STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345446	A. BUILDING _____ B. WING _____	08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLEGE PINES HEALTH AND REHAB CENTER	95 LOCUST STREET CONNELLYS SPRINGS, NC 28612

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F 000	INITIAL COMMENTS The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification survey on 8/6/2015. During the recertification survey, the survey team found the facility had provided substandard quality of care at the Immediate Jeopardy level. Immediate Jeopardy began on 5/30/2015 and the facility was notified of the immediate jeopardy on 8/5/2015 at 7:40pm Immediate Jeopardy was removed 8/6/2015 at 4:30pm when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of the systems put in place and 100% of employee training.	F 000		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to have interventions in place to prevent 1 of 3 residents (Resident #13) that was cognitively impaired with wandering behaviors from exiting unsupervised from the facility. On 5/30/15 Resident #13 was found	F 323	¿Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts set forth in the statement of deficiencies. The Plan of Correction is prepared in/or executed	8/28/15

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

Electronically Signed | 08/28/2015

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F 323	Continued From page 1 outside in the parking lot by a visitor of the facility approximately 98 feet from the exit door. Immediate Jeopardy began on 5/30/15. Immediate Jeopardy was removed 8/6/15 at 4:30pm when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D), to ensure monitoring of the systems put in place and 100% of employee training. The finding included: Resident #13 was admitted to the facility on 10/29/2011 with diagnosis which included: hypertension, non- Alzheimer's dementia, anxiety disorder, depression, psychiatric disorder, muscle weakness, difficulty walking, abnormal posture, atrial fibrillation, memory loss, diabetes mellitus, hyperlipidemia, chronic airway obstruction, hypothyroidism, and history of stroke. The Plan of Care dated 1/1/2015 listed the following under Social Work: · History of wandering with a goal that resident will remain safe while wandering as evidenced by no reports of injuries acquired due to wandering behavior. Intervention for wandering were listed as redirect when wandering occurs to assure safety, report wandering behaviors, report any elopement risks. Quarterly Minimum Data Set (MDS) dated 2/22/15 indicated that Resident #13 was severely cognitively impaired and had exhibited wandering behaviors 1 to 3 days during assessment reference period. Her activities of daily living (ADL's) indicated that Resident #13 required extensive assistance of two persons with transfers and walking in corridor and required extensive assistance of one person with bed mobility, locomotion on unit, dressing, toileting,	F 323	solely because the provisions of the Federal and State Law require it.¿ A. Visible warning signs were posted on every facility exit door to remind everyone to not assist any resident in exiting the facility without staff authorization. Visitor access in and out of the facility is limited to the front door. A monitoring system was implemented at that door on 8/6/15, and any elopement attempts are documented daily. Residents and/or their responsible parties were notified by mail of changes to the entrances and exits of the facility. Maintenance checks all door alarms and key pads weekly; concerns with any exit door function will be documented and reported to the Director of Nursing (DON)or designee. B. All residents will be evaluated prior to admission for tendency to wander. The type and extent of wandering behavior will be considered to ensure all residents admitted to the facility can safely wander within the confines of the building or campus. once a resident is deemed a wander/elopement risk, the care plan is updated. The care plan will be reviewed quarterly or with a significant change of status, and updated by the Minimum Data Set (MDS) Coordinator as needed. C. Upon a resident's admission to the facility, the resident's photo is taken by the Activities Director or designee and entered into the electronic medical record system within 72 hours of admission. A	

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F 323	Continued From page 2 and personal hygiene. Review of nurse's notes from March 7, 2015 at 9:51 am revealed "resident was found outside making her way toward the front parking lot from living room A. She has been up all night. Resident has been agitated/combative on this shift also. Resident stated she was going outside to get her pocketbook out of her car. Resident has been accusing various staff members of stealing 100 dollars from her also. She begins to get agitated and combative when staff attempts to talk to her about this. Resident was brought back inside and started on q (every) 15 minute monitoring. PRN (as needed) Ativan was also administered to try to help with resident anxiousness & combativeness. Will continue to monitor." Review of email (official communication from weekend to nursing administration/management) sent March 08, 2015 at 6:43 pm from Nurse #4 to administrative/management staff read in part: 100 hall Resident #13 "Saturday confused, agitated, awake all night, packed belongings, 3rd reported removing several butter knives out of night stand as she was packing, went out the door from Living Room A at 9:30 am, rolling wheelchair down sidewalk headed straight to parking lot, door alarm sounded, placed on Q (every) 15 min monitoring x 24 hours, then q 30 min. DON notified." The most recent MDS which was a significant change assessment dated 5/17/15 indicated that Resident #13 was severely cognitively impaired but had not exhibited wandering during the assessment reference period. Her ADL' s indicated that Resident #13 required extensive assistance of two persons with bed mobility, walking in corridor and required extensive assist of one person with transfers, locomotion on/off unit, dressing, toileting, and personal hygiene.	F 323	copy of the photo is placed on the Medication Administration Record. Once a resident has been deemed a wander/elopement risk, a picture of that resident will be placed in an Elopment Risk Book at the monitoring station in the front lobby. A written procedure for resident at risk for elopement was placed on the front of the Elopement Risk Book for quick reference by staff. The Nurse Manager or designee will check the book daily and document the resident status is current and the written procedure is available for quick reference. D. Inservices were provided to all nursing staff regarding elopement system changes including elopement risk assessments, Elopement Risk Book and ensuing documentation. All staff were inserviced on door access, the Elopement Risk Book use, and policy and procedure for elopements; new staff will be educated on the above during facility new employee orientation. F. The Administrative Management team (DON, Assistant Director of Nursing (ADON), Nurse Managers, and Department Managers) discuss residents in the daily stand-up meeting (held Monday through Friday to include weekends) and will include reports of any attempted elopements as well as identification of residents who may have potential for change in behavior/wandering/elopement risk. (How the facility plans to monitor the	

