| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345289 | A. BUILDING ______ B. WING ______ | C 06/08/2023 |

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| CURRITUCK HEALTH & REHAB CENTER | 3907 CARATOKE HIGHWAY BARCO, NC 27917 |

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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 06/05/23 through 06/08/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #679Q11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey was conducted from 06/05/23 through 06/08/23. Event ID #679Q11. The following intakes were investigated NC00199158, NC00202241, NC00202294, NC00202535, and NC00198490. 1 of the 16 complaint allegations resulted in a deficiency.<br><br>Past noncompliance was identified at:<br><br>CFR 483.25 at tag F689 at scope and severity (J)<br><br>The tag F689 constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 01/01/23 and was removed on 01/07/23. An extended survey was conducted.<br><br>The facility came back into substantial compliance effective 06/08/23. | F 000 | | |
| F 623 SS=C | Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a | F 623 | | 7/3/23 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/03/2023

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 623 | Continued From page 1<br>language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge; | F 623 | | |

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| F 623 | Continued From page 2<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure | F 623 | | |

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In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to provide written notification for reason of discharge to hospital to the Resident and Responsible Party (RP) for 8 of 8 residents reviewed for hospitalization (Resident #28, Resident #31, Resident #60, Resident #69, Resident #50, Resident #80, Resident #2, and Resident #85).

The findings included:

1. Resident #28 was admitted to the facility on 4/12/2023.

The change in condition assessment dated 4/12/2023 revealed Resident #28 was sent to the Emergency Department for further evaluation and amputation for acute hematogenous osteomyelitis of his left femur.

A record review of the nursing progress notes revealed there was no documentation Resident #28 and his Responsible Party (RP) received written notification of the reason for transfer to the Emergency Department.

Resident #28 was discharged to the hospital on 4/12/2023 and returned to the facility on 5/4/2023.

F 623

F Tag 623 Notice Requirements Before Transfer/ Discharge
This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services for our residents.
F623 Notice Requirements Before Transfer/ Discharge
A. How corrective action will be accomplished for residents(s) found to have been affected:

7 out of 8 residents affected by this deficient practice were readmitted to the facility and currently still reside in the facility. On July 3, 2023 DON provided education to those residents on the

F 623

Continued From page 4

In an interview with the Director of Nursing (DON) on 6/7/2023 at 9:00 a.m. she stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.

During an interview with the Administrator on 6/7/2023 at 9:32 a.m. she revealed the facility did not have the letter to the Resident and the RP explaining the reason for transfer to the Emergency Department in place at this time.

2. Resident #31 was admitted to the facility on 12/17/2021.

The change in condition assessment dated 4/29/2023 revealed Resident #31 was sent to the Emergency Department for further evaluation for shortness of breath.

Record review of the nursing progress notes revealed there was no documentation Resident #31 and his Responsible Party (RP) received written notification of the reason for transfer to the Emergency Department.

Resident #31 was discharged to the hospital on 4/29/2023 and returned to the facility on 5/2/2023.

In an interview with the Director of Nursing (DON) on 6/7/2023 at 9:00 a.m. she stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.

During an interview with the Administrator on 6/7/2023 at 9:32 a.m. she revealed the facility did not have the letter to the Resident and the RP explaining the reason for transfer to the

F 623

requirement of the facility to provide written notification for reason of discharge to the hospital. DON also provided a copy of the discharge letter to 7 of the 8 residents affected. One of the eight residents affected was not readmitted to the facility and has since expired.

B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed:
On June 7, 2023, the DON reviewed residents with immediate discharge/ transfer to hospital in last 7 days who had not received the written notification for reason of discharge to the hospital. The facility identified two residents were affected in last 7 days.
On June 7, 2023, The Business Office Manager and Social Worker informed those two residents or resident representative via phone of the state specific discharge letter with written notification for transfer to the hospital. The facility sent a copy of written notification for reason of discharge to the hospital via certified mail to the resident's representative.

C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?
To prevent this from happening again the facility provided education to licensed nurses, social worker and business office manager on the discharge/ transfer letter policy.

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F 623

Continued From page 5
Emergency Department in place at this time.

3. Resident #60 was admitted to the facility on 12/17/2021.

The change in condition assessment dated 4/29/2023 revealed Resident #60 was sent to the Emergency Department due to abnormal vital signs.

Record review of the nursing progress notes revealed there was no documentation Resident #60 and his Responsible Party (RP) received written notification of the reason for transfer to the Emergency Department.

Resident #60 was discharged to the hospital on 4/29/2023 and returned to the facility on 5/5/2023.

In an interview with the Director of Nursing (DON) on 6/7/2023 at 9:00 a.m. she stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.

During an interview with the Administrator on 6/7/2023 at 9:32 a.m. she revealed the facility did not have the letter to the Resident and the RP explaining the reason for transfer to the Emergency Department in place at this time.

