STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(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 survey was conducted onsite from 4/28/22 through 4/29/22. Additional information was obtained through 5/5/22. Therefore, the exit date was changed to 5/5/22. 1 of 2 allegations was substantiated, NC00188484. 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 4/25/22 and was removed on 5/1/22. A partial extended survey was conducted on 5/5/22.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		5/27/22

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

Electronically Signed | 05/23/2022

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F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the resident's responsible party (RP), the facility failed to notify the responsible party of elopement for 1 of 3 residents reviewed for notification of change (Resident #1). The findings included:	F 580	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 04/25/22, resident #1 was found outside. The responsible party (RP) was	

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F 580	Continued From page 2 Resident #1 was admitted to the facility on 1/11/19. A document entitled, "Order on Application for Appointment of Guardian," dated 6/24/20 in Resident #1's medical record indicated the Court concluded that it was not in the best interest of the respondent (Resident #1) that he retain certain rights and privileges set forth. It was ordered that the person named (Resident #1's responsible party) was appointed as guardian of the respondent to serve in the capacity designated. A progress note in Resident #1's electronic medical record dated 4/25/22 at 7:41 AM written by Nurse #1 indicated assistance was requested by the Administrator with an incident outside at the back of the building. Resident #1 was found outside by the loading dock on the ground on his left side. Responsible party (RP) will be notified when directed to do so by the Administrator. The Administrator requested to wait to call when he had completed his investigation. An interview with Nurse #1 on 4/28/22 at 9:46 AM revealed on the morning of 4/25/22 around 6:50 AM, she was alerted by Housekeeper #1 that a resident was lying on the ground outside near the loading dock at the back of the building. She told the Administrator that they needed to notify Resident #1's RP about the elopement incident but the Administrator told her that he would notify her after he had finished with the investigation. An interview with Nurse #3 on 4/29/22 at 11:29 AM revealed she had talked to Resident #1's RP on the phone on 4/26/22 but she did not mention	F 580	not notified properly due to the administrator having left a voicemail on phone. The administrator was in-serviced 1:1 by the regional nurse consultant on 05/19/2022, on the timeliness of resident representative notification of any change of a resident□s condition. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: A review of current resident medical records for the past 30 days was completed by the social worker/designee to ensure that resident representatives were notified timely of a resident change of condition and discharge to another facility. This audit was completed on 5/19/22. No further issues were identified. Adress what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 5/19/2022 All current licensed nurses, including agency licensed nurses and the social worker were in-serviced by the Administrator / designee on responsible party notification with all significant changes in resident conditions, falls, elopements and rehospitalizations. Any current licensed nurse, including agency licensed nurse, that were not present for this in-serviced are not allowed to return to work until in-serviced. Administrator and/or administrative designee is responsible for the tracking of 100%	

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F 580	Continued From page 3 anything about the elopement or the fall incident because she did not know the specifics of the situation. A phone interview with Resident #1's responsible party (RP) on 4/28/22 at 3:57 PM revealed she called the facility on 4/26/22 and talked to Nurse #3 but nothing was mentioned about an elopement on 4/25/22 that involved Resident #1 or that he had fallen while he was outside. The RP received a phone call from the Administrator on 4/27/22 who asked her if she received the voicemail he left for her. The Administrator told her that he needed to disclose that Resident #1 was found outside the facility on 4/25/22 around 6:30 AM. Resident #1's RP stated she was upset that she didn't get notified right away and she wanted to be notified of any incident that involved Resident #1 as soon as possible especially of an elopement because Resident #1 was at risk for falls, and she did not want him to be left unattended outside of the facility. She also stated that she had left an alternate number on her voicemail that they should have called in case of emergencies, and they needed to get ahold of her right away. An interview with the Director of Nursing (DON) on 4/28/22 at 11:31 AM revealed she was not sure if Resident #1's RP had been notified of the elopement incident on 4/25/22. The DON stated she had talked to the Administrator that they needed to notify the RP about the incident, but he told her the incident was not considered elopement because Resident #1 used to go outside in the courtyard by himself to get some fresh air. The DON stated she disagreed with the Administrator, but he insisted that he wanted to do his investigation into the incident first before	F 580	compliance. As staff come into work the Administrator and/or administrative designee determine which staff have not done in servicing using a logged staffing roster for all nursing staff and those not displayed are provided the necessary education and sign documentation. Human Resources will ensure all new hire orientation on notification of changes. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed: During the morning clinical meeting the DON and/or Administrative Nurse will monitor the pink slips, discharge reports and nurses note in clinical meeting each morning to ensure that the responsible party or resident representative is notified with all significant changes in resident conditions, falls, elopements and rehospitalizations daily/5 days weekly x 1-month, weekly x 1 months, and monthly for one month, to ensure continued compliance. The Director of Nursing and/or Administrative Nurse will complete a summary of audit results and present at the facility monthly Quality Assurance Performance Improvement meeting, to ensure continued compliance. Compliance Date: 05/27/2022.	

