STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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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 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews with staff and resident the facility failed to provide maintenance services by failing to secure a leaking toilet for 2 of 2 Residents' Rooms (Rooms 30 and 28). The findings included: On 11/18/15 at 11:00 AM the adjoining bathroom of rooms 30 and 28, revealed that the toilet had a strong urine smell. The base of the toilet was observed unstable with a 2 inch dark yellow brown substance. Resident #68 resided in room 30 and his quarterly Minimum Data Set ((MDS) dated [DATE] revealed he was cognitively intact. On 11/18/15 at 11:05 AM Resident #68 stated his room smelled really bad every morning because the toilet was not tight and it leaked. There was usually bowel movement (BM) on the floor around the toilet where the toilet was loose. Resident #68 stated the toilet had been that way since he was admitted to Room 30. He stated he was afraid to get on the toilet because he might fall. He stated he told both first and second shift about the toilet not being stable and the odor but they had not told anyone. The resident stated when someone would take him to the bathroom he went really fast because he was afraid the toilet would turn over. The resident stated, It is really scary when you sit on the toilet and it was rocking. On 11/18/15 at 11:31 AM the house keeping staff #1 stated about 2 weeks ago she told maintenance that the toilet was wobbly and leaking. She stated she had tried to clean the toilet and there was two inches of dark brown stain around the base of the toilet. She further stated there was a hole in the back of the toilet where the toilet was leaking. She stated it smelled so bad and she had tried bleach but the odor was still very strong because the toilet was loose. She stated Resident #68's usual Nursing Assistant got him up with assistance and sat him on the toilet but Resident #68 complained it was so wobbly that he was afraid. On 11/18/15 at 11:38 AM Resident #68's Nursing Assistant (NA #1) stated she did not care for the resident very often but he was assign to her today (11/18/15). NA #1 stated Resident #68 had told her that his commode was loose but she had forgotten to tell maintenance. On 11/18/15 at 11:54 AM the Maintenance Manager stated no one had told him that the commode was loose until now. He stated that the process was for staff to fill out a work order and he picked them up daily. On 11/19/15 9:44 AM Resident #68's regular Nursing Assistant, NA#2 stated Resident #68 did use the toilet when she got him in the wheelchair and then he could pull himself up to the toilet. The commode had been loose for a while. She stated she had told maintenance and he had fix it but it got loose again and the maintenance man told her that the resident sat on the toilet too hard and that is why it got loose again.
F 0254 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide clean bed and bath linens that are in good condition.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility records and staff interview the facility failed to discard damaged or stained linen for 1 of 1 Resident Room (room [ROOM NUMBER] Bed A) and 11 of 15 fitted sheets observed on the linen cart. The findings included: A review of the resident council minutes revealed for September 2015 the residents complained that the linen had stains on them. On 11/16/15 at 10:29 AM the fitted sheet in room [ROOM NUMBER] Bed A was observed with small dime sized holes and on the left side of the bed a 5 by 5 inch area that was so thin and worn the bed mattress was observed through the fitted sheet. On 11/18/15 at 9:38 AM, 11 out of 15 fitted sheets were observed with holes and brown yellow stains in the laundry cart to be distributed to all the resident halls. The laundry staff stated that the laundry was laundered at another facility and was washed between 11:00 PM to 5:00 AM. The laundry was returned back to the facility around 6:00 AM to 6:30 AM to be distributed to all halls. She stated the other staff folded the linen and she was not aware the fitted sheets were soiled and had holes. She stated she had been instructed to discard any linen with holes and to rewash any stained linen. On 11/18/15 9:45 AM the Housekeeping Manager stated the facility was in a transition in which they did not clean their own laundry at the facility but at another facility. At the other facility laundry staff cleaned the linen at night. The Housekeeping Manager further stated it was his expectation for the other facility laundry staff to check the linen while folding it and if there were stains to have the linen rewashed. If the stains did not come out then the linen was to be discarded. Also if there were any holes in the linen it should also be discarded. The nursing staff when providing care for the residents were to check for stains and holes and replace with clean sheets or linen. On 11/18/15 10:22 AM in room [ROOM NUMBER] Bed-A quarter and dime sized holes were observed on the bed spread. On 11/18/15 at 11:23 AM Nursing Assistant (NA#3) stated she had made Bed A and had not seen the holes in the bed spread. She stated when there were holes in the linen or if the linen had stains she should discard the bed spread and replace it with another bed spread in good condition. During an interview on 11/19/15 3:20 PM the Director of Nursing (DON) stated her expectation was for staff to provide linens in good condition available to staff for resident care.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to prevent 2 of 4 cognitively impaired residents (Resident #22 and Resident #116) who exhibited wandering behaviors from exiting from the facility while unsupervised. The findings included: Immediate Jeopardy began on 10/11/15 when Resident #116 left the facility unsupervised and was found by a visitor in the front parking lot of the facility. The resident's wanderguard bracelet failed to activate the alarm system on the door. Immediate Jeopardy began on 11/12/15 when Resident #22 left the facility unsupervised and was found outside at night by staff. The dining room exit door failed to alarm due to a dead battery. Immediate Jeopardy was identified on 11/19/15 at 9:45 AM and was removed 11/20/15 at 10:07 AM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings included: 1. Resident #22 was originally admitted to the facility on [DATE]. Resident #22's [DIAGNOSES REDACTED].