4. Resident #69 was admitted to the facility on 12/5/2022, 1/3/2023, 2/22/2023, and lately on 5/12/2023.

The change in condition assessment dated 5/3/2023 revealed Resident #28 was sent to the Emergency Department for further evaluation due

F 623

The Assistant Director of Nursing completed education with licensed nurses regarding the transfer policy letter on June 13, 2023.
The facility Administrator completed education regarding the transfer policy letter with the Social Worker and Business Office Manager on June 7, 2023
D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained:
LNHA/ designee will audit residents discharged to the hospital 5 times per week for 12 weeks to ensure residents discharged to the hospital received written notification of reason for transfer to the hospital. BOM/ SW will mail a copy the state specific discharge letter to resident/ resident's responsible party as soon as practicable.
The LNHA/ designee will bring the results of the audits to the monthly QAPI meeting for review for 3 months, or longer as deemed necessary by the QAPI committee. Revisions will be made as needed.
Adoc HOC QAPI was held on 6/7/23 to discuss the deficient practice related to discharge/ transfer letter policy.
The Assistant Director of Nursing completed education with licensed nurses regarding the transfer policy letter on June 13, 2023.
The facility Administrator completed education regarding the transfer policy letter with the Social Worker and Business Office Manager on June 7, 2023

The facility alleges compliance on July 3,

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| F 623 | Continued From page 6 for pain to his right foot and ankle.<br><br>A record review of the nursing progress notes revealed there was no documentation Resident #28 and his Responsible Party (RP) received written notification of the reason for transfer to the Emergency Department.<br><br>Resident #69 was discharged to the hospital on 5/3/2023 and returned to the facility on 5/12/2023.<br><br>In an interview with the Director of Nursing (DON) on 6/7/2023 at 9:00 a.m. she stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.<br><br>During an interview with the Administrator on 6/7/2023 at 9:32 a.m. she revealed the facility did not have the letter to the Resident and the RP explaining the reason for transfer to the Emergency Department in place at this time.<br>5. Resident #50 was admitted to the facility on 4/21/22.<br><br>The change in condition assessment dated 10/19/22 revealed Resident #50 was sent to the Emergency Department for further evaluation due to slurred speech, left sided slump and increased drowsiness.<br><br>A review of the nursing progress notes revealed there was no documentation Resident #50 and his Responsible Party (RP) received written notification of the reason for transfer to the Emergency Department<br><br>Resident # 50 was discharged to the hospital on 10/19/22 and returned to the facility on 10/21/23. | F 623 | 2023. | |

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| F 623 | Continued From page 7 | F 623 | | |

In an interview with the Director of Nursing (DON) on 6/7/23 at 9:00 AM she stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.

During an interview with the Administrator on 6/7/23 at 9:32 AM she revealed the facility did not have the letter to the Resident and RP explaining the reason for transfer to Emergency Department in place at this time.

6. Resident #80 was admitted to the facility on 5/5/23.

The change in condition assessment dated 5/16/23 revealed Resident #80 was sent to the Emergency Department for further evaluation due to increased shortness of breath.

A review of the nursing progress notes revealed there was no documentation Resident #80 and her Responsible Party (RP) received written notification of the reason for transfer to the Emergency Department.

Resident # 80 was discharged to the hospital on 5/16/23 and returned to the facility on 6/2/23.

In an interview with the Director of Nursing (DON) on 6/7/23 at 9:00 AM she stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.

During an interview with the Administrator on 6/7/23 at 9:32 AM she revealed the facility did not have the letter to the Resident and RP explaining the reason for transfer to Emergency Department

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| F 623 | Continued From page 8<br>in place at this time.<br><br>7. Resident #2 was admitted to the facility on 3/02/23.<br><br>The Change in Condition Assessment dated 3/31/23 revealed Resident #2 was sent to the emergency department for further evaluation of abnormal laboratory results.<br><br>Record review of the nursing progress notes revealed there was no documentation Resident #2 and her Responsible Party (RP) received written notification of the reason for transfer to the emergency department.<br><br>Resident #2 was discharged to the hospital on 3/31/23 and returned to the facility on 4/14/23.<br><br>During an interview on 6/07/23 at 9:00 am the Director of Nursing (DON) stated she was not aware of a letter to the Resident and the RP explaining the reason for transfer.<br><br>An interview on 6/07/23 at 9:32 am the Administrator revealed the facility did not have the letter to the Resident and the RP explaining the reason for transfer to the emergency department in place at this time.<br><br>8. Resident #85 was admitted to the facility on 1/25/23.<br><br>The Change in Condition Assessment dated 2/08/23 revealed Resident #85 was sent to the emergency department for shortness of breath, | F 623 | | |

