

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

PRINTED: 02/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2017
NAME OF PROVIDER OR SUPPLIER BLUMENTHAL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455	
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F 000	INITIAL COMMENTS A revisit and new complaint investigation survey was conducted from 12/19/17 through 12/21/17. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. A partial extended survey was conducted. The facility had other new and repeat tags at a scope and severity of D. The facility did have a repeat tag at a scope and severity of A. The Statement of Deficiencies was amended on 1/29/18 at tag F689.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to prevent 2 of 3 residents from leaving the facility unattended. Resident #4 who was cognitively impaired left the facility and walked across two 4-lane roads with moderate to heavy traffic before being found	F 689	Past noncompliance: no plan of correction required.	1/29/18

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

TITLE

(X6) DATE

Electronically Signed

01/15/2018

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 689	<p>Continued From page 1</p> <p>approximately 1.2 miles from the facility. Resident #5 who had experienced a change in mental status left the facility dressed in a t-shirt, shorts and no shoes in 37 degree F weather walked approximately 520 feet from the facility and remained out of the facility for approximately 54 minutes.</p> <p>Findings Included:</p> <p>1. Resident #4 was admitted to the facility on 5/17/17 and his diagnoses included Alzheimer ' s disease, dementia and psychotic disorder with delusions.</p> <p>An elopement / wandering risk review dated 5/17/17 for Resident #4 completed by Nurse #4 identified risk factors that included impaired cognition, diagnoses of dementia, wandered aimlessly, ambulated independently and recent admission to facility. The sections for history of elopement, conclusion and interventions were left blank.</p> <p>Review of a nursing note dated 5/17/17 at 9:40 pm for Resident #4 stated the resident was observed by staff attempting to walk out of the front door. The staff was able to easily guide the resident back into the facility. Will continue to monitor.</p> <p>Review of a nursing note dated 5/18/17 at 9:52 am for Resident #4 stated the resident was alert with confusion noted. Difficult to keep resident in his room and he was up and down most of the shift. He showed confusion as to where he was. He was looking for his family and wanted to leave the building. Resident was given Haldol (an antipsychotic) 5 milligrams (mg) which was</p>	F 689			

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F 689	<p>Continued From page 2</p> <p>somewhat effective. Resident was informed it was after 1:00 am in the morning and slept for a short period of time. Within a few hours he was noted walking the hallways again. No acute distress. Staff will monitor resident to maintain safety.</p> <p>A care plan dated 5/18/17 identified that Resident #4 wandered about the facility. Interventions included to observe whereabouts frequently, redirect resident as needed, anticipate needs for hunger, thirst, toileting and other needs, label resident ' s belongings and have familiar objects in his room when available.</p> <p>Review of a general note dated 5/30/17 at 11:55 am stated a care plan meeting had been held with Resident #4 ' s responsible party and his family members. Resident now familiar with the facility routine and not attempting to leave the building as often. Staff must continue to monitor due to past history of wandering.</p> <p>An admission, comprehensive minimum data set (MDS) dated 5/31/17 identified Resident #4 had no behaviors of wandering and had impaired cognition.</p> <p>Review of a nursing note dated 7/1/17 at 8:01 am for Resident #4 stated resident was awake most of the night wandering around in his room. Resident was pleasantly confused and easily redirected. Safety maintained and continued with every 1 hour checks.</p> <p>Review of a nursing note for Resident #4 dated 7/2/17 at 1:40 am revealed resident exited the facility on 7/1/17. The resident was last seen sitting in the common area of unit 1. At 5:45 pm</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>staff started to search for the resident within the building including rooms and common areas. At 6:00 pm a code orange (facility code for a missing resident) was called. At that time all staff began to search for the resident. His family was called at 6:10 pm and arrived at the facility at 6:40 pm. The Director of Nursing (DON) was notified at 6:11 pm. All staff continued to search for the resident. At 6:49 pm the resident ' s family member informed the staff she received a call that Resident #4 had been found by the police and had been taken to the hospital for evaluation. The DON was notified immediately. The resident returned to the facility at 8:00 pm and a head to toe assessment was completed and within normal limits. Resident showed no signs or symptoms of distress. Resident went to bed soon after returning to the facility. Call bell in reach and 15 minute checks were initiated. Elopement assessment completed and will continue to monitor.</p> <p>Resident #4 was discharged to another facility on 8/14/17.</p> <p>The local police department was contacted on 12/19/17 at 2:00 pm. The department representative indicated there was no written report for the incident that occurred on 7/1/17 for Resident #4.</p> <p>An interview on 12/19/17 at 3:24 pm with the facility Administrator revealed the staffing schedule for July 1, 2017 to identify the nursing assistants (NAs) assigned to Resident #4 was not available. The Administrator stated she had started at the facility in September and was unable to locate the staffing schedule for that time frame.</p>	F 689			

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F 689	Continued From page 4 An interview on 12/19/17 at 3:51 pm with Nurse #2 revealed she was familiar with Resident #4 and had been his nurse the evening he was admitted to the facility and the evening he left the facility unattended. She stated Resident #4 was able to walk independently and was very confused. Nurse #2 explained the first night Resident #4 was at the facility she had observed him walk to the front door and attempt to go outside; she was able to persuade him to come back inside. She added she notified her supervisor, the DON who no longer worked at the facility. She was not aware of any additional interventions for his wandering at that time except for staff to keep a close eye on him. Nurse #2 stated the facility did not use wander guards. She added Resident #4 continued to wander throughout the facility, but he would primarily stay between the 2 nursing units and the common areas. He really didn ' t go toward the back of the building and she wasn ' t aware of him going to the front door again until the incident on 7/1/17. Nurse #2 explained she had last seen the resident about 4:45 pm and he was in the common area for unit 1. Around 5:00 pm she didn ' t see Resident #4 and started looking for him. She notified the DON that he was missing and called code orange for elopement; that is when all the facility staff started searching the facility for him. Nurse #2 added staff went outside, looked around the grounds of the facility and drove through the neighborhood looking for him. She stated she had called Resident #4 ' s family member who arrived at the facility around 6:30 pm. Resident #4 ' s family member received a call from another family member that the resident had been picked up by the police who took him to the hospital. Resident #4 ' s family member brought	F 689			

