STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

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THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 7/18/18 to 7/20/18. Past noncompliance was identified at: 483.25 at F689 at scope and severity (J). Tag F689 constituted a substandard quality of care. A partial extended survey was conducted.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) Assessment to reflect the use of a wander/elopement alarm for 2 of 3 residents reviewed for supervision to prevent accidents (Resident #1, Resident #2). The findings included: 1. Resident #1 was admitted to the facility on 6/12/18 and had a diagnosis of Alzheimer ' s dementia. The Admission Nursing Assessment dated 6/12/18 revealed the resident was an elopement risk. The Care Plan for Resident #1 dated 6/12/18	F 641	F 641 Accuracy of Assessments Corrective Action MDS Coordinator corrected Resident #1□'s and Resident #2□'s Minimum Data Set (MDS) Assessments to accurately reflect the use of a wander/elopement alarm on 7/19/2018. Corrective Action for those having the potential to be affected MDS Coordinator reviewed all other current residents with wander/elopement alarms ordered. Corrections were made as errors were noted. All corrections were made on 7/19/2018.	7/27/18

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

Electronically Signed | 08/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 1 noted the resident had the potential for exit seeking behavior related to impaired cognition. The interventions were as follows: Ensure wander alarm bracelet is on each shift and functioning daily. Observe whereabouts frequently. Redirect away from exit doors as needed. Redirect to activities as able. The Admission Minimum Data Set Assessment (MDS) dated 6/18/18 revealed the resident had moderate cognitive impairment. The MDS revealed that the resident was not steady during transitions in walking but was able to stabilize without staff assistance and had no impairment in range of motion of the upper or lower extremities. Under Section P0200 it was noted a wander/elopement alarm was not used. On 7/19/18 at 8:30 AM an interview was conducted with the MDS Nurse and the Director of Nursing (DON). The DON stated a wander alarm bracelet was put on the resident on the day of admission (6/12/18). The MDS Nurse stated she was trained by the corporate MDS nurse that only alarms that were restraints were to be coded on the MDS in section P0200. On 7/19/18 at 4:11 PM a separate interview was conducted with the MDS Nurse. The MDS Nurse stated she called the corporate MDS nurse who read the RAI (Resident Assessment Instrument) Manual. The MDS Nurse stated she had already begun to correct the MDS for all residents in the building with a wander/elopement alarm. On 7/20/18 at 1:28 PM the Administrator stated in an interview he expected the MDS Assessments to be accurate.	F 641	Systematic Changes Laurel Health Care Company□s Regional Clinical Resource Specialist (RCRS) will re-educate MDS Coordinator, Director of Nursing (DON), and Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC) on proper coding of wander/elopement alarms. This in-service was completed on 7/19/2018 (Documentation of in-service is attached). Clinical interdisciplinary team, led by DON will review all physician orders 5 times per week in order to identify any guests with new orders for wander/elopement alarms. DON and MDS Coordinator will initiate MDS Assessments in accordance with MDS schedules to ensure accurate coding of wander/elopement alarm. Monitoring DON, ADON/SDC, and/or RCRS will utilize a Quality Assurance Monitoring tool to review all residents with wander/elopement alarms□ MDS Assessments weekly x 4 weeks. For ongoing compliance, DON, ADON/SDC, and/or RCRS will utilize a Quality Assurance Monitoring tool to review 10 residents with wander/elopement alarms□ MDS Assessments monthly x 4 months to ensure wander/elopement alarms are accurately coded on MDS Assessments and will immediately notify Administrator and MDS Coordinator of any errors. Continued compliance will be monitored through the facility□s Quality Assurance	

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F 641	Continued From page 2 2. Resident #2 was admitted to the facility on 5/22/17 and had a diagnosis of cerebrovascular accident (stroke) with left sided weakness. Review of the physician ' s orders revealed an order for a wander alarm bracelet dated 12/17/17. The Care Plan for Resident #2 most recently revised on 5/20/18, noted the resident had exit seeking behavior related to impaired cognition. The approach was to check placement of the wander alarm bracelet each shift, check functioning of the wander alarm daily and observe whereabouts frequently. The most recent Minimum Data Set (MDS) Assessment dated 7/9/18 revealed the resident was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS noted the resident had impairment of the upper and lower extremity on one side. According to Section P0200 a wander/elopement alarm was not used. On 7/18/18 at 10:45 AM, Resident #2 was observed to sitting in her electric wheelchair in the lobby. A wander alarm bracelet was observed on the resident ' s left ankle. On 7/18/18 at 11:34 AM the Administrator stated in an interview that some time ago the resident ' s family expressed concern about the resident going in and out of the facility in her wheelchair. The Administrator further stated the physician evaluated the resident and the resident answered inappropriately to some questions and it was recommended by the physician the resident not leave the facility alone. The Administrator stated a	F 641	and Process Improvement Plan and Quality Assurance Program for 4 months. Additional education and monitoring will be initiated for any noted issues or concerns. Date of Completion and Person Responsible for Implementation Compliance is alleged on or before 7/27/2018. The Administrator is ultimately responsible for implementation of this plan.	

