STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING _____ B. WING _____	C 04/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CHARLOTTE	5939 REDDMAN ROAD CHARLOTTE, NC 28212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 04/07/2021 through 04/15/2021. The survey team entered the facility on 04/07/2021 to conduct a complaint investigation survey and exited on 04/08/2021. Additional information was obtained through 04/16/2021. The survey team conducted a partial extended survey on 04/20/2021. Therefore, the exit date was changed to 04/20/2021. One of the five complaint allegations investigated was substantiated. Past non-compliance was identified at: CFR 483.25 at tag F 689 at a scope and severity of J. The tag F 689 constituted substandard quality of care. Non-compliance began on 03/21/2021. The facility came back in compliance effective 03/22/2021.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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- (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);	F 580		5/7/21

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

Electronically Signed | 05/07/2021

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F 580	Continued From page 1 (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). (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- (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). §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 an interview with the legal guardian, interviews with staff, and record review, the facility failed to immediately notify the legal	F 580	Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 580	Continued From page 2 guardian, Department of Social Services (DSS), that Resident #2, left the facility on 3/21/21 unauthorized and unsupervised. Resident #2 propelled 0.3 miles from the facility to the pharmacy in her wheelchair with a wander guard (WG) bracelet monitor attached without the knowledge of facility staff or authorization from DSS. This occurred for 1 of 2 sampled residents reviewed for notification of changes. The findings included: Resident #2 admitted to the facility 9/12/19 and re-admitted 10/1/20. Diagnoses included Alzheimer's disease among others. Resident #2's medical record documented a DSS guardian of the person as the legal guardian, and emergency contact. A quarterly minimum data set (MDS) assessment dated 2/17/21, assessed Resident #2 with adequate hearing, adequate vision, clear speech, able to understand and be understood, and intact cognition. Nurse #1 completed an incident report dated 3/21/21 at 8:30 PM, which recorded that she was unable to locate Resident #2 in her room, on the nursing unit or at the vending machine. Nurse #1 alerted staff to look for Resident #2. Staff searched but Resident #2 was not located. During the search, a police officer came to the facility and notified that Resident #2 was with a police officer at the pharmacy near the facility. Resident #2 was returned to the facility, assisted by the police on 3/21/21 around 9:45 PM. Upon return, Resident #2 was assessed by Nurse #1 without injury or pain.	F 580	practice. Social Worker spoke with resident #2's guardian on 3/23/2021 to notify her of the incident on 3/21/2021 after communication via voicemail on 3/22/2021. Social Worker logged a grievance on 3/23/2021 based on resident #2's guardian not being satisfied with the timeframe of the notification from the Center. At that time, nursing leadership educated nursing staff on the Center's policy regarding immediate notification of a family member or responsible party. This education was completed 3/26/2021. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 4/30/2021, the Director of Nursing initiated an audit of incident reports, going back three months, to ensure the resident's family or responsible party was immediately notified of the incident/accident. The audit was completed on 5/5/2021. On 4/30/2021, the Director of Nursing initiated an audit of resident Change in Condition Evaluations to ensure the resident's family or responsible party was immediately notified of a change in condition. The audit was completed on 5/5/2021. Address what measures will be put into	

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F 580	Continued From page 3 A progress note documented by the Administrator dated 3/22/21 at 4:49 PM recorded that the Administrator called the DSS guardian of Resident #2 and left a message. A progress note documented by the social worker (SW) dated 3/23/21 at 4:40 PM recorded that the SW called the DSS guardian for Resident #2 to discuss the incident that occurred on 3/21/21. Review of a grievance filed on 3/23/21 by the DSS guardian for Resident #2 revealed the SW received a verbal grievance in which the DSS guardian expressed she was dissatisfied that she was not informed in a timely manner about an incident that occurred on 3/21/21 regarding Resident #2. The grievance documented that on 3/21/21 Resident #2 left the facility, unsupervised and unauthorized, could not get back into the facility, and went to the pharmacy to call the facility. A phone interview with the DSS guardian occurred on 4/12/12 at 8:22 AM. During the interview, the DSS guardian stated she received a phone call from Resident #2 on Monday, 3/22/21. During this call, Resident #2 asked if she had heard what happened over the weekend. Resident #2 went on to describe that she got into her wheelchair and rolled to the local pharmacy around 9:00 or 10:00 PM the night before. Facility staff came and got her and brought her back. The DSS guardian stated that Resident #2 had been adjudicated incompetent and due to her personality disorder, sometimes her perception could not be substantiated. The DSS guardian stated she needed to verify Resident #2's statement. The DSS guardian stated she	F 580	place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing or designee will audit incident reports and Change in Condition Evaluations to ensure immediate notification of family member or responsible party occurred. These audits will continue weekly for three months unless the QAA Committee changes the frequency to ensure sustained compliance. This measure was put in place on 4/30/2021. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or designee will update the QAA Committee monthly on the results of the weekly audits. The QAA Committee will review documentation and update this plan if necessary, to ensure ongoing compliance.	

