

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

PRINTED: 10/28/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>09/30/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>WINSTON SALEM NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 W 1ST STREET</b> <b>WINSTON-SALEM, NC 27104</b>		
(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 242 SS=D	<p><b>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</b></p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to honor a resident ' s choice of not being on a locked unit (fifth floor) for 1 of 3 residents sampled for choices (Resident #4). Findings included: Resident # 4 was admitted to the facility on 05/27/2016. An annual Minimum Data Set dated 06/03/2016 included diagnoses of hypertension (HTN), hypernatremia (low salt level), aphasia, cerebrovascular accident (CVA), Transient ischemic attack (TIA or stroke), malnutrition, Tardive Dyskinesia, depression (other than bipolar), schizophrenia, chronic obstructive pulmonary disease (COPD), and oxygen therapy. Resident # 4 was cognitively intact as evidenced by a brief interview for mental status (cognitive assessment) score of 15. A record review of the Care Area Assessment (CAA) dated 06/07/2016 revealed areas that included communication, Activity of Daily Living (ADL)/functional rehabilitation, urinary incontinence, falls, nutritional status, dental care, pressure ulcer and psychotropic drug use. All CAA ' s noted with care plan. A care plan dated 07/05/2016 revealed "</p>	F 242	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>1. Corrective action for resident affected. Director of Nursing and Director of Social Service met with Resident #4 on 9/28/16 to assure psycho-social wellbeing and review of behavioral care plan/ interventions. resident # 4 was assessed to no longer be at risk for elopement on 9/30/2016, resident#4 was moved from secure floor room 509b to unsecured floor room 305b on 9/30/2016. wander guard was discontinued on 9/30/2016. Elopement care plan updated</p>	10/21/16	

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

TITLE

(X6) DATE

Electronically Signed

10/21/2016

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 242	Continued From page 1 Resident #4 was at risk for elopement related to exit seeking behaviors. " The goals revealed Resident # 4 will not leave the facility unescorted by family, friends, visitors or staff through the next review 07/05/2016. The care plan was initiated with interventions that included to ensure Resident #4 personal alarm was in place and functioning each shift. Ensure Resident ' s room was located on a secure unit. Ensure staff was aware of resident wandering behavior, monitor and document behavior. Utilize a check in and out log, personalize resident ' s room with familiar objects. A care plan dated 09/09/2016 revealed " Resident #4 stated I have the right to make healthcare choices for myself with input from my designated family member and my physician. The care plan was initiated with interventions that included to approach in a calm, unhurried manner and offer choices if possible, ask about my preferences throughout the day and assist me with choices if needed, provide me with quiet environment when sharing important information with me and family, validate my thoughts/feelings when I get confused or anxious, assist me as needed with communication by offering simple choices, and give me verbal cues/reminders when I cannot remember and give me ample time to respond to questions. A nurse ' s note dated 07/04/2016 at 6:00 PM stated Resident #4 wandered off unit and wanted to go home. The note stated a wander guard was placed and Resident #4 had no complaint. A nurse ' s note dated 07/22/2016 at 2:04 PM revealed Resident #4 was out of bed and out of room and was able to ambulate short distances. The note revealed Resident#4 attended programs of interest that included socials, cooking groups and church services. The note revealed family	F 242	and resolved for resident #4 on 9/30/16.staff education completed on 9/30/2016 that resident #4 has a care plan that states "I have the right to make healthcare choices for myself with out input from my designated RP (guardian, responsible party, family members), and my physician.Resident#4 care plan for self determination right to make choices was updated on 9/27/2016 to add the approach "allow resident to make decisions about leaving the facility with supervision after input from my RP and MD" 2. Corrective action will be accomplished for those residents having potential to be affected by the same deficient practice, all residents have the potential to be affected. Staff education on honoring residents preferences in long term care" on med line university completed by 10/21/2016. 3. Measures/Systemic changes to ensure deficient practice will not occur: Director of Social Service will assure that on initial and quarterly care plan meetings that the resident Care Plans with appropriate interventions are updated and communicated to staff that affect resident's direct care, and choices about aspects of his or her life in the facility that are significant to the resident are honored unless the request is contraindicated. Nursing Managers will assure compliance with daily monitoring. Staff education on the facility policy "quality of life-self determination and participation "including allowing resident choices in healthcare that are consistent with his/her		

