

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

PRINTED: 04/02/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345183</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/22/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSAL HEALTH CARE &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>430 BROOKWOOD AVENUE NE</b> <b>CONCORD, NC 28025</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A complaint investigation survey was conducted from 2/17/19 through 2/22/19. Immediate Jeopardy was identified at:  CFR 483.25 at tag F689 at a scope and severity (J)  The tag F689 constituted Substandard Quality of Care.  Immediate Jeopardy began on 1/13/19 and was removed on 2/21/19. A partial extended survey was conducted.	F 000			
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		3/18/19	

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

TITLE

(X6) DATE

Electronically Signed

03/18/2019

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 550	<p>Continued From page 1</p> <p>practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to treat residents with respect and dignity for 1 of 3 residents reviewed for dignity as evidenced by an alert and oriented resident who was left in fecal matter (Resident #2).</p> <p>Findings included:</p> <p>Resident #2 was admitted to the facility on 11/20/2018 with diagnoses to include fractured tibia, care after motor vehicle accident and adjustment disorder. The most recent admission Minimum Data Set (MDS) dated 11/27/2018 assessed Resident #2 to be cognitively intact without behaviors and rejection of care noted 1-3 days. The MDS assessed Resident #2 to require</p>	F 550	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth by the survey team, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for all of our residents.</p> <p>Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Administrator, it was determined that staff did not follow the facility policy with regards to timely incontinent care in order to maintain dignity.</p>		

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F 550	<p>Continued From page 2</p> <p>extensive 2-person assistance with toileting and Resident #2 was frequently incontinent of bowels. The MDS assessed Resident #1 to have adequate vision and hearing.</p> <p>The care plans for Resident #2 were reviewed and a care plan was in place dated 11/30/2018 that identified Resident #2 was at risk for skin breakdown and interventions included to provide incontinent skin care after each incontinent episode.</p> <p>A care plan dated 11/30/2018 and reviewed on 2/18/2019 addressed bowel incontinence for Resident #2 and goals were Resident #2 would be clean, dry and odor-free daily and no signs or symptoms of infection related to incontinence. Interventions for the care plan included provide incontinence care after each incontinence episode.</p> <p>Resident #2 was interviewed on 2/18/2019 at 5:04 PM. Resident #2 reported he had bowel movements first thing in the morning or in the middle of the night and he knew he needed to have a bowel movement but did not always have a lot of warning. Resident #2 reported he was not certain of the date, but it was about 3:00 AM. He reported he used the call light to ask for assistance, but before staff arrived, he had a bowel movement. He further reported he was unable to move his body and laid in feces for almost 30 minutes. Resident #2 pointed to the clock on the wall beside his bed and reported he was able to see the clock and keep track of time. Resident #2 also reported he used his cell phone to keep track of time. He went on to explain that the incident made him feel ashamed because he needed assistance with cleaning himself and</p>	F 550	<p>Immediate action: Resident #2 was given incontinent care and had no further complaints. Resident # 2 Discharged to home per his request on 3/04/19. Prior to discharge resident was a minimum assist with his activities of daily living and was able to toilet himself with minimum assistance. He was alert and oriented and able to make needs known. Prior to discharge on 3/4/19 resident was interviewed by the Director of Admissions with no complaints or concerns noted.</p> <p>Identification of Others: As of 3/18/19 Department Managers which included: Social Services Director, Unit Coordinator #1, Unit Coordinator #2, Business Office Manager, Activities Director, Certified Dietary Manager, Director of Rehabilitation, Admissions Coordinator, Environmental Services Director, Medical Records Director, Staffing Coordinator, Human Resources Director, MDS (Minimum Data Set) Coordinator performed an audit of 100% of interviewable residents to determine if their needs are met while maintaining their dignity. Dignity concerns reported during this audit were reported via the Grievance policy and resolution was accomplished per the residents preferences.</p> <p>Systemic Changes: As of 3/18/19, 100% of nursing employees were educated by the</p>		

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F 550	Continued From page 3 angry because no staff would come to help him. Resident #2 was unable to recall the name of the staff who was assigned to provide him care that night.  The Director of Nursing was interviewed on 2/22/2019 at 7:39 PM and she stated it was her expectation that dignity was maintained for all residents at the highest level.  The Administrator was interviewed on 2/22/2019 at 7:52 PM and she reported it was her expectation that issues were resolved to allow all residents to have a dignified existence.	F 550	Assistant Director of Nursing/Staff Development Coordinator regarding resident's rights including the right to have their needs met in a manner in which their dignity is preserved.  Nursing staff who are unavailable for education will not be allowed to work until they have received the education.  Upon orientation, newly hired staff will be educated by the Assistant Director of Nursing/Staff Development Coordinator regarding the need to honor residents rights and the resident's right to be treated with respect and dignity. Nursing staff will be re-educated annually on Resident Rights with emphasis on dignity.  Monitoring:  As of 3/18/19 Customer Service Action Rounds will be completed by Department Managers to include, Social Services Director, Unit Coordinator 1, Unit Coordinator 2, Business Office Manager, Activities Director, Certified Dietary Manager, Assistant Dietary Manager, Director of Rehabilitation, Admissions Coordinator, Environmental Services Director, Medical Records Director, Maintenance Director, Staffing Coordinator, Human Resources Director, MDS (Minimum Data Set)Coordinator on all residents daily, Monday-Friday x 1 week and weekly thereafter x one year. During these rounds residents will be asked if their needs are being met including on weekends, holidays and off		

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F 550	Continued From page 4	F 550	<p>hours, and if they are treated with dignity and respect. Concerns expressed during these rounds will be investigated to determine the root cause of the concern. Appropriate action will be taken once root cause is determined. Dignity concerns reported during these rounds will be reported via the Grievance policy and resolution will be accomplished per the residents preferences.</p> <p>The Administrator will review these reports daily, Monday-Friday times one week beginning on 3/18/19 and then weekly and report to the Quality Assurance and Performance Improvement Committee (QAPI) the findings of these reports monthly x 1 year.</p> <p>The Quality Assurance and Performance Improvement committee will evaluate the findings from these reports and make changes to the plan as indicated.</p> <p>The Administrator and the Director of Nursing will be responsible for implementing the acceptable Plan of Correction.</p>		
F 689 SS=J	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent</p>	F 689		3/18/19	

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F 689	<p>Continued From page 5</p> <p>accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician and staff interviews, the facility left a cognitively impaired resident unsupervised outside on the facility's front porch (Resident #4) and failed to prevent another cognitively impaired resident from exiting the facility without supervision (Resident #1) for 2 of 3 residents reviewed for accidents. Resident #4 expressed a desire to leave the facility and an elopement risk assessment was not completed by staff. On 1/13/2019 staff assisted Resident #4 outside in his wheel chair and left him unsupervised on the front porch in 30 degree Fahrenheit weather and he self-propelled his wheel chair 50 feet from the facility's front doors before staff saw him and brought him back inside the facility. Resident #1 exited the building on 1/30/2019 in 30 degree Fahrenheit weather dressed in pants and a t-shirt while unsupervised and self-propelled his wheelchair 72 feet to the end of the sidewalk before staff was notified by an anonymous phone call that informed staff the resident was outside the facility without supervision. Residents #1 and #4 were returned inside the facility without injuries.</p> <p>Immediate jeopardy began on 1/13/2019 when Resident #4 was assisted outside to the facility's front porch by a staff member and left unsupervised and while he was unsupervised he self-propelled his wheelchair 50 feet to the wheelchair ramp when staff arrived and returned him to the facility. Immediate Jeopardy continued when Resident #1 exited the facility through two sets of doors and while unsupervised self-propelled his wheelchair 72 feet before staff</p>	F 689	<p>Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Administrator, it was determined that staff did not follow the facility policy with regards to prevention of elopements.</p> <p>Immediate Actions As of 1/14/19 Resident # 4 had an elopement risk assessment completed and a Wanderguard was placed. Resident has had no further instances of exiting the facility unassisted. Resident #4s care plan was updated as of 1/14/19.</p> <p>As of 2/1/19 Resident #1 had an elopement risk assessment completed and a Wanderguard was placed. Resident has not had further instances of exiting the facility unassisted. Resident #1s care plan was updated as of 2/1/19.</p> <p>Identification of Others: 100% of Elopement risk assessments for all current residents completed on 02/21/2019, by the Assistant Director of Nursing, to identify any other residents who might be at risk for exit seeking behaviors. Six other residents who were previously identified to be at risk for elopement were re-identified during this assessment, "Elopement books" were revised and placed at the front desk, and at each nurse's station by Director of Nursing, Assistant Director of Nursing and/or Unit Manager #1 on 2/21/2019.</p>		