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F 580	Continued From page 4 talking to Resident #1's RP. An interview with the Administrator on 4/28/22 at 11:53 AM revealed he had told Nurse #1 to hold off on notifying Resident #1's RP about the elopement incident until he got a conclusion on why and how he got outside the facility. The Administrator stated he wanted to understand the specifics of the incident and didn't want a nurse to call Resident #1's RP. The Administrator stated he wanted to be the one to notify Resident #1's RP but he didn't want to upset her without him knowing or having an idea as to how the resident got out of the facility.	F 580		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with staff and the Nurse Practitioner, the facility failed to have systems in place to alert staff that a severely cognitively impaired resident had exited the facility for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 who had a diagnosis of dementia exited the facility without staff's knowledge at an undetermined time on 4/25/22 and was found lying on the ground outside at the back of the facility at 6:44 AM by a staff member	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/25/22 Resident #1 exited the facility unsupervised sometime after 6 a.m. He was discovered on the ground outside the back of the facility at 6:44 am. Resident #1 was noted by Nurse # 2 to be in his room at approx. 4:30 am as she administered a.m. medication to him.	5/27/22

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F 689	Continued From page 5 coming into work. He was assessed and observed with abrasions to both elbows. Immediate Jeopardy began on 4/25/22 when Resident #1 exited the facility without staff knowledge. Immediate Jeopardy was removed on 5/1/22 when the facility provided and implemented an acceptable credible allegation of compliance. 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, complete elopement drills and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: Resident #1 was admitted to the facility on 1/11/19 with his most recent re-admission on 1/6/22 with diagnoses that included atherosclerotic heart disease, chronic obstructive pulmonary disease, congestive heart failure, diabetes, presbyopia (farsightedness), macular degeneration, cataracts, and dementia. A document entitled, "Order on Application for Appointment of Guardian," dated 6/24/20 in Resident #1's medical record indicated the Court concluded that it was not in the best interest of the respondent (Resident #1) that he retain certain rights and privileges set forth. It was ordered that the person named (Resident #1's responsible party) was appointed as guardian of the respondent to serve in the capacity designated. Resident #1's care plan dated 12/17/21 indicated	F 689	Resident # 2 (resident council president) notes seeing Resident #1 in the hallway after 6 am. Approximately 6:44 am Housekeeper #1 notes seeing Resident #1 outside in the back-parking lot lying on the ground as he was coming into work. Resident #1 was appropriately dressed for the season. Approximately 6:47 am Housekeeper #1 communicates with the Administrator that he saw resident outside. Administrator goes outside with Housekeeper and finds Resident #1 alert while on the ground wearing a jacket, t-shirt, sweatpants, shoes and hat. Administrator communicates for housekeeper to go inside nursing home and request a nurse. Approximately 6:50 am Nurse #1 comes outside, asks the resident questions and assesses resident for injury. Housekeeper #1 was instructed to bring Resident #1□s wheelchair and Resident #1 is escorted back into the facility by Nurse # 1 and Administrator. Nurse takes resident to his room. A full skin assessment was performed for Resident #1, noted that he had small abrasions, they were cleaned with normal saline and dried. Range of motion was performed and when raising left arm discomfort was noted. There was no evidence of any head injury. Vital signs were obtained and indicated an elevated blood pressure of 138/91, pulse 94, temp 97.2, O2 sat 97%. Nurse Practitioner (NP) & RP notified on 4/25/22. Administrator left voicemail on phone for the guardian of Resident #1 due to no response at the time of call. After the resident was returned inside the	

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F 689	Continued From page 6 he was at risk for falls and injury related to weakness, impaired mobility, impaired vision, and poor endurance. His care plan also indicated he had cognitive impairment related to a diagnosis of dementia and he was at risk for having difficulty navigating within the environment and falls related to diagnoses of presbyopia, macular degeneration of both eyes (early dry stage) and nuclear cataracts to both eyes. Resident #1 did not have a care plan for wandering behaviors or risk for elopement. The Elopement/Wandering Risk Review for Resident #1 dated 1/27/22 indicated Resident #1 was not at risk for elopement/wandering at the time of this assessment. The annual Minimum Data Set (MDS) assessment dated 4/7/22 indicated Resident #1 was severely cognitively impaired and had impaired vision and used corrective lenses. Resident #1 was independent with bed mobility but required supervision with transfer, walking and locomotion. His balance during transitions was not steady but he was able to stabilize without staff assistance. Resident #1 did not exhibit wandering behaviors during the assessment period. A document entitled, "Resident Incident Report," dated 4/25/22 at 6:46 AM in Resident #1's medical record and completed by Nurse #1 indicated Resident #1 was found outside at the back of the building on the ground by housekeeping. Resident #1 was assessed and assisted to wheelchair and brought in the building for a full assessment and vital signs. Abrasion to both elbows, wounds cleaned with no further care required.	F 689	facility, he was in a wheelchair within sight at the nursing station (North) for observation. No further wandering behavior noted. Resident #1 elopement risk assessment was completed by Nurse #1 and updated on 4/25/2022. The assessment indicated that Resident #1 was at risk for elopement After the investigation, it was determined that Resident #1 could have opened the West wing door to enjoy weather and was able to exit the building unsupervised. This occurred as a result of the door lock being placed in an override position and floor staff unable to hear the alarm indicative of door being open. Resident #1 behavior care plan was updated by MDS Coordinator to reflect the unsupervised exit on 4/25/2022. Resident # 1 had never had a need for an elopement care plan prior to date 4/25/2022 due to no documented history of wandering behavior On 4/25/2022 during the Nurse Practitioner□s initial assessment of Resident #1, he was found to be awake and alert but with increased confusion from baseline. The patient denied hitting his head during the fall and denied having any headache and the NP did not determine a that there was a need to send patient out to the emergency department. Later in the morning Resident # 1 became less responsive and was sent to the emergency department for evaluation and treatment. Address how the facility will identify other	

