of the security video to go retrieve Resident #56. Nurse #1 was observed to enter the screen at this time as well and followed Housekeeper #1 down the hall and out the same door. This video feed of the entry hallway ended before the resident was returned inside the facility. At 7:49 PM Nurse Aide #1 was observed to reenter the security screen footage on the rehabilitation hall with a beverage in hand and resumed looking for Resident #56 walking down the rehabilitation hall. At 7:53 PM Nurse Aide #1 and Nurse #1 were observed to enter the rehabilitation footage with Resident #56 in his wheelchair. At 7:55 PM Resident #56 was taken to his room by Nurse Aide #1.

During observation on 3/7/19 at 8:25 AM the

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distance traveled by Resident #56 from the door he exited to the services entrance door where he was observed by the housekeeping staff member was measured with Physical Therapist Assistant #1. The distance was measured to be 425 feet. The distance was then measured from the services entrance door to the location Housekeeper #1 and Nurse #1 stated they found the resident when they went outside to retrieve him. The distance was measured to be 84 feet. The rehabilitation dining room doors opened to a paved, covered patio which had two metal, round patio tables with four metal patio chairs at each table. There were three wooden rocking chairs on the patio as well as a wooden bench. Just to the right of the door Resident #56 exited, there was a concrete side walk which led around the back of the building. The ground was flat and there were a few bushes near the side walk as well as a metal chain link fence approximately 7 feet tall that went behind the building alongside the side walk approximately 8 feet to 40 feet from the side walk and varying intervals and the side walk turned around the building. The fence ended near the patio where Resident #56 exited the building and continued around the back of the facility to the service entry paved area. It was not connected to the facility to prevent the resident from either entering the parking lot or entering the densely wooded area between the facility and apartment buildings directly ahead of the rehabilitation dining room door Resident #56 exited. The side walk eventually met the paved lot where the service entrance to the facility was located. This was where trucks could provide deliveries to the facility. There were two large trash dumpsters to the left of where the side walk met the pavement and to the right was 85 feet to the service entrance door where a cardboard

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dumpster was placed next to the service entry door.

Review of the temperatures for 2/10/19 for the facility location at www.localconditions.com revealed at 7:45 PM and 8 PM the temperature was 42 degrees Fahrenheit.

Review of an incident note dated 2/10/19 at 9:49 PM revealed a staff member had discovered Resident #56 outside the facility by trash cans. The resident was brought back inside and was sleeping in his bed at that time. The physician was notified, and the resident's family members were called with no answer. A message was left for them to call the facility back.

Review of a nurse's note dated 2/10/19 at 9:59 PM revealed at 8:00 PM Nurse #1 from the 300-hall came to let the rehabilitation Nurse #2 know that her resident, Resident #56, had gotten out of the building and was spotted out by the trash cans by a staff member. The staff member came to the Nurse #1 and said he thought there was a resident outside. The 300-hall Nurse #1 went out and brought Resident #56 back into the building. The rehabilitation hall Nurse Aide #1 took Resident #56 to his room and got him in bed where he was at that time. The physician was notified with no new order and the resident ' s family members were called twice with no answers and a message was left.

Review of a written statement dated 2/10/19 revealed Housekeeper #1 was waxing the floor in the back-service area of the facility. Resident #56 had opened the back door at five minutes to 8 PM and the Housekeeper #1 stated he asked Resident #56 to wait right there at the door

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because There was wax on the floor and he did not want the resident to slip on the wax. Housekeeper #1 then ran to the hall at the main desk and told the Nurse #1 a resident was outside at the back door. He then ran to the front door and went around the building in case the resident had continued around the facility. He stated the nurse was already with the resident when he got around the facility.

Review of a witness statement dated 2/10/19 revealed Nurse #1 stated on 2/10/19 at 7:55 PM, Housekeeper #1 came running in the hall and said Resident #56 was in the back outside. The nurse said she ran to the dining room and went out that door to get Resident #56 and he was fine, happy, and talking with her as she brought him back in to the facility. She stated the Nurse Aide #1 was coming through the doors from the rehabilitation side looking for Resident #56 and took him back to his room.

