## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

345061

**Date Survey Completed:**

10/21/2017

**Multiple Construction Wing:**

B

**Street Address, City, State, Zip Code:**

3100 Erwin Road

Durham, NC 27705

**Name of Provider or Supplier:**

PruittHealth-Durham

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>Tag</th>
<th>Summary</th>
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<tbody>
<tr>
<td>F 00</td>
<td>A complaint investigation survey was conducted from 10/19/17 through 10/21/17. Immediate Jeopardy was identified at:</td>
</tr>
<tr>
<td>F 278</td>
<td>The tags F323 constituted Substandard Quality of Care. Immediate Jeopardy began on 09/03/17 and was removed on 10/21/17. An partial extended survey was conducted.</td>
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### Assessment Accuracy/Coordination/Certified

- **CFR 483.25 at tag F323** at a scope and severity (J)
- **CFR 483.75 at tag F520** at a scope and severity (J)

### Certification

- **(1)** A registered nurse must sign and certify that the assessment is completed.
- **(2)** Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

**Laboratory Director's or Provider/Supplier Representative's Signature:**

Electronically Signed

11/10/2017

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.
### Statement of Deficiencies

**Provider/Supplier/CLIA Identification Number:**
345061

**Date Survey Completed:**
10/21/2017

**Name of Provider or Supplier:**
PRUITHEALTH-DURHAM

**Address:**
3100 ERWIN ROAD
DURHAM, NC 27705

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
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<th>Summary of Deficiency</th>
<th>ID</th>
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<td>F278</td>
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<td>(j) Penalty for Falsification</td>
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<td>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</td>
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<td>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or</td>
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<td>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.</td>
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<td>(2) Clinical disagreement does not constitute a material and false statement.</td>
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**This Requirement is not met as evidenced by:**

- Based on record review and staff interviews, the facility failed to accurately code the admission minimum data set (MDS) assessment for one of three residents reviewed for wandering behaviors, Resident #1.

**Findings included:**

- Resident #1 was admitted to the facility on 07/11/2017 with diagnoses which included, in part, heart failure, depression, and insomnia.

**The Elopement Risk Observation Form completed upon admission to the facility on 07/11/2017 revealed Resident #1 had a total elopement risk score of 11.** The top of the form indicated that a resident with a score of 11 or greater was to have interventions immediately put into place. Interventions listed on the form were Weekly Behavior Management and Wanderguard Program. There was no signature on the form.

**This plan of correction constitutes a written allegation of compliance.**

**Process that lead to the Deficiency:**

- Root Cause Analysis:
  - Resident #1 was admitted to the facility on 7/11/17.
  - Root Cause Analysis:
    - The resident’s elopement risk assessment score upon admission was 11 (high risk) and the facility failed to
Review of the quarterly minimum data set (MDS) assessment dated 07/18/2017 revealed Resident #1 had severe cognitive impairment and that he exhibited no wandering behaviors. Supervision of one person was required for a walk in his room and for locomotion on and off the unit. The same MDS assessment indicated Resident #1 was not steady while walking or turning around, but was able to stabilize without staff assistance. In addition, he used no mobility devices. In an interview with Nurse #1 on 10/20/2017 at 2:10 PM, she stated she was the admitting nurse who completed the Elopement Observation Risk Form for Resident #1.

In an interview with Nurse #1 on 10/20/2017 at 2:37 PM, the MDS Nurse acknowledged the Elopement Risk Observation Form was a tool for nurses to observe for elopement and wandering behaviors and that a score of 11 or above was considered to be high risk for elopement. She stated the admitting nurse (Nurse #1) completed the Elopement Risk Observation Form upon admission of Resident #1 on 07/11/2017. The MDS Nurse confirmed this elopement risk was completed during the 7-day look back period for the admission MDS assessment dated 07/18/2017, and added that she missed the score of 11 on the form, so it was not captured on the admission assessment.

In an interview with the Director of Health Services (DHS) and the Administrator on 10/21/2017 at 4:11 PM, the DHS stated it was the responsibility of the admitting nurse to complete the elopement risk evaluation. The Administrator stated he would expect for the admission MDS to be coded accurately.

initiate interventions to prevent elopement at that time.

The Admitting Nurse (Nurse #1) was not properly trained on completing the Elopement Risk Observation form. MDS nurses failed to accurately code Resident #1 for wandering and being at risk of elopement.

On 9/3/2017 Resident #1 was last observed on third floor at approximately 1:00pm. Facility was made aware that the resident was not on the premises when the resident’s mother called the facility at approximately 7:30pm and asked the charge nurse (Nurse #1) to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and stated he was trying to get home but had missed the bus. At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1:00pm, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight. Around 8:30pm, the police officer arrived to gather more information about the resident. At approximately 9:00pm, the police officer informed the charge nurse that the resident had been
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<th>F 278</th>
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<tr>
<td><strong>SUMMARY STATEMENT OF DEFICIENCIES</strong></td>
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<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<tr>
<td><strong>PROVIDER'S PLAN OF CORRECTION</strong></td>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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Located in Duke Hospital ER. The resident was re-admitted 9/6/17 at 4:00pm. Upon re-admission, the resident was assessed for elopement by a Licensed Nurse and scored 25 on the Elopement Risk Observation form. The resident's BIMS score was 4. The following interventions were put in place: a wander guard was put in place, the resident's description and picture was placed in the wander guard book by the Medical Records Director. Resident #1 expired in the facility on 9/22/2017 of CHF.