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F 689	Continued From page 7 A progress note dated 4/25/22 at 7:41 AM written by Nurse #1 indicated assistance was requested by the Administrator with an incident outside at the back of the building. Resident #1 was found outside by the loading dock on the ground on his left side. Resident #1 was questioned as to how he ended up out there, with no clear answer. Resident #1 pointed to the door by the cooler, then he pointed to the back door by the time clock. Housekeeping brought Resident #1's wheelchair out. Resident #1 was assisted to his chair and brought to his room for a full body assessment. Range of motion was performed, resident stated there was some discomfort when raising his left arm. Small abrasions were found on both elbows, area was cleaned and dried, no further care needed. Vital signs were taken, blood pressure elevated at 138/91, pulse 94, temperature 97.2 degrees, oxygen saturation 97%. Resident #1 did not state any further problems at this time. An interview with both Housekeeper #1 and Housekeeper #2 on 4/28/22 at 10:28 AM revealed Housekeeper #1 noticed a man lying on the ground by the loading dock at the back of the facility around 6:44 AM on 4/25/22 when he arrived at the facility for work that day. Housekeeper #1 stated he wasn't sure if the man was a resident or a homeless person, so he went inside the facility and immediately informed Housekeeper #2 to identify the man outside. Housekeeper #2 recognized Resident #1's hat when he went outside so he instructed Housekeeper #1 to get some help. Housekeeper #1 came back with the Administrator who then instructed him to get a nurse. The Administrator asked Resident #1 how he got out of the building,	F 689	residents having the potential to be affected by the same deficient practice: On 4/25/2022 at 07:20 am the Administrator conducted facility door checks to ensure that each were locked and secure. Administrator noted one door unlocked (West wing). Administrator placed the unlocked door back in locked fashion. The West wing door found to be unlocked was proximate to the location of where Resident #1 was found lying alert on the ground. On 4/25/2022 at 07:30 am the Director of Nursing Services conducted a facility head count to ensure that all residents were accounted for inside the nursing home. All residents were accounted for and Resident # 1 was noted back in his room. On 4/25/2022 All current census residents were reassessed for exit seeking behaviors, this included completing a new elopement assessment. This task was completed by the Director of Nursing Services and administrative nurses and finalized on 04/28/2022. This also, included ensuring that each resident who was identified as high risk for elopement had a care plan to address their behaviors. On 4/25/2022 all elopement binders were audited by Unit Managers to ensure that they were up to date with current residents with high risk for elopement. These binders are located at the front desk and at each nursing station. These books contain the list of residents with exit-seeking behaviors, their pictures and	

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F 689	Continued From page 8 and he pointed towards the doors behind the wall cooler on the loading dock. They asked him how long he had been outside, and Resident #1 stated to them that he might have been outside for about an hour. Housekeeper #1 stated he notified Nurse #1 about Resident #1 lying on the ground at the back of the facility. Housekeeper #1 also obtained Resident #1's wheelchair which was still inside his room. Both Housekeeper #1 and Housekeeper #2 assisted the Administrator and Nurse #1 in getting Resident #1 into his wheelchair and back into the building. Housekeeper #2 stated Resident #1 couldn't have gone out through the doors behind the wall cooler because these doors led to the laundry room which were locked from the inside. They both remembered Resident #1 was wearing jeans, a black and white hat, red tennis shoes, a shirt, and a hoodie. Housekeeper #2 stated Resident #1 was not wearing his glasses. Housekeeper #2 also stated it had been a little chilly that morning but there was no rain or wind, and it was already light outside. An interview with Nurse #1 on 4/28/22 at 9:46 AM revealed on the morning of 4/25/22 around 6:50 AM, she was alerted by Housekeeper #1 that a resident was lying on the ground outside near the loading dock at the back of the building. Nurse #1 observed Resident #1 lying on his left side on the handicap ramp by the dumpster near the loading dock. The Administrator, Housekeeper #1, and Housekeeper #2 were all standing around Resident #1. Nurse #1 asked Resident #1 how he got outside, and he pointed towards the two exit doors behind the cooler on the loading dock. Nurse #1 stated she thought Resident #1 was confused because it didn't make sense to her how he could have gotten out of	F 689	resident□s description. On 04/28/2022 care plans were updated for all additional residents who triggered for at risk for elopement by the MDS nurse. In total 6 residents were identified with wandering behavior which causes them to be at risk for elopement. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: New residents upon admission, quarterly, and at a significant change of condition are evaluated for elopement risk by the administrative nursing team during clinical morning meeting and weekly standard of care. The assessments identify deficits in cognitive, diagnosis, ADL impairment, and /or history of elopement behavior. At the time of identifying a resident at high risk, the facility director of nursing and or administrative nurse will update their elopement books that are located at each nurse□s station and at the front desk. Facility staff receive training on the updates to the Elopement Manual. This is already a process and it will continue. 4/26/22, Education on Door Alarms and the response to alarms was completed by the Administrator and/or administrative designee to all staff, including agency, all departments. Education also includes ensuring staff door securement response is vigilant by all staff making sure all exit doors are locked and only utilizing one	

