

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/16/2024
NAME OF PROVIDER OR SUPPLIER Deer Park Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 306 Deer Park Road Nebo, NC 28761	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40200</p> <p>Based on observations, record review and staff, Physician Assistant, and Medical Director interviews, the facility failed to supervise a severely cognitively impaired resident with wandering behaviors from exiting the facility unsupervised, without staff knowledge, for 1 of 1 resident reviewed for accidents related to unsafe wandering/elopement (Resident #1). The facility also failed to immediately notify administration of the missing resident. The resident exited the facility which was in a rural residential area and walked 1/3 mile on a two-lane road with no streetlights and no sidewalk without shoes, wearing socks. She was found lying in a ditch beside the road by a neighbor walking his dog. On evaluation by Emergency Medical Service personnel, Resident #1's blood sugar was 500 milligrams per deciliter. She was transported to the hospital for evaluation and treatment where she was given intravenous Insulin and fluids. She was later discharged from the hospital to another long-term care facility's locked memory care unit.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with a diagnosis of dementia and Diabetes Mellitus.</p> <p>Review of Resident #1's physician's orders dated 3/09/24 and 3/12/24 revealed orders for antidiabetic medications (non insulin). She was not on scheduled blood sugar checks. Antidiabetic medications ordered:</p> <ul style="list-style-type: none"> - 3/09/24 8:00 PM - Metformin 500 mg by mouth two times a day for Diabetes - 3/12/24 00:00 - Dulaglutide 0.75 milligrams (mg) subcutaneous every Tuesday for Diabetes <p>Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was severely cognitively impaired. She exhibited wandering behaviors 1-3 days during the lookback period. The lookback period was 7 days prior to the MDS date. She was independent for walking at least 150 feet. She did not use a wander/elopement alarm.</p> <p>Review of Resident #1's wandering/elopement assessment dated [DATE] revealed she had no history of wandering and wandered within the home without leaving the grounds. The progress note section read in part that resident ambulates within facility, does not exit seek.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1's care plan dated 7/19/24 had a focus which read in part that the resident is an elopement risk/wanderer related to disoriented to place, exit seeks. The intervention included to distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and book. Another care area focus included the resident had a behavior problem related to dementia. The resident sundowns with increased confusion, wanders, and yells out. The interventions included to divert attention and remove from situation and take to alternate location as needed. Also to monitor behavior episodes and attempt to determine underlying cause. Another care area focus included the resident had Diabetes Mellitus and the interventions included to give Diabetes medication as ordered and monitor for any signs or symptoms of high or low blood sugars.</p> <p>The Weather Underground website revealed the outdoor air temperature where the facility was located on 8/09/24 at 4:54 AM was 71 degrees F with no precipitation.</p> <p>An interview on 8/13/24 at 11:03 AM with Nurse #1 revealed she was the nurse assigned to Resident #1 the night shift of 8/09/24. She stated she had completed a skin assessment on Resident #1 around 3:00 AM and had gone to the nurses' station to document. She heard Nursing Assistant (NA) #2 talking to Resident #1 who had walked out into the hall. Resident #1 did not want to go back to bed and became agitated. Nurse #1 stated she told NA #2 to just let the resident walk in the hall for a little bit. Nurse #1 then left the nurses' station to go to another resident's room and returned to the nurses' station about 20-30 minutes later. Nurse #1 stated that NA #2 was at the nurses' station, and she asked about Resident #1. They looked and Resident #1 was not in her room and they started searching for the resident. Nurse #1 stated that Resident #1 had a history of getting in other resident's beds or going in their rooms. Nurse #1 stated they walked around the outside of the building and were unable to locate the resident. She then informed the Nurse #2 that administration needed to be notified. Nurse #1 stated that they contacted the Director of Nursing (DON) who assisted them in looking at the facility security camera to determine which direction the resident had walked. By looking at the camera, they were able to determine that Resident #1 had walked down the hall toward the front door and had not come back. She stated that the front door was not clearly visualized by the security camera. Nurse #1 was unsure exactly what time the DON had been contacted. She stated she had been educated to notify administration in the event a resident could not be located but was unable to specify a time frame. Nurse #1 stated she did not know how Resident #1 got out the front door. She stated the door was kept locked at all times and required a code to be entered for the door to open. She stated that she had not tested the door during her shift and was unable to state if the door was functioning correctly.