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F 580	Continued From page 4	F 580		

contacted the facility to verify this incident because she was concerned that if the incident occurred, why she had not been notified. The DSS guardian further stated that it concerned her that she had not received a phone call, nor did she have a voice message from the facility about the incident. She stated that if the incident occurred after hours, the facility could have left a message with the after-hour service, but no message was left. The DSS guardian said after speaking to Resident #2 she called the SW on 3/22/21 and left a message. She received a return call from the SW on 3/23/21 in the afternoon. The SW confirmed the incident did occur, stated that Resident #2 was returned to the facility safely and apologized that the DSS guardian had not been notified sooner. The DSS guardian stated that the SW said she had not notified her earlier because the SW just learned of the incident on Tuesday, 3/23/21, late in the day by the Administrator and that the SW was asked to notify DSS.

An interview with the SW occurred on 4/7/21 at 10:39 AM. The SW stated she did not work in the facility on Sunday, 3/21/21 or Monday, 3/22/21. When she returned to work on Tuesday, 3/23/21 she was notified that Resident #2 left the facility over the weekend. The SW stated the Administrator asked her to contact DSS to notify of the incident on 3/21/21 which involved Resident #2. The SW stated she spoke to DSS on Tuesday 3/23/21 in the late afternoon. During the conversation, the DSS guardian expressed she was dissatisfied that she was not notified in a timely manner that Resident #2 left the facility without supervision or authorization. The SW stated she expressed to DSS that she understood and apologized on behalf of the facility.

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F 580	Continued From page 5 The physician was interviewed by phone on 4/8/21 at 1:40 PM and stated that he spoke to Resident #2 on 3/24/21 regarding an incident that occurred on 3/21/21 which was documented in a progress note. He stated that he expected the facility to follow their policy regarding notification. The physician stated Resident #2 had a DSS guardian which was needed for her medical decisions due to her psychiatric state. An interview with the Administrator occurred on 4/8/21 at 4:30 PM. The Administrator stated that he was aware that Resident #2's DSS guardian expressed that she expected immediate notification that Resident #2 left the facility unsupervised, without staff knowledge and without authorization from DSS. He stated that he left a voice message for DSS on Monday, 3/22/21 after 4:00 PM regarding the incident that occurred on 3/21/21 when Resident #2 left the facility. He stated the delay in notification to DSS was because the facility was trying to investigate the incident to let DSS know what occurred. He stated that the facility did not notify DSS immediately because the facility did not perceive the incident as a significant event; the resident was not injured, was only away from the facility a short period of time and returned to the facility safely.	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	F 689		5/7/21

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F 689	Continued From page 6 §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, an interview with the legal guardian, the physician, interviews with staff, and record review, the facility failed to implement elopement interventions to prevent Resident #2's unauthorized and unsupervised exit from the facility. Resident #2, with an appointed Department of Social Services (DSS) guardian of the person, assessed at risk for elopement and a diagnosis of Alzheimer's disease, exited the facility on 3/21/21 after 8:35 PM in her wheelchair with a wander guard management bracelet (WG) on her wheelchair that did not sound to alert staff and the facility exit door automatic lock system did not engage to prevent egress. Resident #2 propelled herself approximately 0.3 miles, to the pharmacy and was returned to the facility assisted by police at approximately 9:45 PM. This occurred for 1 of 2 sampled residents with an appointed DSS guardian reviewed for supervision to prevent accidents. The findings included: Resident #2 admitted to the facility 9/12/19 Diagnoses included Alzheimer's disease and paranoid schizoaffective disorder, among others. Resident #2's medical record documented a DSS guardian of the person as the legal guardian, and emergency contact. A Mecklenburg County (MC) Guardianship Policies Memo of Understanding, signed 9/20/19, recorded, in part, that MC DSS was appointed	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 7	F 689		