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THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

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F 641	Continued From page 3 wander alarm bracelet was put on the resident at that time. On 7/19/18 at 8:30 AM an interview was conducted with the MDS Nurse and the Director of Nursing (DON). The MDS Nurse stated she was trained by the corporate MDS nurse that only alarms that were restraints were to be coded on the MDS in section P0200. On 7/19/18 at 4:11 PM a separate interview was conducted with the MDS Nurse. The MDS Nurse stated she called the corporate MDS nurse who read the RAI (Resident Assessment Instrument) Manual. The MDS Nurse stated she had already begun to correct the MDS for all residents in the facility with a wander/elopement alarm. On 7/20/18 at 1:28 PM the Administrator stated in an interview he expected the MDS Assessments to be accurate.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		7/27/18

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F 657	Continued From page 4 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to include in the Care Plan the use of a wander/elopement alarm for a resident with intermittent confusion for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #3). The findings included: Resident #3 was admitted to the facility on 6/1/18 and had a diagnosis of generalized muscle weakness, falls and abnormalities of gait and mobility. Review of the Admission Minimum Data Set (MDS) Assessment dated 6/7/18 revealed the resident was cognitively intact and required extensive assistance with transfers and with most activities of daily living. It was noted that locomotion on the unit occurred only once or twice. Section P0200 of the MDS noted a wander/elopement alarm was not used for the resident.	F 657	F 657 Care Plan Timing and Revision Corrective Action Minimum Date Set (MDS) Coordinator added use of wander/elopement alarm to Resident #3□'s Care Plan on 7/19/2018. Corrective Action for those having the potential to be affected MDS Coordinator reviewed the Care Plans of all other current residents with wander/elopement alarms ordered. No other issues noted. Systematic Changes Laurel Health Care Company□'s Regional Clinical Resource Specialist (RCRS) will re-educate MDS Coordinator, Director of Nursing (DON), and Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC) on ensuring	

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	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

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F 657	Continued From page 5 There was a physician ' s order dated 7/3/18 to check wander alarm bracelet placement and function every shift. The resident ' s Care Plan did not contain information regarding a wander alarm bracelet. On 7/18/18 at 1:05 PM an interview was conducted with Nurse #4 who was assigned to Resident #3. The Nurse stated the resident would get up in her wheelchair and propel her wheelchair around the building. On 7/19/18 at 9:45 AM an interview was conducted with the Director of Nursing (DON) and the MDS Nurse. The MDS Nurse stated the initial care plan did not include the wander alarm bracelet because it was placed on the resident after the MDS was done and did not trigger a care area assessment. The MDS Nurse further stated the wander alarm bracelet was placed on 6/23/18 due to intermittent confusion and should have been care planned. The DON stated new orders were discussed in their morning meetings and any changes were added to the Care Plan during the meetings and this one got missed. On 7/20/18 at 1:28 PM the Administrator stated in an interview he would expect the wander alarm bracelet to be care planned.	F 657	wander/elopement alarms are included on Care Plans on for all residents with physician orders for wander/elopement alarms. This in-service was completed on 7/19/2018 (Documentation of in-service is attached). Clinical interdisciplinary team, led by DON will review all physician orders 5 times per week in order to identify any guests with new orders for wander/elopement alarms. DON and MDS Coordinator will review Care Plans to ensure inclusion of wander/elopement alarms. Monitoring DON, ADON/SDC, and/or RCRS will utilize a Quality Assurance Monitoring tool to review all residents with wander/elopement alarms Care Plans weekly x 4 weeks. For ongoing compliance, DON, ADON/SDC, and/or RCRS will utilize a Quality Assurance Monitoring tool to review 10 residents with wander/elopement alarms Care Plans monthly x 4 months to ensure wander/elopement alarms are accurately included on Care Plans and will immediately notify Administrator and MDS Coordinator of and errors. Continued compliance will be monitored through the facility's Quality Assurance and Process Improvement Plan and Quality Assurance Program for 4 months. Additional education and monitoring will be initiated for any noted issues or concerns. Date of Completion and Person Responsible for Implementation	