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F 689	<p>Continued From page 6</p> <p>returned him to the facility. Immediate Jeopardy was removed on 2/21/2019 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.</p> <p>Findings included:</p> <p>1. Resident #4 was admitted to the facility on 4/29/2016 and readmitted 1/5/2019 with diagnoses to include chronic obstructive lung disease, cerebral vascular accident (stroke), high blood pressure and difficult walking.</p> <p>A review of care plans for Resident #4 revealed care plan in place for wandering or potential elopement was not developed until after 1/13/2019.</p> <p>A nursing note dated 1/5/2019 at 7:43 PM written by Nurse #4 documented Resident #4 was attempting to get out of bed and he stated, "I'm going to get out of bed and go outside to smoke." Nurse #4 documented she reassured Resident #4, instructed him to use his call bell for assistance to transfer and his call bell was in reach.</p> <p>Nurse #4 was interviewed on 2/20/2019 at 9:44 AM. Nurse #4 reported she had been assigned to provide care to Resident #4 on 1/5/2019 on 2nd shift (3:00 PM to 11:00 PM) and she had written the note documenting Resident #4 had expressed a desire to leave the facility and she had reported</p>	F 689	<p>These books contain a list of residents with exit seeking behaviors, their pictures and resident's descriptions. 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).</p> <p>Measures/Systematic changes made to ensure that the deficient practice will not re-occur</p> <p>Effective 2/21/2019, 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; to include but not limited to, behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, staying near an exit door, and/or attempts to exit the facility. Residents identified as having these behaviors will be re-assessed for elopement risk, interventions will be implemented, and resident's care plan will be revised and updated immediately by licensed nurses. Direct care staff will be notified of new interventions put forth by a licensed nurse through resident's care guide which are located in the electronic nursing aide documentation software at each unit. Appropriate intervention to ensure residents who are cognitively impaired receive necessary supervision to</p>		

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F 689	<p>Continued From page 7</p> <p>his behavior to UM #1. Nurse #4 reported she had not completed an elopement risk for Resident #4 because he was not getting out of the bed on 1/5/2019 due to his recent hospitalization.</p> <p>Nursing notes for Resident #4 were reviewed and a note dated 1/6/2019 at 11:40 AM written by Nurse #1 documented a statement made by Resident #4, "I'm going to get up and walk and leave here, I don't care what anyone says." Nurse #1 documented she told Resident #4 he was not able to walk because of the weakness on his left side and Resident #4 replied, "Your (sic) lying, that's not true." Nurse #1 documented she reassured Resident #4 and "he calmed down."</p> <p>Nurse #1 was interviewed on 2/20/2019 at 10:52 AM and she reported she was assigned to provide care to Resident #4 on 1/6/2019 and she had documented Resident #4 had made statements about leaving the facility. She reported she did not complete an elopement risk assessment on 1/6/2019 when the resident expressed a desire to leave the facility because he was not getting out of the bed on that date because he had a stroke and was unable to move the left side of his body. Nurse #1 further stated she had reported to UM #1 about Resident #4's statement regarding leaving the facility.</p> <p>An elopement risk assessment completed by Unit Manager (UM) #1 dated 1/8/2019 was reviewed. This assessment did not identify Resident #4 as an elopement risk, but answers to some of the questions on the assessment found to be inaccurate. The question "Has the resident expressed the desire to go home" was checked "no". The question "have there been any</p>	F 689	<p>prevent accidents while outside the facility will also be included in residents' care plan effective 2/21/2019.</p> <p>Effective 2/21/2019, if a resident expressed a desire to go outside to the receptionist #1 or #2, the receptionist #1 or #2 will contact a licensed nurse who cares for and is familiar with the resident requesting to go outside to validate whether the resident is safe to go outside or not. If resident is not safe to go outside alone Receptionist #1 and/or #2 will not allow the resident to go outside unsupervised. Effective 2/21/19 If any resident that desires to be outside in an unsecured area, the facility will provide direct supervision while outside and allow the residents; to include resident #4 and resident #1; to exercise their rights. Receptionist #1, #2 or designated staff will be scheduled to implement this process daily including Saturdays and Sundays effective 2/21/2019,</p> <p>Effective 2/21/2019 and moving forward the facility implemented the process of signing residents out when leaving the facility for an appointment. The transportation company employee will sign the resident out at the front desk before leaving the facility. The Receptionist will educate new transportation employees on this procedure before transporting the next resident from the facility effective 2/21/19</p> <p>Effective 2/21/2019 all the facility exit doors are locked and can only be</p>		

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F 689	<p>Continued From page 8</p> <p>changes to the resident's status" was not included in the elopement assessment completed 1/8/2019.</p> <p>An interview was conducted with UM #1 on 2/20/2019 at 12:44 PM. UM #1 reported she did not recall receiving report from Nurse #4 on 1/5/2019 or Nurse #1 on 1/6/2019 regarding Resident #4's statements about leaving the facility. UM #1 reported she completed the elopement risk assessment on 1/8/2019 and did not consider him a risk for elopement because he had not attempted to leave the building in the past, and he had not stayed around the exit doors waiting for the doors to open, so he could leave. UM #1 reported elopement risk assessments were completed quarterly and as needed and because Resident #4 was not getting out of bed due to a stroke, he was not an elopement risk.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment dated 1/12/2019 revealed Resident #4 was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 and wandering behaviors noted. The MDS assessed Resident #4 to require extensive 2-person assistance to transfer and he was non-ambulatory, using a wheelchair for all locomotion. Resident #4 was assessed to have adequate vision and hearing and he was able to be understood by others and was assessed to be able to understand others. Resident #4 required limited one-person assistance with locomotion on the unit and was assessed to be independent with locomotion off the unit. Resident #4 was assessed to require total one-person assistance with dressing.</p> <p>A nursing note written 1/13/2019 at 5:30 PM by</p>	F 689	<p>accessed using key code with a pin number. Visitors will utilize the facility main entrance to enter the premises, effective 2/21/19. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and/or open from the inside. This is in compliance with Federal and State life safety code.</p> <p>Effective 2/21/2019, the center interdisciplinary team, which includes Director of Nursing, Assistant Director of Nursing and/or, Unit Manager #1 initiated a process for reviewing clinical documentation for all current residents to identify any elopement risk behaviors documented to include but not limited to, behaviors of wandering aimlessly, cognitively impaired residents expressing a desire to go home, packed belongings to go home, staying near an exit door, and/or attempts to exit the facility. Any identified elopement behavior will be addressed promptly, a new elopement risk assessment will be completed, plan of care will be developed as appropriate and resident name and picture will be added to the "elopement binders for easy identification by staff promptly by the facility DON, ADON and/or Unit Manager #1. This process will be completed daily Monday through Friday effective 2/21/2019. Findings from this systemic process will be maintained in the facility's</p>		

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F 689	<p>Continued From page 9</p> <p>Nurse #3 documented "nurse was called to lobby ... receptionist pushed resident (#4) out onto the porch and had stated to the receptionist he want(ed) to go outside for a minute because he was 'leaving this place'. Resident (#4) assisted back into the building by the receptionist after staff educated the resident he could not go outside unassisted. Resident (#4) stated he does not want to be here, that he wants to go home ... received phone call from the administrator to start 30 min checks and apply a wanderguard to resident. Resident (#4) stated ... if a wanderguard was going to be applied, he would find a way to cut it off. Staff monitoring resident as ordered."</p> <p>An interview was conducted with Receptionist #2 on 2/19/2019 at 3:25 PM via phone call. Receptionist #2 reported he worked the evening of 1/13/2019 and Resident #4 had approached the receptionist desk after 4:00 PM and asked Receptionist #2 to assist him outside because he wanted to wait for a family member. Receptionist #2 went on to explain Resident #4 was fully dressed and had a coat with a hood on and the hood was up on his head. Receptionist #2 asked Resident #4 if he had talked to his assigned nurse and Resident #4 reported he had told the nurse he was going out for supper. Receptionist #2 reported he assisted Resident #4 to the covered front porch and placed him in an area where Receptionist #2 could view him. Receptionist #2 went on to explain he had gotten busy with something at the desk and when he looked up, Resident #4 was no longer in his sight, so he went out onto the front porch and discovered Resident #4 was self-propelling his wheelchair on the sidewalk and was at the wheelchair ramp 50 feet from the front doors.</p>	F 689	<p>daily clinical meeting binder.</p> <p>Effective 2/21/2019 a new elopement risk assessment will be completed for any cognitively impaired resident who voiced a desire to go home or exhibited any elopement risk behaviors. Residents at risk for elopement will be identified using elopement books located at the front desk and at each nurse's station. Elopement Books, contain pictures and detailed descriptions of each residents listed as elopement risks.</p> <p>Effective 2/21/2019 Director of Nursing, Unit manager#1, or designated staff will review and update the Elopement books with changes as they are identified for elopement via risk assessments. Elopement books are in a location accessible to all staff for easy identification of elopement risk residents.</p> <p>On 2/21/2019, The Facility Administrator re-educated receptionist #1, and #2 on the importance of ensuring that the licensed nurse that cares for and is familiar with the resident, requesting to go outside is contacted to validate whether resident is safe to go outside before the resident is allowed to go outside. 2/21/2019 Education on the receptionist responsibilities pertaining to elopement management process will be provided by the facility Administrator for any new receptionist upon hire and annually.</p> <p>On 2/21/2019, The Facility Administrator re-educated receptionist #1, and #2 on</p>		

