Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060019	A. BUILDING: ______ B. WING ______	C 09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF CHARLOTTE	6000 PARK SOUTH DRIVE CHARLOTTE, NC 28210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a complaint investigation on 09/22/15 and 09/23/15. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 08/28/15.	D 000	Addendum: POC Approved following conversation with Amy Blalock on 11/06/15 @ 1:25pm. Latest date of correction for All non-compliance is 10/28/15.	
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 A2 VIOLATION Based on observation, interview, and record review the facility failed to assure adequate supervision for residents in the special care unit when the main exit door was unlocked resulting in 2 of 5 sampled residents (Resident #1 and Resident #3) eloping from the Special Care Unit (SCU) and facility. The findings are: Interview with the Administrator on 7/17/15 at 4:00 pm revealed: -The SCU main exit door had a 10 second delay upon door closure until locking mechanism engaged. -The policy for monitoring the SCU main exit door required a staff member inside the unit to wait	D 270		

"Reviewed + accepted c̄ Revisions" -- [signature] 11/06/15

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D 270	Continued From page 2 been placed on the SCU interior door. -He stated, "At one time, the SCU door locked and secured. For some reason the door had a few second delay before it locked again." -An outside contractor was in the SCU at that time to remove the egress from the interior SCU door so that the door would close and lock immediately. -Prior to the egress being removed, the SCU staff were to monitor the SCU door when someone came in or left the SCU unit. -This process was to assure the door locked and engaged without residents getting out of the unit. -Only the facility team members had the code to the SCU door. -All exit doors of the SCU were to be checked between shifts by Lead Care Manager. -The second shift Lead Care Manager was responsible for checking the SCU doors that lead to the gated courtyard and stairwells within the SCU. -He stated that when a resident in the SCU repeatedly banged on the interior door, it would open after approximately 110 seconds. -The policy was that the SCU staff were to monitor the door when the alarm sounded to prevent residents from getting out of the SCU. -The SCU staff were to remain at the SCU interior door until it locked and engaged prior to the egress being removed. -He was not in the facility at the time Resident #1 and Resident #3 eloped from the SCU on 09/11/15. -He recalled 2 different scenarios regarding Resident #1 and Resident #3 elopement from the SCU on 09/11/15. -The first scenario included Resident #1 and Resident #3 being found at the front desk in the AL lobby of the facility. -The second scenario included Resident #1 and	D 270		

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D 270	Continued From page 4 Based on observation, record review and staff interviews, it was determined Resident #1 was not interviewable. Interview with Resident #1's family member on 09/23/15 at 4:45pm revealed: -He was notified on 09/11/15 at 6:00pm that Resident #1 eloped from the SCU. -He stated Resident #1 had not eloped from the SCU prior to 09/11/15. b. Review of Resident #3's current FL-2 dated 08/11/15 revealed: -Diagnoses included dementia, diabetes, hypertension, anxiety, osteoarthritis, and glaucoma. -Resident #3 was oriented to person and place. -Resident #3 was intermittently oriented to time. -Resident #3 did not have a history of wandering. Review of Resident #3's Register revealed an admission date of 09/30/13 to the SCU. Review of Resident #3's Care Plan dated 03/12/15 revealed: -Direct care staff were "to give Resident #3 redirections and assurance when she exhibited wanting to go home." -Documentation revealed she was a "High Risk for Elopement." -Direct care staff were to perform frequent checks and monitor her whereabouts each day and night. -Resident #3 required assistance with memory and cognition. -Documentation noted Resident #3 as a "known wanderer." -Resident #3 was independent with ambulation. Review of facility's incident report dated 09/11/15 for Resident #3 revealed:	D 270		

