STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445422	A. Building B. Wing	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Etowah Health Care Center	409 Grady Road Etowah, TN 37331

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policy, medical record review, review of the facility self-reported incident (FRI), review of the video surveillance footage, review of National Weather Service (NWS) data, review of Satellite imaging (Google Earth), observations, and interviews, the facility failed to monitor and secure delayed egress doorways (doors equipped with a magnetic lock and keypad system which can be opened with 15 seconds direct pressure to the door handle without door codes) on the clinical units, which resulted in the elopement of 1 resident (#1) a cognitively impaired, ambulatory resident, with a history of wandering and other associated behaviors, of 9 residents reviewed. The facility's failure placed Resident #1 in Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more conditions of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident) when Resident #1 wandered to the delayed egress door on the D wing hallway, applied pressure to the doorhandle, opened the door, triggered the door alarm, then exited the building undetected to the outside. The facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the IJ on 7/21/2022 at 12:10 AM, in the conference room. The facility was cited F-689 at a scope and severity of J which constitutes Substandard Quality of Care. The IJ was effective 7/4/2022 and was removed on 7/22/2022. An acceptable Removal Plan, which removed the immediacy of the IJ, was submitted on 7/21/2022 at 5:40 PM. The removal plan was validated by the surveyor onsite 7/21 - 7/22/2022. The findings included: Review of the facility policy Risk of Elopement/Wandering and Missing Resident Guidelines, revised 4/24/2013, revealed .A resident wearing an anti-elopement bracelet that gets out a secured door without being in vision of a staff member or without immediate response by staff member when alarm is sounded is CONSIDERED AN ELOPEMENT .placement of an anti-elopement bracelet as ordered by the physician shall be checked every shift . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy Wandering/Elopement Guidelines, revised 8/4/2014 revealed .the facility will maintain an alarm system .the front entrance to the building is secured by an alarm but also by a locking device .the electronic receiver alarm located at the entrance is triggered by a transmitter worn by the resident [anti-elopement bracelet/Wanderguard] .the door will remain locked for 15 seconds .after 15 seconds of continuous pressure on the door, the locking mechanism will release and permit the resident to exit .therefor it is of most importance that the staff responds immediately to the alarm .the alarm will need to be reset by staff .when resident is removed from danger of elopement .Safety checks on wanderguard/safety device shall be completed on each shift and documented on treatment administration record .in event of elopement . refer to the missing resident procedure . Medical record review showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia with Behaviors, Cognitive Communication Deficits, and Anxiety Disorder. Review of the Care Plan for Resident #1 showed interventions for behaviors dated 3/9/2021 which revealed . she has periods of increased anxiety, agitation, wandering .verbal aggression .packs her belongings telling staff .coming to take her home .or that she is moving .she wanders the facility all the time .impaired decision making ability .impaired safety awareness .asks staff why she is here .Wanderguard [an electronic anti-elopement device] to left ankle .check placement .function .every shift .document . Medical record review of a Psychiatric Evaluation Note dated 4/7/2022 revealed .History of Present Illness, Staff request evaluation as resident continues to experience anxious behaviors, intermittent aggression towards others .difficult to redirect at times .Resident continues to display manic like behaviors, elevated mood and fixation on discharge .paranoid delusions .significant short term memory loss .will frequently request information on being discharged . Medical record review of hospital records showed Resident #1 was admitted to an acute Psychiatric Hospital on 4/11/2022, due to deteriorating mental status, hallucinations, paranoid behaviors, and aggression. She was discharged back to the nursing home on 5/4/2022. Review of the Nursing Home Psychiatric Evaluation and Psychiatric Progress Notes showed upon her return to the nursing home on 5/4/2022 through 6/9/22, Resident #1 continued to exhibit multiple behaviors including hallucinations, delusions, and wandering. Review of the Minimum Data Set (MDS) dated [DATE] showed Resident #1 was severely cognitively impaired with a Brief Interview of Mental Status Score of 5 out of 15. Resident #1 had disorganized thinking, inattention, moderate symptoms of depression, hallucinations, delusions, wandered daily, and had behaviors directed at others 1 to 3 times weekly. Review of the Elopement Evaluation dated 6/10/2022, showed the facility documented Resident #1 as not at risk for elopement, despite multiple care plan interventions and clinical progress notes which outlined her behaviors and risk factors for elopement, including wandering and talk of leaving/discharge. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nursing Notes written by the D Wing Licensed Practical Nurse (LPN) #1 dated 7/4/2022 at 4:14 PM showed .this nurse was at the nurses desk assisting a resident who was agitated when I heard a door alarm going off .this nurse .went to check on the door .noted one of the ambulatory residents on the hall was walking back up the hall away from the door .went down the hall and opened the door .noting it was unlocked and alarming .This nurse looked outside and did not see anything, but noted that I did not see [Resident #1] in the hallway .came back up the hallway looking in rooms as I went .looking through the window in one room to the parking lot and did not see anything .walked to C hall .and saw resident [#1] passing by, outside the door .stepped into dining room and called to A/B Nurses station for help .this nurse and 2 other staff members ran down the hallway and out the door to get the resident [#1] .Assisted resident [#1] back inside . resident was cooperative .asked why she left .she stated the door said hold for 15 minutes [seconds] and it will open so I thought I would go walk outside . Review of nursing notes dated 7/4/2022 at 4:45 PM, written by A hall LPN #2 who assisted in bringing Resident #1 back inside, revealed .This nurse was sitting at A/B nurses station when the nurse from C Hall requested my help .As I followed her she told me and another staff member [Resident #1] was outside the back door .we all three ran outside and assisted her back into the building .which she was agreeable to . Review of the FRI report dated 7/4/2022 revealed .What type of plan will the facility put in place to ensure this type of incident does not recur .A stop sign was placed at the exit door . Review of Resident #1's care plan showed interventions dated 7/4/2022, .every 15-minute checks due to resident going out exit door Additional interventions added on 7/5/2022 read, .redirect away from exit doors, stop sign placed on D Hall exit door . Review of video surveillance footage of Resident #1's elopement on 7/13/2022 at 2:00 PM, with the Administrator, showed there was no footage of Resident #1's exit from the D wing Door as described in the nursing notes. The camera system at the door was not operational. Review of footage of the incident captured on the exterior camera positioned near the C wing smoking porch and the interior C wing door (the door in which Resident #1 re-entered the facility) revealed the following: 7/4/2022 3:36:00 PM- Resident #1 comes into view, ambulating through the rear yard of the facility outside the closed gate on the North side of the porch in front of the camera view. Stands at gate briefly, turns, walks back down into yard away from gate, southern direction, towards base of bank and wood line. 3:36:20 Voice off camera is heard calling out to Resident #1 ([Resident #1], NO!! .) First staff member dressed in red scrubs appears on frame, approaching resident through the gate on the porch, followed by 2 others. Search party and resident disappear temporarily due to camera angle. 3:37:53 Search party accompany Resident #1 back into view, walking uphill from the lower portion of embankment, towards the C Hall porch, around the shallow end of the embankment/yard. 3:38:10 Search party on porch with Resident #1. 3:40:00 Search Party escort Resident #1 inside. (No audio detectable). Resident #1 is shoeless, dressed in long pants, and a shirt, appears to have layered shirts. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the NWS (National Weather Service) weather data for 7/4/2022 cross referenced to Global Positioning System (GPS) Data for the facility showed at the time of the elopement, it was sunny and 92 degrees, with 74% humidity, and a 7 mile per hour wind from the southwest. Observations of the D Wing Hallway on 7/13/2022 at approximately 1:20 PM, revealed the D Wing was approximately 120 feet long with the delayed egress door at the end of the wing, distal to the nursing station. The door was not secured with a stop sign as reported in the FRI. Residents, including Resident #1, were observed wandering about the D wing and common areas. Observations of the D wing delayed egress door showed it was secured with a magnetic lock and keypad system but had no anti-elopement or Wanderguard system (Wanderguard systems function via radio signal detection. The bracelet worn by a user emits a radio signal, specific to the antennae system used to detect it. Antennae are placed near the exits where egress is discouraged. When the radio transmitter bracelet comes within a pre-programmed proximity to the door antennae, the system is activated, an audible alarm sounds, magnetic door locks are temporarily engaged until the radio transmitter is moved out of the specified detection range of the antennae or the door is manually reset by an attendant with a specific code to input into the door system). Observations of the adjacent C wing exit door, common dining area exit door, and B and A wing exit doors showed all were equipped with delayed egress doors, and none had functioning Wanderguard antennae in place. None of the other units had stop signs placed in front of the delayed egress doors. Other wandering residents were observed as they wandered about the A and B halls socializing with staff and peers. Three wandering residents were observed equipped with Wanderguard bracelets affixed to their persons or their wheelchairs. Observation of the facility Wanderguard system on 7/13/2022 showed the Wanderguard system was non-operational on 5 out of 6 delayed egress doors at the facility, which included all the resident hallways and the central common dining area, which also functioned as an area for socialization and activities in the X shaped facility. Observation showed the only door in the facility equipped with the Wanderguard system was the main, front door of the facility. Interview with LPN #2 on 7/13/2022 at 2:35 PM, revealed she was the person dressed in red scrubs identified on the surveillance video footage. LPN #2 reported Resident #1 was found behind the facility, at the bottom of the steep embankment, in very close proximity to the wood line when recovered. Resident #1 was calm but very confused, as was her baseline. LPN #2 was informed by the nurse assigned to Resident #1 that day (LPN #1) the resident had escaped through the delayed egress door at the end of the D hallway unobserved, and the nurse had found it open and alarming before she called for help, which prompted the