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	345534	A. BUILDING _____ B. WING _____	C 09/24/2019

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

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F 000	INITIAL COMMENTS A complaint survey was conducted from 9/23/2019 through 9/24/2019. Past non-compliance was identified at: CFR 483.25 at tag F689 at a scope and severity J. Non-noncompliance began on 9/18/2019. The facility came back into compliance effective 9/19/2019. An extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff interviews, resident Power of attorney (POA) interview, and dentist office staff interview, the facility failed to provide supervision to a non-verbal cognitively impaired resident, who was assessed to be a risk for elopement, during a visit to a dental office for 1 of 3 residents reviewed for accidents (Resident #1). The resident was left unattended at the dental office. He self-propelled his wheelchair out of the building, traveled approximately 25-30 feet where he rolled off the sidewalk. The wheelchair overturned and the resident fell forward out of the chair and onto the concrete parking lot. The resident was transported to the hospital by Emergency Medical	F 689	Past noncompliance: no plan of correction required.	10/10/19

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

Electronically Signed | 10/10/2019

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Services (EMS), where he was treated for superficial cut to his head, abrasions on both elbows and both hands. After being treated at the hospital, the resident returned to the facility.

Findings included:

Resident #1 was admitted to the facility on 10/16/2014 with diagnosis that included cardiovascular accident with right side hemiplegia, aphasia, and dementia with behavioral disturbance.

The resident's most recent annual Minimum Data Set (MDS) dated 9/10/2019 revealed the resident had moderately impaired cognition and is coded as needing supervision/oversight with locomotion.

Resident #1's active care plan dated 9/17/2019 indicated the resident exhibited signs of cognitive loss/dementia with impaired memory and had a wanderguard (a departure alert system to prevent residents from exiting the facility unsupervised) secondary to wandering/elopement risk. The goal indicated, "resident will not leave secured area unattended." Interventions/approach for wandering/elopement risk included to observe resident's whereabouts when out of bed.

The resident's nursing notes revealed a note written on 9/17/2019 at 11:05 PM that specified the nurse aide (NA) working on resident's hall found the resident face down on the fall mat next to his bed which was noted to be in the lowest position. The NA made the nurse aware and the resident was assessed for injuries. The nurse's documentation indicates the resident had redness to right cheek and ear as well as a dime size abrasion to his left knee. The doctor, Director of

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Nursing (DON), and POA were notified of the fall. The POA requested the resident be sent to the emergency department for evaluation of injuries.

The EMS report dated 9/18/2019 indicated they received the call from the facility at 1:03 AM, reached the resident at 1:20 AM, where he was found to be in his bed asleep, easily aroused and responding appropriately to staff. The report indicated he arrived at the hospital at 1:55 AM on 9/18/2019.

Resident #1's hospital records indicated he was evaluated for injuries, diagnosed with oral thrush, and transported back to the facility where EMS noted transfer of care at 7:05 AM on 9/18/2019.

In a nurse's progress note dated 9/18/2019, Nurse #1 documented that Resident #1 was transported from the facility to a dental appointment by a contracted transport company around 10:15 AM. She also indicated she sent paperwork with the resident and that the Power of Attorney (POA) was scheduled to meet the resident at the dental office. Nurse #1, later documented the dental office receptionist had called the facility at approximately 11:30 AM to let them know the resident had wheeled himself out into the parking lot, fallen, and was injured. The dental office receptionist reported EMS had transported the resident to the hospital emergency department (ED).

The EMS report dated 9/18/2019 indicated they reached the resident at 11:13 AM and found him lying on the concrete next to a concrete car stopper. Resident #1 was on his right side with obvious laceration to his right forehead that was not actively bleeding. The report indicated the

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dental office staff advised EMS the resident was left unattended by facility transport and that he wheeled himself out to the parking lot where the resident fell forward out of the wheelchair onto the concrete. EMS noted the resident was non-verbal but answered yes/no with his head. Resident #1 was transported to the hospital where he was evaluated for injuries.

Review of ED provider note dated 9/18/2019 revealed Resident #1 arrived at the ED at 11:27 AM and was evaluated for injuries after an "unwitnessed fall from his wheelchair". Computed Tomography (CT) of the cervical spine revealed no evidence of fracture. CT of the pelvis revealed no acute fracture. ED physician reported resident had laceration to head. Bleeding was controlled with no need for laceration repair, however, surgical glue was applied at the request of the POA for "wound protection".