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F 657	Continued From page 6	F 657	Compliance is alleged on or before 7/27/2018. The Administrator is ultimately responsible for implementation of this plan.	
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 record review, staff and physician interviews and observations the facility failed to prevent a cognitively impaired resident from exiting the facility while unsupervised for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). This unsupervised exit from the facility resulted in Resident #1 falling and she was sent to the hospital for evaluation and treatment and was found to have sustained le forte fractures (facial fractures). The resident expired at the hospital. The findings included: Resident #1 was admitted to the facility on 6/12/18 and had a diagnosis of Alzheimer's dementia, chronic obstructive pulmonary disease (COPD) and acute on chronic respiratory failure and generalized muscle weakness.	F 689	Past noncompliance: no plan of correction required.	

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	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

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F 689	Continued From page 7	F 689		

The Nursing Admission Assessment dated 6/12/18 noted the resident was an elopement risk due to cognitive impairment, wandering behaviors and new admission.

The Care Plan for Resident #1 dated 6/12/18 revealed the resident was at risk for fall related injury related to impaired vision, unsteady gait, impaired mobility, psychotropic drug use, history of falls and recent episodes of dizziness. The interventions included the following: Observe for fatigue and/or unsteadiness and encourage rest periods. The Care Plan also noted exit seeking behavior related impaired cognition. The interventions included the following: Ensure wander alarm bracelet is on each shift and functioning daily. Observe whereabouts frequently. Redirect away from exit doors as needed. Redirect to activities as able.

The Admission Minimum Data Set (MDS) Assessment dated 6/18/18 revealed the resident had moderate cognitive impairment and walked in room or corridor only once or twice during the 7 day assessment period. The MDS revealed the resident's balance during transitions was not steady but was able to stabilize without staff assistance and had no impairment of the upper or lower extremities. The MDS noted the resident received occupational therapy for 7 days and physical therapy 6 days.

The resident's Care Area Assessment (CAA) dated 6/18/18 for Cognitive Loss/Dementia noted the following: "The resident had impaired cognition evidenced by a score of 12 (8-12 moderate cognitive impairment) on the BIMS (Brief Interview for Mental Status) due to a diagnosis of Alzheimer's dementia. Has COPD as

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	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

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F 689	Continued From page 8	F 689		

well as acute and chronic respiratory failure contributing to confusion. Has impaired decision making for daily activities. She is often disoriented in the nursing home environment and needs cues." The CAA for Falls dated 6/18/18 noted the following: "Resident was admitted from the acute hospital where she was treated for respiratory failure with hypoxia (low oxygen levels). Her generalized weakness related to her respiratory failure places her at risk for fall and fall related injury."

An activity note dated 6/25/18 at 12:33 PM revealed the following: "The resident was alert and oriented to person and place and was able to make own choices. On average she is awake during the day, is up in the mornings and naps off and on throughout the day. She is ambulatory and walks all through the facility and is able to get to and from out of room groups."

A nurse's note documented on 6/29/18 at 10:00 PM, noted the following: At 8:30 PM a nursing assistant (NA) stated Resident #1 was not in her room. Code White was immediately initiated. All staff looked for resident and she was found outside of the facility in the facility's parking lot where she had fallen and hit her face on the curb. Resident was brought inside. Care was given to wounds and her nose that was bleeding.

A review of the facility's report of the incident dated 6/29/18 at 9:00 PM for Resident #1 revealed the following: Found in parking lot. Laceration, bleeding nose. Exiting behavior/elopement. Diagnosis dementia. Alert and oriented to person prior to incident. RP and MD notified on 6/29/18. A diagram of a human body revealed injuries to the face. Immediate

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F 689	Continued From page 9	F 689		

interventions: New wander alarm bracelet applied.

Review of the June 2018 Treatment Administration Record for Resident #1 revealed an entry dated 6/12/18 to check placement of the wander alarm bracelet and was documented as done on every shift from 6/12/18 through 6/29/18. There was an entry to check the functioning of the wander alarm bracelet daily on every night shift and was documented as done on every night shift from 6/12/18 through 6/28/18.

A nurse's note dated 6/30/18 at 2:01 AM revealed Resident #1 was sent to the Emergency Department (ED) for evaluation of uncontrolled nose bleed.