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Nursing note dated on 04/04/15 at 4:15 PM read in part: At 9:45 AM a member of the housekeeping staff brought Resident #22 to the C hall stating that a resident had seen Resident #22 going out a breezeway door that connects the LTC (long term care) to the assisted facility living. The alarm to the door did not sound. The housekeeping staff found Resident #22 sitting outside the door and returned her to the C hall. The resident stated she was looking for her baby. No c/o pain or discomfort. Q (every) 15 minute checks were initiated. Resident received Xanax 0.25 PO (by mouth) for anxiety, her wanderguard was checked for placement and proper functioning. DON (Director of Nursing), Administrator, and member of the Maintenance was notified of the incident at 10:30 AM. Responsible Party was notified at 10:30 AM. Currently resident is sitting at the nursing station asking to see family member. Will continue to monitor. No acute distress. Note written by Staff Nurse #5. Nursing note dated on 09/15/15 at 7:05 PM read in part: Resident brought back in from outside by nurse (nurse name) where she had been sitting under bridgeway (breezeway) beside ambulance after setting off door alarm. Nurse (nurse name) had been responding to alarm when it sounded to see what had set it off when she found her sitting there. Resident was given evening meds at that time and put on q (every) 15 minute checks x 24 hours. She then sat quietly in her w/c (wheelchair). 7:30 PM - Reported to DON (Director of Nursing). 7:35 PM - Notified responsible party. 7:38 PM - Notified Dr. (name of doctor). 10:15 PM - Put to bed and was cooperative at this time. Bed alarm attached and functioning. Resident with eyes closed and respirations even and unlabored. Q (every) 15 minute checks continuing. Note written by Staff Nurse #6. Review of elopement assessment dated on 10/13/15 revealed elopement/wandering risk review indicated elopement risk included interventions of frequent monitoring, personalization of room, staff aware of resident's wander risk and wanderguard was placed. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #22 was severely cognitively impaired and exhibited wandering behavior occurring 1 to 3 days. The assessment also indicated the resident needed extensive assistance of one person physical assist for transfer, dressing and hygiene and limited assistance of one person physical assist for locomotion. The resident was coded as balance not steady, only able to stabilize with human assistance. The resident was assessed to require a wheelchair for mobility. Review of form entitled Report of Resident Exit Seeking/Wandering: Missing From Facility dated 11/12/15, 10:40 PM read in part B hall nurse was pushing resident down hall to her room and made writer aware that resident was behind the dining room outside of the facility on her knees knocking on the window. Resident had went out of door in dining area, door did not alarm. Alarm was broken. Resident had gotten out of wheelchair and had mud on her clothes from knees down. Resident was not hurt. Nurse made CNA (certified nursing assistant) aware of the situation and CNA cleaned resident up and put her into bed. Action taken: Resident on q (every) 15 minute checks. A new plan of care/intervention has been completed to prevent further events. Nursing note dated on 11/12/15 at 11:42 PM read in part: Resident was found outside of dining room this pm, resident was banging on door to come in. Resident was assisted into wheelchair and brought back into building, C Hall nurse and CNA's notified. DON (Director of Nursing) was called and notified also. Resident does have wanderguard on and also personal alarm which are in working order. No apparent injuries noted at first sight. Note written by Staff Nurse #7. Review of the weather history for November 12, 2015 indicated that the actual temperature was 78 degrees Fahrenheit and the low was 46 degrees Fahrenheit. The weather history indicated that it rained on November 10, 2015. Review of Resident #22 updated care plan dated on 11/18/15 addressed the problem of the Resident has exit seeking behavior. Resident was found outside of dining room on 11/12/15 with no injuries. Goal: Resident will not leave building unattended thru next review. Approaches: Personal secure alarm as ordered. Check functioning of secure alarm per policy. Check placement per protocol. Redirect resident PRN (as needed). Observe frequently. Attempt diversional activities PRN (as needed). Routine risk assessment. Meds as ordered. Contact MD (medical doctor) and family of attempts to leave facility. Q (every) 15 minute checks indefinitely. Neuro checks initiated. RP (responsible party) notified. MD (medical doctor) notified. Administrator/DON (Director of Nursing) notified. Maintenance in to fix door. Observation was made of the resident on 11/18/15 at 7:40 AM in her room sitting up in wheelchair waiting for breakfast with the wanderguard attached to the back of the wheelchair. During an interview on 11/18/15 at 7:45 AM, NA (nursing assistant) #6 indicated that she has seen the resident go to the front area and look out the window. The NA #6 further stated that she was told by the Nurse on the hall that the resident is on Q (every) 15 minute checks due to trying to exit the facility. During an interview on 11/18/15 at 8:30 AM, the MDS Coordinator indicated that the resident does wander throughout the facility and a wander guard was placed for safety. Observation was made on 11/18/15 at 10:00 AM of resident sitting in wheelchair behind the nurse's station drinking a soda and the