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F 689	<p>Continued From page 5</p> <p>him back to the facility around 8:00 pm and they implemented 15 minute checks. Nurse #4 stated the front door to the facility was locked at 8:00 pm. She believed Resident #4 followed another resident ' s family out of the front door. She added that Resident #4 walked fairly quickly and she suspected that is why he got as far away from the facility as he did. She believed all together it was 30 to 40 minutes from the time they started looking for the resident until his family heard he was in the emergency room.</p> <p>An interview on 12/19/17 at 4:47 pm with Nurse Unit Manager #2 revealed she was familiar with Resident #4 and was the nurse manager for the unit he resided on. She stated he was confused and would wander from unit 1 to unit 2, sit in the common areas and talk about trying to get to work. She added she was not aware of him attempting to go to any exit doors. Unit Manager #2 stated the first night Resident #4 was admitted he did go to the front door and attempt to go outside, but the staff was with him the whole time and he was easily redirected to come back inside. She added that was when he was identified as an elopement risk and added to the elopement profile book. Unit Manager #2 then explained she wasn ' t sure when the elopement profile books were implemented and she couldn ' t be sure if that was before or after Resident #4 eloped on 7/1/17. She added the facility did not have a wander guard system and at the time of his elopement the exit doors were not alarmed but had key pad codes. She stated she could not recall what nursing assistants (NAs) routinely worked with the resident.</p> <p>An observation was made on 12/20/17 from 8:00 am until 8:30 am of the potential route Resident</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>#4 walked on 7/1/17. The facility was located at the end of an unmarked, paved two-lane street. To the right of the facility there was a small residential neighborhood. To the left of the facility one side of the street was wood covered and the other side of the street was an open field with one large commercial building. It was approximately 1.1 miles from the facility to the mid-point of the street where Resident #4 was found. This street was an unmarked paved two-lane road in a residential area. To reach this location from the facility there were two 4-lane roads with moderate to heavy traffic that would need to be crossed. There was a paved side walk on one of the 4-lane roads. There was a stop light at the intersection of the two 4-lane roads. The 2 4-lane roads had a combination of businesses, churches and residential properties. The majority of the grounds were paved parking lots and flat grass covered grounds.</p> <p>An interview on 12/20/17 at 8:50 am with Nurse #4 revealed she was the nurse that admitted Resident #4 to the facility and had completed his admission elopement / wandering risk assessment. Nurse #4 stated she only answered the questions she knew the answers to and at the time she had completed the assessment the resident hadn't demonstrated any behaviors of wandering. She added the assessment wasn't fully completed because it took some time to determine the answers to some of the questions and the assessment should have been updated after Resident #4 attempted to leave the building the first night he was there. Nurse #4 explained she was frequently the day (7:00 am to 3:00 pm) nurse for the resident during his stay at the facility and he did wander up and down the hallways on her shift. She added Resident #4 didn't really</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>show any pattern to his wandering and would also sleep on and off during the day. There were times that he was placed on 15 minute checks to monitor his whereabouts but that was not continuous.</p> <p>A phone interview on 12/20/17 at 9:44 am with the DON of the facility during the time of Resident #4 ' s stay at the facility revealed she was aware of his elopement from the facility on 7/1/17. She stated the first evening Resident #4 was at the facility he did attempt to go out of the front door, but the staff was with him the entire time. She believed he was put on 15 minute checks after that incident. The DON added that his admission wandering / elopement risk assessment should have been updated at that time, but she could not remember if it was or not. The DON stated Resident #4 did continue to wander throughout the facility and the staff were aware to keep a close eye on him. She added the facility did not have a wander guard system at that time. She explained there was a receptionist on duty at the front door until 8:00 pm and then the front door was locked and you needed a code to enter and exit the door. The DON stated the evening Resident #4 left the building she believed it was about 5:00 pm and he followed a group of visitors out the front door. She was not aware if any staff member actually saw him leave the facility. She explained the resident ' s nurse realized shortly after that he was missing and started looking for him. A code orange was called and all facility staff searched inside the building, the facility grounds and drove through the neighborhood looking for the resident. She added the nurse called her and she returned to the facility. The DON stated Resident #4 ' s family had been called and they came to the facility. She was with the family</p>	F 689			

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F 689	<p>Continued From page 8</p> <p>member when they received a call from another family member that the police had found Resident #4 sitting on a curb and they had taken him to the emergency room for evaluation. Resident #4 ' s family went to the emergency room who determined the resident was fine and the family brought him back to the facility. The DON stated it was approximately 20 minutes from the time the staff realized Resident #4 was missing until the police found him and notified his family. She added she had spoken with the police officer who told her he found the resident at 5:49 pm and the location that he was found. The location was approximately 3000 yards from the facility. She stated the police officer told her the resident appeared fine and was able to provide the officer with his name and told the officer he was just out for a walk. The previous DON added the police officer did not write a report regarding the incident. She was unable to provide the officer ' s name.</p> <p>An observation of the facility exit doors was made on 12/20/17 at 10:30 am. The facility had a total of nine exit doors. During the observation eight of the nine exit doors were locked and had key pads used for entrance / exit from the doors. The front door located in the facility lobby was unlocked. There was a receptionist located in the front lobby who had an unobstructed view of the front door.</p> <p>A review of the weather for 7/1/17 identified the average temperature was 80 degrees F and there was 0.04 inches of precipitation on that day.</p> <p>An interview with the facility Administrator on 12/20/17 at 11:12 am revealed the front door was locked from 5:00 pm until 8:30 am and required a key code to be unlocked. She stated the facility</p>	F 689			

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F 689	<p>Continued From page 9</p> <p>was in the process of installing a wander guard system to the exit doors and anticipated this being completed within a few weeks. The Administrator explained there was a 24 hour a day receptionist located at the front door until the wander guard system was operational. She added all of the other facility exit doors were locked at all times. Staff members were provided with the code for the employee entrance door located in the back of the facility. The key codes for the other exit doors were only know by a few administrative staff members.</p> <p>2. Resident #5 was admitted to the facility on 11/24/17 with diagnoses that included hip fracture, pneumonia and Parkinson ' s disease. She was discharged to the hospital on 12/5/17 and re-admitted to the facility on 12/7/17 with an additional diagnosis of hallucinations possibly from Parkinson ' s disease, meds or encephalopathy.</p> <p>Review of the admission elopement / wandering risk review dated 11/25/17 for Resident #5 identified she was not at risk for elopement.</p> <p>A review of the admission Minimum Data Set (MDS) dated 12/1/17 for Resident #5 revealed she required limited assistance with ambulation, was alert and oriented and had not exhibited any behaviors during the look back period.</p> <p>Review of a nursing note for Resident #5 on 12/5/17 at 2:11 pm stated the resident had been noted to have bizarre behaviors and hallucinations. Due to such a significant change in behavior psychiatric services were sent a referral to assess and treat this resident as soon as possible.</p>	F 689			

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F 689	Continued From page 10 Review of a nursing note for Resident #5 on 12/5/17 at 11:47 pm revealed the resident had increased confusion, hallucinations and attempted to vacate the facility. Ativan (used to treat anxiety) 1mg was administered and the resident was assisted into bed. The height of the bed was lowered. At 6:00 pm resident was noted lying on the floor beside her bed, no signs of injury. The resident was unable to tell the staff how the incident occurred and was able to walk with assistance back to bed. She remained restless in bed with tremor of her upper extremities. One to one care was initiated. Her physician and family were notified. The physician gave an order to send the resident out to the emergency room and she was transported to the hospital at 7:30 pm. Review of the hospital history and physical dated 12/5/17 for Resident #5 revealed she presented with agitation and altered behavior. The resident had been okay since being at the nursing home until today when per nursing she was restless in the morning, hallucinating, confused with nonsensical speech and attempted to pack her bags and leave the facility. She was treated with Ativan, slept for 1 hour, and was then found lying on the floor. The resident continued to hallucinate so she was sent to the emergency room. The patient was oriented to self and place, but otherwise had disorganized thinking and unable to answer questions. She appeared to be responding to internal stimuli, talking to herself and laughing. She became aggressive and had to be sedated with Haldol (an antipsychotic that can treat hallucinations), the police were called to the room and she was admitted.	F 689			

