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	NH0457	A. BUILDING: _____ B. WING _____	C 04/29/2024

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SCOTIA VILLAGE-SNF	2200 ELM DRIVE LAURINBURG, NC 28352

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D 000	Initial Comments A state licensure complaint investigation survey was conducted on 4/29/24. Event ID# 2ZTE11. The following intake was investigated NC00216247. 1 of the 2 complaint allegations resulted in deficiency.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observation, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to ensure a newly admitted resident with severe cognitive impairment was not able to exit the facility and walk down the side walk along the parking lot approximately 173 feet from the road unattended and without the knowledge of staff for 1 of 3 residents reviewed for elopement. The findings included: Resident # 1 was admitted to the facility on the assisted living unit on 4/08/24 with diagnoses which included hypertension and a history of surgical repair of thoracic vertebra (lower back) fracture. Review of the Elopement Risk Screening	D 270	Tag 0270-10A NCAC 13f .0901(b) Personal Care and Supervisi on (Adult Care Home Rules): Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms. This plan of correction represents Scotia Village's allegation of compliance. The submission of the following plan of correction does not constitute an admission or agreement by the provider as to the truths of the facts as alleged or conclusions presented by survey consultants from NCDHSR relating to alleged deficient practice. The plan is prepared and executed solely because it is required by the provisions of State and Federal law.	5/21/24

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D 270	Continued From page 1 completed on 4/08/24 by Nurse Supervisor #1 revealed Resident #1 was not determined to be an elopement risk. Review of the Care and Service Plan Evaluation dated 4/08/24 revealed Resident #1 was independent with mobility, was not always oriented and required reminders. Resident #1 was noted as not capable of making decisions. Review of the Brief Interview for Mental Status (BIMs) dated 4/10/24 and completed by the Social Worker revealed Resident #1 had severe cognitive impairment. The nursing progress note dated 4/19/24 at 3:42 pm by Nurse Supervisor #2 revealed Resident #1 was observed walking down the sidewalk toward the road way side of the facility. Nurse Supervisor #2 notified Nurse #1 in the assisted living unit that Resident #1 was outside the facility. Nurse #1 was not aware Resident #1 was outside the facility. An observation was conducted on 4/29/24 at 11:55 am of Resident #1. Resident #1 was in her room with the door closed. Resident #1 was pleasant but was unable to be interviewed. An observation was conducted on 4/29/24 at 2:05 pm on the facility grounds. The exit door for the assisted living unit opened to a grassy area with a level sidewalk that led to a courtyard with tables and chairs to the left, straight out from the exit door was a parking lot, and to the right of the exit door was a level sidewalk which went along the parking lot towards the skilled nursing unit entrance. The sidewalk around the facility was level with a grassy area between the parking lot and sidewalk. The speed limit in the community	D 270	Address how corrective action will be accomplished for the resident found to have been affected by the deficient practice. 1. Resident #1 reassessed for elopement risk on 4.19.24. Resident #1 did not meet the assessment threshold for an elopement risk based on assessment criteria. 2. On 5.2.24, Audible stairwell door alarms and stop signs were placed by a designee of the Maintenance Director on the stairwell doors to cue resident #1 and other assisted living residents not to use the doors installed on all unit stairwells except in case of emergency. 3. Neurology referral for resident #1 was made for a cognitive assessment and medication review by the Nurse Mentor on 5.16.24. 4. On 5.15.24, The Nurse Mentor created an order and task in the electronic medical record for accompanied daily staff walks with resident #1 as part of the treatment administration record that is signed off on by staff daily. Resident #1 has not gone outside unaccompanied since 4.19.24. 5. Since admission on 4.8.24, staff have worked with resident #1 on acclimating her to her new home and wayfinding. resident #1 locates her room, the dining room, and other amenities in the unit with little or no cueing from staff. As an additional wayfinding tool, the Community Mentor placed resident #1's room number on her ID badge that she wears. 6. Care plan conference held for resident #1 on 5.8.24 with daughter present. The administrator, social worker, assited living	