Process for implementing the acceptable plan of correction for specific deficiency. On 9/3/2017, all other residents were accounted for in the facility by conducting a head count. 100% elopement assessments were initiated on 9/3/2017 and completed on 9/4/2017 by the Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. The residents were assessed by the Interdisciplinary Team for further intervention recommendations. Behavior documentation on MARs was initiated on 9/4/2017 for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were reviewed and/or revised and,
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**SUMMARY STATEMENT OF DEFICIENCIES**

- Each deficiency must be preceded by full regulatory or LSC identifying information.

**PROVIDER'S PLAN OF CORRECTION**

- Each corrective action should be cross-referenced to the appropriate deficiency.

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**Implemented as needed based on the assessment.**

The Administrator, the Director of Health Services and, the Facility Clinical Consultants educated the MDS nurses on coding wandering assessments accurately based on RAI guidelines. The education was initiated on 10/21/2017 and completed on 10/24/2017. MDS assessments are reviewed upon admission, readmission and, significant change for accuracy according to RAI manual, for elopement and supervision, by the IDT during daily risk meeting. Monitoring procedure to ensure that the plan of correction is effective.

The Administrator and the Director of Health Services will conduct a weekly review of MDS assessments for residents that wander to ensure accuracy based on the RAI guidelines. The admission, quarterly and significant change care plans are reviewed for accuracy by the Case Mix Director, Social Service Director and Director of Nursing in the area of wandering during the morning clinical meeting to ensure the care plan matches the coding on the MDS and resident assessments. This will be done for 6 months until compliance is sustained.

The Administrator and the Director of Health Services will review and report any findings of non-compliance to the Quality Assurance and Performance Improvement committee for recommendations as needed.
### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
</tr>
<tr>
<td>PRUITTHEALTH-DURHAM</td>
</tr>
<tr>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td>3100 ERWIN ROAD</td>
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<td>DURHAM, NC 27705</td>
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<tbody>
<tr>
<td>Title of Person Responsible for implementing the acceptable plan of correction.</td>
</tr>
<tr>
<td>The Administrator is responsible for implementing the acceptable plan of correction.</td>
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<tr>
<td>Date of Compliance: 11/15/2017</td>
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<tr>
<td>11/15/17</td>
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**Summary of Deficiency:**

- **F 278** Continued From page 5

**Correction Measures:**

1. **F 323**
   - **FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**
   - **CFR(s): 483.25(d)(1)(2)(n)(1)-(3)**
   - **(d) Accidents.**
     - The facility must ensure that:
       1. The resident environment remains as free from accident hazards as is possible; and
       2. Each resident receives adequate supervision and assistance devices to prevent accidents.

   - **(n) - Bed Rails.** The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.
     1. Assess the resident for risk of entrapment from bed rails prior to installation.
     2. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.
     3. Ensure that the bed's dimensions are
A. BUILDING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

345061

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ____________________________

B. WING ____________________________

(X3) DATE SURVEY COMPLETED

C 10/21/2017

NAME OF PROVIDER OR SUPPLIER

PRUITT HEALTH - DURHAM

STREET ADDRESS, CITY, STATE, ZIP CODE

3100 ERWIN ROAD
DURHAM, NC  27705

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 323 Continued From page 6

This REQUIREMENT is not met as evidenced by:

Based on record review and physician, staff, and
responsible party interviews, the facility failed to
prevent elopement from the facility for one of
three residents who had cognitive impairment,
Resident #1. The facility was unable to account
for Resident #1’s location for a period of
approximately 7 hours until he was found by
police at the downtown bus terminal.

The immediate jeopardy began on 09/03/2017
when Resident #1 left the facility unobserved.
Resident #1 was transported by emergency
medical services (EMS) at 8:27 PM to a hospital
emergency department after being found by at a
bus terminal by police. Resident #1 was admitted
to the hospital after the emergency department
evaluation revealed acute on chronic congestive
heart failure, acute kidney injury, elevated liver
function tests, and major neurocognitive disorder.
The Immediate Jeopardy was removed on
10/21/2017 when the facility provided an
acceptable credible allegation of compliance.
The facility will remain out of compliance at a
scope and severity of no actual harm with the
potential of no more than minimal harm that is not
immediate jeopardy (D). The facility was in the
process of full corrective action at that time.

Findings included:

Resident #1 was admitted to the facility on
07/11/2017 with diagnoses which included, in
part, heart failure, depression, and insomnia.

The Elopement Risk Observation Form competed

F 323

This plan of correction constitutes a
written allegation of compliance.
Preparation and submission of this plan of
correction does not constitute an
admission or agreement by the provider of
truth of the facts alleged or the corrections
of the conclusions set forth on the
statement of deficiencies. The plan of
correction is prepared and submitted
solely because of requirements under
state and federal law.