Review of the ED physician's note documented on 6/30/18 at 3:41 AM revealed the following: "Had a fall last night at 8:15 PM face first in the parking lot. Nasal bleeding and mouth trauma. History of severe dementia, COPD on chronic oxygen who presents after injury. Patient apparently fell earlier on her face, she had some bleeding from her nose initially. Does not appear to have any bleeding at this time. Patient has swelling and abrasion to the upper lip region without any significant laceration, there is some blood in the oral cavity but no significant active bleeding."

The ED record noted a Head CAT (Computed Axial Tomography) Scan (dated 6/30/18) revealed multiple bilateral facial fractures with minimal displacement and no acute intracranial abnormality.

A note by the Hospitalist on 6/30/18 at 6:49 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

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F 689	Continued From page 10	F 689		

revealed "the case had been discussed with ENT (Ears/Nose/Throat specialist) who recommended she be admitted for possible surgical repair." The Physician noted during his exam Resident #1 was asleep and was unable to wake her up. "Plan: She will be admitted to medical telemetry and seen by ENT for possible surgical repair of bilateral complicated facial fractures."

A note by the ENT Physician dated 6/30/18 at 10:46 AM revealed the following: "Resident #1 had a fall yesterday which resulted in significant midfacial trauma." It was noted the resident remained somnolent (sleepy, drowsy) this morning but was otherwise stable. Recommendations were as follows: "The patient's bone is so thin that internal fixation is not likely to be successful. The only surgical option worth considering would be to wire the jaws together. I do not feel with her nutritional status and mental status that she would tolerate this intervention. I have therefore recommended observation with soft diet for 4 weeks."

The hospital Discharge Summary documented on 7/6/18 at 8:25 PM noted the following:" Recently discharged from out hospital to a nursing facility. Patient was initially alert but then had respiratory distress likely from aspiration. This required intubation and transferred to the Intensive Care Unit. Patient had repeat CAT Scan of the head which showed no intracranial bleeding. Patient continued to deteriorate. Patient further declined and expired."

The Death Certificate for Resident #1 noted the resident expired on 7/6/18 at 5:18 PM. The immediate cause of death: 1. Complications of facial fractures. 2. Fall.

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F 689	Continued From page 11	F 689		

Interviews were conducted with Nurse #1 on 7/18/18 at 2:43 PM and 10:22 PM and on 7/19/18 at 4:00 PM. Nurse #1 stated she was assigned to Resident #1 on the 3 PM to 11 PM shift on 6/29/18. The Nurse stated on 06/29/18 3 doors started alarming and she went to the front door and there was no one there and she opened the door and looked around outside and did not see anybody so she turned off the alarm and reported back to the charge nurse. The Nurse further stated one of the Nursing Assistants reported Resident #1 was not in her room and a Code White was called and she and Nurse #2 started down the hall to the front door and the charge nurse received a phone call that a resident was outside and she and Nurse #2 were beside the resident within 10 seconds of the phone call. The Nurse stated they assessed the resident and noted she had some bleeding from her nose and they helped her up and walked the resident back into the building and sat her in a wheelchair and put an ice pack on her nose. Nurse #1 further stated the nose bleed stopped and the resident had difficulty communicating and was unable to explain what had happened. Nurse #1 stated she had observed Resident #1 to push on the door at the end of the hall but had not observed the resident at the front door and had not heard the resident talk about wanting to leave the facility. The Nurse further stated in the evening Resident #1 would sometimes be in her room lying down or watching TV or walking around on the unit.

Interviews were conducted with the 3 PM to 11 PM Charge Nurse on 7/18/18 at 1:16 PM and 7/19/18 at 9:00 AM and 4:00 PM. The Charge Nurse stated Resident #1 had been intubated while in the hospital for exacerbation (increase in