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| F 623 | Continued From page 9<br>low blood oxygen saturation, and elevated heart rate.<br><br>Record review of the nursing progress notes revealed there was no documentation Resident #85 and her RP received written notification of the reason for transfer to the emergency department.<br><br>Resident #85 was discharged from the facility on 2/08/23 and returned to the facility on 2/09/23.<br><br>During an interview on 6/07/23 at 9:00 am the Director of Nursing (DON) stated but she was not aware of a letter to the Resident and the RP explaining the reason for transfer.<br><br>An interview on 6/07/23 at 9:32 am the Administrator revealed the facility did not have the letter to the Resident and the RP explaining the reason for transfer to the emergency department in place at this time. | F 623 | | |
| F 625 SS=B | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; | F 625 | | 7/3/23 |

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(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review, and staff interviews, and resident interview, the facility failed to notify the Resident or Resident Representative of the facility bed hold policy for 4 of 8 residents reviewed for hospitalization (Resident #2, Resident #85, Resident #50, and Resident #80).

The findings included:

1. Resident #2 was admitted to the facility on 3/02/23.

The Change in Condition Assessment dated 3/31/23 revealed Resident #2 was sent to the emergency department for further evaluation of abnormal laboratory results. Resident #2 was discharged to the hospital on 3/31/23.

Record review of the nursing progress notes revealed there was no documentation Resident #2 and her Responsible Party (RP) received the bed hold policy for the 3/31/23 discharge.

F 625

F Tag 625 Notice of Bed Hold Policy Before/ Upon Transfer
This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services for our residents.
F625 Notice of Bed Hold Policy Before/ Upon Transfer
A. How corrective action will be accomplished for residents(s) found to have been affected:
3 of 4 residents affected by this deficient

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| F 625 | Continued From page 11<br>The Minimum Data Set quarterly assessment revealed Resident #2 was cognitively intact.<br><br>An interview with Resident #2 on 6/05/23 at 12:00 pm revealed she did not recall being given the bed hold policy when she discharged on 3/31/23.<br><br>During an interview on 6/07/23 at 9:00 am the Director of Nursing (DON) stated the bed hold policy was sent with the resident, but the facility did not keep record of it being given. She stated the floor nurse was responsible for documenting in the medical record that the bed hold policy was given at time of discharge. The DON was unable to find documentation to confirm the bed hold policy was given for Resident #2's discharge on 2/08/23.<br><br>2. Resident #85 was admitted to the facility on 1/25/23.<br><br>The Change in Condition Assessment dated 2/08/23 revealed Resident #85 was sent to the emergency department for shortness of breath, low blood oxygen saturation, and elevated heart rate. Resident #85 was discharged from the facility on 2/08/23.<br><br>Record review of the nursing progress notes revealed there was no documentation Resident #85 and her RP received the bed hold policy for the 2/08/23 discharge.<br><br>During an interview on 6/07/23 at 9:00 am the Director of Nursing (DON) stated the bed hold policy was sent with the resident, but the facility did not keep record of it being given. She stated the floor nurse was responsible for documenting in the medical record that the bed hold policy was | F 625 | practice were readmitted to the facility and currently still reside in the facility. On July 3, 2023, the DON provided education to those residents on the requirement of the facility to provide a copy of the bed hold policy to the resident or resident representative upon discharge to the hospital. The DON also provided a copy of the bed hold policy to 3 of the 4 residents affected. 1 of the 4 residents affected was not readmitted to the facility and has since expired.<br><br>B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed:<br>The facility DON on June 7, 2023 reviewed residents with immediate discharge/ transfer to hospital in the last 7 days prior to the identification of the issue. Two residents were identified as affected by this deficient practice. On June 7, 2023, the Business Office Manager and Social Worker informed those two residents and/ or their representative via phone of the Bed Hold Policy and sent a copy of the bed hold policy to the resident representative via certified mail.<br>The Assistant Director of Nursing completed education with licensed nurses regarding the Bed Hold Policy on June 13, 2023.<br>The facility Administrator completed education regarding the Bed Hold Policy with the Social Worker and Business Office Manager on June 7, 2023. | |

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given at time of discharge. The DON was unable to find documentation to confirm the bed hold policy was given for Resident #85's discharge on 2/08/23.

3.Resident #50 was admitted to the facility on 4/21/22.

The change in condition assessment dated 10/19/22 revealed Resident #50 was sent to the Emergency Department for further evaluation due to slurred speech, left sided slump and increased drowsiness.

Resident # 50 was discharged to the hospital on 10/19/22.

A review of the nursing progress notes revealed there was no documentation of Resident #50, and his Responsible Party (RP) received the bed hold policy for the 10/19/22 discharge.

The Quarterly Minimum Data Set Assessment dated 3/25/23 revealed Resident #50 was cognitively intact.

An interview with Resident #50 on 6/7/23 at 9:22 AM revealed he did not recall being given the bed hold policy when he discharged on 10/19/22.