Process that lead to the Deficiency:
Resident #1 was admitted to the facility on
7/11/17.

Root Cause Analysis:
The facility failed to provide supervision to
prevent elopement.
The resident’s elopement risk
assessment score upon admission was
11 (high risk) and the facility failed
to initiate interventions to prevent elopement
at that time.
The Admitting Nurse (Nurse #1) was not
properly trained on completing the
Elopement Risk Observation form.
Resignations and Nurse Management
changes specific to Director Health
Services and Clinical Competency
Coordinator caused a gap in orientation
and education/training for licensed staff.

On 9/3/2017 Resident #1 was last
observed on third floor at approximately
1:00pm. Facility was made aware that the
resident was not on the premises when
the resident’s mother called the facility at
Upon admission to the facility on 07/11/2017 revealed Resident #1 had a total score of 11. The top of the form indicated that a resident with a score of 11 or greater was to have interventions immediately put into place. Some of the interventions on the form were Weekly Behavior Management and Wanderguard Program. (A Wanderguard is a monitoring system to prevent a resident from exiting the facility unsupervised.) This form was not signed by the staff member who completed it.

Review of the admission minimum data set (MDS) assessment dated 07/18/2017 revealed Resident #1 had severe cognitive impairment and that he exhibited no signs of wandering or rejection of care behaviors. Supervision of one person was required for a walk in his room and for locomotion on and off the unit. The same MDS assessment indicated Resident #1 was not steady while walking or turning around, but was able to stabilize without staff assistance. In addition, he had functional limitation of his upper extremity on one side and that he used no mobility devices.

The nursing care plan for Resident #1 which was last updated on 07/24/2017 revealed there were goals and interventions in place for the potential for injury from falls related to general weakness, cognitive deficits, and the use of psychotropic medications. An additional goal with interventions was in place for the potential for side effects and/or adverse reactions related to the use of antidepressants for depression. The care plan did not address Resident #1’s risk for elopement.

Review of the facility’s incident report for the elopement of Resident #1 dated 9/03/2017 at approximately 7:30pm and asked the charge nurse (Nurse #1) to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and stated he was trying to get home but had missed the bus. At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1:00pm, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight. Around 8:30pm, the police officer arrived to gather more information about the resident. At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The resident was re-admitted 9/6/17 at 4:00pm. Upon re-admission, the resident was assessed for elopement by a Licensed Nurse and scored 25 on the Elopement Risk Observation form. The resident’s BIMS score was 4. The following interventions were put in place: a wander guard was put in place, the resident’s description and picture was placed in the wander guard book by the Medical Records Director. Resident #1 expired in the facility on 9/22/2017 of CHF.
7:30 PM was reviewed. The report indicated Resident #1 left the facility on his own and could not be located. The immediate action listed on the report read, "Res. (Resident) in ER" (emergency room.) The incident report form noted Resident #1 was "taken to hospital: [Hospital #1]" and that the Interim Director of Health Services prepared the report.

In an interview with a responsible party (RP) #1 on 10/19/17 at 5:45 PM, she stated that she and 2 other RPs called the facility on 09/03/2017 during the evening hours (not certain of the time) to notify the staff that she had talked with Resident #1 on the phone and he stated he was at the "bus stop." RP #2 explained she didn’t know whether to believe him, and she wanted the staff to check his room to see if he was in the facility. She stated she waited while the staff observed his room, and the staff returned to the phone and reported he was not there. RP #2 added that she and the 2 other RPs came to the facility at that point to help find him. She stated she called the police and that the police called the facility back later that evening to say that Resident #1 had been found at the hospital’s emergency department.

In an interview with Nursing Assistant (NA) #1 on 10/20/2017 at 10:50 AM, he stated he was working 7:00 AM to 3:00 PM on 09/03/2017, but Resident #1 was not on his assignment. He stated he received a call from a facility staff member after he left work that day (not sure of the time) to ask him if he had seen Resident #1. He stated he told the staff member he had last seen Resident #1 around 1:00 PM on 09/03/2017 as he passed by his room.
On 10/20/2017 at 10:59 AM, an interview was conducted with NA #2, who was assigned to care for Resident #1 on the 3:00 PM to 11:00 PM shift on 09/03/2017. NA #2 stated she arrived about 3:30 PM for her shift and that she did not see Resident #1 in his room at that time. She explained she saw his lunch tray sitting on the over bed table and it still had the cover over the plate as though it had not been eaten. NA #2 explained she thought he was probably out with family members, as he did this from time to time. She added that she did not check the sign out book at the nurse's station and took no other action to locate Resident #1.

The interview with NA #2 continued, and NA #2 stated she then assisted other residents with supper meals around 5:00 PM in the dining room. NA #2 did not pass out dinner trays on the hall. She explained that sometime after dinner, Nurse #1 informed her that Resident #1 could not be found, so she started to search for him in his room, the bathroom, the rest of the hall, and the other floors in the facility. NA #2 further clarified that Resident #1 was ambulatory, did not have a Wanderguard and was free to walk to other areas of the facility and go outside. She added there was no code needed for the residents to access the elevator to go to other areas of the facility, and since Resident #1 had no Wanderguard, there was no alarm that would sound if he boarded the elevator or exited the facility.