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F 323	Continued From page 3 Review of the nurse's notes indicated: May 30, 2015 "Resident noted to be wandering today. Resident witnessed by staff to be attempting to open doors to outside. At 2pm resident reported by a visitor to be out in the parking lot. Resident found outside of facility in parking lot. Resident states "I was just going home" Nurse Manager (Nurse 1) notified. Resident placed on Q15 min monitoring. Resident has becoming increased agitation with staff. MD (medical doctor) notified. Will monitor." This nursing note was signed by Nurse#2. A review of a facility document entitled: Subject Profile Of Incident dated 5/30/15 included a description of incident, written by Nurse #2 which indicated that at 2pm a visitor reported that resident was outside the building heading towards parking lot and that the resident exited the door after a visitor. Nurse #2 and Nurse #3 went outside to investigate. Resident was observed to be propelling wheelchair outside in the parking lot attempting to roll up a slight incline. Resident stated "I was just going home." Resident was reoriented and taken back inside. No injuries were noted. Nurse #1 notified. MD notified. Family notified. Resident placed on q 15 min monitoring. Attached to the facility document entitled: Subject Profile of Incident dated 5/30/15 was an additional paper that was a SBAR that is a Situation, background, assessment recommended report that is used by the facility: S (situation) - "Visitor came to this RN (Nurse #1). She voiced Resident #13 was in the parking lot. Voiced that another visitor let her out the door. No door alarm sounding." B (background) - "Alert and oriented to self at baseline. Poor short term memory/recall. History of elopement. No attempts at elopement since	F 323	measures to make sure solutions are sustained and specify how the plan will be integrated into the QA system) The DON or designee will audit the documentation of attempted elopements, 24-hour reports, Elopement Risk Assessments, and Elopement Risk Book documentation daily x 4 weeks, once a week x 2 months, then monthly x 6 months. Corrective actions will be implemented as indicated. The door and alarm check documentation will be audited weekly by the DON or designee x 2 months then monthly x 6 months. These audit results will be reported to the Quality Assurance Process Improvement (QAPI) team each month for at least 9 months with the need for further monitoring to be determined by the QAPI team.	

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3-7-15. History of agitation with combative behaviors. Diagnosis of dementia with behaviors, depression, mood disorder, anxiety."
A (assessment) - "As soon as reported by visitor Nurse #2 went to intervene and get resident back in facility. Per Nurse #2 resident was " going towards her car. " Nurse #2 reported that she was near the handicap parking. Resident came back with staff without difficulty. Resident was visibly anxious and slightly agitated."
R (recommended) - "Implemented q 15 monitoring immediately and monitor closely for continued attempts on elopement or for behaviors. Doctor #1 emailed by Nurse #2, new orders received to increase Depakote to 250 mg by mouth twice a day. Doctor #1 voiced to involve her in activities."
Care plan was revised on 5/30/15, and the revision indicated "Update: Resident elopement attempted on 5/30/15." No further interventions were added to the care plan at that time.
Review of email (official communication from weekend to nursing administration/management) sent May 31, 2015 from Nurse #1 to administration/management team read in part: 100 hall per report Resident #13 "did not sleep Friday night. Saturday was up to wheelchair, wanting to find a way out. SHE DID .....got out the door with a guest that was coming in. Started on increased monitoring. She was very anxious/slightly agitated. Doctor #1 did not want to change anxiolytics, increased Depakote to 250 mg by mouth twice a day, encourage her to participate in activities."
Interview with the Assistant Director of Nursing (ADON) on 8/5/15 at 5:26PM, revealed that she was aware of the elopement with Resident #13 on 5/30/15 She indicated that the door handle could be held down for 15 seconds and the door