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F 242	Continued From page 2 and friend visits that included out of facility events at times. A nurse ' s note dated 07/22/2016 at 2:04 PM revealed the wander guard for Resident #4 was discontinued due to no display or attempts to leave unsupervised. The note stated Resident #4 voiced understanding of the facility rules to sign out with a responsible party to leave the building. " A nurse ' s note dated 09/28/2016 an episode of exiting seeking was observed. Resident #4 moved to the secure unit for safety and wellbeing. A record review revealed Resident # 4 signed self out of the facility ten times between 07/20/2016 and 08/31/2016 while residing on an unlocked unit (second floor). The sign out log revealed Resident #4 was accompanied with another person during time away from the facility. On 09/28/2016 at 7:50 PM an interview was conducted with the Administrator (ADM). The ADM stated " The Resident never tried to leave before, only when he first got here. Then he was just coming from the hospital and he was sick. He ' s not tried to leave before. We put an elopement care plan and a wander guard on him in July because when the resident first came in there were exit seeking behaviors such as he ' s going to leave, and getting on the elevator. We did not move him to the secure unit because he was a very sick resident when he first came in; he was not ambulatory at the time. We kept the care plan in place because he got better and adjusted well; but the concern was there as an elopement risk. There had been no elopement behavior until 09/28/2016. So when the resident was brought back into the building we decided to put him on the secure unit with a wander guard so that we could monitor him because this was not normal behavior. "	F 242	interest,assesments,and plans of care will be added to new orientation effective by 10/21/16.Staff education on facility policy "exercise of rights "added to the new employee orientation by 10/21/2016.Staff education on honoring residents preferences in long term care" on med line university added to new orientation effective by 10/21/2016.Staff education on facility policy "exercise of rights"will be completed annually for all staff.Staff education on honoring residents preferences in long term care" on med line university will be completed annually. 4.Monitoring Process-Unit Managers, Director of Nursing ,MDS nurses and Assistant Director of Nursing will update and complete care plan audits weekly times 4 weeks and then monthly times two months and report results of the audit to the Administrator and Quality Assurance team at the Quality Assurance and Performance Improvement meeting times three months.The administrator or designee will complete resident choices QAPI audit with interviewable residents monthly x 12 months. The results of the residents choices QAPI audit will be reported to the QAPI committee on a monthly basis.		

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F 242	<p>Continued From page 3</p> <p>The record revealed Resident # 4 was moved from an unsecured floor (Floor #2) to a secured floor (floor #5) on 09/28/2016.</p> <p>An interview was conducted with Resident #4 on 09/30/2016 at 1:30 PM. Resident #4 stated " I like it in this facility, my plan is to stay, but I don ' t like being locked on this floor. " Resident #4 stated " they moved me up here a couple of days ago because I needed to go and deposit a check and have my sister taken off the account because she did not pay my car payment. I was in the parking lot and they brought me back, changed my room and brought me up here " (fifth floor).</p> <p>An interview was conducted with the Social Worker (SW) on 09/30/2016 at 3:30 PM. The SW stated the Healthcare Power of Attorney (POA) was aware of the move. The SW stated the POA was concerned for the safety of Resident #4 due to the condition of Tardive Dyskinesia. The SW stated the POA was fearful that when Resident #4 would wheel outside and attempt to get to the bank that Resident #4 may fall into traffic. The SW stated the move was made on 09/28/2016 until a safe plan was in place. The SW stated as of 09/30/2016 as soon as a bed was available on a non-secured floor Resident #4 would be moved to that room.</p> <p>An interview was conducted with the unit secretary on 09/30/2016 at 8:30 0 AM. The unit secretary stated at times Resident #4 was kept busy and socializing with other resident ' s in the dining area, but kept to self in the room. The unit secretary stated when Resident # 4 wanted to leave the unit the resident would sign the pass book and exit the building in the wheelchair. The unit secretary stated at times the resident would be accompanied with someone, but other times not.</p> <p>An interview was conducted with the Nursing</p>	F 242		