On 9/23/2019 at 10:30 AM the resident was observed in his room within the secured unit, lying in his bed, eyes closed with NA #1 at bedside in one on one capacity. The resident appeared to understand communication from others but did not attempt to respond verbally. The resident had bandages on right temporal region with redness and bruising just below the bandage. He also had bandages covering the right elbow, right thumb, left elbow, and left thumb. Observed wander guard on left ankle.

An interview was conducted with NA#1 9/26/2019 at 10:30 AM. NA #1 stated the resident had been one on one since his fall on 9/18/2019. NA#1 reported the resident communicates mainly through gestures. She gave examples of how he gestured for "smoke", "go to bed", and "get

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wheelchair". She stated he did very well self-propelling himself down hall when going to smoking area. NA#1 described the resident's exit seeking behaviors occur mostly when he is wanting to smoke.

On 9/23/2019 an interview was conducted at 1:10 PM with the receptionist at the dental office where this incident occurred. The receptionist working the day of the incident stated Resident #1 was brought into the office in a wheelchair being pushed by the driver for the contracted transport company. She reported the driver came to the desk and gave her the resident's name and paperwork prepared by the facility. At that time, the receptionist stated she told the driver the resident would not be seen by the dentist without a POA present. The driver then told her the POA was on her way to meet the resident at the dental office per the facility. The dental receptionist further stated the driver told her she could not stay with the resident because she (the driver) had other residents on the van that needed to be transported to appointments as well. The dental receptionist stated she turned her back to the resident to look up the facility's number and call the facility. She stated she spoke with a nurse, she could not recall her name, regarding the POA not being in the office and that the dentist would not be able to see the resident without a POA being present. She was told by the nurse, they would try to contact the POA and if they could not get up with her, they would call transport to go back to the office and get the resident. The dental receptionist stated when she hung up the phone and turned around, Resident #1 had made his way out of the building. She immediately called the facility and let them know the resident was no longer in the waiting area. The dental receptionist

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further stated shortly after she hung up the phone, a client ran into the office and asked her to call 911 because a man in a wheelchair had fallen and was bleeding. She called the facility back and let them know what had happened and that EMS was enroute. The dental receptionist reported she was not told the resident was at risk for elopement or wandering by the facility or by the transport driver.

A phone interview was conducted on 9/24/2019 at 8:34 AM with the driver who transported Resident #1 to his dental appointment on 9/18/2019. She stated she picked the resident up at the facility on the morning of 9/18/2019. She stated when she got there, the resident was in his wheelchair and parked inside the building at the side entrance sliding door with several other residents scheduled for transport that morning. The nurse handed her his paperwork and gave her his name and where he was to be transported. The transport driver stated she was never told the resident lived in the secured unit, wore a wander guard, or had behaviors such as wandering. She further stated she pushed the resident into the dentist office, checked him in and told the receptionist the POA was meeting the resident at the office. The receptionist at the dental office told her the resident would not be seen without a POA, and stated she would call the facility. The transport driver stated she had other residents on the van that needed to get to medical appointments. The transport driver reported returning to the dental office after receiving a call from the facility. She did not remember what time that call was received. She was instructed to go back and get the resident from the dental office and bring him back to the facility. The driver stated when she returned to the dental office, she

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passed the ambulance as she was pulling into the parking lot of the dental office.

A phone interview with the POA was conducted on 9/23/2019 at 12:17 PM. She stated the resident had a scheduled dental appointment on 9/18/2019 at 11:00 AM to be seen for mouth ulcers on the resident's lower lip. On the night before the appointment she received a call from the facility stating the resident had fallen. She requested the resident be transported to the ED for evaluation. The POA further stated she was present in the ED when the ED physician evaluated the oral ulcers, diagnosed the resident with thrush, and prescribed medications to treat the thrush. The resident was transferred back to the facility in the early morning hours of 9/18/2019, she was not certain of the exact time. The POA stated on the morning of 9/18/2019 she called the facility and spoke with Nurse #2 regarding the medication for thrush. The POA stated she did not tell the nurse to cancel the dentist appointment but assumed she would since the ulcers were the reason the resident was going to the dentist. The POA further stated that later that same morning she got a call from the facility regarding the dental appointment and fall.

