

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER The Greens at Maple Leaf		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Maple Care Lane Statesville, NC 28625	
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 - Minimal harm or potential for actual harm</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** 37280</p> <p>Based on observations, record reviews and staff interviews, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised and without knowledge of the staff. On 04/23/24 between the hours of 6:00 PM and 7:00 PM Resident #325 was observed by Nurse Aide (NA) #2 in the back parking lot walking away from the building approximately 30 yards away from the exit door.</p> <p>The findings include:</p> <p>Resident #325 was admitted to the facility on [DATE] with diagnoses that included coronary artery disease, hypertension, atrial fibrillation and cerebral vascular accident (CVA).</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #325's cognition was severely impaired, and she ambulated independently with a walker. No wandering behaviors were noted during the observation period.</p> <p>On 05/12/24 at 6:30 AM during an interview with Nurse Aide (NA) #2 the NA explained that one evening of 04/23/24 he was working second shift instead of his normal third shift and was assigned to the hall that Resident #325 resided on which was the first time he had worked with the Resident. The NA described Resident #325's behavior that day as having to be redirected multiple times back to her room. He continued to explain that after he collected the supper trays, he took the meal cart back to the kitchen and on his way, he stopped at the nursing desk to inform Nurse #4 who was the Nurse on the hall that he was going to take his break. The NA reported when he came back from the store and was sitting in his car in the back parking lot, he saw Resident #325 walking away from the building toward his car approximately 30 yards from an exit door holding a plastic bag with her clothes in it with no staff following her. NA #2 stated he did not know which exit door the Resident went out of to leave the facility. The NA stated he redirected Resident #325 to the entrance door to the service hall and as they approached the door Nurse #4 and Nurse #5 were running up to them to bring the Resident back inside the facility. NA #2 reported he did not know which exit door Resident #325 left out of, but he heard that it was determined to be the exit door at the end of 400 hall which was the hall the Resident resided on. The NA stated he did not notice any cuts or bruises on Resident #325 that would indicate she had fallen while outside the facility.</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of the back parking lot was made on 05/12/24 at 6:47 AM. The back parking lot contained a flat black top surface that was surrounded by a wooded lot. The parking lot contained several parking spaces that staff used but no other obstacles, structures, or hazards were noted.</p> <p>An interview was conducted with Nurse Aide #3 on 05/12/24 at 12:19 PM. The NA explained that she did not remember the day, but she was on 100 hall and looked out the exit door at the end of the hall and noticed a resident bending over to pick up something from the ground behind a truck. When the Resident stood up, she realized that she was one of the residents and went toward the nursing desk to alert the nurses when as she passed the service hall she noticed NA #2 bringing the Resident back into the building. By that time the NA stated the nurses were at the service hall and met NA #2 with the Resident.</p> <p>An interview was conducted with Nurse #4 on 05/12/24 at 9:51AM who confirmed she was the Nurse on the hall when Resident #325 left the building unsupervised on 04/23/24. The Nurse explained that the Resident was acting like her usual self that evening in that she was pleasantly confused and would piddle around in her room and mess in her drawers which was what she always did. The Resident ate her supper meal sitting in her chair in her room. Nurse #4 continued to explain that she and Nurse #5 were sitting at the nursing desk when NA #2 stopped by to let her know that he would be taking his break after he delivered the meal cart back to the kitchen. Approximately 10-15 minutes later Nurse Aide #3 was down on 100 hall hollered up to the desk and asked if we had a resident walking around outside. At that time Nurse #4 and Nurse #5 ran to the service hall and out the door to find Nurse Aide #2 had already gotten to Resident #325 and was bringing her back into the building. Nurse #4 reported the Resident was carrying a water pitcher and a bag of clothes and she was wearing a sweat outfit of a pink top and gray pants and shoes. The Nurse explained that they got a wheelchair and took her back to her room where she conducted a full body skin assessment to determine if she had fallen when she was outside and there were no areas like cuts or bruises noted on her skin assessment. The Nurse stated after the skin assessment Resident #325 sat in her chair in her room for a while then went to bed where she stayed for the rest of the shift (11:00 PM). Nurse #4 reported that as she assessed the Resident, Nurse #5 called the facility management to inform them of Resident #325 exiting the building. She stated the management came to the facility and a resident head count was conducted to ensure every resident was accounted for. The Nurse continued to explain that the management team investigated the incident and determined Resident #325 exited the building from the exit door at the end of 400 hall because they found the door had been left unlocked.