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F 242	Continued From page 4 Assistant (NA) on 09/30/2016 at 8:35 AM. The Nursing Assistant (NA) stated Resident # 4 needed a one person assist with transfers, but other than that the resident was able to get around without difficulty. The NA stated care was provided according to the care plan and if there were concerns or changes in condition the nurse would be informed.	F 242			
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 record review, staff interviews, and observations, the facility failed to prevent 2 of 2 cognitively impaired sampled residents (Residents #1 and #2) from exiting the facility while unsupervised. On 09/26/16 Residents #1 and #2 exited the facility while unsupervised and were found by a staff member walking in the facility ' s parking lot. Immediate Jeopardy (IJ) began on 9/26/16 at 7:30PM when Nurse #1 observed Resident #1 and Resident #2 unsupervised outside the facility. The IJ was abated on 9/30/16 at 12:20 PM when the facility provided an acceptable allegation of compliance. The facility remains out of compliance at a lower scope and severity at a D level (an isolated deficiency at no actual harm	F 323	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Winston-Salem Nursing & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." 1.The facility must ensure that the resident remains as free of accident	10/21/16	

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F 323	<p>Continued From page 5</p> <p>with a potential for no more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included:</p> <p>1. a. Resident #1 was admitted to the facility ' s 5th floor secure unit on 9/7/16 with diagnoses which included Alzheimer ' s disease. An Elopement Risk Assessment dated 9/7/16 revealed Resident #1 was cognitively impaired with poor decision making skills, had a diagnosis of Alzheimer ' s disease, ambulated independently, and had a hearing, vision, or communication problem. Resident #1 was assessed to have been at risk for elopement at the time of the assessment.</p> <p>A review of the 14 Day Minimum Data Set (MDS) dated 9/21/16 revealed Resident #1, had long and short term memory problems, disorganized thinking and wandering behavior. Activities of Daily Living (ADLs) were completed independently, except locomotion on the unit, which required supervision, and dressing and toileting, which required extensive assistance. Resident #1 was able to steady himself during transfers and ambulation.</p> <p>A Care Plan dated 9/13/16 revealed: " Resident (Resident #1) is at risk for elopement. " Goals included: Resident will suffer no injuries related to (r/t) wandering behaviors through next review. Resident will not leave facility unescorted by family, visitors or staff through next review. Interventions included: Ensure resident ' s (brand name of an alarming bracelet worn to prevent resident elopements) is in place and functioning each shift. Ensure resident ' s room is located on secure unit. Ensure staff is aware of resident ' s wandering behaviors. Monitor resident ' s whereabouts frequently throughout the day. Ensure exits and stairwells are coded with</p>	F 323	<p>hazards as possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident #1 was returned to the fifth floor on 9/26/16 and was assessed by nursing staff, wander guard equipment checked and wander guard bracelet was replaced. Resident #2 was returned to the fifth floor on 9/26/16 and was assessed by nursing, equipment checked, and wander guard bracelet was replaced. Quick mar was updated to reflect MD order to check wander guard placement and function every shift to add results on 9/29/16 for both resident #1, and resident #2. Wander guard placement and function will continue to be monitored every shift as long as the wander guard order is in place for resident #1 and resident #2.</p> <p>Staff members were placed on the fifth floor on both long hall and short hall exit doors for added security on 9/29/2016, and will continue in place until new door alarms are installed on all doors through out the building. Additional staff members were placed on all exit doors on 200,300,400, halls for added security on 9/29/2016 until all the residents with wander guards were re-assessed and moved to the 5th floor if indicated. The new secure door locks will be installed as soon as plans are approved from DHSR engineering department, at which time the additional staff members for door security will be discontinued when all doors are tested and secured by</p>		