search for Resident #1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with LPN #1 (the nurse assigned to care for Resident #1 on the day she eloped) on 7/13/2022 at 3:30 PM, revealed at the time of Resident #1's elopement, LPN #1 was the only staff member assigned to the unit with 16 residents on the D wing. LPN #1 reported at the time of the elopement, she was managing behaviors of an agitated resident near the nursing station, while simultaneously trying to monitor wandering behaviors of 2 other residents, including Resident #1. LPN #1 stated she lost track of Resident #1 for this reason. LPN #1 reported sometime around 4:00 PM (couldn't recall exact time), she heard the delayed egress door alarm at the far end of the hall sounding. She walked to the door and noted a wandering resident in proximity and initially believed this person had activated the door alarm. The door was ajar. LPN #1 looked outside the door, saw nobody outside, closed the door, manually rearmed it, then noted Resident #1 was not present on the unit. LPN #1 began searching rooms on the unit working her way back down the hallway towards the nursing station, when she looked outside the window of a room about 2/3 way down the hallway and saw Resident #1 ambulating across the back yard of the facility in the general direction of the adjacent C unit. LPN #1 immediately ran to the common dining area in line of sight of the A/B hallway nursing station, called for help, and with 2 other staff members, ran up the length of the closed C unit, exited the door there, crossed the smoking porch, and intercepted Resident #1 as she ambulated near the woods in a grassy area behind the nursing home. LPN #1 asked Resident #1 how she got outside and the resident told her she read the delayed egress door instructions and opened the door to take a walk outside. LPN #1 notified the DON of the elopement, and she did not notice Resident #1's exit until she had already opened the delayed egress door and sounded the alarm. LPN #1 knew Resident #1 wore a Wanderguard but was not aware it was non-functional on the clinical unit until after Resident #1 had been recovered outside. LPN #1 reported in her estimation, Resident #1 was outside the facility for 5 minutes or less before she was located and recovered. LPN #1 confirmed the facility was aware Resident #1 was high risk for elopement and at least 3 residents who either lived on or frequented the D Wing during the day had behaviors and were also high risk for elopement. Telephone interview with Registered Nurse (RN) #1 on 7/13/2022 at 4:10 PM, revealed she was a staff member identified on the video surveillance tape who helped bring Resident #1 back inside after she was found behind the facility. RN #1 responded immediately to LPN #1's calls for help, exited her post near the end of the B Wing hallway through the rear door, came around the back of the building, checking the rear parking lot as she did so, then witnessed 3 or 4 staff members below the C Wing porch as they escorted Resident #1 around the embankment and back inside. RN #1 stated .we were lucky she didn't end up in those woods . RN #1 reported Resident #1 had a long history of behaviors and wandering, had been hospitalized due to them a few months beforehand, and staff knew she was at risk for elopement. RN #1 reported in her estimation, the elopement incident was around 3 minutes in duration from the time she responded to calls for help from the D wing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Maintenance Director on 7/14/2022 at 2:15 PM, outside the D Wing delayed egress door, while taking measurements of the areas involved in the elopement, revealed he had begun the position as Maintenance Director January 2022 and very early in his tenure during a meeting with the Regional [NAME] President, Administrator, and other members of the facility leadership group, he mentioned the facility anti-elopement system was not equipped with antennae on any of the doors except the main entrance, and questioned why this was the case. The Maintenance Director reported his question was not answered and the [NAME] President did not seem to be aware of that. During measurements of the embankment behind the facility where Resident #1 was found, the Maintenance Director, who was standing at the top of the embankment near the smoking area, as he held the tape measure used by the surveyor below, slipped and fell . He slid several feet down the roughly 40-degree incline before he was able to stop himself. The embankment as measured near a tree growing centrally on it, was 36 feet high from its top to the base. The Maintenance Director agreed had Resident #1 ambulated across the top of the embankment on the narrow footpath outside the fenced smoking area at the top of the embankment, or attempted to walk across it anywhere, she would have likely fallen down the embankment, which posed a grave risk of injury or worse to the resident. Observations of the facility exterior on 7/14/2022 at 2:15 PM, showed the route Resident #1 took when seen once outside the building. Resident #1 ambulated across the grassy, uneven surface immediately outside the D Wing doorway, then crossed the back yard of the facility unobserved for approximately 177 feet to a closed gate near the smoking porch outside the doors of the adjacent C wing, which was at the top of a grassy embankment, with an approximately 40 degree slope, that was 36 feet high from a flat surface where the fenced in smoking patio was, to the base of the embankment. Resident #1 stood there briefly, then ambulated around 25 feet back into the yard downhill, then ambulated around the base of the embankment. Resident #1 was found standing in a narrow strip of grass around 15 feet wide, between the base of the embankment and a wooded area behind the facility, which was out of line of sight of anyone other than persons on the porch directly above it. When she was found, Resident #1, who was barefooted at the time, stood approximately 2 feet from the edge of a heavily wooded area, several acres in size, which had a paved road running through it near the rear of the parcel behind the facility, which was strewn with briars and undergrowth at its edge which bordered the facility. Telephone interview with Certified Nurse Aide (CNA) #2 on 7/14/2022 at 4:00 PM, revealed she worked the D Wing on the day of the elopement but had left the facility at the end of her shift around 3:00 PM, before the incident. CNA #2 reported during the day hours of 7/4/2022, Resident #1 had not been agitated, but had wandered throughout the facility all day and required close monitoring as she was at risk for elopement. CNA #2 reported she knew Resident #1 wore a Wanderguard, but she was unaware the system did not work on any of the clinical units. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA #1 on 7/14/2022 at 4:15 PM, revealed she was one of the staff members seen bringing Resident #1 inside on the surveillance video. CNA #1 reported at the time Resident #1 eloped, she heard the delayed egress door alarm from the D hallway activate sometime between 2:45 PM to 3:15 PM in her estimation, but could not recall the exact time, but knew it happened shortly after shift change at 3:00 PM. CNA #1 did not hear a Wanderguard audible alarm activate at the time of the incident. CNA #1 stated . [LPN #1] came over calling for help. We responded. I checked the dining hall first, then went down the C hall to the smoking porch . CNA #1 reported Resident #1 was located behind the facility, at the base of the embankment below the porch, at the edge of the woods. CNA #1 confirmed Resident #1 was barefooted at the time. CNA #1 was aware Resident #1 was an elopement risk and at the time of the incident wore a Wanderguard bracelet. CNA #1 confirmed at the time she escorted Resident #1 back inside, the Wanderguard bracelet was affixed to Resident #1. CNA #1 confirmed she had not heard the Wanderguard alarm at the time she heard the door alarm trigger, nor had it sounded an alarm when Resident #1 was brought back inside via the C hall doorway. CNA #1 reported she was unaware the facility Wanderguard system did not work on the clinical units anywhere inside the facility except the front door until after the incident had occurred. During interview on 7/19/2022 at 8:58 PM, the DON confirmed on 7/4/2022, Resident #1 eloped from the facility via the delayed egress door on the D wing unobserved. The DON confirmed this was likely due to inadequate monitoring of the exit, secondary to a staffing error which had left the unit staffed with only an LPN to monitor 16 residents, several of which had behavioral and psychological symptoms of Dementia. During discussions of the facility Wanderguard System and its limitations, the DON reported she raised concerns and questioned Administration and Corporate staff as to why there were no Wanderguard antennae situated on doors other than the main entrance, shortly after she took the DON position sometime around September 2021. The DON confirmed the facility anti-elopement system as configured was ineffective in preventing elopement for Resident #1 on 7/4/2022. The DON confirmed all delayed egress doors in the facility had not been secured with stop signs and tab alarms, which would sound before the delayed egress system was activated, until 7/15/2022. The DON confirmed Resident #1 was located near the wood line behind the facility at the base of the embankment. The DON agreed, despite no negative outcome or actual harm to the resident, Resident #1's elopement on 7/4/2022 placed her at substantial risk of severe harm, injury, impairment, or death. Facility corrective actions included: 1. Resident #1's environment was modified by placing a stop sign on the exit door of the D wing on 7/5/2022. 2. Stop signs were placed over all exit doors with audible clip alarms in place that will alert staff when the Velcro stop signs are removed completed on 7/15/2022. Staff education related to the door alarms and stop signs began on 7/14/2022 and was completed on 7/15/2022. The surveyor verified stop signs with functioning tab alarms were in place on all delayed egress doors 7/18/2022, 7/19/2022, and again on 7/22/2022. Clip alarms were tested by triggering them and staff response times observed. No concerns were noted. 3. The facility implemented door check logs for the exit doors with stop signs and alarms affixed twice daily on 7/20/2022. The surveyor validated the door check logs were in use on 7/22/2022. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Staff education related to the door stop signs, audible alarms and twice a day door check logs began on 7/20/2022 and was completed on 7/21/2022. Education was verified by observation of the staff education sign in sheets and staff interviews on the relevant procedures on 7/22/2022. 5. Current Residents were assessed for elopement risk on 7/15/2022 by a licensed nurse. Residents identified as at risk for elopement were added to the facility elopement prevention program (happy feet). The happy feet manual was updated by a licensed nurse on 7/15/2022. The Surveyor validated the Happy Feet Manuals were in place, updated and staff were aware of their location on 7/22/2022. Staff education related to the manuals was assessed by reinterview of 4 staff (3 licensed nurses and 1 CNA) on 7/22/2022. 6. The facility Registered Nurse or Designee will perform daily audits of the door check logs for at least 2 weeks. The audit results will be evaluated by the Quality Assurance Committee, (QA) which shall include the Administrator, DON, Medical Director and at least 3 other staff members. The Daily door check program began on 7/21/2022 and was validated by the SA surveyor on 7/22/2022 via review of the logs. Noncompliance continues at a scope and severity of D for monitoring of the effectiveness of corrective actions. The facility is required to submit a Plan of Correction (POC).

