STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495366	A. BUILDING _____ B. WING _____	C 02/11/2021

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LAKE PRINCE WOODS, INC	100 ANNA GOODE WAY SUFFOLK, VA 23434

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E 000	Initial Comments An unannounced Medicaid/Medicare abbreviated survey was conducted on 02/09/21 through 02/10/21. Two complaints were investigated: VA 00050447 was substantiated with a deficiency, VA00049351 was substantiated with no deficiency. No corrections are required for Emergency Preparedness compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 40 bed facility was 21 at the time of the survey. The survey sample consisted of 3 current resident reviews (Residents #1 through #3) and two closed record (Residents #4 and #5).	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 02/09/21 through 02/11/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey: VA00050447 was substantiated without deficiencies; VA00049351 was substantiated with deficiency. The census in this 40 certified bed facility was 21 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3) and 2 closed record reviews (Residents #4 through #5).	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		2/25/21

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

Electronically Signed | 02/25/2021

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F 689	Continued From page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, observations, clinical record review, staff and resident interviews and facility document reviews, the facility staff failed to ensure supervision and safety measures were in place to include a consistent functioning wander-guard system, as well as engagement of the back-up door alarm to prevent elopement for 1 or 5 residents (Resident #1) in the survey sample. The findings include: Resident #1 was admitted to the nursing facility on 3/4/20 with diagnoses that included dementia, abnormal gait and mobility, difficulty walking and insomnia. The Admission Minimum Data Set (MDS) assessment dated 3/11/20 coded the resident with a score of 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the necessary skills for daily decision making. Resident #1 was assessed with the ability to sometimes understand staff and was sometimes understood by them. The resident was coded to have wandering behavior, but no other behavior symptoms (physical, verbal) directed towards others. The resident was assessed to require supervision while ambulating on and off the unit without any assistive mobility devices. No falls or	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

fractures were recorded within the last 6 months prior to admission to the nursing facility. This assessment coded the resident with muscle weakness, difficulty walking and lacked safety awareness. The resident was also assessed with cellulitis of left lower extremity and localized edema. The reason for Resident #1's admission from assisted living home care to the nursing facility was due to a significant change in functional status and cognitive decline with an inability to manage his self-care and his significant other's care.

The MDS assessment dated 8/31/20 was a quarterly and coded the resident with a score of 8 out of a possible score of 15 on the BIMS which was a decline from the previous assessment (10), but still moderately impaired in the skills for daily decision making. The resident was assessed to continue wandering behavior. Resident #1 was coded for one fall and one fall with minor injury since admission of prior assessment. The resident was assessed to continue to require supervision while ambulating on and off the unit without any assistive mobility devices.

The MDS assessment dated 11/30/20 was a quarterly and coded the resident with a score of 8 out of a possible score of 15 on the BIMS which indicated he was still moderately impaired in the skills for daily decision making. The resident was assessed to continue wandering behavior, requiring supervision while ambulating on and off the unit without any assistive mobility devices. This assessment did not code the resident for any previous falls.

Two elopement risk assessments were reviewed: 3/4/20=0, no elopement risk. 3/5/20=9, very high

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F 689	Continued From page 3 risk if 6 or higher. The care plan with a date range of 3/4/20 through 11/1/20 identified the resident was at risk for falls and experience an actual fall (no injury) on 3/12/20 related to not locking his significant other's wheelchair before sitting in it. Another fall was noted on 6/15/20 (no injury). The care plan also identified a fall on 7/23/20 with injury (scratch) to left side of his nose. Resident #1 was care planned for risk of skin integrity problems with actual skin tears identified on the care plan. The resident was identified at risk for bleeding due to anticoagulant therapy. The care plan identified that the resident demonstrated wandering exit seeking behaviors. The goal set by the staff for the resident was that he would demonstrate no exit seeking and minimal wandering/behaviors will be verbally directed by the staff through next review. Some of the interventions by the staff to accomplish this goal included engage him in activities of interest and one to one interaction to stimulate mood, socialization, have him verbalize his feelings and needs, offer snacks or activities of interest as a distraction from unwanted behaviors, as well as placement of a wander-guard to left ankle as ordered. The care plan with a date range of 11/2/20 through 2/9/21 continue to identify the resident for wandering behaviors and elopement, as well as at risk for falls, skin integrity problems and bleeding due to anticoagulant therapy. The care plan identified that Resident #1 exited the building and went to the sidewalk on community campus searching for his wife and had a history of exit seeking behavior.	F 689		

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F 689	Continued From page 4 The nurse's notes dated 11/15/20 8:16 a.m. entered by Licensed Practical Nurse (LPN) #2 indicated "upon arrival of the staff of oncoming shift, resident was found in the parking lot of the facility having left through the courtyard door. Wander-guard was in place and emergency alarm was sounding. Resident was escorted back onto the unit and given a snack. He is currently sitting in lounge area of unit. Courtyard door has been armed to prevent further episodes. Resident says he was looking for his wife. Close visual monitoring continues." On 2/9/21 at 10:50 a.m. LPN #1, stated although she was not present, she was aware of Resident #1's elopement on 11/15/20 and the entire staff received in-service on ensuring the back-up alarm on the courtyard was activated, as well as shift checks of the functioning of the wander-guard device/roam alert and that it was in place. She demonstrated the wander-guard system by escorting the resident toward the courtyard door, and once in the vicinity of the keypad (about 2 feet) a chirping sound is activated that can be heard at the keypad and nurse's station and a red light in the ceiling if lit. She stated the magnetic lock at the top of the door will then engage which will prevent the resident from opening the door. She stated, "The backup alarm (detex alarm) should be turned on with a key so if the wander-guard fails, that siren sound will go off after pressing on the bar of the door for 15 seconds, letting us know someone went out the door." LPN #1 also escorted the resident to the keypad at the entrance front hall of the unit in which the system activated, locked properly, preventing the resident from exiting the unit. The LPN stated shift checks are conducted of the placement of the resident's wander-guard	F 689		

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F 689	Continued From page 5	F 689		

and the alarm function checked weekly using a (brand name) machine. LPN #1 demonstrated with the machine that the wander-guard device on the resident's ankle was activated and functioning properly. The signed nurse entries on the Treatment Administration Record (TAR) reviewed from 2/1/20 to current 2/9/21 verified a functioning wander-guard ankle device.