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F 323	Continued From page 6 alarms. Utilize a check in and out log. On 9/26/16, the Care Plan revealed: Exit seeking behavior noted. (Brand name of an alarming bracelet worn to prevent resident elopements) replaced. On 9/27/16 the Care Plan was reviewed and updated to continue the plan of care. A Care Area Assessment (CAA) for Resident #1 dated 9/14/16 was reviewed and revealed a problem r/t cognitive loss/dementia. It was noted " No amount of reorientation/reminders will be sufficient enough to help resident be able to make sense of things. " It was also noted " (Resident #1) is a confused, ambulatory resident with Alzheimer ' s dementia. He has difficulty communicating needs and wanders throughout the facility. " A physician order dated 9/12/16 revealed " (brand name of an alarming bracelet worn to prevent resident elopements) placement- check function and placement Q (every) shift. " A nursing note dated 9/26/16, and signed by Nurse #2 read, " Resident (Resident #1) left unit with another resident (Resident #2) and was found in courtyard with that resident without harm to the bother (both). Check(ed) his (Resident #1) alarm, found it was not working, (a) new device was placed on resident after testing with no further issue. " A review of an incident report dated 9/26/16 for Resident #1 revealed Resident #1 was located on the facility grounds with another resident (Resident #2) and brought back into the building by a nurse (Nurse #1). Resident #1 was noted to ambulate independently and was disoriented. 1. b. Resident #2 was admitted to the facility on 5/5/12 with diagnoses which included non-Alzheimer ' s dementia with Lewy bodies. The resident resided on the facility ' s 5th floor (secured unit).	F 323	secure med. 2. The fire panel was re-labeled to easily identify all exit doors and alarm locations on 9-29-16. Code Pink in-services and drill was conducted on all shifts on 9-27-16.Code Pink drills will continue monthly on all shifts effective 9-27-16 for 12 months, then quarterly indefinitely. Staff education on Elopement Policy & Procedure was initiated on 9-26-16 and completed on 9-29-16 using group in-servicing, 1:1 education and group messaging. No staff will be allowed to work prior to receiving the training. Staff members identified as absent from in-services and drill are not allowed to work until they receive current code pink training. Staff in-service education on Elopement Policy & Procedure will be added to New Employee Orientation effective 9/29/16. Staff in-service education on Elopement Policy & Procedure will be completed annually for all staff effective 9-29-16. South med secure care rep evaluated the current alarm system and made the recommendations to upgrade all doors with new secure med alarm switches on all exit doors through out the building 9-30-16. South Med and DHSR are currently in the planning phase of alarm implementation for all exit doors at the facility with a tentative completion date of 11/7/2016 .Staff members were posted at all exit doors on 5th floor from 9/30/2016 and will remain until new secure med alarm units are installed on. Residents on 5th floor identified as a non elopement risk due to non ambulatory status were		

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F 323	<p>Continued From page 7</p> <p>A review of the quarterly MDS dated 9/9/16 revealed Resident #2 was severely cognitively impaired, had delusions present, wandering was present daily. ADLs required supervision for transfers, walking in room, walking in corridor, locomotion on unit, dressing, and eating. Balance during transfers and ambulation was steady at all times without assistance. Active diagnoses included non-Alzheimer ' s dementia.</p> <p>A CAA dated 5/5/16 was reviewed and revealed Resident #2 showed signs of disorganized thinking and inattention, had a diagnosis of dementia with Lewy bodies, and had behavioral symptoms r/t dementia which included wandering daily.</p> <p>A Care Plan dated 5/12/16 and updated 9/13/16 revealed care planning r/t Resident #2 being at risk for elopement r/t exit seeking behaviors (stands at elevator, pushes keys on code pad, resident wanders constantly. Goals included: " Resident will not leave the secured unit or facility grounds without supervision from staff and/or family through the next review. " Interventions included: " ensure (brand name of an alarming bracelet worn to prevent resident elopements) is in place and working properly q (every) shift. Obs (observe) for safety (provide (brand name alarming bracelet) if ordered). Interventions were updated 9/26/16 and included: " Exit seeking behavior noted. (Brand name alarming bracelet) replaced. "</p> <p>Physician ' s orders dated 9/1/16 through 9/30/16 revealed: (brand name of an alarming bracelet worn to prevent resident elopements)-check placement and function every shift.</p> <p>A review of the Quick Medication Administration (Quick MAR- an electronic charting system used by the facility which indicated the ordered (brand name alarming bracelet) checks were completed)</p>	F 323	<p>transferred to other unsecured units on 9/29/16 thru 9/30/2016. Residents that were identified as elopement risk and continue to require a wander guard were transferred to the secured unit on 9/29/16.</p> <p>#3.Measures/Systemic changes to ensure deficient practice will not occur: Director of nursing, mds,and all unit managers will assure that on initial admission assessments, quarterly assessments, and all standards of care daily and weekly meetings, that each resident that is identified as an elopement risk will be assessed and if identified as a true elopement risk will be placed on or moved to the secured unit with all appropriate communications and interventions in place. Residents care plans will be updated and communicated to staff immediately of possible exit seeking behaviors. Director of Nursing,MDS,and Nursing Managers will assure compliance with daily monitoring. Staff education on the facility policy " missing resident/elopement-code pink will be added to the new hire orientation packet starting 10-21-2016,and annually for all staff. Monthly elopement drills on all shifts will be added to maintenance tells list starting 10-21-2016.</p> <p>4.Monitoring Process-Unit Managers, Director of Nursing ,MDS nurses and Assistant Directors of Nursing will update and complete care plan audits weekly times 4 weeks and then monthly times two months and report results of the audits to the Administrator and Quality Assurance team at the Quality Assurance and Performance Improvement meeting</p>		