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D 270	Continued From page 2 was 19 miles per hour. An interview was conducted on 4/29/24 at 12:05 pm with Nurse #1 who revealed she was working on the day Resident #1 was walking outside alone. She stated she was not aware Resident #1 was outside and was not sure if she used the steps or elevator to exit the unit. Nurse #1 stated Resident #1 was not oriented and required constant redirection. Nurse #1 reported that Resident #1 would be given her room number and directed towards her room but would forget by the time she approached the door and would need redirection. She stated the assisted living unit did not use door alarms, door locks, or wander alarms even for residents that were not oriented, but she stated they try to keep an eye out and redirect. Nurse #1 stated residents on assisted living unit had the right to leave the area, but we asked the residents to let us know before leaving the unit. Nurse #1 stated Resident #1 was not able to remember to let them know she was taking a walk off the unit. Nurse #1 stated Resident #1 would normally walk the on the assisted living unit and down the hall to the independent living unit but had not known her to go down exit stairs or the elevator alone prior. Nurse #1 stated she re-educated Resident #1 about telling her before leaving but she was unable to retain information. Nurse #1 stated since Resident #1 was outside, the facility had activated a stair door alarm at the end of the assisted living unit that would alarm if opened, but she stated the elevator did not have any alarms. Nurse #1 stated she did not feel Resident #1 was appropriate for placement on the assisted living unit due to her severe cognitive impairment, but she stated she had not reported her concern to anyone.	D 270	nurse mentor, and the therapy manager were in attendance. 7. Care plan updated to inlcude the following interventions for resient #1. CNAs will monitor resident #1 each shift and report any behaviors to the nurse mentor immediately. Staff nurses and the social worker will perform quarterly elopement risk assessments and a BIMS on resident #1. Other interventions for resident #1 include behavior logs, scheduled walks with staff, recreational activities, and the use of a GPS tracking/alert device. The device uses GPS and cellular technology to provide a real time location for resident #1. Staff are alerted through device notifications, email, and text when resident #1 leaves assisted living. The device also allows for two-way communication between staff and resident #1. Staff were educated by the nurse mentor on the use of the device starting on 5.14.24 with a completion date set for 5.21.24. 8. Resident #1 was issued the GPS tracking/alert device on 5.15.24. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 1. On 5.14.24, all assisted living residents were reassessed using the Elopement Risk Assessment. 2. On 5.14.24, the interdisciplinary team, including the Administrator, DON, assisted living nurse mentor, and social worker, reviewed all current BIMS scores on assisted living residents. A BIMS assessment was completed by the social worker on assisted living residents who	

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D 270	Continued From page 3 During an interview on 4/29/24 at 12:22 pm with Nurse Aide (NA) #1 who was assigned to Resident #1 on 4/19/24 revealed she was not aware Resident #1 had gone outside to take a walk until she was told. She stated she did not see Resident #1 leave the unit and she was unsure if she took the elevator or stairs to get outside. NA #1 stated Resident #1 enjoyed walks and often would want to visit her Responsible Party (RP) who worked at the facility. NA #1 stated Resident #1 was confused and required frequent redirection, but she stated she had not expressed any desire to leave the facility, she just liked to walk. NA #1 stated the assisted living unit did not have door or elevator alarms since the residents were able to leave and go out, but she stated we try to keep an eye on the residents that have some confusion. NA #1 stated since Resident #1 went outside alone the facility had activated the stair door alarm at the end of the hall and the alarm sounded when opened now so we can hear when the door opens. An interview was conducted with NA #2 on 4/29/24 at 12:30 pm who revealed she did not work with Resident #1 but was aware she enjoyed walking on the unit. NA #2 stated she was assigned to the other hall on the assisted living unit and was told Resident #1 was outside, but she did not observe her leave the unit. NA #2 stated the residents on the assisted living unit were able to walk around the facility and they did not have alarms to stop them from leaving the unit. During an interview with the Community Mentor on 4/29/24 at 12:34 pm she revealed she was in charge of quality of life for the residents on the assisted living unit. The Community Mentor stated she knew Resident #1 had cognitive	D 270	have had potential changes on 5.17.24. 3. On 5.17.24, the interdisciplinary team, including the Administrator, DON, assisted living nurse mentor, and social worker, reviewed residents with updated assessments for appropriate interventions and updated care plans accordingly. 4. On May 17, the Director of Maintenance initiated a preventative maintenance work order for the installed stairwell door alarms to ensure that the battery and alarm are functioning properly. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 1. On 5.15.24, members of the interdisciplinary team, including the Administrator, DON, Nurse Mentor, and Social Worker, reviewed different elopement risk assessments that could be used in assisted living. A new assessment for assisted living was chosen that is more robust and holistic. 2. Starting 5.14.24, assisted living residents who were identified as having a potential to develop an elopement risk, severe cognitive impairment, and any assisted living residents who have had a status change are discussed at the weekly Patients at Risk (PAR) meeting for any necessary interventions or care plan updates. The PAR meeting is a multidisciplinary team including nursing, social work, administration, dining, and life enhancement. PAR is also a component of the the QAPI plan. 3. By 5.21.24, the DON and Nurse Mentor will ensure that all assisted living staff	