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D 270	Continued From page 6 -She did not recall what time the door alarm was sounding but it was during dinner time which started at 5:00pm. -She reported that a SCU resident was redirected from the door area and the door alarm was reset. -She briefly looked out the main interior SCU door prior to resetting the alarm and did not see any residents in the vicinity. -She observed a resident's unattended walker near the main SCU door inside the SCU when the auditory alarm was sounding. -She did not have the SCU staff complete a head count at that time. -She received a call from front desk staff at approximately 5:30pm and learned that Resident #1 and Resident #3 were out of the SCU. -Resident #1 and Resident #3 were returned to the SCU via a CM in the SCU. -The SCU staff completed a head count at that time. -Vital sign checks were conducted and a physical observation of Resident #1 and Resident #3 was conducted. -Resident #1 and Resident #3 did not appear distressed or injured upon returning to the SCU. -She learned at 7:30pm on 9/11/15 that Resident #1 and Resident #3 had been returned to the front desk from outside the building by a concerned citizen. -She was not aware of which door in the AL that Resident #1 and Resident #3 used to get out of the AL unit. -She completed a facility incident report in accordance with the elopement policy as directed by the facility Administrator. -She had originally informed the Administrator that Resident #1 and Resident #3 were found outside the SCU at the front lobby of the facility. -She failed to update the Administrator regarding Resident #1 and Resident #3 being returned the	D 270		

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D 270	Continued From page 8 member at the facility's front desk on the Assisted Living (AL) side) on 09/23/15 at 4:00pm revealed: -She was responsible for monitoring the front door of the facility at all times while on duty. -When she had to leave the desk for breaks, she was to have someone monitor the front desk of the AL lobby until she returned. -She was not aware that Resident #1 and Resident #3 eloped from the SCU on 09/11/15 until both residents were brought to the front desk in the AL lobby. -She did not know which door in the AL unit Resident #1 and Resident #3 used to get out of the facility. -An unknown citizen entered the main facility door entrance on 09/11/15 at 5:45pm and stated, "I think I have something that belongs to you." -The unknown citizen had accompanied Resident #1 and Resident #3 back into the facility. -She failed to obtain contact information from the unknown citizen. -Neither Resident #1 nor Resident #3 were in distress. -She contacted the CM in the SCU regarding Resident #1 and Resident #3 being at the front desk. -The SCU staff retrieved Resident #1 and Resident #3 back to the SCU. Interview on 09/23/15 at 4:00 pm with a second CM in the SCU revealed: -She had worked at the facility for 2 weeks, and was not working when the two residents eloped. -She worked as a CM in the SCU on 2nd shift. -When a resident eloped from the SCU, the Lead Care Manager (LCM) would be notified. -A CM would go to the resident and stay with the resident and take the resident back to the SCU. Interview with a third CM on 09/23/15 at 4:20 pm	D 270		

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D 270	Continued From page 10 were each assisted to the bathroom and then to the dining room. -She was unaware if the residents had left the building or if they had been outside the building. -She did not know which door in the AL that Resident #1 and Resident #3 used to get out of the facility. Interview with the Administrator on 09/22/15 at 3:00pm revealed:	D 270		
	-She conducted an internal investigation regarding the elopement of Resident #1 and Resident #3. -She did not know why the Concierge failed to obtain the contact information for the unknown citizen that returned Resident #1 and Resident #3 to the facility. -She stated additional training would be provided to the Concierge staff related to resident elopement. -She had a conversation with the County Adult Home Specialist (AHS) prior to elopement of Resident #1 and Resident #3 regarding concerns for the egress electrical programming of the main SCU door. -The egress of the SCU door had a 10 second delay in the locking mechanism to engage. -She had submitted a work order request to remove the egress on 09/11/15. -She was unable to obtain authorization to modify the egress electrical programming on the main SCU door until 09/22/15. Interview with Administrator on 9/23/15 at 10:15 am revealed: -An email request was sent to the facility ' s IT department on 9/11/15 at 7:36pm requesting the removal of the egress function from the SCU main exit door. -On 9/16/15 at 10:47 am, she received			

