

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345370	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Pinehurst Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  300 Blake Boulevard Pinehurst, NC 28374	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33778</b></p> <p>Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to provide effective supervision for a cognitively impaired resident when Resident #1 left the facility through the locked main entrance door. The resident was outside without staff knowledge for approximately twenty minutes and the staff found her sitting in her wheelchair between the covered main entrance and the first parked car in the parking lot. Resident #1 was assessed with no injuries noted. This deficient practice was identified for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia with mood disturbance, anxiety disorder, and brain cancer.</p> <p>Review of the significant changes Minimum Data Set (MDS) assessment, dated 1/31/25, revealed Resident #1 had severe cognitive impairment, and wandering behaviors were indicated to occur daily. The MDS also indicated Resident #1 was non-ambulatory and used a wheelchair.</p> <p>Review of the physician's orders for Resident #1, dated 1/4/25, revealed the order to check the wanderguard bracelet is on every shift and a wanderguard battery check every day shift.</p> <p>Review of the recent wandering assessment, dated 4/23/25, revealed that Resident #1 was at high risk for elopement.</p> <p>Review of the plan of care, dated 4/24/25, revealed Resident #1 was a wanderer and at risk for elopement due to wandering and exit-seeking behavior, with a goal to minimize risks for elopement through current interventions over the next 90 days. Interventions included the wanderguard placement to her left ankle, redirection away from exits as needed, and notifying the Director of Nursing (DON) of exit-seeking behaviors.</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>On 5/8/25 at 2:15 PM, during an interview, Nurse Aide #1 indicated that on 5/3/25, approximately at 11:55 AM, she went to her car in the parking lot. She found Resident #1 between the main entrance and the first parked vehicle. The resident was in her wheelchair, in a good mood, smiling, and could not explain why and how she went outside of the facility. Nurse Aide #1 did not observe a wanderguard bracelet on the resident. Nurse Aide #1 pushed the resident in the wheelchair back to the facility and notified Nurse #1.</p> <p>Review of the nurses' notes provided by Nurse #1, dated 5/3/25 at 2:36 PM, revealed that Resident #1 was observed in a front parking lot with no wanderguard bracelet. The resident was returned to the facility immediately, assessed, and no injuries were noted. The resident remained in bed until the new wanderguard applied.</p> <p>Review of the written statement, provided by Nurse #1, dated 5/3/25, indicated that on 5/3/25 (no time was documented), Resident #1 was noted outside the facility and immediately returned to the facility. She did not have her wanderguard on. The new wanderguard was applied and checked for efficiency. The physician on call and family were notified.</p> <p>During a phone interview on 5/7/25 at 11:40 AM Nurse #1 indicated that on 5/3/25, she was assigned to Resident #1 on the 7:00 AM to 7:00 PM shift. Nurse #1 was aware of Resident #1's elopement risk, but became busy and did not check the placement of the wanderguard at the beginning of her shift on 5/3/25. At approximately at 11:40 AM Nurse #1 observed Resident #1 in the middle of the hallway, and the resident was at her baseline behavior, self-propelling in the hallway. At approximately 12:00 PM, Nurse Aide #1 brought Resident #1 in the wheelchair to the nurses' station, and she reported that she found the resident unattended in the parking lot without a wanderguard bracelet. Nurse #1 indicated Resident #1 was assessed and had no injuries, was not in distress, and did not have her wanderguard bracelet on. Resident #1 could not explain how she left the facility or where she went. The interview further revealed Resident #1 remained in her room for about thirty minutes until the new wanderguard was applied to her left ankle and checked for functionality. Nurse #1 stated she notified Nurse 2, Nurse Supervisor, the provider on call, and the family member.</p> <p>An interview with Nurse #2 (Nurse Supervisor) on 5/7/25 at 11:50 AM revealed that after 12:00 PM on 5/3/25 Nurse #1 reported that Resident #1 was found unattended in front of the main entrance. She was not wearing her wanderguard bracelet. Together with Nurse #1, Nurse #2 assessed the resident and did not find injuries. The resident was not in distress and could not explain where she went when leaving the facility. Nurse #2 stated a new wanderguard bracelet was applied to the resident's left ankle.