guardian of the person for Resident #2. The Clerk of Court gave MC DSS guardianship responsibilities and by law, MC DSS was required to make all decisions regarding the care and maintenance of Resident #2, which included a leave from the facility.

Review of the medical record for Resident #2 revealed a nursing progress note dated 8/20/20 at 6:20 PM which recorded that Resident #2 was noted by the Unit Manager #1 (UM #1) with exit seeking behavior and verbalized a desire to leave the facility.

A significant change Wandering Risk assessment dated 8/20/20 assessed Resident #2 at risk of elopement due to exit seeking behavior and verbally stating a desire to leave the facility.

Resident #2's medical record documented a physician order dated 8/20/20 to place a WG to the back of her wheelchair, check for placement and function each shift, and change as needed.

A nursing progress note dated 12/26/20 at 01:15 AM documented Resident #2 verbalized to Nurse #1 a desire to go home.

A quarterly Wandering Risk assessment dated 01/06/21 assessed Resident #2 at high risk of elopement, due to a history of wandering behavior in the past month. The assessment noted that a WG was in place for Resident #2.

A care plan, updated 2/14/21, identified that due to Alzheimer s disease, impaired cognitive function, impaired thought processes, difficulty making decisions and an expressed desire to be out of the facility unattended, Resident #2 was at

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risk for elopement. Interventions included staff to cue, reorient and supervise as needed, Resident #2 to inform staff when going out of the facility and for staff to apply a WG as ordered/tolerated.

A quarterly minimum data set (MDS) assessment dated 2/17/21, assessed Resident #2 with adequate hearing, adequate vision, clear speech, able to understand and be understood, intact cognition, no behaviors during the review period, and no functional limitations.

Review of the March 2021 medication administration record (MAR) revealed, nurse's initials were recorded daily each shift to indicate that the placement and function of Resident #2's WG was verified. Further review of the March 2021 MAR for Resident #2 documented by the UM #1 that on 3/21/21 Resident #2's WG was checked for function and placement to the back of her wheelchair during the 3 PM - 11 PM shift. The time was not documented.

Nurse #1 completed an incident report dated 3/21/21 at 8:30 PM, which recorded that she was unable to locate Resident #2 in her room. Staff stated Resident #2 reported she was going to the vending machine. Resident #2 was not observed at the vending machine. Nurse #1 alerted staff verbally and with an overhead page to look for Resident #2. Staff searched inside/outside facility, but Resident #2 was not located. During staff search, a police officer came to the facility and notified that Resident #2 was with a police officer at the pharmacy near the facility. Resident #2 was returned to the facility, assessed by Nurse #1 without injury or pain. Vital signs were assessed as blood pressure 126/85, temperature 98, pulse 96, respirations 20, and oxygen

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saturations 94% via nasal cannula. Resident #2's description of the events included a statement that she was waiting for UM #1 to stop her, but nobody stopped her so she went outside, could not get back into the facility, so she went to local pharmacy for them to call the facility. Resident #2 then stated, she felt like it was all a joke.

A review of Weather.com, revealed the outside temperature the evening of 3/21/21 was 45 degrees Fahrenheit and weather was partly cloudy.

A physician progress note dated 3/24/21 documented a comprehensive monthly follow up that Resident #2 was without signs of psychosis, mood disturbance, emotional symptoms or psychiatric exacerbation at the time of the assessment, alert and oriented to person and place, and clinically stable on continuous oxygen at 4 liters per minute. The physician noted that Resident #2 recently left the facility unattended and was picked up at the local pharmacy after making a phone call to the facility and returned to the facility without issue. Resident #2 reported to the physician she left because she thought there was a party outside.