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F 689	<p>Continued From page 11</p> <p>Review of the hospital discharge summary dated 12/7/17 for Resident #5 revealed a discharge diagnosis of hallucinations, possibly from Parkinson ' s disease, medications or encephalopathy. Psychiatry was consulted and started on risperidone (an antipsychotic) and patient was much better. Discharge instructions included to avoid too many sedating medications. Patient has tramadol and Percocet for pain control, please use with caution. New medication was risperidone at bedtime.</p> <p>Review of the re-admission facility elopement / wandering risk review dated 12/7/17 for Resident #5 identified resident was not at risk for elopement.</p> <p>Review of a nursing note for Resident #5 dated 12/8/17 at 12:02 am stated resident appeared to be very confused. She had not unpacked her bags since arriving back to the facility at 5:00 pm. She continued to sit in the same position on her bed, unzipped her luggage and would take a few things out. She would then place those items back in her luggage. Several staff members have tried to help her get situated in her room but she has refused any help.</p> <p>Review of a nursing note for Resident #5 dated 12/8/17 at 12:08 am was identified as a late entry. Resident arrived at 5:00 pm to the facility via ambulance. Resident is alert, but confused.</p> <p>Review of a nursing note for Resident #5 dated 12/9/17 at 3:30 am was identified as a late entry for 12/8/17. The note stated at approximately 5:38 am a nursing assistant (NA) informed me that the resident went toward the front of the building. I told the NA to come with me to the</p>	F 689			

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F 689	<p>Continued From page 12</p> <p>front. When I got to the front door I noticed the resident ' s wheelchair was at the front door and the resident was not in it. I contacted the unit manager to inform her of the current situation. I went outside and looked in both directions to see if the resident was in site. I did not observe her. I ran back inside and instructed the receptionist to call code orange for a missing resident. At approximately 5:41 am the Director of Nursing (DON) was called and as the phone connected I observed Resident #5 at the edge of the woods swinging and screaming. I explained to the DON the situation and was instructed to call 911. The resident kept walking up the street and began stating she wanted to call her family. At approximately 5:48 the officers arrived to assist with the resident. The resident was accompanied back to the facility and placed on 1 to 1 supervision. The resident would not allow staff to complete a head to toe assessment.</p> <p>Review of a telephone order dated 12/8/17 for Resident #5 stated to send out to the emergency department for evaluation.</p> <p>She was discharged from the facility on 12/8/17.</p> <p>An interview on 12/19/17 at 4:07 pm with Nurse #2 revealed she was the nurse for Resident #5 the morning she left the facility. She stated this was the first time she had worked with the resident as she had been re-admitted to the facility on her unit. Nurse #2 explained the resident was confused and agitated when she came on shift at 11:00 pm. The resident was sitting on her bed with her personal items around her and she kept zipping and unzipping her suitcase. The resident was upset about her medications and kept telling the nurse that she</p>	F 689			

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F 689	Continued From page 13 was not giving her the correct amount of her Parkinson ' s medicine. The nurse added Resident #5 wanted to call her family and she tried to call him twice using the facility phone at the nursing desk but did not reach him. The resident also dialed 911 from the facility phone, but didn ' t speak to anyone. Nurse #2 stated later in the shift a NA told her the resident had left her room going up towards the front. The resident was walking pushing her wheelchair. She explained it was around 5:00 am at that point and she headed up to the front lobby. She stated the receptionist was at the front desk and told the nurse she had unlocked the front door so the funeral home staff could leave and Resident #5 had run out the front door. Nurse #2 stated she went out the front door and saw an empty wheelchair but did not see the resident. She then notified the unit manager who told her to notify the DON, call a code orange for elopement and call 911. Nurse #2 explained as she and a NA were calling out and looking for the resident she heard some rustling and yelling in the woods located at the front right side of the property. She observed it was Resident #5 who was yelling the nurse wouldn ' t give her the right medicine and she needed to call her family. She added the resident had a stick and was shaking it at the staff at they approached her. The resident came out of the wooded area to the street in front of the facility. Nurse #2 stated the police arrived within about 4 minutes and tried to take the resident to the emergency room, but the resident refused to go. The resident would not come back in the facility, but she eventually allowed one of the officers to wheel her back into the facility. The resident ' s family arrived at the facility approximately 30 minutes to an hour later and he took the resident home against medical advice	F 689			

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F 689	<p>Continued From page 14</p> <p>(AMA.) Nurse #2 stated it was cold out and the resident had gone out wearing a t-shirt, shorts and had no shoes on.</p> <p>An interview on 12/19/17 at 4:55 pm with nurse unit manager #2 stated she was familiar with the resident. She explained during the course of her stay the resident became confused and was hospitalized. The resident had been re-admitted to the facility the day prior to the incident. Unit Manager #2 stated she received a phone call from Nurse #2 that the resident was becoming more confused and somewhat combative with staff and I told the nurse to keep an eye on the resident and she was on her way back up to the facility and to notify the physician if needed. She added on the way to the facility she received another call from Nurse #2 at approximately 5:20 to 5:30 am from Nurse #2 who told her Resident #5 had left the building. She instructed her to call the DON and Administrator to notify them of the incident. Unit Manager #2 continued that when she pulled onto the street she observed the resident sitting on the curb with Nurse #2, a NA and the police officers. She stated the resident was calmed down by then and the officers tried to get the resident into their car but the resident wouldn't and eventually the resident agreed to let the officers push her back to the facility in her wheelchair. Unit Manager #2 stated when they got back into the facility lobby she helped the resident call her family who told them he was on his way and that she needed to let the staff take her back to her room. She explained they took the resident back to her room and placed her on one to one observation. When her family arrived at the facility he signed the resident out AMA. Unit Manager #2 stated it was cold out that morning and the resident had on a t-shirt, she believed</p>	F 689			

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F 689	Continued From page 15 bedroom slippers and wasn ' t sure what type of pants. A phone interview was conducted on 12/19/17 at 5:50 pm with NA #2 who stated he was the NA for Resident #5 the morning she left the facility. He stated the resident had just returned from the hospital and this was the first time he had worked with her. NA #2 explained he came on shift at 11:00 pm and the resident was sitting on her bed with all kinds of personal items spread all over her bed and she just kept going through them. He added the resident was talking very loud and fast and seemed kind of incoherent. He stated he checked on her throughout the shift and tried to get her to lay down but she wouldn ' t and never slept during the night. NA #2 explained around 4:30 to 5:00 am he saw Resident #5 leave her room and she was walking very quickly; she had on a t-shirt, Capri pants and no shoes. He stated he didn ' t go after her right then because he thought she was just up based on her behavior during the night. NA #2 added another NA had notified Nurse #2 that she saw the resident running up the hallway to the front lobby. The Nurse and NA went up to the front to check on her and found the resident ' s wheelchair outside on the front porch but didn ' t see the resident. He stated he went outside to help look for the resident and she was up in the woods and they eventually convinced her to come out but she would only come out on the street. She had a stick and was waving it at them and yelling that the nurse had given her the wrong medicines and she needed to talk to her family. NA #2 described her location at being about halfway between the facility and the commercial business up the street. He stated the police came and they eventually were able to get her to come back in	F 689			