</p> <p>An interview on 8/13/24 at 11:35 AM with Nursing Assistant (NA) #1 revealed she was working the night shift and assigned to Resident #1 on the early morning of 8/09/24. She stated around 3:00 AM she and NA #2 were making resident rounds when Resident #1 walked out into the hall. She stated that NA #2 attempted to redirect Resident #1 back to bed, but when the resident got agitated, Nurse #1 just told them to let her walk around the facility. NA #1 stated they continued resident rounds and later Nurse #1 asked them if they had seen Resident #1 and they started searching the facility for her. NA #1 stated she thought this was around 3:50 AM and they looked in and outside the facility for approximately 1 hour prior to calling the DON. NA #1 stated that she had tried all the exit doors when searching for the resident and they were all locked. She stated that she did not know how Resident #1 got out the front door. She also stated that she had seen Resident #1 exit seeking in the past.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 8/13/24 at 11:51 AM with NA #2 revealed that she was working the night shift on the early morning of 8/09/24. She stated that she and NA #1 were making resident rounds when she saw Resident #1 out in the hall. She stated that the resident did not want to go back to bed and Nurse #1 just told them to let the resident walk around. She stated she and NA #1 resumed resident rounds and when they came back to the nurses' station, they noticed Resident #1 was not in her bed. A room-by-room search was initiated for the resident. She stated that she did not know how the resident got outside.</p> <p>An interview on 8/13/24 at 12:15 PM with Nurse #2 revealed that she was in the facility as the Unit Manager on 8/09/24 when Resident #1 eloped. She stated it was around 4:40 AM with the DON was contacted. She stated the DON talked her through accessing the security camera to determine which direction Resident #1 had gone. She stated that she could see the resident go down the hall toward the front door and then didn't see her again. Nurse #2 stated she had no idea how Resident #1 got out the front door and did not believe the resident could have entered the door code. She stated she had observed Resident #1 to exit seek and open doors in the past. Nurse #2 stated she had received education on resident elopement which included notification of administration, and she thought the timeframe for notification was 30 minutes.</p> <p>An interview on 8/13/24 at 1:37 PM with the DON revealed Resident #1 had some wandering behaviors, got confused, and would go in and out of other resident's rooms. She stated that she had no idea how Resident #1 got out the door. She stated that Nurse #2 contacted her at 4:56 AM on 8/09/24 and she drove to the facility. She stated local law enforcement had been notified at 5:19 AM. The DON stated that Resident #1 had never exited the facility in the past. She stated that the staff had looked for the resident for approximately 1 hour prior to notifying her. She stated that the staff had received training on a missing resident which included notifying administration but did not specify a timeframe.</p> <p>Review of Emergency Management Services report dated 8/09/24 revealed they were called to the facility at 6:48 AM and arrived at 7:00 AM. The report narrative read in part that the resident was located sitting in a wheelchair in the front office. She had no obvious injuries and was noted that her blood sugar level was 500 milligrams per deciliter (mg/dL). A normal blood sugar range is 72 to 108 mg/dL. The resident was conscious and alert, however, has severe dementia and is unable to recall any of the events. The resident was transported to the hospital at 7:13 AM.</p> <p>An interview on 8/13/24 at 12:38 PM with the facility Physician Assistant (PA) revealed he had been notified of Resident #1 elopement on 8/09/24 around 7:00 AM and given the order for her to be transported to the hospital for evaluation after she was located. He stated he did not think the resident could have entered the door code. He also stated that he expected the facility to keep the resident safe.</p> <p>Review of the hospital emergency room report dated 8/09/24 at 7:37 AM read in part that this wanderer does not have any apparent injury. The resident was given intravenous Insulin and fluids to bring the blood sugar down to the 200s. The diagnosis read in part that the hyperglycemia was suspected to be stress response. The resident was discharged to a dementia unit in another facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 8/13/24 at 10:33 AM with the Maintenance Director revealed when he checked the door on 8/09/24 after Resident #1's elopement, it was working correctly. He stated he tested it with and without the facility electrical power, using the generator, and he was unable to get it to malfunction. He stated the door stayed locked 24/7.</p> <p>An interview on 8/13/24 at 5:17 PM with the Medical Director revealed he had been notified of the situation and it was 'less than ideal'.