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F 000	INITIAL COMMENTS A complaint investigation was conducted on 09/19/22 through 09/20/22. 1 of 7 allegations were substantiated. Intake# NC00193041 was investigated and resulted in immediate jeopardy. Past noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity of J. Tag F689 constituted substandard quality of care. Non-compliance began on 09/10/22. The facility came back into compliance effective 09/13/22. A partial extended survey was conducted on 09/20/22.	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 review, staff, resident, Local Law Enforcement, and Medial Director interview the facility failed to prevent a cognitively impaired resident from exiting the facility without supervision for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). Resident #1 was severely cognitively impaired, and he exited the front door of the facility in his wheelchair and traveled	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 10/06/2022

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approximately one quarter mile down the road to a neighborhood where he climbed into a car and was apprehended by local law enforcement using K-9 dogs for suspicion of breaking into a car. Resident #1 was taken to the local emergency room for treatment of dog bites. The facility was unaware Resident #1 had exited the facility until local law enforcement arrived at the facility to confirm his identity and notify the facility that Resident #1 had been taken to the emergency room for treatment. Resident #1 sustained bruises and puncture wounds to his extremities from dog bites.

The finding included:

Resident #1 was admitted to the facility on 08/24/22 with diagnoses that included: numerous fractures to upper and lower extremities and pelvis, cerebral infarction (stroke), aphasia (difficulty talking), cognitive communication deficit (difficulty with thinking), and traumatic brain injury.

A wandering assessment was completed on 08/24/22 and indicated that Resident #1 was at low risk for wandering.

Review of an admission Minimum Data Set (MDS) dated 08/31/22 indicated that Resident #1 was severely cognitively impaired and required limited assistance with mobility on the unit. The MDS further indicated that Resident #1 had no wandering behaviors during the assessment reference period.

An interdisciplinary note dated 09/08/22 read in part, Resident #1 expressing wanting to go home now. Family lives out of state. Asked family to let the facility know of a date for discharge so they

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could plan appropriately. Resident #1 is wanting to discharge.

A wandering assessment was completed on 09/08/22 and revealed that Resident #1 was high risk for wandering.

A physician order dated 09/08/22 read; wanderguard (device that resident wears and sounds alarm if they go near an exit door) placed on left ankle with expiration date of March 2024. Monitor placement and skin integrity every shift. Check strap to ensure it is secure but loose enough to get one finger behind strap.

Review of a physician order dated 09/10/22 read: check wanderguard device every shift for placement and function.

Review of a care plan dated 09/09/22 read in part; Resident #1 is an elopement risk related to impaired safety awareness. The interventions included: ensure that the area the resident wanders in is safe and wanderguard to left ankle.

A nursing note dated 09/10/22 read; Medical Director (MD) notified of elopement and resident status.

Review of the facility's daily schedule dated 09/10/22 indicated that Nurse #1, Nurse Aide (NA) #1, NA #2, and NA #3 were assigned to work the unit where Resident #1 resided.

Review of a Disposition Summary from the local Emergency Room (ER) dated 09/10/22 read in part: Discharged ordered to nursing home. Condition stable, Diagnoses bitten by dog multiple puncture wounds, fall on same level,

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contusion of right elbow. The summary further read: "this resident was found by the police trying to break into a vehicle. Apparently, he is a resident at a local nursing facility who left the residence and started wandering through the town. When the police tried to confront the patient, it was initially felt that he was breaking into the car. He was initially held at gunpoint and when the patient resisted, the police dog was initiated to restrain the patient. The patient was bitten by the dog several times. He ended up falling at some point. He did have injury to the right side of his head, shoulder, and elbow. He does have bites to his right knee, left leg as well as left buttock. Also has scratches to his lower back. Patient does have a history of traumatic brain injury however he presents today with confusion." Resident #1 was prescribed Amoxicillin (antibiotic) 875 milligrams (mg)/125 mg by mouth every 12 hours for 10 days and returned to the facility,

A weekly skin review dated 09/10/22 revealed that Resident #1 had new skin issues that included an abrasion to left elbow, bruise right cheek and shoulder and puncture areas to bilateral lower extremities was completed by the Director of Nursing (DON).

