STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345285	A. BUILDING _____ B. WING _____	C 02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT HENDERSONVILLE LLC	200 HERITAGE CIRCLE HENDERSONVILLE, NC 28791

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F 000	INITIAL COMMENTS A compliant investigation survey was completed on 2/3/20. There were 10 allegations investigated and 3 were substantiated and cited. Event ID # W2F511. The survey team entered the facility on 2/3/20 to conduct a complaint investigation survey and exited on 2/3/20. Additional information was obtained on 2/14/20. Therefore, the exit date was changed to 2/14/20.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and resident guardian interview, the facility failed to provide supervision to prevent accidents by not checking on a resident every two hours to maintain her safety for 1 of 3 residents reviewed for accidents (Resident #29). The findings included: Resident #29 was admitted to the facility on 10/04/12 with diagnoses that included paranoid personality disorder, unsteadiness on feet, ataxic gait, dementia and lack of coordination.	F 689	1. Resident#29 was safely discharged to another skilled nursing facility as requested by the resident's guardian on 1/30/2020. Prior to discharge, nursing staff, including CNAs, Nurses, and Hospitality aides made direct observation of Resident #29's location a minimum of three times per shift; early in the shift, approximately mid-way through the shift and near the end of the shift, to assure resident #29 did not exit the building without staff knowledge. 2. Residents who are able to exit the	2/27/20

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

Electronically Signed | 02/24/2020

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F 689	Continued From page 1 Resident #29's annual Minimum Data Set (MDS) dated 12/03/19 revealed Resident #29 was severely cognitively impaired and required supervision with bed mobility, transfers, toileting, locomotion and personal hygiene. Resident #29 did not exhibit any behaviors and had not experienced any falls. Review of Resident #29's activities of daily living (ADL) Care Area Assessment (CAA) summary dated 12/03/19 revealed she required supervision with ADL and would ask for assistance when needed. Resident #29's care plan initiated on 12/09/19 indicated that Resident #29 was to be encouraged to participate in activities and would be encouraged to feed the community cats as long as she was able and found it enjoyable. Resident #29's care plan specified she would go outdoors after dark and in all weather conditions to feed and spend time with the cats. Interventions included encouraging the resident to come back into facility before dusk to maintain safety. The goals of the care plan intervention were for Resident #29 to maintain safety and avoid injury from being outside after dark. An incident report dated 1/21/20 at 1:00 AM filed by Nurse #1, revealed Resident #29 was found outside the facility lying on her right side with her wheelchair to her left side. Resident #29 was wearing a coat, gloves, hat, scarf and shoes and was able to converse with staff. Resident #29 reported she had tried to feed the cats and fell to the ground from her wheelchair. Immediate action taken included a physical exam which did not reveal any injuries, vital signs were taken and the resident was warmed up with a blanket and a	F 689	building at will independently, are at risk to be affected by potential accidents related to leaving without staff awareness or proper preparation. The door to the outside of the facility automatically locks at 8 pm. Nursing staff, contract agency or employee, Social Work, Activities, Maintenance staff was in-serviced beginning on 2/20/2020 and completed on 2/27/2020 by the Staff Development Coordinator and/or Director of Nursing not to allow a resident to exit to the outside unless properly assessed, prepared, and documented by a nurse. Residents who exit the building to the safe-smoking area will be monitored approximately each 15 minutes to assure they are present and safe. Residents who are at risk for wandering have Gates Wandering Assessment completed within the last quarter to assure those at risk are properly identified and have a WanderGuard bracelet in place. Exit doors are equipped with WanderGuard signaling device for resident safety. WanderGuard door function is confirmed monthly by Maintenance that checks all doors are functioning properly and nursing has a device to perform once daily checks assuring that the WanderGurad bracelet is functioning properly and checks off on the MAR. In-Service of Nursing staff, including nurses, CNA and hospitality aides included the completion of resident location checks on all resident on A-Hall and B-Hall who were include on the Midnight census report, with location	

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warm drink. Her temperature was measured at 98 degrees Fahrenheit. It was noted on the incident report that Resident #29 had propelled her wheelchair to the cathouse outside of facility to feed the cats which was her normal routine 2 to 3 times a day/night.

On the evening of 01/20/20 the temperature remained at 22 degrees Fahrenheit from 7:00 PM until 5:00 AM on 01/21/20, it was overcast and the wind speed ranged from 13-15 miles per hour according to weather records from CustomWeather, Inc.