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	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

severity) of her COPD and when admitted to the facility was on oxygen and with therapy had improved to the point she only used her oxygen at night and was able to ambulate in the hall. The Charge Nurse further stated in the evening Resident #1 started to get tired from walking and would get more confused and her speech would become garbled and if the staff tried to re-direct the resident she would strike out at the staff. The Charge Nurse stated the staff tried to keep wandering residents close to the nurses' station so they could keep an eye on them and Resident #1 went to bed anywhere from 7:00 PM to 10:00 PM depending on when she wore herself out from walking up and down the halls. The Charge Nurse stated on 6/29/18 at around 8:15 PM, 3 door alarms went off at the same time and the staff was trying to figure out what was going on. The Nurse further stated staff responded to the alarms with Nurse #1 responding to the alarm at the door in the main lobby and she reported she did not find the cause of the alarm. The Charge nurse further stated about that time Nursing Assistant (NA) #1 reported that Resident #1 was not in her room so they initiated a Code White (missing resident) and all the staff started looking for the resident. The Charge Nurse stated their procedure was to check every room, bathroom and closet for the resident and 2 staff members would go out the front door, one staff member going to the right and one going to the left and do a perimeter search of the entire outside of the building. The Charge Nurse further stated Nurse #1 and Nurse #2 were on their way to the front door when Visitor #1 called on the phone and told them someone was outside and she called to the nurses and told them there was someone outside. The Charge Nurse stated NA #1 reported she had observed Resident #1 in her room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

approximately 10 minutes prior to the alarms going off and Resident #1 could have been mistaken for a visitor and could walk quickly down the hall. The Charge Nurse further stated when the resident was brought back inside the building through the front door the staff noticed her wander alarm bracelet did not alarm and when checked the bracelet was not functioning and a new wander alarm bracelet was put on the resident and the staff started neurology checks. The Charge Nurse stated the resident ' s behaviors that night were no different than usual and could not understand why Resident #1 went to the main lobby. The Charge Nurse stated during her shift on 6/29/18 after the incident they took all residents with a wander alarm bracelet to the front door to ensure all the bracelets were functioning and checked the expiration date and all were found to be in date and functioning properly. The Charge Nurse stated they also checked all exterior doors to ensure the alarms were working and there were no problems with the alarms.

On 7/18/18 at 1:44 PM the Maintenance Director stated in an interview he had an electronic box to check the door alarms and checked the alarms on the doors once a week. The Maintenance Director further stated several weeks ago he was asked to check the door alarms three times a week. The Maintenance provided documents that revealed the doors alarms were checked and were functioning once a week during the month of June 2018 prior to 6/29/18 when the documentation revealed the alarms were being checked three times a week and all alarms were functioning. The documentation revealed the front door alarm was last checked on 6/27/18 and was functioning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

On 7/18/18 at 2:08 PM an interview was conducted with Visitor #1 who stated on the evening of 6/29/18 he walked out the front door and saw a woman on the pavement under the covered area in a fetal position against a post. The Visitor stated at first he thought it was a visitor but finally realized she was a resident so he called the nurses' station to let them know she was outside. The Visitor further stated he did not witness the fall but she had bleeding from her face.

On 7/18/18 at 2:43 PM the facility's front door and outside of the front of the facility was observed with Nurse #1. The front door was observed to have a device on the left side of the interior of the door near the bottom of the door frame that had been previously identified by the Administrator as an alarm for the wander alarm bracelets. After going through this door was an area approximately 8 feet square surrounded by glass and another door to the outside of the building. There was a wide walkway that was covered and there were 3 posts spaced at different intervals on each side of the walkway to support the cover. The cover continued at the end of the walkway to include a circular drive that could be used to drop off visitors and/or residents. On the other side of the circular drive, the covered walkway continued to the parking lot. There was approximately 2 feet between the 3rd post and the curb of the circular drive. Nurse #1 stated Resident #1 was found unsupervised on 6/29/18 sitting on the curb near the circular drive behind the post on the left side of the walkway. The location where the resident was found was 23 feet 10 inches from the outside door of the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 On 7/18/18 at 2:52 PM an interview was conducted with Nurse #2 who stated at around 8:30 PM on the evening of 6/29/18 3 door alarms went off and staff started checking the alarms. The Nurse stated she and Nurse #1 started for the front door and the Charge Nurse called a Code White saying they could not find Resident #1. The Nurse stated when she and Nurse #1 reached the resident she was sitting on the curb and had bleeding from the nose and the resident was assessed and assisted to stand and she walked back in the building and they sat her in a wheelchair. The Nurse further stated they checked her vital signs, did neuro checks and cleaned her up and brought her back to the nurses' station and when they checked her wander alarm bracelet it was not working. The Nurse stated they put her to bed around 11:00 PM and her nose had stopped bleeding and she did not see any deformities or swelling of her face. On 7/18/18 at 3:04 PM an interview was conducted with NA #1 who worked on the 3:00 PM to 11:00 PM shift on 6/29/18. The NA stated several alarms were going off and the NAs went from room to room to check on residents and noticed that Resident #1 was not in her room and she reported this to the charge nurse and a Code White (missing resident) was called. The NA further stated she had observed Resident #1 in her room lying in bed with her head towards the foot of the bed approximately 10 minutes prior to the alarms going off. The NA stated Resident #1 usually went to the dining room for supper and after supper was usually in her room or at the nurses' station and did not usually go to the lobby. The NA further stated he had not observed Resident #1 to try to leave the building.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

