

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/01/2020
NAME OF PROVIDER OR SUPPLIER DEER PARK HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 306 DEER PARK ROAD NEBO, NC 28761		
(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	E 000			
F 000	<p>An unannounced COVID-19 Focused Survey was conducted on 11/23/20 with exit from the facility on 11/23/20. Additional information was through 12/01/2020. Therefore, the exit date was changed to 12/01/20 The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# KO3D11</p> <p>INITIAL COMMENTS</p> <p>An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 11/23/20 with exit from the facility on 11/23/20. The survey team returned to the facility on 12/01/20 and completed the extended survey. Therefore, the exit date was changed to 12/01/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p> <p>1 of the 5 complaint allegations was substantiated resulting in deficiencies.</p> <p>Immediate Jeopardy was identified at:</p> <p>CFR 483.25 at tag F-689 at a scope and severity (J)</p> <p>The tag F-689 constituted Substandard Quality of Care.</p> <p>Immediate Jeopardy began on 11/14/20 and was removed on 11/25/20. An extended survey was conducted.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/17/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580 SS=D	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p>	F 580		12/12/20	

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F 580	<p>Continued From page 2</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and resident, resident representative and staff interviews, the facility failed to notify the responsible party of resident elopement for 1 of 3 residents (Resident #1) reviewed for notification of change.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 11/2/18 with the following diagnoses: dementia, Alzheimer's disease and psychotic disorder.</p> <p>On 11/23/20 at 11:20 AM, an interview was conducted with Resident #1 with Nurse Aide (NA) #2 as interpreter. Resident #1 stated he remembered being outside of the facility about two weeks ago. He said he got out through the front door, but he could not remember how long he had been outside. Resident #1 stated he had a fleece coat, long-sleeve shirt, jeans, socks and shoes on. He remembered it being chilly outside and that he had started to freeze before he could get back inside the facility. Resident #1 further stated that he had been anxious and was tired of being inside the facility, so he decided to leave.</p> <p>On 11/24/20 at 9:01 AM, a phone interview with</p>	F 580	<p>1) Resident is no longer at the facility. RP was notified of the resident being outside on 11/24/2020. All residents have the potential to be affected by this deficient practice. The DON/Designee reviewed current residents' medical records including incident reports & changes in condition for the past 30 days to identify other residents that may have been affected with notifications and completed as appropriate. Any issues identified in the audit were corrected by DON/Designee and noted in residents' medical record.</p> <p>2) DON/Designee initiated 100% of the licensed nursing staff on the need to notify responsible party when a resident presents with a change of condition that requires notification. Including to report to the oncoming shift or DON of need to continue attempts to notify RP when unable to contact RP timely. Education was completed on 12/12/2020 and will continue with new hires/agency use through orientation.</p> <p>3) Audits of residents' medical records by the DON/Designee for notification of</p>		

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F 580	<p>Continued From page 3</p> <p>Resident #1's responsible party (RP) revealed that he had talked to Resident #1 over the phone on 11/14/20. Resident #1 told his RP that he wanted to go home and that he was going to get out. Resident #1's RP did not think of letting the staff know of what Resident #1 told him over the phone. Resident #1's RP stated that he had not been notified Resident #1 had gotten out of the building on 11/14/20 without the staff's knowledge.</p> <p>On 11/24/20 at 9:16 AM, a phone interview with Nurse #1 revealed when Resident #1 went outside the building on 11/14/20, she had been assigned to him but she was on the South side of the facility on the back hall giving medications to her other residents, so it was hard for her to keep an eye on Resident #1. Nurse #1 stated when she was informed of Resident #1 being found outside of the facility, she tried to call his RP, but he never answered the phone. Nurse #1 further stated that she worked again the next day but did not call and follow up with Resident #1's RP regarding his elopement from the day before.</p> <p>On 11/24/20 at 2:00 PM, a phone interview with the Director of Nursing (DON) revealed she had tried to call Resident #1's RP on 11/14/20 to notify him that Resident #1 had gotten out of the facility. Resident #1's RP did not answer his phone and she was unable to leave a voicemail because his voicemail had not been set up. The DON stated staff should have tried to notify Resident #1's RP of his elopement the next day since they didn't get him on 11/14/20.</p> <p>On 11/24/20 at 3:35 PM, a phone interview with the Administrator revealed she had assumed that Resident #1's RP had been notified of his</p>	F 580	<p>the responsible party of any change in condition are documented timely.</p> <p>Audits continue 5x/week for 4 weeks, 3x/week for 4 weeks, weekly/4 weeks, and monthly/3 months. Results of audits will be reported to QAPI by the DON/Designee for 6 months to monitor for ongoing substantial compliance.</p> <p>5) Compliance date is 12/12/2020</p>		