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F 689	Continued From page 9	F 689		

either door that he pointed to. Resident #1 also kept on saying that he needed to go to work. Resident #1 was wearing red tennis shoes, gray sweat pants, black pullover t-shirt and a green jacket that was zipped up. He did not have his glasses on when she observed him. After assessing Resident #1 and making sure it was safe to move him, Housekeeper #1 obtained Resident #1's wheelchair which was still inside his room. They assisted Resident #1 to his wheelchair and brought him inside the building and into his room. As they brought him back inside, they asked him again how he exited the facility and he pointed to the nearest door where they found him which was the door by the time clock. Nurse #1 stated she didn't think Resident #1 could have gotten out of that door either because it was controlled by a keypad where you have to enter a code in order to lock or unlock it. She completed a full body assessment and observed abrasions to Resident #1's elbows. She did not observe any other signs of significant injuries. His blood pressure was a little elevated, but it wasn't abnormal for him. Nurse #1 stated Resident #1 had not tried to get out of the facility before and he never walked around without pushing his wheelchair. She remembered the weather that morning to be comfortable for her even without a jacket and it wasn't raining or windy.

An observation on 4/28/22 at 10:09 AM with Nurse #1 of the handicap ramp where Resident #1 was found on 4/25/22 revealed it was approximately 50 feet to the nearest door. The path to the door was curved but paved with a slight incline. The ramp was about 20 feet away from the loading dock and led straight to the back parking area. Another side walk approximately

entry and exit from the facility that being the front entrance to the facility. Current staff, including agency will not be allowed to work until they have completed this training. No staff members who have not received the education will work until they complete the education. Administrator and/or administrative designee are responsible for the tracking of 100% compliance. As staff come into work the Administrator and /or administrative designee determines which staff have not done in servicing using a logged staffing roster for all staff, all departments and those not displayed are provided the necessary education and sign documentation. Human Resources will ensure all new hire orientation on door alarm education and elopement policy. 4/29/22, Administrator and/or administrator designee provided education to current nursing staff, including agency staff, all departments related to the Elopement Policy. Education includes the facility policy for elopement or suspected elopement, signs/symptoms of elopement risk, supervision of residents with exit seeking behavior and intervention strategies, and elopement booklet locations. Resident safety is the responsibility of all staff. At the time of a door alarm sound the staff member at the door site will immediately initiate an extensive search of the surrounding outside area. Any staff member who becomes aware of a missing resident will alert all personnel using the facility approved protocols (internal alert code: code AMBER). A head

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F 689	Continued From page 10 100 feet away led to the West hall exit door which was found unlocked after the elopement incident. There was a grassy area next to the paved side walk. The facility was surrounded by a wooded area and approximately 100 feet from the handicap ramp was a paved walkway that led directly to the church parking lot next to the facility. The 4-lane main road with a posted speed limit of 45 mph (miles per hour) was approximately 500 feet from the back of the facility where Resident #1 was found. An interview with the Administrator on 4/28/22 at 11:53 AM revealed Resident #1 was found outside at the back of the facility on 4/25/22 around 6:45 AM. Staff identified him and then they came to him for help. They worked to get him back inside the facility. Resident #1 stated he was looking to go home. The Administrator stated he did not know if this was normal behavior for Resident #1. When the Administrator went outside, it was obvious to him that Resident #1 fell, and he was lying on his left side. Resident #1 pointed towards the wall cooler and then to the exit door where the time clock was when he asked him how he got out the building. Nurse #1 assessed Resident #1 for any injuries. Once Resident #1 was back inside, the Administrator started interviewing staff members and residents who were there. He stated the resident council president told him that he last saw Resident #1 around 6:00 AM in the hallway walking without his wheelchair. He inspected all the exit doors and found out that all the exit doors were locked except for an exit door on the West hall, which was unlocked, and he observed the switch to be turned down instead of up. The Administrator stated he couldn't determine who had unlocked the West hall door, but the	F 689	count will be immediately prompted to ensure 100 percent of residents are accounted. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units. Staff should promptly report any resident who exhibits elopement or wandering behaviors to the charge nurse or Director of Health Services. Staff will coordinate search teams with resident identification for a resident not found in the building or on the grounds or on an authorized leave, notify the Administrator, legal representative, attending provider and law enforcement officials. Current staff, including agency will not be allowed to work until they have completed this training. No staff members who have not received the education will work until they complete the education. Newly hired staff will receive this education during orientation. Administrator and/or administrative designee is responsible for the tracking of 100% compliance. As staff come into work the Administrator and /or administrative designee determines which staff have not done in servicing using a logged staffing roster for all staff, all departments and those not displayed are provided the necessary education and sign documentation. Human Resources will ensure all new hire orientation on door alarm education and elopement policy. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed:	