An observation and interview were conducted with Resident #1 on 09/19/22 at 3:29 PM. Resident #1 was up in his wheelchair in his room. Resident #1's room was approximately 50 feet from the front exit door. He was observed to have a dressing that was clean and intact to his right elbow. Resident #1 recalled the events of 09/10/22 and stated, "it was just a mistake." He stated he went out the front door in his wheelchair and no alarm sounded and "no one told me I

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couldn't go" and indicated he was looking for a "ride home." Resident #1 stated that his family lived out of state, and he was going to live with them but then the "cops showed up and they turned the dogs on me" but the bite marks were healing well. Resident #1 stated that he had a (wanderguard) "bracelet" on his left ankle and indicated he had it on 09/10/22 when he exited the facility in his wheelchair out the front door.

Medication Aide #1 was interviewed on 09/19/22 at 12:58 PM who stated that she was working on the other side of the building on 09/10/22 and around 10:00 AM to 10:15 AM was talking to the Director of Nursing (DON) on the phone about a staffing issue. The DON had asked to speak to the nurse, so Medication Aide #1 stated she walked to the nursing station with the DON on the phone and when she got to the nursing station the local law enforcement officer was at the station telling the staff that they had found Resident #1 outside in a nearby neighborhood and had taken him to the local ER for treatment. Medication Aide #1 stated that when she arrived for work at 6:30 AM she had to walk past Resident #1's room to get her to assigned unit and he was resting in his bed at that time. Medication Aide #1 confirmed that she had not heard any door alarm sound that morning and had no idea that Resident #1 had exited the facility until the local law enforcement came to the facility and reported it.

The Maintenance Assistant was interviewed on 09/19/20 at 1:11 PM and confirmed that he checked the wanderguard system weekly. He stated he took a wanderguard bracelet with the signaling device on it to each of the doors equipped with the wanderguard device to ensure

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that the door locked, and the alarm sounded as it should. Once the weekly check was completed the Maintenance Assistant stated he logged the check into his computer. He stated that he had checked the wander guard system several times during the week of 09/04/22 including Friday 09/09/22 and each door that was equipped with the wanderguard system worked as they should. The Maintenance Assistant stated that after Resident #1 had gotten out of the facility they contacted a repair man to come and look at the wanderguard system and after looking at the system and front door where Resident #1 exited from they determined that there was a 1-inch gap in the center of the door that was a "dead spot" and did not pick up the signal to lock the door and sound the alarm. He indicated that the repair man adjusted the range to cover the spot and then tested it again and it was operating properly again.

Review of an invoice from the Door System repair company dated 09/13/22 read in part; "checked the door at the front entrance with a transmitter to see how it would pick up; found a space of about one inch in the center of the door that is a dead spot; adjusted the range on the antennas to cover this spot. Tested again to make sure the door is operating properly. Set the time schedule from 9:00 am to 7:00 PM as requested. Service call taken 09/13/22."

Nurse #1 was interviewed on 09/19/22 at 5:00 PM via phone who confirmed that she arrived to work on 09/10/22 around 6:45 AM. She stated when she got report that day Resident #1 was in his room in his wheelchair. She continued to say that around 8:00 AM to 8:30 AM a member of the housekeeping staff came to tell her that Resident

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#1's bathroom sink was clogged and not to use it until it could be repaired. Nurse #1 stated she walked to Resident #1's room at that time and he was in his wheelchair right outside of his room. Nurse #1 stated that at around 10:00 AM she got a call that she had a family emergency and had to leave the facility. She stated that she counted the cart with Medication Aide #1 and reported off and left the facility. She stated that on her way out of the facility she saw local law enforcement at the nursing station but had no idea what was going on. Nurse #1 confirmed that she did not hear any door alarm sound that morning and was unaware that Resident #1 had exited the facility.