On 7/18/18 at 3:13 PM an interview was conducted with NA #2 who worked on the 3:00 PM to 11:00 PM shift on 6/29/18. The NA stated she was on her way back from her lunch break (unable to remember the time) and let Visitor #1 out of the front door. The NA stated she heard a Code White called and when she reached the nurses' station she heard Resident #1 was missing and the resident was found outside on the sidewalk.

On 7/18/18 at 3:18 PM an interview was conducted with NA #3 who worked on the evening of 6/29/18. The NA stated she heard 3 door alarms sound and Nurse #1 and Nurse #2 headed to the front door and NA #1 realized Resident #1 was missing. The NA further stated they received a phone call that a resident was outside and the 2 nurses went outside to the resident. The NA stated she went to where the resident was found and observed her to be barefooted and her nose was bleeding and the nurses brought her inside and started cleaning her up. The NA stated the resident had mild bruising and swelling of the left eyebrow.

On 7/18/18 at 3:25 PM an interview was conducted with NA #4 who stated he was assigned to Resident #1 on the evening of 6/29/18. NA #4 stated he last saw the resident around 7:00 PM after supper but was busy getting his residents ready for bed and did not recall if he saw the resident again prior to her exiting the building.

On 7/18/18 at 3:36 PM an interview was conducted with the Director of Nursing (DON) and the Administrator. The DON stated in an interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

they had not had a problem with wandering residents leaving the building without supervision. The DON further stated she could not explain how the resident got out of the building and wondered if someone went out and thought she was a visitor and let her out. The DON stated she questioned the staff about any damage to the box on the wander alarm bracelet thinking the alarm could have been damaged during the fall and there was no apparent damage to the box. The Administrator joined the interview and stated they had completed a plan of correction and the staff continued to check placement of the wander alarm bracelets every shift and instead of checking the function of the bracelet once a day, they were checking the function every shift. The Administrator stated all the staff in the building (except for staff on leave) had been in-serviced to respond promptly to alarms and if no cause for the alarm was found, to go outside and check to see if a resident had gone out of the door. The Administrator further stated the staff that were currently on leave would receive the in-service before they would be allowed to work. The Administrator stated staff had recommended the fire doors at the end of the hallway that lead to the front door be closed in the evening as a reminder to confused residents to not go past that point and if the door was opened, the door would slam shut alerting staff to someone going out of the fire door.

On 7/18/18 at 7:33 PM an interview was conducted with Nurse #3 who worked the 11:00 PM to 7:00 AM shift on 6/29/18 and 6/30/18. The Nurse stated when she arrived at work that night she was told in report that Resident #1 had gone outside around 8:15 PM and fell and they were doing neurological checks. The Nurse further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

stated when she first observed the resident she had some bleeding from the nose that would stop and later start again. The Nurse stated Resident #1 was her usual alert but confused self and kept digging in her nose. The Nurse further stated she was unable to stop the nose bleed completely and her blood pressure and pulse were going up a little and she sent the resident to the hospital around 2:00 AM.

On 7/19/18 at 12:30 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated all the doors in the facility were always locked except for the door in the main lobby and staff had to enter a code on the key pad to open the doors. The Administrator further stated if a door was held open for longer than 30 seconds the alarm would sound. The Administrator stated there was a box on the lower left door frame of the front main lobby door that would set off an alarm if a resident with a wander alert bracelet approached the door and the door would lock down for 15 seconds and then would open after 15 seconds of continuous pressure on the door handle. The Administrator stated this was due to fire safety code so anyone could exit the building in case of a fire. The Administrator stated the front door automatically locked at 8:00 PM and could be opened after entering a code on the key pad or pushing on the handle of the door for 15 seconds which would set off an alarm. The DON stated the business office staff usually left the building around 5:00 PM and there was no staff in the lobby after that time until the next morning. The Administrator stated there was a panel at the nurses ' station listing the doors in the facility with a red dot beside each door and when a door alarmed the light would light up to indicate which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19	F 689		