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F 689	Continued From page 11 receptionists were supposed to check all the exit doors every 6 hours and he was told by the Receptionist that she had last checked it on 4/25/22 at 6:00 AM and she observed the West hall exit door to be locked. A review of the weather conditions per Weather Underground website revealed the following data for Charlotte, North Carolina on 4/25/22 at 5:52 AM: 61 degrees Fahrenheit (F) with no precipitation, South wind speed at 6 miles per hour (mph). The conditions at 6:52 AM were 60 degrees F with no precipitation, South-Southeast wind speed of 5 mph. An observation of the West hall exit door with the Administrator on 4/28/22 at 12:15 PM revealed a code had to be entered on the keypad on the wall right next to the door in order to unlock and lock it. He pointed to a switch that was covered by a plastic cover. The Administrator stated when he inspected all the exit doors, the switch to the West hall exit door was turned down instead of up, indicating that the door was unlocked. He lifted the plastic cover and flipped the switch down. As soon as he lifted the plastic cover, a loud alarm was heard but it stopped right after the plastic cover was replaced. There was enough time to flip the switch down and unlock the door without having to enter a code on the keypad on the wall near the door. He opened the door and an alarm sounded which could only be heard at the keypad and it only sounded while the door was opened. When he closed the door, the keypad alarm stopped but the door was still unlocked because the switch was in the down/override position. A phone interview with Nurse #2 on 4/28/22 at	F 689	The Administrator implemented on 4/29/2022 an ongoing every15 minute monitoring of the exit doors to ensure that the door lock has not been placed in an override position. These rounding efforts will be documented and reviewed on an ongoing basis. Facility exit doors will be monitored by receptionists and/or designee every 15 minutes daily for 4 weeks, then weekly for 10 weeks. The Maintenance Director checks the doors daily as a regular preventative maintenance task Monday through Friday to determine functionality of the lock and the door alarms. All receptionists and other specific designees were appointed by Administrator to complete every 15-minute daily monitoring checks. On 4/29/2022 the Administrator completed education to all designated receptionists and other specific designees on every 15 minutes daily monitoring. On 4/29/2022 Administrator coordinated a visit with Modern Systems Inc to increase the volume of west wing door alarm. On 4/30/2022 Modern Systems Inc came and reviewed the west wing door identified as softly beeping and reprogrammed the door and another that was found not loud enough by the Maintenance Director on 04/29/2022. The Maintenance Director audited all exit doors on 4/29/2022 for which doors needed a volume level increase. The Maintenance Director will complete elopement drills monthly for 3 months then ongoing quarterly thereafter utilizing	

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F 689	Continued From page 12 11:42 PM revealed she took care of Resident #1 on 4/24/22 on the night shift. At the start of the shift, she saw him coming up to his door and looking out into the hallway for Nurse Aide #2 to come into his room. She didn't see him again until 4:30 AM to 5:00 AM when she gave his medications. Nurse #2 stated she had to wake him up to take his medication, but he never said anything to her. Nurse #2 stated she did not know that Resident #1 had exited the facility that morning. Nurse #2 further stated she found out that Resident #1 had exited the building when the Administrator spoke with her after she had given report to the oncoming nurse. A phone interview with Nurse Aide (NA) #2 on 4/29/22 at 4:26 PM revealed she was the NA assigned to Resident #1 during the time of the elopement on 4/25/22. NA #2 stated she wasn't aware that Resident #1 had gotten out of the building until this interview. She couldn't remember what time she last laid her eyes on him that shift but remembered seeing him out of his room when the shift started around 11:30 PM. Resident #1 walked without his wheelchair and sat down on the couch with her and watched the television for a few minutes before going back into his room. NA #2 stated Resident #1 didn't say anything to her, and she was not sure if this was normal behavior for Resident #1 because she only worked on the weekends and was not familiar with Resident #1. NA #2 stated she couldn't say if she noticed any change in Resident #1's behavior that night. NA #2 also stated she did not remember hearing any exit door alarms on her shift. An interview with NA #1 on 4/28/22 at 5:57 PM revealed she worked on the West hall on the	F 689	the Elopement Drill and Event Worksheet. Elopement drills have been a routine quarterly drill conducted by the Maintenance Director. During the morning clinical meeting the director of nursing will review incident reports, resident progress notes, and 24-hour report to identify any new behaviors of wandering or exit seeking by current residents. This is a new process for the facility morning clinical meeting. DON will complete this review daily for 5 days for 4 weeks, then monthly, to ensure continued compliance Director of Nursing and/or Administrative Nurse will complete a summary of audit results and present at the facility, monthly Quality Assurance Performance Improvement meeting, to ensure continued compliance. Compliance Date: 05/27/2022	

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night shift (4/24/22 to 4/25/22) and she observed Resident #1 who resided on the North hall walking on the hallway towards her without his wheelchair a little after 12:00 AM. NA #1 asked him where his wheelchair was, and Resident #1 stated he left his wheelchair in his room. Resident #1 sat on the couch by the nurses' station and talked to her. NA #1 stated she noticed Resident #1 was confused because he was looking for his room. Resident #1 was also chattering about something, but she couldn't understand everything that he said. NA #1 explained she got up and answered a call light and by the time she came out of the room Resident #1 had already left. NA #1 stated she did not notify NA #2 or Nurse #2 who were assigned to him about his confusion and that he was walking in the facility, trying to find his room. NA #1 stated she assumed they would see him when he went back to his room. NA #1 stated she did not know that Resident #1 had exited the building. She said she did not hear any exit alarm door sound during the night shift on 4/24/22 or early morning on 4/25/22. NA #1 stated it was hard to hear the code alarm on the West hall exit door whenever the door was opened, and she was working with a resident on the hall with the door closed.