</p> <p>An interview on 8/13/24 at 5:31 PM with the Administrator revealed that had she had been notified of the elopement after the resident had been located and taken to the hospital. She stated that she and the DON had reviewed the footage and put together a timeline of events. She also stated that staff education and resident elopement assessments had been completed. The Administrator stated that the PA, Medical Director, and resident representatives had all been notified. She stated that the front door had been extensively checked and they were unable to determine how Resident #1 was able to exit the facility. The Administrator stated that Resident #1 was transported from the hospital to another facility with a locked memory care unit which had been approved by the resident representative.</p> <p>An additional interview and observation were completed on 8/13/24 from 2:45 PM until 3:15 PM with the Maintenance Director. The observation was a recreation of the possible path Resident #1 took after exiting the facility front door. As stated by the Maintenance Director, Resident #1 was located by a neighbor walking his dog lying in a ditch calling for help. Maintenance Director stated he had arrived at the facility around 5:00 AM and immediately started looking for the resident. He looked in the wooded area beside the facility and then started looking down the road. The road was a 2-lane paved road with a double yellow line in the center. The posted speed limit was 40 miles per hour. Maintenance Director stated he and the Maintenance Assistant had taken a truck down the road using flashlights to look for the resident. Approximately 3/10th's of a mile down the road they observed the neighbor with the resident. The neighbor had already gotten the resident out of the ditch. The Maintenance Director stated the resident was wearing pants, a sweatshirt, and socks. He stated her clothing was dry and he had not observed any obvious injuries. The Maintenance Director and the Maintenance Assistant had assisted the resident into the truck and brought her back to the facility. The Maintenance Director stated the grass was wet with dew and the roads were dry. He stated that Resident #1 kept saying she was sorry for the trouble and asking for water.</p> <p>Observation of the front door on 8/13/24 at 3:20 PM revealed a single door with a push bar to exit. There was a door code box located on the right side of the door. The exit code was 4 digits with a hashtag to unlock the door. The door automatically closed and locked when released. The door had no audible alarms when opened or when held open. There was no automatic release if the push bar was held down. There was no method to bypass the door code to exit the door.</p> <p>The Administrator was notified of Immediate Jeopardy on 8/13/24 at 5:50 PM.</p> <p>The facility provided a corrective action plan with alleged date of compliance of 8/10/24. The corrective action plan indicated.</p> <p>Problem Identified:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #1 was admitted to the facility on [DATE] with the following diagnosis: left femur fracture, diabetes, dementia, cardiovascular disease, hypertension, hyperlipidemia and depression. Resident #1 has a BIMS of 3 as of 5/12/24. On August 9, 2024 at approx. 3:30am Resident #1 had an unsupervised exit via the front door of the facility. Order of events: Approximately 4:15am the facility staff noticed during routine rounds that Resident #1 was not in her bed and began searching for her. The Director of Nursing was notified at 4:56am that Resident #1 was missing and could not be found. The Director of Nursing gave the facility instructions to call the administrator, the police and to continue searching every room, as well as outside. The Director of Nursing arrived at the facility at 5:30am, reviewed the security cameras and noted Resident #1 leaving the facility via the front door at 3:20am. At 5:39am the Director of Nursing notified all management staff that Resident #1 was missing, and all available staff were to report to the facility and search on their way to the building. The sheriff department and Emergency Medical Services first responders arrived at approximately 6:00am and received a description of Resident #1. The Deputy reviewed the security camera footage and issued a silver alert. At approximately 6:30am the Maintenance Director and his assistant located Resident #1 and brought her back to the facility. The Emergency Medical Services with the Director of Nursing present assessed her for injuries and no injuries were identified. Resident #1 was identified as having a blood glucose level in the 500s by Emergency Medical Services. The Nurse Practitioner was notified at 6:45am and based on the resident's glucose levels Resident #1 was sent to the emergency room for further evaluation.</p> <p>Address how corrective action will be accomplished for resident (s) found to have been affected.</p> <p>On 8/9/24 at approximately 6:30am the Maintenance Director and his assistant located Resident #1 and brought her back to the facility. The Emergency Medical Services with the Director of Nursing present assessed her for injuries and no injuries were noted. A full set of vital signs and blood glucose monitoring was also conducted. Resident #1 was identified as having a blood glucose level in the 500's by Emergency Medical Services. The Nurse Practitioner and Medical Director were notified at 6:45am and based on the resident's current condition, orders were given to send the resident to the emergency room for further evaluation. Resident #1 was sent to Mission Hospital at approx. 