</p> <p>On 5/7/25 at 11:55 AM, during the phone interview, Nurse Aide (NA) #2 indicated that she was assigned to Resident #1 on 5/3/25 for the 7:00 AM to 3:00 PM shift. The resident always wore her wanderguard, but Nurse Aide #2 could not remember if she had the wanderguard on her ankle on 5/3/25. NA #2 indicated at approximately at 11:30 AM she provided incontinence care for Resident #1, placed her in the wheelchair, and observed Resident #1 self-propelling in the hallway. NA #2 stated she was in other residents' rooms and did not witness how Resident #1 left the building. NA #2 indicated she learned about the incident after 2:00 PM.</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 5/7/25 at 12:20 PM, during an interview, Nurse Practitioner (NP #1) expected the staff to check the wanderguard placement and functioning according to the order. At the time of the incident with Resident #1, the staff assessed her for injury, placed the new wanderguard, and notified the provider and family.</p> <p>On 5/7/25 at 12:35 PM, during an interview and observation of the facility's wanderguard system, completed with the Maintenance Director, he indicated that the front lobby door was locked automatically every day from 8:00 PM to 7:00 AM, and a code was needed to unlock the keypad and open the door. He continued that during the day, there was a receptionist that monitored the door to keep the residents from wandering outside. He demonstrated that when a person wearing a wanderguard got within approximately 7 feet of the exit door or closer, the alarm would chirp loudly, and it would automatically lock. The Maintenance Director mentioned that the facility and the parking lot are located far from the highway, on a street with no traffic except visitors to the facility.</p> <p>Receptionist #1 was interviewed on 5/7/25 at 1:10 PM and indicated that she was responsible for preventing residents with wanderguards from exiting the building. She worked Monday through Friday, and when Resident #1 left the facility on Saturday, she was not in the building. Another receptionist worked on weekends from 4:00 PM to 8:00 PM and the main lobby exit door was locked if nobody was at the front desk. Receptionist #1 said she checked the elopement book on the front desk daily to ensure nobody had left or had been added to the list. Receptionist #1 stated Resident #1 was in the elopement book, with her name, room number, serial number of the wanderguard, and an expiration date. Resident #1 was not allowed to go outside without supervision. Receptionist #1 mentioned that she usually tried to distract the residents from setting off the alarm and got them away from the door.</p> <p>On 5/8/25 at 1:15 PM an observation of the parking lot revealed it was enclosed by a fence and a stretch of woods, which separated the facility from the surrounding area. There was one driveway that provided access in and out with slow traffic of occasional vehicles. On the left and right sides of the main entrance, there were several parked cars in designated spaces.</p> <p>An observation and interview with Resident #1 on 5/7/25 at 2:10 AM revealed Resident #1 was in her wheelchair in the middle of the hallway. She had her wanderguard on the left ankle. The resident indicated that she did not leave the facility last weekend.</p> <p>An interview with the Director of Nursing (DON) on 5/8/25 at 10:20 PM revealed that over the last two weeks Resident #1 was in the hospital Emergency Department twice for an evaluation. At the time of the transfer to the hospital, the wanderguard was removed and reapplied at return to the facility. On 4/30/25, since Resident #1 returned from the hospital, the staff observed her with the wanderguard on. The DON indicated it was unclear why Resident #1 was not wearing a wanderguard bracelet on 5/3/25. When this was determined, the nurses immediately replaced it with the new wanderguard bracelet. DON confirmed that all the staff were responsible for monitoring residents with the wanderguard to prevent them from leaving the building unattended.</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>The Administrator indicated during an interview on 5/8/25 at 12:45 PM he expected staff to check the wanderguard placement and functionality as ordered. He indicated that the facility employed a receptionist who worked Monday through Friday from 8:00 AM to 4:30 PM and another who usually worked from 4:30 PM to 8:00 PM. The incident with Resident #1 occurred on the weekend. At the time of the incident, there was no weekend receptionist at the front door. The Administrator mentioned that it was everyone's responsibility to monitor the front door and respond if a wanderguard alarm was going off, preventing residents with wanderguards from exiting the building.</p> <p>The facility provided the following Corrective Action Plan.