</p> <p>A review of Resident #325's progress note dated 04/23/24 at 9:56 PM written by Nurse #5 read wander guard placed to left ankle at this time. Checked the device to make sure it was working properly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/13/24 at 11:45 AM during an interview with Nurse #5, the Nurse explained that he was at the nursing desk with Nurse #4 when NA #3 called to the desk that a resident was outside in the parking lot. When he and Nurse #4 got to the service hall NA #2 was bringing Resident #325 back into the building. They put her in a wheelchair and took her to her room where Nurse #4 did a head-to-toe assessment to determine if there were any injuries on her and there were no injuries on the Resident. Nurse #5 continued to explain that the management team was notified of the Resident exiting the facility and soon after the management team arrived at the facility. The Nurse stated he applied a wander guard bracelet on Resident #325's left ankle and made sure the device was working properly. He reported they conducted a resident head count to make sure all the residents were accounted for, then they started an investigation to determine how Resident #325 got out of the facility. When they checked all the exit doors to ensure they were locked they found that the exit door at the end of 400 hall was unlocked therefore they determined Resident #325 left out of that door. Nurse #5 described Resident #325 as being pleasantly confused and liked to piddle around in her room or near her room but that he had not known of her having exit seeking behaviors.</p> <p>On 05/13/24 at 1:29 PM during an interview with the Maintenance Supervisor (MS) the Supervisor stated that on the evening of 04/23/24 he was called back to the facility because Resident #325 was discovered outside the building. He explained that he completed an investigation of all the exit doors and found that the exit door at the end of 400 hall where the Resident resided was unlocked. He continued to explain that the power to the exit door was turned off and the switch was in the off position. He continued to explain that you must have a key to unlock the door and the key was in the unlocked position as well. The MS reported that the only time the door was unlocked was for deliveries and the oxygen company delivered oxygen supplies earlier that same day and he was the one who unlocked the door for the delivery. The MS stated he stayed at the door during the delivery and made sure he locked the door after the delivery was complete. The MS continued that the door had a screamer alarm and when the cover was raised it should have made a loud sounding alarm, but no staff admitted to hearing an alarm during the evening shift. The MS explained in response to the incident he made two rounds every day on all the exit doors to ensure the doors were locked and when he was not at the facility the weekend office staff made the rounds in his place. He also added the facility was in the process of installing cameras throughout the facility as well.</p> <p>An interview was conducted with the Wound Nurse on 05/13/24 at 1:05 PM. She explained that the management team was called back to the facility on the evening of 04/23/34 because Resident #325 had gotten out of the facility unsupervised. It was determined that she exited the facility from the exit door at the end of 400 hall because the door was not locked. The Nurse stated she conducted a head-to-toe assessment on Resident #325 when she returned to the facility and found no indication of injuries that she could have attained through a fall or injury.</p> <p>Interviews were conducted with the Nurse Practitioner (NP) on 05/13/24 at 12:23 PM and 3:26 PM. The NP explained that Resident #325 had a history of a brain bleed (CVA) that left her cognition impaired, but she was physically getting stronger with her ambulation. She continued that she was notified by the facility the evening of 04/23/24 that Resident #325 exited from the building, and she visited the Resident the next day. The NP performed a thorough assessment on the Resident and found no skin tears or injuries. The facility conducted a complete resident count and checked the exit doors and wander guards. They moved Resident #325 to the locked unit shortly after that. The NP stated that because of her history and poor safety awareness Resident #325 was not cognitively safe to be outside on her own.