wander guard was attached to the back of wheelchair. During an interview on 11/18/15 at 10:10 AM, Nurse #8 indicated that she has not seen the resident try to exit the building. Nurse #8 further stated that the resident was put on Q 15 minute checks for exiting out of the dining room door. During an interview on 11/18/15 at 10:15 AM, NA #7 indicated that she has not seen the resident try to exit the building. NA #7 further stated that the resident does wheel herself in wheelchair throughout the building. During an interview on 11/18/15 at 10:18 AM, the Social Worker stated that the resident does wheel herself in wheelchair throughout the facility and only tries to exit the facility if she has a Urinary Tract Infection. During an interview on 11/18/15 at 10:20 AM, the Assistant Director of Nursing (ADON) stated that the resident may go to the door to look out but is easily redirected. The ADON further stated that she has not seen the resident try to exit the building. Observation was made on 11/18/15 at 2:30 PM of the resident sitting up in wheelchair in the foyer area visiting with a family member. Observation was made of the wanderguard attached to the resident's wheelchair on the back. During an interview on 11/18/15 at 3:50 PM, NA #8 stated that she saw the resident sitting up in her wheelchair rolling around on the hall at 10:15 PM and 10:40 PM when she was made her last rounds. During an interview on 11/18/15 at 5:00 PM, the Maintenance Director indicated that the dining room door alarm system uses a 9 volt heavy duty battery. The Maintenance Director further stated he checks the battery life by sound every Thursday and does not keep a log when the battery is changed. The Maintenance Director indicated that he has a meter and has not used it in the past to check the life of the battery. The Maintenance Director stated he would contact the alarm system company for manufacturer's instruction. The Maintenance Director further stated that the dining room door alarm is not tied in with the wanderguard system, the dining exit door will alarm when it is opened. The Maintenance Director further stated that he changed the battery on the alarm system for the dining room exit door on 11/13/15 around 12:30 AM when he was notified at home that Resident #22 was found outside. Observation was made of the dining room exit door on 11/18/15 at 5:00 PM of the 9 volt battery and door was alarming properly when opened. During a telephone interview on 11/18/15 at 11:45 PM, Nurse #9 indicated that she saw the resident at 10:00 PM on 11/12/15 sitting in her wheelchair in her room doorway. Nurse #9 further stated that the resident was on Q 15 minute checks due to her wandering throughout the facility. Nurse #9 stated that the nurse on B hall Nurse #7 heard a banging noise and found the resident outside of the dining room door on her knees banging on the glass door with a rock. Nurse #9 stated that the Nurse #7 was pushing Resident #22 in her wheelchair back into the facility. The Nurse stated that the resident was assessed and there was no apparent injuries. The Nursing Assistant (NA) got the resident out of her muddy clothing and cleaned up and put Resident #22 to bed. Nurse #9 said she did not hear the door alarm. The Administrator and the Maintenance Director were notified. During an interview on 11/19/15 at 8:00 AM, Nurse #7 stated that she heard a banging noise and walked around in the facility to find out where the banging noise was coming from and saw the resident on her knees outside the dining room door banging on the door with a rock. Nurse #7 stated she yelled for help and she went out another door about 10 feet away from the resident. Nurse #7 stated that the resident wheelchair was about 6 feet away from her stuck in the mud. Nurse #7 said she checked the resident while she was outside and she was able to stand. The resident was put in her wheelchair and rolled back into the facility. Nurse #7 said the weather outside was damp and the air was brisk. Nurse #7 stated said she

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) immediately called the DON. During an interview on 11/19/15 at 7:55 AM, housekeeping staff #2 revealed that she saw Resident #22 attempt to go out of the door near the kitchen area on last week and she redirected Resident #22. Observation was made on 11/19/15 at 10:30 AM of the area where the Resident #22 was found and there was 12 foot cement sidewalk that goes out from the dining room exit door. Observation was of the construction site which was about 40 feet from the dining room exit door. Review of the manufacturer's instructions dated on December 23, 2014 read in part Parts breakdown depiction: 9 volt battery. Low battery alert: Simultaneous siren chirps and red LED flashes occur at 45 seconds intervals when the battery reaches approximately 7 volts. The Maintenance Director had the manufacturer's instruction sent to facility on 11/19/15. Review of the manufacturer's manual, titled Code Alert, Senior Living Solutions, Wander Management Transmitters, User Guide,release date 5/21/15, page 7, read in part, Warning: When the code watch (wanderguard) is placed on a resident's ankle, be sure to adjust the antennae at each door to a 4 to 5 ft. range to the ankle. Failure to do so may allow a resident to elope because they will be closer to the door when the door detects the transmitter. Also pg. 9 of the manual, read in part, Note: To monitor a resident in a wheelchair, attach the transmitter to the seat or the back of the chair as the metal on the chair can interfere with the transmitter's signal. #4 Adjust the band so that the transmitter is