</p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 05/03/2025, it was discovered that the Resident #1 exited the facility without staff escort or authorization. Resident #1 was identified as a wander risk and was assigned a wander guard transmitter. The Health Information Manager (HIM) staff previously identified that the wander guard transmitter was in place. Resident #1 was observed by Certified Nursing Assistant (CNA) #1 outside in the parking area adjacent to the front door of the facility at 12:05 PM who immediately assisted Resident #1 to safely return to the facility. Upon return to the facility the wander guard transmitter was not present on the resident. At the time of the event Nurse #1 had not confirmed placement of the wanderguard for her shift and it is unclear whether the resident was wearing her assigned wanderguard transmitter.</p> <p>On 05/03/2025, The Resident #1 was placed on 1:1 monitoring until a wanderguard was placed and staff ensured there were no exit seeking behaviors. Nurse #1 completed a total body assessment to identify any injury and there were no injuries observed. On 05/03/2025, the Director of Nursing (DON) completed a risk assessment that includes a wandering risk scale. The risk assessment identified that Resident #1 as at risk for wandering. On 05/03/2025, the Provider and Responsible Party were both notified of the event by Nurse #1. The DON also talked with the responsible party on 05/03/2025 to discuss the event. The Nurse Consultant reviewed the care plan to ensure it reflected the wandering risk, which it did. The wander guard was placed by the Treatment Nurse on 05/03/2025 to the left ankle. On 05/03/2025, the DON validated that Resident #1's picture was in the facility elopement risk book.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>On 05/05/2025 a 100% audit/search was initiated and completed by the DON and the Licensed Practical Nurse (LPN) Support Nurse to assure all current residents were present and accounted for on the premises. The results included: All 116 current residents were accounted for.</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 05/05/2025, the Nurse Consultant reviewed the current residents admitted since 04/08/2025 to ensure that each resident had a risk assessment that would be completed and if the risk assessment indicated risk to wander that a wander guard was placed, and order for wander guard was entered into the Electronic Medical Record, and that a care plan was initiated for wandering risk if not already in place. This was completed on 05/05/2025. The results indicated that 3 residents required a risk assessment to be completed, the risk assessments had previously been started and not finalized. A corrective action was completed on 05/06/2025 when the risk assessments were completed for the 3 residents who required a risk assessment to be completed. None of the 3 residents who required a risk assessment to be completed triggered as being at risk for wandering therefore no interventions were required.</p> <p>On 05/05/2025, the DON, LPN Support Nurse, Nurse Consultant, and Social Services (SS) Director began identification of residents that were potentially impacted by this practice by completing an audit of all current residents at risk for elopement. This was accomplished by reviewing residents' risk assessment scores (9 &amp; above indicating high risk) to ensure a care plan was in place. This was completed on 05/05/2025. The results included: There were 6 care plans that were required to be initiated or updated. On 05/05/2025 a corrective action was initiated by the SS Director to add or update the plan of care to include risk for wandering.</p> <p>On 05/05/2025, the HIM completed a review of all residents with current wander guard orders. This audit consisted of a review to ensure the wander guard was physically in place and functioning by testing each wander guard. The serial numbers and expiration date of each wander guard was reviewed and updated on the facility elopement risk book for each resident. This was completed on: 05/05/2025. The results included: One resident required her wander guard to be replaced due to the battery functioning and reading battery level was low. One resident was added to the wander guard list. Corrective action was completed on 05/05/2025 when wander guards were placed for these residents, orders were validated, and care plan was updated. The DON or designee will be responsible for checking the wander guard and wander guard battery expiration date including updating the elopement risk book with any new residents identified as a wandering risk.</p> <p>On 05/05/2025, the DON, LPN Support Nurse, Nurse Consultant, and SS audited the facility elopement risk book to ensure all moderate and high-risk residents had a current picture/face sheet in the facility elopement risk book identifying their risk for elopement and the serial number and expiration date of the wander guard. This was completed on 05/05/2025. The results included: All current residents with orders for wander guards had a picture and the serial number and expiration date in place. New residents who had wander guards initiated were also added to the facility elopement risk book.