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F 580	Continued From page 4 elopement on 11/14/20. She stated that she was not aware that the two attempts to call Resident #1's RP had been unsuccessful and stated staff should have tried to notify him again the next day and if they were still unable to contact him that they should have let her know so she could have followed up.	F 580			
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, resident and staff interviews and observation, the facility failed to supervise a cognitively impaired resident that demonstrated wandering behavior in the facility (Resident #1) from exiting the facility unsupervised for 1 of 3 residents reviewed for supervision to prevent accidents. Resident #1 who had diagnoses of dementia and Alzheimer's disease exited from the facility without staff's knowledge and was found outside when he knocked on the door at the end of the North side of the facility on hall six. Immediate Jeopardy began on 11/14/20 when Resident #1 exited from the facility without staff's knowledge, was unattended and unsupervised and was discovered outside when he started knocking on the door at the end of the North side	F 689	1) On November 14, 2020 around 8:30 PM, Nurse #2 heard knocking on the door and observed Resident #1 to be outside the building. Staff brought Resident #1 back into the building, two attempts were made to contact the responsible party for Resident #1, a body audit was performed with no findings, resident was Put on increased supervision. Staff had not been aware that Resident #1 was outside of the building and were unable to determine which door the resident had exited from. 2) Residents identified at risk to elope have the potential to be affected by the deficient practice. On November 24, 2020, the interdisciplinary team reviewed all current residents for the risk of	12/12/20	

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F 689	<p>Continued From page 5</p> <p>of the facility on hall six. Immediate Jeopardy was removed on 11/25/20 when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 11/2/18 with diagnoses that included Alzheimer's disease, dementia and seizure disorder.</p> <p>The annual Minimum Data Set (MDS) assessment dated 10/19/20 indicated Resident #1 had both long-term and short-term memory loss and modified independence for daily decision-making. Resident #1 was usually able to recall the location of his own room, staff names and faces and that he was in a nursing home. Resident #1 was independent with all activities of daily living with no set up or physical help required from staff. Resident #1's balance during transitions and walking was not steady but he was able to stabilize without staff assistance. The MDS further indicated that Resident #1 was usually understood, and he usually understood others. Resident #1 did not exhibit wandering behaviors during the assessment period.</p> <p>A review of the Elopement Risk Evaluation for Resident #1 dated 10/19/20 indicated Resident #1 had potential risk factors for elopement that included psychiatric history, cognitive impairment and independent ambulation but he had no</p>	F 689	<p>elopement, MDS nurses updated care plans with appropriate interventions for elopement and direct care staff were notified of the care plan updates and interventions.</p> <p>3) On November 24, 2020, the Director of Nursing and designees initiated education with 100% of staff on elopement procedure, reporting residents exhibiting potential risk of elopement, how to identify residents identified at risk to elope, clarification that the North nurse's station door is an emergency exit only, clarification that the South nurse' station door is to remain locked at all times except during resident smoking, and an instructed to the newly implemented sign-off sheet for coral med cart nurse for verification of South nurse's station door being locked after resident smoke breaks. The Staff Development Coordinator, educated November 24, 2020, will include this training in new hire orientation and to any agency staff when used. As a part of our 100% staff education, staff were directed to the locations of the updated elopement risk lists that are available for review by all staff, including the binders at each nurse's station that are available to clinical staff with specifics about residents that are deemed an elopement risk. Training was completed by the end of the day on November 25, 2020 with all staff being educated in person or by phone, and prior to next shift worked. On November 24, 2020, all door locking mechanisms were checked and elopement drills for all three shifts were initiated by the Maintenance Director.</p>		