Observation of the dental office parking lot and interview with dental office receptionist on 9/23/19 at 1:10 PM revealed the parking lot was located at the top of a hill that lead to a heavily traveled, four lane highway with a 45 miles per hour speed limit. The receptionist pointed out the sidewalk where Resident #1 self-propelled his wheelchair approximately 20-25 feet before falling forward out of his wheelchair onto the concrete, next to a concrete car stopper. The receptionist specified the resident was found lying on his right side with

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a laceration to his right forehead. The receptionist stated the Dental office staff stayed with the resident until EMS arrived.

Interview with the administrator was conducted on 9/23/2019 at 11:45 AM, she was aware of the incident with Resident #1 being left at dentist office unaccompanied and the subsequent fall. She further stated the POA was to meet the resident at the dental appointment but did not show. The facility administrator reported she learned of the incident when the dental office called the facility and let them know the POA had not shown for the appointment. The administrator stated the facility attempted to call the POA, and then called the transport driver to go back and get the resident. By the time the transport van returned to the office, the resident had been transported to the hospital ED by ambulance. The facility administrator acknowledged the resident was left at the office unattended and did self-propel his wheelchair out of the dental office which lead to a fall and injury. The administrator confirmed the resident did live in the "secured unit" and did wear a wanderguard due to risk for elopement.

At 2:26 PM on 9/24/2019 another interview was conducted with the facility administrator in which she reported the facility typically transported residents but they did occasionally use two other transport companies. She stated they put a performance improvement plan into place immediately on 9/18/2019. This included a staff member accompanying residents who needed supervision during transport and to outside appointments. She reported Resident #1 was evaluated by a physician in the ED, returned to the facility the same day, and was immediately

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F 689	Continued From page 8 placed on one to one observation with a staff member. She further stated he has remained on one to one since the incident on 9/18/2019. The following is the facility's corrective action plan: Facility compliance date of corrective action 9/19/2019. Corrective Action for the resident involved: Resident involved in the elopement was transported from the dental office to the hospital ED by EMS for evaluation. The resident returned to the facility via EMS from the ED post evaluation. No follow up treatment was required for the resident. To prevent the event from recurring, the resident will be accompanied by a staff member to all outside appointments. Identification of potentially affected residents and corrective actions taken: An audit of all resident with need for supervision who had appointments on 9/18/2019 was conducted to ensure a staff member would be present with the resident at the appointment and during transport. Completed 9/18/2019. One resident requiring supervision had an appointment on 9/18/2019 at 2:15pm, this resident was accompanied by a NA. Systemic Changes: Education On 9/18/2019 the Staff Development Coordinator and RN Supervisor began education of all	F 689		

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licensed nurses and transportation aides/transport drivers that included the following information: All appointment schedules must be reviewed daily by Nurse Administration to ensure any identified resident in need of supervision has an appointed staff member assigned to them to accompany the resident to scheduled appointment. A staff member from the facility must attend appointment with resident and stay with them until the arrive back to the facility. If family decided to transport the identified resident, then a staff member does not have to accompany resident to the appointment.

Quality Assurance
The Director of Nursing, Administrator, Unit Manager, RN Supervisor, or Staff Development Coordinator will review the transportation log daily, Monday thru Friday to assess which residents are in need of supervision at the outside appointment. Any resident that has triggered as an elopement risk, resides in the secured unit, or needs additional supervision for tasks required at the outside appointment shall have a staff member accompany them. The employee that will accompany the resident on an outside appointment will be written next to the resident's name on the transportation appointment calendar.

The Director of Nursing, Administrator, Unit Manager, RN Supervisor, or Staff Development Coordinator will review the transportation log Monday thru Friday for four weeks, then monthly for one month to ensure that residents who have need for supervision had a staff member present during an appointment unless a family member took the resident to the appointment.

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The Director of Nursing will review these audits monthly and present the findings to the facility Quality Assurance Committee for further recommendations monthly for two months.

The facility's date of compliance was validated as 9/19/2019.

Review of the facility Plan of Correction on 9/23/2019 revealed an Inservice record for ensuring any identified resident in need of supervision had an appointed staff member assigned to them to accompany them to outside appointments dated 9/18/2019, which included a sign in sheet with signatures of nurse, nurse aides, and transportation aides/drivers.

Review of the transportation calendar from 9/19/2019 thru 9/24/2019 revealed the facility utilized accompanying staff member on one occasion, 9/24/2019, and that the daily transportation calendar was reviewed by one of the designated staff members as signified by their initials and date signed.

Additionally, staff interviews and observations were conducted during the survey which showed staff were knowledgeable on plan of correction and received the education on 9/18/2019. Review of the facility plan of correction revealed evidence of 100% auditing of residents requiring transportation.