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F 689	<p>Continued From page 16</p> <p>the building. NA#2 added the resident ' s family came to the facility and he never saw the resident again.</p> <p>A phone interview was conducted on 12/20/17 at 9:06 am with NA #3 who stated she was working on third shift (11:00 pm to 7:00 am) the evening Resident #5 left the facility. She explained she saw the resident running toward the front of the building pushing her wheelchair. She added she didn ' t know the resident but it startled her because of the time of the night and you typically don ' t see residents moving that fast. NA #3 stated she reported it to the med aide who was her supervisor that evening and she told her to let the resident ' s nurse know. She added when she notified Nurse #2 she took her with her to the front lobby door and the resident was gone. She stated it was very cold outside and she went and grabbed a jacket and took the wheelchair off of the front porch and started pushing it up the street to look for the resident. NA #3 stated the first time she saw the resident she was half way between the facility and a commercial business on the street. She added the resident was only dressed in shorts, a t-shirt with no socks or shoes. The resident was yelling and had a stick she was shaking at the staff. She explained the resident would not come back in the building with them but the police arrived and they eventually convinced the resident to sit in her wheelchair and she allowed them to push her back to the building.</p> <p>An observation was made on 12/20/17 from 9:15 am to 9:25 am of the route Resident #5 took the morning of 12/8/17. Upon exiting the front door of the facility there was a covered cement porch that led to a paved parking lot. Approximately 130</p>	F 689			

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F 689	<p>Continued From page 17</p> <p>feet to front right of the front porch was a wooded area. This included a curb and slightly elevated grassy area to walk into the woods. The street the facility was located on was an unmarked, paved two-lane street. It was approximately 520 feet from the facility to the commercial building that the resident was located per the 911 report.</p> <p>A review of the weather for 12/8/17 revealed the average temperature was 37 degrees F and the precipitation was 0.75 inches on that date.</p> <p>On 12/20/17 phone messages were left at 2:00 pm, 3:50 pm, 4:30 pm and 5:23 pm for the receptionist that was working the morning Resident #5 left the facility. The receptionist no longer worked at the facility and did not return any of the calls.</p> <p>An interview was conducted on 12/20/17 at 5:50 pm with the Administrator and DON. The Administrator stated the receptionist that was working on 12/8/17 had initially told her Resident #5 had run out the front door in front of the funeral home attendants and she could see the resident the entire time. The Administrator explained during the investigation of the incident she determined that could not have been true because interviews with Nurse #2 and NA #3 stated the funeral home attendants left after Resident #5 left the building. She stated during a follow-up interview with the receptionist she admitted that her first story wasn't what happened. The receptionist told the Administrator she had unlocked the front door to "get ahead" so the funeral home attendants could get out and Resident #5 went out the front door pushing her wheelchair prior to the funeral home attendants getting to the door. The receptionist saw the</p>	F 689			

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F 689	<p>Continued From page 18</p> <p>resident go out the front door but did not go out to check on her. The Administrator stated the receptionist was terminated for not following the protocol she was trained on when a resident attempted to leave the building and for lying. The DON stated during the investigation of the incident the following time line of events was determined:</p> <p>12/8/17 at 5:36 am - Resident #5 went out the front door 12/8/17 at 5:38 am - Nurse #2 and NA #3 arrived at the front lobby 12/8/17 at 5:40 am - Receptionist called code orange 12/8/17 at 5:41 am - Nurse #2 spotted Resident #5 in the woods 12/8/17 at 5:44 am - Receptionist called 911 12/8/17 at 5:48 am - Police arrived 12/8/17 at 6:30 am - Police convinced resident to come back in the building</p> <p>A review of the 911 communication event information identified a call to 911 on 12/8/17 at 5:43 am requesting transport for a patient. Officer dispatched at 5:46 am and arrived at 5:52 am. Additional officer dispatched at 5:48 am and arrived at 5:57 am. The notes revealed at 5:47 am the subject was holding a stick, not waving it, could hear the subject yelling at the staff in the background, subject was in front of the commercial building on street of the facility. At 5:48 am no one injured at this time. At 5:52 am first officer arrived and patient was sitting on the sidewalk and seemed to be calming down a little. At 5:50 am patient refused to go back in the building. At 6:21 am resident returned to the building.</p>	F 689			

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F 689	<p>Continued From page 19</p> <p>An interview with the Administrator on 12/20/17 at 6:20 pm revealed the facility had put a plan of correction in place following both incidents.</p> <p>The facility provided a plan of correction for the incident that happened on 7/1/17. The facility corrected the deficient practice on 7/3/17. The corrective action was as follows:</p> <p>1. Processes that lead to the alleged deficiency cited:</p> <p>Resident #4 exited the facility on 7/1/2017 between 5:00PM - 5:30PM by following another person; resident was observed by Greensboro Police Department (GPD) officer on Kerry road at 5:49PM, about 3000 feet from the facility. Greensboro Policy officer, contacted Greensboro EMS. Resident #4 was transported to the hospital via Greensboro Emergency Medical Services (EMS) at 5:49PM. Per GPD officer resident was able to state his name, but was unable to say where he resides. GPD officer shared those information with the facility Director of Nursing by phone on 7/3/3017, officer added that, while at hospital emergency department, staff at the hospital was able to locate resident #4's demographic information using his name that he provided. The information ware located in the hospital electronic records, as resident had previously being in that Hospital. Hospital staff contacted a family member listed on resident's hospital record who confirmed resident #4's identity after arriving at the Emergency room. Resident #4 assessed at the Emergency Room (ER) and was transported back to the facility by his family via a personal vehicle. The resident was unharmed as evidenced by completed clinical assessment completed upon return to the</p>	F 689			