During an interview with the Director of Nursing (DON) on 6/7/23 at 3:16 PM, she stated the bed hold policy was sent with the resident. The DON stated the floor nurse was responsible for documenting in the medical record that the bed hold policy was given at the time of discharge.

4. Resident #80 was admitted to the facility on 5/5/23.

F 625

C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?
To prevent this from happening again, the licensed nurses, social worker and business office manager were educated on the bed hold policy.
The Assistant Director of Nursing completed education with licensed nurses regarding the Bed Hold Policy on June 13, 2023.
The facility Administrator completed education regarding the Bed Hold Policy with the Social Worker and Business Office Manager on June 7, 2023

D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained:
LNHA/ designee will audit immediate discharges 5 times per week for 12 weeks to ensure residents discharged to the hospital received the bed hold letter.
BOM/ SW will mail a copy the bed hold policy to the resident/ resident’s representative as soon as practicable after resident is discharged to the hospital.
The LNHA/ designee will bring the results of the audits to be reviewed in monthly QAPI meeting for 3 months; or longer as deemed necessary by the QAPI committee.
Adoc HOC QAPI was held on 6/7/23 to discuss the deficient practice related to bed hold policy.
The facility alleges compliance on July 3, 2023.

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The change in condition assessment dated 5/16/23 revealed Resident #50 was sent to the Emergency Department for further evaluation due to shortness of breath and decreased oxygen saturation.

Resident # 80 was discharged to the hospital on 5/16/23.

A review of the nursing progress notes revealed there was no documentation of Resident #80, and her Responsible Party (RP) received the bed hold policy for the 5/16/23 discharge.

The Admission Minimum Data Set Assessment dated 5/12/23 revealed Resident #80 was cognitively intact.

An interview with Resident #80 on 6/6/23 at 8:57 AM revealed she did not recall being given the bed hold policy when he discharged on 5/12/23.

During an interview with the Director of Nursing (DON) on 6/7/23 at 3:16 PM, she stated the bed hold policy was sent with the resident. The DON stated the floor nurse was responsible for documenting in the medical record that the bed hold policy was given at the time of discharge.

F 689 SS=J Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) F 689

§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

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| F 689 | Continued From page 14<br>accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff interviews, Responsible Party (RP) interview, and Physician interview the facility failed to provide supervision of a resident with severe cognitive impairment and known exit seeking behaviors to prevent an unsupervised exit for 1 of 7 residents reviewed for accidents (Resident #56). On 1/01/23 Resident #56 exited the facility out the dining room exit doors unsupervised and without staff knowledge. An alarm sounded, however the alarm announcement was muffled and had static which made the announcement unclear, so the staff were not aware the announcement was in reference to an elopement. Staff did not respond to the alarm due to the poor quality of sound and did not initiate a search for Resident #56. Resident #56 was found by a visitor outside the facility near the dining room door. This dining room door had a one lane exit road on its left that was bordered by a brush covered area on the opposing side and to the right of the dining room door was an access road for dietary deliveries. There was a high likelihood for Resident #56 to suffer serious injury.<br><br>Findings included:<br><br>Resident #56 was admitted to the facility on 4/19/21 with a diagnosis of dementia and depressive disorder.<br><br>A physician order dated 5/13/21 for wander guard alarm (a device placed on a resident's wrist or ankle when they are determined to be at risk for exit seeking which would activate an alarm announcement to notify staff when the resident | F 689 | Past noncompliance: no plan of correction required. | |

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was near an open exit door or tried to open an exit door) related to wandering/exit seeking behaviors.

A care plan initiated on 5/13/21 revealed Resident #56 had a care plan in place for elopement risk/wanderer related to history of attempts to leave the facility unattended and impaired safety awareness. Interventions included redirection of Resident #56 from wandering by offering structured activities, frequent monitoring during periods of restlessness, and to identify a pattern of wandering to intervene as appropriate.

The Nurse Aide (NA) care guide (not dated) revealed Resident #56 had a wander guard alarm related to elopement risk.

The Elopement Risk Assessment completed on 5/19/22 revealed Resident #56 was a high risk for elopement related to her history of wandering within the facility and verbalized or exhibited exit seeking behaviors.

The Minimum Data Set (MDS) quarterly assessment dated 10/26/22 revealed Resident #56 had severe cognitive impairment and was coded for antidepressant medication. The wander guard/elopement alarm was used daily, and she was not coded for wandering behaviors during the 7-day lookback period. Resident #56's ambulation was coded as steady at times with supervision or cueing and she did not require an assistive device.

The Interdisciplinary Team (IDT) meeting progress note dated 12/29/22 revealed Resident #56's behavior and elopement risk were reviewed. The IDT noted Resident #56 was more

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difficult to redirect during periods of confusion.

A nursing progress note dated 12/31/22 at 7:52 pm by Nurse #2 revealed Resident #56 pushed on the 200 Hall exit door twice exhibiting exit seeking behaviors. Resident #56 did not exit the facility and was redirected back to her room.