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will open, but that an alarm will sound. She additionally indicated that she was not aware if the alarm sounded on 5/30/15. She further stated that the door to living room A was equipped with a key pad for entry/exit, and once the code was entered into the keypad the door would open without an alarm sounding. A follow-up interview with the ADON at 6:35pm revealed that the alarm was not sounding off on the 5/30/15 incident and that Resident #13 left out of the door as it was opened by a visitor. She additionally stated that the door in living room A that Resident #13 eloped from was still used daily by visitors and staff.
Interview with Nurse #1 who communicated the elopement of Resident #13 (of 5/30/15) to supervisory staff was conducted at 6:50PM on 8/5/2015. During this interview, the Nurse#1 indicated that a visitor reported to her that Resident #13 was in the parking lot and was let out of the building by another visitor. She stated that on 5/30/15 Resident #13 got out of the building and into the parking lot and was located " towards the end of the sidewalk " . She stated that the door alarm was not sounding off and that no staff observed the resident to leave out of the door and no staff was aware that Resident #13 was out of the building. Nurse #1 indicated she did not remember what visitor reported the resident in the parking lot. She additionally indicated that the door in living room A was used daily by staff and visitors until 8:00PM.
An additional interview at 6:58PM on 8/5/15 with Nurse #1, ADON and the Director of Nursing (DON) revealed that the door through which Resident #13 left out of on 5/30/15 was open for visitor use until 8:00PM. They all additionally indicated that the only changes that were made to Resident #13' s plan of care after the elopement, was to put the resident on every 15 minutes

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monitoring x 24 hours and a medication change.
Observation of Resident #13 at 7:00pm on 8/5/15 revealed Resident #13 sitting in her room in wheelchair at bedside watching TV.
The DON, ADON, and Quality Management Staff were notified of the immediate jeopardy on 8/5/15 at 7:40pm.
The facility presented a credible allegation of compliance on 8/6/15 at 3:40 pm which included:
Corrective action was accomplished by placing Resident #13 on 1:1 (a staff member assigned to the resident at all times) monitoring at 6:25 p.m. on 8/5/15. Staff were instructed by the DON on 8/5/15 at 6:20 p.m. that without exception the resident had to be in visual sight at all times. A 1:1 tracking sign-in form was implemented to provide documentation of who was assigned and who provided relief and the times of the observation. The other two residents who have the potential for elopement do not have the ability to transfer or ambulate independently so they are only at risk when they are up in their wheelchairs, at which time they will be placed on 1:1 monitoring until they are again returned to their beds.
All residents who were at risk for wandering had the potential to be affected by the alleged deficient practice. Corrective action was accomplished on 8/6/15 at 10:30 a.m. for those residents by limiting all traffic to enter and exit only through the front door, and closing access to all other doors (except for emergency egress which will then sound an alarm). Signs were also placed at all doors to alert visitors not to let residents out without staff knowledge.
Additionally, the 1:1 observations on the three residents were lifted at 8/6/15 at 10:30 a.m. after determining all the doors were locked.
The following systemic changes have been put

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into place: An in-service about the change in entry and exit through only the front door was provided to all staff beginning on 8/6/15. Any unavailable full-time, part-time or PRN staff will not be allowed to work in the facility until they have completed the in-service. This in-service for all staff included:
a. Information that Resident #13 exited the facility with a visitor
b. Notice that all traffic into and out of the building will be through the front door only
c. The front door will be monitored to assure residents identified as an elopement risk are safe and not allowed outside unsupervised
d. Emergency egress is possible through the locked door and an alarm will sound when opened
e. Staff nearest a door sounding an alarm will be expected to respond immediately
An observation of Resident #13 8/6/15 at 10:04 am revealed resident was bed with eyes closed. Staff providing 1:1 was present at bedside.
An observation of Resident #13 8/6/15 at 11:14 am revealed resident was in bed with eyes closed. 1:1 staff that present an hour earlier was no longer at bedside.
Observation of Living Room A door on 8/6/15 at 1:15 pm revealed a visitor that had exited thru this door. The door alarm was sounding and staff promptly responded to alarm. There was a posted sign on door that said " Enter and Exit Front Door only " and a sign that read ATTENTION: please check with staff before allowing any resident outside.
Immediate Jeopardy was removed on 8/6/15 at 4:30 pm. Observations revealed the living Room doors were not able to be opened (unless for emergency egress).Review of facilities Monitoring Log revealed Resident #13 had 1:1 staff from

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F 323	Continued From page 8 8/5/15 at 6:25pm to 8/6/15 at 10:40 am. Interviews with direct care staff and licensed staff confirmed that they had received in-servicing on responding to residents with exist seeking behaviors. Observations of staff monitoring the front door was observed. Signs were observed posted at entrance/exit doors.	F 323		