In an interview with the MDS Nurse on 10/20/2017 at 2:37 PM, she stated the Elopement Risk Observation Form was typically completed by the nurse who admitted the resident and she acknowledged the form dated 07/11/2017 with the signs of exit seeking behavior to. 100% education will be completed by 11/10/2017. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on elopement during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services.

Education for all licensed nurses including Nurse #1 and all nursing aides on identifying and reporting behavior changes was initiated on 10/21/2017 and completed on 11/10/2017. Licensed nurses and nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and nurse aides will be educated on identifying and reporting behavior changes during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services.

Education was also initiated on 10/21/2017 and completed on 11/10/2017 for all licensed nurses including Nurse #1 on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation form and initiating interventions as needed. Licensed nurses who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses will be educated on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation Form.
total score of 11 was not signed. The MDS Nurse stated that the nursing department, would initiate a Wanderguard for residents who were at a high risk for elopement based on Resident #1's score of 11.

In a telephone interview with the Interim Director of Health Services (IDHS) on 10/20/2017 at 11:32 AM, she stated she received a call from Nurse #1 on Sunday night, 09/03/2017, (was not certain of the time) to inform her that Resident #1 was missing from the facility. She explained she did not come in to the facility at that time because she did not live in the area.

In an interview with NA #3 on 10/20/2017 at 12:50 PM, she stated she was on duty on the 3:00 PM to 11:00 PM shift when Resident #1 wandered away from the facility. She indicated she first became aware that Resident #1 was not in his room on 09/03/2017 when she was picking up dinner trays around 7:00 PM. NA #3 explained that she and another nursing assistant were asked to search for him, so they drove through nearby apartment complexes, gas stations, and the bus terminal and they were unable to find him. She stated they continued looking for him until it got too dark and then they returned to the facility. NA #3 added that typically, the resident was quiet and did not socialize much, but he did come out of his room and was ambulatory.

On 10/20/2017 at 2:10 PM, and interview was conducted with Nurse #1 who was on duty on 09/03/2017 on the 3:00 PM to 11:00 PM shift. Nurse #1 stated the Resident #1 had free access to the building, so when he was not in his room, it was possible he was elsewhere on the campus. She explained he did not have a Wanderguard

Risk Observation form during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services.

The Administrator, the Director of Health Services and, the Facility Clinical Consultants educated the MDS nurses on coding wandering assessments accurately based on RAI guidelines. The education was initiated on 10/21/2017 and completed on 10/24/2017.

The admission, quarterly and significant change care plans are reviewed for accuracy by the Case Mix Director, Social Service Director and Director of Nursing in the area of wandering during the morning clinical meeting to ensure the care plan matches the coding on the MDS and resident assessments. This will be done for 6 months until compliance is sustained.

Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition for all residents at risk of elopement. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be placed in the wander guard notebook/elopement risk book with description of the resident; a wander guard will be placed on the resident as needed.

The Maintenance Supervisor and/or Housekeeping Supervisor will check
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<th>(X4) ID</th>
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**F 323 Continuation From page 11**

and at times, he would sit outside the facility. Nurse #1 stated on 09/03/2017, Resident #1’s family member had called the facility (could not recall what time it was) and asked her if Resident #1 was in the facility, so she went to check his room and noted he was not there. Nurse #1 returned to the phone and informed the family member he was not in his room, and she would check other areas of the facility and call her back. At that time, she asked two nursing assistants to search other floors of the facility, including the basement level. Nurse #1 stated she called the family member back and reported he was not in the facility, and the family member responded she had called his cell phone, and that Resident #1 stated he was at the bus the bus terminal. Nurse #1 stated she then asked the two nursing assistants to go to the bus station to search for him. She added that she called the police and notified the IDON and the Administrator. In addition, Nurse #1 confirmed she was the nurse who filled out the Elopement Observation Risk Form upon his admission on 07/11/2017. She stated she was told she should have notified the IDHS and initiated behavior monitoring and the Wanderguard Program. She did not specifically remember who told her this, but said she had received in-service education after Resident #1 eloped from the facility.

In a follow up interview with Nurse #1 on 10/21/17 at 11:25 AM, she stated the police notified her around 9:00 PM on 09/03/2017 that Resident #1 was found at the bus terminal by a bystander who called EMS.

In an interview with the Administrator and the current Director of Health Services (DHS) on 10/20/2017 at 4:11 PM, the DHS explained she doors for wander guard compliance using the wander guard tester every day. The Maintenance Director will educate all department heads and weekend supervisors on checking doors for wander guard compliance. On the weekend, the supervisor and/or the Manager on Duty will check the doors for wander guard compliance.

Monitoring procedure to ensure that the plan of correction is effective. As of 10/21/2017, an elopement observation audit tool is being utilized by licensed nurses and reviewed by the Director of Health Services and/or Nurse Managers daily for 1 week, then 2x weekly for 3 weeks, then weekly for 4 weeks and, monthly for 4 months. The results of the data collected and interventions implemented of the elopement risk observation audit with tracking and trending by the Director of Health Services will be presented to the Quality Assurance Performance Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained.