An attempt to interview Nurse #2 on 6/07/23 at 9:09 am and again on 6/08/23 at 10:30 am were unsuccessful.

A nursing progress note dated 1/01/23 at 1:15 pm by Nurse #1 revealed Resident #56 was last seen by Nurse #1 at 12:45 pm walking in hallway. Nurse #1 was alerted that Resident #56 was outside of the facility at 1:10 pm. She reported she was unable to hear the door alarm due to muffled sound. Nurse #1 reported Resident #56 was brought back into the facility and no injuries were noted.

The Head-to-Toe Evaluation dated 1/01/23 at 2:00 pm revealed Resident 56's vital signs were as follows: blood pressure was 120/68 mm/Hg (millimeter of mercury), pulse was 66 beats per minute, respirations were 16 breaths per minute and regular, her temperature was 98.7 degrees Fahrenheit, and the blood oxygen level was 99% on room air. Resident #56 was pleasant, had no signs or symptoms of distress, she had no complaints of pain, and her skin was normal, warm, and dry.

A nursing progress note dated 1/02/23 at 12:43 by the Unit Manager revealed the physician completed a medication review for Resident #56 and a change was made to her medication regimen.

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An observation on 6/07/23 at 1:00 pm of the area outside the dining room revealed the dining room exit doors opened to a sidewalk at the rear of the building which was to the right of the one lane exit road and bordered by a brush covered area on the left side of the exit road of the facility. To the right of the dining room exit door was an access road for dietary department deliveries and three trash dumpsters were located approximately 200 feet away.

An observation of the 200 Hall to the dining room was completed on 6/07/23 at 5:15 pm and it was found to be the corridor next to the 200 Hall. The corridor did not have any resident rooms. The corridor was observed to have a pantry, staff break room, staff bathroom, and after a bend in the corridor was the entrance to the kitchen on the left side and the kitchen delivery door to the right side of the hall prior to entering the dining room.

A review of the weather conditions per Weather Underground's website (www.wunderground.com) for Barco's weather indicated the temperature on 1/01/23 was 57 degrees Fahrenheit with 87% humidity during the time Resident #56 was outside the facility.

A telephone interview was conducted on 6/06/23 at 3:37 pm with Nurse #1 who revealed she was assigned to Resident #56 on 1/01/23 on the 200 Hall. She reported she observed Resident #56 walking around the 200 Hall after lunch and she was notified about 20 minutes later that Resident #56 was outside the facility unsupervised, but she was unable to recall the exact times. Nurse #1 stated she was not aware Resident #56 had

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| F 689 | Continued From page 18<br>exited the facility and was unable to state how long Resident #56 was outside unsupervised. She stated she heard the intercom system attempt to make an announcement, but she was unable to determine what was being reported because it sounded low and muffled. She stated it was not clear that it was a door alarm announcement, so she did not know it was the wander guard alarm. Nurse #1 She stated Resident #56 had a history of exit seeking behaviors by going to the exit door on the 200 Hall, but she had never left the facility. Nurse #1 reported Resident #56 was brought back into the facility and was assessed and found to have no injury.<br><br>An interview was conducted on 6/06/23 at 3:35 pm with the Regional Director of Clinical Services who revealed she was the Director of Nursing (DON) at the time of Resident #56's elopement from the facility. She revealed Resident #56 was able to ambulate independently at the time of the elopement, she did have a history of wandering, and she had the wander guard alarm in place. She stated Resident #56 had traditionally gone toward the 200 Hall doors, but she was easily redirected by staff or her family away from the doors. The Regional Director of Clinical Services stated Resident #56 had a stuffed dog that she was very attached to and after the elopement she stated when she tried to talk to Resident #56 about why she exited she said she was taking the dog for a walk. The Regional Director of Clinical Services stated Resident #56's wander guard alarm was functioning at the time she exited the facility but stated the exit alarm was not functioning properly at the dining room doors. She stated the wander guard alarm announcement was activated at any exit door | F 689 | | |

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| F 689 | Continued From page 19<br>when a resident with the wander guard alarm on was at the exit door when it opened, or they tried to open an exit door. She stated an automatic announcement was broadcasted over the intercom system to check the door at the location of the wander guard alarm activation such as, please check front lobby door or please check 200 Hall exit door depending on the location of the wander guard alarm activation. The Regional Director of Clinical Services stated when the announcement was made staff were required to physically go to the door and check the door location for a resident to ensure no one had exited the facility and would have to reset the alarm by entering the code on the keypad at the activated door. The Regional Director of Clinical Services stated the Maintenance Director adjusted the annunciator volume of the dining room doors on 1/01/23 so the alarm was able to be heard by staff, but it was found that the volume lowered again within a few days, so he scheduled service to the system.<br><br>An interview with the Maintenance Director was conducted on 6/06/23 at 4:28 pm. He revealed he was notified by nursing on 1/01/23 that Resident #56 had exited the facility and that the wander guard alarm system was not functioning properly at the dining room doors. The Maintenance Director stated when he checked the system, he found the annunciator (device that provides information regarding activation of the wander alarm) was not clear and was breaking in and out which made it unable to hear the announcement over the intercom system. The Maintenance Director adjusted the volume of the annunciator for the dining room exit doors on 1/01/23. He stated the wander guard exit alarm did not ring or buzz but was an automatic | F 689 | | |