A phone interview with Nurse #4 on 4/29/22 at 11:58 AM revealed she worked on the West hall on night shift on 4/24/22. Nurse #4 stated she wasn't familiar with Resident #1 because he resided on the North hall, but she remembered him standing in the North hallway with no wheelchair between 2:00 AM and 3:00 AM in the morning. Nurse #4 motioned for NA #2 to alert her that Resident #1 was standing in the hallway, and NA #2 started assisting Resident #1. Nurse

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#4 remembered that Resident #1 was wearing his red shoes. She stated she did not see him again that night and she didn't hear any exit door alarms go off. Nurse #4 stated it was hard to hear the code alarms when the exit doors were opened because they only sounded by the door on the keypad. If she was at the top of the hall, she was not able to hear the door alarm sound because it only sounded on the keypad which was right next to the exit door and the alarm wasn't loud. Nurse #4 stated she didn't know Resident #1 had exited the building.

A phone interview with the Receptionist on 4/29/22 at 11:40 AM revealed she worked from 7:00 PM on 4/24/22 to 7:00 AM on 4/25/22. She was supposed to walk around the facility and check all the exit doors every 6 hours. The Receptionist stated she checked and made sure all the exit doors were locked at 12:00 AM and again at 6:00 AM. She stated she remembered Resident #1 roaming the hallway while propelling himself in his wheelchair on 4/24/22 around 11:00 PM but he never came to the front door and requested to go out of the facility.

An interview with the Maintenance Director on 4/28/22 at 4:24 PM revealed part of his daily routine was checking all the exit doors which he normally did at the start of his shift between 7:00 AM to 8:00 AM. He stated he only worked as on call on the weekends, and he didn't have to come to the facility on 4/24/22. He was also off on 4/25/22. The Maintenance Director stated he heard about Resident #1's elopement when he came in to work on 4/26/22 and the Administrator discussed with him his concerns about the West hall door being unlocked from the day before. The Maintenance Director stated he checked all

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the exit doors to make sure they were functioning, and he determined that they were all functional and were locked when he inspected them at that time. During this interview, an observation of the West hall exit door was conducted with the Maintenance Director. He demonstrated how to unlock and lock the door by entering a code on the keypad on the wall right by the door. After entering the code, he stated the door will open for 15 seconds without an alarm going off. To lock the door back, a code had to be entered again on the keypad. The Maintenance Director motioned to the control switch that was encased by a plastic cover and stated that the switch was a failsafe mechanism that was supposed to be used only for emergency purposes when the code on the keypad won't work to unlock the door. When he lifted the plastic cover, a loud noise was heard but it stopped as soon as the cover was replaced. When he flipped the switch down and opened the door, an alarm went off, but it was only audible right by the keypad. When he closed the door, the alarm at the keypad stopped but the door continued to be unlocked while the switch was down/override position even though the door had been closed back. The Maintenance Director stated staff should be responding to any exit door alarm, but he noticed that didn't always happen. He also stated staff members were not supposed to be using the hall exit doors to enter and exit the facility. He further stated that he just changed the code to the exit door keypads on 4/24/22 and only disclosed it to the Administrator, the Director of Nursing, and the receptionists.

A phone interview with the Nurse Practitioner (NP) on 4/28/22 at 1:21 PM revealed she had assessed Resident #1 on 4/25/22 around 10:30

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AM after he was found outside on the ground, and she noticed that he was more confused than usual, but he did not show any signs of head injury and she didn't think he needed to go out to the hospital for further assessment. The NP stated she ordered an x-ray of bilateral knees because he complained to her of soreness to both knees. She also ordered bloodwork and urinalysis to see if she could determine the cause of his confusion. The NP also stated she didn't think it was safe for him to be outside and unsupervised due to his cognitive deficits.

An interview with the Director of Nursing on 4/28/22 at 11:31 AM revealed she was not sure how Resident #1 had exited the building because all the doors were supposed to be locked. Based on her investigation, Resident #1 was last seen inside the facility on 4/25/22 around 4:30 AM when Nurse #2 administered his medications.

A follow-up interview with the Administrator on 4/28/22 at 5:28 PM revealed he started the exit door check sheet on 4/6/22 because he had been finding exit doors that were unlocked. He decided the receptionists could do them since they were at the facility 24 hours a day. He identified that a possible way that Resident #1 got out of the facility was through an exit door that was unlocked, and he needed everyone to assist him in making sure all exit doors were locked. On 4/26/22, he communicated to all staff to make sure all the doors were locked outside the times that the receptionists were checking the exit doors. The Administrator stated the exit door checks used to be every 6 hours until 4/25/22 after Resident #1's elopement when he changed it to every 4 hours. Starting 4/26/22, he inspected the exit door check sheets daily and talked to the

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receptionists about any issues with any unlocked doors. He also told all staff not to use any of the exit doors and to only use the front door to enter and exit the facility.