in a comfortable position on the resident's wrist or ankle. During a telephone interview on 11/19/15 at 10:33 AM a Technician from the manufacturer of the wander guard code watch, stated the code watch (wanderguard bracelet) should not be placed on the metal portion of a wheelchair because it could interfere with the transmitter's signal. During an interview 11/20/15 at 9:06 AM, the Administrator indicated that it is her expectation that Maintenance Director use the alarm system manufacturer's instructions and change the battery when it is registering 7 volts by using the meter from this point on. 2. Resident #116 was originally admitted to the facility on [DATE]. Resident # 116's [DIAGNOSES REDACTED]. According to the most recent Quarterly Minimum Data Set ((MDS) dated [DATE], Resident #116's Brief Interview for Mental Status (BIMS) noted she was cognitively impaired with severely impaired decision making skills. In the area of behavior, Resident #116 was coded, with no wandering behaviors, and in the area of Activities of Daily Living, Resident #116 required limited assistance with transfers and used a wheelchair. A Nursing Note dated 7/18/15 at 7:04 PM, read in part, Informed per staff seeing resident out of building. Writer noticed resident sitting in wheelchair outside of building in parking lot. Wheeled back into facility. Wanderguard bracelet placed on right wrist. The note was written by Staff Nurse #1. Review of a document titled Elopement Assessment - Report of Resident Exit Seeking/Wandering: Attempting to leave facility revealed: 7/18/15 12:45 PM-Informed per staff of seeing resident out of building. Writer noticed resident sitting in wheelchair outside of building in parking lot. Wheeled back into facility. The document indicated that the resident did not have on a monitoring device. The action taken by the facility included the placement of wanderguard bracelet on the resident. A Nursing Note dated 7/19/15 at 6:27 PM, read in part, Resident alert, some confusion. Out of bed in wheelchair, propelling within facility. Noticed resident had removed wanderguard bracelet. Placed back onto right ankle. The note was written by Staff Nurse #1. During an interview on 11/18/15 at 5:40 PM Nurse Supervisor# 1, stated she did not recall the elopement incident of 7/18/15. She revealed she did not work that often. Nurse Supervisor #1 was noted on Resident #116's elopement incident report of 7/18/15 as Staff Nurse #1's immediate supervisor. During an interview on 11/18/15 at 5:38 PM, Nursing Assistant #1, stated she did not recall Resident # 116 eloping from facility on 7/18/15. She said she could not recall anything about an elopement incident. On 11/18/15 at 5:48 PM an effort was made to contact Staff Nurse #1 who retrieved Resident #116 from the parking lot and wrote the elopement incident report on 7/18/15. Staff Nurse #1 was no longer employed with the facility and her telephone was disconnected. The resident was discharged to the hospital on [DATE] and was readmitted to the facility on [DATE]. According to the most recent Quarterly Minimum Data Set ((MDS) dated [DATE], Resident #116's Brief Interview for Mental Status (BIMS) was 00, which meant Resident # 116 was cognitively impaired with severely impaired decision making skills. In the area of behavior, Resident #116 was coded, with no wandering behaviors, and in the area of Activities of Daily Living, Resident #116 required extensive assistance with transfers and used a wheelchair. A Nursing Note dated 10/11/15 at 8:15 PM, read in part, Another resident's family member was pushing resident down hallway to nurse and stated resident was sitting outside. Registered Nurse supervisor and Assistant Director of Nursing made aware and stated to start every 15 minute checks. Resident #116's responsible person/family member was called and left message to return call. Night nurse made aware. Will monitor. Resident in room at this time. The note was written by Staff Nurse #2. Review of a document titled Elopement Assessment Report of Resident Exit Seeking/Wandering: Attempting to leave facility revealed: 10/11/15 5:00 PM Another resident family member brought resident back in stated she was outside in parking lot. The document indicated the facility's security alarm did not sound, and the resident's monitoring device was observed on the resident at the time the resident was found outside of the building. However, the device was not working. The action taken by the facility included to check the resident's whereabouts every 15 minutes. A Nursing Note dated 10/12/15 at 8:07 AM, read in part, Resident without attempt to leave facility. On every 15 minute checks. The note was written by Staff Nurse #4. Review of Resident #116's Care Plan dated 10/14/15, read in part, Personal secure alarm as ordered, Wanderguard. Check functioning of secure alarm per policy. Check placement per facility protocol. Observe resident's whereabouts frequently. During an interview on 11/18/15 at 3:10 PM Staff Nurse #2 stated she was doing a medication pass on 10/11/15 when another resident's family member brought Resident #116 back into the facility. She stated the family member pushed Resident #116 in her wheelchair down to the medication cart and informed her that Resident #116 was found sitting in her wheelchair in the parking lot. Staff Nurse #2 said at first she did not see a wanderguard bracelet on Resident #116, but she recalled the wanderguard bracelet was on the resident's wheelchair. She stated she did not know how long Resident #116 had been missing. Staff Nurse # 2 said she did not remember which staff member was assigned to work