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F 689	<p>Continued From page 6</p> <p>exit-seeking behaviors so Resident #1 was not considered at risk for elopement.</p> <p>Resident #1 did not have a care plan for wandering behaviors or risk for elopement prior to 11/14/20.</p> <p>A review of Resident #1's medical record revealed a late entry nurses' note written by Nurse #1, dated 11/14/20 at 8:30 PM, which read in part: Code green was initiated, an emergency code used to indicate a high-risk resident was missing. All staff except for two on the South side and on the North side began looking for Resident #1. He was found outside walking towards the lower parking lot. Unable to determine which door he left out of. Resident #1 was escorted back to his room by Nurse Aide #1. Nurse #1 completed total body check. No skin issues or injuries noted. 15-minute checklist started. DON (Director of Nursing) was already in the facility and aware of elopement. Resident #1 had been agitated prior to elopement. He wanted to call his (family member). Resident #1 talked with his (family member), began talking loudly and became more agitated.</p> <p>An interview with Resident #1 was conducted with Nurse Aide (NA) #2 present as interpreter on 11/23/20 at 11:20 AM. Resident #1 stated he remembered being outside of the facility about two weeks ago. He said he got out through the front door, but he could not remember how long he had been outside. Resident #1 stated he had a fleece coat, long-sleeve shirt, jeans, socks and shoes on. He remembered it being chilly outside and that he had started to freeze before he could get back inside the facility. Resident #1 further stated that he had been anxious and was tired of</p>	F 689	<p>Hourly checks of external doors (including North and South nurse's station doors) were initiated until resident #1 transferred to another facility and external checks were then changed to once per shift. On November 24, 2020 the sign-off sheet for coral med cart nurse for verification of South nurse's station door being locked after resident smoke breaks was implemented. There are up to four resident smoke breaks per day, none of which are during scheduled nurse med pass times. The staff member who comes into the building with the last resident attends the door until it is locked. South staff use the walkie talkie kept on coral cart to direct North staff to lock the South nurse's station door, and once North staff reply that it has been locked, staff physically check the door to ensure it is locked. The coral cart nurse signs the signoff sheet that a verification of the door being locked has been performed</p> <p>4) An AdHoc QAPI action plan was implemented on 11/25/2020. The medical director was notified of the plan and approved on 11/25/2020.</p> <p>The ADM/DON will complete audits to ensure completion of the documentation of the smoke break door verification process and the external door lock verification checks. Audits will continue 5x/week for 4 weeks, 3X/per week for 4 weeks, weekly/4weeks and monthly for 3 months. The ADM/DON will report results of the audits to the QAPI committee for 6 months to ensure ongoing substantial compliance.</p> <p>Compliance date is 12/12/2020</p>		

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F 689	<p>Continued From page 7</p> <p>being inside the facility, so he decided to leave. During the interview, Resident #1 was asked to show which door he tried to exit from, and he led the way towards the front door. Resident #1 was observed ambulating without the assistance of a device or another individual. Resident #1 wore shoes, walked slowly and appeared slightly unsteady but did not get out of balance while walking in the hallway. During this observation and interview on 11/23/20 at 11:25 AM, NA #2 stated it would have been impossible for Resident #1 to exit through the front door because a code would need to be entered on the keypad prior to unlocking the front door. Resident #1 denied having gone out through the South nurses' station door that led to the smoking area and said that it was locked.</p> <p>A phone interview with Nurse #2 on 11/23/20 at 11:59 AM revealed she was working on the North side of the facility and was giving medications to her residents around 8:30 PM when she started to hear what sounded like someone hollering and knocking on a door. Nurse #2 stated that at first, she thought the noise was coming from inside the facility, so she started checking on her residents. She could not find the source of the noise, but she saw a man standing outside the door at the end of hall six, so she started walking towards the door and realized the man outside looked like Resident #1. She paged the supervisor on call overhead and asked her to come to the North side of the facility. Nurse #2 and NA #1 went outside through the back door and found Resident #1 standing at the top of the steps to the lower parking lot and facing the road. When they saw Resident #1, they told him to come back into the building and he turned around and went back inside with Nurse #2 and NA #1. Resident #1</p>	F 689			