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on medical record review, observation, review of the facility layout, review of census, review of facility staffing, review of facility punch reports and payroll data, and interviews, the facility failed to maintain sufficient nurse staffing to monitor residents with behaviors. The facility's failure to ensure sufficient staffing resulted in the elopement of 1 resident (#1) of 9 residents reviewed. Resident #1 wandered to the delayed egress door on the D wing hallway and exited the building undetected around 3:40 PM on 7/4/2022, placing Resident #1 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more conditions of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to resident). The facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the IJ on 7/21/2022 at 12:10 AM, in the conference room. The IJ was effective 7/4/2022 and was removed on 7/22/2022. The findings included: Medical record review showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia with Behaviors, Cognitive Communication Deficits, and Anxiety Disorder. Medical record review of hospital records showed Resident #1 was admitted to an acute Psychiatric Hospital on 4/11/2022, due to escalating behaviors, which included packing her belongings to leave, wandering behaviors, paranoia, delusions, hallucinations, and aggression towards others. She returned to the nursing home on 5/4/2022. Review of the Nursing Home Psychiatric Evaluation and Psychiatric Progress Notes showed upon her return to the nursing home on 5/4/2022 through 6/9/2022, Resident #1 continued to exhibit multiple behaviors including hallucinations, delusions, and wandering. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #1 was severely cognitively impaired with a Brief Interview of Mental Status (BIMS) Score of 5 out of 15. Resident #1 had disorganized thinking, inattention, moderate symptoms of depression, hallucinations, delusions, wandered daily and had behaviors directed at others 1 to 3 times weekly. Resident #1 was dependent upon one or more persons for activities of daily living (ADLs). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Nursing Notes written by the D Wing Licensed Practical Nurse (LPN) #1 dated 7/4/2022 at 4:14 PM showed .this nurse was at the nurses desk assisting a resident who was agitated when I heard a door alarm going off .this nurse .went to check on the door .noted one of the ambulatory residents on the hall was walking back up the hall away from the door .went down the hall and opened the door .noting it was unlocked and alarming .This nurse looked outside and did not see anything, but noted that I did not see [Resident #1] in the hallway .came back up the hallway looking in rooms as I went .looking through the window in one room to the parking lot and did not see anything .walked to C hall .and saw resident [#1] passing by, outside the door .stepped into dining room and called to A/B Nurses station for help .this nurse and 2 other staff members ran down the hallway and out the door to get the resident [#1] .Assisted resident [#1] back inside . resident was cooperative .asked why she left .she stated the door said hold for 15 minutes [seconds] and it will open so I thought I would go walk outside . Observation and review of the facility layout showed the facility was configured in an X shape. A dining area and the rehabilitation area were at the junction of the X, which served as a common area accessible to both units. The main lobby, reception desk, and the facility main entrance was situated centrally at this junction, a few steps north of the dining room. The clinical units were situated on the arms of the X. Each unit was around 120 feet long with resident rooms on both sides of the hallways. Each unit had a common nursing station at the junctions of the clinical units, in a roughly V-shaped configuration, at the proximal end of the units, nearest the central lobby and common dining room. The delayed egress doors on the facility clinical units were at the far ends of the units, distal to the nursing stations, common dining hall, and lobby. The D wing delayed egress door led to the side and back yard of the facility west of the front parking area. The C wing delayed egress door led to a gated porch area atop a flat surface with a steep embankment immediately beyond a chain link fence used to enclose the porch at the rear of the facility. This area was referred to by staff as the smoking porch as the designated smoking area was located there. The B wing door led to the rear parking lot. The A wing door led to a parking lot near the rear/side of the facility and a delayed egress door in the rear of the common dining hall led outside to a service area near the facility generators and adjacent employee parking area in the rear of the facility between the B and C wing exits. Review of the facility census for 7/4/2022 showed there were 57 residents in the facility. Sixteen Residents were located on the D wing where Resident #1 resided, 21 were located on the A wing, and 20 were located on the B wing. The C wing, situated directly beside the D wing, was vacant and not in use. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the posted staff schedule for 7/4/2022, showed multiple changes were penned onto the document throughout the day. The document showed Certified Nurse Aide (CNA) #3 was assigned to all 3 units in the facility at the same time (including 4 hours on the D wing between 3:00 PM and 7:00 PM). No fewer than 8 changes to the document were made between 7:00 AM and 7:00 PM. There were blanks as to where staff worked, and multiple unit assignments had been scratched out or changed. Staff were assigned to multiple units, some rotating assignments across the facility in 4-hour blocks. Scheduled work hours had been adjusted for at least 9 personnel listed on the units, and at least 2 persons listed on the schedule had been marked off as absent. At least 3 staff members were scheduled for 16-hour rotations. Both of those persons were CNAs assigned to the A and B wings. The schedule also showed 2 non-licensed CNA trainees assigned to work that day, one of which had called in sick. One certified CNA scheduled for a 12 hour shift that day was known to be at home on isolation due to COVID 19 infection and did not work, but her staff hours were listed on the schedule. Her open slot on the schedule did not appear to have been filled by an alternate. Nursing management on the schedule included the ADON for 8 hours on the morning shift. Three open CNA positions appeared to have not been filled by replacements to make up for call-ins. Review of the staff schedule and corresponding payroll data revealed between 3:00 PM and 7:00 PM that day, there were no CNAs assigned to the D wing and only 1 nurse assigned, who was responsible for total care of 16 residents. Review of the facility master schedule for 7/4/2022, showed CNA #3, who had been placed on the posted staffing schedule as assigned to the D Wing Hallway for 4 hours between 3:00 PM and 7:00 PM, was only scheduled to work 12 hours that day, assigned initially to the B wing, but rotated to the D wing, from 7:00 PM to 7:00 AM. Review of the employee Roster and Agency Employee List showed 16.9 percent of the facility's total clinical staff was comprised of paid contractors employed by nursing agencies with written agreements in place to provide staffing services to the facility. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with LPN #1 on 7/13/2022 at 3:30 PM, revealed she was the nurse assigned to the D wing on 7/4/2022. LPN #1 reported between the hours of 3:00 PM and 7:00 PM, she had no CNA coverage for her unit due to a staffing error that was not discovered until shift change at 3:00 PM. LPN #1 reported facility management were informed of the staffing problem when it was discovered, but no corrective actions were taken, and the unit was not sufficiently staffed until CNA #3 arrived for his regularly scheduled shift at 7:00 PM on 7/4/2022. LPN #1 reported at the time of Resident #1's elopement, she had seen her about five minutes earlier ambulating towards the common dining area, which was a normal behavior for the resident that time of day. LPN #1 was alone on the unit and assigned 16 residents. LPN #1 reported she lost track of Resident #1 while caring for an agitated resident at the nursing station and assisting another resident as they made a phone call to loved ones from the nursing station phone. Another resident was wandering the hallways near the far end adjacent to the exit door, and LPN #1 was also monitoring that person. LPN #1 reported when she heard the delayed egress alarm sound on the door, she immediately responded once she realized it was the door on the far end of the D wing. LPN #1 estimated this took around 10 seconds to figure out and she walked down the hall, scanning the unit as she approached the door that took less than a minute to reach. LPN #1 found the exit door to the D wing ajar, but did not see anyone outside, closed the door, rearmed it, and initially assumed the resident standing in the hallway near the door had inadvertently triggered it. LPN #1 rearmed the door, noted Resident #1 was not visible on the D wing, nor was she visible in the common dining room visible past the nursing station at the other end of the hallway. LPN #1 immediately began searching rooms on her way back down the unit, and as she passed a room, she looked outside through the window in the room and observed Resident #1 outside ambulating across the back yard of the facility, standing near the gated porch of the adjacent C wing. LPN #1 ran to the dining area and shouted for staff to assist her as she turned and ran up the C wing to intercept Resident #1 outside near the porch. LPN #1 confirmed by the time staff intercepted Resident #1 outside, she had ambulated downhill behind the embankment and was standing barefoot near the edge of the woods behind the facility. LPN #1 reported not having a CNA on the unit to help supervise the unit directly contributed to Resident #1's elopement. LPN #1 reported staffing problems and scheduling errors as occurred on 7/4/2022 had been commonplace in the facility for an extended period. Interview with LPN #3 on 7/14/2022 at 3:06 PM, revealed LPN #3 was a contracted agency nurse who had been in the facility for approximately 30 days. LPN #3 reported she observed lots of turnover at the facility and she felt the facility was short staffed. Interview with CNA #4 on 7/14/2022 at 3:18 PM, revealed she was a contracted employee who had been taking assignments at the facility since 2021. CNA #4 reported she had observed times when only 2 CNAs were assigned to the entire facility on overnight shifts. CNA #4 was informed by a witness to Resident #1's elopement that there were no CNAs assigned to the D wing that day and only 2 CNAs assigned to care for all residents on the A and B wings at the time Resident #1 exited the facility. Interview with LPN #4 on 7/14/2022 at 3:48 PM, revealed she was a contracted employee of a nursing agency who had taken assignments at the facility for around 3 weeks. She reported the facility had multiple open shifts every week and used agency personnel when available to fill them. Interview with CNA #5 on 7/14/2022 at 3:58 PM, revealed she was an employee of the facility for the past 3 years. CNA #5 reported she frequently rotated between units and was regularly asked to work overtime when already scheduled, work extra shifts due to call-ins, or was called to work on her days off by the facility. CNA #5 reported she believed the facility was regularly understaffed. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with CNA #2 on 7/14/2022 at 4:00 PM, revealed frequent schedule changes at the facility were common due to staffing issues and she frequently worked overtime to cover empty slots in the schedules. CNA #2 was on duty until 3:00 PM the day Resident #1 eloped, had worked the D hallway, but was not asked to remain at the facility or work over. CNA #2 was also responsible for central supply inventories and had worked in the central supply room from 2:30 PM to 3:00 PM that day before going home and had not been back to the D hallway before leaving. CNA #2 was aware on 7/4/2022 at the 3:00 PM shift change, there were only 2 CNAs assigned to cover both the A and B hallways with an unlicensed trainee floating between the A and B halls. CNA #2 confirmed in her opinion, the facility was understaffed at times. Interview with CNA #1 on 7/14/2022 at 4:15 PM, revealed she was an agency employee. CNA #1 routinely worked (3) 16-hour shift rotations per week. CNA #1 stated .They have few actual staff of their own here I think .mostly agency and it's pretty awful . CNA #1 was a witness to Resident #1's elopement and helped retrieve her from outside. At shift change on 7/4/2022, CNA #1 was initially assigned to work the D wing from 3:00 PM to 7:00 AM but was pulled from her assignment and moved to the A and B wings to cover staff shortages there. CNA #1 moved to the A wing where she was assigned 26 residents. She confirmed at the time she was moved to the other wing, the lone CNA there at shift change had been assigned 40 or more residents to care for with an unlicensed trainee to assist. CNA #1 reported unlicensed personnel were prohibited from providing care alone, or entering documentation into the medical records, so they functioned as hospitality aides doing non-clinical tasks or assisting with tasks requiring certification or licensure. CNA #1 reported the posted staffing that day on the units showed CNA #3 was to work 16 hours from 3:00 PM until 7:00 AM and stated she knew it was not correct, then stated, . [CNA #3] is just a kid, he's like [AGE] years old, he never works 16-hour shifts . CNA #1 stated she knew CNA #3's usual assignment was 12 hour shifts on the overnight rotation, where his father was also employed as a nurse. CNA #1 went on to say the DON routinely made errors on the posted staffing and stated .DON routinely does that with the schedule, so it looks full, but that's not who is on the master schedule payroll . CNA #1 reported multiple schedule errors by the DON or her subordinates had led to frequent incidents of short staffing, usually not detected until shift changes occurred and staff absences were discovered. CNA #1 stated .she [DON] has agency staff, she just can't schedule them right . CNA #1 reported I left here for 3 months .wouldn't renew my contract in March, April, or May [2022] because of it . CNA #1 reported when she refused to renew her contract, she put her concerns about short staffing in writing and gave them to the Administrator. CNA #1 stated .but he didn't do anything . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with CNA #3 on 7/14/2022 at 6:10 PM, revealed on 7/4/2022, he was listed on posted staffing to work a 16-hour rotation from 3:00 PM to 7:00 AM, but was not informed of it. CNA #3 stated had he been aware, he would have taken the overtime. CNA #3 reported scheduling errors were common at the facility and stated . the DON or somebody adds names to the posted staffing but doesn't tell the workers . and stated this frequently led to staff shortages not being detected until shift changes occurred. CNA #3 reported this led to frequent instances where clinical staff were forced to .scramble . to cover open gaps in the schedules, reassigning staff, and often extra personnel to fill the open slots were not obtained, which led to chronic short staffing situations. CNA #3 reported when staffing errors or multiple call-ins occurred, CNAs often found themselves assigned to care for 30 or more residents alone. CNA #3 reported many residents at the facility were severely disabled and required 2-person assistance for care. CNA #3 reported frequent bouts of short staffing often led to single CNAs assigned to care for entire wings themselves. When the CNAs from adjacent hallways assisted one another, if the nurse on duty was occupied with other tasks, it often meant units went unmonitored for several minutes. CNA #3 reported the facility augmented it's staffing during a recent annual Recertification survey, but staffing levels were reduced afterwards. Interview with the Administrator on 7/18/2022 at 1:45 PM, revealed the master schedules for staffing at the facility were created by the DON, assisted by the ADON. Floor nursing staff were often involved in rearranging schedules to account for replacements when the need arose. The master schedule was made, and copies given to staff two weeks in advance, and as changes to the schedule occurred, those were first addressed by the floor level staff, if there was a need for adjustments, and then addressed by the on-call nursing management if issues were not resolved. The Administrator confirmed on 7/4/2022, it appeared floor staff did not involve the on-call administration when the staffing shortage on D wing was discovered. The Administrator reported it was his expectation if a call-in could not be covered by supplemental staffing, the on-call nurse was to report for duty, and it was the DON's responsibility to ensure this occurred. The Administrator confirmed on 7/4/2022, a scheduling error involving CNA #3 had occurred and led to short staffing on the D wing not filled by an on-call administrative nurse or other staff. Interview with LPN #10 on 7/18/2022 at 5:03 PM, revealed on 7/4/2022, a scheduling error on the master schedule led to short staffing on the D wing before Resident #1 eloped. LPN #10 reported frequent schedule changes at the facility complicated by scheduling errors or unexpected staff absences were the norm. LPN #10 stated the facility had substantial numbers of agency staff available and willing to fill schedule openings, but they were frequently .improperly scheduled . and it was not uncommon to see names on the posted staffing of employees who were known to be off duty, and in a few cases, names of employees who had not worked in months or who were no longer employed. LPN #10 stated problems with scheduling and staffing had been ongoing for months. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON and ADON on 7/18/2022 at 5:21 PM, revealed development of the master nursing schedule was delegated LPN #1 (the nurse on duty on the D wing the day of the elopement). The DON reported the master schedule was usually formulated month in advance, but recently had been formulated 1 to 2 weeks in advance. Once created by LPN #1, the schedule was reviewed and approved by the DON then distributed to staff. The DON reported she delegated development of the master CNA schedule to CNA #2, who followed the same process, submitting it for approval and distribution 1 to 2 weeks in advance. In the event of unexpected staff absences, absent employees were to call in advance to the facility unit where they were assigned, or call the DON, so alternate staffing could be arranged. At that point, the floor clinical nurse was to call employees in attempts to fill the open position and if unsuccessful, the floor nurse was to call the on-call nurse manager (DON or ADON) for assistance. Members of the management team would then mandate overtime for staff already on duty until relief was obtained, call off duty employees in to work, or seek agency staff to fill open slots in the schedule. The ADON confirmed on 7/4/2022, transcription errors on the master schedule she altered led to the short staffing on the D hallway. The ADON added hours to CNA #3's schedule on the staffing used on the floor but did not add them to the master schedule which had already been formulated and approved. The ADON confirmed CNA #3 was not aware of the extra hours she assigned him to work on 7/4/2022. Interview with Registered Nurse (RN) #4 on 7/19/2022 at 8:00 PM, revealed he was a facility employee and currently was working the night shift assigned to care for residents on both the A and B wings and he had 1 CNA assigned per wing. RN #4 reported each CNA had 20 or more residents assigned and his assignment totaled 41 residents. RN #4 usually had 2 CNAs assigned per wing and stated the facility was chronically understaffed on the overnight shifts. RN #4 stated frequent scheduling errors contributed to staffing difficulties, further exacerbated by a lack of full-time employees and the facility's dependence on contracted staffing services to meet scheduling needs. RN #4 stated they often worked short staffed as agency staff were often .not scheduled appropriately . RN #4 stated .at night here, if there are no problems you can barely keep up .you are busy .but if one thing goes wrong you are behind and you stay behind and things can get out of hand .feel it is risky here . RN #4 stated multiple agency staff had also complained to management about the staffing situation at the facility with little change in it. RN #4 stated he believed if the facility corrected its staffing problems, most of the other issues identified at the facility .would resolve themselves . Interview with CNA #3 on 7/19/2022 at 8:20 PM, revealed he was assigned 20 residents that night and was the only CNA assigned to the B wing. CNA #3 noted if the A wing CNA came over to the B Wing to assist with residents who required use of lifts rf other 2-person assistance, one of the two wings would be unmonitored if the nurse was engaged in care of other residents. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #11 on 7/19/2022 at 8:22 PM, revealed she was an agency nurse. LPN #11 reported she had been employed at the facility for a month. LPN #11 stated, .communication in this place between management and the clinical staff sucks, and you can quote me on that . LPN #11 noticed multiple residents at the facility exhibited behavioral and psychological symptoms of Dementia. LPN #11 considered the facility . chronically understaffed . and stated often during her shifts, the facility was staffed by more agency personnel than its own staff members. LPN #11 reported she initially refused to fulfill her contract at the facility after 1 shift and stated .4 weeks ago I refused shifts here after 1 shift because I feared for my license . the schedules are disorganized here .chronic understaffing and everything they do seems so disorganized . After speaking with the Administrator and DON, LPN #11 was assured conditions in the facility would improve .so I agreed to return but I have been speaking my mind . LPN #11 stated 2 days prior, she spoke to the DON and Administrator about incorporating resident acuity into the facility staffing on the D wing, which she felt was not being considered, due to the number of residents there with significant behaviors, which included wandering and aggressive tendencies, and increased needs for ADL assistance. The facility continued to staff 1 CNA to the D wing and LPN #11 stated .I have difficulty keeping eyes on all residents on the unit . The CNAs also had difficulties completing all their assigned tasks due to acuity of the residents and the current staffing levels assigned on the D wing, which she also reported to the DON. LPN #11 stated both residents and staff at the facility were .at risk . if improvements in staffing were not implemented. Interview with CNA #9 on 7/19/2022 at 8:38 PM, revealed she was a facility employee. CNA #9 reported she frequently had problems completing all assigned tasks by the end of her shift due to the numbers of residents with behaviors on the D wing, which required more of her time caring for them. CNA #9 reported the nursing staff on the D wing frequently assisted her with resident care, but when they were engaged with clinical tasks, she had to seek help from a CNA on the A or B wings across the building, which usually only had 1 CNA on duty at night with more residents assigned to them than her. CNA #11 reported the facility usually only staffed 3 CNAs for 50 or more residents at night, many of whom required 2-person assistance for ADLs. CNA #11 reported this was further complicated by staff scheduling errors or unexpected staff absences which she referred to as .common . and stated they frequently resulted in floor staff having to shuffle assignments to fill empty slots discovered at shift changes. CNA #11 stated overtime work was the norm at the facility. CNA #11's mother was employed at the facility as a CNA on the adjacent A hallway and CNA #11 stated .some nights I go home after work and think I don't want to come back here .I stay to help my mom . CNA #11 reported the facility schedule recently had another CNA scheduled to work that everyone in the facility knew was out of work due to COVID 19, and that night 2 CNAs had called in sick before the shift started. The employee out with COVID 19 was still listed on the schedule. None of the 3 open slots at shift change had been filled by replacements to her knowledge and CNA #11 was assigned all 16 residents on the D wing herself. CNA #11 stated she strongly believed the facility was chronically understaffed. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #12 on 7/19/2022 at 10:15 PM, revealed she was an agency employee. LPN #12 reported she came to work at 3:00 PM that day, but it was not her usual shift assignment. She usually worked 7:00 PM to 7:00 AM on the A/B wings on Thursdays, Fridays, and Saturdays. She frequently rotated between units on the facility as needs dictated. LPN #12 reported this night she was assigned as a .floating nurse . which was not a usual occurrence. LPN #12 had never worked as .floating nurse . at the facility and she had worked there since January 2022. She came in early to cover the evening shift from 3:00 PM to 11:00 PM, as the agency nurse previously assigned (LPN #2) had worked a 16-hour shift on 7/18/2022, was off duty of 8 hours, then returned to the facility for another scheduled 16-hour shift, from which she had departed early around 3:00 PM. LPN #12 stated the facility was understaffed and frequent overtime was the norm. LPN #12 reported schedule changes at the facility were frequent and the norm. LPN #12 commented the scheduling at the facility had slightly improved over the past month, but issues with understaffing persisted. Interview with CNA #12 on 7/19/2022 at 10:38 PM, revealed she was a facility employee of over [AGE] years. CNA #12 reported the facility was chronically understaffed and she had 25 residents assigned to her care that night, which was not unusual. On multiple occasions in the past year due to scheduling errors and unexpected staff absences (call-ins), she had 40 or more residents assigned to her care alone. During the past year, on the night shift, there were multiple instances where there was only 1 CNA and 1 nurse assigned to cover both the A and B units, which averaged over 20 residents each. CNA #12 stated scheduling at the facility was .grossly mismanaged . and .there were no consequences . for unexpected absences or employees who failed to show up to work as scheduled without proper advance notice. CNA #12 reported the posted staffing sheets often included names of persons who had not worked in months or who had previously quit work there. CNA #12 reported large numbers of employees had resigned the past several months and were replaced by agency personnel. The agency personnel were often mis-scheduled, which led to unfilled open slots on shifts. CNA #12 reported on the 3-11 PM shift, which was one of the busiest times in the facility due to evening care. There were frequently only 3 CNAs present in the facility to care for more than 50 people. CNA #12 reported evening shift CNAs had multiple duties in addition to resident care, which included stocking of routine supplies, housekeeping duties, stocking shower rooms, and removing trash from the facility, and she frequently had problems completing all those other tasks due to low staffing levels. CNA #12 had difficulties completing all required charting on 25 persons, while fulfilling the clinical duties and performing all the ancillary tasks assigned her that were not directly related to resident care. CNA #12 believed the facility did not put substantial efforts into the recruitment or retention of employees and that was evidenced by heavy usage of agency staff. Interview with the DON, Administrator, and ADON on 7/19/2022 between 11:55 PM and 12:10 AM on 7/20/2022, confirmed a scheduling error led to short staffing on the D wing on 7/4/2022 and agreed it was factor directly related to Resident #1's unobserved elopement. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNAs #13 and CNA #14 on 7/20/2022 at 3:35 PM, revealed both were longtime employees of the facility. Both CNAs reported between the hours of 3:00 PM and 7:00 PM, it was not uncommon to have only 1 CNA assigned to both the A and B wings. Prior to 3:00 PM, the facility staffed those units with 2 CNAs and 2 nurses, but in many cases only 1 nurse was assigned to cover both wings alone. The CNAs stated they considered the facility understaffed. CNA #14 reported understaffing was often an issue on holidays, weekends, and after hours. CNA #13 stated most residents on the A and B wings required 2 people for assistance with ADLs, and when only 1 CNA was assigned to each wing, it was necessary to seek help from personnel stationed on the other adjacent wing or from the D wing. CNA #13 reported she had difficulty completing assigned charting and stated .it's the last thing I can do, because I am so busy with everything else . CNA #14 nodded in agreement and added, some residents on the A and B wings required 3 people for assistance. She too had difficulty completing all assigned charting at times, and both were aware over the prior several months multiple staff members had complained to the DON, ADON and Administrator about staffing levels at the facility. Family interview with Family Member #8 on 7/20/2022 at 3:55 PM, revealed she visited the facility nearly every day since 2020. Family Member #8 reported she had noticed a decline in staffing ratios at the facility for several months, and on more than one occasion had verbalized concerns to the Administrator and DON. Family Member #8 reported the facility usually had 2 or 3 CNAs assigned to each hallway on the morning and evening shift rotations, but for several months it was common to see only 1 CNA and 1 nurse assigned to the A wing in the afternoons and evenings, and on occasions she observed only 1 CNA assigned to the A wing on day shifts. Interview with CNA #15 on 7/20/2022 at 4:40 PM, revealed she had been employed at the facility for 5 months. CNA #15 reported the facility was understaffed and stated .it feels dangerous if only 1 CNA and 1 nurse are here and something goes wrong . Facility Corrective Actions included: The facility continued to contract with staffing agencies in addition to hiring new staff directly to fill open positions to meet the staffing needs of the building. 1. The DON and/or ADON will report staffing numbers/levels to the Administrator or designee in the morning report and what efforts will be completed to cover open positions. The staffing levels will be reviewed again by the administrative team prior to shift change or at other intervals based on any changes in resident acuity and census. On the last business day of the week, the weekend staffing numbers will be reviewed with the Administrator or designee. A licensed nurse will be on-call to address any schedule changes 2. The surveyor confirmed via interview with the Administrator daily meetings to discuss staffing were performed on the morning of 7//21/2022 and observed the afternoon staffing meeting on 7/21/2022 and again on 7/22/2022. Observations of posted staffing on the day shift of 7/21/2022 and again on 7/22/2022 matched staff observed in the facility. 3. The licensed nurse on-call will have a copy of the weekend staffing schedule for reference along with an employee phone list for use while not in the facility. The B Hall charge nurse will be responsible for managing/monitoring the schedule on weekends. The B Hall charge nurse and the licensed nurse on-call will work together to maintain sufficient nursing staff. The on-call nurse will call the facility at the morning shift change and the evenin [TRUNCATED]

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Etowah Health Care Center	409 Grady Road Etowah, TN 37331

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policies, medical record review, review of the Facility Self-Reported Incident (FRI), observations, interviews, and review of the Elopement Manuals (Happy Feet Manuals), the facility failed to maintain accurate and up to date elopement manuals at the nursing stations and failed to educate staff with facility policies and procedures for prevention of elopements and response procedures to be used for a missing resident. The facility's failure placed 1 resident (#1) of 9 residents reviewed, in Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more conditions of participation has caused, or is likely to cause serious injury, harm, impairment or death of resident) when Resident #1 wandered to the delayed egress door on the D wing hallway, applied pressure to the doorhandle, opened the door, triggered the door alarm, then exited the building undetected to the outside. The facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the IJ on 7/21/2022 at 12:10 AM, in the conference room. The IJ was effective 7/4/2022 and was removed on 7/22/2022. The findings included: Review of the facility policy, Wandering/Elopement Guidelines, revised 8/4/2014, revealed .Admission pictures will be taken .photos will be updated annually and as needed .once it has been determined a resident is at risk for wandering/elopement .the nurse shall obtain an order to place resident on 'The Happy Feet Club' .the MDS [Minimum Data Set] Coordinator will be notified and shall complete and maintain the Happy Feet Club Membership form and notebook maintained at each nurses station .in the event of an elopement or unauthorized exit from the facility, refer to Missing Resident Procedure . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy, Risk of Elopement/Wandering and Missing Resident Guidelines revised 4/24/2013, revealed .Definition of Elopement .Elopement occurs when a resident leaves the premises or a safe area without authorization .A resident wearing an anti-elopement bracelet that gets out of a secured door in the vision of a staff member or with immediate response by staff member when the alarm is sounding is NOT CONSIDERED AN ELOPEMENT, Resident is in an unsafe area such as the parking lot or property beyond the parking lot .A resident wearing an anti-elopement bracelet that gets out of a secured door without being in vision of a staff member or without immediate response by a staff member when the alarm is sounded is CONSIDERED AN ELOPEMENT, Resident is in an unsafe areas such as the parking lot or property beyond the parking lot .Missing Resident .Staff .who cannot locate a resident .shall report to the charge nurse for the hall/wing the resident is missing from .when it is discovered a resident is missing a 'CODE ORANGE' including the hall/wing from which the resident is missing shall be called/paged overhead . After the 'Code Orange' has been announced all available staff should proceed to the announced location. The charge nurse becomes the search coordinator who will be responsible for all aspects of the search, and will assign personnel to check the building thoroughly, until relieved by the Administrator, DON [Director of Nursing], or DON designee .if the resident is not found on the premises the charge nurse will inform the Administrator and Director of Nursing Designee .At the instruction of one of the above persons, a search of the immediate neighborhood will be initiated, the police department will be notified and appropriate personnel will be called in to search for the resident .the facility will have search kits available for search teams to use . search kits will be stored in the treatment room and inspected weekly and after each use for restocking of items . Medical record review showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia with Behaviors, Cognitive Communication Deficits, and Anxiety Disorder. Medical record review of hospital records showed Resident #1 was admitted to an acute Psychiatric Hospital on 4/11/2022 due to behaviors including paranoia, delusions, hallucinations, and aggression towards others. She returned to the nursing home on 5/4/2022. Review of the Nursing Home Psychiatric Evaluation and Psychiatric Progress Notes showed upon her return to the nursing home on 5/4/2022 through 6/9/22, Resident #1 continued to exhibit multiple behaviors including hallucinations, delusions, and wandering. Medical record review of the Quarterly MDS dated [DATE], showed Resident #1 was severely cognitively impaired with a Brief Interview of Mental Status (BIMS) Score of 5 out of 15. Resident #1 had disorganized thinking, inattention, moderate symptoms of depression, hallucinations, delusions, wandered daily, and had behaviors directed at others 1 to 3 times weekly. Resident #1 was dependent upon one or more persons for activities of daily living (ADLs). Review of the Elopement Evaluation dated 6/10/2022, showed the facility documented Resident #1 as not at risk for elopement, despite multiple care plan interventions and clinical progress notes which outlined her behaviors and risk factors for elopement. Review of the facility FRI report dated 7/6/2022 showed the facility reported Resident #1 eloped from the facility on the afternoon of 7/4/2022, was located outside the facility and recovered. The facility reported its interventions included every 15-minute checks on Resident #1, and a Velcro stop sign was placed in front of the door from which she exited. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations of the D Wing Hallway, where Resident #1 was reported to have eloped, on 7/13/2022 at approximately 1:20 PM, revealed the D Wing was approximately 120 feet long with the delayed egress door situated at the end of the wing, distal to the nursing station. Observation of the door showed the egress door was not secured with a stop sign as reported in the FRI. Observation showed identical delayed egress door systems located at the ends of every wing (A, B, C, D) wings and another delayed egress door located at the rear of the common dining area adjacent to the kitchen and therapy gyms. None of those doors were equipped with stop signs. All delayed egress doors at the facility had identical signage affixed with instructions to activate the doors in event of emergencies. Investigative interviews and observations conducted on 7/13/2022 - 7/14/2022 with witnesses to Resident #1's elopement, revealed on 7/4/2022 around 3:40 PM, the Resident eloped from the facility unobserved via the delayed egress door on the D wing. Resident #1 was spotted outside by Licensed Practical Nurse (LPN) #3 who responded to the door alarm when it went off and began searching for Resident #1 on the D unit. By the time Resident #1 was spotted, she was standing near a gated entrance to the back porch of the facility's C wing (around 177 feet away from the door where she had eloped), which was atop a flat area, bordered by a steep grassy embankment. At the time she was spotted, Resident #1 stood a few feet from the embankment. LPN #3 ran down the D wing, called for help to staff stationed on the A/B wings across the facility, and then ran down the adjacent C wing hall, which was vacant at the time, to intercept Resident #1 outside. Staff who responded to LPN #3's calls for assistance reported by the time they ran down the C wing hallway to the rear porch and went outside, Resident #1 had ambulated back into the back yard of the facility, downhill, around the embankment, and was intercepted by staff as she stood barefooted between the base of the embankment and an overgrown wood line of a large, wooded area behind the facility. Witnesses reported they considered the incident a critical one that could have resulted in serious negative outcome to Resident #1. At the time of her elopement, Resident #1 had a Wanderguard (an electronic anti-elopement device that automatically alarms and engages door locks temporarily when the user wearing it approaches an exit equipped with a radio-signal receiver/antennae tuned to the device frequency). Witnesses reported at the time of the elopement, no Wanderguard alarm had sounded. Observations revealed only the front entrance of the facility was equipped with the required antennae system, though residents equipped with Wanderguard bracelets moved about the entire facility. Observations showed 5 of 6 delayed egress doors at the facility were not equipped with Wanderguard antennae, thereby eliminating the system's effectiveness anywhere other than the main entrance. Interview with Licensed Practical Nurse (LPN) #2 on 7/13/2022 at 2:35 PM, revealed the facility had not conducted any in-service training or advised her of any changes in policies or procedures related to missing residents and no new training related to Resident #1's elopement or interventions for at risk residents were provided to her. Telephone interview with LPN #1 (the nurse assigned to Resident #1 on 7/4/2022) on 7/13/2022 at 3:30 PM, revealed LPN #1 was not aware of any formal in-service training related to elopements provided to staff in response to Resident #1's elopement. LPN #1 confirmed she did not become aware Resident #1's Wanderguard bracelet would not activate alarms or temporarily lock the door on her unit until after the elopement occurred on 7/4/2022. LPN #1 confirmed she had not received any formal training on the Wanderguard system or its function before 7/4/2022. Observation of the D wing delayed egress door on 7/14/2022 between 2:30 PM and 3:00 PM, revealed the Stop Sign was not in place as outlined in the facility FRI. Staff on the D wing at the time had not noticed it out of place or put it back in place until 3:00 PM. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #3 on 7/14/2022 at 3:06 PM, revealed LPN #3 was an agency nurse and had not been advised of any in-service training, policies, or procedures related to elopements. LPN #3 stated she was not aware Resident #1 had eloped at all until she was informed of it by the DON the day before. LPN #3 did not know the facility emergency code for a missing resident (Code Orange) and was unfamiliar with the procedures. LPN #3 was not on duty on 7/4/2022, but did come to back to work on 7/7/2022, and confirmed since that time, no training related to Resident #1's elopement had been provided to her. LPN #3 knew Resident #1 had a Wanderguard due to her elopement risk and understood the Wanderguard system functions. LPN #3 was unaware Resident #1's Wanderguard would not sound an alarm or activate door locks on the D wing Hall or anywhere other than the front door of the facility. When informed of this by the surveyor, LPN #3 seemed surprised and stated .if there is no alarm, then the Wanderguard is useless .they [facility] didn't tell me that there was no antennae on my hall .I will watch [Resident #1] closely then . Interview with Certified Nurse Aide (CNA) #4 on 7/14/2022 at 3:18 PM, revealed she was a travel agency employee. CNA #4 had not received in-service training related to Resident #1's elopement. CNA #4 was unaware the incident had occurred until informed by other staff members a few days afterwards. CNA #4 was informed by CNA #1 Wanderguards at the facility did not work on the clinical units after Resident #1's elopement occurred and stated before that, she did not know that was the case. CNA #4 was not familiar with the facility emergency code for a missing resident (Code Orange). Interview with LPN #4 on 7/14/2022 at 3:48 PM, revealed LPN #4 was a travel nurse employed at the facility for 3 weeks. LPN #4 had not been trained on the facility Wanderguard system and was not aware it did not function on the clinical units. LPN #4 had not received training related to Resident #1's elopement or training on the facility emergency code for a missing resident. Interview with CNA #5 on 7/14/2022 at 3:58 PM, revealed she was a long-time employee and familiar with the facility code for a missing resident and the procedure. CNA #5 was not aware of any training implemented by the facility in response to Resident #1's recent elopement nor was she aware if travel staff were oriented or trained to the Code Orange policy or procedures. Telephone interview with CNA #2 on 7/14/2022 at 4:00 PM, revealed she had not been informed of Resident #1's elopement on 7/4/2022 until 7/13/2022. CNA #2 was unaware the facility Wanderguard system did not function on the clinical units. CNA #2 was aware the system would alarm at the front door and lock the door temporarily. CNA #2 knew the alarms for the Wanderguard did not sound on the clinical units but did not know they would not engage door locks or why. CNA #2 confirmed the facility had not provided any in-service training to staff related to Resident #1's elopement or elopement prevention procedures at that time. Interview with CNA #1 on 7/14/2022 at 4:15 PM, revealed she was a travel agency employee. CNA #1 was a witness to Resident #1's elopement and stated to the best of her knowledge, the facility had not implemented any training related to the incident afterwards. At the time of Resident #1's elopement, she was unaware Wanderguards in use at the facility did not function anywhere except the front door. CNA #1 reported she realized that was the case after the incident occurred. CNA #1 did not recall any training on the facility's missing resident policy or procedures. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with CNA #3 on 7/14/2022 at 6:10 PM, revealed the facility did not directly in-service night shift staff. CNA #3 reported facility leadership usually sent memos to the night shift related to various changes and performance expectations. Oftentimes night shift employees could not find memos or notes referenced by facility management and CNA #3 confirmed he had not received any in-service training related to Resident #1's recent elopement. CNA #3 was never trained on the facility Wanderguard system but was aware it did not work on the clinical units. CNA #3 was aware of the facility emergency codes but was not aware if other staff were trained in them. Interview with the Administrator on 7/18/2022 at 1:45 PM, confirmed nursing leadership had not thoroughly investigated Resident #1's elopement at the time it occurred. The Administrator reported nursing leadership began staff training and implementation of additional interventions in response to the incident on 7/14/2022 and they were ongoing. Interview with LPN #9 on 7/18/2022 at 3:06 PM, revealed she was a travel nurse. LPN #9 reported she had not received any formal training or orientation to the facility missing resident policy (Code Orange). LPN #9 had not received any in-service training or memos related to Resident #1's elopement. LPN #9 was aware of Resident #1's Wanderguard use. LPN #9 was unaware the Wanderguard did not sound alarms or activate locks on the D wing. When informed the D wing did not have a Wanderguard antennae, LPN #9 stated .It won't work without an antenna. I'm surprised to hear that . Observations and interview with Registered Nurse (RN) #2 on 7/18/2022 at 4:10 PM, at the A/B wing nursing station, showed RN #2 could locate the facility elopement manual (Happy Feet Manual) when asked to produce it. RN #2 reported the elopement manual presented to the surveyor had been created on 7/15/2022 and was placed in the nursing station. RN #2 reported the manual in place before that had not been updated or maintained since 2015 and contained data for residents no longer in the facility and did not contain any data for current at-risk residents. Observation and interview with LPN #10 on 7/18/2022 at 5:03 PM, at the D unit nursing station, showed a new Happy Feet Manual identical to the one at A/B unit nursing station. LPN #10 reported the manual had been put there on 7/15/2022. LPN #10 showed a copy of the Happy Feet Manual cover sheet dated 7/15/2022 at 2:45 PM printed in upper left corner. LPN #10 confirmed the facility nursing leadership began training staff on the new manual, the rationale for alarmed stop signs on each delayed egress door, and the missing resident policy and procedure on 7/15/2022. LPN #10 reported the old Happy Feet Manual that was supposed to be in place at the D wing was never located. During interview with the DON and ADON on 7/18/2022 between 5:12 PM and 5:21 PM, the ADON confirmed the facility did not have a Happy Feet manual in place on the D Wing before 7/15/2022 and the manual located at the A/B nursing station had not been updated. The ADON stated the old manual was approximately 4 years old. The ADON reported the Happy Feet program itself was developed .2 DONs ago . Both confirmed the facility began training of staff related to the missing resident policy and elopement prevention guidelines 7/14 - 7/15/2022 and training was ongoing. No training was started on or shortly after Resident #1's elopement occurred on 7/4/2022. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #11 on 7/19/2022 at 8:23 PM, revealed LPN #11 was a travel nurse. LPN #11 stated . communication between management and the clinical staff here sucks .and you can quote me on that . LPN #11 stated she was never informed Wanderguards on the D wing would not sound an alarm or temporarily activate magnetic door locks. When informed there was no antennae on the floor by the surveyor, LPN #11 stated .are you kidding? then confirmed she had not received any formal orientation related to the facility missing resident policy and procedure or the Wanderguard systems. LPN #11 reported to her knowledge, no in-services or memos related to Resident #1's elopement had been circulated to staff. LPN #11 learned of Resident #1's elopement from peers after it had occurred. Interview with CNA #9 on 7/19/2022 at 8:38 PM, revealed CNA #9 was taught the facility Code Orange Policy and Procedure by the unit charge nurse on 7/18/2022, but prior to that, she was not aware of it, and she had not been instructed on the policy or procedures during new hire orientation. CNA #9 reported she had been employed at the facility for a year. Interview with the DON and ADON on 7/19/2022 at 8:58 PM, confirmed staff training in relation to Resident #1's elopement, the Missing Resident Policy, Elopement Prevention Guidelines, and measures put in place in response to Resident #1's elopement were not implemented until Friday 7/15/2022 (11 days after the incident occurred). The ADON and DON confirmed the Happy Feet program outlined in the facility Missing Resident Policy was not in place at the time Resident #1 eloped from the facility. The DON program was dropped at some point in the past, likely before the DON's tenure, and had not been put back in place. Interview with CNA #12 on 7/19/2022 at 10:38 PM, revealed CNA #12 had been employed at the facility for [AGE] years. CNA #12 expressed concerns the facility had staffing and training issues. CNA #12 reported the facility utilized high numbers of agency staff who were not oriented to emergency response codes, such as the Missing Resident Code (Code Orange). CNA #12 stated she felt the issue was further complicated by high turnover rates at the facility, which over time had led to increased utilization of temporary employees or contractors. CNA #12 reported no training had occurred in response to Resident #1's elopement after the incident and stated the facility had .communication problems . Interview with the DON, ADON and Administrator on 7/19/2022 at 11:55 PM, revealed agency staff were usually oriented to the facility for 1 to 2 shifts with a staff nurse before being permitted to work alone. When advised multiple staff interviews of contract and facility staff members conducted showed substantial numbers of them reported they were not aware of the facility Missing Resident Policy and Procedure (Code Orange) and they had not been trained on the limitations of the facility Wanderguard system, the DON stated she .was not surprised . The DON reported facility employees were trained on emergency codes on hire and the emergency codes were kept in a book at each nursing station. When asked if facility staff and contractors received annual training on emergency codes and the facility anti-elopement system she replied .it will be part of the training now . The surveyor asked the DON if the above training was in place for all staff on 7/4/2022 at the time Resident #1 eloped the facility and the DON confirmed, .it was not . Facility Corrective Actions included: 1. The DON provided education on the facility's Code Orange Alert on 7/20/2022 to nursing staff. Staff education was completed on 7/21/2022. Any staff member that is on vacation, PRN (as needed employee), or not part of the core staff that did not receive education on the Code Orange Alert will have education provided prior to working their next shift. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Surveyor validated training was provided to staff on the Code Orange Alert policy by review of training sign-in sheets on 7/22/2022 and by interviews of selected staff on the floor. All staff interviewed verbalized understanding of the policy/procedure. 2. The facility will post a reference guide listing the facility emergency codes used in the facility in prominent locations including, but not limited to the timeclock, nurse stations and break room. An emergency management manual will be kept at each nurse's station that lists the alerts and guidelines on how to manage the situation. The surveyor observed emergency management guides that were up to date, were present in both the A/B and D nursing stations on 7/22/2022. Selected staff present at the nursing stations were quizzed by the surveyor on the Code Orange Alert, as well as Codes for inclement weather conditions and the active shooter code and requisite immediate actions to be taken. All staff quizzed could recite the appropriate designation for each code they were asked about. Two additional staff not stationed at the nursing stations were also approached and quizzed about Code Orange Alert and the Active Shooter scenario and could recite immediate actions to be taken for both. 3. The agency orientation checklist has been updated to include the facility's emergency alerts, including Code Orange. New facility employees will have training during the initial orientation period on the facility's emergency alerts. The DON provided a copy of the updated orientation checklist to the SA surveyor on 7/22/2022 which was reviewed. 4. The ADON or designee will audit to verify that the reference guide available for staff use is in place daily for 2 weeks. After two weeks, the checks will become weekly times four weeks. The frequency of the audits will be re-evaluated by the Quality Assurance Performance Improvement Committee (QAPI) after the weekly audits have been completed for four weeks. 5. The DON or designee will review the audits for any trends/patterns and report to the QAPI committee. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The QAPI committee will make recommendations to address any trends or patterns identified during the meeting. The surveyor inspected the contents of the facility emergency search kits as outlined in the facility Code Orange alert policy. The kits were in date with all equipment in them was appropriate. Observations on 7/22/2022 of all nursing stations in the facility showed emergency manuals were present. Noncompliance continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction (POC). Refer to F689 (J) and F725 (J)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policies, record reviews, and interviews, the facility Administrator failed to maintain sufficient staffing levels on [DATE], failed to maintain staff competencies and compliance with the missing resident policy and procedures, and failed to take timely corrective actions to address the electronic anti-elopement system (Wanderguard) was not fully functional for 1 resident (Resident #1) of 9 residents reviewed. The facility's failures placed Resident #1 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more conditions of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to resident). On [DATE], Resident #1 wandered to the delayed egress door on the D wing hallway and exited the building undetected, to the outside. Resident #1 was in the backyard of the facility, over 177 feet away from the door from which she eloped. Resident #1 was barefooted and had wandered to the edge of a wooded area, between the base on a high embankment and the wood line, at the rear of the facility. The facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the IJ on [DATE] at 12:10 AM, in the conference room. The IJ was effective [DATE] and was removed on [DATE]. The findings included: Review of the facility policy Wandering/Elopement Guidelines, revised [DATE], revealed .Admission pictures will be taken .photos will be updated annually and as needed .once it has been determined a resident is at risk for wandering/elopement .the nurse shall obtain an order to place resident on 'The Happy Feet Club' .the MDS [Minimum Data Set] coordinator will be notified and shall complete and maintain the Happy Feet Club Membership form and notebook maintained at each nurses station .in the event of an elopement or unauthorized exit from the facility, refer to Missing Resident Procedure . Review of the facility policy Risk of Elopement/Wandering and Missing Resident Guidelines, revised [DATE], revealed .Definition of Elopement .Elopement occurs when a resident leaves the premises or a safe area without authorization .A resident wearing an anti-elopement bracelet that gets out of a secured door in the vision of a staff member or with immediate response by staff member when the alarm is sounding is NOT CONSIDERED AN ELOPEMENT, Resident is in an unsafe area such as the parking lot or property beyond the parking lot .A resident wearing an anti-elopement bracelet that gets out of a secured door without being in vision of a staff member or without immediate response by a staff member when the alarm is sounded is CONSIDERED AN ELOPEMENT, Resident is in an unsafe areas such as the parking lot or property beyond the parking lot . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Etowah Health Care Center	409 Grady Road Etowah, TN 37331