with the resident the day she exited the facility while unsupervised. Staff Nurse #2 said she did know whether or not Resident #116 had exit seeking behavior and she had not observed Resident #116 exhibiting any exit seeking behavior. Staff Nurse #2 explained she did not work on the resident's hall a lot and that she worked every weekend. She stated when she came in to do the incident report staff told her Resident #116 wandered a lot. She relayed that she did not know whether or not the door alarm sounded when Resident #116 exited the facility. During an interview on 11/18/15 at 5:55 PM, Nursing Assistant #4 revealed he was assigned to work with Resident #116 and the resident had never wandered outside of the building. He stated Resident #116 wandered, but she usually sat in her wheelchair near the nursing station. Nursing Assistant #4 said he could not recall whether or not he worked on 10/11/15, the day Resident #116 exited from the facility. During an interview on 11/18/15 at 4:18 PM, the family member that allegedly saw Resident #116 in the parking lot and took her to the staff nurse in the facility, revealed he brought residents back into the facility from outside all the time. The family member stated that some residents sat outside near benches in front of facility, but he did not recall taking any resident to a nurse. During an interview on 11/18/15 at 3:40 PM, the Assistant Director of Nursing said she had not known Resident #116 to have exit seeking behavior and she wondered why Resident #116 was wearing a wanderguard bracelet, because she had never seen her do anything. Although the Assistant Director of Nursing's name was on Resident #116's incident report as a Nurse Supervisor, she did not recall talking to Staff Nurse #2 about the resident exiting the facility on 10/11/15. During an interview on 11/19/15 at 9:00 AM, the Director of Nursing (DON) stated she asked staff to call her about everything. She revealed the Assistant Director of Nursing was on-call in October and she was also on medical leave, the weekend Resident #116 exited the facility while unsupervised. She stated she found out about the incident of 10/11/15 on Monday after the incident. The DON revealed no one notified her when Resident #116 exited from the facility in October. The

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) DON revealed staff should have known Resident #116 was a wanderer because she eloped from the facility in July 2015. The DON said she realized Resident #116 was a wanderer based on the resident's last assessment. She revealed once staff found out Resident #116 had eloped from the facility in July 2015, a wanderguard bracelet was placed on her. The DON said after Resident #116's elopement in July 2015, she expected staff to know whether or not a resident was at risk for elopement, to notify the responsible person and the medical doctor and to initiate fifteen minute checks. She stated she also expected supervisors to start an investigation for her. During an interview on 11/19/15 at 9:29 AM, the Maintenance Director revealed the facility's front door and side door entrance were equipped with a wanderguard system. He stated he usually checked doors once per week. He said he would open the door, set off the door alarm and close the door. He said he would hold a wanderguard bracelet, walk up to the door and set off the alarm. The Maintenance Director stated a wanderguard bracelet had never malfunctioned while he tested the bracelet. He explained the resident with a wanderguard would have to get close to the door in order for the door alarm to sound. The Maintenance Director revealed sometimes he would use a resident with a wanderguard bracelet to test the door alarm and a wanderguard bracelet was placed on a wheelchair because residents would attempt to remove the wander guard when placed on their wrist. The Maintenance Director emphasized that the facility did not have a system in which the door would lock when the resident's wanderguard set off the door alarm. He said there was a code for staff to turn off the alarm once it sounded. The Maintenance Director further revealed individual wanderguard bracelets were tested weekly by a Restorative Aide. During an interview on 11/20/15 at 11:40 AM, a facility Restorative Aide presented documentation indicating that she tested each Resident's wanderguard bracelet weekly. She stated that she always held the testing device away from the wanderguard bracelet, pressed the button down on the tester until it beeped one time and then she tested the wanderguard bracelet itself. She revealed that she would put the testing device next to the wanderguard bracelet until it beeped. The Restorative Aide revealed the green light would come on to indicate the device was working. She revealed if the testing device did not work, she would retest the wanderguard device it at the front door. Review of the manufacturer's manual, titled Code Alert, Senior Living Solutions, Wander Management Transmitters, User Guide,release date 5/21/15, page 7, read in part, Warning: When the code watch (wanderguard) is placed on a resident's ankle, be sure to adjust the antennae at each door to a 4 to 5 ft. range to the ankle. Failure to do so may allow a resident to elope because they will be closer to the door when the door detects the transmitter.Also pg. 9 of the manual, read in part, Note: To monitor a resident in a wheelchair, attach the transmitter to the seat or the back of the chair as the metal on the chair can interfere with the transmitter's signal. #4 Adjust the band so that the transmitter is in a comfortable position on the resident's