The facility was unable to provide contact information for Nurse Aide (NA) #1.

A handwritten statement from NA #1 and dated 09/10/22 read in part; I was doing baths and was unaware of the alert resident that escaped. The statement was signed by NA #1.

Nurse #2 was interviewed on 09/19/22 via phone at 5:05 PM and confirmed that she was working on 09/10/22 but not on the unit where Resident #1 resided. She stated that around 10:00 AM one of her residents was sitting up near the main nurse's station and she decided to go and check on the resident and as she rounded the corner there were 3 local law enforcement officers at the main nursing station talking to the staff. One of the police officers wanted to verify Resident #1's date of birth so Nurse #2 stated that she went to the nearest computer and verified that the date of birth that Resident #1 gave to the police officers matched his medical record. The police officers stated to Nurse #2 that Resident #1 was at the local ER, but they needed more information

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before they could treat him. Nurse #2 stated she spoke to the DON who was on the phone and got permission to fax information over to the ER. She stated that she faxed over the usual documents to the ER and then called the charge nurse at the ER to verify they were received. Nurse #2 confirmed that she was not aware that Resident #1 had exited the facility on 09/10/22 until the local law enforcement officers came to the facility.

NA #3 was interviewed on 09/19/22 via phone at 5:19 PM and confirmed that she worked on 09/10/22 on the unit where Resident #1 resided. She explained that 09/10/22 was her first day back in the facility in over a month. In report she was told that Resident #1 was independent but needed some assistance. NA #3 stated that when she arrived to work that day at around 7:00 AM Resident #1 was already up and dressed and in his wheelchair in his room. She stated that breakfast trays came to the unit around 8:00 AM and we passed out trays including Resident #1's. NA #3 stated around 9:00 AM they were collecting the breakfast trays and Resident #1 was sitting in his wheelchair just outside of the door to his room. She stated that around 10:00 AM the local law enforcement officers came to the facility and told the staff they had found Resident #1 in a nearby neighborhood. They indicated that a neighbor had called the police because Resident #1 had gotten into a car. The local law enforcement stated to the staff that Resident #1 was able to tell the law enforcement officer his name and they had taken him to the local ER. NA #3 stated she left her shift at 3:00 PM that day and Resident #1 had not returned to the facility from the ER. NA #3 confirmed that she had not heard any door alarm sound that morning and did not know that Resident #1 had exited the

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facility that day.

NA #2 was interviewed on 09/19/22 via phone at 5:39 PM and confirmed that she was working on the unit where Resident #1 resided on 09/10/22. She stated that while they passed-out breakfast trays on the unit Resident #1 was sitting in his wheelchair. Once Resident #1's breakfast tray was delivered he continued to sit in his wheelchair in the hallway right outside of his room and eat his meal. NA #2 stated that around 9:00 AM they began collecting the breakfast trays and Resident #1 remained in his wheelchair in the hallway. About an hour or so later NA #2 stated she was taking soiled linen to the soiled utility room across from the nursing station and overheard the local law enforcement officer telling the staff that they had found Resident #1 outside and had taken him to the ER. NA #2 stated that she was aware Resident #1 had a wanderguard on one of his ankles and had seen him near the exit doors in the past, but he was always easily redirected and would generally follow her back to the unit. NA #2 stated that it was not uncommon for Resident #1 to go into the courtyard during the day, so she did not find it unusual when she did not see him sitting in the hallway after breakfast trays had been collected. NA #2 stated that she had not heard any door alarm sound that morning and did not know that Resident #1 had exited the facility that morning. She added that she worked until 11:00 PM that night and was there when Resident #1 returned from the hospital, and he remained in his room for the rest of her shift.

The local Law Enforcement Officer was interviewed via phone on 09/19/22 at 2:52 PM and confirmed that they had received a call that a man had gotten into a car in a nearby

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neighborhood on 09/10/22. The local law enforcement officer stated that Resident #1 was "actively and passively resisting arrest" and he was finally arrested and taken to the local hospital. He stated that was all the information he could share as the incident was still under investigation.

