STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL021008	A. BUILDING: _____ B. WING _____	R 11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDENTON PRIME TIME RETIREMENT VILLAGE	105 MARK DRIVE EDENTON, NC 27932

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 (#6) of 3 sampled residents requiring supervision. The findings are: Review of Resident #6's current FL-2 dated 5/06/14 revealed: -Diagnoses included increased blood pressure, osteoporosis, Degenerative Joint Disease (DJD) and Gastroesophageal reflux disease (GERD). Review of Resident #6's Resident Register revealed an admission date of 7/01/11. Review of Resident #6's current Care Plan dated 5/06/14 revealed: -Documented under the Social/Mental Health History was alert with confusion at times. -Documented under "Memory" was forgetful-needs reminders. Review of the Care Notes for Resident #6 revealed: -On 7/04/14 at 12:30 p.m., another resident came	D 270		

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in and stated Resident #6 and another resident were walking down the sidewalk. Residents were brought back to building and the residents were told that they could not be outside by themselves.
-On 7/30/14 (no time), "Resident's condition continues to go down. She is alert, but very confused. She gets upset often about bathing and changing her clothes and "threatened to leave."
-On 10/21/14 (no time), "very confused."
-On, 11/15/14 [Saturday] (7-3), Resident walked out of the building this afternoon to her physician's office. Stated she had an appointment with the doctor. The office was closed until Monday. Medication Technician escorted her back to the building unharmed.

Observation on 11/20/14 at 1:20 p.m. of the facility's exit doors revealed:
-The front entrance door was unlocked, and 2 beeps sounded as the door was opened and closed.
-An alarm was heard when all other exit doors were opened and closed.

Interview with the medication aide on 11/20/14 at 1:15 p.m. revealed:
-The front entrance door was unlocked between the hours of 7:00 a.m. and 5:30 p.m and 2 beeps sounded when the door was opened and closed.
-The evening hours may vary depending on the weather or the season of the year.
-The front entrance door was locked and alarmed between the hours of 5:30 p.m. and 7:00 a.m.
-All other exit doors except the front entrance entrance door were alarmed at all times.
-The other exit doors could not be assessed from the outside.

Observation on 11/20/14 at 3:00 p.m. of the route

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between the facility's premises and Resident #6's physician office revealed:
-Concrete sidewalk from the facility's entrance door to the length of the building.
-A small parking lot was observed in the front of the physician's office next to the building.
-The parking lot at the physician's office had spaces for 8 cars to park.
-The parking lot was the length of the physician's office.
-40 ft. was the distance between the facility's premises and the physician's office.
-The time to walk from the facility's premises to the physician's office was 1.5 minutes, per surveyor.

Interview with Resident #6 on 11/20/14 at 2:00 p.m. revealed:
-She walked to the doctor's office by herself, but she does not remember the date.
-It was important the doctor see my nose.
-She was allowed to walk out the facility's front entrance unsupervised, prior to her walking to her doctor's office unsupervised.
-After walking to her doctor's office unsupervised, she was not allowed to walk out the facility unsupervised.
-She just remembered staff telling her that she could not walk outside unsupervised, but does not recall why.
-No information on whether or not she walked on the mowed grassy area or driveway to get to her doctor's office.

Interview with Resident #6's family member on 11/20/14 at 9:51 a.m. revealed:
-She had been notified by a visitor that Resident #6 walked unsupervised to her physician's office on 11/15/14 between 2 p.m. and 3:00 p.m..
-The visitor was walking out the facility's front

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entrance door and saw Resident #6 walking on the sidewalk toward her doctor's office alone.
-The visitor alerted facility's staff that Resident #6 was walking toward her doctor's office.
-This was a small town and everybody knows everybody.
-Staff at the facility did not notify family member about Resident #6 walking to her doctor's office unsupervised on 11/15/14.
-The facility staff should have notified me that Resident #6 walked to the doctor's office unsupervised on 11/15/14.
-Resident #6 should have been supervised because she was unsteady on her feet, and she was confused at times.
-Resident #6 stated, "She went to her physician office to check about her nose."
-Resident #6 had forgotten that she went to the doctor on 11/12/14 to get her nose checked.
-Resident #6 "Knew enough to go to the doctor's office"
-This was the 1st time Resident #6 left the facility unsupervised.
-She requested a meeting with the facility's Resident Care Coordinator on 11/17/14 pertaining to Resident #6 walking to her doctor's office unsupervised and not being notified of the incidents.

Review of the physician's orders dated 11/12/14 revealed a biopsy was done on Resident #6's nose on 11/12/14.