A questionnaire on elopement will be completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 3 months to ensure compliance is maintained. The results of the elopement questionnaire will be correlated by the Administrator and
### Summary Statement of Deficiencies

**F 323 Continued From page 12**

was not involved with the elopement incident for Resident #1 because she was not the DHS at that time. She stated that her role at that time was as a Nurse Navigator, a type of case manager for residents. The Administrator stated the last time the facility could confirm that Resident #1 was seen on 09/03/2017 was at 1:00 PM. The Administrator stated he was called about 7:30 or 7:45 PM on 09/03/2017 by Nurse #1 who reported Resident #1 was not in the facility. He added that he asked Nurse #1 to notify all staff in the building and to assign nursing assistants to search outside. He further stated that Nurse #1 contacted him between 8:00 PM and 9:00 PM to report he was found by the police and that the police reported Resident #1 was taken to the hospital by an emergency medical service (EMS.) The Administrator said that he was never able to confirm who called the EMS, but that police reported he was found at the bus station. The DHS stated Nurse #1, the admitting nurse who filled out the Elopement Risk Observation Form, should have contacted a supervising nurse to initiate behavior monitoring and a Wanderguard program.

During the interview on 10/20/2017 at 4:11 PM with the Administrator and the DHS, they provided a corrective action plan the facility had initiated on 09/03/2017 which included educating the nursing staff about the use of the Wanderguard for all residents who had a risk score of 11 or greater with a Brief Interview for Mental Status (BIMS) score of below 13. (A BIMS score below 13 indicates impaired cognition.) On 09/03/2017 through 09/05/2017, Elopement Risk Observation Forms and BIMS assessments were completed for all residents in the facility and Wanderguards were initiated for those who were assessed as reported to the Quality Assurance Performance Improvement Committee until 6 months of continued compliance has been sustained.

Title of Person Responsible for implementing the acceptable plan of correction.
The Administrator is responsible for implementing the acceptable plan of correction.

Date of Compliance: 11/15/2017

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### Corrective Actions

<table>
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<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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| Event ID: O6LZ11 | Facility ID: 923197 | If continuation sheet Page 13 of 27 |
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
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<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 323</td>
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#### F 323

Continued From page 13

- **need**

- **one.** Follow up with 10% of the staff each week was being completed to test staff on knowledge of information provided in in-service education. Care plans were being updated for those residents who were found to be at risk for elopement and behavior monitoring was being completed weekly in the medication administration records. There was no root cause analysis included in the corrective action plan.

- A review of the EMS report dated 09/03/2017 revealed EMS was dispatched to assist the police department for a sick person call. Upon initial assessment at 8:17 PM, Resident #1 had an altered level of consciousness with confusion and disorientation and a heart rate of 95. The report further indicated the resident had bilateral swelling in his feet and that he was transferred to the hospital at 8:27 PM.

- The hospital discharge summary dated 09/06/2017 from Hospital #2 indicated Resident #1 was disoriented upon evaluation in the emergency department and was admitted to the coronary intensive care unit on 09/03/2017 with diagnoses including acute kidney injury, elevated liver function tests, acute on chronic congestive heart failure, tricuspid regurgitation, and major neurocognitive disorder. Upon discharge from the hospital, the diagnosis was cardiogenic shock and no problems were resolved. (Cardiogenic shock is a condition in which your heart suddenly can't pump enough blood to meet your body's needs.)

- In an interview with Resident #1's physician on 10/21/2017 at 1:17 PM, he stated he had end stage congestive heart failure and was experiencing a slow decline in health and that he
F 323 Continued From page 14

felt there was no long term effect on the resident's health due to the elopement. He added that Resident #1 was capable of walking and that it would have been possible for him to ambulate a distance of 3 miles.

Per the google maps revealed the distance between the facility and the bus terminal was 3.0 to 4.5 miles, depending on which route was used.

The weather conditions per AccuWeather on 09/03/2017 for the facility's city was 81 degrees Fahrenheit.

The Administrator and DHS were notified of Immediate Jeopardy on 10/20/2017 at 6:50 PM.

On 10/21/2017 at 6:35 PM, the facility provided an acceptable credible allegation as follows:

Process that lead to the Deficiency:
Resident was admitted to the facility on 7/11/17,
Root Cause Analysis: Failure to provide supervision to prevent elopement.
His elopement risk assessment score was 11 (high risk).
The facility did not initiate interventions to prevent elopement at that time.
Elopement Observation was not completed appropriately.
Admitting Nurse was not properly trained on completing the elopement risk observation form.
Nurse Management change specific to Director Health Services and Clinical Competency Coordinator, caused a gap in orientation and education for licensed staff.
Resignation of positions.
**SUMMARY STATEMENT OF DEFICIENCIES**