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F 689	<p>Continued From page 8</p> <p>said to Nurse #2 that he went out because he wanted to go see his family member and that he had just left the hospital. She clarified that Resident #1 sometimes referred to the facility as the hospital. She could not remember for sure what Resident #1 was wearing but added that he always wore his plaid flannel shirt, blue jeans and shoes. She said it had been cold outside the night of 11/14/20 and stated that she had no idea how Resident #1 had gotten out of the building. Nurse #2 further stated she had not seen Resident #1 on the North side at any time on the evening of 11/14/20 except when she saw him outside by the door at the end of hall six. It took Nurse #2 about twenty-five minutes from the time she first heard someone knocking on the door to the time they found Resident #1 outside because she had been checking inside the facility and did not know the knocking was coming from the outside of the building.</p> <p>A phone interview with Nurse #1 on 11/24/20 at 9:16 AM revealed she was the nurse assigned to Resident #1 on the evening shift on 11/14/20. Nurse #1 stated she had been in the back hall on the South side of the facility, so it was hard for her to keep an eye on Resident #1. Nurse #1 further stated that all staff members went outside to look for Resident #1 except for two NAs who stayed on the North and South halls of the facility. She reported when staff escorted Resident #1 back to his room after being outside, she remembered him wearing a jacket, a shirt, blue jeans, socks and shoes. She performed a full head-to-toe assessment and checked his vital signs and did not note any abnormal findings. Resident #1's vital signs that she recorded included the following: temperature of 97.6 degrees Fahrenheit, pulse of 65 beats per minute</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>and oxygen saturation of 97% on room air. She also took Resident #1's blood pressure but did not record it in his chart, and she could not remember what it was. Nurse #1 added that Resident #1 had a phone call with his family member earlier that night on 11/14/20 around 8:00 PM when he got upset and started talking loudly but in a different language so she could not understand everything that Resident #1 was saying. Nurse #1 remembered Resident #1 being upset and hollering that he wanted to go home after he hung up the phone and then he turned around and walked back to his room. She further stated that Resident #1 had made no previous attempts to exit the building even though he liked to wander and walk down the halls and go over to the North side and he lived on the South side of the facility. She said it was hard to monitor him when he was wandering because he walked from one side of the building to the other.</p> <p>An interview with Nurse #5 on 11/23/20 at 10:25 AM revealed Resident #1 often wandered out of his room but did not usually go to the other residents' rooms or try to exit the building. Nurse #5 stated Resident #1 liked to go to the dayroom and to the North side of the facility and walk up and down the halls.</p> <p>An interview conducted with NA #3 on 11/23/20 at 3:38 PM revealed she was the NA assigned to Resident #1 during the time of the elopement on 11/14/20. NA #3 stated she last saw Resident #1 around 7:32 PM when she was doing her rounds and he was lying in bed while wearing jeans, a shirt and a jacket. She was in the breakroom when NA #3 found out that Resident #1 was seen by a staff member outside of the facility. NA #3 stayed on the South nurses' station while the</p>	F 689			