wrist or ankle. During a telephone interview on 11/19/15 at 10:33 AM a Technician from the manufacturer of the wanderguard code watch, stated the code watch (wanderguard bracelet) should not be placed on the metal portion of a wheelchair because it could interfere with the transmitter's signal. During an observation on 11/19/15 at 9:45 AM, Resident #116 was sitting in her wheelchair in the activity room. The wanderguard bracelet was attached to the lower right corner, metal portion of wheelchair near the right wheel. During an interview on 11/19/15 at 3:27 PM, the Maintenance Director revealed he used a wanderguard bracelet to test doors. The Maintenance Director opened the front double doors about an inch while he had a wanderguard bracelet in his hand. He stated he usually had a resident with him to test the door and the alarm sounded at a shorter distance. After the alarm sounded he keyed in the code to stop the alarm. The Maintenance Director said he would have to open the door in order for the alarm to go off. He revealed if a resident was sitting in front of the door, the alarm would not sound, however if someone opened the door while the resident was sitting in front of door, the alarm would sound. On 11/19/15 at 11:55 AM Resident #116 was observed propelling her wheelchair up the hallway with her feet. On 11/19/15 at 12:25 PM Resident #116 was observed sitting in her wheelchair near the nurse's station with other residents. The resident's wanderguard was attached to the back of wheelchair on a metal brace near the right wheel. On 11/19/15 at 2:12 PM Resident #116 was observed at the hallway entrance near the Social Work office, sitting in wheelchair next to other residents. The resident's wanderguard bracelet was on the back of the wheelchair on the metal brace near the right wheel. On 11/19/15 at 3:19 PM, Resident #116 was observed propelling her wheelchair to the lobby area. Another resident was following her in her wheelchair. Both residents propelled their wheelchairs through the lobby area past the administrative offices and back to the nurse's station. Resident #116's wanderguard remained on the right side of her wheelchair, on a metal brace lower portion of wheelchair near the right wheel. During an interview on 11/19/15 at 11:52 AM, Staff Nurse #3 stated she was assigned to Resident #116's hall on first shift (7:00AM-3:00PM). She said Resident #116 could propel herself in her wheelchair and could go up and down the hall. She stated Resident #116 never left the building by herself. She said most of the time Resident #116 sat in the common areas. Staff Nurse #3 revealed Resident #116 was not one to be monitored for her whereabouts. She relayed Resident #116 used to have a wanderguard bracelet, however, she did not have one anymore because she had not attempted to exit the facility. Staff Nurse #3 revealed she had not observed Resident #116 exhibiting any exit seeking behaviors, was not aware Resident #116 had exited the facility and was not aware the resident had a wanderguard. During an interview on 11/19/15 at 12:09 PM, Nursing Assistant #5, revealed Resident #116 wandered up and down halls in the facility and she never wandered outside of the facility. She stated Resident #116 sat in her wheelchair at the nurse's station and was usually around that area near lunch time. In reference to supervision, Nursing Assistant #5 stated they had a certain number of residents on every fifteen minute checks and Resident #116 was never on the list to check frequently. She stated she had never seen Resident #116 try to open doors. Nursing Assistant #5 said when it was time for Resident # 116 to be checked for toileting, she revealed, nine times out of ten, Resident #116 would be at the nurse's station. Nursing Assistant #5 stated when she started work every morning, the charge nurse would tell them which residents needed to be checked more frequently and Resident #116's name never came up. Nursing Assistant #5 stated she was not aware Resident #116 exited the facility while unsupervised in July 2015 and October 2015. She further revealed she did not know there was a notebook with a list of residents that were wanderers and had exit seeking behaviors. She said no one had discussed the wandering notebook with the nursing assistants. Review of the elopement notebook on 11/19/15 at 12:29 PM revealed Resident #116's exit seeking profile was in the notebook. During an interview on 11/19/15 at 1:06 PM the Director of Nursing (DON) stated from what she was told, Resident #116 was found on 10/11/15 at end of the brick walkway, in the facility parking lot on 10/11/15. On 11/19/15 at 1:58 PM, the Maintenance Director and Assistant Maintenance man measured the distance from the facility doorway to the parking lot. The distance from the front door to the van drop off area in the parking lot, was fifty feet. The distance straight to the second parking lot was another fifty feet. During an interview on 11/19/15 at 2:14 PM, the facility Social Worker stated she did not recall any of Resident #116's elopements. She said the first time she heard about the elopements was yesterday in a staff meeting. She revealed when a resident eloped from the facility, the assigned nurse would call the family to let them know of an elopement. The Social Worker stated all residents go up and down hallways. She said she knew Resident #116 had a chair alarm but she did not know the resident had a wanderguard until yesterday. She revealed Resident #116 would always hang out near the nurse's station. The Social Worker further said usually elopements would be put on 24 hour nursing reports and