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F 689	<p>Continued From page 10</p> <p>Receptionist #2 estimated Resident #4 was outside for approximately 15 minutes. Receptionist #2 reported the role of the receptionist was to monitor the front door for residents and visitors and to identify residents at risk for elopement from the wanderguard book that was at the front desk. Receptionist #2 reported Resident #4 was not in the wanderguard book and he had not contacted Resident #4's nurse to confirm he could leave the building.</p> <p>On 2/20/2019 at 4:21 PM Receptionist #2 showed where he placed Resident #4 in his wheelchair on the facility porch on 1/13/2019. Observations of the area revealed a covered porch area of the facility measured approximately 27 feet by 26 feet and was open on three sides with pillars which supported the roof. The concrete of the porch area was smooth without cracks or uneven areas. During the observation of the porch, Receptionist #2 showed where Resident #4 had self-propelled his wheelchair. This area was observed and revealed a wheelchair ramp on the east side of the porch exited into the parking area of the facility approximately 50 feet from the front doors and where Resident #4 was left by Receptionist #2. The parking lot was asphalt with some uneven areas noted beyond the wheelchair ramp.</p> <p>Weather.com documented the weather on 1/13/2019 for the city the facility is located specified a high of 32 degrees Fahrenheit, low of 5 degrees Fahrenheit, and sunny.</p> <p>An interview was conducted with Resident #4 on 2/19/2019 at 4:32 PM. Resident #4 reported he did not recall the incident of 1/13/2019.</p> <p>An interview was conducted with Nurse #3 on</p>	F 689	<p>the new requirement to sign out residents from the facility at the front desk when leaving for an appointment. Receptionist will ensure transportation company personnel sign resident out on the "resident sign out log maintained at the front desk. Receptionist #1 and #2 will not allow any resident to leave the facility while following a visitor without signing out effective 2/21/19.</p> <p>Education on the receptionist responsibilities pertaining to elopement management process will be provided by the facility Administrator and/or designated staff for any new receptionist upon hire and annually.</p> <p>On 2/21/2019 the facility Administrator, conducted re-education for current interdisciplinary clinical team to include Director of nursing, Assistant Director of Nursing and/or Unit manager #1 on the required new process of reviewing clinical documentation to identify any elopement risk behaviors. This re-education also emphasized the importance of completing a new elopement risk assessment when a resident is noted with such behaviors to include but not limited to; behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, staying near an exit door, and/or attempts to exit the facility. Effective 2/21/2019 Education on reviewing clinical documentation to identify any elopement risk behaviors will be provided by the facility Administrator and/or Director of nursing for any new clinical manager to include ADON, SDC,</p>		

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F 689	<p>Continued From page 11</p> <p>2/20/2019 at 9:26 AM. Nurse #3 reported she was assigned to provide care to Resident #4 on 1/13/2019 and she had been notified by Receptionist #2 that Resident #4 had been assisted outside, but he tried to self-propel his wheelchair away from the facility. Nurse #3 reported she alerted the Administrator and had received guidance to complete an elopement assessment and apply the wanderguard if it was appropriate. Nurse #3 further reported she conducted checks on the resident and there were no adverse effects noted from him being outside. The medical record was reviewed and on 1/13/19 at 6:41 PM Resident #4's vital signs were documented as temperature of 97.0 degrees Fahrenheit, pulse 72, respirations 22, and blood pressure 130/64.</p> <p>An interview was conducted with NA#9 who was assigned to Resident #4 on 1/13/2019 for 2nd shift (3:00 PM to 11:00 PM). NA #9 reported Resident #4 was fully dressed upon her arrival for her shift and that he liked to be dressed in pants, shirt and a hoodie jacket because he smoked. NA #9 reported Resident #4 had not specifically stated on that date he was going to leave, but he had made statements in the past regarding wanting to go home. NA #9 reported she was not concerned by Resident #4's statements and did not inform the nurse.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 2/20/2019 at 12:58 PM. The ADON reported she had heard Resident #4 had expressed a desire to leave the facility, but she was not certain of the date he made those statements. The ADON reported she completed an elopement risk assessment the day after he attempted to leave and assessed him to be an</p>	F 689	<p>and/or Unit Manager upon hire and annually. Facility Administrator will conduct the education/re-education for the facility Director of Nursing upon hire and annually effective 2/21/2019.</p> <p>Director of Nursing, and/or Assistant Director of Nursing conducted re-education for current scheduled staff, full time, part time and as needed employees for all departments on 2/21/2019, this education included checking, identification of resident who are at risk for elopement though the elopement binders, the need to complete a new elopement assessment when a cognitively impaired resident express the desire to go home, the need to maintain the environment as free of accident hazards as is possible (such as; keep rooms and hallway uncluttered, keep floor dry). The education also emphasized the importance to ensure any resident requesting to go outside has "weather appropriate" clothing before they exit the facility. Furthermore, the education included the provision on how to identify residents who are unsafe to go outside unsupervised by contacting the licensed nurse who is familiar with the resident requesting to go outside and validate whether the resident is safe to go outside or not, the education emphasized that, if resident is not safe to go outside alone Receptionist #1 and #2 or designated staff member who monitor the front door will not allow the resident to go outside unsupervised. Any facility employee not re-educated by 2/21/2019 will not be</p>		

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F 689	<p>Continued From page 12</p> <p>elopement risk because he had attempted to leave the building. The ADON reported an elopement risk assessment should have been completed for Resident #4 on 1/5/2019 or 1/6/2019 after Resident #4 made statements about wanting to leave the facility. The ADON concluded by reporting if the elopement risk assessment completed on 1/8/2019 had included accurate information about Resident #4, including his statements to leave the building and the recent change in his health status, and he was found to be an elopement risk, a care plan would have been developed.</p> <p>The Social Worker (SW) was interviewed on 2/20/2019 at 3:28 PM. The SW reported she had completed the sections of the quarterly MDS dated 1/12/2019 regarding behaviors and she coded Resident #4 as having wandering behaviors, but that was an error and she had corrected the coding for the MDS.</p> <p>The facility physician (DO) was interviewed via phone call on 2/20/2019 at 5:21 PM. The DO reported the resident had told her that he went outside on 1/13/2019 because he wanted to go outside. The DO went on to explain Resident #4 had been "egged on" by his roommate to leave the facility and he had went outside as an act of defiance. The DO reported she felt Resident #4 was showing poor judgment when he went outside. The DO reported Resident #4 was not safe and did not make safe judgments.</p> <p>The Administrator was interviewed on 2/21/2019 at 12:11 PM and she reported she received a phone call from Receptionist #2 on 1/13/2019 to report Resident #4 had "lied to him" and had been taken outside by Receptionist #2. The</p>	F 689	<p>allowed to work until educated on this requirement. Effective 2/21/2019 Education on the facility elopement policy and procedure is added on new hire orientation education for all new facility employees. This education will also be provided annually for all staff. The education also included identifying elopement risk behaviors to include but not limited to; behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, staying near an exit door, and/or attempts to exit the facility. Staff members were trained to report those behaviors to licensed nurses promptly for proper follow through.</p> <p>Effective 2/21/2019 the facility will maintain signage in the lobby asking visitors to not let residents out. The signage is in a prominent location visible to visitors from both inside and outside.</p> <p>The Monitoring Procedure to Ensure That the Plan of Correction is Effective</p> <p>Effective 2/21/2019 the Director of Nursing will monitor the accuracy of the elopement books, and completion of elopement risk assessment on admission, re-admission and quarterly Monday through Friday for seven days then weekly for four weeks then monthly for one year.</p> <p>Effective 02/21/2019, Facility Administrator and/or Director of Nursing, will monitor the process of reviewing clinical documentation by conducting</p>		