A psychiatric mental health nurse practitioner progress note dated 3/25/21, documented Resident #2 was seen for medication management of psychotropic medications. During the session, Resident #2 presented with paranoid delusions, irrational thinking, poor insight, and poor judgement. She expressed she was not happy living at the facility because she felt the facility did not meet her mental health (MH) needs. Resident #2 stated she wanted to be at a MH facility. As a result, Resident #2 stated that

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she purposely went outside of the facility and went to the local pharmacy so that any random person would pick her up and take her away from the facility. Resident #2 also expressed that she planned to ask the social worker at an upcoming surgical appointment to help her with placement at another facility.

A re-admission Wandering Risk assessment dated 3/31/21 assessed Resident #2 at low risk for elopement, no WG was indicated, due to the Resident's non-weight bearing and non-ambulatory status.

Resident #2 was observed on 4/7/21 at 9:55 AM in her room across from the nursing station with therapy staff providing services.

On 4/7/21 at 11:30 AM, Resident #2 was observed in her room and interviewed. Resident #2 stated in interview that she remembered when she left the facility and went to the local pharmacy. The day it occurred, she stated she thought someone was outside her door and wanted to hurt her. She went to the door and no one was there, so she then went up the hall to find someone to tell, but she could not find anyone, so she went to the front door of the building and "just left". Resident #2 stated there was no one in the lobby and that when she left the facility, she did not hear an alarm. She further stated that if an alarm had sounded, she would have remembered that. Resident #2 stated that she went through the parking lot, she thought someone would come and bring her back, but that didn't happen, so she kept going all the way to the pharmacy, where an employee called the police and she was brought back to the facility. Resident #2 stated she spoke to the Director of

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Nursing (DON) on the phone when she got back to the facility and told her that she was not trying to leave, but that she just could not get back in the building. She rang the doorbell at the facility, but no one answered, so she went to the pharmacy to call so that staff would let her back in. Resident #2 stated she did not get hurt, she was not bothered by anyone and she did not have any pain when she got back. Resident #2 stated she did not currently have a WG in place.

An observation with the Maintenance Director and the Administrator occurred on 4/7/21 at 2:32 PM of the facility's lobby and WG system at the front door and entrance to the nursing unit. The Maintenance Director tested a WG device to the WG system at the front door and the door which led to the nursing units. The WG device alarm sounded at both the front door, at the door which led to the nursing unit and the alarm was also heard on each nursing unit. Additionally, the front exit door automatically locked.

An observation on 4/8/21 at 945 AM of the route from the facility to the local pharmacy revealed a two-lane road through a residential community with sidewalks shaded by trees on both sides of the road. The sidewalks leading to the local pharmacy was inclined approximately 10 - 15 degrees. The pharmacy was located at the corner of a four lane intersection.

Nurse Aide (NA) #1 was interviewed on 4/8/21 at 3:30 PM and stated she was assigned to care for Resident #2 on 3/21/21, 3 PM - 11 PM shift. NA #1 stated she saw Resident #2 in her room on 3/21/21 around 8:00 PM or 8:30 PM when she provided Resident #2 with ice water, her WG was attached to her wheel chair "like always" and then

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the Resident went up the hall to the vending machine. NA #1 said about 30 - 40 minutes went by, no one saw her so staff started searching inside and outside the facility. NA #1 further stated she did not hear any alarms or doorbells that night and when Resident #2 returned to the facility her WG was still attached to her wheelchair, but it did not alarm.

An interview with Medication Aide (MA) #1 occurred on 4/8/21 at 3:45 PM and revealed that he medicated Resident #2 on 3/21/21 around 8:35 PM. He stated that a little after that Nurse #1 came to him and said she was looking for Resident #2 to check her blood sugar. MA #1 stated he informed Nurse #1 that Resident #2 went to the vending machine about 20 - 30 minutes earlier, so staff checked the Resident's room and bathroom, but did not locate her. Then staff searched inside and outside the facility and then the facility received a call that Resident #2 was at the local pharmacy, so someone brought her back. MA #1 stated when Resident #2 returned, her explanation of what happened did not make sense and that he did not recall what she said. MA #1 further said Resident #2 had not expressed a desire to leave the facility before nor had she previously left the facility unattended.