Review of a witness statement dated 2/10/19 revealed Nurse Aide #1 stated she had just seen Resident #56 in his room when she went into the room across the hall from him. The nurse aide and the resident in that room heard the alarm. The nurse aide left the resident ' s room and went to the door in the rehabilitation dining room which was alarming. She said she looked out of the door and didn ' t see anything. The nurse aide said she then reset the alarm and started looking for Resident #56. After looking in the rooms on the rehabilitation side of the facility she stated she started walking towards the 100 and 300 hall doors and saw the nurse coming up the hall with Resident #56. The nurse aide said she then took the resident to his room and helped him get ready for bed. Resident #56 acted the same as he

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always did; talking and cooperative with getting ready for bed.

During an interview on 3/6/19 at 2:44 PM Housekeeper #1 stated sometime in the evening of 2/10/19 he was putting wax on the floor at the entry way to the building for supplies and dietary deliveries. He stated he had almost finished waxing and he saw Resident #56 open the door to come in through the service entry doors from outside the building and Housekeeper #1 did not know how Resident #56 had gotten outside. He stated he did not hear any alarms going off from the door at that time. He stated he asked the resident to not come in the door because he was afraid Resident #56 would fall since he had just waxed the floor. He then stated the resident let the door close, so he could not see the resident anymore and Housekeeper #1 then went to the nurse's station and informed someone, he did not remember who, that a resident was outside. He stated he then went to go get the resident and by the time he got around to where Resident #56 was standing, the 300-hall nurse, who he did not know, had come outside with a wheelchair and they placed Resident #56 in the wheelchair and brought him back into the facility. He further stated he did not know if the resident had a wander guard in place or not. He stated it was dark outside by that time and was a little cold.

During an interview on 3/6/19 at 3:27 PM Nurse #1 who was the 300-hall nurse stated on 2/10/19 she was pulling medications from her cart at the end of the 300 hall and around 7:30 PM Housekeeper #1 came to the nurse ' s station and shouted to her that there was a resident outside. The housekeeper did not know who it was, but just said a resident was outside. She stated by

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the time she locked her cart and got up to the nurse ' s station Housekeeper #1 had gone back outside to the resident, so she was looking around at the different doors to see where they were. After a couple of minutes, she went out the dining room door and around the side of the building where the loading area was and found Housekeeper #1 holding Resident #56 ' s wheelchair and the resident was standing near the housekeeper having a conversation with him. She stated Resident #56 had taken his wheelchair outside with him which was why the chair was there. No other staff members were present at that time. She further stated upon seeing Resident #56 she knew the resident from working on the rehab hall and knew he was not supposed to be outside. She asked him where he was going, and he told her he was looking for his car. She stated she then asked him to come back in because it was cold outside, and the resident agreed and sat in his wheelchair. She further stated she looked and Resident #56 had his wander guard in place at that time and was wearing a jacket and shoes. She stated she brought him back to his unit on the rehabilitation hall and reported the incident to the Nurse #2 and Nurse Aide #1 on the rehabilitation unit. She further stated the Staff Development Coordinator then went and checked all the doors and the doors worked and they checked Resident #56 ' s wander guard and it worked. She stated she had worked on the rehabilitation hall multiple times and Resident #56 had a wander guard since January 2019 and she knew he was an elopement risk. She further stated for that reason she would observe for the resident coming on to her hall if she was not on the rehabilitation hall, however he did not come on that side of the unit that night that she was aware of. She further

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stated she did could not figure out which door he got out of because the panel on the double doors that separated the 100 and 300 halls from the rehabilitation unit he resided on was not flashing which would have indicated he had forced his way through to the 100 hall and 300 halls from the rehabilitation unit. For that reason, she thought maybe he had exited through the rehabilitation unit doors to the outside and gone around the building on the other side. She concluded she had not heard any alarms that shift and did not know Resident #56 was outside the building unattended until Housekeeper #1 alerted her.

