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E 000	Initial Comments A recertification and complaint investigation survey was conducted from 12/16/24 through 12/19/24. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # 9J1511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted at the facility from 12/16/24 to 12/19/24. Event ID # 9J1511. The following intakes were investigated: NC00216906, NC00223843, NC00223406, NC00213255, NC00212592, NC00212483. 1 of the 20 complaint allegations resulted in a deficiency.	F 000		
F 689 SS=D	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 record review, staff interviews and observations, the facility failed to provide supervision to prevent a moderately cognitively impaired resident (Resident #9) from being outside alone without nursing staff's knowledge when the Nursing Assistant Instructor entered the	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 01/08/2025

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code on the wander guard system without ensuring there were no residents with wander guard alarms that had passed the threshold and exited the facility. This deficient practice was identified for 1 of 4 residents reviewed for supervision to prevent accidents.

Findings included:

Resident #9 was admitted on 12/11/20 with diagnosis which included dementia with behavioral disturbance, epilepsy and history of falls.

Review of Resident #9's quarterly Minimum Data Set (MDS) assessment dated 9/19/24 revealed resident had moderate cognitive impairment, wandering was not exhibited, and he used a wheelchair for mobility.

Review of Resident #9's electronic health record revealed a health status note written by Nurse #1 dated 11/1/24 at 7:10 PM. The note revealed Resident #9 was found having exited the building, wandered into the parking lot and then positioned himself into an unlocked vehicle and claimed it was his own. The note indicated Resident #9 was assisted out of the vehicle and helped back into the building. A wander guard was placed on his right lower extremity.

Review of an elopement incident report dated 11/1/24 at 7:10 PM prepared by the Director of Nursing (DON) revealed Resident #9 was found having exited the building and was sitting in an unlocked private vehicle. Resident #9 claimed the vehicle was his. Resident #9 was assisted out of the vehicle and brought back into the facility uninjured. The physician and responsible

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party were notified. Resident #9 stated he did not recall what had occurred. The incident report indicated predisposing factors were impaired memory. Medical record review indicated Resident #9 was able to propel himself independently in the wheelchair. The root cause was determined to be Resident #9's impaired cognition. The intervention implemented to prevent further elopement was to place a wander guard on the resident.

An interview was conducted with Nurse #1 on 12/17/24 at 11:55 AM. Nurse #1 indicated he was assigned to Resident #9 on 11/1/24 from 7:00 PM to 7:00 AM. Nurse #1 indicated he was getting report from the 7:00 AM to 7:00 PM nurse when a family member called the facility and reported a resident was outside. Nurse #1 stated she and another nurse, he could not recall which nurse, went outside and Resident #9 was found outside the facility sitting in an unlocked car parked on the first row of cars outside the building. Resident #9 was in the back passenger seat of the car. No injuries were observed, and the resident was assisted back into the building. Prior to this incident the nurse indicated Resident #9 had not attempted to exit the building that he was aware of. Nurse #1 stated a wander guard device was applied to Resident #9. Nurse #1 stated the wander guard was checked to see ensure it was functioning properly.

An interview was conducted with Nurse #2 on 12/17/24 at 2:40 PM. Nurse #2 stated she was working on 11/1/24 from 7:00 AM to 7:00 PM. Nurse #2 stated on 11/1/24, a family member called the facility and informed her that a resident was outside the building. Nurse #2 stated she and Nurse #1 who was coming on for 7:00 PM to

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7:00 AM shift went outside and brought the resident back into the facility. After the incident that occurred on 11/1/24, Nurse #2 stated a wander guard was placed on Resident #9 and it was checked that it was working properly. After the incident on 11/1/24, Resident #9 continued to exhibit exit seeking behavior by going to the front door repeatedly and sounding the alarm.

A review of Resident #9's electronic health record revealed a nursing progress note dated 11/2/24 at 3:11 PM written by Nurse #2 indicated resident had confusion and was trying to go out the front door numerous times but the wander guard was alarming. Staff redirected the resident several times to his room.

A review of Resident #9's electronic health record revealed a health status note dated 11/3/2024 at 2:50 PM written by Nurse #2 which indicated a staff member assisted resident back into the facility from outside of the facility. The resident had a wander guard bracelet on, and the note indicated the wander guard alarm did not sound. Resident #9's wander guard bracelet was checked following the incident and was working. Resident #9 stated that he was going home. Resident #9 made no further attempts to go out of the building since the incident.