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F 689	<p>Continued From page 20</p> <p>facility completed by the Registered Nurse that indicated no injuries. Resident was not admitted for observation or consulted in the ER. No ER report on file.</p> <p>Resident #4 exited the facility following another person through the facility main entrance door. This is concluded based on resident's cognitive and physical in-ability to open the front door alone (BIMS score 6). Front door was locked by the receptionist approximately 15 minutes before the last time resident was observed in the facility and was still locked at the time resident was reported being observed at Kerry Drive.</p> <p>Resident #4 transported back to the facility safely, accompanied by his family, upon his return licensed nurse #1 obtained vital signs for this resident, vital signs noted to be within limits. Head to toe skin assessment completed by Registered Nurse, no injuries noted. The intervention implemented for resident #4 included every 15 minutes check, and monitoring the front door using human shield around the clock 24hours daily. Staff on duty was alerted by licensed nurse #1 via overhead code "orange "announcement that resident #4 had exited the facility, the attending physician, who is also the facility Medical Director, notified on 7/1/2017 at 11:30PM and Responsible Party were also notified on 7/1/2017 at 6:10PM . At present, resident #4 has been transferred to a private room number 217. The procedures for implementing the acceptable credible allegation for the specific alleged deficiency:</p> <p>100% of Elopement risk assessments for all current residents completed on 07/01/2017 and 7/02/2017, by the Director of Nursing, Assistant Director of Nursing, Quality Assurance nurse and Licensed nurse #1 to identify any other residents</p>	F 689			

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F 689	<p>Continued From page 21</p> <p>who might be at risk for exit seeking behaviors. Four other residents were identified to be at risk for elopement. "Elopement books" established and placed at the front desk, and at each nurse's station. These books contain a list of residents with exit seeking behaviors, their pictures and resident's descriptions. These "Elopement" books were reviewed by Corporate Quality Assurance Consultant on 7/02/2017 to validate all noted residents who are at risk are included. The Elopement books are located in a place accessible to all staff for easy identification of elopement risk residents (at the front desk, and at each nurse's station). Director of Nursing and/or Staff Development Coordinator initiated re-education to all current staff on how to identify residents who are at risk for elopement on 7/01/2017, this education was completed on 07/03/17. Any staff not educated by 07/03/2017 were not be allowed to work until educated. Signed education sheets is located in Staff education binder located in the Director of Nursing office.</p> <p>All exit doors were checked for proper closure and locking by Maintenance Director on 07/01/2017 and 07/02/2017. All doors are functioning properly. Maintenance Director also changed codes for all exit doors on 7/2/2017. Six of eight exit doors, had codes changed to an anonymous code, only known to the Administrator, Director of Nursing and Maintenance Director.</p> <p>100% of all resident's minimum Data set (MDS 3.0) audited on 7/2/2017 by Regional MDS Consultant #1 to validate all residents elopement risk behaviors were coded appropriately on (Section E) per RAI guidelines. This audit</p>	F 689			

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F 689	<p>Continued From page 22</p> <p>revealed 5 of 5 resident at risk for elopement were accurately coded in MDS section E, per RAI guidelines.</p> <p>100% of all resident's Care Area Assessments for the most recent comprehensive MDS assessment was audited on 7/3/2017 by Regional MDS Consultant #1 and MDS Consultant #2 to validate all coded elopement risk behaviors are assessed in details and Plan of Care developed by RAI guidelines. This audit revealed 5 of 5 resident at risk for elopement was accurately coded in MDS assessment per, RAI guidelines.</p> <p>100% of all exterior wall windows were audited by corporate plant operation consultant, Maintenance Director and/or Assistant maintenance director on 7/3/2017 to validate all windows are secured properly. Findings of this audit is documented on facility floor pan titled "exterior windows audit located in the facility "compliance binder" All identified windows are now secured to open up to 8 inches. The monitoring procedures to ensure that the credible allegation is effective and the specific deficiency remains corrected and / or in compliance:</p> <p>Effective 7/2/2017, and moving forward, licensed nurses will complete elopement risk assessments for all residents on admission/re-admission, quarterly, with any significant changes of resident's condition, and/or whenever a resident is noted to exhibit exit seeking behaviors/attempts. Any noted concerns will be addressed and corrected by licensed nurses immediately; interventions will be implemented and resident's care plan will be revised and updated immediately by licensed nurses. Direct</p>	F 689			

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F 689	<p>Continued From page 23</p> <p>care staff will be notified of new interventions put forth by a licensed nurse through resident's care cards which are located on each nurse's station immediately after new intervention is put in place.</p> <p>Effective 7/2/2017, the center assigned an employee will monitor the front door, 24 hours a day, 7 days a week. This employee is responsible to validate any resident at risk for elopement will not leave the building unattended. Residents at risk for elopement will be identified using elopement binder located at the front desk and at each nurse's station.</p> <p>Effective 7/2/2017, the center interdisciplinary team, which includes DON, ADON, SDC, Quality Assurance nurse, Social worker #1, Social worker #2, Activity Coordinator #1, Activity Coordinator #2, initiated a process for reviewing all new admission/re-admissions Monday through Friday and will address the findings in a timely manner. This team will review new admits for any prior history of aggressive behaviors, elopement, physical aggression and/or attempts to harm self or others. Any identified issues will be addressed promptly and plan of care developed as appropriately.</p> <p>Effective 7/2/2017, week end RN supervisor and/or designated licensed nurse will review all new admission/re-admissions every Saturday & Sunday and will address the findings immediately. The week end staff will review new admits for any prior history of aggressive behaviors, elopement, and physical aggression and/or attempts to harm self or others. Any identified issues will be addressed immediately and plan of care developed as appropriately.</p>	F 689			