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D 270	Continued From page 4 impairment prior to admission but she did not have any behaviors prior to admission. The Community Mentor stated Resident #1 did not express any desire to leave the facility, she just wanted to take a walk when she went outside. She stated she was not aware Resident #1 had left the unit until she was notified, she was outside. The Community Mentor stated Resident #1 was on the sidewalk when observed walking outside and when asked, Resident #1 responded she just wanted to take a walk. The Community Mentor stated Resident #1 enjoyed reading in her room and taking walks, but she had not known her to go outside without someone before. An interview was conducted on 4/29/24 at 12:51 pm with Nurse Supervisor #2 who revealed she was on her way back from lunch and saw Resident #1 outside the skilled nursing entrance at the end of the facility near the parking lot. She stated Resident #1 was observed to walk down the ramp outside the double doors of skilled nursing entrance and turn right toward the parking lot. Nurse Supervisor #2 stated she waved for Resident #1 to come toward her, and Nurse Supervisor #2 stated she was able to catch up with Resident #1 at the base of the ramp before she got to the end of the sidewalk. Nurse Supervisor #2 stated she initially thought Resident #1 was a family member that was attempting to enter the facility but when she realized she was a resident she asked what she was doing outside, and Resident #1 told her she was taking a walk. Nurse Supervisor #2 stated Resident #1 seemed confused, so she waited outside with her until the Nurse Supervisor #1 and the Community Mentor arrived. Nurse Supervisor #2 stated she had not seen Resident #1 outside prior to that day.	D 270	have completed training on the new tracking device and how it operate, as well as, when to to update elopement risk assessments. The DON will provide additional education to all staff on what to do if there are concerns about a resident who has exited or has attempted to exit, and what to do when they find that someone has exited. All new hires will be provided the same education during the orientation process starting on 5.21.24. 4. Effective 5.15.24, any resident being admitted with cognitive impairments will be assessed by the Nurse Mentor prior to admission. The assessment will include an elopement risk assessment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 1. On 5.17.24, a Resident Safety Quality Review Tool was reviewed and accepted by the Quality Assurance Performance Improvement Committee. 2. The DON or designee will complete resident safety care reviews using the Resident Safety Quality Review Audit Tool weekly for the next 4 weeks, every other week for 2 months, and then monthly for the next 12 months. Any identified issues will be corrected immediately upon discovery and the Administrator will be notified. 3. The Administrator and the DON will review the results of the Resident Safety Quality Review Tool every other week for 2 months and then monthly for the next 10 months. 4. The Adminstrator or DON will share results from the audit with the Quality	

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D 270	Continued From page 5 A telephone interview was conducted on 4/29/24 at 1:01 pm with Nurse Supervisor #1 who managed the assisted living unit, revealed that Resident #1 was a new resident of the assisted living unit of the facility and had not yet had time to adjust to the new environment. She stated she was notified by Nurse #1 that Resident #1 was outside alone and she stated she went outside to check on Resident #1. Nurse Supervisor #1 stated Resident #1 reported she was fine and just wanted to take a walk for some fresh air. She stated Resident #1 did not seem lost or confused when she arrived outside, and they continued her walk around the grounds of the facility. Nurse Supervisor #1 stated Resident #1 was able to go outside and get fresh air because the assisted living unit did not have restrictions and they were able to move freely throughout the property. She stated when Resident #1 was admitted to the facility she was determined not to be an elopement risk even though she had severe cognitive impairment, she was easily redirected, and she had not voiced or demonstrated any intention for elopement. Nurse Supervisor #1 stated the assisted living unit was not a locked unit, and they did not utilize door or elevator alarms, or wander alert bracelet for residents that resided on the unit. Nurse Supervisor #1 stated she did not feel Resident #1 eloped from the facility on 4/19/24, but she just wanted to take a walk which was allowed. During an interview with the Social Worker on 4/29/24 at 2:18 pm he revealed that Resident #1 was assessed and determined to have severe cognitive impairment. He stated when new residents were admitted to the assisted living unit there was an adjustment period and they have found that residents with severe cognitive impairment thrived in the assistant care unit once	D 270	Assurance Performance Improvement Committee for the next 4 quarterly meetings. The committee will discuss trends, results, and make recommendations to ensure resident safety.	