Interview with the Resident Care Coordinator (RCC) on 11/20/14 at 11:00 a.m. revealed:
-She was not notified by the medication aide that Resident #6 walked unsupervised to her doctor's office on 11/15/14.
-She asked the medication aide if something happened over the weekend after Resident #6's

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family member requested a meeting with her on 11/17/14.
-The medication aide stated, "The resident walked to her doctor's office on 11/15/14 because she wanted her doctor to check her nose."
-The medication aide should have notified the resident's family member and Manager on call that Resident #6 walked to her physician office unsupervised.
-Prior to the incident on 11/15/14, Resident #6 was allowed to walk in the circle in front of the building unsupervised.
-Resident #6 had not required increased supervision, prior to 11/15/14.
-All residents were allowed to walk in the circle in front of the building unsupervised, prior to 11/15/14.
-After the incident on 11/15/14, Resident #6 had to be supervised outside of the facility.
-She was alert to person, place and disoriented to time.
-She had not notified Resident #6's physician that resident walked to his office unsupervised on 11/15/14.
-Staff was not told to increase monitoring for Resident #6 after she walked to her physician office unsupervised on 11/15/14.

Interview with a personal care aide on 11/20/14 at 11:30 a.m. revealed:
-She had been notified by the medication aide that Resident #6 walked to her doctor's office unsupervised around 2:00 p.m. on 11/15/14.
-Prior to the incident on 11/15/14, Resident #6 was allowed to walk in the circle in front of the building unsupervised.
-She had not been told that Resident #6 required increased supervision, prior to 11/15/14.
-After the incident on 11/15/14, Resident #6 had to be supervised outside of the facility.

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-She was not told to increase monitoring for Resident #6 after the resident walked to her doctor's office unsupervised.
-She continued to monitor Resident #6 every hour.
-Resident #6 was confused about "Where she is or what she is doing at times."

Interview with the medication aide on 11/20/14 at 12:10 p.m. revealed:
-A visitor was going out the facility's front entrance door, the visitor saw the back of Resident
#6's head, and the resident was walking on the sidewalk toward her doctor's office.
The visitor alerted the medication aide.
-The medication aide walked to Resident #6's physician's office and found Resident #6 standing alone in the empty parking lot.
-Resident #6 stated "She went to her doctor's office to get her nose checked because it was itching."
-Resident #6 had forgotten that she went to the doctor to get her nose checked on 11/12/14.
-She was unsure if she reported to the Manager on Call on 11/15/14 or 11/16/14 if Resident #6 walked to her doctor's office unsupervised.
-She had not notified Resident #6's family member or physician that resident walked to the physician's office unsupervised on 11/15/14.
-She did report the incident to 2nd shift medication aide on 11/15/14.
-Prior to the incident on 11/15/14, Resident #6 was allowed to walk in the circle in front of the building unsupervised.
-After the incident on 11/15/14, Resident #6 had to be supervised outside of the facility.
-She had not been told that Resident #6 required increased supervision, prior to 11/15/14.
-She was not told to increase monitoring after

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D 270	Continued From page 6 Resident #6 walked to her doctor's office unsupervised. Interview with the Manager on call (Business Office Manager) on 11/20/14 at 12:50 p.m. revealed: -She had not been notified by the medication aide that Resident #6 walked to her physician's office unsupervised on 11/15/14. -She was at the facility between the hours of 8:00 a.m. and 10:00 a.m. on 11/15/14 and between the hours of 12:00 p.m. and 2:00 p.m. on 11/16/14. -She should have been notified by the medication aide that Resident #6 walked to the physician office unsupervised. -She would have notified the Resident Care Coordinator and asked for advice. Interview with the Vice President Residential Communities on 11/20/14 at 1:05 p.m. revealed: -She was not aware Resident #6 walked to her physician's office unsupervised. -If she had known, Resident #6 would have been put on 1:1 and 15 minutes checks. -Prior to 11/15/14, Resident #6 had not been identified as requiring extra supervision, and she was allowed to walk in the circle in front of the building unsupervised. Resident #6's physician was unavailable by phone. _____ Review of the facility's plan of protection dated 12/5/14 revealed: -Effective 11/20/14, implementation of 15 minutes checks and documentation of supervision checks for any resident identified requiring supervision based on their assessed needs. -Staff was retrained on identifying and reporting	D 270		

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D 270	Continued From page 7 residents need of increased supervision. -A list of identified residents requiring supervision will be available to staff and updated as residents needs change. -This list will be done by the Resident Care Coordinator/Management Designee. -If an identified residents supervision needs required more than 15 minutes checks then 1:1 supervision will be implemented in additional to the scheduled staff on duty and or additional placement will be found if resident's supervision needs cannot be met within the facility. -Resident Care Coordinator/Management Designee will supervised and insure implementation of routine checks, monitoring devices and /or techniques according to the need of each resident per policy. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 4, 2015.	D 270		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision.	D912		

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D912	Continued From page 8 The findings are: Based on observations, record reviews and interviews, the facility failed to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 1 (#6) of 3 sampled residents requiring supervision. [Refer to Tag D 270 10A NCAC 13F .0901(b) (Type B Violation)]	D912		