7:08am. While Resident #1 was in the emergency room arrangements were made with her RP's approval for her to be transferred to a sister facility with a secure unit. Once Resident #1 was cleared to be discharged from the emergency room the facility transported Resident #1 from the emergency room to our sister facility around 12:00pm.</p> <p>Address how corrective action will be accomplished for resident(s) having potential to be affected by the same issue needing to be addressed:</p> <p>A 100% review of residents was conducted for the entire facility on 8/9/2024 to identify residents at risk for elopement to ensure they have an elopement risk assessment and care plan to address their behaviors. This review was completed by the Director of Nursing. Those residents identified were added to the Elopement Risk binder. Elopement binders were reviewed, updated accordingly and placed at each nurses' station by the Unit Manager on 8/9/24. These books contain the list of residents with exit-seeking behaviors, their pictures and resident's description. The Admission Coordinator will continue to be responsible for maintaining the elopement binders based on information provided by the Director of Nursing or Administrator. The Admission Director was reeducated on this task by the Administrator on 8/12/24 (upon her return from vacation). Also, those residents identified care plans and care guides were updated by the DON and MDS Coordinator on 8/9/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Door checks were completed on 8/9/2024 by the Regional Director of Facility Maintenance to ensure all doors are locking properly. All doors were locking properly.</p> <p>Address what measures will be put in place and systemic changes made to ensure that the identified issue does not occur in the future.</p> <p>All staff working on 8/9/2024 were educated by the administrative nurses (Director of Nursing and Unit Managers) and Maintenance Director currently in the facility and completed phone education for those not present in the facility regarding the facility elopement policy, the location of the elopement binder to identify residents who are at risk for elopement, ensuring residents who are assessed at risk for elopement are supervised by facility staff, where to locate care plan intervention regarding residents at risk for elopement, immediate notification of the Administrator and Director of Nursing when it is identified a resident maybe missing. Any staff members who have not received the education after 8/9/2024, will not be allowed to work until they have completed the education. This education will be included in the new hire orientation for employees including agency personnel, which is conducted by the Staff Development Coordinator. The Staff Development Coordinator was educated by the Administrator regarding this matter on 8/12/24 (upon her return from vacation).</p> <p>On 8/9/24, the Interdisciplinary Team (IDT) to include but not limited to the Director of Nursing, Unit Manager, Activities Director, Social Worker, MDS Coordinator, Maintenance Director and Dietary Manager were re-educated by the Administrator on the Elopement Policy to include ensuring residents who are assessed at risk for elopement are supervised by facility staff and signs of elopement risk are recognized. Additionally, they were educated on their role in developing plans/interventions in response to any elopement risk. This includes a written care plan with elopement risk interventions formulated.</p> <p>On 8/9/24 all licensed nurses including licensed agency personnel were educated on completion of the Elopement assessments by the Director of Nursing and Unit Managers. They are completed on admission, then quarterly and/or as needed by the Licensed Nurse. Any newly identified residents noted at risk will be communicated by the licensed nurse during shift huddle at the change of each shift.</p> <p>On 8/9/24 the Maintenance Director was educated by the Regional Director of Facility Maintenance on conducting monthly elopement drills and weekly door checks (with all exit doors).</p> <p>Indicate how the facility plan to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the corrective action evaluated for its effectiveness.</p> <p>Effective 8/9/24, the Director of Nursing (DON) will review the residents at risk for wandering or exit-seeking behaviors, which will include the residents currently in the elopement binder and any newly identified residents based on their elopement assessment and/or behaviors weekly for 12 weeks to ensure interventions/behaviors are being managed. Residents exhibiting new behaviors of wandering or exit seeking will be reviewed to ensure the wandering/elopement assessment is accurate, care plan updated, and interventions are in place. The Director of Nursing (DON) will report findings monthly to the Quality Assurance Performance Improvement Team (QAPI) for 3 months.</p> <p>(continued on next page)</p>		

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