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F 689	<p>Continued From page 13</p> <p>Administrator reported she had talked to the nurse and recommended performing an elopement assessment and applying a wanderguard if needed. The Administrator reported she was not certain if the incident was discussed at the daily morning meeting or if the team discussed the incident. The Administrator reported she did not know Resident #4 to know if he made poor judgements and he seemed to be alert and oriented.</p> <p>2. Resident #1 was admitted to the facility on 1/15/2016 and readmitted 2/5/2016 with diagnoses to include hemiplegia following cerebral vascular accident (stroke), memory deficit after stroke, encephalopathy and muscle weakness.</p> <p>An elopement risk assessment dated 6/28/2018 was reviewed and Resident #1 was assessed as an elopement risk due to cognitive impairment, a pertinent diagnosis, communication problems and he had expressed a desire to leave the facility.</p> <p>A care plan dated 7/16/2018 assessed Resident #1's risk for falls, and the stated problem documented "he is impulsive and forgets to ask for assistance due to memory deficit". Interventions for the fall care plan included to reassesses quarterly and with any change of condition and to encourage Resident #1 to be in common areas when he was out of bed.</p> <p>A care plan that addressed Resident #1's attempt to leave the building without staff assistance with the goal "will not attempt to exit the building on his own" was marked as "achieved" on 7/4/2018 and was not active from 7/4/2018-1/31/2019.</p>	F 689	<p>clinical meeting daily (M-F), this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, any admission/readmission occurred from the last clinical meeting and/or any incidents or accidents that have occurred from the prior clinical meeting, and validated whether resident's clinical records were reviewed for any elopement risk behaviors. Any identified issues will be evaluated for corrective actions. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow up is completed. Facility Administrator and/or Director of Nursing will review the completion of clinical meeting daily (M-F) for two weeks, weekly for two more weeks, then monthly for three months.</p> <p>Effective 2/21/2019 facility Business office manager will verify that the receptionist is at his/her station and ensure that coverage is provided if they need to leave the area. This monitoring process will take place twice daily on Monday through Friday for two weeks then once daily for five more days then weekly for four weeks. On weekends, holidays or off hours the receptionist will continue to notify the Nurse Supervisor on duty at that time.</p> <p>Effective 2/21/2019 facility Business Office Manager will monitor compliance of signing out residents at the front desk by comparing the list of residents who exit</p>		

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F 689	<p>Continued From page 14</p> <p>An elopement risk assessment completed by Nurse #2 and dated 10/11/2018 assessed Resident #1 not at risk for elopement.</p> <p>An interview was conducted with Nurse #2 on 2/18/2019 at 4:04 PM via a phone call. Nurse #2 reported she completed the elopement risk assessment on Resident #1 on 10/11/2018 and because he was not getting out of bed or leaving his room, she assessed him to be not at risk for elopement.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment dated 12/22/2018 assessed Resident #1 to be moderately cognitively impaired Brief Interview for Mental Status (BIMS) score of 9. No physical behaviors, rejection of care or wandering were noted on the MDS of 12/22/2018. The MDS assessed Resident #1 to be totally dependent on 2-person assistance for transfers and he was non-ambulatory, and dependent on 1-person assistance for locomotion.</p> <p>Review of Resident # 1's medical record revealed no elopement risk assessments were completed between 10/12/2018 and 1/30/2019.</p> <p>The Assistant Director of Nursing (ADON) was interviewed on 2/20/2019 at 12:58 PM. The ADON reported she was working the day Resident #1 got out of the building, but she did not observe him outside. The ADON reported UM #1 had reported to her Resident #1 had gotten outside and the receptionist was made aware Resident #1 was outside by a phone call from a visitor. The ADON reported Resident #1 had been in bed and not mobile for several months, but physical therapy had provided treatment for him</p>	F 689	<p>the facility for an appointment and validate each resident is signed out on the resident sign out log before leaving the facility. This monitoring process will take place daily(Monday through Friday)for two weeks then,weekly for four weeks.</p> <p>Facility Quality Assurance committee was notified of the alleged noncompliance and the plan outlined in this credible allegation on 2/21/2019. The Quality Assurance and Performance Improvement(QAPI) committee adapted the plan and will be the authorized entity to make any needed modification effective 2/21/2019.</p> <p>Effective 02/21/2019 and moving forward the facility Administrator and/or Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI) for any additional monitoring or modification of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.</p> <p>The title of the person responsible for implementing the acceptable plan of correction</p> <p>Effective 2/21/2019 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this credible allegation of immediate jeopardy removal.</p>		

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F 689	<p>Continued From page 15</p> <p>and he was able to get up in a high-back wheelchair and self-propel himself in the wheelchair. The ADON was not certain of the length of time he had been using the high-back wheelchair. The ADON further reported that based on Resident #1's previous behaviors of attempting to leave the building, an elopement risk assessment should have been completed when he returned to his baseline level of activity during the month on January 2019, but staff failed to reassess the resident's risk of elopement prior to his unsupervised exit from the facility on 1/30/19.</p> <p>A nursing note written by Nurse #1 and dated 1/30/2019 at 2:24 PM noted Resident #1 "at the front desk, noted following transportation company out front door, staff went and encouraged resident back inside without any problems, wanderguard placed to right ankle for safety; notified Responsible Party." Vital signs for Resident #1 on 1/30/2019 at 1:40 PM were documented as temperature of 97.9 degrees Fahrenheit, pulse 74, respirations 20 and blood pressure 144/80.</p> <p>Nurse #1 was interviewed on 2/20/2019 at 10:52 AM and she reported on 1/30/19 she arrived at the front lobby as Resident #1 was being brought back in the building and she did not go outside to get him.</p> <p>A nursing assistant (NA) #1 was interviewed on 2/19/2019 at 10:01 AM. NA #1 reported she had been assigned to Resident #1 on 1/30/2019. NA #1 went on to explain she had tried to find Resident #1 to assist him into bed to perform incontinence care, but she could not locate him. NA #1 reported she went around the inside of the</p>	F 689	<p>Date of Immediate Jeopardy removal: 2/21/2019</p> <p>Immediate Jeopardy removal was verified as 2/21/2019.</p> <p>The following verified the facility's Credible Allegation of Immediate Jeopardy removal:</p> <p>The elopement book was observed to be at the front desk and included a picture and demographics of the residents currently identified at risk for elopement. The staff in-services conducted were reviewed and included: the facility policy on elopement, the elopement book and the location, the receptionist desk to be staffed 7 days per week, 8:00 AM to 5:00 PM and the front doors will be locked at 5:00 PM. The front doors were not to be left unattended during the day from 8:00 AM to 5:00 PM. The attendance records confirmed that all staff had been in-serviced. Receptionist staff are to sign all residents in and out of the building and if a resident is unattended, the receptionist is to call the assigned nurse to clarify if the resident can leave the building.</p> <p>Random staff interviews were conducted including staff from all shifts. All staff members could describe the topics covered during the in-service on elopement.</p> <p>The Assistant Director of Nursing is also the Staff Development Coordinator for the facility and she was interviewed. She reported she provided education to all staff in-house and via phone calls to staff not on duty for the signs and symptoms of</p>		