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy Wandering/Elopement Guidelines, revised [DATE] revealed .the facility will maintain an alarm system .the front entrance to the building is secured by an alarm but also by a locking device .the electronic receiver alarm located at the entrance is triggered by a transmitter worn by the resident .the door will remain locked for 15 seconds .after 15 seconds of continuous pressure on the door, the locking mechanism will release and permit the resident to exit .therefor it is of most importance that the staff responds immediately to the alarm .the alarm will need to be reset by staff .when resident is removed from danger of elopement .Safety checks on wanderguard/safety device shall be completed on each shift and documented on treatment administration record .in event of elopement .refer to the missing resident procedure . Medical record review showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia with Behaviors, Cognitive Communication Deficits, and Anxiety Disorder. Review of the Quarterly MDS dated [DATE], showed Resident #1 was severely cognitively impaired with a Brief Interview of Mental Status Score of 5 out of 15. Resident #1 had disorganized thinking, inattention, moderate symptoms of depression, hallucinations, delusions, wandered daily, and had behaviors directed at others 1 to 3 times weekly. Resident #1 was dependent upon one or more persons for activities of daily living (ADLs). Resident #1 was classified as at risk for elopement and had an anti-elopement bracelet (Wanderguard, an electronic system which uses radio signals emitted from a bracelet, to trigger automatic door locks and an audible alarm, when the user approached a fixed antenna, system located near an exit). Medical record review revealed on [DATE], Resident #1 wandered to the delayed egress door on the D wing hallway, applied pressure to the doorhandle, opened the door, triggered the door alarm, then exited the building undetected to the outside. The resident was observed through a window walking outside and staff retrieved the resident by a steep embankment and returned her to the facility. Observations conducted throughout the facility between [DATE] and [DATE] showed the facility Wanderguard system did not have receiver antennae located at any of the delayed egress doorways other than the main entrance of the facility. The Wanderguard System as configured would not sound audible alarms, nor would it temporarily engage magnetic door locks on 5 of 6 exits equipped with delayed egress systems at the facility. Four of 6 delayed egress doors were on clinical units. One of 6 delayed egress doors was at the rear of the common dining room, adjacent to the therapy areas. The last delayed egress door system was at the main entrance, where Wanderguard antennae were in place at the doorway and functional. Staff interviews conducted between ,d+[DATE] - [DATE] revealed 14 of 19 clinical staff members with direct resident care duties were unaware the facility Wanderguard system was not fully functional. Staff interviews included a mix of Certified Nurse Aides (CNAs), Licensed Practical Nurses (LPNs), and Registered Nurses (RN). Staff knowledge deficits included both full time employees of the facility who had completed new hire orientation and training periods, as well as contracted agency staff members who completed an initial 2 shift orientation period under supervision of a facility employee, before independently practicing in the facility. Fourteen of 14 interviewees who reported they were unaware of limitations in the facility anti-elopement system, also reported they had not been advised of it on hire, or formally trained on the Wanderguard System during orientation or training. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews of clinical staff conducted between [DATE] and [DATE] revealed 16 of 19 were unaware of the facility missing resident procedures (CODE ORANGE) and the related Happy Feet Club policy. Those 16 employees who were unaware of the CODE ORANGE policy, also confirmed they were not trained on the topic after hire or during in-service training immediately after Resident #1 eloped the facility. Multiple staff interviewed reported they were unaware Resident #1 had eloped the facility at all, or reported they were not informed of the occurrence, until after [DATE]. Staff interviews conducted on [DATE], revealed the facility had not updated the elopement manuals (Happy Feet Club) until [DATE], (11 days after the incident occurred). Two staff nurses revealed the elopement manuals observed at the A/B wing nursing station on [DATE], had not been updated since 2015. Continued interviews revealed the A/B wing manual in use before [DATE], contained data on residents that had not been in the facility for years (some were long deceased) and the out-of-date manual was replaced with new manual on [DATE] by the DON and ADON. On [DATE], a nurse on the D Wing (wing where Resident #1's elopement occurred) provided a copy of the new elopement manual placed in the nursing station on [DATE], which showed it was printed on [DATE]. This nurse confirmed the facility had been unable to locate the old manual that was supposed to be kept at the nursing station. The nurse reported it appeared no elopement manual (Happy Feet Club) had been maintained on the D Wing at all, prior to [DATE]. Review of facility training sign-in sheets dated [DATE], revealed training related to Wandering and Elopement, the facility Missing Resident Policy and Procedure (CODE ORANGE), and Elopement Manuals (Happy Feet Club) had not been implemented until after [DATE]. Review of the nurse staffing levels for [DATE] and investigative interviews conducted on [DATE] to [DATE] revealed on the afternoon of Resident #1's elopement, the D Wing was staffed with one Licensed Practical Nurse (LPN) and no Certified Nurse Aide (CNA) to supervise 16 residents. Interviews and review of the posted staffing and corresponding payroll data revealed insufficient staffing had occurred due to scheduling errors. Investigative interviews with 17 of 17 clinical staff members conducted on every unit at the facility, across every shift, between [DATE] and [DATE], revealed clinical staff considered the facility chronically short staffed. Multiple personnel interviewed attributed the facility's staffing problems to a pattern of recurrent scheduling errors, which often went undetected until shift changes occurred, and frequently went unaddressed/unresolved by management afterwards. Multiple employees reported they had repeatedly complained to the DON or Administration about chronic scheduling problems, unexpected staff absences/absenteeism, low staffing levels or unsafe staffing patterns, as those occurred. Resident and family interviews conducted on the afternoon of [DATE], revealed concerns related to numbers of staff in the facility on each shift, the number of residents on each unit, staff assignments (patient loads), and a pattern of declining staffing over several months. Family Member #8 and Family Member #9 reported they had expressed concerns related to insufficient staffing to the Administrator and DON with minimal responses to their concerns. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations and interviews conducted on the evening and overnight shifts made shortly after shift change on [DATE] until the early hours of [DATE], showed on the A wing Hall, a single CNA reported she was assigned to between 21- 25 persons. On the adjacent B Wing Hall, a single CNA reported he was assigned to 20 persons. On the D Wing, a single CNA was assigned to 16 persons, several of which had behaviors. CNA interviews revealed it was not uncommon to be responsible for 30 or more persons individually on the overnight shift if scheduling problems arose. The staffing pattern observed on the evening/overnight of [DATE] was the identical pattern reported to have been in place on the evening/overnight shift of [DATE], when scheduling errors did arise and Resident #1 eloped. The facility census on both dates was identical, 57 residents. Interview with the DON and ADON on [DATE] at 8:58 PM, revealed the DON reported at the time of Resident #1's elopement, nursing administration was not informed of .the full nature . of Resident #1's elopement. Both the ADON and DON confirmed the facility administration had not launched an investigation, interviewed all witnesses to the incident, or obtained written statements from them at the time the incident occurred. Both confirmed the facility investigation and interventions observed did not begin until ,d+[DATE] - [DATE]. Both confirmed the facility had not performed a thorough, systematic investigation of Resident #1's elopement as outlined in the facility policy. Interview with the Administrator, DON, and ADON on [DATE] at 11:55 PM, confirmed facility administration failed to assure compliance with its policies and procedures, failed to educate staff related to Elopement Prevention and the Missing Resident Policy, and failed to maintain sufficient nurse staffing on [DATE], which resulted in inadequate supervision of Resident #1 and her elopement. Facility Corrective Actions included: 1. On [DATE], the Director of Nursing and Administrator reviewed the schedule and staffing levels. Based on the review, there is now adequate staffing to meet the needs of the residents in the facility and the facility will maintain adequate staffing levels moving forward. The surveyor validated staffing was sufficient on [DATE] via review of posted staffing, observations of the personnel on the floor, and interview with the DON who reported additional agency resources were contracted for the evenings and overnight shifts. No concerns were noted with staffing. 2. DON and/or the ADON will report staffing levels to the Administrator or Designee in the morning report and what efforts will be completed to cover any open positions. The staffing levels will be reviewed again by the administrative team prior to shift change or at other intervals based on any changes in resident acuity or census. On the last business day of the week the weekend staffing numbers will be reviewed by the Administrator. A licensed nurse will be on call to address schedule changes. The surveyor observed evening shift staffing meetings on [DATE] and again on [DATE] at shift change. Observations of staffing levels at shift change showed staffing was sufficient. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The Licensed Nurse on call will have a copy of the weekend schedule for reference along with an employee phone list for use while not in the facility. The B Hall charge nurse will be responsible for managing/monitoring the schedule on weekends. The B Hall charge nurse and the licensed nurse on call will work together to maintain sufficient nursing staff. The on-call nurse will call the facility at the morning shift change and the evening shift change to review staffing levels with the B hall charge nurse. If staffing needs change between the morning and evening shift, the B hall charge nurse will notify the on-call licensed nurse. The on call licensed nurse will make arrangements to cover the shift with available staff. The surveyor validated the on-call process with the Administrator and Corporate Nurse on [DATE]. Review of the employee rosters showed they were up to date and accurate for agency and facility staff. 4. The DON provided education on the facility's Code Orange alert/Happy Feet on [DATE] to the nursing staff. Staff education was completed on [DATE] on the facility's Code Orange Alert. Any staff member on vacation, PRN (as needed) or not part of the core staff who did not receive education on the Code Orange Alert will have education provided prior to working their next shift by a licensed nurse. The surveyor validated Code Orange teaching had been completed by review of the education sign in sheets and documents on [DATE]. 5. The facility will post a reference guide listing the emergency codes used in the facility in prominent locations including, but not limited to, the timeclock, nurses' stations, and break room. An emergency management manual will be kept at each nurse's station that lists the alerts and guidelines on how to manage the situation. The SA validated reference guides were in place at the locations listed in the allegation of compliance and the guides were up to date. Four nurses at the nursing stations and 2 CNAs on each wing were interviewed on [DATE] and all were familiar with the facility emergency codes and location of emergency manuals. 6. The agency orientation checklist has been updated to include the facility's emergency alerts, including Code Orange. New facility employees will have training during the initial orientation period on the facility's emergency alerts. The surveyor validated the orientation checklist had been updated on [DATE] as reported. Copies of the new checklist were obtained. 7. The ADON or designee, will audit to verify the reference guide available for staff use is in place daily for two weeks. After 2 weeks, the checks will become weekly times four weeks. The frequency of the audits will be re-evaluated by the QAPI committee after the weekly audits have been completed for four weeks. The QAPI process was validated via interview with the Administrator on [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Stop signs were placed over the other exit doors with an audible clip alarm that will alert the staff when the Velcro sign is removed. The stop signs with alarms were placed on the doors on [DATE]. The surveyor validated stop signs and clip alarms in place on all delayed egress doors were intact, functional, and staff recognized the alarms. All audible alarms were tested , and staff responses timed with no concerns initially on [DATE] and again on [DATE]. 9. A licensed nurse will check the exit doors for the stop signs and alarms twice a day and log the checks on the exit door log. The exit door log was initiated on [DATE]. Education about the exit door log was provided by a RN on [DATE] to the licensed staff on duty and will be completed with the licensed nursing staff by [DATE]. Any licensed staff member on vacation or not available will have education prior to working their next shift. The state agency validated door check logs were in use on [DATE]. 10. A Registered Nurse or designee will perform daily audits of the exit door logs for a minimum of two weeks for compliance. After two weeks the daily audits will be conducted weekly by Registered Nurse or designee. The weekly audits will continue for a minimum of 4 weeks and then be re-evaluated by the QAPI committee. The state agency validated this component of the QAPI follow up with the Administrator on [DATE]. 11. Current residents were assessed on [DATE] by a licensed nurse and those residents identified as at risk for elopement were added to the Happy Feet Program. The Happy Feet book was updated by a licensed nurse on [DATE]. Reviews of the Happy Feet Manuals on [DATE] showed they were updated. Record Reviews on [DATE] for Residents #3, #4, #5, #8 and #9 showed elopement risk assessments for all Residents were updated. 