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Medical Director (MD) on 05/14/24 at 12:23 PM. The MD explained that Resident #325 had a history of spontaneous brain hemorrhage which left her cognition compromised but she was progressing slowly physically with skilled therapies. He continued that he saw the Resident during his rounds on the Tuesday (04/23/24) and Thursday (04/18/24) prior to the incident and found her to be as her normal behavior of walking from chair to chair. The MD reported that he was notified the evening of the incident and was informed that they would be moving Resident #325 to the locked unit on 300 hall which he stated was more appropriate for her.</p> <p>A review of Resident #325's progress note dated 04/26/24 at 4:23 PM written by the Director of Nursing read interdisciplinary team (IDT) meeting held to discuss Resident ambulating outside. The Resident was moved to 300 hall locked unit and a wander guard bracelet was applied. The Resident has adjusted well and seems to like her new room. No further concerns at this time.</p> <p>An interview was conducted with the Director of Nursing (DON) on 05/13/24 at 2:18 PM. The DON explained that Resident #325 was alert but confused and mainly piddled around in her room which was nothing out of the ordinary. She was not on their radar of wandering. The DON continued that on the evening of 04/23/24 she was notified by Nurse #5 that Resident #325 was found outside of the facility in the back parking lot and was brought back inside the building. She explained that she instructed them to do a head-to-toe assessment on the Resident and do a resident head count to ensure all the residents were accounted for. The DON stated that by the time she arrived at the facility Nurse #4 or Nurse #5 had discovered that the exit door at the end of 400 hall was unlocked and locked it back. She reported that by that time most of the management team was at the facility, and she instructed the Wound Nurse to conduct another head-to-toe skin assessment on Resident #325 and found nothing. The DON explained that at that time they conducted a reenactment of the situation and had NA #2 and both Nurses #4 and #5 walk them through the entire situation and it was determined that Resident #325 left the facility out of the unlocked exit door at the end of 400 hall since that was the only exit door found unlocked. The DON reported the last time the 400 hall exit door was known to be used was earlier in the day when the Maintenance Supervisor unlocked it for the oxygen company to deliver the oxygen. She stated the Maintenance Supervisor insisted that he locked the door back but there was no other explanation as to why the door was unlocked since the door required a key and a code to unlock the door. The DON stated she had Nurse #5 place a wander guard bracelet on Resident #325, and she called the Resident's family member and explained the situation to them. She informed the family member of the situation and that they had placed a wander guard bracelet on the Resident and that they wanted to move her to the locked unit for her protection which they did move the Resident to the unlocked unit. The DON reported that she notified the Nurse Practitioner that evening. The DON added that the facility was in the process of installing cameras facility wide for surveillance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Administrator on 05/13/24 at 2:50 PM. The Administrator explained that she was notified of Resident #325's elopement by the DON on the evening of 04/23/24 and had the management team return to the facility for the investigation. She continued to explain that through a reenactment with the staff involved they determined the Resident left the building through the exit door at the end of 400 hall which was found unlocked at the time of the incident. She reported at that time the only time the exit door was used was when the oxygen company delivered oxygen once a week and they happened to deliver oxygen earlier that same day as the elopement. She stated the only explanation was that the door had mistakenly been left unlocked. The Administrator reported to ensure Resident #325's safety they placed a wander guard bracelet on her and moved her to the locked unit. The Administrator continued to explain that the facility developed a plan of correction that included the exit door at the end of 400 hall was not used for anything including the oxygen company delivery and that all deliveries had to go through the front main entrance.</p> <p>The facility provided the following corrective action plan with the completion date of 04/25/24.</p> <p>All items listed on this self-imposed action plan were complete and implemented on 04/23/24 with ongoing monitoring to ensure compliance. This includes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 04/25/24.</p> <p>The facility identified concerns regarding Resident #325 exited side door and observed in the parking lot by staff and</p> <p>returned to the facility without issue on 04/23/24.