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announcement that was activated by a resident that had a wander guard near the door when it was opened, and it would announce the location of the wander guard alarm activation over the intercom. He stated the announcement would continue to repeat until the door that was breached was reset with the code on the keypad at the door. The Maintenance Director stated he had not been notified prior to Resident #56's elopement of an issue with the wander guard alarm announcement in the dining room.

A phone interview was conducted with NA #2 on 6/06/23 at 5:55 pm who revealed she worked on the 200 Hall on 1/01/23 but she was not assigned to Resident #56. NA #2 stated Resident #56 was sitting at the nursing station because she and NA #1 were collecting lunch trays and Resident #56 was following them into other resident rooms. NA #2 stated she did not see Resident #56 leave the area of the nurse station and did not know Resident #56 exited the facility. NA #2 reported the wander guard alarm system did not work properly that day because she was unable to hear what was being said over the intercom speaker. NA #2 stated she did not check the exit doors but stated Resident #56 was brought back into the facility by NA #1. She was unable to state what time Resident #56 went outside or how long she was outside unsupervised. NA #2 stated Resident #56 had a history of wandering, so they kept a close eye on her, but she had not known her to exit the building in the past.

An interview was conducted with NA #1 on 6/06/23 at 6:02 pm who revealed she was assigned to the 200 Hall and Resident #56 on 1/01/23. NA #1 stated Resident #56 was sitting at the nursing station while she collected the lunch

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trays from the 200 Hall at approximately 12:45 pm -1:00 pm. NA #1 stated she did not see Resident #56 leave the nurse station. She reported she took the tray cart back to the kitchen and she saw a family member at the kitchen delivery door, and she waved her over. NA #1 stated she opened the door, and the family member notified her Resident #56 was outside, so she ran outside immediately and saw Resident #56 standing on the sidewalk at the dining room doors. NA #1 stated she brought Resident #56 back into the facility at the kitchen delivery door and took her to the nurse. She stated Resident #56 did not say how she got outside. She stated she heard something over the intercom, but she was unable to tell what was being said when she collected the lunch trays because it sounded like radio static and was very low. NA#1 stated she did not know Resident #56 was outside the facility and stated she did not check the exit doors because she was unable to determine if the wander guard alarm had been activated. She stated she knew Resident #56 was an elopement risk, but she normally did not go to this area of the facility. NA #1 reported Resident #56 was dressed on 1/01/23 with long pants, a long-sleeved shirt, socks, and shoes and possibly her sweater, as this was her normal clothing choice.

An interview was conducted on 6/06/23 at 6:08 pm with NA #4 who revealed she was assigned to the 300 Hall on 1/01/23. She stated she did not know the wander guard alarm activated due to the poor quality of the announcement over the intercom and did not know Resident #56 exited the facility. NA #4 stated she was told Resident #56 had exited the facility and was she found outside by the dining room. NA #1 stated she

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went to help but when she got to the dining room, NA #1 was with Resident #56.

During an interview on 6/06/23 at 6:16 pm Nurse #3 revealed she worked on 1/01/23 but she left prior to Resident #56's elopement. She stated she was notified of the elopement when she called to check in with the staff at the facility. Nurse #3 stated Resident #56 was confused but easily redirected and she enjoyed being with staff. Nurse #3 reported the wander guard alarm would at times go in and out during heavy storms, but she had not noticed the alarm not working properly on 1/01/23 when she was working.

A telephone interview was conducted on 6/06/23 at 6:21 pm with Resident #56's Responsible Party (RP) who revealed she was notified of the elopement but was unable to recall if the facility was able to determine how she was able to exit the facility. She stated she came to the facility immediately and stated Resident #56 was calm and did not appear to be under any stress.

During a telephone interview on 6/06/23 at 7:05 pm with NA #5 who revealed she worked on the 400 Hall on 1/01/23 but stated she did not hear the wander guard announcement alarm sound and she did not know Resident #56 exited the facility. NA #5 stated the information over the intercom was not clear and she was unable to determine what was being said. NA #5 stated she began to count the residents on the 400 Hall when she was notified Resident #56 was found outside the facility to make sure no other residents had exited.