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they have gotten into the routine of the unit.

An interview was conducted on 4/29/24 at 2:25 pm with Resident #1's RP revealed Resident #1 living independently and was not taking her medications or eating, she had weight loss, and she had a fall with a fracture, so she moved Resident #1 into her home. The RP stated she made the decision to have Resident #1 admitted to the assisted living unit for the assistance she required because she had difficulty finding reliable in-home care. She stated Resident #1 did not have any behavioral issues and did not leave the home prior to admission but she did need someone to administer medications and provide meals. The RP stated she was aware Resident #1 was outside, but she did speak with her and was told that she just wanted to take a walk. She stated Resident #1 enjoyed sitting on porch reading and walking around the yard prior to admission, so she felt it was her normal routine to take a walk when she wanted to. The RP stated she has coordinated volunteers to walk outside with Resident #1 to allow for her to continue her walks safely.

A telephone interview was conducted on 4/29/24 at 3:40 pm with the Nurse Practitioner (NP) who revealed she completed Resident #1's admission assessment and stated Resident #1 had short-term memory loss but did not have a diagnosis of dementia or advanced dementia so she felt the placement on the assisted living unit was appropriate. The NP stated she was unable to state if Resident #1 would have been able to find her way back into the facility or if she would know where she was going due to her short-term memory loss and the NP stated she could understand there would be a concern for her safety. The NP stated if a concern was identified

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that Resident #1 was an elopement risk it would be time to discuss if she was still appropriate for the assisted living unit.

An interview with the Director of Nursing (DON) was conducted on 4/29/24 at 4:06 pm. The DON stated she was not at the facility when Resident #1 was outside walking around the facility, but she was notified when she returned to work. She stated Resident #1 was able to take a walk around the facility and outside because she was an assisted living resident. The DON stated the assisted living unit was not a locked or a controlled unit and they were able to walk around the campus. The DON stated Resident #1 was still new to the facility and she did not know her well enough to say she was an elopement risk other than by the elopement risk assessment that was completed, but she did state there were some concerning elements that Resident #1 was outside alone.

A telephone interview was conducted on 4/29/24 at 5:12 pm with the previous DON who was employed at the facility when Resident #1 was observed outside independently. The Previous DON stated she was outside when Resident #1 was observed walking on the sidewalk coming down the ramp from the entrance door of the skilled nursing unit. The previous DON stated Resident #1 appeared to be wandering aimlessly and she did not believe Resident #1 should have been out of the facility alone. The previous DON stated she considered Resident #1's exit from the facility an elopement and she stated she expressed her concern about Resident #1 remaining on the assisted living unit, but she stated the Administrator did not agree.

An interview was conducted with the

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D 270	Continued From page 8 Administrator on 4/29/24 at 4:46 pm who revealed Resident #1 was recently admitted to the assisted living unit and she was not considered an elopement risk, so she was able to enjoy the grounds. The Administrator stated Resident #1 was not wandering aimlessly but was walking down the sidewalk and made no effort to walk in the parking lot or leave the facility grounds, so he stated it was not an elopement. He stated Resident #1 was appropriate for placement on the assisted living unit and stated he felt once Resident #1 was settled and in a routine, she will continue to maintain a high level of function and independence. The Administrator stated the assisted living unit did not use alarms, door locks, or wander alert alarms for free movement throughout the facility. The Administrator stated the previous DON did not express the concern that Resident #1 was a risk for elopement and had not reported her concern of Resident #1 residing on the assisted living unit of the facility. He stated since the facility was unable to determine if Resident #1 had gone down the exit stairs or the elevator the facility made the decision to activate the door alarm on the exit stairs so staff would be alerted when the door was opened. The Administrator stated he did not find it ideal that Resident #1 decided to walk outside independently without notifying staff before going out, but he stated he felt she was just taking a walk and did not attempt to leave the sidewalk or the property while outside.	D 270		