During an interview on 3/6/19 at 7:20 PM Nurse #2 stated she was Resident #56 ' s assigned nurse on 2/10/19, and fifteen minutes before Resident #56 got out of the facility on 2/10/19 between 6:45 PM and 7 PM she had taken Resident #56 back to his room and helped him to his reclining chair in his room. She stated he had been up and down the hall all night long and she was the only nurse on the rehabilitation unit and she had chased him down two or three times trying to go to the 100 and 300 hall doors. The last time she found him doing this she asked him to come to his room to relax for a little bit. She stated she went back around the corner of the hall where there were call lights going off and entered another resident ' s room to take the resident to the bathroom and waited till the resident was done because that resident was a fall risk. When she came back out of the room the 300-hall nurse came and found her around ten minutes after she had last seen Resident #56 and informed her Resident #56 had been found outside the facility. She stated she did not hear any alarms during that ten-minute period. Nurse

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#2 stated Nurse Aide #1 was in another room at that time as well. She further stated she was not aware he had gotten out of the facility until the 300-hall Nurse #1 informed her. The nurse continued to state she had checked his wander guard at the beginning of her shift to ensure he was wearing it. She stated the door he exited the building from had both and emergency alarm and a wander guard alarm and once the alarms started, a staff member would have to clear the alarm for the alarm to stop if the door had been opened. The nurse stated she did not clear either the wander guard alarm or the emergency door alarm so someone else must have cleared the alarms. She further stated Resident #56 had been continually setting off the wander alarm at the rehabilitation dining area door through her shift which started at 3 PM so she knew the wander guard was working. She further stated she was educated about how to check wander guard functioning and that was the only education she received after the incident. She further stated that night they called a staff member in and placed the resident on 1 on 1 observation.

During an interview on 3/7/19 at 8:32 AM Nurse Aide #1 stated she worked the rehabilitation hall and was assigned Resident #56 on 2/10/19 starting her shift at 7 PM. She stated she got her report and was told one of the residents wanted to go to bed. She stated between 7 PM and 7:15 PM she had seen Resident #56 sitting in his wheelchair at the nurse's cart on the rehabilitation unit talking to Nurse #2. She stated she went in the other resident's room to help the resident to bed and the television in the room was loud. She stated after she got the resident to bed the family member in the room turned the television off and she heard an alarm. She stated at first, she

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thought the alarm was in the resident's room and was looking around in the room but could not find anything making the noise. The nurse aide then put her head out the resident's door and heard it was from down the hall, so she told the resident she would be right back. Nurse Aide #1 stated she did not see any other staff and went to the rehabilitation dining room door and cut the door alarm off and peeked outside to see if anyone was outside the door but did not see anyone outside. She stated she then went back to the top of the rehabilitation hall and began to look in each room for Resident #56 because she knew he had to be the resident that set the alarm off because he had a wander guard and was a wanderer. She stated because the alarm had been going off other staff must have been aware, so she did not need to tell anyone to look for him. She stated she searched all the rooms on the rehabilitation hall and did not find him, so she began to go through the doors to the 100 and 300 halls. At that point she saw Resident #56 being brought back to the rehabilitation unit by the 300-hall nurse and that was when she was informed he had gotten outside of the facility at about 7:35 PM. She stated the doors to the rehabilitation dining room were supposed to lock automatically if there was a wander guard near them and not open, so she did not know how he got outside. She stated she did not think he could have been outside because of the wander guard which was why she began searching inside the building for him and did not go outside. Nurse Aide #1 concluded she did not receive any education or further information about how he got out or how to avoid it happening in the future.