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F 689	<p>Continued From page 16</p> <p>building twice to find Resident #1 and notified NA #3 and Nurse #1 she could not find Resident #1. NA #1 then explained when she got to the front lobby, she was told by Receptionist #1 Resident #1 was outside and NA #1 went out to retrieve him. NA #1 reported Resident #1 was dressed in a short-sleeve t-shirt, pants that were rolled up to his knees and a baseball cap on 1/30/2019. NA #1 estimated Resident #1 was missing for approximately 15 minutes.</p> <p>Receptionist #1 was interviewed on 2/21/2019 at 11:27 AM and she reported she noticed Resident #1 pass by the front desk on 1/30/2019 and she thought he was going out with transportation staff. Receptionist #1 stated she did not notice how Resident #1 was dressed. Receptionist #1 reported she did not observe Resident #1 after he went through the double doors to the patio. She stated that she received a phone call from a visitor who reported there was a resident on the walkway in front of the facility. Receptionist #1 reported she was not aware Resident #1 was outside the facility unsupervised until she received the phone call. Receptionist #1 reported as she received the phone call, the Dietary Manager (DM) was walking up front. Receptionist #1 reported she had signaled for the DM to go outside. The Central Supply manager (CSM) also arrived at the front desk and Receptionist #1 told her to go outside to help DM. Receptionist #1 concluded by reporting that she was not certain who brought Resident #1 in from outside and she wasn't certain how long he had been outside.</p> <p>A driver for the transportation company was interviewed on 2/20/2019 at 11:21 AM. The driver reported she was picking up a resident for an appointment on 1/30/2019 and as she and the</p>	F 689	<p>potential elopement behaviors.</p> <p>Unit Manager #1 was interviewed and she reported she supported the Staff Development Coordinator with reinforcing teaching to staff. She further reported she was responsible for updating the wanderguard/elopement book and if she was not in the building, the supervisor in charge would update the book.</p> <p>Unit Manager #2 was interviewed and she reported she supported the Staff Development Coordinator by reinforcing teaching to unit staff.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 689	<p>Continued From page 17</p> <p>resident were attempting to leave, Resident #1 was in front of them going through the front doors. The driver reported no alarm sounded when Resident #1 went through the front doors.</p> <p>The DM was interviewed on 2/21/2019 at 11:40 AM and she reported that when she went to the front desk to give invoices to Receptionist #1, the DM was signaled by Receptionist #1 to go outside. She noted Receptionist #1 was on the phone. The DM went on to explain she did not see anyone when she exited the building and she walked to the end of the covered porch and looked right and then left and saw Resident #1 at the end of the walkway. The DM reported she did not remember which staff members came out to assist her to bring Resident #1 back into the building.</p> <p>The CSM was interviewed on 2/21/2019 at 11:00 AM. She reported she was passing through the front lobby on 1/30/2019 when Receptionist #1 told her to go help the DM. The CSM reported she stepped out to the covered porch and did not see Resident #1, but when she walked to the end of the porch, she could see Resident #1 on the walkway and the DM had her arms around his upper body. CSM reported Resident #1's front wheel on his wheelchair was off the end of the sidewalk and the DM was holding him from falling. CSM further reported she lifted the wheelchair back onto the walkway and by then Nurse #1, NA #1 had arrived, and they escorted Resident #1 back into the building.</p> <p>An interview was conducted with NA #2 on 2/20/2019 at 10:19 AM. NA #2 reported she was working in the dining room on 1/30/2019 and it was lunch time. She looked out of the dining</p>	F 689			

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F 689	<p>Continued From page 18</p> <p>room windows and saw Nurse #1, NA #1 and the UM #1 at the end of the walkway outside with Resident #1.</p> <p>NA #3 was interviewed on 2/20/2019 at 10:29 AM and she reported she was working 1/30/2019. She further reported she had been told by NA #1 that Resident #1 was missing and NA #3 started to search the building for him and when she arrived in the front lobby, Resident #1 was being brought in through the front doors by NA #1, Nurse #1 and UM #1.</p> <p>NA #4 was interviewed on 2/21/2019 at 9:15 AM. NA #4 reported she was working in the dining room on 1/30/2019 and she observed the DM running down the walkway in front of the dining room windows. NA #4 reported she saw Nurse #1, NA #1 and Central supply manager outside with Resident #1. NA #4 concluded by reporting that she and NA #3 watched staff bring Resident #1 in from outside through the dining room windows.</p> <p>Resident #1 was observed on 2/18/2019 at 4:15 PM independently self-propelling his wheelchair in the halls of the facility using his feet. He was observed to be able to maneuver around other residents and obstacles.</p> <p>Resident #1 was interviewed on 2/19/2019 at 11:33 AM and he was unable to recall the incident. Resident #1's family member was in the room and she reported she was not aware Resident #1 had been outside without supervision and she had been notified only that a wanderguard was applied to him due to wandering behaviors.</p>	F 689			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 689	<p>Continued From page 19</p> <p>The rehabilitation director (RD) was interviewed on 2/21/2019 at 9:25 AM. The RD reported physical therapy had started treatment with Resident #1 in December 2018 because he was having back pain and he was not able to support himself in the wheelchair. The RD reported physical therapy had worked with Resident #1 to improve his back strength and had introduced him to a high-back wheelchair at the beginning of January 2019 and once Resident #1 had back support, he was able to independently self-propel the wheelchair in the facility. The RD further explained that Resident #1 had poor endurance, but if he was determined to get somewhere in his wheelchair, he would do it.</p> <p>Unit Manager (UM) #1 was interviewed on 2/21/2019 at 10:38 AM. UM #1 reported the incident with Resident #1 was discussed at the interdisciplinary team meeting the next day. She further reported she was completing elopement risk assessments, but nursing staff were being trained to complete the assessments. She reported Resident #1 had a change in his level of activity for several months and he was assessed to not be an elopement risk. UM #1 reported she knew therapy had given Resident #1 a high-back wheelchair, but she was not aware he was able to self-propel the wheelchair.</p> <p>NA #1 was interviewed on 2/21/2019 at 9:44 AM. NA #1 showed where on the walkway Resident #1 was located after he left the building and the distance was measured with the Maintenance Director and the facility's Regional Director of Operations. The distance between the front double doors and where Resident #1 was found was 72.5 feet. The walkway in front of the facility dropped off approximately 6 inches into the</p>	F 689			

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F 689	<p>Continued From page 20</p> <p>parking lot, which sloped downward. Multiple areas were noted with broken asphalt. NA #1 reported she had searched for Resident #1 and was unable to locate him, and when she arrived at the front lobby, she was told a visitor had called to report a half-dressed resident was outside on the walkway. NA #1 reported she, the Central Supply manager and another person assisted Resident #1 back into the facility and she then assisted him back to bed.</p> <p>Weather.com documented weather on 1/30/2019 for the city the facility is located specified high of 31 degrees Fahrenheit and a low of 5 degrees Fahrenheit and partly cloudy.</p> <p>The facility physician (DO) was interviewed via a phone call on 2/20/2019 at 5:21 PM. The DO reported Resident #1 is not safe to be outside unsupervised. The DO went to report she had assessed Resident #1 on 1/31/2019 and he did not have any adverse effects from being outside.</p> <p>The Administrator was interviewed on 2/21/2019 at 12:11 PM. The Administrator reported she was notified by the DON that Resident #1 had gone out onto the front porch and he was brought back into the building by staff. The Administrator reported she had called the facility consultant and after discussion with the consultant, they determined it was not an elopement because Resident #1 had expressed a desire to get fresh air and he did not have wandering behaviors. The Administrator concluded by reporting she did not believe Resident #1 was unsafe, but she did not know him well enough to determine if Resident #1 made good decisions.</p>	F 689			

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F 689	<p>Continued From page 21</p> <p>The Administrator, Director of Nursing, Chief Clinic officer, Regional Clinical Consultant and Regional Director of Operations were notified of Immediate Jeopardy on 2/21/2019 at 2:12 PM. The facility provided an acceptable credible allegation of Immediate Jeopardy removal on 2/22/2019.</p> <p>Date: 02/21/2019</p> <p>Corrective action accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident #4 exited the facility on 1/13/2019 at approximately 04:15PM through the front door of the facility. Resident #4 was assisted to the front porch by the facility receptionist #1 upon his request. Review of resident #4's Brief Interview for Mental Status (BIMs) assessment completed on 11/30/2018 indicated resident #4 scored 14 which is interpreted as alert and oriented.</p> <p>Resident #4 was also coded in MDS assessment with assessment reference date 12/21/2018 indicated resident can make himself understood and understand others always. Likewise; quarterly MDS assessment dated 1/12/19 noted BIMs of 11 which is moderately impaired.</p> <p>Interview with receptionist #1 conducted by the facility Administrator on 2/21/2019 indicate that resident #4 was outside for about 7-10 minutes. Resident #4 is not deemed incompetent and is able to make his decision and has rights to come and go in and out of the facility as he's pleased. Elopement risk assessment completed on 01/08/19 indicates resident was not at risk for elopement hence, the facility maintained resident#4 rights to go and come as he is pleased based on the assessment and per resident's bill</p>	F 689			