A nursing progress note, written by Nurse #1 at 1:15 AM on 1/21/20 noted that around 12:30 AM the nurse was notified by Nurse Aide (NA) #1 that Resident #29 was not in her room. The resident was found outside the building around 12:50 AM in front of the cat house on her right side with her wheelchair leaned over to the left side. The nurse was able to converse with the resident who was wearing her winter jacket, hat, gloves, and shoes at that time. The resident was transferred to bed and was able to move independently. She was given a warm blanket and a physical assessment was completed which did not reveal any bruising or apparent injuries. The Director of Nursing (DON) and the facility Physician were notified.

A telephone interview was completed with Nurse #1 on 02/03/20 at 9:49 AM who recalled that around 12:00 AM NA #1 discovered that Resident #29 was not in her room. At that time staff began searching for the resident, both inside and outside of the building. According to Nurse #1, around 12:30 AM the resident was found outside on the ground in front of the cat house. Nurse #1 went outside to evaluate her and found her able

noted whether in or out of the building, three times each shift at intervals and recorded on the midnight census report for. In-Service for this process were started on 2/20/2020 and completed on 2/27/2020 by the Staff Development Coordinator and/or Director of Nursing.

4. Resident location checks described in #3, are documented on the Midnight Census forms and will be maintained in a notebook by the Director of Nursing for review of data 5 times per week for one month beginning 2/20/2020 through 3/20/2020, then 3X per week for one month and one time per week for three months. Results of the checks will be presented to the QAPI Committee monthly by the Director of Nursing for review and recommendations as to how to continue the safety checks process to assure compliance with this corrective action is sustained.

Corrective action I completed a of 2/27/2020

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to converse and she did not show signs of injury. Nurse #1 was not familiar with the resident, but she was informed by staff that the resident commonly went outside to tend to the cats, unsupervised. Nurse #1 could not state how long the resident had been outside or how she exited the facility.

A telephone interview was conducted on 02/03/20 at 2:32 PM with Nursing Assistant (NA) #1. NA #1 stated she was assigned to Resident #29's hall during the 11:00 PM to 7:00 AM shift when she was found outside on 1/21/20. NA #1 reported when she came in for her shift she took report and began to check on her assigned residents. NA #1 stated she did not get to Resident #29's room until around 12:30 AM. At that time, she became aware that Resident #29 was not in her room. NA #1 said she reported to Nurse #1 that Resident #29 was not in her room and staff began to search for the resident. NA #1 knew that Resident #29 frequently went outdoors even at night to feed the cats but reported it was odd for her to be out that late. The NA indicated that the resident was commonly in her room when she began her shift. NA #1 recalled that she went outside to search for Resident #29, and found her around the side of the building, in front of the cat house. NA #1 could not state how long the resident had been outside. NA #1 reported that Resident #29 was able to use her wheelchair to get around on her own and she was able to put her winter clothing (coat, hat, gloves) on without assistance. NA #1 did not feel there was a safety concern with Resident #29 going outside after dark unsupervised as she had been doing so for a long time and there had never been any issues.

On 02/03/20 at 4:57 PM Nursing Assistant (NA)

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#3 was interviewed, who had worked on Resident #29's hall during the 3:00 PM -11:00 PM shift on 01/20/20. NA #3 recalled last seeing Resident #29 on 1/20/20 at around 9:45 PM when Resident #29 brought her dinner tray to NA #3 in the hall. NA #3 stated it was not uncommon for Resident #29 to go outside of the facility unsupervised around 9:30 PM to 10:00 PM to feed the cats and would generally be out there for 20 to 45 minutes. The NA said there had never been any issues in the past, NA #3 did not see this as a safety concern. NA #3 stated that normally the resident would come back inside when she was ready by knocking on the door at the employee entrance which was visible from the nurse's station on the 200 hall.

On 02/03/20 at 10:15 AM a telephone interview was completed with NA #2. NA #2 stated on 1/21/20 she was working not working on the hallway Resident #29 resided when she was alerted that Resident #29 was missing. NA #2 reported she and other staff members went outside to look for her because they knew she went outside to feed the cats frequently, even after dark. NA #2 was present when the resident was found and the resident stated she was not hurt and a nurse evaluated her. NA #2 reported that it was common for Resident #29 to go outside on her own without any supervision and she usually remained out there (in front of the building with the cats or at the cat house) for 45 minutes to 1 hour. NA #2 did not feel that it was a safety concern for Resident #29 to go outside unsupervised, even at night. The resident propelled herself in her wheelchair and would exit through the front doors of the facility without any supervision or assistance.