During an interview on 3/6/19 at 4:20 PM the Staff Development Coordinator stated on 2/10/19 she

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had left work and the Administrator called her and told her Resident #56 has gotten out of the building but had been brought back in. She stated she came back to the facility and checked the wander guard sensors on all the doors and checked all the residents wander guards in the facility to make sure they were functioning. She stated she verified all of the door sensors and all of the resident's wander guards were functioning appropriately including Resident #56 ' s wander guard. She stated Resident #56's wander guard was functioning correctly when she tested it the evening of 2/10/19. She stated they then checked the computer system to ensure it was functioning as well and it was, and a nurse aide was pulled to provide 1 on 1 observation. She further stated the facility did not have a secured unit and if anyone put pressure on the door for 15 seconds even with a wander guard, the door would open. The Staff Development Coordinator stated if someone tried to open the door but did not get it open, the alarm would stop, however, once the door opens after 15 seconds of continuous pressure, the alarm would continue to go off to indicate someone had opened the door. The alarm would continue until someone cleared the alarm. She further stated Resident #56 had wandered the entire time she had been working since 12/31/18 and had a wander guard in place prior to his unwitnessed exit from the facility on 2/10/19. She concluded she educated staff how to test the wander guards and ensuring the computer system for the wander guards was up. She stated that was all the education provided to staff following the incident. She stated she was told the Administrator had observed the security taps and witnessed Resident #56 had gone into the rehabilitation dining room which was not in use at that time and pressed on the door for the fifteen

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seconds which allowed the door to open and he dragged his wheelchair out behind himself and the door then closed. She stated he then had wandered around the building to the service entrance where he was attempting to get back in again.

During an interview on 3/7/19 at 9:42 AM the Administrator stated the 300-hall nurse called her on her cell phone around 8 PM and said Resident #56 was outside and they brought him in. She was already at the facility, so she interviewed all involved staff to find out what happened. The Administrator stated she then called security to see if she could see the surveillance cameras. She concluded she felt her staff and the interventions in place had functioned well and this was normal behavior for Resident #56 because he would push on a door and when the alarm sounded he would redirect himself. She stated following his exit from the facility he was placed on 1 on 1 observation that night. She further stated the next morning at the morning meeting they spoke that since he demonstrated he could read the sign and follow it, they needed to look for another secure, locked area for the resident and the social worker began placing calls and the resident was transferred to another facility with a locked unit on 2/13/19. She further stated he had 1 on 1 every night following the incident. The Administrator stated he had no injuries and no further follow up was needed. She further stated Housekeeper #1 did what he needed to do because he could not get to the resident over the wet wax on the floor between him and the door the resident was opening. She did not believe he could have kept Resident #56 in his eyesight without endangering himself or the resident. The Administrator concluded Resident #56 had all the

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appropriate interventions in place and felt the staff had responded adequately to the incident and therefore, the incident was handled appropriately and did not require further investigation for the root cause. The interview further revealed She did not believe there were any further interventions or actions the facility could have taken to avoid the incident since the wander guard was working, the door alarms were working, and she could not lock her facility.

The Administrator was notified of the immediate jeopardy on 3/7/19 at 11:19 AM. On 3/8/19 at 4:55 PM the facility provided the following credible allegation of compliance for immediate jeopardy removal:

Submitted by Wilson Rehabilitation and Nursing Center to the Nursing Home Licensure and Certification Section of the North Carolina Department of Health and Human Services

F689- Each resident receives adequate supervision and assistance devices to prevent accidents.
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Resident #56 was admitted on 12/14/2018 with diagnosis of cerebral infarction of embolism of right cerebella artery, hemiplegia, and hemiparesis affecting his left dominant side. The resident was severely impaired cognitively on admission with a BIMS of 7. The resident's 30 day and discharge assessment demonstrated improvement with moderately impairment and a BIMS of 8.

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On 2/10/19 at 7:45 pm the rehab dining room door alarm sounded. The CNA on rehab responded to the alarm at 7:49 pm and noted that there was no one on the patio. She reset the alarm. She searched for resident #56 knowing that he was wearing a wander guard and could have triggered the door alarm.

At 7:49 pm resident #56 had opened the service entrance doors from the outside to the service hallway as the housekeeping staff were waxing the floors. At 7:49:30 pm the housekeeping staff notified the nurse and at 7:50:52 pm resident #56 was escorted into the building.

The incident was documented, the MD was notified at 8:50 pm and the family was attempted to be notified at 7:55 pm and 8:00 pm with no answer.

The Administrator was present in the building at the time of the incident and when notified of the event, immediately observed the resident and took staff statements regarding the incident. Due to the location of the Administrator ' s office from the nursing desk, the alarm was not heard.