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 323</td>
<td>Continued From page 15</td>
<td>On 9/3/2017 resident was last observed on third floor at approximately 1300. Facility was made aware that he was not on the premises when the resident's mother called the facility at approximately 1930 and asked the charge nurse to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and said he &quot;was trying to get home but had missed the bus.&quot; At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1300, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight of resident. Around 8:30pm, the police officer arrived to gather more information about the resident (physical description again). At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was readmitted 9/6/17 at 4:00pm and was reassessed for elopement by the Licensed Nurse; a wander guard was then put into place. The Resident's description and picture was placed in the wander guard book by the Medical Records Director. Resident expired in the facility on 9/22/2017 of CHF. Process for implementing the acceptable plan of correction for specific deficiency. On 9/3/2017, all other residents were accounted for in the facility. 100% elopement assessments were initiated on 9/3/2017 and completed on</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>F 323</td>
<td>Continued From page 16</td>
<td>9/4/2017 by the Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. The residents were assessed by the Interdisciplinary Team for further intervention recommendations. Three-day behavior logs were initiated for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were implemented, reviewed and/or revised as needed based on the assessment. Education was initiated on 9/3/2017 by the Administrator, Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff on elopement including assessment of risk, signs of exit seeking behavior, location of the elopement risk book and, who to report signs of exit seeking behavior to 100% education was completed by 9/11/2017. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on elopement during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator. Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be</td>
<td>F 323</td>
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| PROVIDER PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | |
| | | |

Event ID: O6LZ11 Facility ID: 923197

If continuation sheet Page 17 of 27
A questionnaire on elopement is being completed with 10% of all staff by the Administrator, Director of Health Services, Clinical Competency Coordinator and, Department Managers weekly for 4 weeks then monthly for 2 months to ensure compliance is maintained. The results of the elopement questionnaire will be correlated by the Administrator and reported in the Quality Improvement Committee by the Director of Health Services until 6 months of continued compliance has been sustained.
Continued From page 18

Assurance / Performance Improvement Committee until 6 months of continued compliance has been sustained

Title of Person Responsible for implementing the acceptable plan of correction.
The Administrator is responsible for implementing the acceptable plan of correction.

On 10/21 at/2017 at 7:45 PM, validation of the credible allegation was evidenced via interviews with nurses, nursing assistants, residents, and unit supervisors who stated they received in-service education regarding the importance of observing for signs of elopement. Nurses stated they understood the need for completing elopement risk assessments accurately upon admission and after a significant change in condition especially for residents who had severe cognitive impairment. Staff also stated that residents who had a risk of elopement had pictures with their names in an elopement book kept at the nurse's stations for ready reference. An observation of the facility's two exit doors were observed for Wanderguard function, and each door's alarms and locks engaged upon activation by the Wanderguard. There were no residents observed in the outside area at the time of validation.

(g) Quality assessment and assurance.

(1) A facility must maintain a quality assessment and assurance committee consisting at a
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<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 520</td>
<td>Continued From page 19 minimum of:</td>
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<tr>
<td></td>
<td>(i) The director of nursing services;</td>
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<td>(ii) The Medical Director or his/her designee;</td>
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<td>(iii) At least three other members of the facility’s staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</td>
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<td>(g)(2) The quality assessment and assurance committee must :</td>
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<td>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</td>
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<td>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</td>
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<td>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</td>
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<td>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on record review and physician, staff, and responsible party interviews, the facility's Quality Assessment and Assurance (QAA) Committee</td>
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<td>This plan of correction constitutes a written allegation of compliance. Preparation and submission of this plan of</td>
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## F 520

Continued From page 20

failed to identify how a cognitively impaired resident exited the facility without supervision in order to prevent future elopement. This was evident in one of three cognitively impaired resident with exit seeking behaviors. (Resident #1). The facility was unable to account for Resident #1's location for a period of approximately 7 hours until he was found by police at the downtown bus terminal.

The immediate jeopardy began on 09/03/2017 when the facility failed to do a root cause analysis in an attempt to determine how Resident #1 left the facility unobserved. Resident #1 was transported by emergency medical services (EMS) at 8:27 PM to a hospital emergency department after being found at a bus terminal by police. Resident #1 was admitted to the hospital after the emergency department evaluation revealed acute on chronic congestive heart failure, acute kidney injury, elevated liver function tests, and major neurocognitive disorder. The Immediate Jeopardy was removed on 10/21/2017 when the facility provided an acceptable credible allegation of compliance. The facility will remain out of compliance at a scope and severity of no actual harm with the potential of no more than minimal harm that is not immediate jeopardy (D). The facility was in the process of full corrective action at that time.

Findings included:

This tag is cross referenced to F323:

Based on record review and physician, staff, and responsible party interviews, the facility failed to prevent elopement from the facility for one of three residents who had cognitive impairment, Resident #1. The facility was unable to account correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.

Process that lead to the Deficiency:

Resident #1 was admitted to the facility on 7/11/17.

Root Cause Analysis:

The facility failed to provide supervision to prevent elopement.

The resident’s elopement risk assessment score upon admission was 11 (high risk) and the facility failed to initiate interventions to prevent elopement at that time.

The Admitting Nurse (Nurse #1) was not properly trained on completing the Elopement Risk Observation form. Resignations and Nurse Management changes specific to Director Health Services and Clinical Competency Coordinator caused a gap in orientation and education/training for licensed staff.