The Administrator was informed of Immediate Jeopardy on 4/29/22 at 2:22 PM.

The facility provided the following Credible Allegation of IJ removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The annual MDS dated 4/7/22 indicated Resident #1 was severely cognitively impaired.

On 4/25/22, Resident #1 exited the facility unsupervised sometime after 6:00 AM. He was discovered on the ground outside the back of the facility at 6:44 AM.

After the investigation, it was determined that Resident #1 could have opened the West wing door to enjoy weather and was able to exit the building unsupervised. This occurred as a result of the door lock being placed in an override position and floor staff unable to hear the alarm indicative of door being open.

Resident #1 was noted by Nurse #2 to be in his room at approximately 4:30 AM as she administered AM medication to him.

Resident #2 (resident council president) noted seeing Resident #1 in the hallway after 6:00 AM.

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Approximately 6:44 AM, Housekeeper #1 noted seeing Resident #1 outside in the back parking lot lying on the ground as he was coming into work. Resident #1 was appropriately dressed for the season.

Approximately 6:47 AM, Housekeeper #1 communicated with the Administrator that he saw resident outside. Administrator went outside with Housekeeper #1 and found Resident #1 alert while on the ground wearing a jacket, t-shirt, sweatpants, shoes, and hat. Administrator communicated for housekeeper to go inside nursing home and request a nurse.

Approximately 6:50 AM, Nurse #1 went outside, asked the resident questions, and assessed resident for injury. Housekeeper #1 was instructed to bring Resident #1's wheelchair and Resident #1 was escorted back into the facility by Nurse #1 and Administrator. Nurse #1 took resident to his room. A full skin assessment was performed for Resident #1, noted that he had small abrasions, they were cleaned with normal saline and dried. Range of motion was performed and when raising left arm discomfort was noted. There was no evidence of any head injury. Vital signs were obtained and indicated an elevated blood pressure of 138/91, pulse 94, temperature 97.2, oxygen saturation 97%.

Nurse Practitioner (NP) & RP (responsible party) notified on 4/25/22. Administrator left voicemail on phone for the guardian of Resident #1 due to no response at the time of call.

After the resident was returned inside the facility, he was in a wheelchair within sight at the nursing station (North) for observation. No further

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wandering behavior noted.

On 4/25/22 at 7:20 AM, the Administrator conducted facility door checks to ensure that each door was locked and secure. Administrator noted one door unlocked (West wing). Administrator placed the unlocked door back in locked fashion. The West wing door found to be unlocked was proximate to the location of where Resident #1 was found lying alert on the ground.

On 4/25/22 at 7:30 AM, the Director of Nursing Services conducted a facility head count to ensure that all residents were accounted for inside the nursing home. All residents were accounted for, and Resident #1 was noted back in his room.

Resident #1 elopement risk assessment was completed by Nurse #1 and updated on 4/25/22. The assessment indicated that Resident #1 was at risk for elopement.

Resident #1 behavior care plan was updated by MDS Coordinator to reflect the unsupervised exit on 4/25/22. Resident #1 had never had a need for an elopement care plan prior to date 4/25/22 due to no documented history of wandering behavior.

On 4/25/22 during the Nurse Practitioner's initial assessment of Resident #1, he was found to be awake and alert but with increased confusion from baseline. The patient denied hitting his head during the fall and denied having any headache and the NP did not determine that there was a need to send patient out to the emergency department. Later in the morning, Resident #1 became less responsive and was

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sent to the emergency department for evaluation and treatment.

On 4/25/22, all current census residents were reassessed for exit seeking behaviors. This included completing a new elopement assessment. This task was completed by the Director of Nursing Services and administrative nurses and finalized on 4/29/22. This also included ensuring that each resident who was identified as high risk for elopement had a care plan to address their behaviors.

On 4/25/22, all elopement binders were audited by Unit Managers to ensure that they were up to date with current residents with high risk for elopement. These binders were located at the front desk and at each nursing station. These books contained the list of residents with exit-seeking behaviors, their pictures and residents' description.

On 4/28/22, care plans were updated for all additional residents who triggered for "at risk" for elopement by the MDS nurse. In total 6 residents were identified with wandering behavior which caused them to be "at risk" for elopement.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

All residents upon admission, quarterly, and at a significant change of condition are evaluated for elopement risk by the administrative nursing team during clinical morning meeting and weekly standard of care. The assessments identify deficits in cognitive, diagnosis, ADL (activities of

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	345489	A. BUILDING _____ B. WING _____	C 05/05/2022

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daily living) impairment, and/or history of elopement behavior. At the time of identifying a resident at high risk, the facility Director of Nursing and/or administrative nurse will update their elopement books that are located at each nurses' station and at the front desk. Facility staff receive training on the updates to the Elopement Manual. This is already a process, and it will continue.

4/26/22, Education on Door Alarms and the response to alarms was completed by the Administrator and/or administrative designee to all staff, including agency, all departments. Education also includes ensuring staff door securement response is vigilant by all staff making sure all exit doors are locked and only utilizing one entry and exit from the facility that being the front entrance to the facility. Current staff, including agency will not be allowed to work until they have completed this training. No staff members who have not received the education will work until they complete the education. Administrator and/or administrative designee are responsible for the tracking of 100% compliance. As staff come into work the Administrator and/or administrative designee determines which staff have not done in servicing using a logged staffing roster for all staff, all departments and those not displayed are provided the necessary education and sign documentation. Human Resources will ensure all new hire orientation on door alarm education and elopement policy.