The Administrator contacted the SDC at 8:03 pm who arrived at 8:20 pm and tested the wander guard on resident #56 and all other residents using the system. No issues were found with the wander guard system. The wander board was also verified and was up to date.

The Administrator contacted the DON at 8:15 pm who started calling staff to come in to sit with resident #56 as a 1 to 1.

The Administrator notified Hospital Security at

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8:20 pm to determine if surveillance was available. Administrator and Security Manager spoke by phone and Security Manager to review surveillance recording in am as arrives to work around 5:30 am. Security Manager and Administrator reviewed recording of the resident while in the Rehab dining room, exiting and CNA coming to door looking out and resetting alarm.

The resident was provided with 1 to 1 monitoring for the rest of that evening and all night. The next day shift provided 1 hour checks and 1 to 1 on afternoon/ night shifts.
On 2/11/19 at 09:30 am the IDT team met to discuss this incident. It was recommended that resident #56 would remain on 1 to 1 while a secured unit could be located for placement. Social Worker discussed plans and bed found with family at 3:34 pm. Resident #56 was discharged to a secured unit facility the morning of 2/12/19.

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

All residents will receive an elopement assessment upon admission by the admitting nurse and documented in PointClick Care (PCC). This practice is already in effect. The MDS nurse will complete an elopement assessment form on day 7 or within one day before or after day 7 of an resident's admission date and then quarterly. This will be documented in PCC. The process for performing an elopement assessment for day 7 is effective 3/8/2019 for the next applicable patient. The MDS nurse will complete the quarterly elopement assessment form and document in PCC. This practice has already in effect. The

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elopement policy will be updated to reflect when the door alarms, the staff have been instructed to go out the door that alarmed and look immediately around the grounds and down each side of the building. The MDS nurses provided input to the plan and are aware of the new 7 day elopement assessment.

If at any time a resident triggers as an elopement risk, the use of a roam alert (wander guard bracelet) will be placed on resident ' s wrist and their picture will be added to the Wander Board located in each nurse's station. They will receive orders for checking placement of the wander guard every shift and function of the system nightly. The resident's assigned nurse will check for presence of wander guard every shift and the night assigned nurse will check the functionality of the wander guard every night and documents this check on the Medication Administration Record (MAR). This practice has already been in effect. The policy will be updated to reflect when the door alarms, the staff have been instructed to go out the door that alarmed and look immediately around the grounds and down each side of the building effective. The Staff Development Coordinator or designee in her absence will perform the daily system check on the facility doors effective 3/8/2019.

Any resident that is identified as a new elopement risk will be discussed at daily Interdisciplinary team morning meeting to determine the facility's ability to meet their wandering needs. Discussion of new elopement risk residents has already been in effect. The IDT met 3/8/2019 to review the process as evidenced by sign in sheet.

Address what measures will be put into place or

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systemic changes made to ensure that the deficient practice will not recur.

All staff members will look at the closest monitoring computer located at the main nursing desk, Rehab nursing desk, Rehab documentation room or business office area to determine which door has been activated, if not in vision of a monitored door. If in vision of the resident that activated the alarm, staff member will redirect the resident and reset the alarm. The Staff Development Coordinator or designee, in her absence will perform the daily computer check and door mechanisms for functionality effective 3/8/2019.

If the resident is not immediately observed, the staff closest to the alarming door will exit that door and look immediately around the grounds and down each side of the building. If the resident is not seen, the supervisor or designee will announcement Code Silver, repeated three times, for all staff to report to the nurse's station. The resident's assigned hall nurse will print resident's picture from Point Click Care with height and weight. Picture will be shown to all on-duty staff with a description of what the resident was wearing and receive designated areas for a search. The Administrator, Director of Nursing and hospital security will be notified. Staff will report back to nurse's station after a thorough search of their assigned areas. If resident is not located staff may be assigned to another area. Upon locating the missing resident the person in charge will be notified, who will then announce a "code silver all clear".