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D 270	Continued From page 12 of the form. The form was signed by 2 staff members. -The 2 additional names handwritten on the bottom of the form were new resident in the SCU. -The computer generated sheet dated 09/08/15 was signed by one staff member, had the breakfast and lunch meals checked off and the spaces for the dinner meal were blank, no one had documented attendance for the dinner meal. Two additional names were handwritten on the bottom part of the form. -The computer generated sheet dated 09/09/15 had the breakfast and lunch meals checked off, no documented attendance for the dinner meal and was signed by a staff member. Two names were handwritten on the bottom of the page. -The computer generated sheet dated 09/10/15 was signed by a staff member, had the breakfast and lunch meals checked off, no documented attendance for the dinner meal and had 2 handwritten names on the bottom of the form. -The computer generated sheet dated 09/11/15 was signed by a staff member, had the attendance for the breakfast meal checked, no documented attendance for the lunch or the dinner meal and 3 additional handwritten names at the bottom of the form. -The computer generated sheet dated 09/12/15 had all three meals checked off for attendance, three handwritten names at the bottom of the form and was signed by a staff member. -The computer generated sheet dated 09/13/15 was signed by a staff member, had all 3 meals checked off for attendance and had 3 handwritten names at the bottom of the form. Interview on 09/23/15 at 4:50 pm with the Administrator revealed: -The Resident Meal Attendance Sheet was to be filled out at each meal by the LCM in the SCU.	D 270		

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D 270	Continued From page 14 -The walkway decreased to 2 feet wide along the sidewalk that lead to the front of the facility. -The walkway had a slight grade throughout. -There were 2 storm drains noted within the AL courtyard. -The walkway to the left of the facility measured approximately 50 feet from the curved sidewalk area to the front of the building. -The front of the facility contained areas for vehicle parking and a curved sidewalk that lead to the front door main entrance of the AL. -The main highway was approximately 100 feet away from the front of the facility. -There was a paved sidewalk throughout the perimeter of the building. -There was approximately 110 feet from the edge of the building to the front door main entrance of the AL. Observation on 9/23/15 at 5:05 pm to 5:10 pm of the main highway directly in front of the facility revealed: -From the front door exit of the facility to the sidewalk in front of the main highway was estimated 150 feet. -The facility parking lot was located in front of facility, which lead to the main highway. -The main highway was 4 lanes with a 3 story parking deck directly across the street from the entrance of the facility. -A shopping mall and multiple business building were located to the left of the facility front entrance on the opposite side of the street. -An intersection with a stop light was approximately 50 yards from the sidewalk near the street. -The posted speed limit was 35 miles per hour. -A bus stop was directly in front of the facility near the bottom entrance to the facility. -From 5:05 pm to 5:06 pm there were 58	D 270		

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D 270	Continued From page 16 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 observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision. The findings are: Based on observation, interview, and record review the facility failed to assure adequate supervision for residents in the special care unit when the main exit door was unlocked resulting in 2 of 5 sampled residents (Resident #1 and Resident #3) eloping from the Special Care Unit (SCU) and facility. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision. (Type A2 Violation)].	D912		

Sunrise Senior Living
Plan of Correction

Name of Community: Brighton Gardens of Charlotte
Address: 6000 Park South Drive, Charlotte, NC 28210
License number: HAL – 060- 019
Inspection date(s): September 22nd & September 23re 2015
Name and Title of Sunrise Representative Signing the Plan of Correction:
Amy Blalock, Executive Director
Signature of Sunrise Representative: Amy Blalock
Date of Submission: 10/28/15