door was alarming. The Administrator further stated the intercom system would give a message announcing which door was alarming and would say something like "Courtyard door ajar, please check". The Administrator stated 3 alarms went off at about the same time during the evening of 06/29/18 and the system would announce the alarm that went off first, then the second one and then the third one. The Administrator stated the system announced this information very slowly and by the time the last alarm was announced (front door) the resident could already be out of the building. The DON stated 2 of the doors alarmed when staff held the door open for longer than 30 seconds while taking out the trash. The Administrator stated when the 3 alarms went off the staff were trying to figure out what was happening and when the nurse responded to the front door alarm, she did not see a cause for the alarm and turned off the alarm (via the key pad) and reported back to the nurses ' station. The Administrator stated when Resident #1 was brought back in the building the wander alarm did not sound and when checked the wander alarm bracelet was not functioning. The Administrator stated the wander alarm bracelet had been checked by the 11:00 PM to 7:00 AM nurse at 6:30 AM that morning and was functioning at that time

On 7/19/18 at 8:10 AM an interview was conducted with a representative of the company that made the wander alert bracelets. The Representative stated he could not say for sure without checking the wander alarm bracelet used for Resident #1 but the transmitter could have malfunctioned or could have been damaged when the resident fell without obvious damage to the outside of the box on the bracelet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20 On 7/19/18 at 2:50 PM an interview was conducted with a physician that cared for Resident #1 when re-admitted to the hospital on the morning of 6/30/18. The Physician stated the resident had facial fractures and her bones were very fragile so the bones could not be wired together. The Physician stated an EEG (Electroencephalogram - test of brain function) showed reduced brain activity but no seizures. The Physician further stated the resident was critically ill with multiple facial fractures, COPD, CHF (Congestive Heart Failure) and other comorbidities. The Physician stated her blood work was all pretty much normal with nothing to explain the decreased level of consciousness and the head injury was probably the cause of the resident's death. On 7/20/18 at 1:30 PM the Administrator stated in an interview this was a very unfortunate set of circumstances and would expect the staff to always respond to any alarm promptly, timely and effectively. CORRECTIVE ACTION PLAN: F689. On June 29, 2018 at approximately 8:30 PM Resident #1 was located outside the facility approximately 23 feet in front of the front door at the main entrance. Just prior to this, multiple door alarms had sounded. Those were the 400 hall, the courtyard door and the front door. Location of alarms announced through alarm system based on location through announcements that state: "The 400 hall door is ajar. Please check, the 400 hall courtyard door is ajar. Please check. The front door is ajar. please check." In the event that multiple alarms are set off, the system will cycle through based on the order alarm was triggered.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

As multiple alarms were sounding, staff also checked the panel at the nurse ' s station that would indicate which doors were alarming. Nursing staff immediately responded to all alarms, with different staff members responding to each location. The staff member that responded to the front door did not immediately determine the cause of the front alarm. She opened the door and looked outside, but did not see any cause for the alarm. She silenced the alarm at this point. There were 9 total staff members (3 nurses and 6 nursing assistants). They therefore immediately began to verify the whereabouts of all residents. When it was noted that Resident #1 was not in her room, Code White was immediately called. Per protocol, 2 nurses immediately headed towards the front door to each circle the perimeter of the facility. As the staff was in the process of attempting to locate resident #1 and the 2 nurses were headed towards the front door, another resident's spouse called the facility from the parking lot to tell facility staff Resident #1 was outside the facility. Resident #1 was located at this point. It appeared she had fallen. She had blood on her face (source appeared to be nose) but had no complaints of pain. Vital signs were within normal limits and nursing assessed her, cleaned her up and notified physician and the resident's family member. Resident #1's family member was appreciative of nursing staff's response and in agreement with plan to keep her in house. Neuro checks were initiated per protocol. Of note, nursing staff reported that Resident #1's wander monitoring device that was applied to her left ankle did not alarm when she re-entered the building. Resident #1's nurse checked the function of the wander monitoring device and noted it to be working properly earlier in the day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