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F 323	<p>Continued From page 8</p> <p>dated 9/1/16 through 9/30/16 revealed staff initials present each shift for Resident #1 and Resident #2.</p> <p>An interview was conducted with the Director of Nursing (DON) on 9/29/16 at 2:45 PM. She stated, " If the (brand name alarming) bracelet isn ' t checked there won ' t be any initials in the box. We chart by exception so if something was wrong with the (brand name alarming bracelet) there would be a notation. There are no notations, so the (brand name alarming bracelets) were working. "</p> <p>A review of a nursing note dated 9/26/16 and signed by Nurse #2 revealed, " Resident (Resident #2) alert on tonight. Patient was found out in courtyard with another resident. Her alarm was not working. New alarm place(d) on resident after activation and tested with no other issue. "</p> <p>A review of an incident report dated 9/26/16 revealed Resident #2 was located on the facility grounds. The report also indicated, "(Resident #2) with another resident (Resident #1) managed to get off the unit, were immediately brought up to unit from outside front door. Heard alarm going off, nurse went to check all exits when 3rd floor nurse (Nurse #1) brought residents back up to floor." The resident's condition at the time was disoriented, and ambulated independently."</p> <p>An interview was conducted with Nursing Assistant (NA) #4 on 9/28/16 at 7:40 PM. She stated, " I typically care for (Resident #2). She frequently exhibits exit seeking behaviors like saying she ' s going home, pushing the buttons on the elevator, and pushing on all the doors. I check on her every hour, which is easy because she basically follows me around. I know the elevator won ' t move if a resident wearing a (brand name alarming bracelet) gets on it. All the doors up here (5th floor) have alarms on them</p>	F 323	<p>times three months.The administrator, and Director of Nursing and MDS nurses completed Elopement QAPI Audit on 9/30/2016. The Director of Nursing and or designee will complete Elopement QAPI Audit monthly x 12 &amp; report results to the QAPI Committee.</p>		

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F 323	Continued From page 9 because this is the only unit considered a secured unit. " An interview was conducted with Nurse #1 on 9/28/16 at 9:15PM. She stated, "I work 3pm-11pm. On Monday night (9/26/16) I was out at my car to get some money. As I was walking out of the facility I saw 2 residents walking outside in the parking lot. I recognized them so I took them up to the 5th floor. It was raining earlier that day, but not when they were outside. They weren't wet or anything. Their (brand name alarming bracelets) were on. I took the elevator up to the 5th floor, with both residents and told their nurse (Nurse #2) they were outside. I don't think the elevator should have worked if their (brand name alarming bracelets) were working." An interview was conducted with Nurse #2 on 9/28/16 at 8:45PM. She stated, "I typically work 3pm-11pm. I was working on the 5th floor Monday night (9/26/16). Right after supper, they started putting people to bed and an alarm started going off. So we stopped what we were doing and started searching for which door alarm was ringing. The panel said fire door on the long hall so I told one of the nursing assistants (NA #1) to see if anybody had gone out. Nobody was visible from the doorway. So then we started searching the unit to see if a resident was gone. We found out 2 residents (Resident #1 and Resident #2) had gotten out. When the nurse from downstairs (Nurse #1) brought them back upstairs we assessed them and then just went on with the rest of the night. They had (brand name alarming bracelets) on, but they weren't working. They had gone to the elevator doors several times during supper time. The (brand name) alarming bracelets weren't working when they got back from outside so I put new ones on. I tested them and documented that they were working.	F 323			