The DON was interviewed on 09/19/22 at 12:20 PM and confirmed that she had gotten a call from Medication Aide #1 on 09/10/22 at approximately 10:00 AM. During that call Medication Aide #1 had taken the phone to the nursing station and during that time was informed that Resident #1 had gotten outside of the facility and wandered into a nearby neighborhood and crawled into the back seat of car. The owners of the car did not know Resident #1, so they called the local police. Apparently before the local police showed up Resident #1 had gotten out of the back seat of the car and wandered to another house and was standing between a boat and a car and he refused to comply with the local police, and they used the K-9 dogs to apprehend Resident #1 and they took him to the local ER for treatment. The DON stated after she was told of what happened she immediately came over the facility. The DON stated she called Resident #1's family and made them aware of the situation and began the investigation while she waited for Resident #1 to return to the facility from the ER. She indicated that Resident #1 was assessed upon admission for wandering and posed no risk but on 09/08/22 when the team began discussing discharge plans with Resident #1, he was adamant that he was going home "now." The DON stated she reassessed him and he was now a high risk for wandering and a wanderguard was placed on his left ankle. The DON stated that during the

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investigation they learned that the alarm either had not sounded or sounded but with a delay so they immediately locked the front door and had receptionist at the door until the door could be looked at and/or repair. She stated that the door technician came last week and had found a "dead spot" on the door and repaired it. The DON stated that they had completed an investigation, had the door repaired, and educated all the staff on the elopement process and what to do if a resident eloped. The education included updating the elopement binders with resident information at the front door and at each nursing station. The DON further stated the doors were checked daily for 7 days and then weekly as before.

The Administrator was interviewed on 09/19/22 at 1:43 PM and confirmed that he was notified that Resident #1 had eloped on 09/10/22. He stated he immediately came to the facility and began the investigation along with the DON. The Administrator stated that he tested the front door alarm about 25-30 times using the wanderguard bracelet that Resident #1 had on and was able to walk through the door 2 times without it alarming or locking. He stated that the door was locked, and receptionist was placed at the front door 24 hours a day until the door was repaired on 09/13/22.

The Medical Director was interviewed on 09/19/22 at 4:34 PM and confirmed that she was notified of Resident #1's elopement on 09/10/22. She stated that Resident #1 had a history of a stroke and when she first met him, he was able to follow instructions but was unable to verbalize very much. However, she stated she saw Resident #1 on 09/13/22 and he was much improved and was able to carry on a good

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conversation. She stated that she educated Resident #1 on the importance of communicating with staff when he desired to leave the facility. The Medical Director stated that with the damage to Resident #1's brain from the stroke he should not be outside alone for a long period of time. She did say that he was appropriate to leave the facility with friends or family but again should not be left alone unattended for a long period of time.

The Administrator was notified of the Immediate Jeopardy on 09/20/22 at 10:09 AM.

The facility provided the following the following corrective action plan with completion date of 09/13/22:

Based on record review, staff interviews, and observation, the facility failed to prevent a resident from exiting the facility unsupervised, propelling himself in wheelchair and getting into a neighbor's car.

According to statements from staff on 9/10/22, at approximately 8:00 am, resident was observed sitting in hallway outside lobby doors and NA#1 redirected him back to his room. NA's #2 and #3 observed resident sitting in his doorway eating breakfast at approximately 8:45 am. According to the statement from resident #1, he ate his breakfast and exited the front door at approximately 9:15 am, and he got into the backseat of a neighbor's car.

At approximately 9:45 am, Police received a call that resident was standing in the driveway of another neighbor between the car and boat. Police attempted to apprehend resident #1 utilizing K9 assistance and they had him

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transported to local hospital. Resident #1 returned to facility at approximately 3:45 pm. Resident #1 was assisted into bed, placed on every 15-minute checks and wander guard replaced. Licensed Nurse completed head to toe skin assessment and observed bruises and puncture areas to upper and lower extremities, abrasions to right elbow and right shoulder, bruise to right cheek. Vital signs WNL. No additional exit seeking or wandering behaviors noted. Wandering assessment, incident report and care plan updated accordingly for Resident #1, as well as notifications to family and Medical Director with follow up order to refer to psych services.