On 2/9/21 at approximately 11:15 a.m., the Assistant Maintenance Director stated that at the time Resident #1 eloped from the facility, it was determined that the magnetic pieces did not line up correctly to lock the door which was tied into the wander-guard system, thus the door did not lock. He stated, "Plus, they had disengaged the back-up alarm panic bar system because they were having visitations outside in the courtyard, utilizing this door. They probably did not want that siren alarm going off each time they let a resident out to visit their families. So (resident #1's name) left out undetected by the nurses, at least that is what I was told."

On 2/9/21 at 4:00 p.m., the Maintenance Director basically stated the aforementioned information about the wander-guard system failure and disengagement of the back-up alarm at the time Resident #1 eloped from the facility. He stated on 11/17/20 he called a repair company to evaluate the door because the resident should not have been able to exit if the wander-guard system portion of the door, the magnetic lock at the top of the door functioned properly. The repair requisition dated 11/17/20 indicated a misalignment of the two magnetic bar connections on the door failed that directly links to the wander-guard keypad which gave the resident opportunity to exit. Repairs were made

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F 689	Continued From page 6	F 689		

to the magnetic bar. The Maintenance Director presented his annual inspection of the delayed egress was conducted on 12/13/19 and as recent as 1/14/21 in which lacking hardware operated properly. The weekly wander-guard "roam alert" checks were also presented for 10/2020 and on 11/13/20 that indicated a functioning system. Two days after 11/13/20, the roam alert failed. In addition, it had been determined that the back-up alarm (detex alarm) had been disengaged.

An interview was conducted with the Certified Nursing Assistant (CNA) #1 that found Resident #1 outside and escorted him back into the building on 11/15/20. She stated between 6:15 a.m. and 6:30 a.m., she saw Resident #1 at the bridge area that leads across the road into the assistive living area. She stated the resident was fully dressed with shoes on as she placed him in her truck and proceeded to park in the employee lot. She stated she brought the resident through the employee entrance into the back hallway and once she was near the wander-guard keypad, the resident's wander-guard began to chirp and activation of the red hall way ceiling light became visible. She stated she led the resident to the front hallway nurse's station to inform the 11:00 p.m. to 7:00 a.m. LPN (#2) the resident had been outside when she came to work.

On 2/10/15 at 5:15 p.m., a phone interview was conducted with LPN#2. The LPN stated Resident #1 had been walking the hallways all night long and she saw him, but could clearly see him when he was in front of the nurse's station in the common area. She said, "They have asked me over and over, when I last saw him. I know the CNA brought him to the nurse's station at the start of her 7:00 a.m. to 3:00 a.m. I can't give an

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F 689	Continued From page 7 exact time as to when I last saw him before he got out of the building." The two employees, social worker and activities, that assisted in scheduling visitations during 11/2020 were interviewed on 2/10/21 at 3:20 p.m. They stated visitations at the time were accessed at the end of the back hall through one of the outside doors that led to the courtyard. She stated based on the incident with Resident #1 exiting without detection by the staff, the visitation area was changed to the family room at the front of the facility. They presented evidence that the last visitation prior to the elopement incident was on 11/12/20, which may have indicated the back-up alarm was not engaged from 11/12/20, Resident #1 eloped from that specific exit door undetected outside into the courtyard area. On 2/9/21, at approximately 1:00 p.m., the Administrator had presented a Plan of Correction (POC) dated 11/15/20 that addressed the failure of wander-guard and the detex alarm. This POC was reviewed along with additional facility documentation that detailed the following: Problem-Resident's wander-guard failed to auto lock the door when the wander-guard was near. Staff had been using this exit door for outdoor visitation. How corrective action would be accomplished for those residents found to have been affected by the undesired outcome-Resident #1 was the only resident in the facility with a wander-guard and the only resident with exit seeking behaviors. The wander-guard system was checked to include the ankle bracelet, keypad and door mechanisms, which activated and locked and the 15 second	F 689		

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F 689	Continued From page 8 panic bar was activated. Plant operation staff reviewed the process with this incident and found something in the door mechanism is allowing the door to be opened with the wander-guard on then when it is closed, the second attempt will not allow the door to open. The company who maintains the system was contacted to come on site and figure out problems with the systems due to intermittent failure of the wander-guard door lock mechanism. The company came out to assess the problem on 11/17/20. The repair requisition dated 11/17/20 indicated a misalignment of the two magnetic bar connections on the door failed that directly links to the wander-guard keypad which gave the resident opportunity to exit. Repairs were made to the magnetic bar. Back exit door was checked every 2 hours (verified through review of the logs and signatures, 11/15/20 through 11/30/20), as well as resident checks every 20 minutes (verified through review of the logs and signatures from 11/15/20 through 11/30/20). Wandering and Elopement Essentials education was reviewed as completed for all facility nursing staff, as well as caring for persons with dementia. Based on review of the aforementioned POC, resident observations, staff interviews, facility documentation (door repairs, staff education, supervision logs and door check logs), as well as no further Resident #1 elopements, it was determined the facility was in substantial compliance for the deficient practice, thus no POC is required.	F 689		

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F 689	Continued From page 9 Complaint Deficiency (Past Non-Compliance)	F 689		