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F 323	<p>Continued From page 10</p> <p>(Resident #2) always exhibits exit seeking behavior, but we've always caught her, until this time."</p> <p>An interview with NA #1 was conducted on 9/28/16 at 7:15PM. She stated, "The alarm to the back stairs was going off while I completed incontinent care for another resident. I made sure the resident I was doing incontinent care on was safe, lowered his bed, covered him up, and made sure he was mostly clean. Then I went down the long hall to the stairs and turned off the alarm. I didn't see anyone so I went down to the 3rd floor from the 5th floor, and didn't see anyone. Then I came back upstairs and finished my resident's incontinence care. After I finished, I realized I had run out of washcloths and towels so when I was going to get more of them I saw a nurse (Nurse #1) getting off the elevator with 2 residents that had gotten off the unit. When residents with (brand name) bracelets get near the elevator or the exit door near the day room, an alarm goes off. The door locks. If they get on the elevator the doors won't close. (Resident #2) frequently exhibits exit seeking behaviors like taking another resident ' s hand and saying stuff like, 'Let's get out of here.' or 'Let's go home' stuff like that. If she (Resident #2) sees a door she tries to open it, and she pushes the elevator buttons but doesn't know the code."</p> <p>An interview was conducted with Nurse #3 on 9/28/16 at 3:47PM. She stated, " I ' m the Unit Coordinator for the 2nd floor. I was working Monday night when the alarm went off for one of the exit doors. I looked at the panel and saw it was a fire exit door at the end of the long hall. I went to the doors and checked. There were no residents there. Then I went down to the ground floor and checked all the doors. Since I didn ' t see any residents I went back upstairs. The alarm</p>	F 323			

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F 323	Continued From page 11 was still going off when I got back upstairs. I filled out the incident reports. " She also stated, " If a fire door alarm goes off we are supposed to do a head count. To my knowledge, they did a head count and that ' s when they realized there were 2 residents missing. " An interview was conducted on 9/28/16 at 7:50 PM with the facility Administrator. She stated, "I was told (Residents #1 and #2) went out a door that isn't connected to the (brand name) alarming system. It's alarmed, and if you push on it for 15 seconds it opens, and the alarm starts if you don't push the code in before pushing the bar. It's everybody's responsibility to pay attention to alarms. It wouldn't have mattered if the (brand name alarming bracelets) were working or not because of the door they left from. (Resident #1 and Resident #2) had a (brand name alarming bracelet) on. Whether or not it was working wouldn't have mattered because of where they exited from. The weather that night was rainy. It had been raining earlier. The staff are supposed to call a Code Pink if they discover a resident is missing. They find out who it was, what door was alarming, go through the door and down the stairs to the bottom, search the building, do a head count, notify the Director of Nursing (DON) and Administrator, and the resident is hopefully found immediately. If the missing resident or residents aren't found within 15 minutes we search the perimeter, call the police, call the family, and call the doctor. On Monday night (9/26/16) they did a head count, notified the DON, and notified me. By the time (Nurse #3) got to the alarm the residents were already back in the building. They (Resident #1 and #2) came down the stairs, exited the building, did a round around the building and a staff member's family saw them. The family called the staff member, but then another staff	F 323			

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F 323	<p>Continued From page 12</p> <p>member (Nurse #1) saw them while she was outside so she brought them upstairs."</p> <p>An interview was conducted on 9/29/16 at 8:55 AM with the Maintenance Director. He stated, "I became Maintenance Director about 3 weeks ago. I was a maintenance tech before that. All fire exit doors are checked daily. They have a 15 second delay to open. The alarm sounds immediately. The 5th floor elevator doors and the door by the dayroom are the only doors connected to the (brand name) alarming system on the 5th floor, and I check them daily too. If there's a malfunction I fix it immediately. Like on Tuesday (9/27/16) when I came in and found out the exit door to the resident smoking area (facing 1st Street) had a magnet at the top that wasn't functioning, and the sensitivity was too low. That door is connected to the (brand name) alarming system. I have called the (brand name) alarming system company and they are coming on Friday to check all the doors and make recommendations to improve our (brand name) alarming system."</p> <p>An interview was conducted with Nurse #5 on 9/29/16 at 3:30 PM. She stated, " We were in-serviced on elopements last month. If a fire door alarm goes off I check the door, go through the door and go all the way down to the ground floor to look for a resident. Other staff members do a head count. If a resident is missing we do a facility wide check, and check outside. We call the DON, the Administrator, the doctor, the family, and the police if necessary. (Resident #1) is a wanderer and elopement risk. She constantly walks and will take other residents with her. She sometimes goes to the doors and pushes on them, and sometimes she just stands by them. "</p> <p>An interview was conducted on 9/29/16 at 12:45 PM with the Doorman/Valet/Security. He stated</p>	F 323			