</p> <p>CORRECTIVE ACTION THAT WILL BE ACCOMPLISHED:</p> <p>On 04/23/24 Resident #325 was assisted into the facility by CNA and assessed by licensed nurse with no injury noted.</p> <p>On 04/23/24 licensed nurse notified responsible party and medical provider of incident.</p> <p>On 04/23/24 Resident #325's elopement assessment was updated by licensed nurse to reflect current wandering behaviors.</p> <p>On 04/23/24 an order for wander guard device obtained from provider by licensed nurse and applied to the Resident. On 04/23/24 the Resident's photograph was placed in the Elopement risk book at the front desk and nurses' station.</p> <p>On 04/23/24 the Resident's care plan was updated by licensed nurse to reflect new orders and new behaviors.</p> <p>On 04/23/24 all exit doors were checked by the Maintenance Director to validate that doors were functioning/locked/alarming properly with any unlocked / non alarmed door reset to ensure proper locking and alarming.</p> <p>On 04/23/24 Administrator educated the Maintenance Director on assurance of locking/alarming doors after any vendor enters the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>IDENTIFICATION OF OTHER RESIDENTS:</p> <p>On 04/23/24 licensed nurses conducted a 100% audit of current residents to validate all residents were accounted for. All residents were present and accounted for.</p> <p>On 04/23/24 licensed nurses reviewed wandering assessments for all current residents to ensure appropriate interventions are in place for those residents identified as a wandering risk. No one was out of compliance, but we did identify a resident who had a change of status, and we placed a wander guard bracelet on her.</p> <p>On 04/23/24 the licensed nurses conducted an audit of residents identified with wander guard bracelets to validate that the bracelets were in place and functioning.</p> <p>MEASURES FOR SYSTEMIC CHANGE:</p> <p>The process to address residents identified with new behavior of wandering or exit seeking was updated to include Educated all staff to notify management if a resident begins to have new behaviors of wandering or exit seeking. When management is notified, a new assessment will be completed to determine if a wander guard needed to be initiated. Process to address all doors checked whenever vendor enters/exits to ensure locked, and alarm activated: Maintenance Director was educated by the Nursing Home Administrator on 04/23/24 regarding validation of exit door lock and alarm after use and routine checks twice daily on all exit door locks and alarms. The Administrator will appoint another Department Head if the Maintenance Director is absent/vacation and the weekend receptionist responsible for doing checks on weekends.</p> <p>Director and/or Administrator completed education for all staff on or before 04/24/24 regarding identification of and response to residents with exit seeking behaviors, missing residents and process to check that doors are properly secured. Education will be provided for all new hires in orientation.</p> <p>HOW CORRECTIVE ACTION WILL BE MONITORED:</p> <p>The decision to formulate how the corrective action will be monitored was made on 04/23/24. The Director of Nursing and or the Administrator will review progress, wandering assessments and 24-hour reports 5 days a week times 4 then 3 times a week for 2 months to identify residents with wandering or exit seeking behaviors and validate that appropriate interventions are initiated. The Administrator will audit the exit door securement logs five days a week for four weeks and then weekly for eight weeks to ensure twice daily checks completed.</p> <p>The Administrator and or Director of Nursing will review the audit to identify patterns and trends and will adjust the plan to maintain compliance.</p> <p>The Administrator and or Director of Nursing and interdisciplinary team inclusive of Medial Director and or the Nurse Practitioner held an ad hoc QAPI to review incident and root cause analysis in its entirety with proposed plan of correction interventions.</p> <p>The Administrator or Director of Nursing will review the plan during the monthly QAPI meeting, and the audits will continue at the direction of the QAPI committee.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Validation Statement: During the recertification and complaint survey investigation the facility provided information through observations and interviews from staff to support the facility conducted a 100 % audit of resident census on 04/23/24 after Resident #325 was discovered outside the building in the back parking lot. The facility also provided information such as exit door audits twice a day, 100% facility wide education to current employees and new hires on the new process, the elopement risk assessments and the updated elopement notebook and the clinical morning meeting of discussion of the information and audits conducted. The completion date of 04/25/24 was validated.</p>		