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F 689	<p>Continued From page 10</p> <p>other staff members looked for Resident #1 outside. NA #3 stated Resident #1 could have gotten out through South nurses' station door because this door to the smoking area stayed unlocked and they always had to call the North side to get this door locked because the control panel to lock all the doors was located on the North side of the facility. NA #3 added that the South nurses' station door stayed unlocked because staff used it as well to go out for their smoking breaks. NA #3 also stated that Resident #1 liked to come up to the nurses' station and sometimes verbalized that he wanted to leave and to go home but he had not made previous attempts to exit the building.</p> <p>An interview conducted with NA #1 on 11/23/20 at 3:04 PM revealed she was working on the South side of the facility on the evening shift on 11/14/20 but she was assigned to another group that did not include Resident #1. NA #1 stated when the supervisor on-call got paged overhead, NA #1 went over to the North side of the facility and was asked by Nurse #2 to go outside with her to start looking for Resident #1. NA #1 stated she and Nurse #2 saw Resident #1 standing at the top of the steps to the lower parking lot. NA #1 remembered that it had been cold the night of 11/14/20. NA #1 stated Resident #1 was wearing his jacket, blue jeans and shoes. NA #1 assisted Resident #1 back into his room. NA #1 stated she had not seen him before he exited the building because she was busy with her assigned residents but thought that he might have gotten out of the North nurses' station door. NA #1 stated they hardly had any resident who smoked at 8:00 PM but this door was not always locked because staff used it to go out on their smoking breaks. NA #1 stated that the North nurses'</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>station door was supposed to be locked at all times and one of the staff members could have forgotten to lock it back after coming back from their break.</p> <p>A phone interview with Nurse #4 on 11/23/20 at 1:34 PM revealed she was working on the North side of the facility when she saw Resident #1 walking down to the North side from the South side right before 8:00 PM. Resident #1 was holding a sheet of paper with his family member's phone number and was wanting to call him. Nurse #4 stated Resident #1 did not seem agitated at that time. Around 8:30 PM, Nurse #4 heard a noise that sounded like someone was banging on the wall or pounding on a table. Nurse #4 realized that the sound was coming from the door at the end of hall six. At first, Nurse #4 thought that someone was trying to break into the facility, so she asked Nurse #2 to check the door at the end of hall six. Nurse #2 recognized the man that was knocking on the door at the end of hall six had been Resident #1. Nurse #4 went outside to help locate Resident #1. Nurse #4 stated she could not remember exactly what Resident #1 was wearing but said that he was fully dressed. Nurse #4 thought Resident #1 could have gotten out through the North nurses' station door because this door was not locked all the time although it was supposed to be always locked. Nurse #4 could not remember if there were resident smokers who smoked at 8:00 PM but stated that staff members used this door as well to go out to the smoking area for their breaks.</p> <p>An interview conducted with Nurse #3 on 11/23/20 at 11:51 AM revealed she was the supervisor-on call on 11/14/20 and had to work as</p>	F 689			

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F 689	<p>Continued From page 12</p> <p>a NA on the South side of the facility. Nurse #3 stated she had finished with her NA tasks and was getting ready to go home when she got paged overhead to come to the North side of the facility. Nurse #3 was notified by Nurse #2 that she had seen Resident #1 outside so Nurse #3 directed all staff members except for 2 NA to go outside and search for Resident #1. Nurse #3 went out through the front door and saw Nurse #2 assisting Resident #1 back into the building. Nurse #3 found out that Nurse #2 had seen somebody knocking on the door at the end of hall six and discovered that it was Resident #1. Nurse #3 conducted a head count on both sides of the facility and checked all the doors. Nurse #3 noted that both the North and the South nurses' station doors were unlocked. Nurse #3 stated a staff member might have forgotten to lock the doors back after they went out for their smoking break. Nurse #3 notified the DON (Director of Nursing) and the Administrator.</p> <p>A review of the weather conditions per Weather Underground website revealed the following data for Nebo, North Carolina on 11/14/20 at 7:54 PM: 52 degrees Fahrenheit (F) with no precipitation, South wind speed at 7 miles per hour (mph), 45 degrees F. The conditions at 8:54 PM were 51 degrees F with no precipitation, South-Southeast wind speed of 3 mph, 45 degrees F.</p> <p>An interview was conducted with the Director of Nursing (DON) on 11/23/20 at 1:51 PM who stated that she received a phone call from Nurse #3 when they observed Resident #1 outside the building on 11/14/20. The DON stated Resident #1 was already back in bed by the time she arrived at the facility, so she was not sure what he was wearing when he got out. The DON also</p>	F 689			