All staff will be in-serviced on the Wander Guard System to include how it works, what to do when

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the alarm goes off, as indicated in the updated policy and the door locking system. This will include all current nursing staff including NAs administrative staff, housekeeping staff, dietary staff and rehabilitation staff. This 100% staff in-service will begin on 3/7/19 as evidenced by in-service sign in sheets. Staff who are not working at the time of the original in-service will have an information sheet mailed to them 3/8/2019 with a self-stamped envelope to return the signed in-service after reading. The SDC will audit returned forms to verify staff in-service complete for all staff.

Indicate how the facility will plan to monitor its performance and ensure solutions are sustained.

The Staff Development Coordinator will conduct drills for elopement on alternating shifts starting 3/8/2019 2x/week for 4 weeks, once a week for 4 weeks and then once per month for 3 months and then quarterly thereafter.
The MDS Nurses will continue to keep log of elopement risk residents, ensure orders placed on MAR to check presence of wander guard every shift, and function test nightly. The MDS nurses will monitor daily nursing documentation for each order effective 3/8/2019.
The QAPI team will do on-going review at the monthly scheduled meetings on the fourth Tuesday of the month (March) of the documentation for the wander guard system checks, any new elopement risk residents and any identified issues during drills.

Submitted by: Betty Lancaster, Administrator

2. Resident #156 was admitted to the facility on 2/19/2019, with diagnoses that included syncope

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(loss of consciousness) and collapse, urinary tract infection, cognitive communication deficit.

Record review of the most current Minimum Data Set Assessment (MDS), dated 2/26/2019, revealed resident #156 was assessed as cognitively moderately impaired and required total assistance from two persons for transfers. The MDS revealed the resident used a wheelchair but was dependent on staff for all efforts of mobility.

Review of the care plan for Resident #156, dated 2/19/2019, documented Resident #156 had a deficit in performing Activities of Daily Living (ADLs) and not ambulatory. The care plan for risk of falls, dated 2/19/2019, noted to follow facility fall protocol and physical therapy (PT) to evaluate and treat as ordered or as necessary (prn). Updated care plan for ADLs, dated 2/25/2019, revealed transfers required total assistance from two staff members and the staff to use the mechanical lift. Risk for falls care plan updated on 3/1/2019 revealed a fall occurred on 2/28/2019, with no injury, due to poor balance and core strength. The plan of care noted to continue interventions on the at-risk plan, to determine and address causative factors of the fall, and (PT) consult for strength and mobility, and to make sure all transfers were with mechanical lift and two staff members.

Record review of nursing notes, dated 2/20/2019-2/28/2019, revealed resident #156 transferred out of bed to the wheelchair using a mechanical lift daily seven times. On 2/28/2019 at 11:20 am, nurse's notes documented a description as "patient weak and lowered to floor during transfer". The use of a mechanical lift was confirmed during the interview process. The

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intervention documented on 2/28/2019 at 11:20am was "assessed, no injury, mechanical lift up to bed by three staff members."

Nurses notes from 3/1/19-3/4/19 revealed Resident #156 transferred out of bed using the mechanical lift.

Review of the physical therapy initial assessment dated 2/20/19 revealed resident #156 required maximum assistance to maintain balance and transfers bed/chair and sit-stand. The initial assessment also revealed the resident's inability to walk and use of a mechanical lift.

Review of the Kardex, used by nursing staff to communicate important information on patients, dated 2/19/2019, revealed Resident #156 was not ambulatory at this time and needing total assistance from two staff to use mechanical lift for transfers out and into bed/chair. Transfer section dated a fall for 2/28/19 and noted make sure all transfers are with mechanical lift and two staff members.

Review of a nurse aide care documentation report dated 2/19/19-2/28/19 noted Resident #156 required total assistance with 2 persons physical assistance in transferring for the 7 am-3 pm shift. No transfers were documented for the 3 pm-11 pm or 11 pm-7 am shift.