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F 689	<p>Continued From page 24</p> <p>The Director of Nursing will review and sign for accuracy, elopement books daily (Monday through Friday) and week end RN supervisor on Saturday and Sundays, the Administrator will review and sign weekly for the previous week for next 6 months. Any negative findings will be addressed immediately and reported to the monthly QAPI committee meeting by the Director of Nursing.</p> <p>Elopement Books, which contain pictures and detailed descriptions of all residents listed as elopement risks, have been placed at every unit and at the front desk on 7/01/2017. Nurse Managers or designated staff will review and update binders with changes as they are identified for elopement risk assessments. Elopement books are in a location accessible to all staff for easy identification of elopement risk residents. Staff Development Coordinator initiated re-education to all current staff of how to identify residents who are at risk for elopement (elopement book) on 7/01/2017, any staff not educated by 7/3/17 will not be allowed to work until educated.</p> <p>Effective 7/2/2017, the center assigned an employee will monitor the front door, 24 hours a day, 7 days a week. This employee is responsible to validate any resident at risk for elopement will not leave the building unattended. This will continue until the wander control system is installed on all means of egress, and verified to work consistently for at least seven days without any negative findings through daily test.</p> <p>On 7/03/2017, an authorized licensed vendor was contacted by Corporate Plant Operation Consultant to obtain proposals for installation of</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>the door security system and Annunciators for each nurse's at nurse station to validate staff are able to hear door alarms when activated while at any nurse's station</p> <p>Effective 7/01/2017 Maintenance Director, or designated staff will check and log the proper closure and locking of all exit doors daily on "exit doors function check form". This form will be kept in "Elopement book". Any noted concerns will be addressed and corrected immediately. Administrator will review and sign findings in these forms weekly for 8 weeks to validate compliance. Any negative findings will be forwarded to Monthly QAPI committee for review and recommendation.</p> <p>The facility provided a plan of correction for the incident that happened on 12/8/17. The facility corrected the deficient practice on 12/9/17. The corrective action was as follows:</p> <p>2. Processes that lead to the alleged deficiency cited:</p> <p>Resident #5 exited the facility on 12/08/2017 at approximately 5:36 AM: resident #5 was observed by the front desk receptionist #1, pushing her wheelchair and running through the lobby and out the front lobby doors of the facility. The receptionist #1 stated she unlocked the front doors to let the funeral home employee exit the facility when resident #5 ran passed the funeral home employee and exited the facility through the front lobby doors. Resident #5 was assessed on 11/25/2017 and 12/7/2017 and on both occasion resident was deemed not to be at risk for elopement. The facility is in the process of installing the wander control system, the</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>installation is planned to start on 12/26/2017 by a licensed vendor.</p> <p>The receptionist #1 stated she attempted to relock the front door but the resident exited the front lobby doors before she could do this. At approximately 5:38AM Nurse # 1, who was notified by CNA # 1, that resident #5 was headed toward the front of the facility. Nurse # 1 and CNA # 1 proceeded to the front lobby. Nurse # 1 observed a wheelchair at the entrance to the front lobby doors. Nurse # 1 asked the receptionist #1 where resident # 5 was and the receptionist #1 responded that resident # 5 ran out the front lobby doors. Nurse # 1 instructed the receptionist #1 to call a code orange (resident exited the building). At 5:40 AM the receptionist #1 overhead paged code orange. Nurse # 1 and CNA #2 exited the front lobby doors. At 5:41 AM Nurse # 1 observed resident # 5 across the side walk next to the tree line. Nurse # 1 remained with resident # 5. At 5:42 AM Nurse # 1 contacted the Director of Health Services and was instructed to call 911. At 5:44 AM Nurse # 1 contacted 911 and requested assistance with resident # 5. Elopement risk assessment book is located at the each nurse's station and at the front desk. Reception staff will utilize the book at the front desk to identify residents who is at risk for elopement.</p> <p>At 5:48 AM Greensboro 911 officers arrived to assist as resident wanted to remain outside the facility at that time. Resident # 5 stated she wanted to call her family and go home. At 6:30 AM Greensboro Officers (#1 and #2), Nurse # 1 and Nurse #2 accompanied resident # 5 into the facility. Resident # 5 refused a head to toe skin assessment when offered and attempted by nurse #1, no visible skin alteration observed. Resident #5 was placed on 1 on 1 observation</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>until her family arrived approximately 7:00AM. The MD was notified at 6:30 AM. Resident # 5 left the facility with her family at 7:15 AM for a leave of absence.</p> <p>Although resident # 5 exited the facility, the resident was alert with mild confusion BIMS score of 15 and chose to exit the facility with the intention of contacting her family. As of 12/08/2017 the facility has determined that all current facility processes associated with the facilities policy on elopement are currently effective. The receptionist has the responsibility of remotely locking and unlocking the front lobby doors via switch at the reception desk during the hours of 8:00 PM until 8:00 AM. Per interview of staff, including receptionist #1, the receptionist #1 unlocked front lobby door for funeral home staff, creating an opportunity for the resident to exit the facility. Receptionist #1 employment relationship with the facility was ended on 12/11/2017 following this event.</p> <p>The procedures for implementing the acceptable credible allegation for the specific alleged deficiency:</p> <p>100 % of Elopement risk assessments for current residents were completed on 12/08/2017 by the Director of Health Services/Quality Assurance Nurse/Licensed nurses on duty to identify any other residents who may be at risk for exit seeking behaviors. No new residents were identified to be at risk for elopement. Elopement Books, containing pictures and resident description, remain at the front lobby desk and at each nurse's station. The Elopement books were reviewed by the Quality Assurance Nurse on 12/08/2017 to ensure that all residents that have been identified as an Elopement Risk were included.</p>	F 689			

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F 689	<p>Continued From page 28</p> <p>Director of Health Services/Quality Assurance Nurse/Staff Development Coordinator initiated re-in servicing to all current staff on the facility elopement policy, location and use of elopement books, the reception area, locking lobby doors and facility entrances on 12/08/2017. Any staff not educated by 12/08/2017 will not be able to return to work until the education is completed. This education will also be added on new hires orientation process for all new employees effective 12/08/2017.</p> <p>Director of Health Services/Quality Assurance Nurse/Staff Development Coordinator initiated re-in servicing to all current receptionists on the responsibilities of locking and unlocking the front lobby doors, and how to identify residents who are at risk for elopement using the elopement book located at the front desk on 12/08/2017. Any reception staff not educated by 12/08/2017 will not be able to return to work until the education is completed. This education will also be added on new hires orientation process for all new receptionist effective 12/08/2017.</p> <p>The Director of Maintenance/Designee checked all facility exit doors to ensure the properly closing and locking on 12/08/2017.</p> <p>The monitoring procedures to ensure that the credible allegation is effective and the specific deficiency remains corrected and / or in compliance:</p> <p>Effective 12/8/2017, between the hours of 5:00 PM and 8:30 AM the front door is locked, the front door will not be unlocked prior to the person's exiting the facility reaches the front door, the facility receptionist is responsible to ensure the door remained locked. Effective 12/08/2017, The Director of Health Services/Assistant Director of</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>Health Services /Quality Assurance Nurse/Staff Development Coordinator/Designee will monitor compliance of locking and unlocking the front lobby doors during the hours of 5:00PM and 8:30AM by conducting a random audit of observing the receptionist (Monday - Friday). Any issues identified during this monitoring process will be addressed promptly. Findings from this monitoring will be documented on the audit tool and will be filed in a binder in the Director of Health Services.</p> <p>The Director of Health Services will review the completion of the audit tool, daily, Monday to Friday for 2 weeks, weekly for 2 more weeks then monthly for 3 months or until a pattern of compliance is maintained.</p> <p>Effective 12/08/2017 the Director of Health Services will report findings on this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for 3 months or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.</p> <p>The name of the person responsible for implementing the plan of correction: Effective 12/08/2017, the center Executive Director and the Director of Health services will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.</p> <p>The corrective action plan was verified on 12/21/17 at 6:30 pm. Elopement Risk Assessments were completed on all residents present in the facility on 7/1/17, 7/2/17 and 12/8/17. Elopement books were observed to be at each nursing station and the front desk and included a picture and description of the residents</p>	F 689			

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F 689	Continued From page 30 currently identified at risk for elopement. The staff in-services conducted 7/1/17 through 7/3/17 and 12/8/17 were reviewed and included: the facility policy on elopement, the elopement books and their locations, the receptionist desk will be staffed 24 hours a day and should never be left unattended, there will be a sign-in / sign-out sheet for the receptionists to complete when they leave the area. The front door will be locked from 8:00 pm to 8:00 am and the back entrance door was for employees only and employees should not give to code out to anyone. The attendance records confirmed that all staff had been in-serviced. Random staff interviews were conducted on 12/21/17 from 4:30 pm through 6:15 pm and all staff members were able to describe the topics covered during the in-service on elopement. The daily door audits to check that the mag locks were working properly implemented 7/2/17 were reviewed and complete. The MDS and Care Area Assessment audits completed on 7/2/17 and 7/3/17 were reviewed and confirmed completion. The monitoring tools implemented by the facility of random audits that the front door was locked, completion of elopement risk assessments, validation that the elopement books were current and monitoring of exit door function were reviewed and complete.	F 689			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F 759		1/15/18	