During an interview on 6/07/23 at 10:40 am the Unit Manager revealed she was on-call on

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| F 689 | Continued From page 23<br>1/01/23 and came to the facility when she was notified by Nurse #1 that Resident #56 exited the facility. She stated when she arrived the wander guard alarm announcement was still activated and sounded like static. The Unit Manager stated she walked around the facility and confirmed the wander guard alarm was not able to be heard throughout the facility due to the static and low volume. She stated she stood on a table in the dining room to get closer to the intercom speaker and was still unable to determine what was being said. The Unit Manager stated she was unable to determine what door was activated by the announcement, so she walked to each exit door, she opened and shut each door, and then reset each exit door alarm by the keypad until the wander guard alarm silenced. The Unit Manager reported she contacted the Maintenance Director, and he came to the facility. The Unit Manager stated Resident #56 did have a history of exit seeking behaviors, but she would stay on the 200 Hall where her room was located.<br><br>An interview was conducted with the Physician on 6/07/23 at 8:34 am who revealed he was notified that Resident #56 had eloped from the facility. He stated her diagnosis of dementia increased her exit seeking behaviors and he stated after the elopement he adjusted her medications. The Physician reported he was concerned that Resident #56 was out of the facility without supervision as she was not able to fully care for herself.<br><br>The Administrator was notified of Immediate Jeopardy on 6/07/23 at 2:43 pm.<br><br>The facility provided the following corrective action plan with a completion date of 1/07/23: | F 689 | | |

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1. How corrective action will be accomplished for resident(s) found to have been affected:

Resident #56 was assessed head to toe with no adverse findings. Resident #56 was assessed for reduced exit seeking behavior and was placed on one to one (1:1) observation for safety and the 1:1 observation remained in place until 1/30/23. Resident #56's RP and Physician were notified of the elopement.

On 1/02/23 the Physician completed a medication review and changes were made to Resident #56's medication regimen.

2. How corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed:

The facility completed a head count of residents on 1/01/23 to ensure no other residents were affected during the event.

Elopement assessments were completed, and high-risk residents will be monitored for exit seeking behaviors and discussed during the weekly interdisciplinary team (IDT) meeting. The Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Unit Managers completed elopement assessments and chart reviews. Two residents were identified to have potential risk of elopement related to independent ambulation.

On 1/01/23 The DON, ADON, and Unit Managers completed elopement assessments on all residents to ensure completion and accuracy and implementation of any wander alarms as

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indicated.

On 1/01/23 the DON, ADON, and the Unit Managers completed education with all facility staff which included housekeeping, dietary, rehabilitation, administrative, and nursing staff. The education was via power point handout and verbal discussions that included the definition of elopement, the elopement policy reporting process, elopement response, identification of at-risk residents, and possible interventions. All staff working on 1/01/23 were provided with training immediately. Staff reporting to work for the next shift were educated upon arrival at the facility and before starting their work shift. All other staff were provided with education via telephone by the DON and ADON. The DON and ADON will track staff education to ensure education has been completed. The education was completed on 1/02/23.

On 1/01/23 the Maintenance Director inspected all doors leading outside and noted volume issue on alarm in dining room and back conference room area. The Maintenance Director initiated elopement drills for all shifts to ensure staff compliance.

3. What measure will be put in place or systemic changes made to ensure that the identified issues does not occur in the future:

The Maintenance Director completed daily door audits to ensure proper functioning. When an exit door is opened while a resident with a wander alarm is in proximity an annunciator will report via overhead intercom system the location of the door that was activated/alarmed. The Maintenance Director noted volume control

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issues after initial correction completed.

On 1/04/23 VSC Fire & Security, Inc.(vendor) was contacted by the Maintenance Director and assessed the needs of the system and determined the system needed to be rewired. VSC rewired the system inputs 7 and 11 on 1/04/23 to correct announcements.

On 1/06/23 VSC Fire & Security, Inc. returned to the facility and re-recorded door messages on 3 doors and inspected wiring and re-recording to ensure continued operation, appropriate volume control, and resolution of concern.

4. Indicate how the facility plans to monitor its performance to make sure the solutions are achieved and sustained:

A Quality Assurance and Performance Improvement (QAPI) meeting was held on 1/03/23 with the QAPI Committee to review the root cause analysis of the elopement and review the facility's corrective action plan.

a. The Maintenance Director conducted elopement drills on all three shifts completed 1/05/23.

Beginning on 1/01/23 the Maintenance Director performed door alarm audits daily for 8 weeks. The Maintenance Director continues to perform weekly door alarm audits.