Regulation	Target Date by Which Correction will be completed	Plan of Correction
10A NCAC 13F .0901 Personal Care and	09/11/2015	**A. With respect to the specific resident/situation cited:** Residents #1 and #3 experienced no negative outcomes as a result of exiting the special care unit.
Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	09/11/2015 09/12/2015, 09/13/2015, & 09/14/2015	Resident #1and Resident #3 returned to the special care unit and were provided hydration and nutrition. The Lead Care Manager completed a physical assessment with no injuries noted, skin intact and no signs or symptoms of any identified health concerns. Residents' #1 and #3 responsible party and physician were notified of the incident. The Wellness Nurse assessed both residents and completed follow up/assessments with Resident #1 and Resident #3 for 72 hours after the incident and noted residents were alert, no pain/discomfort voiced. Ambulatory to dining room for meals, attending group activities, smiling and pleasant spirits. Vital signs for both residents were within normal range. No additional reports of attempts to exit the special care unit were noted during the 72 hour period and there have been no exit seeking or elopement behaviors from Reminiscence since 09/11/2015.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	09/23/2015	The Executive Director reprogrammed the alarm system on the exit doors to the unsecured Assisted Living Neighborhood and both exit doors will alarm each time the door is opened alerting team members with an audible sound and via the pager system. Team members will respond appropriately and take action accordingly.
	09/30/2015	The Interdisciplinary Team reviewed residents who were/are at risk for potential exit seeking and/or elopement behaviors and ensured that their Individualized Service Plans (care plans or ISP's) included individualized strategies and interventions to address these behaviors.
	10/14/2015	Training was provided to clinical Coordinator's reviewing the following: assessments, behavior observations/interventions, personal care and supervision documentation with review of the Interdisciplinary review process.
	Initiated on 09/11/2015 and Completed 09/22/2015	The Executive Director contacted the IT department requesting program changes be made to the entrance/exit doors to the special care unit. A technician was on site on 09/22/2015 and took the necessary action to change the door function. The egress system was removed and the doors will not open unless code is entered into the key pad. The doors mag lock immediately reengages upon closing.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	09/30/2015 and Ongoing	In addition, as an ongoing means to identify residents with the potential for exit seeking or elopement behaviors, the Interdisciplinary Team meets two or three times a month to discuss residents who are at risk, and to initiate action and provide direction and guidance to team members regarding these residents. This meeting includes focused discussions regarding individual residents as needed. The discussion at Interdisciplinary Team meetings includes a review of daily communication, concerns and observations from the care manager from all shifts, Wellness Nurses, and observations gathered by the Care Coordinator; a review of any incidents that have occurred; a review of feedback and/or

Regulation	Target Date by Which Correction will be completed	Plan of Correction
		progress notes from medical, mental, and other health care professionals and partners; and concerns and suggestions from family members.
	Ongoing	The Resident Care Director is responsible for monitoring the Automated Care System to ensure all residents are reviewed, assessed and changes in current systems/condition are completed timely resulting in ongoing updated care plans addressing each residents needs.
	09/23/2015 and Ongoing	The Resident Meal Attendance form will be completed at each meal by the Lead Care Manager. The Reminiscence Coordinator will review the form daily for accuracy, address any concerns and/or issues and provide additional training to the front line team as necessary.
	09/11/2015 and Ongoing	Elopement/missing resident drills will be completed and documented on a monthly basis.
	09/30/2015	The Executive Director and Coordinator's provided elopement/missing resident re-training to all front line team members.
	9/30/2015	The Executive Director and Business Office Coordinator provided elopement/missing resident re-training to the Concierge Team. Training included the Concierge's responsibility and documentation needs related to obtaining beneficial information at the time of a resident's return into the community after an elopement.
	09/23/2015	Executive Director provided training to the 1st Shift Concierge and the Maintenance Assistant regarding the front door security. Doors are locked nightly at 7:30pm and unlocked by the Concierge upon arrival daily at 8am. The front entrance doors will not be unlocked until the Concierge is present and monitoring the door daily.
		D. With respect to how the plan of correction will be monitored:
	10/12/2015 and Ongoing	The Executive Director or designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur.