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F 759	<p>Continued From page 31</p> <p>Based on observation, record review and staff interview the facility's medication error rate was greater than 5% as evidenced by 4 medication errors out of 29 opportunities. 1 of 4 Residents (Resident #10) reviewed had medication errors during the observation of the medication pass. The Medication error rate was 13.7 percent.</p> <p>Review of medical record for Resident #10 revealed she was admitted 11/2/13 with diagnoses of Dementia, Diabetes, Heart Failure, Atrial Fibrillation, and Hypertension.</p> <p>Review of Medication Administration Record for Resident #10 revealed the following medications and administration times:</p> <ul style="list-style-type: none"> " Oxycontin 10 mg tablet twice daily (8:00 am and 8:00 pm) for pain; " Metoprolol Extended Release 25 mg twice daily (9:00 am and 5:00 pm) for hypertension; " Furosemide 40 mg tablet daily (9:00 am) for edema; " Cholecalcefol 1000 unit tablets take 2 tablets daily (9:00 am) for vitamin D deficiency; " Aspirin 325 mg one tablet once daily (9:00 am) atrial fibrillation; Digoxin 125 mcg one tablet once daily (9:00 am) for atrial fibrillation; " Miralax Powder 17gm daily (9:00 am) for constipation; " Levemir 100 units/ml 160 units subcutaneously daily (7:30 am) in am for diabetes; " Potassium Chloride Extended Release 20 meq tablet one tablet daily (9:00 am) for supplement; " Refresh Liquidgel 1% eye drops one drop in both eyes four times a day for dry eyes (8:00 am); " Humulog 10 units daily with meals for 	F 759	<p>ROOT CAUSE</p> <p>Plan of correction the specific deficiency. Process that lead to the deficiency cited. Nurse #4 was scheduled to work 7am until 3pm on 12/20/17. Nurse #4 did not report to work until 8:15 am at which time she started her 8am medication pass. Nurse #4 did not report to nursing management that she was late in administering medications on 12/20/17. Nurse #4 was asked per unit coordinator #1 on several occasions x3 did she need any assistance with anything. Nurse #3 stated she was okay. Nurse #4 was educated and counseled by Director of Nursing on: reporting to work on time, adhering to facility policy on medication administration guidelines when administering medication, and reporting late medication administration immediately to Unit Coordinator. This education was completed on 12/20/17.</p> <p>IMMEDIATE ACTION</p> <p>Facility Physician Assistant (PA) was notified of late administration of medications for patient #10, on 12/20/17 by Director of Nursing, and orders received for further direction in administering the late medications to hold medications and administer at a later time or to proceed with administration.</p> <p>IDENTIFICATION OF OTHERS</p> <p>All residents have the potential to be affected by this same deficient practice. 100% audit of all current resident with medication orders completed on 12/20/2017 by Director of Nursing, Assistant Director of Nursing, and Licensed nurse #1, #2, to identify any</p>		

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F 759	<p>Continued From page 32 diabetes.</p> <p>During observation of a medication pass with Nurse #4 on 12/20/17 at 11:55 am the nurse was observed giving medications for Resident #10 that were scheduled for 8:00 am and 9:00 am at 11:55 am. When asked about the discrepancy in the administration time Nurse #4 stated she had a lot going on this morning and had not been able to get her medications passed on time. She also stated she had not reported the late administration of Resident #10's medications to her Supervisor. Four of the twelve medications Nurse#4 administered were ordered more than once daily:</p> <p>Oxycodone Extended Release 10 mg was ordered twice daily for pain; Hydralazine 25 mg was ordered three times a day for hypertension; Cholecalciferol 100 units was ordered two tablets twice daily for vitamin D supplement; and Metoprolol Extended Release was ordered twice daily for hypertension.</p> <p>The Director of Nursing notified Resident #10's physician and orders were received for the following on 12/20/17: "Hold scheduled Metoprolol Extended Release 25 mg tablet 5:00 pm dose and administer at 8:00 pm. Hold scheduled Hydralazine 25 mg tablet 5:00 pm dose and administer today at 8:00 pm. Check blood sugar at 7:30 pm today and notify on call provider of blood sugar prior to scheduled dose at 8:00 pm Insulin Detemir (Levermir) 100 units/ml inject 35 units subcutaneously daily at bedtime for further administration instructions proceed with administration of Insulin Lispro (Humalog) 100 units/ml give 10 units daily subcutaneously with meals at 11:30 am if blood sugar is greater than 100."</p>	F 759	<p>other resident with medication that was administered out of window of opportunity on the last 24 hours from 12/20/17. 100% audit of all current resident's Medication Administration records (Emar) completed on 12/20/2017 by Director of Nursing to determine any non-compliance of medication administration, to include timeliness of medication administration per physician orders . 5 other residents with non-compliance issues noted at that time and MD/PA notified.</p> <p>Procedure for implementing the acceptable plan of correction for specific deficiency cited: Effective 1/15/2017, and moving forward, If a Licensed nurse delayed to document in Electronic Medication Administration Record (eMAR) immediately after medication administered within 60 minutes of administration opportunity window, the Licensed nurses will document administration both on eMARs immediately after is able and will also add an addendum in residents nurses notes indicating the time of administration. In this event the physician will not be notified as the insulin administration took place within the 60 minutes window of administration opportunity and MD/PA notified of any time non-compliance. Effective 1/15/2018, and moving forward, all physician orders will be administered within 60 minutes of administration opportunity window. Licensed nurses will document administration time immediately after administration is done in Electronic Health Record. In the event that the administration will take place outside the</p>		

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F 759	Continued From page 33 Interview with the Director of Nursing on 12/21/17 at 4:43 pm revealed his expectation was that the medication error rate would be 0%. He stated his expectation was that medications would be administered according to the physician's orders and if there was a discrepancy the staff would notify the physician.	F 759	60 minutes window of administration opportunity, resident attending Physician will be notified immediately. Director of Nursing (DHS), Assistant Director of Nursing (ADHS) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education will be on the importance of administering medication as ordered by physician and in a timely manner. The education will also cover; the adjustment of medication times for improved time management when administering medications. Reporting to Nurse Management, any non-compliance with timely medication administration immediately for further guidance. Notification of MD, PA and RP of any time non-compliance of medication administration. This education will be completed by 1/15/2018. Any Licensed Nurse or Medication Aide not educated by 1/15/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 1/15/2018. MONITORING PROCESS Effective 1/15/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with timely, and accurate medication administration by reviewing administration records from previous day to ensure timely administration and documentation as ordered by physician.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/21/2017
NAME OF PROVIDER OR SUPPLIER BLUMENTHAL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3724 WIRELESS DRIVE GREENSBORO, NC 27455		
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F 759	Continued From page 34	F 759	<p>This audit will be completed daily Monday through Friday and ensure that appropriate actions are taken in an instance that ordered medication is administered in deviation of the physician orders. Findings from this monitoring process will be documented on a Medication administration report tool and filed in the facility compliance binder. This monitoring process will take place daily Monday through Friday for 2 weeks, then 3x/week for two more weeks, then weekly for 2 weeks then monthly afterwards. Effective 1/15/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.</p> <p>Title of person responsible for implementing the acceptable plan of correction: Effective 1/15/2018, the center Executive Director and the Director of Nursing will be ultimately responsible for implementation of this plan of correction for the alleged noncompliance to ensure the facility attain and maintain substantial compliance.</p> <p>Compliance date: 1/15/18</p>		