would be discussed during morning staff meetings. During an interview on 11/19/15 at 2:25 PM, the Minimum Data Set (MDS) Coordinator stated she knew about Resident #116's first elopement in July 2015, and that was when the wanderguard was initiated for Resident #116. The MDS Coordinator revealed she was not aware of the second elopement in October 2015. She said during morning meetings they would discuss protocols regarding falls or elopements and the nurse was supposed to immediately update the resident's care plan. During an interview on 11/20/15 at 9:01 AM, the Administrator revealed her expectation was for Resident #116 not to have any more exit seeking behaviors and the wanderguard would be placed on her ankle. She further stated her expectation was staff would report elopements to the Director of Nursing, the Assistant Director of Nursing, then to her. The Administrator's expectation was for staff to document elopement on the 24 hour report and notify the family and medical director. The Administrator said they usually communicated with Nursing Assistants about elopements. During an interview on 11/18/15 at 11:59 AM, the Facility Medical Director stated he was aware of the wanderers but it had not been discussed during Quality Assurance (QA) meetings. He revealed QA should have looked at wandering and we could have

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	345213	A. BUILDING _____ B. WING _____	11/20/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE LILLINGTON	1995 EAST CORNELIUS HARNETT BOULEVARD LILLINGTON, NC 27546

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

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) fixed it before it became a detriment to the residents. It has to be a safe environment and the safety of the patients. The Administrator was notified of the Immediate Jeopardy on 11/19/15 at 8:45 AM. The facility provided the following Credible Allegation on 11/20/15 at 10:18 AM. Problem/Incident: 1) Resident # 116 was observed by a family member at 8:15 pm on 10/11/15 sitting in her wheelchair at the edge of the driveway to the front entrance patio and was brought back inside the facility. Resident #116 was assessed and found to be without injury. Staff was alerted to resident #116's exiting the facility, the attending MD and RP were notified. The intervention implemented for resident #116 was placement of a wanderguard to her right ankle and 15 minute checks by staff as to location x 72 hours as precautionary measure after placement of the wanderguard. Resident #116 has had no other exit seeking events since 10/11/15. 2) Resident #22 was discovered on her knees on the sidewalk outside the dining room door at 10:40 pm on 11/12/15. She was assisted back into the facility by nursing staff and asse
F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** Based on observation, record review and staff interviews the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor these interventions that the committee put into place in October of 2014. The deficiency was in the area of failure to prevent accidents. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Immediate Jeopardy began on 10/11/15 when Resident #116 left the facility unsupervised and was found by a visitor in the front parking lot of the facility. The resident's wanderguard bracelet failed to activate the alarm system on the door. Immediate Jeopardy began on 11/12/15 when Resident #22 left the facility unsupervised and was found outside at night by staff. The dining room exit door failed to alarm due to a dead battery. Immediate Jeopardy was identified on 11/19/15 at 9:45 AM and was removed 11/20/15 at 10:07 AM when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level of D (an isolated deficiency, with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put in place and completion of employee training. The findings included: This tag is cross referenced to F 323: Based on record review and staff interviews, the facility failed to prevent 2 of 4 cognitively impaired residents (Resident #22 and Resident #116) who exhibited wandering behaviors from exiting the facility while unsupervised. During an interview on 11/18/15 at 11:59 AM, the Facility Medical Director stated he was aware of the wanderers but it had not been discussed during Quality Assurance (QA) meetings. He revealed QA should have looked at wandering and we could have fixed it before it became a detriment to the residents. It has to be a safe environment and the safety of the patients. During an interview on 11/20/15 at 9:06 AM, the Administrator indicated that residents with wandering behavior did not come up as a concern in QAA. The Administrator further stated that residents with wandering behavior will be reviewed in QAA. The Administrator was notified of the Immediate Jeopardy on 11/19/15 at 8:45 AM. The facility provided the following Credible Allegation on 11/20/15 at 10:18 AM. Problem Identified: Facility failed to develop and implement a Quality Assurance and Performance Improvement (QAPI) for residents with wandering/exit seeking behaviors. Interventions: Corporate Management Clinical Support Nurse has completed re-training with facility Administrator, Director of Nursing and Assistant Director of Nursing regarding F520 Quality Assurance, regarding unsafe wandering or elopement including identification of resident wandering behavior, creating a safe environment, completion of resident assessments at the time of admission and the time of any event of unsafe wandering or elopement, notification of any events with potential of adverse resident outcomes to Clinical Support Nurse and