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F 323	Continued From page 13 he was working Monday night (9/26/16) and did not see the 2 residents come through the lobby. He also stated there was someone in the lobby every day from 11:00 AM through 7:00 AM the next morning. He stated his duties included making sure no residents go out the front or back door, he assisted residents off the elevator if they wanted to get snacks, and answered the telephone. He also stated, " I knew the (brand name) alarming system wasn't working on the exit door that faces 1st Street because it hasn't been working for about a month." An interview was conducted with the Staff Development Coordinator (SDC) on 9/30/16 at 9:45 AM. She stated, " Elopement Risk Assessments are completed on all residents at admission. We have an admission nurse (Nurse #4) that completes all admission assessments. If she isn ' t here the unit manager or weekend supervisor completes the assessments. The staff get trained on elopement/wandering risks during orientation and as needed. If an exit alarm goes off, the staff are supposed to check all resident rooms, and do a head count. Each NA does her assigned hall and the nurse checks behind them to verify their results. The process shouldn ' t take more than 15 minutes. If a resident is missing, a Code Pink is called, a staff member from the floor where the resident resides goes down to the 2nd floor to check the alarm panel and locates which door alarm is going off. Once the door is identified, the staff member is to go through the door, down the steps to the ground floor, and exit the building to look for the residents. This happens while other staff members are completing the head count. If the resident can ' t be immediately located, the police are called, the family and physician is called, and a perimeter search is conducted. "	F 323			

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F 323	<p>Continued From page 14</p> <p>An interview was conducted with Nurse #4 on 9/30/16 at 10:10 AM. She stated, " Elopement Risk Assessment are completed on every resident at the time of their admission. If I ' m not here there is a designated staff member to complete the assessments, usually the Unit Manager. If a resident is an elopement risk I notify the DON and Unit Manager, initiate a (brand name alarming bracelet), and work on placing the resident on the 5th floor. That is our secured unit. Elopement risk gets communicated to the MDS and care plan nurses, and the Unit Manager. The Unit Manager places the (brand name alarming bracelet) on the resident. "</p> <p>An interview was conducted on 9/30/16 at 4:00 PM with the facility medical director. He stated, " She (Resident #2) has been here for several years. She walks independently with a lot of residents around her. She tries every door and door knob. If the elevator opens she jumps in. She pushes on all the doors constantly. She is steady on her feet and physically capable of going down 5 flights of steps. (Resident #1) is a newer admission to me, and I ' ve seen him once. He wears a (brand name alarming bracelet) and I think is physically able to go down 5 flights of stairs. "</p> <p>An observation was made of the fire exit door located at the end of the 'long hall' on the 5th floor on 9/27/16 at 7:30 PM. An audible alarm sounded immediately when the horizontal metal bar was pushed. The door remained locked for approximately 15 seconds, with the alarm sounding, and then opened to a stairwell. There were sixty-seven (67) steps from the 5th floor to the ground level where the Resident #1 and Resident #2 eloped. The door at the ground level opened directly to the outside of the facility, perpendicular to a 2 lane road with a posted</p>	F 323			

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F 323	<p>Continued From page 15 speed limit of thirty-five (35) miles per hour.</p> <p>An observation was made on 9/28/16 at 8:00 AM of the area outside the facility where Residents #1 and #2 were observed by a staff member on 09/26/16. The area was approximately 50 feet from an entry/exit door located at the back side of the building, with an asphalt (black top) surface which sloped downward away from the facility. Vehicles were observed parked perpendicular (at an angle of 90 degrees) to the facility beyond a single lane designed for vehicle traffic.</p> <p>Observations of both Resident #1 and Resident #2 was made on 9/28/16 at 4:30PM: Resident #2 was observed ambulating independently throughout the unit holding the hand of another resident. She was also observed turning the door knobs on exit doors and pressed the code key buttons for the elevator. She stated, " I ' m going home. " Staff re-directed her and she continued ambulating throughout the unit. A (brand name alarming bracelet) was in place on her right ankle. Resident #1 was observed seated in the activity room with a (brand name alarming bracelet) on his right ankle. He was observed watching television.</p> <p>An observation was made on 9/30/16 at 11:00 AM of Resident #2 on the 5th floor. Resident #2 was observed walking without assistance throughout the unit with a steady gait, a (brand name alarming bracelet) was visible around her right ankle, and she was observed going to the opened elevator doors and getting on. The elevator alarm sounded, and the doors remained open until Resident #2 exited the elevator and continued walking away from the opened doors.</p> <p>The facility administrator was notified of the IJ on 9/30/16 at 10:00 AM. On 9/30/16 from 8:00 AM through 12:20 PM,</p>	F 323			