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F 689	<p>Continued From page 22 of rights.</p> <p>Licensed nurse #1 walked to the front lobby after being summoned by the receptionist #1. Receptionist #1 walked outside and observed resident #4 on the side walk 50 feet from the location where the resident was placed originally. Receptionist #1 assisted resident #4 back to the facility through the front door. Licensed nurse #1 rolled resident #4 to his room and completed a head to toe assessment and noted no changes from his baseline. Licensed nurse #1 contacted attending physician and resident #4 responsible party on 1/13/19 to notify them of resident #4 action of exiting the facility. A Licensed nurse #1 completed an elopement risk assessment and deemed resident #4 to be at risk for elopement on 1/13/2019, wander/elopement alarm obtained and applied to resident #4 right ankle by licensed nurse #1.</p> <p>Resident #1 exited the facility on 1/30/2019 at approximately 01:15PM through the front door of the facility. Receptionist #2 witnessed resident #1 exiting the facility in the midst of the multitude. (The multitude included the staff members from a contracted transportation company that was exiting the facility). Review of resident #1's Brief Interview for Mental Status (BIMs) assessment completed on 12/21/2018 indicated resident #1 scored 9 (moderately impaired cognition) Resident #1 was also coded in MDS assessment with assessment reference date 12/22/2018 indicated resident #1 can make himself understood, and usually understand others. Review of section E of MDS assessment with ARD 12/22/2018 indicate resident #1 does not have wandering behaviors. Receptionist #2 called the licensed nurse #2 to alert the nurse that resident #1 was at the front porch.</p>	F 689			

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F 689	<p>Continued From page 23</p> <p>Interview conducted by the facility Administrator on 2/21/2019 to receptionist #2 and Dietary manager indicated; receptionist #2 received a phone call from the visitor who was leaving the facility. The caller indicated resident #1 was observed outside. Dietary manager walked outside immediately while the receptionist #2 was still on the phone and observed resident #1 approximately 72 feet away from the front door. All four wheels were on the side walk. Receptionist #2 indicated that resident #1 was outside for approximately less than 10 minutes.</p> <p>Licensed nurse #2 walked to the front porch and assisted resident #1 back to the facility. Licensed nurse #2 notified Assistant Director of Nursing (ADON) that resident #1 was at the front porch. ADON completed an elopement risk assessment and deemed resident #1 to be at risk for elopement on 2/21/2019. Unit Manager #1 notified resident #1 attending physician and licensed nurse #2 notified resident #1 responsible party on 2/21/2019. New order for wander/elopement device obtained and applied to resident's right ankle by licensed nurse #2 on 2/21/2019. Unit Manager #1 updated resident #1 care plan and added wander/ elopement device in place on 2/21/2019.</p> <p>Receptionist #1 and #2 were hired to work at the facility on 09/11/18 and 07/02/2018 respectively. Although both receptionists were educated on the facility elopement management process upon hire, it is concluded that the emphasis on their responsibilities pertaining to elopement management process wasn't well understood. Receptionist #1, and #2 were re-educated by the facility administrator on 2/21/2019 on the</p>	F 689			

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F 689	<p>Continued From page 24</p> <p>importance to ensure that the licensed nurse who care and familiar with the resident who is requesting to go outside is contacted to validate whether the resident is safe to go outside or not.</p> <p>Effective 2/21/2019, and moving forward the facility implemented the process of signing residents out when leaving the facility for an appointment. The transportation company employee will sign the resident out at the front desk before leaving the facility. All transportation company employees will be educated on this requirement before transporting the next resident from the facility effective 2/21/19</p> <p>Address how corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice.</p> <p>100% of Elopement risk assessments for all current residents completed on 02/21/2019, by the Assistant Director of Nursing, to identify any other residents who might be at risk for exit seeking behaviors. Six other residents who were previously identified to be at risk for elopement, re-identified during this assessment, "Elopement books" revised and placed at the front desk, and at each nurse's station by Director of Nursing, Assistant Director of Nursing and/or Unit Manager #1 on 2/21/2019. These books contain a list of residents with exit seeking behaviors, their pictures and resident's descriptions. 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).</p> <p>Measures/Systematic changes made to ensure</p>	F 689			

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F 689	Continued From page 25 that the deficient practice will not re-occur  Effective 2/21/2019, 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; to include but not limited to, behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, stayed near an exit door, and/or attempts to exit the facility. 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 care staff will be notified of new interventions put forth by a licensed nurse through resident's care guide which are located in electronic nursing aide documentation software at each unit. Appropriate intervention to ensure residents who are cognitively impaired receive necessary supervision to prevent accidents while outside the facility will also be included in residents' care plan effective 2/21/2019.  Effective 2/21/2019, if a resident expressed a desire to go outside to the receptionist #1 or #2, the receptionist #1 or #2 will contact a licensed nurse who cares for and is familiar with the resident requesting to go outside to validate whether the resident is safe to go outside or not. If resident is not safe to go outside alone Receptionist #1 and/or #2 will not allow the resident to go outside unsupervised. If any resident desire to be outside, the facility will provide necessary supervision while outside and	F 689			

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F 689	<p>Continued From page 26</p> <p>allow the residents to include resident #4 and resident #1 to exercise their rights effective 2/21/2019. Receptionist #1, #2 or designated staff will be scheduled to implement this process daily including Saturdays and Sundays effective 2/21/2019,</p> <p>Effective 2/21/2019 and moving forward the facility implemented the process of signing residents out when leaving the facility for an appointment. The transportation company employee will sign the resident out at the front desk before leaving the facility. All transportation company employees will be educated on this requirement before transporting the next resident from the facility effective 2/21/19</p> <p>Effective 2/21/2019 all the facility exit doors are locked and can only be accessed using key code with a pin number. Visitors will utilize the facility main entrance to enter the premises, effective 2/21/19. All the facility exit doors are locked using a magnetized lock that releases in case of fire. In case of any other emergency, each locked facility exit door is equipped with an emergency release override switch located beside each exit door to allow the door to demagnetize and/or open from the inside. This is in compliance with Federal and State life safety code.</p> <p>Effective 2/21/2019 and moving forward the facility implemented the process of signing residents out when leaving the facility for an appointment. The transportation company employee will sign the resident out at the front desk before leaving the facility. All transportation company employees will be educated on this requirement before transporting the next resident from the facility effective 2/21/19</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>Effective 2/21/2019, the center interdisciplinary team, which includes Director of Nursing, Assistant Director of Nursing and/or, Unit Manager #1 initiated a process for reviewing clinical documentation for all current residents to identify any elopement risk behaviors documented to include but not limited to, behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, stayed near an exit door, and/or attempts to exit the facility. Any identified elopement behavior will be addressed promptly, a new elopement risk assessment will be completed, plan of care will be developed as appropriate and resident name and picture will be added to the "elopement binders for easy identification by staff promptly by the facility DON, ADON and/or Unit Manager #1. This process will be completed daily Monday through Friday effective 1/31/2019. Findings from this systemic process will be maintained in the facility's daily clinical meeting binder.</p> <p>Effective 2/21/2019 a new elopement risk assessment will be completed for any cognitively impaired resident who voiced a desire to go home or exhibited any elopement risk behaviors. Residents at risk for elopement will be identified using elopement books located at the front desk and at each nurse's station. Elopement Books, contain pictures and detailed descriptions of each residents listed as elopement risks.</p> <p>Effective 2/21/2019 Director of Nursing, Unit manager#1, or designated staff will review and update the Elopement books with changes as they are identified for elopement via risk assessments. Elopement books are in a location accessible to all staff for easy identification of</p>	F 689			

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F 689	<p>Continued From page 28 elopement risk residents.</p> <p>On 2/21/2019, The Facility Administrator re-educated receptionist #1, and #2 on the importance to ensure that the licensed nurse who care and familiar with the resident, requesting to go outside is contacted to validate whether resident is safe to go outside or not before the resident is allowed to go outside. 2/21/2019 Education on the receptionist responsibilities pertaining to elopement management process will be provided by the facility Administrator for any new receptionist upon hire and annually.</p> <p>On 2/21/2019, The Facility Administrator re-educated receptionist #1, and #2 on the new requirement to sign out resident from the facility at the front desk when leaving for an appointment. Receptionist will ensure transportation company personnel sign resident out on the "resident sign out log maintained at the front desk. Receptionist #1 and #2 will not allow any resident to leave the facility following the visitors without signing out effective 2/21/19. Education on the receptionist responsibilities pertaining to elopement management process will be provided by the facility Administrator and/or designated staff for any new receptionist upon hire and annually.</p> <p>On 2/21/2019 the facility Administrator, conducted re-education for current interdisciplinary clinical team to include Director of nursing, Assistant Director of Nursing and/or Unit manager #1 on the required new process of reviewing clinical documentation to identify any elopement risk behaviors. This re-education also emphasized on the importance of completing a new elopement risk assessment when a resident is noted with</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>such behaviors to include but not limited to; behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, stayed near an exit door, and/or attempts to exit the facility. Effective 2/21/2019 Education on reviewing clinical documentation to identify any elopement risk behaviors will be provided by the facility Administrator and/or Director of nursing for any new clinical manager to include ADON, SDC, and/or Unit Manager upon hire and annually. Facility Administrator will conduct the education/re-education for the facility Director of nursing upon hire and annually effective 2/21/2019.</p> <p>Director of Nursing, and/or Assistant Director of Nursing conducted re-education for current scheduled staff, full time, part time and as needed employees for all departments on 2/21/2019, this education included checking, identification of resident who are at risk for elopement though the elopement binders, the need to complete a new elopement assessment when a cognitively impaired resident express the desire to go home, the need to maintain the environment as free of accident hazards as is possible (such as; keep rooms and hallway uncluttered, keep floor dry). The education also emphasized on the importance to ensure any resident requesting to go outside has "weather appropriate" clothing before they exit the facility. Furthermore, the education included the provision on how to identify resident who are safe to go outside unsupervised by contacting the licensed nurse who is familiar with the resident requesting to go outside and validate whether the resident is safe to go outside or not, the education emphasized that, if resident is not safe to go</p>	F 689			