This is documented as occurring at 6:32 AM on June 29, 2018. The front door magnetically locked at 8:00 PM per settings and could have only been opened through security code being entered or through emergency egress procedures (15 seconds of pressure on door handle). The facility's investigation concluded that the door had been opened by pressure being applied to the door handle which allowed the door to open after 15 seconds of pressure.
Resident #1 was closely monitored with neuro checks every 15 minutes. However, later in the night, Resident #1 ' s nose began to bleed and she was sent to the hospital for evaluation and treatment. The family was notified via voice mail.
On 7/2/18 the deficient processes that were identified were the timeliness of the response to door alarms and the failure to check outside of the door that was alarming. Our analysis concluded the reason why this happened was the facility placed too much confidence in the facility's wander monitoring alarm system. Had the staff responded more timely to the alarming of the front door, Resident #1 could have been re-directed and remained inside the facility.
Plan related to Alarm Response:
1. On 6/29/18, Resident #1 exited the facility by applying pressure to the locked front door which released after 15 seconds per emergency egress procedures. Resident #1 was assessed by nursing staff and Responsible Party and the attending physician were notified. She was brought back in the facility and noted to have a wander monitoring sensor that did not cause door to alarm upon re-entering. Resident #1's wander monitoring device was immediately replaced and new order given to check function and placement on 6/29/18.
2. On 6/29/18 nursing staff verified that all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23	F 689		

wander monitoring devices that were on residents were working correctly and were in date. Nursing staff also verified on 6/29/18 that all doors were secured and alarms were working properly. Elopement book was checked by nursing staff on 6/29/18 to ensure all information was present and current. Outside place of fall was checked by nursing staff for issues with pavement on 6/29/18 and no issues noted. No other residents were noted to have exit seeking behaviors on 6/29/18.

3. On 7/3/18 all residents requiring wander monitoring devices per nursing assessment will have function and placement of device monitored every shift (at least every 8 hours). Previously, placement was checked every shift and function checked daily. Results will continue to be documented by nurses in Point Click Care in the Treatment Administration Records. Any issues will be immediately reported to the Administrator, Director of Nursing and Assistant Director of Nursing/Staff Development Coordinator. Care Cards were verified to include "wander monitoring device" box checked for all residents with wander monitoring devices on 7/2/18. Furthermore, all residents with wander monitoring devices had "Maintain resident location while out of room" added to Care Cards on 7/2/18. Nursing staff will continue to complete Elopement Assessment for all new admissions upon admission, as part of their quarterly assessment and as needed as condition changes. Assistant Director of Nursing/Staff Development Coordinator reviewed all elopement assessments on 7/2/18. Director of Nursing or Assistant Director of Nursing/Staff Development Coordinator will review all elopement assessments and initiate increased monitoring as needed.

4. Assist Director of Nursing/Staff Development Coordinator with assistance from other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24	F 689		

administrative nursing staff and department heads will in-service all staff in all facility departments on responding to alarms with emphasis placed on going outside to verify the cause of the alarm. In-services began on 7/2/18 and all staff will be in-serviced prior to working next scheduled shift. A total of 66 employees were in-serviced between 7/2/18 and 7/3/18. No one worked their next shift after 7/2/18 without first being in-serviced. Employees on leave were in-serviced prior to returning to work. The only remaining employees to be in-serviced remain on leave, but will be in-serviced prior to returning to work.

5. Facility staff (Maintenance Director and/or Administrator will check all doors three times per week for one month and then in accordance with facility's preventative maintenance schedules to ensure all function correctly. This was initiated 7/2/18.

6. Facility determined on 7/2/18 to conduct weekly door alarm/wander monitoring device response drills for 6 weeks. Administrator, Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator will lead drills.

7. QA (Quality Assurance) Committee members initially all notified by 7/2/18. This plan and results will be reviewed by facility ' s Quality Assurance and Performance Improvement Committee for 3 months. Additional education and monitoring will be initiated as needed.

8. The facility's Quality Assurance Committee led by the Administrator, Director of Nursing and Assistant Director of Nursing/Staff Development Coordinator are responsible or implementation of the plan. The Administrator will ultimately be responsible for implementation of the plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. BUILDING _____ B. WING _____	C 07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

The facility alleges full compliance with this plan of correction effective 7/3/18.

As part of the validation process on 7/18/18, 7/19/18 and 7/20/18 the plan of correction was reviewed including the re-education of staff and observations of staff responding to alarms. Treatment Administration Records were reviewed to ensure wander monitoring devices were checked for functioning and placement three times a day on each shift. Review of maintenance logs revealed the door alarms were checked three times a week with no incidence of alarms not functioning. Documentation was reviewed that showed wander monitoring device response drills were taking place weekly. Interviews with nurses, nursing assistants and staff from other departments revealed they had received training to respond promptly to alarms and in the event a cause for the alarm not found they were to go outside and check to see if a resident had exited through the door to set off the alarm. The staff stated they had wander monitoring device drills weekly.

The validation process verified the facility's compliance effective 7/03/18.