Nurse #1 stated in interview on 4/7/21 at 2:19 PM that she was the nurse assigned to Resident #2 on 3/21/21, on the 3 PM - 11 PM shift. Nurse #1 stated she observed the WG to Resident #2's wheelchair between 7:30 PM - 8:00 PM that day when she conducted nursing rounds, but that she only checked placement of the WG and not function. She further stated she did not have the monitoring tool to check the WG for function, she did not know where the tool was located because

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no one had shown her. Nurse #1 stated that she noticed Resident #2 was not in her room on 3/21/21 around 9:00 PM, she asked staff and staff said Resident #2 was observed going up the hall towards the vending machine. Nurse #1 said she went to the vending machine, but Resident #2 was not there, so she returned to the unit, notified staff verbally and via the overhead call system to begin a search to locate Resident #2. She stated that staff searched both inside and outside the facility but could not locate Resident #2. During the search, MA #1 came to Nurse #1 and told her that a police officer came to the facility asking if staff knew Resident #2 and informed staff that Resident #2 was at the local pharmacy with another police officer. Nurse #1 stated she left the facility and was assisted by the police to bring Resident #2 back to the facility. When Resident #2 returned, she was wearing pants, a long-sleeved shirt, shoes, and socks. Nurse #1 further stated that she thought Resident #2 was also wearing a jacket, but that she was not certain. Nurse #1 stated when Resident #2 returned, her WG was on her wheelchair, but it did not alarm when the WG passed through the WG monitoring systems at the front entry of the building or at the entrance to the nursing units. Nurse #1 then said she conducted a head to toe skin assessment for Resident #2 and checked her vital signs, with no injuries noted, Resident #2 denied pain and her vital signs were normal. Nurse #1 said Resident #2 was monitored every 15 minutes for location until she discharged to the hospital on 3/29/21 for a planned surgical appointment. Nurse #1 said that she did not hear a WG alarm sound or a doorbell ring during her shift on 3/21/21. She further stated, "I would have heard it (alarm), I don't know if it (WG) was functioning." Nurse #1 stated that during her

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assessment of Resident #2, the Resident reported that she left the facility because she thought someone would stop her before she got to the front door, but no one did, so she kept going.

An interview with UM #1 occurred on 4/12/21 at 11:40 AM. UM #1 stated that she came to the facility on 3/21/21. UM #1 stated that she did not usually work weekends, but that sometimes she came into the facility to assist and check on residents when the staffing pattern included a nurse and a MA. UM #1 said on 3/21/21 sometime after dinner, possibly around 6:30 PM, she came to the facility, conducted a nursing round, observed Resident #2 with a WG to her wheel chair, verified its function using the monitoring tool on the medication cart and signed the MAR.

An interview on 4/8/21 at 9:30 AM was conducted with a sales associate (SA) of the local pharmacy. The SA stated that he was SA in the local pharmacy on 3/21/21 when a customer came inside around 9:00 PM and told him there was a lady (Resident #2) outside who wanted to speak to an employee. The SA stated he notified his supervisor and went outside and saw a lady (Resident #2) seated in a wheelchair. The SA stated the lady (Resident #2) was wearing pants, a shirt, shoes, and a jacket and that it was a little cold outside that night. He stated the lady (Resident #2) asked him to call the police. The SA further stated that the lady (Resident #2) did not appear to be injured or hurt, she was calm and appeared appropriately dressed, so he asked her to come inside the pharmacy and wait at the front of the store while he called the police. The SA stated he called the police and they arrived

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about 10 - 15 minutes later. He stated that when the police arrived, two officers came and spoke to her (Resident #2), but he could not hear the conversation. One police officer waited inside the pharmacy while the other police officer left and came back. When the police officer returned, he informed the lady (Resident #2) that staff at the nursing home (NH) down the street were looking for her because they didn't know where she was. The police officers told her (Resident #2) they were going to take her back to the NH and then they took her with them and left.