12. An Ad Hoc QAPI meeting was held on [DATE] to review the events and contributing factors surrounding the elopement. The clinical and administrative team participated in the meeting and put additional interventions in place to address the identified issues. The next QAPI meeting will be held on [DATE] at noon. The surveyor validated the ad hoc QAPI meeting had occurred by Administrator interview on [DATE]. The next QAPI meeting was denoted on the facility leadership Calendar for [DATE] as reported. 13. The Administrative staff will be responsible for maintaining compliance with staffing, the Happy Feet Program, and the facility QAPI program. Validated on [DATE] via interview with the Administrator and DON prior to exit conference. Noncompliance continues at a scope and severity of D for monitoring of the effectiveness of corrective actions. The facility is required to submit a Plan of Correction (POC). (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Refer to F689 (J), F725 (J) and F726 (J)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647 Based on review of facility policies, medical record review, review of the Facility Reported Incident (FRI) report, observations, and interviews, the facility failed to perform a thorough Quality Assurance Performance Improvement (QAPI) analysis of an elopement incident for 1 resident (#1), of 9 residents reviewed. The facility's failure to perform a systematic QAPI analysis of the elopement, led to the failure to identify significant causative factors, which included insufficient nurse staffing secondary to scheduling errors on the D Wing, vulnerabilities in the facility electronic anti-elopement (Wanderguard) system and delayed egress door systems, and staff training deficits related to the missing resident procedures. The facility's failure placed Resident #1 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more conditions of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to resident). On 7/4/2022, Resident #1 wandered to the delayed egress door on the D wing hallway and exited the building undetected, to the outside. The facility Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were notified of the IJ on 7/21/2022 at 12:10 AM, in the conference room. The IJ was effective 7/4/2022 and was removed on 7/22/2022. The findings included: Review of the facility policy Quality Assurance Committee, dated 2017, revised 2020, revealed .Facility has developed and maintains an effective .(QAPI) program .takes a systematic, comprehensive, and data driven approach to maintaining and improving safety .is ongoing .anticipatory and retrospective in it's efforts .an adverse event is an untoward, undesirable and usually unanticipated event that causes .or the risk of death or serious injury to a resident .The QA committee shall meet .and as needed to coordinate and evaluate . activities .shall develop and implement plans of action .Guiding Principals .focuses on systems and processes rather than individuals to identify gaps rather than blaming individuals .Methodology .uses a systematic approach to determine when in depth analysis is needed to fully understand the problem, it's causes and implications .identifies and prioritizes problems and opportunities that reflect organizational processes .corrective actions address gaps in systems .clear expectations are set around safety . communication about QAPI activities is shared in multiple ways including but not limited to staff meetings and trainings .Feedback .and Monitoring .has in place systems to monitor care .drawing data from multiple sources .It also includes investigating and monitoring Adverse Events and investigation protocols to include actions to prevent recurrences . Medical record review showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia with Behaviors, Cognitive Communication Deficits, and Anxiety Disorder. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #1 was severely cognitively impaired with a Brief Interview of Mental Status (BIMS) Score of 5 out of 15. Resident #1 had disorganized thinking, inattention, moderate symptoms of depression, hallucinations, delusions, wandered daily and had behaviors directed at others 1 to 3 times weekly. Resident #1 was dependent upon one or more persons for activities of daily living (ADLs). Resident #1 was at risk for elopement and had an anti-elopement bracelet (Wanderguard, an electronic system which uses radio signals emitted from a bracelet, to trigger automatic door locks and an audible alarm when the user approaches a fixed antennae system located near an exit). Medical record review revealed on 7/4/2022 Resident #1 wandered to the delayed egress door on the D wing hallway, applied pressure to the doorhandle, opened the door, triggered the door alarm, then exited the building undetected to the outside. The resident was observed through a window walking outside and staff retrieved the resident by a steep embankment and returned her to the facility. Review of the FRI report dated 7/4/2022 showed, .What type of plan will the facility put in place to ensure this type of incident does not recur .A stop sign was placed at the exit door . Observations of the D Wing Hallway on 7/13/2022 around 1:20 PM, revealed the D Wing was approximately 120 feet long with the delayed egress door situated at the end of the wing, distal to the nursing station. The door was not secured with a stop sign as reported in the FRI. Interviews with witnesses to Resident #1's elopement on 7/4/2022 were conducted 7/13 - 7/14/2022. All witnesses reported they had not been interviewed by members of the facility leadership or QAPI committee or asked to submit written statements related to the incident. None of the witnesses interviewed reported they were aware of any investigation of the incident. All witnesses interviewed reported they had not received any additional training, clinical updates, or had received memorandums related to the incident and to their knowledge, no changes in facility policies or processes for Resident #1 or other at-risk residents were implemented after the incident to prevent recurrences. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviews conducted between 7/13 - 7/20/22 revealed 14 of 19 clinical staff members with direct resident care duties were unaware the facility Wanderguard system (anti-elopement system functions via radio signal detection. The bracelet worn by a user emits a radio signal, specific to the antennae system used to detect it. Antennae are placed near the exits where egress is discouraged. When the radio transmitter bracelet comes within a pre-programmed proximity to the door antennae, the system is activated, an audible alarm sounds, magnetic door locks are temporarily engaged until the radio transmitter is moved out of the specified detection range of the antennae or the door is manually reset by an attendant with a specific code to input into the door system.) only functioned at the main entrance doorway and didn't sound alarms or temporarily activate door locks on the clinical units. Sixteen of 19 were unaware of the facility policies and procedures for a missing resident. All 19 confirmed they had not received any in-service training or clinical updates related to residents at-risk for elopement after the incident. Multiple staff interviewed reported they were unaware Resident #1 had eloped the facility at all, or reported they were not informed of the occurrence, until after 7/13/2022. Multiple staff reported they did not receive instruction on the use of alarmed stop signs on the doors until 7/14 - 7/15/2022, at the time those were implemented. Two staff nurses reported the facility had not updated the missing resident manuals until 7/15/2022, (11 days after the incident occurred). Two staff members revealed elopement manuals had not been updated since 2015 and contained data on residents that had not been in the facility for years. One staff member provided a copy of the new elopement manual placed in the nursing station on 7/15/2022, which showed it was printed on 7/15/2022, and confirmed prior to that, no elopement manual had been maintained at the D wing nursing station, where Resident #1's elopement occurred. Review of facility training sign-in sheets dated 7/15/2022 showed training related to Wandering and Elopement had not been implemented until 7/15/2022. Interview with the DON and ADON on 7/19/2022 at 8:58 PM, confirmed no systematic investigation of Resident #1's elopement was performed at the time it occurred. Due to the lack of a thorough investigation of the incident immediately after it occurred, the facility failed to identify insufficient staff levels on the D wing as a key contributing factor, failed to identify staff knowledge deficits related to the facility missing resident procedures, and failed to identify vulnerabilities in the Wanderguard system which also contributed to the incident. Interview confirmed because the facility had not conducted a systematic investigation using the prescribed processes outlined in its QAPI policy, no training, or interventions in response to the incident were implemented until 7/14 - 7/15/2022. Facility corrective actions included: 1. The facility completed root cause analysis of the incident on 7/15/2022. The surveyor validated an analysis of the incident was completed as reported by interview with the Administrator on 7/22/2022. 2. An ad hoc QAPI meeting was held on 7/15/2022 to review the events and contributing factors surrounding the elopement. The clinical and administrative team participated in the meeting and put additional interventions in place to address the identified issues. The next scheduled QAPI of the incident was scheduled for 8/3/2022 at 12:00 PM. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The surveyor validated the facility held and Ad Hoc QAPI of the incident via interview with the corporate nurse on 7/22/2022 and reviewed correspondence relevant to the upcoming QAPI meeting scheduled for 8/3/2022. 3. Stop signs were placed over the exit doors with an audible alarm that will alert the staff when the Velcro stop sign is removed on 7/15/2022. The surveyor validated all stop signs equipped with audible alarms remained functional and in place on 7/22/2022. 4. A licensed nurse will check the doors for stop signs and alarms twice daily and log the checks on the exit door log. The exit door log was initiated 7/20/2022. Education related to the exit door log was completed 7/21/2022. Any staff member on vacation or unavailable will have education completed before the start of their next shift. The surveyor validated staff education was completed by review of education sign in sheets on 7/22/2022. The final evening shift staff training meeting occurred and staff arriving to attend it were observed as they arrived at the facility on 7/21/2022. 5. A registered nurse or designee will perform daily audits for a minimum of two weeks of the door logs for compliance. After two weeks daily audits will be conducted weekly. The weekly audits will continue for a minimum of 4 weeks and then be re-evaluated by the QAPI committee. The surveyor validated that daily audit of the door logs were in progress on 7/22/2022 via review of the logs in use. 6. The DON will review the results of the audits for trends/patterns and report results to the QAPI committee for review and follow up action as deemed necessary. The QAPI committee consists of the Administrator, Medical Director, Director of Nursing and at least 3 other staff members. 7. On 7/20/2022, the DON and Administrator reviewed the schedule and staffing levels. Based on the review, there is adequate staffing to meet the needs of residents in the facility and the facility will maintain adequate staffing going forward. Observations of posted staffing on 7/21/2022 and 7/22/2022 showed all staff listed on the schedules were on duty in the facility. The facility was sufficiently staffed. The afternoon staffing meeting was observed on both 7/21/2022 and 7/22/2022. 8. The facility continues to contract with staffing agencies in addition to hiring new staff directly to fill open positions. The DON confirmed staffing agencies were to provide 3 additional night shift CNAs for contracts at the facility on 7/20/2022 and reported additional staff had been contracted as of 7/22/2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445422	A. Building B. Wing	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Etowah Health Care Center	409 Grady Road Etowah, TN 37331

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. The DON or ADON will report staffing numbers/levels to the Administrator (or designee) in the morning report and what efforts are being completed to cover any open positions. The staffing levels will be reviewed again by the administrative team prior to shift change or at other intervals based on changes in the resident acuity or census. On the last business day of the week, the weekend staffing numbers will be reviewed with the Administrator or designee. A licensed nurse will be on call to address any schedule changes. The surveyor validated the employee list was up to date. The on-call nurse schedule was observed and rotated between the ADON and DON. The agency staff list was observed as up to date on 7/22/2022. 10. The licensed nurse on call will have a copy of the weekend staffing schedule for reference along with an employee phone list for use while not in the facility. The B Hall charge nurse will be responsible for managing/monitoring the schedule on weekends. The B Hall charge nurse and the licensed nurse on-call will work together to maintain sufficient staffing. The on-call nurse will call the facility at morning shift change and the evening shift change to review staffing levels with the B Hall charge nurse. If staffing needs change between the morning and evening shift change, the B hall charge nurse will notify the on-call licensed nurse. The on-call licensed nurse will make arrangements to cover the shift with available staff. The surveyor validated the weekend staffing interventions as reported in the Removal Plan were in place and monitoring by the Administrator was in process by interview on 7/22/2022. Corporate staff corroborated the facility staffing model and QAPI process related to it would be monitored going forward as part of the corporate oversight of the pending plan of correction. Noncompliance continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction (POC). Refer to F689 (J), F725 (J) and F726 (J)