completion of Quality Assurance and Performance Improvement Plan to prevent re-occurrence of any adverse outcomes regarding resident care and safety. The DON or administrative nurse will review the 24 hour report, physician's telephone orders and resident incident report daily to ensure that all potential adverse events regarding resident care and safety are addressed and appropriate interventions are in place started 11/19/15. Compliance will be monitored daily by Director of Nursing/administrative nurse and/or facility Administrator with review of daily 24 hour reports, physician telephone orders, and resident incident reports to ensure that all potential adverse events regarding resident care and safety are addressed and interventions are in place. Director of Nursing and/or administrative nurse will conduct a weekly standards of care meeting with review of any resident with unsafe wandering and/or exit seeking behavior. This meeting will include input from facility psychological group and attending physician for current interventions and any necessary changes to the resident care to ensure residents are receiving timely interventions. Potential Residents: All Current residents were reassessed on 11/20/15 by the ADON to identify any residents who are at high risk for wandering behavior. Residents identified as having exit seeking behaviors have a new and/or updated Care plan completed 11/20/15 by MDS nurse. CNA Care Guides have been updated and reviewed with staff to ensure they are aware of residents with a high risk of wandering on 11/20/15 by the ADON. Two notebooks were created that contain the pictures of all residents identified as high risk for wandering on 11/19/15. The notebooks will be located at the receptionist desk and nurse's station to ensure staff is able to identify any resident with a high risk for wandering. All residents currently with a wanderguard have been assessed for wander guard placement. All wander guards are placed on residents as recommended by the manufacturer as of 11/19/15. As of 11/19/15 newly admitted residents will be assessed for the risk of wandering /exit seeking behaviors within 24 hours of admission. As of 11/19/15 any resident experiencing an exit seeking event will be immediately re-assessed and intervention put in place. The DON/Administrator will be notified for follow-up. Training will be completed with all current staff on unsafe wandering or Elopement including, identification of resident wandering behavior, creating a safe environment, and providing a safe environment for residents by the ADON on 11/19/15. Any staff not available for this training will not be allowed to work until training is complete. Maintenance will check wanderguard boxes daily for functioning and document finding on the Door Alarm Check monitoring tool. Any wanderguard box not functioning properly will be corrected immediately by maintenance. All wander guard boxes were audited 11/19/15 by maintenance and are working properly. Maintenance will check the voltage of batteries and audible alarm on all door alarms 4 x weekly for battery life by using a meter and follow manufacturer's recommendation of changing battery when reading is 7.0 voltage or less. Maintenance will document his finding on the Door Alarm Check monitoring tool. All doors alarms were audited 11/19/15 by maintenance and documented with all battery voltage over 7.0 Monitoring: Beginning 11/19/15 the Administrator will monitor the Maintenance Door Alarm Check sheets daily x 4 weeks; then, weekly times 3 months to ensure compliance. The Facility DON and/or designee will monitor the wanderguard placement of identified residents weekly x 4weeks and compare to MARs documentation on wander guards. If any discrepancies are found, the nurse will be identified, reeducated and counseled by the DON or ADON. Director of Nursing will submit a summary of the standards of care meeting at the monthly QAPI meeting x 3 months, then every other month for review, discussion and/or needed changes to ensure compliance until resolved. The facility Administrator will complete a summary of all monitoring efforts and will present it at the facility QAPI

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F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) meeting monthly with facility Medical Director and facility QAPI committee. The credible allegation was verified on 11/20/15 at 11:30 AM as evidenced by staff interviews on the use of wander guard monitoring tools, when Wander guards boxes are to be checked for functioning; how often voltage of batteries and audible alarms checked on doors and how often wander guard sensor doors would be checked for accuracy of alarming and proper placement. In addition updated Care Plans, care guides and assessments were verified as well as elopement notebooks. Observations of proper placement of wander guards and wanderguard system working effectively. The credible allegation was verified on 11/20/15 at 11:30 AM as evidenced by: interview of all staff related to their being able to identify residents at risk for elopement and verifying staff understood how to identify, report and monitor residents at risk for wandering. Interview staff on when wanderguard boxes are to be checked for functioning; how often voltage of batteries and audible alarms checked on doors and how often wanderguard sensor doors would be checked for accuracy of alarming and proper placement. In addition updated care plans, care guides and assessments were verified as well as elopement notebooks. Observations of proper placement of wanderguards and wanderguard system working effectively.