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F 689	<p>Continued From page 13</p> <p>stated they were not sure how he got out because nobody saw him exiting the building, but she thought he might have gotten out through the North side of the facility nurses' station door based on Nurse #4's recount that she last saw him around 8:00 PM on the North side. The DON was not sure if any of the residents smoked on the North side of the facility, but she stated that this door should have been locked by the staff member who came in last through the door after taking her break. The DON emphasized that both the North and the South side of the facility nurses' station doors were supposed to be locked all the time. Prior to the elopement incident on 11/14/20, Resident #1 was being monitored at least every two hours when the staff members did their rounds but after the incident, Resident #1's visual monitoring was increased to every 15 minutes. The DON investigated the incident by interviewing all staff members who worked on the evening shift of 11/14/20 about what had happened to Resident #1 and how he was able to exit the building unsupervised. The DON stated the staff were used to seeing Resident #1 walking up and down the halls and since he was not disruptive to the other residents, she did not think he needed a care plan for wandering.</p> <p>An observation was made with the DON on 11/23/20 at 2:55 PM of the outdoor area on the North side of the facility where Resident #1 was observed knocking on the door at the end of hall six. The distance from the North nurses' station door where the DON suspected he exited from to the door at the end of hall six was approximately 105 feet. The area was uncovered and grassy with uneven terrain. This path connected to a cemented walkway which extended towards the top of the steps which led to the lower parking lot.</p>	F 689			

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F 689	<p>Continued From page 14</p> <p>The distance from the side door on the North side to the top of the steps to the lower parking lot where Resident #1 was located was approximately 200 feet. There was a wooded area which was separated from the facility with a wooden fence and it was approximately 300 feet away from the North nurses' station door. The country road was about 200 feet away from the lower parking lot, but the driveway was curved and sloping downwards in an approximately 30-degree incline. The control panel for locking all the doors to the facility which was located on the North nurses' station was also observed and indicated that all the doors were locked during this observation.</p> <p>An interview with the Administrator on 11/23/20 at 2:11 PM revealed she received a call from Nurse #3 on 11/14/20 at the same time as the DON was informed of Resident #1's elopement. The Administrator said she was told by Nurse #3 that staff saw Resident #1 at the top of the steps to the lower parking lot and that he was not agitated. The Administrator stated she was not sure if there was any resident who went out to smoke at 8:00 PM but the staff members had started using both the North and the South nurses' station doors to go out for their breaks to reinforce social distancing during breaktimes. The Administrator further stated they had theorized that the nurses' station doors on both sides did not get locked right away after the staff members used these doors to go outside for their breaks. The Administrator added that they implemented the use of walkie talkie on 11/14/20 for staff to be able to communicate with staff on the other side of the facility since the control panel for the South nurses' station door was located on the North side of the facility. She said the staff should have</p>	F 689			

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F 689	<p>Continued From page 15</p> <p>been monitoring the residents at risk for elopement more often than every two hours and should have been alert and aware of Resident #1's whereabouts whenever he was wandering inside the facility.</p> <p>A follow-up phone interview with the DON on 11/24/20 at 2:00 PM revealed she started education with all staff members on 11/14/20 on the facility's elopement policy and for staff to ensure the doors were locked. The DON stated she read the elopement policy to the staff members and talked to them about what elopement was, what was considered elopement and what to do if a resident was missing or had eloped.</p> <p>The Administrator was informed of Immediate Jeopardy on 11/24/20 at 5:14 PM.</p> <p>On 11/25/20, the facility provided the following Credible Allegation of Compliance:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:</p> <p>On November 14, 2020 around 8:30 PM, Nurse #2 heard knocking on the door and observed Resident #1 to be outside the building. Staff brought Resident #1 back into the building, two attempts were made to contact the responsible party for Resident #1, a body audit was performed with no findings, resident was put on elopement risk. Staff had not been aware that Resident #1 was outside of the building and were unable to determine which door the resident had exited from.</p>	F 689			