A telephone interview with the receptionist occurred on 4/9/21 at 12:45 PM. During the interview, the receptionist stated that she worked Monday - Friday, 8:30 AM - 5:00 PM and at times a receptionist covered the evenings, however a receptionist did not work on Sunday evening 3/21/21. The receptionist stated part of her responsibilities included to monitor the lobby area. She stated that if a resident with a WG approached the front doors, the WG alarm sounded and the front door locked. The receptionist stated that Resident #2 had a WG and enjoyed sitting outside at the front entrance, so at times the Resident was assisted outside by staff. The receptionist would inform her nurse and the Resident was monitored by staff while she was outside. The receptionist also stated that about a year ago, Resident #2 was witnessed to propel outside in the parking lot, unattended, so after that, a WG was placed.
The physician was interviewed by phone on 4/8/21 at 1:40 PM and stated that he spoke to Resident #2 on 3/24/21 which he documented in a progress note. Resident #2 described the incident on 3/21/21 to the physician by saying she thought there was a party down the street and

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she was missing out. Resident #2 stated she left the facility to find the party. The physician stated that once Resident #2 got out of the facility, he believed she got confused and went to the local pharmacy to get help. He described Resident #2 as having a history of schizophrenia, mild psychosis with intermittent confusion and delusional behavior at times. The physician stated Resident #2 had a DSS guardian which was needed for her medical decisions due to her psychiatric state, but that Resident #2 did not need a one to one sitter; she did not need constant monitoring. The physician stated that in his opinion, Resident #2 just got confused but was not in danger, the incident did not pose a safety issue for her, she left the facility and returned all within a couple of hours and she was returned safely without incident or injury.

An interview with the Maintenance Director occurred 4/7/21 at 2:11 PM. The Maintenance Director stated he began employment at the facility on 2/22/21 and worked Monday - Friday. He stated that since his employment, he conducted daily checks of the facility's WG system, Monday - Friday. He stated that he used a WG monitoring device to verify that the monitoring system did alarm and the front door automatically locked within a 10-foot radius of the WG antenna. He stated the WG alarm when sounded, could be heard throughout the facility. He further stated that he was not sure who checked the WG system on Saturday or Sunday. A follow up interview with the Maintenance Director occurred on 4/8/21 at 11:35 AM. During the interview he provided written guidance from the vendor service for the WG system. The guidance recorded that the alarmed doors typically had a maximum 8-foot radius from the

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WG antenna based on the adjustment and radio frequency interference of the WG device. The vendor service recorded that best practice for placement of the WG tags was to place the WG on the resident's wrist or ankle. The Maintenance Director described that in his experience, the WG system functioned best when the WG was placed on the resident rather than the wheelchair in case the resident got separated from the wheelchair, but that if the WG was placed on the wheelchair, it should still alarm if the WG was working. Review of documentation provided by the Maintenance Director during the interview revealed he last checked the WG system on Friday, 3/19/21 prior to the elopement of Resident #2. He stated that no concerns were identified.

On 4/8/21 at 3:06 PM, the Administrator and DON were interviewed. The interview revealed that in the past, Resident #2 sat at the front of the facility with her bags for hours, but that she never said she was going to leave the facility, only that she wanted to be somewhere else, refused to wear a WG and had cut it off before. The Administrator and DON stated they received a phone call from staff to inform that Resident #2 left the facility and returned. The DON stated that she spoke to Resident #2 via phone on 3/21/21 after she returned to the facility and the Resident stated that she wasn't trying to go anywhere, she wasn't leaving, but rather going to the local pharmacy to call the facility to get back in. Resident #2 reported that she informed NA #1 that she wanted to go sit outside, so she let NA #1 know and went to the front of the facility, after about 10 minutes, Resident #2 stated she wanted to come back in, rang the bell but no one answered so she went down the street to the local pharmacy to call the facility to get back in. The Administrator stated he

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was not certain why Resident #2's WG did not sound and that he could not confirm that the WG function was checked on 3/21/21. He stated that a power surge could have affected her WG or Resident #2 could have manipulated it. He stated that when Resident #2 returned the WG did not sound at the front door, staff reported they did not hear an alarm during the shift, nor did staff hear a doorbell. The interview further revealed that the Administrator and DON spoke to Resident #2 in person the next day, 3/22/21 and she provided the same course of events as given during the phone interview on 3/21/21. The Administrator stated that in the facility's investigation, they could not corroborate that Resident #2 told a staff member that she was going to sit outside. The Administrator stated Resident #2 was safe to sit outside without staff supervision, but that if she wanted to leave the grounds, staff preferred that she inform staff so that staff could coordinate that with her DSS guardian.