4/29/22, Administrator and/or administrator designee provided education to current nursing staff, including agency staff, all departments related to the Elopement Policy. Education includes the facility policy for elopement or

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suspected elopement, signs/symptoms of elopement risk, supervision of residents with exit seeking behavior and intervention strategies, and elopement booklet locations. Resident safety is the responsibility of all staff. At the time of a door alarm sound the staff member at the door site will immediately initiate an extensive search of the surrounding outside area. Any staff member who becomes aware of a missing resident will alert all personnel using the facility approved protocols (internal alert code: code AMBER). A head count will be immediately prompted to ensure 100 percent of residents are accounted for. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units. Staff should promptly report any resident who exhibits elopement or wandering behaviors to the charge nurse or Director of Health Services. Staff will coordinate search teams with resident identification for a resident not found in the building or on the grounds or on an authorized leave, notify the Administrator, legal representative, attending provider and law enforcement officials. Current staff, including agency will not be allowed to work until they have completed this training. No staff members who have not received the education will work until they have completed this training. No staff members who have not received the education will work until they complete the education. Newly hired staff will receive this education during orientation. Administrator and/or administrative designee is responsible for the tracking of 100% compliance. As staff come into work the Administrator and/or administrative designee determines which staff have not done in servicing using a logged staffing roster for all staff, all departments and those not displayed are

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provided the necessary education and sign documentation. Human Resources will ensure all new hire orientation on door alarm education and elopement policy.

The Maintenance Director will complete elopement drills monthly for 3 months then ongoing quarterly thereafter utilizing the "Elopement Drill and Event Worksheet". Elopement drills have been a routine quarterly drill conducted by the Maintenance Director.

The Administrator implemented on 4/29/22 an ongoing every 15-minute monitoring of the exit doors to ensure that the door lock has not been placed in an override position. These rounding efforts will be documented and reviewed on an ongoing basis. Facility exit doors will be monitored by receptionists and/or designee every 15 minutes daily for 4 weeks, then weekly for 10 weeks. The Maintenance Director checks the doors daily as a regular preventative maintenance task Monday through Friday to determine functionality of the lock and the door alarms. All receptionists and other specific designees were appointed by Administrator to complete every 15-minute daily monitoring checks. On 4/29/22, the Administrator completed education to all designated receptionists and other specific designees on every 15 minutes daily monitoring.

On 4/29/22, Administrator coordinated a visit with the door alarm contractor to increase the volume of West wing door alarm. On 4/30/22, the door alarm contractor came and reviewed the West wing door identified as softly beeping and reprogrammed the door and another that was found not loud enough by the Maintenance Director on 4/29/22. The Maintenance Director

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audited all exit doors on 4/29/22 for which doors needed a volume level increase.

During the morning clinical meeting the Director of Nursing will review incident reports, resident progress notes, and 24-hour report to identify any new behaviors of wandering or exit seeking by current residents. This is a new process for the facility morning clinical meeting.

Alleged date of IJ removal: 5/1/22

The credible allegation for the immediate jeopardy removal was validated on 05/05/22 and the immediate jeopardy removal date of 05/01/22 was confirmed. Elopement books were observed to be at each of the nurses' stations and the front desk and included a picture and description of the residents currently identified at risk for elopement.

The staff in-services conducted on 4/26/22 through 4/29/22 were reviewed and included: the facility policy on elopement or suspected elopement, signs/symptoms of elopement risk, supervision of residents with exit seeking behavior and intervention strategies and elopement booklet locations. The attendance records confirmed that all staff had been in-serviced. Random staff interviews were conducted on 5/5/22 from 9:25 AM through 12:01 PM and all staff members were able to describe the topics covered during the in-service on elopement.

An interview with the Maintenance Director on 5/5/22 at 8:56 AM revealed he conducted a facility-wide elopement drill on 5/2/22 on the day shift. He stated he would continue to conduct an elopement drill once a month and include the

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evening and night shifts.

An observation with the Maintenance Director of all the exit doors revealed three alarms were activated to increase exit door security. The Maintenance Director stated he added the following safety features to the alarms to the doors: an alarm would go off once the safety plastic cover was lifted, another alarm would go off once the switch was deactivated and then another alarm would go off when the door was opened. All three alarms won't stop until a code was entered on the keypad of which only the Administrator, the Maintenance Director, the transportation aide, and the receptionists were aware of.

The sign-off sheets for the door checks started on 4/29/22 were reviewed and complete. The 15-minute door audits by the receptionists and designated staff members to physically check all exit doors and ensure all doors were locked were reviewed and complete. The daily door audit completed by the Maintenance Director was also reviewed and complete.

A review of a work order dated 4/30/22 by the door alarm contractor indicated the back west door only softly beeped when opened without using a code. They reprogrammed the keypad to alarm via sensor when forced open. They also reprogrammed a second door on the West hall for the same issue. Both are now fully alarmed when forced open.