On 9/3/2017 Resident #1 was last observed on third floor at approximately 1:00pm. Facility was made aware that the resident was not on the premises when the resident’s mother called the facility at approximately 7:30pm and asked the charge nurse (Nurse #1) to establish if the resident was in the room. The charge
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>345061</td>
<td>A. BUILDING _________________</td>
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<td>B. WING _________________</td>
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**NAME OF PROVIDER OR SUPPLIER**

PRUITH-HEALTH-DURHAM

**STREET ADDRESS, CITY, STATE, ZIP CODE**

3100 ERWIN ROAD

DURHAM, NC 27705

<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 520</td>
<td>Continued From page 21 for Resident #1's location for a period of approximately 7 hours until he was found by police at the downtown bus terminal.</td>
<td>F 520</td>
<td>nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and stated he was trying to get home but had missed the bus. At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident was seen, third floor at approximately 1:00pm, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight. Around 8:30pm, the police officer arrived to gather more information about the resident. At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was re-admitted 9/6/17 at 4:00pm. Upon re-admission, the resident was assessed for elopement by a Licensed Nurse and scored 25 on the Elopement Risk Observation form. The resident's BIMS score was 4. The following interventions were put in place: a wander guard was put in place, the resident's description and picture was placed in the wander guard book by the Medical Records Director. Resident #1 expired in the facility on 9/22/2017 of CHF. Process for implementing the acceptable plan of correction for specific deficiency.</td>
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On 9/3/2017, all other residents were accounted for in the facility. 100% elopement assessments were initiated on 9/3/2017 and completed on 9/4/2017 by the Interim Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. Residents with a score of 11 or above, indicating a high-risk for elopement and, have a BIMS score of less than 13, and/or not alert and oriented, had interventions put in place to include a wander guard placed immediately upon notification of the Resident Representative and the Physician. The residents at risk reviewed weekly by the Interdisciplinary Team for any further interventions as needed. Three-day behavior logs were initiated for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were implemented, reviewed and / or revised as needed based on the assessment.

On 9/3/2017 Resident #1 was last observed on third floor at approximately 1 PM. The facility was made aware that he was not on the premises when the resident's mother called the facility at approximately 8:30 PM and asked the charge nurse to establish if the resident was in the room. The charge nurse quickly checked the room and informed the mother that the resident was not in his room. The mother at this point informed the charge nurse that the resident had called his sister and said he "was trying to get home but had missed the bus." At around 7:54pm, charge nurse notified Administrator and Director of Health Services. At around 8:17pm, the charge nurse called 911 to report the resident missing. The Nurse described the last location the resident could have got out from either one of these doors since he did not have a wanderguard.

The Administrator was notified of Immediate Jeopardy on 10/20/2017 at 6:50 PM.

On 10/21/2017 at 6:35 PM, the facility provided an acceptable credible allegation as follows:

Process that lead to the Deficiency:
Root Cause Analysis:
The Quality Assurance process was ineffective to address supervision, MDS assessment and care plan. QA process was not properly implemented. Director of Nursing was not properly trained on QA process. DON was new to her position and new to being a DON. Resignation of positions.

On 9/3/2017, all other residents were accounted for in the facility. 100% elopement assessments were initiated on 9/3/2017 and completed on 9/4/2017 by the Interim Director of Health Services and Nurse Management team. Residents with a score of 11 or above, indicating a high-risk for elopement and that have a BIMS score of less than 13, and/or not alert and oriented, had a wander guard placed immediately. Residents with a score of 11 or above, indicating a high-risk for elopement and, have a BIMS score of less than 13, and/or not alert and oriented, had interventions put in place to include a wander guard placed immediately upon notification of the Resident Representative and the Physician. The residents at risk reviewed weekly by the Interdisciplinary Team for any further interventions as needed. Three-day behavior logs were initiated for residents who are able to move self throughout the facility with a score of 5-10, identified medium risk on elopement observation form, and were kept on behavior management for 4 weeks. Care plan interventions were implemented, reviewed and / or revised as needed based on the assessment.

Education was initiated on 10/21/2017 by the Administrator, Interim Director Health Services, Clinical Competency Coordinator, Nursing Management team and Department managers for all staff on elopement including assessment of risk, signs of exit seeking behavior, location of the elopement risk book and, who to report signs of exit seeking behavior to
Continued From page 23

**F 520**

was seen, third floor at approximately 1 PM, description of clothing (tan pants, dark shirt and black lace up shoes) that he was wearing as well as the physical description of resident including height and weight of resident. Around 8:30pm, the police officer arrived to gather more information about the resident (physical description again). At approximately 9:00pm, the police officer informed the charge nurse that the resident had been located in Duke Hospital ER. The Resident was readmitted 9/6/17 at 5 PM and reassessed for elopement by the Licensed Nurse; a wander guard was then put into place. The Resident's description and picture were placed in the wander guard book by the Medical Records Director. Resident expired at the facility on 9/22/17 of congestive heart failure.

Process for implementing the acceptable plan of correction for specific deficiency.