</p> <p>On 05/03/2025 and 05/04/2025, the Maintenance Director completed an audit of the wander guard system doors to ensure appropriate functioning. The results included: All wander guard doors were functioning properly.</p> <p>As of 05/05/2025 all of the above areas related to the elopement process were in compliance.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>On 05/03/2025, the DON or designee began in-servicing of all staff (full time, part time, including agency) from all departments (department directors, nursing, environmental, and dietary) on Elopement Prevention and Management to include:</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>	<ul style="list-style-type: none"> <li>- Elopement Prevention Response</li> <li>- How to identify residents at risk for elopement</li> <li>- What are exit seeking behaviors</li> <li>- What do we do for residents that are high risk for elopement</li> <li>- What else can we do for residents that are high risk</li> <li>- What should we do if the wanderguard system alarm sounds</li> <li>- What to do if a resident is missing</li> </ul> <p>During this training staff were educated on the importance of monitoring and supervising residents who may be at risk for elopement or wandering. This monitoring should include the identification of exit seeking behaviors such as sitting for long periods of time at the doors, packing clothes, trying to open the doors/windows and other activities that involve trying to leave the facility and verbalizing that they want to leave or are going to leave. They were also educated on techniques to implement if exit seeking behaviors are identified. This may include 1:1 supervision, monitoring more frequently, redirecting residents, addressing physical causes such as toileting, hunger, thirst, and/or pain, and activities, as well as appropriate functioning of the wander guard system and immediate notification of the Administrator of any concerns related to functioning of the wander guard system.</p> <p>Additionally, the Quality Assurance (QA) Committee whose members include: Administrator, Director of Nursing, MDS Coordinator, Therapy, HIM, and Dietary Manager discussed adding an additional layer of safety by having the department directors to monitor the wander guards for functioning and wander guard doors for functioning at a frequency agreed upon. At this time the frequency will be daily and will be validated in daily stand up meeting. Any changes to the frequency will go through the QA Committee.</p> <p>As of 05/06/2025, the DON will ensure that any of the above identified staff who does not complete the in-service training will not be allowed to work until the training is completed. The DON or designee will ensure this education is reviewed for all new hires during general orientation.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>Include dates when corrective action will be completed.</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>Beginning on 05/05/2025 the DON or designee will monitor this issue using the Elopement Risk Process Quality Assurance Tools for compliance with the elopement process to include that a risk assessment is completed and if wandering risk is identified that a wander guard is physically in place, that the wanderguard is functioning, that an order for a wanderguard is entered into the Electronic Medical Record (EMR), and that a care plan is in place for the wandering risk. This will be completed weekly times 3 weeks beginning on 05/05/2025 then monthly times 2 months or until resolved by QA Committee. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action was initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, HIM, and Dietary Manager.</p> <p>Compliance Date: 05/06/2025</p> <p>The Corrective Action plan was validated onsite on 5/8/25 when staff interviews revealed they had recently received education on Elopement Prevention and Management. In-service reports and sign-in sheets were used to verify this information. The facility provided the audit tools to ensure all current residents were present and accounted for on the premises. The audit tools for all current residents at risk of elopement were reviewed. This audit consisted of a review to ensure the wanderguard was physically in place and functioning by testing each wanderguard. Review of the documents, provided by the facility revealed the audit to make sure the facility elopement risk book to ensure all moderate and high-risk residents have a current picture/face sheet in the facility elopement risk book identifying their risk of elopement and the serial number and expiration date of the wanderguard. The audit, completed by the Maintenance Director, of the wanderguard system doors to ensure appropriate functioning. Multiple staff interviews revealed they could verbalize education training provided in reference to the Elopement Prevention and Management process.</p> <p>The facility's completion date of 5/6/25 for the Corrective Action plan was validated on 5/8/25.</p>		