Review of an incident report completed by Nurse #2 dated 11/3/24 at 2:50 PM revealed a staff member stated she was returning from her break when she observed Resident #9 outside the facility unsupervised and she brought him back in. The incident report indicated the wander guard alarm did not sound and Resident #9 stated to the Nursing Assistant (NA) that he was going home. Immediate action was taken. The

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wander guard was checked and was working. Resident #9 was brought to his room and was asked why he exited the building and resident stated he was going home. Resident #9 was assessed, and no injuries were noted. The root cause was the Nursing Assistant (NA) Instructor silenced the wander guard alarm without checking the surroundings for residents that were identified as high risk for wandering or elopement. One on one (1:1) was initiated for the resident and education was initiated for all staff and the NA Instructor and students on the elopement process/policy.

An interview was conducted with NA #1 on 12/17/24 at 2:09 PM. NA #1 stated Resident #9 talked about wanting to go home before the elopement incident on 11/1/24 but he was not actively exit seeking. NA #1 indicated she knew Resident #9 eloped on 11/1/24, had a wander guard placed on him after the incident and was able to propel his wheelchair independently. NA #1 stated as she was returning from her break, she observed Resident #9 sitting in his wheelchair on the sidewalk to the left of the building a short distance from the driveway at the entrance to the facility. NA #1 stated Resident #9 was not near the road. NA #1 stated she brought Resident #9 back into the building when she saw him outside as she was returning from her break. NA #1 stated she knew Resident #9 was not supposed to be outside unsupervised. NA #1 stated the front door had a wander guard alarm sensor that sounds when a resident with a wander guard approaches the door.

An interview was conducted via phone with the Nursing Assistant (NA) Instructor on 12/17/24 at 2:17 PM. The NA Instructor stated she was

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bringing students to the facility for clinical instruction for several months but stated she did not know about all the policies. The NA Instructor stated she instructed the NA students to stop and act when they heard an alarm sounding in the facility. The NA Instructor stated she recalled the incident on 11/3/24 in which the wander guard alarm was sounding near the front door and she entered the code on the key pad to silence and reset the alarm. The NA Instructor stated she was explaining to the NA students about how to silence and reset the alarm. She indicated she did not look around to ensure there was not a resident near or exiting the facility. The NA Instructor stated she could have done more to prevent a resident from eloping and that she should have gotten a facility employee to check for a resident that was high risk for elopement that might have been in the area. The NA Instructor stated she had been given the code to reset the keypad for the wander guard system, but she could not recall by whom. The NA Instructor stated she should not have silenced and reset the alarm.

An interview with the Administrator on 12/17/24 at 3:05 PM revealed the facility had video surveillance that she and the DON reviewed following the elopement on 11/3/24 but the video footage storage did not go back that far. The Administrator stated she and the Director of Nursing (DON) reviewed the video surveillance immediately after the elopement incident occurred and determined that the NA Instructor had silenced the wander guard alarm thus staff were not aware that Resident #9 exited the building unsupervised.

An interview and observation conducted with the

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Maintenance Director on 12/17/24 at 3:20 PM indicated there are three wander guard sensors in the building that sound the alarm and have keypads in place. The Maintenance Director used a transmitter device to demonstrate the sounding of the first wander guard sensor that was positioned at the threshold of the lobby at the front of the building. The alarm sounded when the transmitter device was in close proximity to the sensor and was silenced when a code was entered into the key pad. The Maintenance Director demonstrated the activation of the wander guard sensor positioned just before the sliding exterior exit door. The alarm sounded and was silenced when the code was entered on the key pad. The Maintenance Director demonstrated the activation of the wander guard sensor located at the back door using the transmitter device. The alarm sounded and was silenced when the code was entered on the key pad. The Maintenance Director stated he was called on 11/3/24 to come out and check the wander guard sensor alarms following the incident. He indicated that the doors were working properly. The Maintenance Director stated normally, when the wander guard sensor in the lobby just before the sliding door is activated, the sliding exterior door will not open. The Maintenance Director stated if people were standing in front of the sliding door, the door remains open and does not lock.

An interview and reenactment of Resident #9's elopement incident that occurred on 11/3/24 was conducted on 12/17/24 at 3:45 PM with the Director of Nursing (DON). The DON provided the reenactment of what occurred with Resident #9 during the incident on 11/3/24 based on her review of the video footage. The DON

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demonstrated that Resident #9 propelled his wheelchair up the hallway and into the lobby. As he passed the first wander guard sensor that is at the threshold to the lobby, the alarm sounded. The Nursing Assistant Instructor was close to the keypad at the threshold to the lobby. The NA Instructor went to the keypad and entered the code silencing the wander guard alarm. Resident #9 continued to propel his wheelchair to the front sliding exterior door which was open due to a group of NA students standing in front of the door thus causing the door to remain open and not lock down when Resident #9's wander guard was sensed. The DON indicated that if someone is standing in front of the sliding door it remains open and will cause the wander guard sensor to not sound the alarm. The DON stated the video footage revealed that Resident propelled his wheelchair out the sliding exterior door. The video footage indicated 9 minutes later at 2:02 PM, Resident #9 was assisted back into the facility by a nursing assistant that was walking up towards the facility returning from her break. The DON stated the NA walked up and observed Resident #9 outside and realized he should not be outside unsupervised and assisted him back inside.