Beginning on 2/01/23 the Maintenance Director/designee will conduct a monthly elopement drill for 1 shift for 4 months, then ongoing for 1 shift quarterly. The elopement drills will be reviewed in the QAPI meeting monthly

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| F 689 | Continued From page 27<br>ongoing.<br><br>The door alarm audits continue to be reviewed in the QAPI monthly meeting.<br><br>b. Beginning 1/03/23 the DON, ADON, and Unit Managers reviewed in the weekly IDT risk meeting (reviews nursing notes and behavior monitoring) to ensure interventions are appropriate and initiate changes to plan of care as identified. During the weekly IDT risk meeting those residents that are triggering high on the elopement assessment and are independently mobile are assessed for changes in behavior or exit seeking and that appropriate interventions were implemented. This is an ongoing review now included in the weekly IDT risk meeting.<br><br>The DON is responsible to bring the results of the audits/drills to the monthly QAPI meeting and revised as needed for 3 months or longer as deemed necessary by the QAPI Committee. Alleged date of compliance: 1/07/23.<br><br>Onsite validation was completed on 6/07/23 through 6/08/23 through record review, staff interviews, and observations of the wander guard alarm system. Staff were interviewed to validate the in-service was completed on the wander guard alarm process and elopement drills. A review was completed of the wander guard audits, and IDT risk meeting minutes. Review of the elopement drills and the door alarm audits were completed with no issues noted. Observations of the wander guard alarm system during the survey revealed clear annunciation and notification of the door location activation and staff responded to the designated door throughout the facility. | F 689 | | |

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| F 689 | Continued From page 28<br><br>The facility's corrective action plan was validated to be completed as of 1/07/23. | F 689 | | |
| F 727 SS=C | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to prevent the Director of Nursing (DON) from having a resident care assignment including working on the medication cart with a facility census of greater than 60 residents for 15 of 92 days reviewed (5/20/2022, 6/4/2022, 6/24/2022, 6/25/2022, 6/27/2022, 6/28/2022, 6/29/2022, 6/30/2022, 7/4/2022, 7/5/2022, 7/6/2022, 7/7/2022, 7/8/2022, 7/18/2022, and 7/19/2022).<br><br>The findings included:<br><br>A review of the staffing schedule for May, June and July 2022 showed the average facility census was 68. | F 727 | F Tag 727 RN 8 Hrs/ 7 days/ Wk, Full Time DON<br>This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services | 7/3/23 |

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| F 727 | Continued From page 29<br><br>A record review of the schedules from 5/1/2022 through 7/31/2022, revealed the DON worked as a nurse on the floor on 5/20/2022, 6/4/2022, 6/24/2022, 6/25/2022, 6/27/2022, 6/28/2022, 6/29/2022, 6/30/2022, 7/4/2022, 7/5/2022, 7/6/2022, 7/7/2022, 7/8/2022, 7/18/2022, and 7/19/2022.<br><br>An interview was conducted on 6/7/2022 at 2:40 p.m. with the Scheduler. The Scheduler revealed when a nurse called out for their shift, the Director of Nursing (DON) was used to fill the assignment.<br><br>During the same interview the Scheduler further stated the DON worked a full eight-hour assignment on 5/20/2022, 6/4/2022, 6/24/2022, 6/25/2022, 6/27/2022, 6/28/2022, 6/29/2022, 6/30/2022, 7/4/2022, 7/5/2022, 7/6/2022, 7/7/2022, 7/8/2022, 7/18/2022, & 7/19/2022 with the facility census of over 60 residents.<br><br>During the interview the Scheduler stated she was unaware the DON was unable to have a clinical assignment when the building's census was higher than 60 residents.<br><br>In an interview with the Regional Clinical Services Director (RCSD) who was the prior DON on 6/7/2023 at 3:00 p.m. she revealed she filled call out clinical assignments as needed. During the interview the RCSD stated she was aware she could not have a clinical assignment when the facility had a census of higher than 60 residents. She revealed she was unable to find coverage for the clinical assignments.<br><br>An interview was conducted with the Administrator on 6/7/2023 3:45 p.m. She revealed | F 727 | for our residents.<br>F727 N 8 Hrs/ 7 days/ Wk, Full Time DON<br>A. How corrective action will be accomplished for the facility.<br>The DON conducted an audit on July 3, 2023 and verified 8 hours of RN coverage was provided in the last 14 days.<br>B. How corrective action will be accomplished the facility issue needing to be addressed:<br>The DON/ Scheduler will ensure an RN is scheduled for 8 hours per day 7 days a week.<br>C. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?<br>To prevent this from happening again the DON and the scheduler were educated on the RN staffing policy. The facility Administrator completed education with DON and Scheduler on June 8, 2023<br>D. Indicate how facility plans to monitor its performance to make sure that solution is achieved and sustained:<br>DON/ designee will audit time punches for RNs 5x weekly x 12 weeks to ensure there was a full 8 hours of RN coverage daily.<br>The DON/ designee will bring the results of the audits to be reviewed in monthly QAPI meeting. Revisions will be made as needed for 3 months; or longer as deemed necessary by the QAPI committee<br>The facility alleges compliance on July 3, 2023 | |

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| F 727 | Continued From page 30 she is aware the DON cannot work on a clinical nurse assignment when the facility census was higher than 60 residents. | F 727 | | |