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

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F 689	<p>Continued From page 30</p> <p>outside alone Receptionist #1 and #2 or designated staff member who monitor the front door will not allow the resident to go outside unsupervised. Any facility employee not re-educated by 2/21/2019 will not be allowed to work until educated on this requirement. Effective 2/21/2019 Education on the facility elopement policy and procedure is added on new hires orientation education for all new facility employees. This education will also be provided annually for all staff. The education also included identifying elopement risk behaviors to include but not limited to; behaviors of wandering aimlessly, cognitively impaired residents expressing desire to go home, packed belongings to go home, stayed near an exit door, and/or attempts to exit the facility. Staff members were trained to report those behaviors to licensed nurses promptly for proper follow through.</p> <p>Effective 2/21/2019 the facility will maintain a signage in the lobby asking visitors not to let residents out. The signage is at the prominent location visible to visitors from both inside and outside.</p> <p>The Monitoring Procedure to Ensure That the Plan of Correction is Effective</p> <p>Effective 2/21/2019 the Director of Nursing will monitor the accuracy of the elopement books, and completion of elopement risk assessment on admission, re-admission and quarterly Monday through Friday for seven days then weekly for four weeks than monthly for three months or until the pattern of compliance is maintained.</p> <p>Effective 02/21/2019, Facility Administrator and/or Director of Nursing, will monitor the process of reviewing clinical documentation by conducting</p>	F 689			

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F 689	<p>Continued From page 31</p> <p>clinical meeting daily (M-F), this meeting covers any change of resident condition that occurred from the prior daily clinical meeting, any admission/readmission occurred from the last clinical meeting and/or any incidents or accidents occurred from the prior clinical meeting, and validated whether resident's clinical records were reviewed for any elopement risk behaviors. Any issues identified during this monitoring process will be addressed promptly. Findings from this meeting will be documented on a daily clinical report form and filed in clinical meeting binder in Director of Nursing office after proper follow ups are done. Facility Administrator and/or Director of Nursing will review the completion of clinical meeting daily (M-F) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established.</p> <p>Effective 2/21/2019 facility Business office manager will spot check the front lobby and reception desk to make sure staff is in place at all times. This monitoring process will take place twice daily on Monday through Friday for two weeks then once daily for five more days then weekly for four weeks or until the pattern of compliance is maintained.</p> <p>Effective 2/21/2019 facility Business office manager will monitor compliance of signing out resident at the front desk by comparing the list of residents who exit the facility for an appointment and validate each resident is signed out on the resident signed out log before leaving the facility. This monitoring process will take place daily (Monday through Friday) for two weeks then, then weekly for four weeks or until the pattern of compliance is maintained.</p>	F 689			

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F 689	<p>Continued From page 32</p> <p>Facility Quality Assurance committee was notified of the alleged noncompliance and the plan outlined in this credible allegation on 2/21/2019. The QAPI committee adapted the plan and will be the authorized entity to make any needed modification effective 2/21/2019.</p> <p>Effective 02/21/2019 and moving forward the facility Administrator and/or 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 of this plan monthly for three months, or until the pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.</p> <p>The title of the person responsible for implementing the acceptable plan of correction</p> <p>Effective 2/21/2019 the facility Administrator and the Director of Nursing will be ultimately responsible for the implementation of this credible allegation of immediate jeopardy removal.</p> <p>Date of Immediate Jeopardy removal: 2/21/2019</p> <p>Immediate Jeopardy removal was verified as 2/21/2019.</p> <p>The following verified the facility's Credible Allegation of Immediate Jeopardy removal: The elopement book was observed to be at the front desk and included a picture and demographics of the residents currently identified at risk for elopement. The staff in-services conducted were reviewed and included: the facility policy on elopement, the elopement book and the location, the receptionist</p>	F 689			

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F 689	Continued From page 33 desk to be staffed 7 days per week, 8:00 AM to 5:00 PM and the front doors will be locked at 5:00 PM. The front doors were not to be left unattended during the day from 8:00 AM to 5:00 PM. The attendance records confirmed that all staff had been in-serviced. Receptionist staff are to sign all residents in and out of the building and if a resident is unattended, the receptionist is to call the assigned nurse to clarify if the resident can leave the building. Random staff interviews were conducted including staff from all shifts. All staff members could describe the topics covered during the in-service on elopement. The Assistant Director of Nursing is also the Staff Development Coordinator for the facility and she was interviewed. She reported she provided education to all staff in-house and via phone calls to staff not on duty for the signs and symptoms of potential elopement behaviors. Unit Manager #1 was interviewed and she reported she supported the Staff Development Coordinator with reinforcing teaching to staff. She further reported she was responsible for updating the wanderguard/elopement book and if she was not in the building, the supervisor in charge would update the book. Unit Manager #2 was interviewed and she reported she supported the Staff Development Coordinator by reinforcing teaching to unit staff.	F 689			
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725		3/18/19	

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F 725	<p>Continued From page 34</p> <p>practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations, staff interview and resident interview the facility failed to provide sufficient nursing staff to provide incontinence care and answer call bells for 1 of 3 sampled residents reviewed for dignity(Resident #2).</p> <p>Findings included:</p> <p>This tag was crossed referenced to:</p> <p>F 550: Based on record review, observations resident and staff interviews, the facility failed to treat residents with respect and dignity for 1 of 3 residents reviewed for dignity as evidenced by an</p>	F 725	<p>Root Cause Analysis:</p> <p>Based on the root cause analysis by the administrative team and the Administrator, it was determined that staff did not follow policy with regards to sufficient nursing staffing.</p> <p>Immediate Actions:</p> <p>Resident # 2 was changed on the date of this occurrence.</p> <p>Resident # 2 Discharged prior to our date of compliance to home per his request on 3/04/19. Prior to discharge resident was a minimum assist with his activities of daily living and was able to toilet himself with</p>		

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F 725	<p>Continued From page 35</p> <p>alert and oriented resident who was left in fecal matter (Resident #2).</p> <p>Nursing assistant (NA) #7 was interviewed on 2/17/2019 at 6:30 AM. NA #7 reported she worked 3rd shift (11:00 PM to 7:00 AM) and she is assigned to 30+ residents for care during her shift and it was difficult to answer call bells in a timely manner. NA #7 concluded by reporting residents complained about the time it took for staff to answer their call bells during 3rd shift.</p> <p>Nurse #7 was interviewed on 2/17/2019 at 6:40 AM and she reported she usually worked 2nd shift (3:00 PM to 11:00 PM) but she was working over to help because of low staffing. Nurse #7 reported 2nd shift had very poor staffing, and it was a "skeleton crew" and it was difficult for the NA to answer call bells in a timely manner.</p> <p>An interview was conducted with NA #6 on 2/17/2019 at 6:50 AM. NA #6 reported she had worked 3rd shift with one other NA for a total of 2 NA for the entire building. NA #6 reported when staffing was low it was difficult to get all the work completed and difficult to answer call bells.</p> <p>NA #8 was interviewed 2/17/2019 at 6:54 AM and she reported she worked all 3 shifts at the facility and stays over to help the next shift. NA #8 further reported residents waited a long time for their call bell to be answered because there were not enough staff to provide care to all residents and she had 32-35 residents in her assignment.</p> <p>The Director of Nursing (DON) was interviewed on 2/22/2019 at 7:39 PM and she reported she had hired staff and they were in orientation. The DON reported she was aware residents were</p>	F 725	<p>minimum assistance. He was alert and oriented and able to make needs known. Prior to discharge on 3/4/19 resident was interviewed by the Director of Admissions with no complaints or concerns noted.</p> <p>Identification of Others: An audit of 100% of interviewable residents was completed as of 3/18/19 to determine if their needs are met while maintaining their dignity.</p> <p>Systemic Changes: 100% of employees were educated regarding resident's rights including the right to a dignified existence as of 3/18/19.</p> <p>The nursing management team which consists of the Director of Nursing, the Assistant Director of Nursing/Staff Development Coordinator, Unit Coordinator #1 and Unit Coordinator #2 and the Staffing Coordinator were educated as of 3/18/19 by the Administrator regarding the need to ensure that the facility has sufficient nursing staff to meet the residents needs including incontinent care and timely care to preserve dignity.</p> <p>Any staff member who is unavailable for education will not be allowed to work until they have received the education.</p> <p>All newly hired staff will be educated regarding the need to honor residents rights while maintaining dignity.</p>		