QA process will be reviewed to put emphasis and focus on root cause analysis to drill down to underlying cause of issues related to supervision to prevent accidents, MDS assessments and care plans related to resident wandering and elopement risk.

MDS assessments are being reviewed upon admission and significant change for accuracy according to RAI manual, for wandering and supervision, by the IDT during daily risk meeting. Based on the elopement observation scores in conjunction with the BIMS scores the Care plans will be updated to reflect interventions put in place.

The Administrator and the Director of Health Services will educate all staff with emphasis and focus on the root cause of what led to the deficiency.

Monitoring procedure to ensure that the plan of

100% education was completed by 11/10/2017. Staff members who have not completed the education will not be allowed to work until they are educated. All newly hired staff will be educated on elopement during new hire orientation by the Director of Health Services and/or the Clinical Competency Coordinator. Education for all licensed nurses including Nurse #1 and nursing aides on identifying and reporting behavior changes was initiated on 10/21/2017 and completed on 11/10/2017. Licensed nurses and nursing aides who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses and nurse aides will be educated on identifying and reporting behavior changes during new hire orientation by the Clinical Competency Coordinator and/or the Director of Health Services.

Education was also initiated on 10/21/2017 and completed on 11/10/2017 for all licensed nurses including Nurse #1 on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation form and initiating interventions as needed. Licensed nurses who have not completed the education will not be allowed to work until they are educated. All newly hired licensed nurses will be educated on assessing residents for elopement risk upon admission and/or change of condition using the Elopement Risk Observation form during new hire orientation by the Clinical Competency
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<td>F 520</td>
<td>Continued From page 24</td>
<td>correction is effective.</td>
<td>Administrator will lead QA meetings with emphasis and focus on root cause analysis in order to assure that basis of issue is addressed to prevent further deficient practices related to MDS assessment, Care Plans and supervision to prevent elopement. Members of the regional team to include senior nurse consultant, clinical reimbursement consultant or area vice president will attend QA meetings for the next six months to ensure that root cause analysis is an integral part of QA process.</td>
<td><em>Title of Person Responsible for implementing the acceptable plan of correction.</em> Administrator is responsible for implementing the acceptable plan of correction. Validation of the credible allegation of removal of the immediate jeopardy was conducted on 10/21/17 at 5:15 PM. The administrator was interviewed and verbalized understanding of the need for a root cause analysis of how the resident left the building. The Administrator could not determine for sure how the resident left the building. Record review revealed that elopement risk observation forms were completed on all residents on 9/4/17. Record review of the inservice education records sign in sheet revealed facility staff were inserviced regarding elopement policy and Code Pink on 9/3/17, 9/4/17 and 9/5/17. Nurses and nursing assistants were interviewed on the 100, 200 and 300 Halls. The nurses and nursing assistant acknowledged that they...</td>
<td>Coordinator and/or the Director of Health Services. On 10/24/2017, the Administrator conducted education for the QAPI committee members on the QAA/QAPI process with the focus on the root cause analysis. Further, the committee members employed by the facility were assigned the QAPI courses on Pruitt University and were completed by 11/3/2017. Completion certificates were obtained upon completion of the education. Elopement Risk Observation forms will be completed on admission/readmission, quarterly and change of condition. Care plans will be updated with assessment/observation as needed to ensure compliance. Licensed nurses will place immediate intervention to include but not limited to placing the resident on 1:1, complete an elopement observation form, a picture will be placed in the wander guard notebook/elopement risk book with description of the resident; a wander guard will be placed on the resident as needed. Monitoring procedure to ensure that the plan of correction is effective. QA process will be reviewed to put emphasis and focus on root cause analysis to drill down to underlying cause of issues related to supervision to prevent accidents, MDS assessments and care plans related to resident wandering and elopement risk. MDS assessments are being reviewed...</td>
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received inservices few weeks ago regarding residents at risk for elopement. The nurses and nursing assistants were able to verbalize the process as described in the facility credible allegation of removal.

A sample of residents with wander guard were checked for placement and functionality of the wander guard placement.

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upon admission and significant change for accuracy according to RAI manual, for wandering and supervision, by the IDT during daily risk meeting. Based on the elopement observation scores in conjunction with the BIMS scores the Care plans will be updated to reflect interventions put in place. The Administrator and the Director of Health Services will educate all staff with emphasis and focus on the root cause of what led to the deficiency. Monitoring procedure to ensure that the plan of correction is effective. Administrator will lead Quality Assurance and Performance Improvement meetings with emphasis and focus on root cause analysis in order to assure that basis of issue is addressed to prevent further deficient practices related to MDS assessment, Care Plans and supervision to prevent elopement. Members of the regional team to include senior nurse consultant, clinical reimbursement consultant or area vice president will attend QAPI meetings for the next six months to ensure that root cause analysis is an integral part of QAPI process. The administrator will report to the Quality Assurance and Performance Improvement Committee and areas of non-compliance on a monthly basis for 6 months.

Title of Person Responsible for implementing the acceptable plan of correction.

The Administrator is responsible for implementing the acceptable plan of correction.
<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<td>F 520</td>
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