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F 760 F 760 SS=D	Continued From page 35 Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide 1 of 3 Residents, Resident #2's, medications timely resulting in the resident's insulin being given 1 hour and 57 minutes after the prescribed dose was scheduled, resulting in a reading of "HI" on the blood sugar scale. Review of Resident #2's medical record revealed she was readmitted to the facility on 12/6/17 with diagnoses of Diabetes, Weakness, Heart Failure, and Hyperlipidemia. Review of Resident #2's Medication Administration Record (MAR) for December 2017 revealed she did not receive a 5:00 pm dose of Insulin Aspart 100 units/ml as ordered at 5:00 pm on 12/9/17. The dose was given at 7:57 pm per the administration time on the MAR for December 2017. Review of Resident #2's Care Plan dated 12/6/17 revealed she was at risk of hypoglycemia and hyperglycemia (low and high blood sugars) and insulin should be administered as ordered. Review of the Blumenthal Daily Blood Glucose Report for 12/9/17 revealed the following blood sugar results: at 6:30 am the blood sugar was recorded as 98; at 11:30 am the blood sugar was recorded as 100; at 4:30 pm the blood sugar was recorded as 252; and at bedtime the blood sugar	F 760 F 760	Plan of correction for specific deficiency. Process that lead to the deficiency cited. This alleged noncompliance was resulted from the facilities medication administration staff not administering 5pm Insulin within 60 minutes of administration window of opportunity, and the assigned medication aide did not utilize licensed staff to assist with this administration. IMMEDIATE ACTION The nurse reporting to duty at 7pm administered scheduled insulin on 12/20/17 and notified the resident's attending Physician, orders received to administer additional insulin and recheck blood sugar in one hour. IDENTIFICATION OF OTHERS 100% audit of all current resident with insulin orders completed on 12/20/2017 by Director of Nursing, Assistant Director of Nursing and/or Unit coordinators #1, & #2 to identify any other resident with the documented times of administration beyond the 60 minutes window in the last 24 hours of 12/20/2017, and verified whether Physician was notified or not. The audit revealed 4 other residents identified with insulin orders with documented times of administration beyond 60 minutes,	1/15/18	

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F 760	<p>Continued From page 36 was recorded as "HI".</p> <p>Review of the Blumenthal Daily Blood Glucose Report for 12/10/17 revealed the following blood sugar results: at 6:30 am the blood sugar was recorded at 370 and at 11:30 am the blood sugar was recoded as 300.</p> <p>Review of Nurses' Note dated 12/9/17 at 7:57 pm revealed Nurse #1 was told by Medication Aide #1 the blood sugar reading for Resident #2 was reading "HI" and she was vomiting. Nurse #1 gave scheduled insulin and called the physician. Nurse #1 received orders from the physician to give extra insulin and recheck Resident #2's blood sugar in one hour.</p> <p>Phone interview on 12/19/17 at 6:15 pm with Nurse #1 revealed she had come into work on 12/9/17 at 7:00 pm and Medication Aide #1 asked her to look at Resident #2 because she "wasn't acting right". Nurse #1 stated she realized Resident #2 was exhibiting signs of hyperglycemia and stated she was nauseous and confused. Nurse #1 stated she checked Resident #2's blood sugar level and it read too high to count by the machine. She stated she called the physician and received an order give Resident #2 extra insulin.</p> <p>Interview with Medication Aide #1 on 12/20/17 at 8:54 am revealed she had worked 7:00 am to 7:00 pm on 12/9/17. Medication Aide #1 stated she had not been able to find a nurse to administer Resident #2's insulin on 12/9/17 at 5:00 pm as it was ordered.</p> <p>Interview with the Director of Nursing on 12/21/17 at 4:43 pm revealed his expectation medications</p>	F 760	<p>attending physician for each resident notified on 12/20/17 by the Director of Nursing. No new orders received from this notification.</p> <p>Procedure for implementing the acceptable plan of correction for specific deficiency cited:</p> <p>Effective 12/20/17 and moving forward, all insulin orders will be administered within 60 minutes of administration window. Medication aides will notify unit coordinator, or assigned supervisor of blood sugar results requiring insulin coverage immediately but not later than 60 minutes from the schedule blood sugar scheduled time.</p> <p>Director of Nursing (DHS), Assistant Director of Nursing (ADHS) and/or Staff Development Coordinator (SDC) will complete 100% education for all licensed nurses and Medication aides, to include full time, part time and as needed staff. The emphasis of this education will be on the importance of administering medication as ordered by physician and in a timely manner for any medication specifically insulin. Also medication aides educated on notification of blood sugars requiring insulin coverage immediately to unit coordinators or assigned supervisor. This education will be completed by 1/15/2018. Any Licensed Nurse or Medication Aide not educated by 1/15/2018 will not be allowed to work until educated. This education will also be added on new hires orientation process for all new licensed nurses and Medication Aides effective 1/15/2018.</p>		

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F 760	Continued From page 37 would be administered according to the physician's orders and if there was a discrepancy staff would notify the physician immediately. The Director of Nursing also stated the Medication Technicians would utilize the nurse assigned to them and follow facility protocols if the assigned nurse was unavailable.	F 760	Monitoring procedure to ensure plan of correction is effective and the specific deficiency cited remains corrected and/or in compliance with regulatory compliance: Effective 1/15/2018, Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator, will monitor compliance with timely, and accurate insulin administration by reviewing insulin administration records from previous day to ensure timely administration and documentation as ordered by physician. This audit will be completed daily Monday through Friday and ensure that appropriate actions are taken in an instance that ordered insulin is administered in deviation of the physician orders. Findings from this monitoring process will be documented on the insulin administration monitoring tool and filed in the facility compliance binder. This monitoring process will take place daily Monday through Friday for 2 weeks, then 3x/week for two more weeks, then weekly for 2 weeks then monthly afterwards. Effective 1/15/2018, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Title of person responsible for implementing the acceptable plan of correction:		

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F 760	Continued From page 38	F 760	Effective 1/15/2018, the center Executive Director and the Director of Nursing will be ultimately responsible for implementation of this plan of correction for the alleged noncompliance to ensure the facility attain and maintain substantial compliance. Compliance date: 1/15/18		