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F 323	Continued From page 16 validation of the credible allegation submitted by the facility administrator was reviewed. · (Brand name alarming system) assessment for function and placement was completed for residents with a (brand name) on 9/27/16. · Elopement risk Assessments were completed on 9/27/16 for all residents in the building with quarterly assessments due. No additional residents were identified. · Quick MAR was updated on 9/29/16 to reflect MD (physician) orders to check (brand name) placement and function every shift to add results. · The fire door panel on the 2nd floor was re-labeled on 9/29/16 to easily identify doors. · Code Pink drills will continue monthly on all shifts effective 9/27/16 for twelve months, and then quarterly indefinitely. · Staff education on elopement policy and procedures was initiated on 9/26/16 and completed by 9/29/16 using group in-servicing, 1 on 1 education, and group messaging. No staff will be allowed to work prior to receiving training. · (Company name) care representative is scheduled 9/30/16 to assess and implement additional (brand name) alarms for remaining doors on the 5th floor. · Staff members will be posted at all exit doors on the 5th floor until new (brand name) alarming units are in place. · Staff members will be posted at all exit doors on 200, 300, and 400 halls indefinitely until those residents requiring a (brand name alarming bracelet) are transferred to the 5th floor. · Residents on the 5th floor, identified as a non-elopement risk due to non-ambulatory status, will be transferred to other units. · Residents that are identified as elopement risk, and require a (brand name alarming bracelet), will be transferred to the secured unit	F 323			

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F 323	Continued From page 17 (5th floor) as soon as beds become available. · Alarm and Resident Elopement in-servicing logs dated 9/26/16 and 9/27/16 were reviewed and revealed no concerns. · The DON, or designee, completed Elopement QAPI (Quality Assurance and Performance Improvement) audits on 9/27/16 and will complete an elopement QAPI audit monthly and report results to the QAPI committee effective 9/27/16. · An interview was conducted with Nurse #2 on 9/28/16 at 8:45PM and she was able to describe the elopement training and protocol. · An interview was conducted with Nurse #5 on 9/29/16 at 3:30 PM and she was able to describe the elopement training and protocol. · An interview was conducted with Nurse #3 on 9/29/16 at 3:47 PM and she was able to describe the elopement training and protocol. · An interview was conducted with the SDC nurse on 9/30/16 at 9:45 AM and she was able to describe the elopement training and protocol. · An interview was conducted with NA #1 on 9/30/16 at 11:02 AM and she was able to describe the elopement training and protocol. · An interview was conducted with NA #2 on 9/30/16 at 11:55 AM and she was able to describe the elopement training and protocol. · An observation was made on 9/30/16 at 12:20 PM of staff posted at all exits doors on the 200, 300, 400, and 500 hall which were the four facility hallways where residents resided. · An interview was conducted with NA #3 on 9/30/16 at 12:00 PM and she was able to describe the elopement training and protocol. · An interview was conducted with the Administrator on 9/30/16 at 12:05 PM. She stated, " We have tripled the staff here today so they can monitor the exit doors. We started monitoring the doors on Wednesday 9/28/16 after	F 323			

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NAME OF PROVIDER OR SUPPLIER  <b>WINSTON SALEM NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 W 1ST STREET</b> <b>WINSTON-SALEM, NC 27104</b>		
(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 323	Continued From page 18 3:00 PM. The company representative for the (brand name) alarming system is here now to check the system and make recommendations for improvement. As of now, there is a staff member posted at every exit door and I have told all staff not to reassign door monitors under any circumstances. Management staff will be called in if necessary to ensure the doors are monitored at all times until the (brand name) alarming system representative ' s recommendations are completed. " Immediate jeopardy was removed on 9/30/16 at 12:20 PM. Observations revealed staff members posted at each fire exit door on the 200, 300, 400, and 500 Halls. Interviews with direct care staff and licensed staff confirmed they had received in-servicing on responding to resident elopements. The (brand name alarming system) was being assessed and tested by a company representative. Observations revealed (brand name alarm bracelets) were present on 5th floor residents who were ambulatory, the DON, or designee, had completed Elopement QAPI (Quality Assurance and Performance Improvement) audits, and an observation of the (brand name alarming system) for the elevator was confirmed it was functioning properly.	F 323			