A phone interview with the DSS guardian occurred on 4/12/12 at 8:22 AM. She stated that she routinely received calls from Resident #2, it was difficult to get direct answers from her and keep her on task during a conversation. The DSS guardian stated she was aware that Resident #2 was assessed at risk for elopement and had a WG placed on her wheelchair because at one point she refused to wear the WG on her person due to complaints of discomfort. The DSS guardian further stated she was aware that Resident #2 had previously requested to move back home to a MH facility but that was not an appropriate placement for her due to her required skilled level needs. She described Resident #2 with behaviors that included chronic paranoia about the people around her, fixated on people,

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circumstances and had irrational perceptions. During the interview, the DSS guardian stated she received a phone call from Resident #2 on Monday, 3/22/21. During this call, Resident #2 asked if she had heard what happened over the weekend. Resident #2 went on to describe that she got into her wheelchair and rolled to the local pharmacy around 9:00 or 10:00 PM the night before. Resident #2 further stated that she thought someone was behind her and that she didn't realize she was going so far. She thought someone would stop her, but she got all the way to the pharmacy. Facility staff came and got her and brought her back. Resident #2 then apologized and said she would not leave the facility again. The DSS guardian stated that Resident #2 did not dwell on this incident and moved on to discuss her upcoming planned surgery. The DSS guardian stated that Resident #2 had been adjudicated incompetent and due to her personality disorder, sometimes her perception could not be substantiated, so the guardian stated she needed to verify her statement. The DSS guardian stated that Resident #2 denied being injured, confirmed that she was safe and currently back in the facility. The DSS guardian stated that she asked Resident #2 how she got out of the facility, but the Resident did not answer her directly. The DSS guardian stated she contacted the facility to verify this incident.

The facility provided a corrective action plan with a completion date of 3/22/21 which included the following information:

1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. ·Skin

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assessment was immediately completed on resident #2 by the nurse to identify any injuries and no injuries were noted. (10:00 pm 3/21/2021) ·15 minutes safety checks-initiated for resident #2 and remain in place. (10:00 pm 3/21/2021) ·Maintenance Director checked all doors and WanderGuard system to ensure proper functioning. Systems were functioning properly. (7:00 am 3/22/2021) ·Supervisor made regular checks to the front of the building until Maintenance Director arrived to check the system the next morning. (10:00 pm 3/21/2021 - 7:00 am 3/22/2021) ·A new WanderGuard assessment was completed for all current residents with a WanderGuard bracelet by members of nursing team. (3/22/2021) ·Care plans reviewed for all residents with WanderGuard bracelets by MDS nurse. (3/22/2021) ·QAA Committee met on 3/22/2021 to develop and approve action plan related to this incident.

2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents with WanderGuard bracelets have the potential to be affected.

3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. ·Staff nurses and medication aides were educated on proper placement of the WanderGuard bracelet and function of the WanderGuard system by DON and ADON. This education was completed on 3/22/2021 for facility employees. Any agency nurse is provided with education packet prior to beginning their first shift by a nursing supervisor on duty. This education was added to the new hire packet and new hires will be educated prior

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to beginning their first shift. ·The Maintenance Director or designee will complete daily WanderGuard and door systems checks to ensure ongoing proper function of the system. Any issues identified as needing corrective action will be addressed immediately and reported to the QAA Committee. ·Nursing will monitor residents with WanderGuard bracelets for placement and function every shift. ·DON will monitor MAR to validate WanderGuard placement and function five times a week for 1 month then weekly for 2 months. ·Administrator will monitor compliance with daily door checks weekly via TELS system.

4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. ·Administrator and DON will report results of on-going monitoring monthly to QAA Committee. The QAA Committee will assess the information to determine if compliance is being maintained and will make any changes or updates to the plan of correction as needed.

On 4/20/21, the facility's corrective action plan, with a correction date of 3/22/21 was validated by the following, observations of wander guard placement and function to 100% residents in the facility identified at risk for elopement, interviews with family, legal guardian and staff, review of monitoring logs, documentation of wander guard placement and function and documentation of training.