Regulation	Target Date by Which Correction will be completed	Plan of Correction
	Next QAPI Meeting is scheduled for 10/28/2015 and ongoing	The Executive Director or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at the monthly Quality Assurance/Performance improvement Meetings and action initiated if required.
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.	09/11/2015 09/11/2015 09/12/2015, 09/13/2015, & 09/14/2015	**A. With respect to the specific resident/situation cited:** Residents #1 and #3 experienced no negative outcomes as a result of exiting the special care unit. Resident #1and Resident #3 returned to the special care unit and was provided hydration and nutrition. The Lead Care Manager completed a physical assessment with no injuries noted, skin intact and no signs or symptoms of any identified health concerns. Residents' #1 and #3 responsible party and physician were notified of the incident. The Wellness Nurse assessed both residents and completed follow up/assessments with Resident #1 and Resident #3 for 72 hours after the incident and noted residents were alert, no pain/discomfort voiced. Ambulatory to dining room for meals, attending group activities, smiling and pleasant spirits. Vital signs for both residents were within normal range. No additional reports of attempts to exit the special care unit were noted during the 72 hour period and there have been no exit seeking or elopement behaviors from Reminiscence since 09/11/2015.

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		B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:
	09/23/2015	The Executive Director reprogrammed the alarm system on the exit doors to the unsecured Assisted Living Neighborhood and both exit doors will alarm each time the door is opened alerting team members with an audible sound and via the pager system. Team members will respond appropriately and take action accordingly.
	09/30/2015	The Interdisciplinary Team reviewed residents who were/are at risk for potential exit seeking and/or elopement behaviors and ensured that their Individualized Service Plans (care plans or ISP's) included individualized strategies and interventions to address these behaviors.
	10/14/2015	Training was provided to clinical Coordinator's reviewing the following: assessments, behavior observations/interventions, personal care and supervision documentation with review of the Interdisciplinary review process.
	Initiated on 09/11/2015 and completed 09/22/2015	The Executive Director contacted the IT department requesting program changes be made to the entrance/exit doors to the special care unit. A technician was on site on 09/22/2015 and took the necessary action to change the door function. The egress system was removed and the doors will not open unless code is entered into the key pad. The doors mag lock immediately reengages upon closing.
		C. With respect to what systemic measures have been put into place to address the stated concern:
	9/30/2015 & Ongoing	In addition, as an ongoing means to identify residents with the potential for exit seeking or elopement behaviors, the Interdisciplinary Team meets two or three times a month to discuss residents who are at risk, and to initiate action and provide direction and guidance to team members regarding these residents. This meeting includes focused discussions regarding individual residents as needed.

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		The discussion at Interdisciplinary Team meetings includes a review of daily communication, concerns and observations from the care manager from all shifts, Wellness Nurses, and observations gathered by the Care Coordinator; a review of any incidents that have occurred; a review of feedback and/or progress notes from medical, mental, and other health care professionals and partners; and concerns and suggestions from family members.
	Ongoing	The Resident Care Director is responsible for monitoring the Automated Care System to ensure all residents are reviewed, assessed and changes in current systems/condition are completed timely resulting in ongoing updated care plans addressing each residents needs.
	09/23/2015 and Ongoing	The Resident Meal Attendance form will be completed at each meal by the Lead Care Manager. The Reminiscence Coordinator will review the form daily for accuracy, address any concerns and/or issues and provide additional training to the front line team as necessary.
	09/11/2015 and Ongoing	Elopement/missing resident drills will be completed and documented on a monthly basis.
	09/30/2015	The Executive Director and Coordinator's provided elopement/missing resident re-training to all front line team members.
	09/30/2015	The Executive Director and Business Office Coordinator provided elopement/missing resident re-training to the Concierge Team. Training included the Concierge's responsibility and documentation needs related to obtaining beneficial information at the time of a resident's return into the community after an elopement.
	09/23/2015	Executive Director provided training to the 1st Shift Concierge and the Maintenance Assistant regarding the front door security. Doors are locked nightly at 7:30pm and unlocked by the Concierge upon arrival daily at 8am. The front entrance doors will not be unlocked until the Concierge is present and monitoring the door daily.

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		D. With respect to how the plan of correction will be monitored:
	10/12/2015 and Ongoing	The Executive Director or designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur.
	Next QAPI Meeting is scheduled for 10/28/2015 and Ongoing	The Executive Director or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at the monthly Quality Assurance/Performance improvement Meetings and action initiated if required.