On 3/5/2019 at 8:40am during an interview conducted with Resident #156, the resident stated while staff were getting her up to the side of the bed, there was a blanket on the floor, and she just sat down. Resident #156 further stated she thought there was one person helping her but was not sure. Resident #156 denied injury from

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the fall. Resident #156 further stated staff informed her to call if she needed to get up and to go to the bathroom, one person comes to help me in the wheelchair.

On 3/5/2019 at 12:15 pm Nurse #4 stated during an interview she was present the day the resident fell on 2/28/19. She said that physical therapy had gotten the resident up in the wheelchair. The resident wanted to go back to bed and when the NA#4 stood the resident up, resident was weak and was lowered to the floor. Nurse #4 stated resident #156 had been using a mechanical lift for transfers. Nurse #4 stated NA #4 was pulled to the hall to work that day and the Resident #156 had told the NA #4 that she could help NA#4.

On 3/5/19 at 3:46 pm during an interview with the Physical Therapy aide (PTA)#1, PTA #1 stated it was protocol if a resident was maximum assistance (2 persons) or total assistance, a mechanical lift was automatically used for transfers and each resident had their own lift pad that was left in the room.

On 3/6/19 at 10:08 am an interview with NA #4, care provider during the transfer on 2/28/19, was conducted. NA#4 stated January 2019 as her hired date with orientation and training lasting two weeks that included demonstration of the lift. NA #4 stated that during the training she was assigned the Rehabilitation hall once. NA#4 further stated she wasn't familiar with Resident #156, but one day Resident #156 yelled out as she walked by. When NA#4 went into Resident #156's room, Resident #156 wanted to go back to bed. NA#4 admitted to seeing a lift pad in the wheelchair underneath the resident but when the NA#4 asked Resident #156 if she could transfer

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or had to use the lift, Resident #156 told the NA#4 "both". NA #4 stated after standing Resident #156, the resident became weak, couldn't move, and as Resident #156 was starting to sit down, NA#4 eased her to the floor. NA#4 stated she went next door to get physical therapy (PT) to help her and Nurse#4 was notified. NA#4 further stated the PT informed her to always use a lift when a lift pad was in the wheelchair. During the interview, NA#4 stated the needs of each resident was shared among staff through room to room conversations with other shift, word of mouth, checking Kardex and asking the nurse. NA#4 stated max assistance was total assistance and required two persons and if resident's care changes during the day, therapy or the nurse would inform the nurse aides.

On 3/6/19 at 11:30 am during an interview with the Rehabilitation Director PT #1 stated after evaluations of the residents, PT #1 plan of care was entered into the computerized system and the nurse aides could see on the Kardex. PT #1 stated a two-person extensive assistance for a resident would indicate the use of a lift. PT#1 further stated changes in care of the resident were communicated to the nurse, nurse aides, and during Leadership Morning Meetings and the Rehabilitation MDS Coordinator updated the care plan. PT#1 stated he was familiar with Resident #156 and recalled NA#4 going next door while he was working with another resident requesting his help. PT #1 stated Resident #156 was on the floor and complained of a little back pain. PT#1 further stated the nurse was notified, came into the Resident's room, and using the lift, the three of them assisted resident #156 back into the bed. PT#1 stated NA#4 was new to the hall and informed NA#4 if you see a lift pad, to use the lift.

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F 689	Continued From page 46 On 3/6/19 at 11:50 am during an interview with Nurse #4, Nurse #4 stated om 2/28/19 Resident #156 was on the floor when she entered the room and complained of back pain. Nurse #4 stated Resident #156 was assessed, the Resident's physician and the Resident's family were notified. Nurse#4 stated nurse aides gathered information on resident's care needs from room to room reports with the previous shift and the nurse in charge of the unit. Nurse #4 stated when changes in resident care occur, changes are verbally communicated to the nurse aide. On 3/6/19 at 4:40 pm an interview was conducted with the MDS Rehabilitation Coordinator who evaluated Resident #156's functional abilities. MDS Rehabilitation Coordinator stated Resident #156 was a lift for transfers. She stated on 3/1/2019 the fall of Resident #156 was discussed at the Leadership Morning Meeting and Resident #156's care plan and Kardex were updated after the meeting.	F 689		