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An interview on 02/03/20 at 2:32 PM with Nurse #2, who worked on Resident #29's hall on 01/20/20 from 3:00 PM to 11:00 PM before it was discovered Resident #29 was missing. The nurse reported that it was her first night at the facility and she did not know Resident #29. Nurse #2 stated that she completed her rounds around 8:00 PM and recalled seeing Resident #29 in her room. The nurse explained that Resident #29 had blocked the door with a small trashcan in an attempt to keep people from entering. Nurse #2 stated she did not attempt to check on Resident #29 again before she left the facility at 11:00 PM because she was told by another staff member that Resident #29 did not like people going into her room. Nurse #2 had no knowledge that the resident frequently went outside to tend to the cats.

On 02/03/20 at 7:20 PM an observation was made of the facility's "cat house" located on the right side of the facility. The parking area was lit but it was dark on the side of the facility where the cat house was located. The cat house and sidewalk in front of it were not visible from the parking area. There was a sidewalk from the front of the building that ran alongside the building, in front of the "cat house" which resembled a dog house with blankets inside. The sidewalk sat higher than the ground, approximately 3 inches. There were no potential hazards observed. The cat house was estimated to be 50-75 feet away from the facility entrance.

A physician note was completed by Nurse Practitioner (NP) #1 on 01/21/20 at 14:42 indicating that Resident #29 had a fall without injury. It was noted that she was outside at the time, tending to "her cats". The NP reported that

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Resident #29 had progressing dementia and was delusional most of the time. The NP indicated they would continue to work with the nursing team to keep Resident #29 safe and comfortable.

A telephone interview was completed with NP #1 on 02/14/20 at 11:48 AM who reported that she had evaluated Resident #29 on 01/21/20 and the resident did not exhibit any signs of injury or frostbite. NP #1 reported she often saw the resident going outside unsupervised to spend time with the cats at the front of the building and at the cathouse during the day. NP #1 reported she did not feel it was a safety concern for the resident to go outside unsupervised on her own during the day. NP #1 further reported she was not aware of her habits in the evening because the NP was not on site in the evenings and she could not comment on whether or not she felt it was a safety concern for Resident #29 to go outside unsupervised after dark. NP #1 reported Resident #29 could open the doors on her own, she could dress herself and she went in and out to care for the cats as she pleased. NP #1 stated that while Resident #29 "lived in her own world" she functioned in "ours" very well.

A telephone interview was completed with Resident #29's guardian on 02/03/20 at 10:43 AM. The guardian recalled that she was notified by the Director of Nursing (DON) of the incident and it was reported to her that the resident had been found outside around 11:30 PM and had maybe been outside for a couple of hours. The Guardian was aware Resident #29 frequently went outdoors to tend to the cats, but before this incident she was unaware that the resident went outside unsupervised at night which she thought was a safety concern.

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An interview was completed with the DON on 02/03/20 at 12:52 PM. The DON stated that early on 01/21/20 she had received a call that Resident #29 had been outside feeding the cats and her wheelchair had tipped over. The DON indicated she did not know how long the Resident #29 was outside. According to the DON, Resident #29 went outside unsupervised 2-3 times/day to feed the cats and would stay outside for multiple hours at times. The DON reported that this was the first time Resident #29 had fallen outside, that the resident was able to get in and out of her wheelchair on her own and it was not unusual for staff to let Resident #29 go outside without supervision even at night. The DON stated that staff should have checked on Resident #29 every 2 hours, but failed to check on her from around 9:45 PM on 1/20/20 to 12:30 AM on 1/21/20 (approximately 2.75 hours) when she was found by staff on the ground outside of the facility.

On 02/03/20 at 5:57 PM the Administrator was interviewed. The Administrator reported that Resident #29 was found outside at 12:30 AM on 01/21/20. The Administrator stated that Resident #29 went outside every night usually around 8:30-9:00 PM unsupervised to feed the cats and it was generally not a problem, she would always come back inside on her own. The Administrator reported it was not unusual for the resident to go outside late at night on her own and that the facility had created a care plan for this. The Administrator reported that staff should have been checking on Resident #29 every 2 hours, but failed to do so. After the incident, staff were instructed to accompany Resident #29 outdoors when she wanted to go out.