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F 689	<p>Continued From page 16</p> <p>There was a high likelihood of serious harm for Resident #1 because staff did not realize that Resident #1 was missing until he alerted them that he was outside the building. There was also a high likelihood of serious harm for the 4 residents in the facility with elopement risk.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>On November 24, 2020, the Director of Nursing and designees initiated education with 100% of staff on elopement procedure, reporting residents exhibiting potential risk of elopement, how to identify residents identified at risk to elope, clarification that the North nurses' station door is an emergency exit only, clarification that the South nurses' door is to remain locked at all times except during resident smoking, and an introduction to the newly implemented sign-off sheet for coral medication cart nurse for verification of South nurses' station door being locked after resident smoke breaks. The Staff Development Coordinator, educated on November 24, 2020, will include this training in new hire orientation and to any agency staff when used. Training will be completed by the end of the day on November 25, 2020 with all staff being educated in person or by phone, and prior to next shift worked. On November 24, 2020, all door locking mechanisms were checked by the Maintenance Director, hourly checks of external doors (including North and South nurses' station doors) were initiated, and elopement drills were initiated for all three shifts. On November 24, 2020, the interdisciplinary team reviewed all current residents for the risk of elopement, MDS</p>	F 689			

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F 689	<p>Continued From page 17</p> <p>nurses updated care plans with appropriate interventions for elopement, and direct care staff were notified of the care plan updates and interventions. As a part of our 100% staff education we directed staff to the locations of the updated elopement risk lists that are available for review by all staff, including the binders at each nurses' station that are available to clinical staff with specifics about residents that are deemed an elopement risk.</p> <p>On November 24, 2020, the sign-off sheet for coral medication cart nurse for verification of South nurses' station door being locked after resident smoke breaks was implemented. There are up to four resident smoke breaks per day, none of which are during scheduled nurse medication pass times. The staff member who comes into the building with the last resident attends the door until it is locked. South staff use the walkie talkie kept on coral cart to direct North staff to lock the South nurses' station door, and once North staff reply that it has been locked, staff physically check the door to ensure it is locked. At this time, the coral cart nurse signs the sign-off sheet that a verification of the door being locked has been performed.</p> <p>For independent smokers, South staff use the walkie talkie kept on coral cart to direct North staff to unlock the South nurses' station door and contact them again to lock it once the independent smoker has exited the building. The door is attended by the staff member who let the resident out of the building during this time. Once North staff reply that it has been locked, staff physically check the door to ensure it is locked. At this time, the coral cart nurse signs off the sign-off sheet that a verification of the door being</p>	F 689			

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F 689	<p>Continued From page 18</p> <p>locked has been performed. When the independent smoker is ready to come into the building, they ring the doorbell that sounds at the North nurses' station. The staff member that lets them back into the building once the door is unlocked attends the door until it is locked. South staff use the walkie talkie kept on coral cart to direct North staff to lock the South nurses' station door, and once North staff reply that it has been locked, staff physically check the door to ensure it is locked. At this time, the coral cart nurse signs the sign-off sheet that a verification of the door being locked has been performed.</p> <p>There was no system or formal education done before to ensure that the door was locked. We believe that this will solve the issue until we can get a keypad installed on, at a minimum, the South door by the nurses' station.</p> <p>Deer Park therefore alleges compliance and removal of Immediate Jeopardy as of November 25, 2020.</p> <p>The credible allegation was verified on 12/1/20 at 12:30 PM. Elopement books were observed to be at the nurses' stations on both sides of the facility and included a picture and description of the residents currently identified at risk for elopement. In addition, a list of residents with the potential to elope was also posted on the pantry doors on both sides of the facility and in the kitchen. The staff in-services conducted on 11/24/20 through 11/25/20 were reviewed and included: the facility policy on elopement, elopement procedure, residents exhibiting elopement risk, how to identify residents assessed as elopement risk, North nurses' station door was emergency exit only and stayed</p>	F 689			

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F 689	Continued From page 19 locked, South nurses' station door stayed locked except during resident smoke breaks and sign-off sheet for coral cart nurse for verification of South nurses' station door being locked after smoking. The attendance records confirmed that all staff had been in-serviced. Random staff interviews were conducted on 12/1/20 from 9:22 AM through 11:29 AM and all staff members were able to describe the topics covered during the in-service on elopement. The sign-off sheets for coral cart nurse for verification of the South nurses' station door was locked after smoking were reviewed and complete. The hourly door audits by the nurses on both nurses' stations to physically check all exit doors and ensure all doors were locked were reviewed and complete. The facility's date of immediate jeopardy removal of 11/25/20 was validated.	F 689			