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F 725	Continued From page 36 unhappy with the timeliness of call bell response from the staff.  The Administrator was interviewed on 2/22/2019 at 7:52 PM and she reported it was her expectation the facility had adequate staff to meet the needs of the residents.	F 725	Monitoring: As of 3/18/19 Customer Service Action Rounds will be completed by Department Managers to include, Social Services Director, Unit Coordinator 1, Unit Coordinator 2, Business Office Manager, Activities Director, Certified Dietary Manager, Assistant Dietary Manager, Director of Rehabilitation, Admissions Coordinator, Environmental Services Director, Medical Records Director, Maintenance Director, Staffing Coordinator, Human Resources Director, MDS (Minimum Data Set)Coordinator on all residents daily, Monday-Friday x 1 week and weekly thereafter x one year. During these rounds, Residents will be asked if their needs are being met with dignity as well as call light response time including on weekends, holidays and off hours, and if they are treated with dignity and respect. Concerns expressed during these rounds will be investigated to determine the root cause of the concern. Dignity concerns reported during these rounds will be reported via the Grievance policy and resolution will be accomplished per the residents preferences.  Appropriate action will be taken once root cause is determined.  The Director of Nurses or the Assistant Director of Nursing and the Staffing Coordinator will review staffing schedules one week in advance Monday-Friday x one week then weekly x one year to ensure that the facility has adequate		

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F 725	Continued From page 37	F 725	nursing staff to answer call lights timely and offer care in a manner in order to preserve dignity, this review will include weekends, off hours and holidays.  The Director of Nursing will review these reports daily, Monday-Friday for one week and then weekly and report to the Quality Assurance and Performance Improvement Committee (QAPI) the findings of these reports monthly x 1 year.  The QAPI committee will evaluate the findings from these reports and make changes to the plan as indicated.  The Administrator and the Director of Nursing will be responsible for implementing the acceptable Plan of Correction.		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)  §483.75(g) Quality assessment and assurance.  §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review, observations, physician and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 5/11/2018 compliant investigation survey. This was for one deficiency	F 867	Root Cause Analysis: Based on the root cause analysis by the administrative team and the facility Administrator, it was determined that staff did not follow the facility policy with regards to the Quality Assurance and Performance Improvement.	3/18/19	

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F 867	<p>Continued From page 38</p> <p>in the area of residents receiving adequate supervision to prevent accidents which was originally cited in May 2018. The deficiency was recited again on the current complaint investigation of 2/22/2019. The continued failure of the facility during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance program.</p> <p>The findings included:</p> <p>This tag is cross referenced to:</p> <p>F689: Based on record review, observations, physician and staff interviews, the facility left a cognitively impaired resident unsupervised outside on the facility's front porch (Resident #4) and failed to prevent another cognitively impaired resident from exiting the facility without supervision (Resident #1) for 2 of 3 residents reviewed for accidents. Resident #4 expressed a desire to leave the facility and an elopement risk assessment was not completed by staff. On 1/13/2019 staff assisted Resident #4 outside in his wheel chair and left him unsupervised on the front porch in 30 degree Fahrenheit weather and he self-propelled his wheel chair 50 feet from the facility's front doors before staff saw him and brought him back inside the facility. Resident #1 exited the building on 1/30/2019 in 30 degree Fahrenheit weather dressed in pants and a t-shirt while unsupervised and self-propelled his wheelchair 72 feet to the end of the sidewalk before staff was notified by an anonymous phone call that informed staff the resident was outside the facility without supervision. Residents #1 and #4 were returned inside the facility without injuries.</p>	F 867	<p>Immediate Action: Resident # 2 discharged from the facility to home per his choice on 3/4/19, prior to our date of compliance. Prior to discharge resident was a minimum assist with his activities of daily living and was able to toilet himself with minimum assistance. He was alert and oriented and able to make needs known. Prior to discharge on 3/4/19 resident was interviewed by the Director of Admissions with no complaints or concerns noted.</p> <p>As of 2/28/19 a 100% audit of nursing notes for the past 90 days was completed by Choice Health Management Services Quality Assurance Nurse. This audit was completed in order to identify other residents who may be at risk for the same deficient practice. These audits did not identify additional residents who demonstrated wandering or eloping behaviors.</p> <p>Identification of others: As of 3/18/19 Nursing notes will be reviewed daily, Monday through Friday by the Nurse Management Team to include: Director of Nurses, the Assistant Director of Nursing, Unit Coordinator #1 or Unit Coordinator # 2 to identify any residents who express a desire to leave the facility or otherwise demonstrate exit seeking behaviors. These audits will continue x one year.</p> <p>The Nursing Management team will report to the Administrator daily, Monday through</p>		

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F 867	<p>Continued From page 39</p> <p>During the compliant investigation survey of 5/11/2018 the facility failed to provide supervision to prevent a cognitively impaired resident from exiting the facility (Resident #1) for 1 of 3 residents reviewed for supervision. Resident #1 exited the facility while unsupervised and self-propelled her wheelchair 29 feet to the end of the sidewalk and fell to the asphalt pavement of the parking lot, sustaining a fractured nose, abrasions to her face, hands and knees and a laceration to her left forehead, as well as bruising to her face</p> <p>An interview was conducted with the Administrator on 2/22/2019 at 7:52 PM and she stated the QAA committee met monthly and the facility had a quarterly Quality Assurance Performance Improvement meeting. The Administrator reported it was her expectation for the QAA and QAPI to identify and address issues through observation, complaint trends, family members and to resolve grievances as a team. The Administrator reported the incidents with Resident #4 and Resident #1 were not identified as elopement issues and not discussed by the QAA team.</p>	F 867	<p>Friday, the results of these audits and the corrective actions put in place as a result of these audits as indicated x one year.</p> <p>The QAPI committee will evaluate trends and review suggestions from residents, staff and family members to determine areas of improvement that should be developed by the QAPI committee.</p> <p>Systemic Changes: 100% of the Nursing Management team were re-educated as of 3/18/19 By the Assistant Director of Nursing/Staff Development Coordinator regarding the need to review the nursing notes daily, Monday through Friday and weekend notes on Mondays to identify wandering behaviors in order to prevent elopement.</p> <p>As of 3/18/19 100% of the Administrative Team was educated by the Administrator regarding the need to identify and develop a Quality Assurance and Process Improvement (QAPI) Plan on all identified areas of concern. As of 3/18/19 the Administrative team were educated regarding current QAPI action areas and the need to follow the QAPI plan for each of them.</p> <p>Newly hired Nursing Team Managers will be educated at the time of hire by the Assistant Director of Nursing/Staff Development Coordinator regarding the need to review the nursing notes Newly hired Administrative Team members will be educated by the Administrator at the time of hire regarding</p>		

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:  <b>345183</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/22/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSAL HEALTH CARE &amp; REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>430 BROOKWOOD AVENUE NE CONCORD, NC 28025</b>		
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F 867	Continued From page 40	F 867	<p>the need to identify and develop QAPI on areas of concern as well as the need to follow the QAPI action plan once developed.</p> <p>The Director of Nursing will compile a report on these findings and present to the QAPI team monthly x one year.</p> <p>The Director of Nursing will monitor compliance with current QAPI plans and report the findings to the QAPI committee monthly x one year.</p> <p>The QAPI committee will evaluate the findings of these audits monthly x one year and make changes to the plan as needed.</p> <p>The Administrator and the Director of Nursing will be responsible for implementing the acceptable Plan of Correction.</p>		