An interview was conducted with the Physician Assistant (PA) on 12/19/24 at 11:30 AM. The PA stated Resident #9 had moderate dementia, impaired communication and seizure disorder. The PA stated Resident #9 should not be outside unattended. The PA indicated Resident #9 had potential for medical issues related to seizure disorder and required supervision from staff when going outside.

The facility provided the following Corrective Action Plan with a completion date of 11/15/24:

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1. On 11/3/24 at 1:53 PM Resident #9 approached the first wander guard alarm sensor. Resident #9 continued to the front exit door where another wander guard sensor was located. The Nursing Assistant (NA) Instructor from the local community college was seen entering the code into the keypad for the wander guard alarm without checking for a resident with a wander guard bracelet that wandered too close to the sensor or eloped the facility. Root cause analysis indicated the NA Instructor did not check the area for a resident with a wander guard alarm that triggered the alarm, and this action allowed the resident to pass through the door. NA students were standing outside the front sliding door in a way that kept the door from closing and the resident was able to propel himself outside.

2. A head-to-toe assessment of Resident #9 was completed to ensure the resident sustained no injuries after he was returned from outside the facility.

On 11/3/24 following Resident #9's elopement incident, the staff nurses identified residents that were potentially impacted by this by completing a head count of all current residents and ensuring wander guards were present and functioning properly for all residents at risk for wandering.

On 11/4/24, the Director of Nursing (DON) identified the residents that were potentially impacted by ensuring all residents had an accurate elopement risk assessment. 7 of 77 residents required updated risk assessments. In addition, the DON completed interviews with staff to identify residents with exit seeking behaviors or wandering not previously identified. No other

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residents were identified.

On 11/4/24, the Maintenance Director conducted a 100 percent audit on all doors to ensure the doors were functioning and closing properly. There were no identified concerns with the doors or the wander guard system.

3. On 11/4/24, the reeducation on the Elopement Process policy was completed with the NA Instructor, NA students and all full, part-time and as needed staff. The training included all facility and agency staff. The training included: the difference between wandering, elopement, near miss and missing resident, how to identify residents at risk for elopement, what are exit seeking behaviors, what to do for residents that are high risk for elopement, what to do if the wander guard system alarm sounds and what to do if a resident is missing.

The DON will monitor Elopement Prevention and Elopement System Review and Door Functioning weekly for 2 weeks and then monthly for 3 months or until resolved for signs of exit seeking behavior as well as risk scores and proper functioning of the wander guard system. Reports will be presented weekly at the Quality Assurance committee by the Administrator or DON to ensure corrective action was initiated as appropriate.

4. The results of the elopement and door functioning audits will be discussed at the monthly Quality Assurance and Performance Improvement (QAPI) meeting for 3 months to sustain substantial compliance.

5. Allegation of Compliance Date: 11/15/24.

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The Corrective Action plan was validated on 12/19/24 by the following:

Review of Resident #9's care plan revealed the care plan was updated and included a care plan dated 11/4/24 which indicated resident was at risk for elopement related to exit seeking behaviors and episodes of confusion. Interventions dated 11/4/24 included check wander guard transmitter for placement, education initiated for all staff, the NA instructor and students on the elopement process, encourage family to visit as much as possible, especially during episodes of exit seeking behavior, notify the DON of exit seeking behaviors, notify nurse immediately if resident spends long periods of time close to the door/exits, notify nurse immediately if resident verbalizes desire to leave, and re-direct away from exits as needed.

An interview with NA #1 on 12/17/24 at 2:09 PM revealed she received in-service training regarding the wander guard system and the elopement policy following the incident on 11/3/24.

An interview with the NA Instructor on 12/17/24 PM at 2:17 PM revealed that following the incident on 11/3/24 she and the nursing assistant students received an in-service education regarding the wander guard system and elopement. The NA Instructor stated she was informed of the facility elopement policy.

An interview with the Maintenance Director on 12/17/24 at 3:20 PM revealed on 11/4/24 all wander guard sensor alarms on the doors were functioning properly. The Maintenance Director

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F 689	Continued From page 11 further stated he checked the door alarm sensors weekly. Logs were reviewed which indicated the doors were checked weekly starting on 11/4/24 with no issues noted. Further interviews with nursing staff revealed the facility had provided education and training on the elopement process policy, exit seeking behaviors and the wander guard system alarm. Staff interviewed all verbalized they received reeducation prior to starting their next shift. Review of the monitoring tools that began on 11/4/24 revealed that audits were completed weekly as outlined in the corrective action plan with no concerns identified. The completion date of 11/15/24 for the corrective action plan was validated.	F 689		