On 9/10/22, the facility conducted an Ad Hoc QA meeting with key department heads to discuss incident, review facility elopement policy and to initiate a performance improvement plan based on root cause analysis. Root cause analysis determined that front door wander guard receiver was intermittently malfunctioning. Device technician notified and appointment set up for emergency service, front door code changed, front doors to remain locked 24 hours a day, receptionist 24 hours a day.

Effective 9/10/22, Resident #1 will remain on every 15minute checks with wander guard in place until further indicated by the IDT and Medical Director.

On 9/10/22, the facility completed 100% census verification and Elopement drill to ensure residents safety. All residents accounted for and safe. Elopement drills were conducted on each shift on 09/10/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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
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On 9/10/22, DON assessed all residents with wander guards for placement and proper function. No concerns identified.

On 9/10/22, the facility updated the Wandering Risk Assessments on current facility residents. Those identified at risk for elopement were reviewed for appropriate care plan and wander guard orders where indicated. The Director of Nursing updated the Elopement Risk Binder to contain resident profiles and photographs, current Wandering Risk Assessment and placed at nurses ' station and receptionist desk. A copy of the Wandering/Elopement Policy and Elopement Drill Documentation tool also in place in front of binders for quick response reference in the event of a missing resident.

On 9/10/22, the facility provided elopement education with all current facility and agency staff. Education included response to alarming doors and providing supervision for cognitively impaired residents with wandering and exit seeking behaviors to prevent unsupervised exits from the facility. Education also included proper response in the event of a missing resident. Facility and agency staff will not be permitted to work until receiving education. The ADON/Staff Development Coordinator will include the facility and agency orientation process and checklists. The ADON is responsible for tracking the education of the staff.

Effective 9/10/22, the facility DON and/or Administrator will conduct quality improvement audits to determine the continued safety of the residents as to prevent unsupervised exiting of the facility Monitoring will be completed weekly for four weeks. This audit will consist of:

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1. Understanding the elopement policy and response to a missing resident
2. Ensuring Elopement binders are at each nursing station and are up to date
3. If resident is on 1:1, every 15, or every 30-minute checks, there will be appropriate documentation in place.
4. Residents with wander guards have corresponding orders on the eMar to check placement and functionality and the wander guard is care planned.
5. Daily door checks x 7 days and then weekly door checks x 4 weeks

The results of the monitoring will be discussed in weekly Risk meeting and during monthly QAPI meeting with the IDT. Changes made to the plan as necessary to maintain compliance with resident safety.

Root cause was temporarily addressed on 9-10-22 when the front door was reprogrammed to remained locked 24 hours a day. Root cause was fully resolved on 9-13-22 when the technician identified the reason the door failed and completed repairs/adjustments to ensure proper function going forward.

Accordingly, the facility returned to full compliance on 9-13-22.

The Corrective Action Plan was validated on 09/20/22 and concluded the facility had implemented an acceptable corrective action plan on 09/13/22. The facility provided education and training on the facility's elopement policy and procedures, placed elopement binders at each nursing station and the front desk, ensured all

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components of the wanderguard system and door alarm were functioning and ensured staff knew how to respond to an elopement and door alarms. In addition, all residents who were at high risk for wandering were identified using the wandering risk assessment and ensured all had a care plan with interventions in place.

The root cause analysis that was completed on 09/10/22 was reviewed as was the monitoring tools for 09/10/22, 09/12/22, and 09/19/22 for door inspections including the doors equipped with the wanderguard system. Staff interviewed along with education sign in sheets revealed that all staff had been trained and were aware where the elopement binders were located, how and when to complete wandering risk assessments, and how to respond to door alarms or a reported elopement. The corrective action plan was reviewed in an ad hoc QAPI meeting on 09/10/22.